BOARD MEETING

9am on Thursday 29th March 2018

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
9am on 29th March 2018
Board Room, University Hospital Llandough

AGENDA

Chair to give a brief introduction on "Time to Change" a mental health initiative and photo opportunity

STAFF STORY Kathryn Murray, Clinical Trials Pharmacist My Mental Health Journey – "Time to Change"		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	Oral
4	Minutes of the Board meeting of 25th January 2018	*Chair*
5	Action Log	Oral *Chair*
6	Chair's Report	*Chair*
7	Chief Executive's Report	*Chief Executive*
8	A Major Trauma Network for South and West Wales and South Powys - Report on Consultation with Supporting Documents: 1 - Initial Equality Impact Assessment 2 – Board Report January 2017 3 – Independent Panel Terms of Reference 4 – Independent Panel Agenda 5 – Independent Panel Report 6 – Board Report September 2017 7 – Consultation Plan 8 – Details of Public Meetings 9 – Consultation Mid Way Review 10 – Collaborative Executive Group Paper January 2018 11 – Numerical/Thematic Analysis of Consultation Response 12 – Consultation Responses Analysis Against Framework 13 – Post Consultation EQIA	*Medical Director*
9	Patient Safety Quality and Experience Report	*Executive Nurse Director*
10	Finance Report	*Director of Finance*
11	Performance Report	*Medical Director*

12	Integrated Medium Term Plan 2018/21 See separate document for whole IMTP	*Director of Planning*
13	Delivering our Strategy - Presentation	*Dr Anna* Kuczynska
14	Developing the Cardiff and Vale Way	*Chief Executive*
15	Wales Audit Office Annual Audit Report 2017	*Anne Beegan Wales Audit Office*
16	Audit of the Contractual Relationship with RKC Associates Limited and its Owner	*Director of Corporate Governance*
17	Well-being Plans for Cardiff and the Vale of Glamorgan	*Director of Public Health*
18	UHB Research and Development Implementation	*Medical Director*
19	Whitchurch Hospital – Disposal of Site	*Director of Planning*
20	Funded Nursing Care	*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		
21. 1 2 3 4 5 6 7 8 9 10 11 12	**Minutes from other Boards/Committees** Strategy and Engagement Committee – November Charitable Funds Committee – December Finance Committee – January x 2 Health and Safety Committee – January Resource and Delivery Committee – January Joint Meeting of Health Professionals' Forum and Stakeholder Reference Group – January Local Partnership Forum – February Quality, Safety and Experience Committee – February New Strategy and Delivery Committee - March WHSSC Joint Committee – September and November briefing Collaborative Leadership Forum – December Emergency Ambulance Services Committee – November and Chair's summary – January	 *J Antoniazzi* *A Hanuk* *J Union* *M Imperato* *C Janczewski* *P Martyn/S Bailey* *M Driscoll* *S Elsmore* *C Janczewski* *L Richards* *M Battle* *L Richards*
22	Agenda of the Private Board Meeting	*Chair*
23	To note the date of the next Board Meeting 31 May 2018 at 1pm	*Chair*
24	**Dates for 2018/19** Thursday 26th July (plus AGM), 27th September (and Trustees), 29th November, 31st January, 28th March	

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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.

4

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD HELD AT 1PM ON 25 JANUARY 2018 BOARD ROOM, UNIVERSITY HOSPITAL LLANDOUGH

Present:

Maria Battle	Chair
Abigail Harris	Director of Strategic Planning
Akmal Hanuk	Independent Member – Community
Charles Janczewski	Vice Chair
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Dr Graham Shortland	Medical Director
John Antoniazzi	Independent Member –Estates
John Union	Independent Member – Finance
Len Richards	Chief Executive
Martin Driscoll	Director of Workforce and OD
Michael Imperato	Independent Member - Legal
Robert Chadwick	Director of Finance
Ruth Walker	Executive Nurse Director
Sara Moseley	Independent Member – Third Sector
Dr Sharon Hopkins	Director of Public Health
Steve Curry	Chief Operating Officer
vacant	Independent Member – Trades Unions
Cllr Susan Elsmore	Independent Member – Local Authority
Paula Martyn	Associate Member – Chair, SRG

In Attendance:

Malcolm Latham	Cardiff and Vale of Glamorgan CHC
Peter Welsh	Director of Corporate Governance
Satyajeet Bhatia	Chair, Local Negotiating Committee

Secretariat Julia Harper

Apologies:

Eileen Brandreth	Independent Member – ICT
Prof Gary Baxter	Independent Member – Cardiff University
Lance Carver	Associate Member – Director of Social Services
Sue Bailey	Associate Member – Chair, HPF
Indu Deglurkar	Chair, SMSC
Stephen Allen	Chief Officer, Cardiff and Vale of Glamorgan CHC

UHB 18/001 PATIENT STORY

The UHB Chair, Miss Maria Battle, advised the Board that it had been decided to present the story at the next Board Development Day instead. The Executive Nurse Director advised the Board that the story would be about a mother's experiences, both positive and negative, following the birth of her baby with complex medical issues.

Action – Mrs Ruth Walker

UHB 18/002 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting of the Board.

UHB 18/003 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

UHB 18/004 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. Ms Paula Martyn declared an interest in item 9 – Joint Commissioning and Pooled Budgets for Older Peoples Services.

UHB 18/005 MINUTES OF THE BOARD MEETING HELD ON 30th NOVEMBER 2017

The Board **RECEIVED** and **APPROVED** the minutes of the meeting held on 30th November 2017.

UHB 18/006 ACTION LOG FOLLOWING THE LAST MEETING

The Board **RECEIVED** the Action Log from the November meeting and **NOTED** the following:

UHB 17/229 Fracture Service – Mr Curry reported that arrangements had been made to transfer the Fracture Service phone to the Directorate Office when clinic staff were unable to answer it. No further problems had been reported. Complete.
Transgender Service – This agenda was changing rapidly and an update would be brought to either the February or April Quality, Safety and Experience Committee.
Action – Dr Graham Shortland

UHB 17/128 Patient Experience and Quality – There may be a need to produce a Memorandum of Understanding with Cardiff University and this would be known after the next meeting.

UHB 16/218 SOs and SFIs – As the action was outside UHB control, it was decided to close this from the Board Action Log.

UHB 17/184 Chief Executive's Report – It was noted that format and presentation of Board reports would be considered in detail at the February Board Development Day.

UHB 18/007 CHAIR'S REPORT

The Board **RECEIVED** the written report of the Chair. The Board:

- **NOTED** the report.
- **RATIFIED** the Chair's action.
- **ENDORSED** the affixing of the Common Seal.

UHB 18/008 CHIEF EXECUTIVE'S REPORT

The Board **RECEIVED** the written report of the Chief Executive. The following areas were expanded:

1. **Targeted Intervention –** The Chief Executive reported that conversations had started with Welsh Government on the Integrated Medium Term Plan (IMTP) and the UHB's financial position. Welsh Government expected further improvement and wanted to explore UHB assumptions. However, the financial progress already made was recognized.

2. **Thoracic Surgery Services in South Wales –** The Independent Panel had met but their decision had not yet been communicated.

The Board **NOTED** the report of the Chief Executive. The Board agreed that the written report format was preferred.

UHB 18/009 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Executive Nurse Director, Mrs Ruth Walker, answered the questions raised by Independent Members at the Chair's Governance Group. This covered the number of patient falls in St. David's Hospital, confidentiality breaches through computer sharing, the response times to concerns particularly the hotspot in surgery, concerns about ophthalmology services, a "never" event in Dental and the number of unexpected deaths of patients known to the drug and alcohol services.

Mrs Walker advised Board that Health Inspectorate Wales had undertaken 3 inspections; Daffodil Ward, Mental Health Act and The Links Centre. Feedback had been very positive. In addition, she advised that WHSSC would be undertaking an inspection of Paediatric Surgery following the issues raised in the last year.

The Chair invited further comments:

- Members were invited to challenge any breaches of confidentiality during the patient safety Walkrounds.
- The Quality, Safety and Experience Committee would be monitoring and driving improvements in ophthalmology waiting times.

- Some patients in the drug and alcohol service chose not to engage with health services.
- Under "Putting Things Right" patients were advised of their right to compensation.
- The wider austerity agenda was impacting on the ability of staff to care properly for patients for example issues of homelessness.
- The greater involvement of the Citizens Advice Service within the UHB was welcomed.
- Members were referred to the Substance Misuse Area Planning Board Annual Report for 2016/17 for further information on the drug misuse agenda (this was received at the Board on 28th September 2017).
- Nurse recruitment was currently 91% against the target of 95%. Mr Bhatia suggested that advantage be taken of combining nurse recruitment with overseas doctor recruitment.
- In terms of the impact of the Brexit decision, it was noted that interest from European nurses had fallen and anxiety remained amongst those already in the country. Overall, the national position was that more nurses were leaving the profession.

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 where available.
- 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 18/010 CARDIFF AND VALE OF GLAMORGAN JOINT COMMISSIONING AND POOLED BUDGETS FOR OLDER PEOPLES SERVICES

The Director of Planning, Ms Abigail Harris introduced the work underpinning the report and set out the importance of joint commissioning. Given the profile of the work, strong scrutiny was expected from Welsh Government.

Cllr Elsmore advised that the UHB would be the first organization to sign up to these joint arrangements and this would support the drive to the highest quality of care and she asked for the Board's thanks to be passed to Rachel Jones for leading this work.

It was confirmed that Third Sector would be fully involved in the agenda through the Regional Partnership Board and as part of the engagement framework.

ASSURANCE was provided by:

- The commissioning intentions were developed in a workshop facilitated by the Institute of Public Care to ensure alignment with Cardiff and Vale UHB, Cardiff Council and Vale of Glamorgan Councils' commissioning strategies and organisational priorities.
- The Market Position Statement and Commissioning Strategy had been subject to a stakeholder workshop on 5th July 2017 across statutory partners, third sector, providers and Registered Social Landlords.
- The Market Position Statement and Commissioning Strategy was considered and approved by the Regional Partnership Board on 13th November 2017.
- The proposed approach in relation to joint commissioning and the establishment of a pooled budget for older people care accommodation had been developed by a joint project board with Cardiff Council and Vale of Glamorgan Council and the same report was due to be approved by all three partners in January 2018.

The Board **APPROVED** the following recommendations:

- Noted the progress regarding meeting the Part 9 requirements which included the establishment of a pooled budget for care accommodation.
- Approved the establishment of a pooled budget for older people care accommodation from 1st April 2018, with Cardiff Council to act as the host organisation in 2018/19.
- Delegated authorisation of the Partnership Agreement in relation to the pooled budget to the Chief Executive.
- Approved the Market Position Statement and Commissioning Strategy for Older People Care and Support Services as set out in **Appendix 1.** http://www.cvihsc.co.uk/wp-content/uploads/2017/12/MPS_English-051217-Final.pdf

UHB 18/011 CARDIFF AND VALE OF GLAMORGAN AREA PLAN FOR CARE AND SUPPORT NEEDS

The Director of Planning, Ms Abigail Harris reiterated that the core component of the Plan was pooled budgets. Health and care needs assessments had been undertaken with Pubic Health and the Local Authorities and the work had been overseen by the Regional Partnership Board. The Board's attention was drawn to the links to the detailed work and action plan within the report. A particular theme throughout the work was social isolation and loneliness as it was known that this had a huge negative impact on health.

ASSURANCE was provided by:

- The Chair, Vice Chair, Chief Executive and Director of Planning were members of the RPB which had overseen the development of the Plan.
- A Partnership Steering Group informed the development of the Area Plan and included representatives from the UHB.
- The Steering Group also worked with representatives of the Public Service Boards to ensure alignment with the development of the Well-being Plans in Cardiff and Vale of Glamorgan.

The Board:

- **NOTED** the Cardiff and Vale of Glamorgan Area Plan and Action Plan for Care and Support Needs (as set out in **Appendix 1** and **Appendix 2**), subject to final approval at the meeting of the Regional Partnership Board on 1st February 2018.
- **AGREED** for the Chair to action the sign off of the final version of the plan at the RPB on 1st February 2018.

UHB 18/012 FINANCE REPORT

The Director of Finance, Mr Robert Chadwick advised that the report had been presented to the Finance Committee the previous day for detailed consideration. He commented that the UHB was £1m ahead of its target this month as the issue of NCO drugs had abated and other risks were being managed.

It was anticipated that the year-end position may improve between £2m and £4m and it was hoped that Welsh Government may give this back to the UHB next year (anything below a £30.9m deficit would be returned).

The Chair welcomed the improvement and congratulated colleagues on the savings that had been achieved so far.

LIMITED ASSURANCE was provided by:

- The work undertaken to develop the 2017/18 operational plan;
- The scrutiny of financial performance undertaken by the Finance Committee;
- The month 9 position which was £0.998m less than the profiled deficit within the financial plan;
- The identification of a full £35m savings programme.

The Board:

- **NOTED** that the UHB had an one year operational plan that had a planned deficit of £30.900m for the year;
- **NOTED** the £22.177m deficit at month 9 which included a planning deficit of £23.175m and budget underspends of (£0.998m);
- **NOTED** that the UHB now had a savings plan that was fully identified;
- **NOTED** the key risks that were outside the current expenditure projection that needed to be managed.

UHB 18/013 INTEGRATED MEDIUM TERM PLAN 2018-2021

The Director of Planning, Ms Abigail Harris reminded Board that commissioning intentions and key priorities and deliverables had been previously agreed. Stakeholders including the Community Health Council had been engaged and had provided comments on the Plan. The full report was still work in progress and for that reason it would be considered in the private Board meeting, however the intention was to produce a "plan on a page" when it was approved for widespread circulation.

There was still a challenge to balance finance and workforce to the Plan but it would be submitted to Welsh Government for comment.

ASSURANCE on the development of the UHB 2018/21 Integrated Medium Term Plan (IMTP) was provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process and planning liaison meeting.
- Compliance with the 2018/19 NHS Wales Planning Framework timeframes and requirements.

The Board **RECEIVED** an oral update on the development of the draft IMTP.

UHB 18/014 PERFORMANCE REPORT

The Director of Public Health, Dr Sharon Hopkins described the evolution of the report to its current format and offered to work with the Board on what type of report they wanted in the future . However, the level of compliance to the various targets was currently not acceptable.

The Chair invited further questions and comments:

- RTT targets had been met for the twelfth quarter.
- Improvements had been made in the cancer service.
- Mental Health performance had improved as the new pathway was managing demand differently, although the rise in demand was an acknowledged risk.
- Every 12 hour wait was being investigated through a root cause analysis from a patient safety and experience view.
- Compliance with risk assessments for pressure ulcers was not formally audited but investigations demonstrated they were being completed. However, whilst the UHB had the right mattresses to minimise pressure damage, emergency trolleys did not and this posed a risk when patients remained on them for long periods. In addition, the UHB reported all pressure damage and many cases were not acquired in hospital.
- Delayed Transfer of Care was in the best position of the last 3 years.

- There had been a 64% uptake by staff of the 'flu vaccine and the UHB was leading the way.

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 21 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.
- **AGREED** to consider at the Board Development Day what information the Board should be asked to scrutinize and how general performance information should be received by Members in the future.
  Action – Mr Peter Welsh

UHB 18/015 CORPORATE RISK AND ASSURANCE FRAMEWORK UPDATE

The Director of Corporate Governance, Mr Peter Welsh reported that the new-look risk register would go live in April and would be tied into the UHB strategic objectives. Wales Audit Office had concurred that this approach was considered best practise.

ASSURANCE was provided by:

- Assignment of risks to a Lead Executive and Committee.
- The CRAF was a standing agenda item at Board and its Committees.
- The review of the CRAF that was currently taking place recognised that this area could be strengthened to provide better assurance and was aimed at achieving this.

The Board **NOTED** this progress update.

PART 2 – ITEMS FOR INFORMATION ONLY

UHB 18/016 MINUTES FROM OTHER BOARDS / COMMITTEES

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

1. **Audit Committee** December
2. **Finance Committee** October and November
3. **Health and Safety Committee** October
4. **Resource and Delivery Committee** November
5. **Mental Health and Capacity Legislation Committee** November

6. **Joint Meeting of Health Professionals' Forum and Stakeholder Reference Group** November
7. **Organ Donation Committee** November
8. **Quality Safety and Experience Committee** December
9. **Emergency Ambulance Services Committee** September and November Summary
10. **Shared Services Partnership** November

The minutes were **NOTED.**

UHB 18/017 AGENDA OF THE PRIVATE BOARD MEETING

In terms of openness, the agenda for the Private meeting was published and **NOTED.**

UHB 18/018 REVIEW OF THE MEETING

There was nothing further to add to the meeting.

UHB 18/019 DATE OF THE NEXT BOARD MEETING

The next meeting would be held at 1pm on 29th March 2018 in the Board Room, University Hospital Llandough.

UPDATED BOARD ACTION LOG FROM JANUARY 2018

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
UHB 17/052 UHB 17/226	30.3.17 30.11.17	Patient Safety, Quality and Experience	Explore improvements in out of hours emergency CAMHS inpatient treatment through WHSSC. To consider with the Chief Executive, referral to WHSSC Joint Committee to stimulate debate.	Dr S Hopkins	Discussion taken place. Tier 4 service does not take OOH referrals. Crisis team which operates 9am to 9pm 7 days a week has been offering a restricted service but will be up to full service again in February. The OOH responsiveness will be kept under review.
UHB 17/089 UHB17/182 UHB 18/006	25.5.17 28.9.17 25.1.18		Share with Mr Hanuk UHB's use of foreign languages and opportunity to work with Cardiff University Business School.	R Walker A Harris Dr G Shortland	The need for a Memorandum of Understanding would be known after the next meeting. Mrs Harris and Dr Shortland meet regularly with the University and are working on an agreement for the work programme and joint priorities for the next year. The next meeting with the University is 1st August 2018.
UHB 17/144 UHB 17/182	27.7.17 28.9.17	IMTP Development Process	Full integration of finance and workforce plans to be given more consideration as to how this could be achieved.	L Richards	This was being considered as part of the IMTP and was ongoing.
ACTIONS TO BE BROUGHT FORWARD ON ANOTHER AGENDA					
UHB 17/066	30.3.17	Health and Safety	Produce Estate rationalization plan for discussion at Board meeting.	A Harris	Board agreed to receive the comprehensive Estates Plan

5

		Committee			in **Spring 2018.** Not raised as planned at S&D Committee on 13th March. **Proposed date for Plan to be received at Board or position statement is awaited.**
UHB 17/185	28.9.17	Patient Safety, Quality and Experience Report	QSE to give consideration of ways of addressing big rise in community infection and falls prevention.	R Walker	**Quality, Safety and Experience Committee** Falls on April agenda
UHB 18/014	25.1.18	Performance Report	Agree what information should be shared and what information should be scrutinized at Board. Schedule for consideration at February Board Development Day.	P Welsh	Discussed in February and further consideration to be given in April. To be reported to May Board and referred to in Chair's March report. **Board Development Day April 2018 and Report to May Board**
UHB 17/233	30.11.17	HTA Report	Outcome of root cause analysis and lessons learned to be brought back to Board.	S Curry	Independent Review commencing February. **Board in April 2018. Deferred to June.**
ACTIONS COMPLETED SINCE LAST MEETING					
UHB 17/229 UHB 18/006	30.11.17 25.1.18	Patient Safety Quality & Experience	Update Board on Fracture Services	S Curry	Telephone arrangements improved. **Complete**
UHB 15/122 UHB16/218 UHB 18/006	5.5.15 24.11.16 25.1.18	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 **2017/18.** As outside UHB control it was decided to **CLOSE** the action.
UHB 17/229 UHB 18/006	30.11.17 25.1.18	Patient Safety Quality & Experience	Update Board on Transgender Service	G Shortland	Report received at Private **QSE in February. Complete**

5

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	Lifts have been investigated and there is nothing further to add. A major lift refurbishment is being considered which will require Welsh Government funding – this will be added to the **S&D Committee. Complete**
UHB 17/141 UHB 17/182	27.7.17 28.9.17	Patient Safety Solutions, Alerts and Notices	Fully cost and discuss again with Management Executive, the funding of patient identification solutions.	R Walker	QSE told that from April 2018, funding had been allocated for an electronic system. **Complete**
UHB 17/184 UHB 18/006	28.9.17 25.1.18	Chief Executive's Report	Review format and presentation of Board reports including Members' views.	L Richards	**February Board Development Day Complete**
UHB 17/065	30.3.17	WHSSC	Discuss system rules separately.	M Battle	Discussions ongoing in many different fora. **CLOSED 15.3.18**
UHB 17/143	27.7.17	Performance Report	Appoint Champion for Hand Hygiene and Bare Below Elbow.	M Battle	Under review due to changes in Board Membership. Miss M Battle will take on this role. **COMPLETE**
UHB 17/239	30.11.17	LPF Minutes – Dementia Strategy	Discuss implications for people who could not engage themselves and only had support from friends.	M Battle	Meetings ongoing with all key people by Chair and Executive Director of Nursing **CLOSED 15.3.18**
UHB 18/001	25.1.18	Patient Story	Present the Mother's story that was deferred, at a Board Development Day.	R Walker	**Board Development Day – February 2018** As we were unable to shorten this story, it will not be used for Board and will be utilized elsewhere. **CLOSED**

5

CHAIR'S REPORT TO THE BOARD	
Name of Meeting: Board Meeting	**Date of Meeting:** 29 March 2018

Executive Lead: N/A
Author: Director of Corporate Governance Tel 029 2074 4230
Caring for People, Keeping People Well: The report aligns where appropriate with the Strategy and Strategic Objectives of the Health Board.
Financial impact: N/A
Quality, Safety, Patient Experience impact: N/A
Health and Care Standard Number: N/A
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

6

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Board is asked to:

- **NOTE** the report
- **RATIFY** the Chair's Action
- **ENDORSE** the affixing of the Common Seal

SITUATION

At each public Board meeting, the Chair presents a report on key issues to be brought to the attention of the Board since its last meeting. This written report provides an update on relevant matters, outlining where the Chair has been required to affix the Common Seal of the Health Board and, where appropriate, Chair's Action has been taken in line with Standing Orders which requires ratification of the Board.

BACKGROUND

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

ASSESSMENT AND ASSURANCE

1. **Thank you to staff – Adverse Weather**

   At the beginning of March we experienced extreme adverse weather conditions for several days. On behalf of the Board, we would like to thank all those staff who made considerable efforts to get to work. This showed the NHS working as a team, both clinical and non-clinical staff, to ensure we continued to deliver our services. Also a thank you from the Health Board to our amazing communities and partners, who have inundated us with offers of support in getting people to work and accommodating them next to two of Wales biggest hospitals, University Hospital Wales and University Hospital Llandough

2. **Staff Recognition Awards**

   On the 9th March 2018, the Annual Staff Recognition Awards took place. As in previous years, this event "showcased" the excellent work of individuals and teams and their total commitment to providing the highest standard of quality care to patients.

3. **South East and Central Planning Forum**

   The third meeting of the above Forum was held on the 13thFebruary. The meeting focused on further collaborations between Health Boards on the delivery of clinical services. These include:

   - Paediatrics, Obstetrics and Gynaecology
   - Ear, Nose and Throat
   - Vascular Surgery
   - Diagnostics
   - Ophthalmology
   - Orthopaedics

   A further meeting of the Forum will be held on 11th April 2018.

4. **Strategy and Delivery Committee**

   Following detailed discussions, the Strategy and Engagement and Resource and Delivery Committees have been replaced with the above. The first meeting of the Committee was held on the 13th March, at which the proposed Terms of Reference were discussed. A final version is being prepared and will be brought to the next meeting for Board endorsement.

5. **Board Development Day – 22nd February 2018**

   The above development day was held to discuss how the Board and its Committees could work more efficiently and effectively. The outcomes of the day included:

- The Board Meeting held in public will focus on the Strategy of the Health Board and its Committees will further focus on scrutiny and assurances.
- A baseline review of our Strategy and its trajectory will be undertaken.
- Review of contents and presentation of Board and Committee papers
- Improving the use of Clinical data / Performance management and its presentation
- Further work on our values, cultures and behaviour

A further discussion will be held at the Board Development Day on 27th April. A full report will then be brought to the Board Meeting on the 25th May 2018.

6. Significant Diary Commitments/ Meetings attended since the last Board Meeting

- 31/1/18 – Huw Irranca-Davies – Visit to Llanishen Independent Living Centre
- 6/2/18 – Hosted Chris Wood – Medical Director for Inter Mountain Health Care in Utah (he was in Cardiff for the NHS Confed18 Conference)
- 15/2/18 - National Pensioners Convention – Engagement session
- 27/2/18 - Grangetown Wellbeing in Action Meeting – Engagement session
- 28/2/18 - Unicef Training – Child Friendly Cities – Cardiff has been chosen as one of the first cities in the UK to work with Unicef towards becoming a Child Friendly City
- 3rd and 4/3/18 – Visits to UHW and UHL with CEO and Medical Director to thank staff for the efforts made by our staff, some walking for miles to get to their place of work, some sleeping on site and others making personal arrangements with children and elderly parents to still come in and care for their patients
- 9/3/18 - Staff Recognition Awards
- 13/3/18 – Chair's visit to Rookwood to thank the artists and patients for their work in celebrating 100 years anniversary
- 19/3/18 – Chair's meeting with Cabinet Secretary
- 21/3/18 – Heath Dystonia Support Group
- 22/3/18 – Easter Concert UHL
- 22/3/18 - Signing of the Motor Neurone Disease Charter with Cardiff County Council
- 28/3/18 – Single Cancer Pathway Workshop

7. Affixing the Common Seal / Chair's Action and other signed documents.

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

a) 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
832	Renewal Lease. Regional Land Holdings Ltd. & Cardiff and Vale UHB
833	Car parking Lease. Cardiff and Vale UHB & Velindre NHS Trust. (Land at Whitchurch Hospital)
834	Licence to carry out works. Cardiff and Vale UHB & City Eyecare Ltd.

b) Chair's Action / Contracts

16/01/2018 – Cochlear Implants

23/01/2018 – Roof Refurbishment/Demolition/Construction works affected by window replacement

23/01/2018 – CRI Safeguarding to address deterioration of building & asbestos removal.

31/01/2018 – Supply of WiFi hardware and software.

14/02/2018 – F4 Interventional Suite Replacement

14/02/2018 – Surveys of Ventilation

c) Other signed legal documents

25/01/2018 – Services Agreement Cardiff and Vale UHB, Genomics England Ltd & Cardiff University to participate in the 100,000 Genomes Project and associated Data Sharing Agreement Cardiff and Vale UHB & Genomics England Ltd

30/01/2018 – Delivery Agreement Part A. CRI Bld, Open Plan Office – CFMS0107

30/01/2018 – Delivery Agreement Part A. UHW Theatre 10 Refurbishment – CFMS0108

19/02/2018 – The Maggie Keswick Jencks Cancer Caring Centres Trust. Licence to Occupy site compound within the grounds of Whitchurch Hospital

20/02/2018 – Short Contract. Renal Dialysis Unit, Pelican Ward No: CP040

20/02/2018 – Short Contract. Refurbishment of Ground Floor Treasury Building, Lansdowne. No:DC17058

22/02/2018 – Deed of Novation. Cardiff and Vale UHB, Kier Construction Limited & Hoare Lea LLP

22/02/2018 – Deed of Novation. Cardiff and Vale UHB, Kier Construction Limited & IBI Group UK Limited

22/02/2018 – Deed of Novation. Cardiff and Vale UHB, Kier Construction Limited & WSP UK Limited

22/02/2018 – Deed of Novation. Cardiff and Vale UHB, Kier Construction, WSP (Deed of Warranty in relation to Neonatal Unit)

22/02/2018 – Delivery Agreement Part A. CRI Safeguarding (construction phase) – CFMS0097

28/02/2018 – Bathroom Ward Upgrade B4

CHIEF EXECUTIVE'S REPORT	
Name of Meeting: Board Meeting	**Date of Meeting:** 29 March 2018

Executive Lead: Chief Executive
Author: Director of Corporate Governance 029 2074 4230
Caring for People, Keeping People Well: The report aligns with the Health Board's strategy and strategic objectives.
Financial impact: There are no direct resource implications
Quality, Safety, Patient Experience impact: Ensures the Board makes fully informed decisions.
Health and Care Standard Number: Governance & Accountability and relevant to the 7 Quality Themes
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

7

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Executive Team has contributed to the development of information contained in this report

The Board is asked to:

- **NOTE** the report.

SITUATION

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

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

BACKGROUND

This is the second written report being presented and, where appropriate, has been informed by updates provided by members of the Executive Team. This report will continue to be developed, focusing on our Strategy and related objectives and specifically on providing strong governance and assurance.

ASSESSMENT AND ASSURANCE

The following matters are brought to the attention of Board Members:

1. **Board Strategy "Shaping Our Future Wellbeing"**

   The Board's over-arching role is to ensure its Strategy "Shaping for Future Wellbeing" is delivered and the related organisational strategic objectives align with the Integrated Medium Term Plan (IMTP).
   As mentioned in the Chairs report, the importance of the role of the Board on monitoring the implementation of the Strategy was discussed at the Board Development Day held on the 22nd February. I will be leading a baseline review on where we are with the Strategy and what we need to do to make further progress and agreed timelines.
   The Board will also be focusing on this and how it is delivered through the IMTP. The Board will continue to be informed on this work at future meetings.

2. **Corporate Risk Assurance Framework**

   A new template for analyzing and reporting on our corporate risks has been developed. This template is aligned to the UHB strategic objectives and was used to report to the February Audit Committee. Planned workshops with Corporate Departments and Clinical Boards will work through their risk registers with a view to launching the proposed new system, and defining the organization's Risk Appetite Statement, at the April Board Development Day.

3. **Targeted Intervention**

   The next meeting with Welsh Government is to be held on 28th March 2018 and a verbal update will be provided at the Board meeting.

4. **Thank you to staff - Adverse Weather**

   Like the Chair, I wish to thank all staff for their commitment in ensuring we continued to operate as normally as possible during the unprecedented conditions experienced earlier this month, and acknowledge the heart-warming community response. Many staff walked long distances to work and stayed overnight in on site accommodation to ensure they were available to care for our patients. Many volunteer drivers also came forward to help transport our staff to and from work.

   We worked incredibly hard to ensure as little disruption as possible in emergency treatment, clinical appointments, feeding our patients and staff and gritting our sites. Whilst we did have to cancel a high number of planned appointments and treatments due to the adverse weather, we have since taken a range of remedial actions to recover the position. These will continue between now and over the Easter weekend.

5. Winter Pressures

In keeping with health services across the UK, Cardiff and Vale winter pressures have been particularly challenging this year. Despite the Health Board leading on the development of an Integrated Winter Plan, through working with its system partners in WAST, local authorities and the voluntary sector, our urgent and emergency care system has experienced prolonged difficulties. Characteristically, our staff have risen to this challenge – particularly in the face of a number of exceptional circumstances.

Increased emergency admissions between Christmas and New Year and again throughout the month of February, along with two periods of severe weather conditions has made normal winter pressures even more challenging. In addition to this, significant levels of flu and other infective conditions has resulted in an increased demand in the older, frail and more acutely ill patient groups. These pressures have been apparent across the system - from high demand at GP practices right through to significant over-occupancy in our critical care services.

Although this has had a detrimental effect on the Health Board's unscheduled care performance, we have been supporting our frontline teams while they remain focussed on key indicators which reflect patient quality, experience and outcome.

Throughout this period, our staff have been remarkably resilient. Every part of our system has been affected and whether it is in GP and community services or secondary care teams and support services, the commitment and professionalism of our staff has remained constant. This was most apparent during the period of heavy snow in February, when individuals in every part of our system went beyond the call of duty to maintain services and keep patients safe and cared for. I have acknowledged this separately but remain extremely proud to be part of such a dedicated team.

6. Emergency Department Review

As part of on-going discussions in follow up to the last Emergency Department review within the Health Board, I have continued to meet with key staff members to respond to concerns and, in doing so, have acknowledged areas within the review that could have progressed in a different way. I will continue to work with these teams to ensure issues are addressed, as part of fostering a culture of individual respect and collective support for frontline teams.

7. Clinical Service Plan

In support of progressing our Strategy further work has commenced on a Clinical Services Plan in relation to UHW and UHL and the long term role for each hospital, working towards a consensus on the clinical

services model across the two sites. A workshop was held to discuss this on 15th March 2018 which included the Executive Team and Clinical Board Directors.

The outcome of the workshop was a high level understanding of the make-up of each site which demonstrated some critical areas of consensus around the future development of the Llandough site in terms of scheduled elective care, specialised rehabilitation, building on the CAVOC model and also the existing plans for Rookwood Hospital. There was also a high degree of consensus about UHW developing as the Critical Care high acuity site.

There is modelling work to do as a result of the workshop and we will be reconvening in late April/early May to discuss the implications of that modelling work.

A further report will be contained in my report at the May Board.

8. Major Trauma Centre

Members have already been advised on the proposals associated with the development of Major Trauma Networks and a Major Trauma Centre for Mid and South Wales. Consultation closed on 5th February 2018.

Following consultation, Health Boards will be asked to consider the related recommendations at the Board Meeting in March 2018 and a separate report will be circulated to Members.

9. Outline Business Case for the new Velindre Cancer Centre

Velindre NHS Trust, with approval from Welsh Government, is leading a Transforming Cancer Services (TCS) in South East Wales programme. The first phase of this includes the redevelopment of a new Velindre Cancer Centre to address the significant challenges presented by the existing Velindre Hospital estate. Velindre NHS Trust has worked with Commissioners (Health Boards) and Welsh Government colleagues through Collaborative and Financial Scrutiny processes to develop an Outline Business Case 2018 for a new Velindre Cancer Centre (OBC 2018 for nVCC), which has been assessed for reasonableness in relation to building size and projected additional costs.

Velindre NHS Trust issued the OBC 2018 for nVCC and Executive Summary following approval at its Board meeting in January 2018 and is now seeking formal approval from Commissioners and Welsh Government. Due to commercial sensitivity the Board will consider the OBC 2018 for nVCC in its private session.

10. Bridgend Local Government changes and Implications for Health Board boundaries

The Cabinet Secretary for Local Government has recently consulted on proposals to re-align Health Board boundaries of the Bridgend catchment population with Cwm Taf. The closing date for comments was the 7th March 2018.

The Management Executive discussed our response at their meeting held on the 5th March and agreed to submit support to re-align the Bridgend Local authority boundary within the footprint of the Cwm Taf Health Board area. However it was noted that the change in boundary may introduce a different dynamic for the flow of specialist patients. This potential will be picked up in our planning meetings with ABMU as any changes in the flow of specialist patients could have an adverse impact on both Cardiff and Vale and ABMU.

11. Tertiary Services Provider

Attached at the end of this report is a proposal to establish a Tertiary Services Provider Partnership Board between ABMU and Cardiff and Vale. The proposal has emerged from discussions between the senior leadership teams in both organisations. The purpose of the Partnership approach is to recognise the status of Morriston Hospital and UHW as tertiary centres within South Wales, and to energise the clinical staff across both organisations to develop clinical models that will be sustainable into the long term.

12. Single Cancer Pathway

Health Boards have recently received a report regarding progress on the Implementation of the Single Cancer Pathway across Wales. A workshop was held on 28th March 2018 to review progress and next steps.

This report was received at the Management Executive meeting on the 5th March and up-dates were received on progressing this All Wales plan within the Health Board.

The implementation date is April 2019 and the Management Executive will continue to monitor progress.

13. Car Parking Management Contract

A competitive tender process for the management of car parking commenced in May 2017. The tender process covers all of the larger sites within the Cardiff and Vale UHB estate. During the first stage six suppliers expressed an interest and responded to a pre-qualification questionnaire. The procurement process has been managed as a competitive dialogue allowing the UHB's representatives to develop a

suitable solution with the shortlisted suppliers. A technical evaluation team including staff side representation was formed to assess the proposed solution with the shortlisted suppliers. The competitive dialogue process has allowed the UHB to assess the proposed solutions from suppliers to understand how they would align with the objectives and values of the UHB. This included the shortlisted suppliers presenting an outline of their proposals to an executive advisory group.

The shortlisted suppliers will submit their final tenders in March. The tenders will be evaluated to identify the winning bidder. Any recommendation will then be ratified by the Board. The new contract is due to commence on the 5th June 2018 on the UHW site and 1st November 2018 for all other sites.

14. Annual Report and Accounts for 2017-18

For 2017-18 the Accountability Report and Financial Statements are to be submitted by 1st June 2018 with a final unified version of the Annual Report and Accounts due by 31st July 2018.

A timetable has been produced providing for sign off of the Accountability Report and Financial Statements at May Board and Audit Committee and the unified Annual Report and Accounts at the AGM and Board on 26th July 2018.

15. Car Parking Management Process

A competitive tender process for the management of car parking commenced in May 2017. The procurement was managed under the OJEU competitive dialogue process and following the evaluation of the final tenders, a preferred supplier has now been identified for consideration by the UHB. The preferred supplier cannot be announced until the relevant suppliers have been notified of the outcome and a 10 day 'standstill' period has elapsed. This period affords relevant parties the opportunities to challenge the process should they deem it appropriate.

The programme for implementation of the new car parking management arrangements remains on course for commencement on 5th June 2018.'

Tertiary Services Provision in South Wales
Proposals for a partnership between ABM UHB and Cardiff and Vale UHB

Situation

South Wales has two main tertiary and regional provider units which are primarily based at Morriston Hospital in Swansea provided by ABMU Health Board, and at UHW in Cardiff provided by Cardiff and Vale UHB.

These specialist services are commissioned for the South Wales population by the Welsh Health Specialist Services Commission (WHSSC) on behalf of all health boards. There is no overarching strategic plan for the development of tertiary services in South Wales, although WHSSC is developing its longer term commissioning intentions. These and other, more regional services, have traditionally developed on a service-by-service basis, often in response to the fragility of the service, the availability of a new service or procedure, or evolving clinical expertise and specialisation.

Both health boards providing these services in South Wales recognise that there is merit in developing a partnership approach to planning the delivery of regional and tertiary services, so that a longer term plan can be developed for services to ensure that they remain sustainable, provide the best outcomes for patients and provide the best value for money.

Background

The two main regional and tertiary services units have developed services over the last decade in response to a number of factors including local clinical expertise driving services forward, WHSSC commissioning intentions and service sustainability issues.

However, it is also clear that due to a number of factors to include specialisation, workforce considerations and emerging standards of service, some of these services are fragile and at times become unviable. To date changes to these services have followed a Commissioning model, and at times it has felt that the two tertiary centres have been pitched into a competitive environment meaning that the outcome often describes a “win-lose.” This is not conducive to effective implementation or indeed to developing the requisite working relationship to enable to two tertiary centres to work together to provide services to the South Wales population.

Assessment

In order to be sustainable, the regional and tertiary services provided in South Wales must be able to meet nationally agreed service standards so that the best outcomes are achieved for patients (measured by comparison with national benchmarking data for similar centres in and across the UK and internationally). In recent years, a number of tertiary services have been reviewed and changes have been made to the way services are provided: neurosurgery services were provided from both centres in South Wales and these have been consolidated on

the UHW site; ABM provides fertility services for South Wales, delivering the service from Neath Port Talbot and UHW (a "bicycle" model); thoracic services have been the subject of an engagement exercise which considered expert clinical views about how best the service should be delivered to improve patient outcomes and secure long term service sustainability (in particular for lung cancer). The outcome of this was the recommendation that thoracic surgery services should be provided from Morriston Hospital, and the two Health Boards are developing a joint implementation plan to support this.
Both health boards are currently reviewing their clinical services to include regional and tertiary services, and it is agreed that there is merit in forming a working partnership between the two organisations to review tertiary services together, to agree how services can be provided across the two centres in South Wales to ensure the best patient outcomes and the best value for money. It is important to state that there is mutual agreement between the two Chief Executives that any work carried out in this area should be done with the intention of maintaining the two Tertiary Centres, and at the same time strengthening the services that are offered. This partnership would be a provider forum . Such an approach should enable both organisations to reach a shared view about how services should develop over the next decade. This would then need to be considered as part of the formal commissioning processes, and any changes to the current pattern of service delivery would be the subject to agreed engagement and consultation processes.

Recommendation
To support the establishment of a regional and tertiary services provider partnership to undertake a joint, high-level review of such services across South Wales with a view to identifying a shared view about how services should develop over the future, and to identify the priority areas where a collaborative approach will address current service risks associated with services sustainability. It is suggested that the partnership meetings would be attended by the CEOs, Directors of Strategy/Planning, Chief Operating Officers and Medical Directors in the first instance. Other directors, service, clinical and operational leaders would be invited to attend the partnership meetings as and when needed, and six monthly joint executive team meetings might also be helpful to share progress of the partnership working. WHSSC could be invited to be an observer on the Partnership where appropriate.
Agreement would need to be granted by the Boards of both organisations.

Attached is a draft terms of reference of the partnership group.

Tertiary Services Provider Partnership – ABM and Cardiff and Vale UHBs
Terms of Reference

1. **Purpose**

   The Regional and Tertiary Services Provider Partnership between ABM and Cardiff and Vale UHBs has been established to provide a forum for the two organisations to develop a shared view about how best to deliver sustainable services across the two tertiary centres in South Wales in the future. This is not about replacing the commissioning process for services, rather, ensuring collaborative relationships between the two providers to deliver the best quality and outcomes of care possible to patients.

2. **Scope**

   In order to inform the work programme, a high-level review of the current provision of regional and tertiary services is required to identify those services which are most at risk due to service sustainability issues (either workforce, patient population critical mass to meet standards, or below peer outcomes). In parallel with this, the HBs should identify one or two critical services where urgent collaboration is required to deliver improvements to test the approach. The partnership would seek to develop shared plans to ensure the sustainability of services into the future. This may result in needing to change the way services are delivered. This could include the location of services, changes to the commissioning arrangements, and new forms of service delivery between organisations via networking arrangements. Any changes to services would be subject to commissioner agreement and appropriate engagement and consultation processes.

   It is recognised that a high level plan for tertiary services that would emerge from the work of the partnership would need to inform and be informed by WHSSC's commissioning intentions, and the local clinical services plans of both ABM and Cardiff and Vale UHBs.

3. **Membership**

   The partnership will be made up of the CEOs, Strategy/Planning, Chief Operating Officers and Medical Directors of the two organisations in the first instance, with the Managing Director and Planning Director of WHSSC invited to attend the meetings as observers (where appropriate). Senior clinical and operational leaders from the tertiary services may also be invited to attend as appropriate.

   Other directors would be invited to attend as needed.

4. **Reporting arrangements**

   The partnership would be working on behalf of both Boards and would report into the Boards via appropriate committees on a regular basis (Strategy and Delivery Committee for Cardiff and Vale UHB and Strategy Planning and Commissioning Group for ABM UHB).

The outputs from the partnership will inform discussion with the WHSSC Joint Committee by the two CEOs to keep the WHSSC partners informed and involved when needed.
The partnership will also provide updates as appropriate to the two regional planning committees for SE and SW Wales.

MAJOR TRAUMA NETWORK DEVELOPMENT	
Name of Meeting : Board Meeting	**Date of Meeting** 29 March 2018

Executive Lead : Executive Medical Director
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 is available as a supporting document to the main report

8

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The NHS Wales Health Collaborative has led on the development of a service model and on public consultation on a major trauma network for South and West Wales and South Powys.
- The service model and the approach to consultation were based on the advice of the Collaborative Leadership Forum and Major Trauma Project Board.

The Board is asked to:

- **CONSIDER** the recommendation of the Collaborative Leadership Forum set out in the Health Collaborative Report attached as Appendix 1, taking into account the views and comments of the Cardiff and Vale Community Health Council.
- **APPROVE** the establishment of a Major Trauma Network for South and West Wales and South Powys, subject to the mitigations identified and in line with the recommendations of the Independent Panel.

SITUATION

The Health Collaborative has produced a report, attached as Appendix 1, which provides an overview of the work which has been undertaken to develop recommendations for a major trauma network for the region, a description of the consultation process, an analysis of the consultation responses and a recommendation from the Collaborative Leadership Forum to the Health Boards based on conclusions drawn from the consultation.

The report seeks the agreement of Health Boards to a recommendation by the Collaborative Leadership Forum (NHS Wales' chairs and chief executives) to establish a major trauma network for South and West Wales and South Powys, in line with the recommendations of an Independent Panel. In considering the recommendation, Boards are to take into account the views and comments of the Community Health Councils. A commentary from the Cardiff and Vale CHC will be provided at the Board meeting.

BACKGROUND

The 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.

In September 2017, Health Boards in the region received a copy of the report of the Independent Panel alongside their recommendations. All Health Boards agreed, in principle, to the recommendations of the Independent Panel as the basis for a formal public consultation.

ASSESSMENT AND ASSURANCE

A 12 week consultation ran from 13 November 2017 to 5 February 2018. The consultation process was designed in accordance with the Welsh Government 'Guidance on Engagement and Consultation on Changes to Health Services'. A consistent approach was adopted across the region aimed at ensuring equality of opportunity for all population groups to provide views; the Cardiff and Vale Community Health Council worked with the UHB to develop a local approach to consultation in line with the Consultation Plan agreed through the Health Collaborative.

The attached report provides an overview of the work leading up to the consultation, a description of the consultation process, an analysis of the consultation responses and a recommendation from the Collaborative Leadership Forum to the boards of the Health Boards in the region, based on conclusions drawn from the consultation. The recommendation is to approve the establishment of a major trauma network, subject to the mitigations identified and in line with the recommendations of the Independent Panel:

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

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

A Major Trauma Network for South and West Wales and South Powys – Report on Consultation

8

Lead: Rachel Hennessy, Programme Director

Date: 16 March 2018	**Version:** 1a (FINAL)

Purpose of Document:

This paper provides:

- a brief summary of the rationale for a major trauma network for South and West Wales and South Powys ('the region')
- an overview of the work that has been undertaken to develop recommendations for a major trauma network for the region
- a summary of the resulting recommendations made by an Independent Panel
- a description of the process used to consult on the recommendations
- a description of the framework developed and used for analysis of the consultation responses
- an analysis of the consultation responses, using the framework referred to above
- conclusions drawn from the consultation
- a summary of the financial arrangements for the implementation of a major trauma network
- a recommendation from the Collaborative Leadership Forum to the boards of health boards in the region

1 Introduction

This paper provides:

- a brief summary of the rationale for a major trauma network for South and West Wales and South Powys ('the region') – Section 2
- an overview of the work that has been undertaken to develop recommendations for a major trauma network for the region – Section 3
- a summary of the resulting recommendations made by an Independent Panel – Section 4
- a description of the process used to consult on the recommendations – Section 5
- a description of the framework developed and used for analysis of the consultation responses – Section 6
- an analysis of the consultation responses, using the framework referred to above – Section 7
- conclusions drawn from the consultation – Section 8
- a summary of the financial arrangements for the implementation of a major trauma network – Section 9
- a recommendation from the Collaborative Leadership Forum to the boards of health boards in the region – Section 10

The recommendation of the Collaborative Leadership Forum (NHS Wales chairs and chief executives acting to oversee the work of the NHS Wales Health Collaborative) is that boards in the region should approve the establishment of a major trauma network for South and West Wales and South Powys, in line with the recommendations of the Independent Panel:

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

Additional background information and more detailed analysis of the consultation responses is contained in various Supporting Documents (see page 42).

2 Rationale for a major trauma network

'Major Trauma' is the leading cause of death in all groups under 45 years of age and is a significant cause of short and long term morbidity. A trauma network works together to make sure a patient receives the best care for life threatening or life changing injuries. Where there is a major trauma network, it has been shown that more patients will survive and make a good recovery, irrespective where in the region covered by the network they suffer a major trauma.

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 (NAO), have produced several reports which draw attention to poor care and outcomes received by patients resulting from a lack of trauma networks.

South and West Wales and South Powys ('the region') is the only region of England and Wales that does not have a major trauma network (MTN) or have access to a designated major trauma centre (MTC). This means that individuals suffering a major trauma in the region are likely to have poorer outcomes and are at greater risk of death.

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 deal appropriately with both individual and mass casualty events. A developing 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.

The establishment of a major trauma network will also contribute to the delivery of aims of the Wellbeing of Future Generations (Wales) Act 2015, by supporting the delivery of a 'healthier Wales' and the goal to "develop a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood".

3 Development of recommendations

3.1 Initial work

The work to develop proposals for a major trauma network has been led by the NHS Wales Health Collaborative Team ('the Collaborative'). The work was undertaken in collaboration with health boards across the region, the Welsh Ambulance Service NHS Trust (WAST), the Emergency

Medical Retrieval and Transfer Service (EMRTS) and has also involved the third sector and Community Health Councils (CHCs).

In late 2014, the Collaborative was asked by the chief executives in NHS Wales to develop a service model for a major trauma network for the region.

North Wales and North Powys were not included in the project. Betsi Cadwaladr University Health Board is already part of the West Midlands Major Trauma Network, with patients in North Wales having access to the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the West Midlands Major Trauma Network via the trauma unit in Shrewsbury.

A Project Board was established, supported by a Clinical Reference Group (CRG). The service model for major trauma services for adults and paediatrics was developed by the CRG, in line with the standards for major trauma, and approved by the Project Board in May 2015.

3.2 Option appraisal

In June 2015, an option appraisal workshop, led by clinicians, was undertaken which identified the need for a major trauma network with a major trauma centre based in South Wales to support the population of South and West Wales and South Powys.

The workshop included health boards, the Welsh Ambulance Service NHS Trust (WAST) and invited patient representatives from voluntary and charity support groups from across the region. Community Health Councils were also invited to observe. The workshop considered several options:

- Do nothing
- No major trauma centre in South Wales, but patients would access services in England (Bristol)
- One major trauma centre for South Wales based at Morriston Hospital
- One major trauma centre for South Wales based at University Hospital of Wales (UHW)
- Two sites, based at Morriston Hospital and University Hospital of Wales (UHW).

The participants in the workshop determined that the preferred option was **a major trauma centre on a single site based within the region and supported by a number of trauma units**.

The workshop did **not** result in a recommendation on a preferred location for the major trauma centre. However, in identifying the preference for a

single site, Morriston Hospital, Swansea and University Hospital of Wales (UHW), Cardiff were assessed to be the only two hospitals in the region that could potentially meet the criteria for a major trauma centre, due to the specialist nature of the service and the need for it to be co-located with relevant specialist services.

The workshop agreed that, to support a population of approximately two million (deemed to be the minimum critical mass for sustainability) the network would need to be supported by a major trauma centre located within the region. This ruled out the option of relying on services from the Bristol major trauma centre. The potential for a dual site solution was considered, but eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.

Following the workshop, an equality impact assessment (EqIA) was undertaken and has continued to be revised across the life of the project (Supporting Document 1).

3.3 The Independent Panel

Building on the earlier work, an independent panel of specialists from across trauma and rehabilitation services in the UK ('the Independent Panel') was commissioned by the Collaborative Board (chief executives), on behalf of health boards in the region, to review the information and evidence available and make a recommendation on the preferred location of a major trauma centre in the region.

A formal report (Supporting Document 2) was considered by health boards in the region in January 2017. This report asked boards to note the arrangements for the Independent Panel to consider the evidence regarding the establishment of the proposed major trauma centre and to bring forward a recommendation of a preferred option for public consultation. This was supported by all health boards in the region.

The Independent Panel convened in February 2017, chaired by the National Clinical Director for Trauma to NHS England. The Independent Panel comprised representatives from across major trauma services in the UK. Panel members were selected based on their national and international reputations as experts in trauma care and the development of trauma systems and having previously been involved in the development of regional major trauma systems.

Representatives were invited to attend from health boards, Public Health Wales, the Welsh Government, Community Health Councils (as observers), Emergency Medical Retrieval and Transfer Service (EMRTS), Welsh Ambulance Service Trust (WAST), Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee

(EASC). The terms of reference and agenda for the day are attached (Supporting Documents 3 and 4).

The Independent Panel was asked to undertake the following:

- Review the service model and specification for major trauma services for adults and paediatrics, across the region
- Consider supporting evidence from Abertawe Bro Morgannwg UHB and Cardiff and Vale UHB for the provision of a 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.

4 Recommendations from the Independent Panel for a major trauma network

After considering the evidence, the Independent Panel made the following five recommendations in their report (see Supporting Document 5):

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

In making their recommendations, the panel identified three main factors that should shape the design of a major trauma network:

- **Clinical interdependencies**, i.e. the services that need to be available at the location of the major trauma centre, as set out in the relevant standards

- **Critical mass**, i.e. the minimum number of people needed to make a service, in this case major trauma, sustainable
- **Travel times**: The Panel considered the geography of Wales and concluded that, with the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the major trauma centre

The panel concluded that providing specific highly specialist services, such as neurosurgery and paediatric neurosurgery, on the same site as the major trauma centre was the main factor in deciding where to locate the centre. It is important to have these specialist services available immediately if you suffer a major trauma. Providing these services on the same site is a minimum requirement.

Health boards formally received a copy of the report from the Independent Panel alongside their recommendations for consideration at their board meetings in September 2017. They were asked to agree, in principle, to the recommendations from the Independent Panel, and, in doing so, agree to a period of consultation on the recommendations of the Independent Panel (Supporting Document 6). **All health boards agreed, in principle, to the above recommendations of the Independent Panel as the basis for a formal consultation.**

5 Consultation process

As the proposals were deemed as substantial service change, a full consultation of twelve weeks was required. The process was designed in accordance with the 'Guidance on Engagement and Consultation on Changes to Health Services'. The process was considered by the Collaborative Leadership Forum, the six health boards in the region and the six Community Health Councils. As a collaborative process, Health Boards and Community Health Councils (CHCs) agreed that a consistent approach should be taken by all, ensuring equality of opportunity for all populations groups regardless of geographical location.

The consultation process commenced on 13 November 2017 and came to a conclusion on 5 February 2018.

In agreement with the CHCs, the consultation asked for individuals in the region and organisations to consider the following specific questions:

1. Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?
2. Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?

3. If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?
4. Do you have any other comments?

To ensure a consistent approach was adopted across the region, a task group was established comprising engagement and equality lead officers from each of the affected health boards and a representative of the CHCs. A consultation plan was developed outlining the objectives of the consultation, a stakeholder mapping and the consultation methods to be employed (Supporting Document 7). Plans for local consultation activity, to be undertaken in line with the overall consultation plan, were agreed between each health board and the respective CHC.

The consultation document was made available in various formats via hard copies and a dedicated web page on the Public Health Wales website (as Public Health Wales is the host body of the Collaborative). Public, stakeholder and staff sessions were held and social media was utilised.

Public meetings were scheduled across the region. Formal notes were provided from each consultation meeting, once agreed with the local CHC. A series of additional meetings took place with other professional/recognised groups. Details of the public meetings are attached at Supporting Document 8.

Social media (Facebook and Twitter), was used by health boards to promote the consultation and public meetings. Hywel Dda and Abertawe Bro Morgannwg UHB also engaged in wider discussions via social media.

A mid-way review meeting took place in December 2017, involving all the Health Boards and CHCs, to review the processes and responses received to date in light of national guidance and determine whether any adjustments needed to be made to the consultation for the remaining period. A table setting out the national guidance and how this guidance was applied in the consultation is provided in Supporting Document 9. Emerging themes were also shared with the engagement group.

Following the end of the consultation, the responses were analysed in line with the agreed framework (see Section 6).

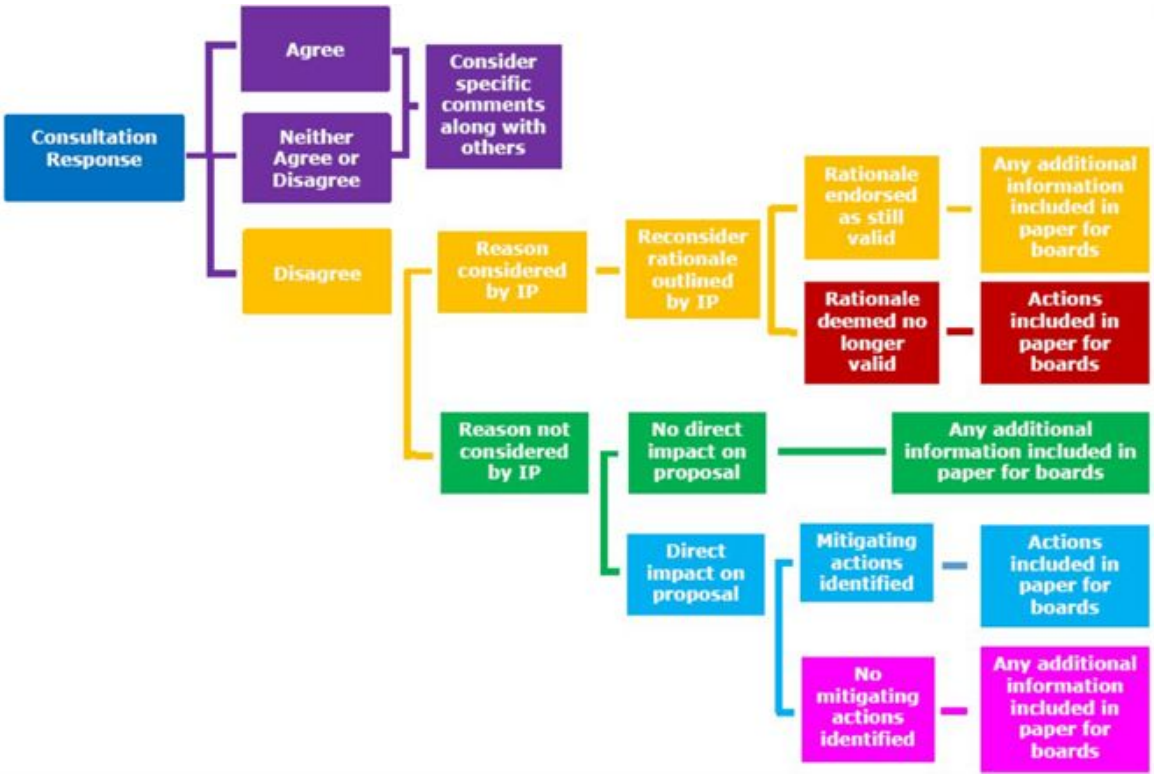
6 Framework for analysis of consultation responses

The Independent Panel considered an extensive suite of information prior to making their recommendations. As a result, health boards agreed, at their board meetings in September 2017, that the basis of the consultation would be the recommendations of the Independent Panel. The framework for analysis of the consultation responses was developed

to assist health boards in their decision making process and an initial version was agreed at the Collaborative Executive Group (formerly the Collaborative Board) in January 2018 (Supporting Document 10).

In February 2018, in considering the initial analysis of responses using the framework, the Collaborative Leadership Forum identified that the framework, as it then stood, could be interpreted as putting the views of the Independent Panel beyond challenge. As a result, the framework was modified to require that, in cases where recommendations had been challenged for reasons already considered by the Independent Panel, the Panel's rationale should be reconsidered and either endorsed as still valid or deemed to be no longer valid.

The framework is illustrated graphically below:



There are multiple steps to the framework:

- Consider whether an individual/organisation agrees or disagrees with the proposals. If there is no disagreement, any specific comments made are considered, along with comments from other responders, and, where appropriate, identified as issues for consideration during implementation. If there is disagreement, the following steps are applied:

- Consider the reason given by an individual/organisation for disagreeing with the proposals and determine whether the Independent Panel considered the issue.
    - If the issue was considered by the Independent Panel, then the rationale of the Panel is reconsidered and either endorsed as still valid or deemed to be no longer valid (in which case further action is required). In some cases, even though the rationale of the Independent Panel was deemed valid, issues were raised that need to be considered further and/or addressed during implementation. In such cases, the comments are still considered in the thematic analysis (see below). If there is deemed to be a direct impact, then further consideration is given as to whether there are any mitigations for the issue raised and, if so, these are documented.
    - If the issue was not considered by the Independent Panel, then further consideration is given to the issue raised using the following steps:
- Consider if the issue raised has a direct impact on the proposals. If there is not deemed to be a direct impact, then the comments are still considered in the thematic analysis (see below). If there is deemed to be a direct impact, then further consideration is given as to whether there are any mitigations for the issue raised and, if so, these are documented.
- Provide information to support boards in their decision making process, including the mitigating circumstances for issues raised.

In applying the framework, care was taken to ensure that all comments made were considered on an equal footing regardless of the format in which they were submitted.

7 Analysis of consultation responses

7.1 Number of responses received

There were 1,041 consultation responses received from across the region, and 254 members of the public engaged in conversation on social media (with potential overlap between these two groups).

Of the 1,041 responses, 999 directly answered the consultation questions asked (60% submitted via the webpage and 40% submitted via post or email). These are shown by health board in the table below:

Health Board	**Responses**	**%**
Abertawe Bro Morgannwg UHB	511	51.1%
Aneurin Bevan UHB	38	3.8%

Cardiff and Vale UHB	126	12.6%
Cwm Taf UHB	32	3.2%
Hywel Dda UHB	224	22.4%
Powys tHB	26	2.6%
Not known (no postcode)	38	3.8%
England	4	0.4%
Total	**999**	**100%**

There were also 42 other letters and emails received in response to the consultation which did not directly answer the consultation questions, but provided clear views about the recommendations of the Independent Panel. The content of these letters and emails was given full consideration on an equal footing with all other responses and the issues raised are included in the analysis presented in this report and Supporting Documents 11 and 12.

Seventeen public meetings were scheduled across the region and a total of 242 people attended comprising health board employees, local residents, local councillors, an assembly minister and representatives of other organisations. Feedback received in these meetings was captured and analysed and considered on an equal footing with all other responses.

In addition, 254 members of the public engaged in conversation on Facebook and Twitter relating to the consultation (18 in Hywel Dda UHB initiated conversations/threads and 236 in Abertawe Bro Morgannwg UHB initiated conversations/threads). Whilst a number of individuals used these conversations to express their views on the proposal, the conversations were also used by individuals to promote and confirm that they had completed a formal questionnaire to respond to the consultation. The key themes identified from the social media conversations were considered on an equal footing with other responses.

7.2 High level summary of responses to the consultation questions

The following summary is supported by a full numerical and thematic analysis of consultation responses (Supporting Document 11).

Question 1 asked "Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?"

- 92.8%* of responders agreed that a major trauma network should be established for the region
- 4.0% disagreed
- 2.7% neither agreed nor disagreed
- 0.5% provided no response

*This includes 242 respondents who used a standard 'template' response and who answered 'Yes' to the question (rather than answering 'Agree' or 'Disagree')

Question 2 asked "Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?"

- 34.6% of responders agreed that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel
- 49.4% disagreed
- 14.2% neither agreed nor disagreed
- 1.8% provided no response

The percentage of responders disagreeing that "the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel" varied to a large extent, based on the health board in which responders live.

Those disagreeing accounted for:

- 68.2% of responders from the Abertawe Bro Morgannwg UHB area
- 36.7% of responders from the Hywel Dda UHB area
- 23.1% of responders from the Powys tHB area
- 13.5% of responders from the Cardiff and Vale UHB area
- 9.4% of responders from the Cwm Taf UHB area
- 7.9% of responders from the Aneurin Bevan UHB area

Question 3 asked "If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?"

Question 4 asked "Do you have any other comments?"

The following are the main themes arising from responses to Questions 3 and 4 (with further detail being provided in Supporting Document 11):

- Many respondents took the opportunity to restate and/or expand on their views that:
  - the Major Trauma Centre should be in Morriston/Swansea or should not be at UHW
  - there should be more than one Major Trauma Centre in the region
  - parts of the region should use Bristol (and/or other English centres) as their Major Trauma Centre
- In implementing the network, there is a need to ensure that:

  - improvements are made in EMRTS, air ambulance services and ambulance services to ensure the time taken to transfer patients to the Major Trauma Centre is minimised on a 24/7 basis
  - the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the Major Trauma Centre, parking etc.
  - there is an adequate focus on the design of the whole network, including the location of trauma units and their facilities and on the entire pathway, including rehabilitation
  - there is access to appropriate diagnostic and treatment services at the Major Trauma Centre
  - there is excellent communication between professionals and with the public during the implementation and delivery of the network
  - implementation proceeds quickly once the decision has been made

- There are concerns about:
  - equity of access in West Wales and other rural areas
  - the impact on existing services at the location of the Major Trauma Centre through additional workload
  - the lack of capacity of estates, facilities and support services at UHW, particularly in relation to views about there being sufficient capacity at Morriston
  - the network's ability to ensure adequate staffing and adequate training for staff
  - the availability of adequate funding to implement the network
  - the downgrading of services away from the Major Trauma Centre
  - lack of co-location with thoracic surgery
  - the potential for the burns unit to move to Cardiff
  - the social and economic impact of further investment in Cardiff at the expense of other areas
  - this being part of a wider agenda to move services from Swansea to Cardiff
  - why it has taken this long to develop proposals for a major trauma network for the region
  - the degree to which the consultation has been genuine and extensive

- Further information would have been welcome in relation to:
  - how well the network is working in North Wales
  - the geographical spread of incidents resulting in major trauma in recent years

7.3 Themes identified from consultation responses

Themes identified from the consultation (through equal consideration of responses to the formal consultation questions, public and stakeholder meetings, social media, letters and emails received) have been reviewed. The key themes are contained in the Appendix and a more detailed analysis is provided in Supporting Document 12.

A small number of responses cited a lack of clarity in the consultation report and insufficient detail/evidence to enable individuals to respond to the consultation.

7.4 Analysis of reasons given for disagreeing with the recommendations of the Independent Panel

As stated in Section 7.2:

- 4% of responders disagreed with the recommendation that "a major trauma network should be established for South and West Wales and South Powys"
- 49.4% of responders disagreed "that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel".

The reasons given for disagreement have been analysed and the full analysis is set out in Supporting Document 12, with a summary being provided below.

Reasons for disagreement already considered by the Independent Panel

Most of the reasons given for disagreeing with the propositions in consultation questions 1 and 2 had already been considered by the Independent Panel. These issues are included in those listed in the Appendix (see Supporting Document 12 for a fuller version).

The two main reasons identified for disagreeing with the recommendations were:

- Do not agree with the recommendation for the proposed major trauma centre to be located at the University Hospital of Wales, citing:
  - the major trauma centre should be in Morriston Hospital
  - the report does not sufficiently take into account travel times from West Wales to Cardiff
  - Morriston Hospital is more central to South Wales
- Proximity of South East Wales to Bristol – people living in South East Wales being able to access the major trauma network in Bristol

The Independent Panel considered clinical interdependencies, critical mass and travel times. The panel made it clear that where there is a major trauma centre you are more likely to survive a major trauma, regardless of the time it takes to travel to the major trauma centre and that, wherever the major trauma centre is located, some people will be a considerable distance from it. The panel did not believe that either Morriston Hospital or University Hospital of Wales as a major trauma centre would have any significant advantage over the other in terms of geography. Rather, the panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre.

The use of the major trauma network centred on Bristol was discounted at the option appraisal in February 2015. The option appraisal workshop agreed that to support a population of approximately two million, the network would need to be supported by a single major trauma centre based within the region (i.e. South Wales). This would include the population of Aneurin Bevan UHB.

Further issues raised, which were considered by the Independent Panel or do not directly relate to the proposals included:

- patient flow and the importance of implementing an automatic acceptance and repatriation policy
- transport and infrastructure requirements (including public transport and road)
- access and support for families and carers.

In applying the framework, the Collaborative Leadership Forum considered carefully all responses, but concluded that the issues raised had been considered by the Independent Panel and that no additional evidence had been produced that would lead the Forum to conclude that the rationale of the Panel was deemed to be invalid. As such, it was concluded that there was no cause, in this stage of the analysis, for the rejection or alteration of any of the specific recommendations of the Independent Panel. There were, however, some aspects of the Independent Panel's recommendations where mitigations were identified to ensure that any negative consequences can be minimised (see section 7.5).

Reasons for disagreement NOT considered by the Independent Panel

There were a number of issues raised in the consultation, which had not been specifically considered by the Independent Panel when making their recommendations. These issues have been considered, are also listed in the Appendix (see Supporting Document 12 for a fuller version) and some of the main points are summarised below:

- The development of the network will lead to a downgrading of other services
- There should be a Major Trauma Network covering the whole of Wales
- South Wales is big enough to need more than one Major Trauma Centre*
- Parts of the region should make use of the Major Trauma Centre in Bristol*
- Existing infrastructure at the proposed site of the Major Trauma Centre is inadequate
- Existing services at the proposed site of the Major Trauma Centre will be overloaded
- The Major Trauma Centre should be on the same site as thoracic surgery
- There needs to be access to 24/7 interventional radiology services
- There is a lack of 24/7 availability of the Emergency Medical Retrieval Service (EMRTS) or air ambulance
- Transport infrastructure is inadequate
- Concerns about:
    - value for money
    - the availability of adequate funding
    - the recruitment, retention and efficient deployment of staff
    - the consultation process
    - the independence and expertise of the Independent Panel
    - the wider social and economic impact of the proposals

*Note that these issues were addressed during the June 2015 option appraisal (see Section 3.2)

In light of the material presented in the Appendix and Supporting Document 12, it has been concluded that, whilst issues have been raised that need to be considered and addressed or mitigated as part of the implementation of a major trauma network, nothing has been raised that requires the rejection or alteration of any of the recommendations of the Independent Panel.

7.5 Specific mitigations identified

Whilst, as stated above, nothing has been raised through the consultation that requires the rejection or alteration of any of the recommendations of the Independent Panel, there are areas where responders have identified potential negative consequences of the recommendations that can and should be mitigated. These mitigations are included in Supporting

Document 12 and some are also included in the Appendix. Many of the most important mitigations identified are summarised below:

- South and North Wales will work closely together so they can share best practice and learn from each other. There will be a major trauma and critical care network board which will include both North and South Wales.
- There will be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered by trauma units.
- Where patients currently access the trauma units in England, they will continue to do so.
- A review of services provided at a regional level by UHW will be undertaken to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Proposals for service change would be subject to further engagement.
- Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site.
- Arrangements will be developed to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery.
- Interventional radiology is being addressed on a regional basis between Cwm Taf, Aneurin Bevan UHB and Cardiff and Vale UHB. A plan has been developed to establish a 24/7 rota.
- The neurosurgery service has plans to reduce waiting times through 2018/19, with the support of WHSSC. A review of Neurosciences is due to conclude shortly which will inform longer term planning.
- Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.
- A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.
- Future operational arrangements of EMRTS and the Wales Air Ambulance will be reviewed as part of the planning for the

implementation of the Major Trauma Network. This will include consideration of both demand and cost/benefit, taking into account any additional survival benefit associated with additional operational hours. Operational hours will be reassessed in the light of this assessment. Further advice about operational procedures will also be taken during implementation, informed by experience elsewhere in England and Wales.

In addition, it should be noted that the development of a major trauma network in the region will be taking place in the broader context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established.

7.6 Consideration of equality and human rights issues

In line with the statutory duty placed on each health board under the Wales Public Sector Equality Duty 2011, an equality impact assessment (EqIA) was undertaken on the proposals for a major trauma network for South and West Wales and South Powys. The assessment informed the content of the consultation plan. A revised EqIA evidence document was published at the launch of the consultation and considered as part of the mid way review held in December 2017 (Supporting document 1). At this point, the opportunity was taken to review the responses received to date and identify any particular impacts on groups of individuals due to their protected characteristic and to identify possible ways to minimise or remove these effects. No issues were raised which resulted in changes to the consultation process. The document was available on the consultation website as part of the supporting documentation. In line with the EqIA, public meetings were held across the region about the proposals to give full equality of opportunity to equality and diversity groups to put their views forward on the options. Information was also available on the website and available in braille, audio and British Sign Language, Welsh and sub titled.

On conclusion of the consultation, the responses received and equality monitoring forms were collated and analysed (Supporting Document 11). The responses to the consultation and analysis will be available on the public consultation website at:

www.publichealthwales.org/majortraumaconsultation

715 equality monitoring forms were received as part of the consultation. For each 'protected characteristic' there were a number of respondents who left the question blank.

There were a number of equality monitoring forms received from organisations, which ticked multiple responses to a single question (e.g. where an age category was required, several age brackets were identified). These forms were acknowledged but were not included in analysis of the monitoring form returns.

The EqIA made an observation 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. However, evidence suggests that should you suffer a major trauma, you are more likely to survive and make a full recovery if you are in a region where there is a major trauma network, regardless of how far you are away from the major trauma centre.

Of the protected characteristics, the EqIA identified that there is potentially no specific impact upon the following protected groups: 'Marriage and civil partnership' and 'Pregnancy and maternity'.

Evidence suggests there are a number of protected groups who may be likely to suffer a major trauma. The EqIA notes that men are at far higher risk of experiencing major trauma than women with age being is a risk factor for suffering. It is the leading cause of death for people under 45 years and a significant cause of short and long-term morbidity. There is evidence, 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) 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 two metres. Major trauma is more than twice as common in urban areas due to concentration of traffic and people. Moreover, it has been identified that people from Black, Asian and other ethnic minority backgrounds 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[1].

Additionally, trans people must be accommodated in line with their gender expression. Privacy is essential to meet the needs of the trans person and other service users. The wishes of the trans person must be considered rather than the convenience of staff. An unconscious patient should be treated according to their gender presentation. Breaching privacy about a person's Gender Recognition Certificate 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.

[1] Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

The EqIA also identified responsibility to comply with the Welsh Language (Wales) Measure 2011 and the related health standards. These standards establish the right for Welsh language speakers to receive services in Welsh and for them to be offered communication in their preferred language choice. Meeting the information and communication needs of victims who speak Welsh must be considered. Research has shown these groups cannot be treated safely and effectively except in their first language. The equality monitoring forms identify responses from the following protected groups:

- Age: Age of respondents ranged from the lowest age bracket 16-24 to 75 or over, with the majority of respondents identifying as 45-54 age bracket (141).
- Gender: The response from individuals identifying as female (394) was slightly higher than the number of individuals identifying as male (279).
- Race: Respondents identified as predominately white (642) with a small number of respondents identifying as Asian or Asian British, Black, African, Caribbean or Black British, Mixed or multiple ethnic groups or another ethnic group (26).
- Disability: Majority of respondents identified as not having their day to day activities limited (533). A number of individuals did identify as having day to day activities limited a little (91) or a lot (39).
- Religion or belief: Majority of respondents identified as Christian (371). A small number identified as Buddhist, Hindu, Muslim or other religion (33). A large number identified as no religion (277).
- Sexual orientation: Respondents predominantly identified as heterosexual or straight (586) with a small number identifying as gay or lesbian, or bisexual (37).
- Welsh language: Majority or respondent identified as non Welsh speaking (530) and (139) identified as Welsh speaking.

Following the consultation, the EqIA has been updated (Supporting Document 13).

8 Conclusions drawn from consultation

A range of opinions have been expressed, analysed and considered as part of the consultation exercise. Whilst there was much support expressed for the recommendations of the Independent Panel, there were also counter arguments and objections. Having considered the conduct of the consultation and the analysis of the responses received, the Collaborative Leadership Forum (NHS Wales chairs and chief executives) is content that:

- the consultation has been conducted in an appropriate manner and in a way that meets the requirements of the applicable Welsh Government guidance
- consultation responses received have been carefully and conscientiously considered
- the Forum has considered all of the arguments and concerns arising from the consultation fairly, rationally, proportionately and transparently
- whilst issues have been raised that need to be considered, addressed or mitigated as part of the implementation of a major trauma network, nothing has been raised that requires the rejection or alteration of any of the recommendations of the Independent Panel (as previously endorsed by boards in the region as the basis for public consultation)
- where required, appropriate mitigations have been identified.

9 Financial arrangements

It is acknowledged 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.

Where major trauma networks have been developed and designated major trauma centres established in other parts of the UK, investment has been aligned to an agreed incremental implementation programme over a number of years. The first phase of the revenue investment is targeted at addressing the core infrastructure requirements, with initial funding identified for any critical shortfalls and a phased approach to meeting clinical standards over time.

Any capital requirements will also need to be identified and considered in the context of the phased implementation programme, the wider site development plans, interdependencies that exist between trauma services and other clinical services and will be subject to formal business case approval by Welsh Government as appropriate. Should the site of the Major Trauma Centre be confirmed as UHW, the development and submission of the business case will be led by Cardiff and Vale UHB, with the support of other health boards in the region. There would also be likely to be additional costs at Morriston, associated with its proposed lead role for the network, and at all trauma units designated within the network.

The Welsh Ambulance Service NHS Trust 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).

The experience from other parts of the UK is that the incremental approach to implementation is essential to mitigate unnecessary additional costs and to also ensure that recruitment, training and development of staff is coordinated alongside new care pathways.

The funding mechanisms, in relation to revenue costs, will need to be developed, in detail, as part of the commissioning process. Costs will be benchmarked against the tariff system operational within England and to which Betsi Cadwaladr University Health Board already subscribes in accessing services for its local population. Revenue requirements will be addressed as part of the usual decision making process between health boards and the Welsh Health Specialised Services Committee (WHSSC), factoring in other priorities. This is in line with the core business of WHSSC as a commissioner of specialised services. The agreed revenue requirements will need to be reflected in the IMTPs of all health boards in the region for the period 2019/20 onwards (costs in 2018/19 will be project costs only).

10 Recommendation to boards

Following the consultation process and the analysis and consideration of the responses received, health boards in the region are recommended by the Collaborative Leadership Forum (NHS Wales chairs and chief executives) to **APPROVE the establishment of a major trauma network for South and West Wales and South Powys**, subject to the mitigations identified and in line with the recommendations of the Independent Panel, which were:

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

In considering the above recommendation, boards should take into account the views and comments of the Community Health Councils.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Appendix – Analysis of and responses to reasons for disagreement

Key Themes	Area for consideration	Information for boards (specific mitigations in bold)
Major trauma Network (MTN) structure	The development of the network will lead to a downgrading of other services.	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency units in North Wales, despite the fact that the Major Trauma Centre (MTC) is based in Stoke on Trent. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the Major Trauma Centre or receive initial treatment at a trauma unit before being transferred to the Major Trauma Centre. **The importance of local access, particularly for the frail and elderly, has been reinforced by the responses received and it is recognised that this should form an important consideration in relevant service models in the future.** Under the recommendations of the Independent Panel, Morriston Hospital would have an enhanced role as a large trauma unit.
	We need a major trauma network that covers all of Wales.	North Wales participates in the West Midlands major trauma network and accesses the Major Trauma Centre in North Staffordshire. Patients in North Wales access a large number of their services from England, due to their highly specialist nature, and will continue to do so. **The regions will work closely together so they can share best practice and learn from each other. There will be a major trauma and critical care network board which will include both North and South Wales.**
	South Wales is big enough to need more than one Major Trauma Centre.	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2). Under the recommendations of the Independent Panel, Morriston Hospital would have an enhanced role as a large trauma unit.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Major trauma Network (MTN) structure (continued)	More emphasis should be given to the establishment of the network, including the location of trauma units and the development of rehabilitation pathways, rather than the location of the Major Trauma Centre.	The implementation of the network, including the redevelopment of the whole pathway of care is as important as the location of the Major Trauma Centre. The Independent Panel was asked to make a recommendation on the location of the Major Trauma Centre only, and not the trauma units. Identifying the Major Trauma Centre location first is helpful in informing where to locate the units. The remaining trauma units will need to be identified by individual health boards for their local area. **There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered by trauma units.** **The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.** The need to develop appropriate and robust rehabilitation pathways as part of the implementation of the Major Trauma Network is accepted.
	Clarity is required over how Powys will be served by trauma units and the exact geographical definition of the major trauma network in relation to Powys.	**Powys secures its secondary care services from neighbouring District General Hospitals**. **Powys tHB will work with each of these health boards and trusts in relation to trauma unit provision. Powys tHB will also be focusing on the provision of rehabilitation services for people as close to their home as possible.** **The consultation proposed that where patients currently access the trauma units in England, they will continue to do so**. At the boundaries of the network, ambulance crews will assess patients and, if the services of a Major Trauma Centre are required, patients will be taken by ambulance or helicopter to an appropriate Major Trauma Centre, which may be the proposed centre in South Wales or one in England.
	There could be a strong argument for a West Wales Mid Wales or Valleys body to take on the leadership role for the network.	As the biggest unit that was not recommended to be the location of the Major Trauma Centre, Morriston was recommended by the Independent Panel to have a leadership role. The rationale of the Independent Panel has been reconsidered and endorsed.
	Concern model proposed is more of hub and spoke model rather than a network.	The model proposed adopts the arrangements used by major trauma networks across England and Wales.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Location of the Major Trauma Centre	Travelling long distances to the Major Trauma Centre could be detrimental to the health of the injured.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the Major Trauma Centre was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the Major Trauma Centre.
	The Major Trauma Centre should be in Morrison/ Swansea (or should not be in UHW/Cardiff) because of geographic location and travel times.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre. Providing this service on-site is a minimum requirement. The Independent Panel considered iscochrone models of travel times for Morriston Hospital and UHW. The Panel considered the geography of Wales and concluded that transfer time to the Major Trauma Centre was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the Major Trauma Centre. Under the recommendations of the Independent Panel, Morriston Hospital would have an enhanced role as a large trauma unit.
	There are concerns about equity of access, particularly in rural/remote areas.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the Major Trauma Centre was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the Major Trauma Centre.
Access and proximity to Bristol	Parts of the region should make use of the Major Trauma Centre in Bristol (or others in England).	The use of the Major Trauma Centre in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a Major Trauma Centre located within the region. This ruled out the option of relying on services from the Bristol Major Trauma Centre.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Existing infrastructure	The Major Trauma Centre should be in Morrison because of room for expansion and facilities at Morriston (inc. a helipad).	This does not call into question the rationale of the Independent Panel in recommending that the Major Trauma Centre should be at UHW. UHW has an existing helipad which provides direct access to the Emergency Unit without the need for an additional transfer. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority.
	The Major Trauma Centre should not be at UHW because of constraints on capacity/ space at UHW.	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients. Cardiff and Vale UHB is working closely with other health boards on the following: • **A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment**. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public. • **Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.** Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service. **Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service:** • **a front door Emergency Unit service with a major trauma team leader available 24/7** • **increased critical care capacity in line with modelling for additional major trauma activity** • **additional theatre capacity** • **creation of a polytrauma unit.** **There are plans being developed to address each of these, dependent on the outcome of consultation.**

8

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Existing infrastructure (continued)	The Major Trauma Centre should not be at UHW because of constraints on capacity/ space at UHW. (continued)	**Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site** **Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.** In addition, it should be noted that the development of a major trauma network in the region will be taking place in the context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are broadly committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established.
	Neither Morriston or UHW could cope with the extra traffic.	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Infrastructure requirements	Appropriate infrastructure and resources will need to be provided. This will need to cover what facilities and resources will need to be provided at UHW. Has consideration been given to the resources and facilities required including ITU beds, IT infrastructure, support services e.g. radiology?	Morriston Hospital and UHW provided high level costs for each site to meet the designation criteria for a Major Trauma Centre. **If supported, UHW will develop a detailed business case which will include an assessment of the resources available and what is required to deliver a Major Trauma Centre. Any additional resources required will be required over a period of time.** **Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service:** • **a front door Emergency Unit service with a major trauma team leader available 24/7** • **increased critical care capacity in line with modelling for additional major trauma activity** • **additional theatre capacity** • **creation of a polytrauma unit.** **There are plans being developed to address each of these, dependent on the outcome of consultation.** **Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site** **Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.** In addition, it should be noted that the development of a major trauma network in the region will be taking place in the context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are broadly committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established.

8

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Infrastructure requirements (continued)	Should the development of the Major Trauma Centre be part of wider discussions regarding the redesign of UHW?	**Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site. A Business Case will be submitted to Welsh Government later this year, reflecting a phased development plan.**
Existing service provision	The Major Trauma Centre should be on the same site as thoracic surgery.	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site rather than the current two. A subsequent recommendation was made by an independent panel that that the site should be Moriston Hospital. The panel specifically considered the issue of colocation. The issue of colocation of the Major Trauma Centre and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the Major Trauma Centre.
	There is a need to ensure that there is access to 24/7 interventional radiology at the Major Trauma Centre.	**This area is being addressed on a regional basis between Cwm Taf, AB UHB and C&V UHB. A plan has been developed to establish a 24/7 rota. This includes some additional appointments, one of which has already been made (start date August 2018). A Business Case is being developed for a hybrid theatre to support the interventional radiology work. In addition to this there is currently work ongoing in Cardiff to finalise the capital plan for an additional single plane interventional suite in order to ensure that there is sufficient room time available across the working week to support regional working. At the point where the major trauma centre is in place there will need to be considerations as to how the rota works to ensure immediate availability of the appropriate staff. This will include extending the on call arrangements for the nurses and radiographers, which has been identified as part of the major trauma case.**
	Waiting times for neurosurgery are too long.	Waiting times for Neurosurgery are longer than we want them to be but have been steadily reducing since the Summer supported by improved repatriation and some additional theatre capacity at UHW (201 patients were waiting over 36 weeks at the end of August, down to 81 at the end of January). **The service has plans to reduce waiting times further through 2018/19, with the support of WHSSC. A review of Neurosciences is due to conclude shortly which will inform longer term planning.**

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Existing service provision (continued)	Moving neurosurgery back to Morriston hospital to sit alongside burns unit would not be a major problem.	The location of neurosurgery at UHW was previously the subject of a formal consultation based on the best available evidence.
	How will proposals work given the configuration of burns and plastics and neurosurgery?	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together. Burns and plastics is already a supra-regional service provided from Morriston Hospital. Neurosurgery is already a regional service provided from UHW. Patients are already managed across the two sites relating to their primary needs.
	Concern that the existing Burns and Plastic Surgery service could be moved from Morriston to UHW.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Whilst it is not critical that the burns and plastic centre is on the same site as the major trauma centre, it is important that UHW and Morriston Hospital work together. There are no plans to move Burns and Plastic surgery Services from Morriston Hospital.
	Significant gaps in community neuro-rehabilitation.	Community neuro-rehabilitation will need to be addressed. This issue does not call into question the recommendations of the Independent Panel.
	Concern about impact on local A&E services, including waiting times for local residents needing A&E services at the site of the Major Trauma Centre.	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency units in North Wales. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the Major Trauma Centre or receive initial treatment at a trauma unit before being transferred to the Major Trauma Centre. Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Existing service provision (continued)	Have plans for Hywel Dda have been taken into account, with the proposed closures?	Plans from Hywel Dda may impact on the future configuration of Accident and Emergency units, but will not be material in relation to the overall recommendations of the Independent Panel.
	Need to consider what services could come off the UHW site.	**Cardiff and Vale UHB is working closely with other health boards on a review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals.** This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public. **Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough which would similarly be subject to further engagement.**
	Difficulties with moving patients into community settings within Cardiff and Vale.	Other than through improving survival, the implementation of the major trauma network will not impact on the need for care in community settings in Cardiff and Vale. **Patients will be repatriated to their home health board before requiring community based care.**
	It may be unclear to the general public the level of accident service hospitals across South Wales presently offer in respect of serious injuries.	**To accompany any implementation plan and information for the public on the use of the Major Trauma Centre and major trauma network, clear guidance will be provided outlining the range of Accident and Emergency services available throughout the region.**
Financial resources	Whether the anticipated costs of this development are being considered in comparison to other ways of spending the money to support other patient groups, comparing years of quality life added.	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Financial resources (continued)	Concern about whether there is enough money to implement the Major Trauma Network and Major Trauma Centre and to provide 24/7 365 day service provision.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. **WHSSC has been identified to lead the development of a commissioning framework for the major trauma network.** **Detailed capital costs will be developed for inclusion in the business case to Welsh Government.** See section 9 for further information about proposed financial arrangements.
	Need for detailed costs and to understand what money will health boards contribute towards the Major Trauma Centre and how WG will support this.	**WHSSC has been identified to lead the development of a commissioning framework for the major trauma network.** Detailed capital costs will be developed for inclusion in the business case to Welsh Government. See section 9 for further information about proposed financial arrangements.
	Need a national approach to commissioning, including new SLAs, recognising that this would not all be new work at UHW.	
Workforce requirements	Concern about the network's ability to ensure adequate staffing and adequate training for staff.	**A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.** A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites. Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.
	Concern about the ability to recruit and retain staff (including doctors) away from the Major Trauma Centre.	

8

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Workforce requirements (continued)	How will staff be occupied if they are not dealing with a major trauma?	The Major Trauma Centre will meet the service specification set for staffing. It would be up to the Major Trauma Centre how they achieve this. **The majority of staff involved in initial trauma care would have other duties in the hospital from which they can be rapidly released when a trauma is admitted.** **As in other major trauma networks it is likely that some substantial or even full time roles would be required to manage trauma patients - e.g. major trauma practitioners who coordinate and review major trauma patients in the Major Trauma Centre on a daily basis.**
	Adequate training, staffing, resources to support air ambulance if they need to make further/longer journeys.	**If the proposal is supported, EASC as the commissioner for Welsh Ambulance Service trusts and Emergency Medical Retrieval and Transfer Service will identify detailed training requirements for the workforce. This will then be part of the commissioner intentions for the service.**
Transport and infrastructure requirements	Road infrastructure and public transport requirements.	There are various patient transfer options that will be used with the proposed major trauma network. Travel times were considered by the Independent Panel. Public transport is not a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport. Nevertheless, it is recognised that there will be an impact on families and carers who might have to travel further while the patient is being treated in the Major Trauma Centre. It is important to note, however, that patients would typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.**

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Access and support for families	There is a need to ensure that the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the Major Trauma Centre, parking etc.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked at the Independent Panel to outline how they would address support for families. Patients will typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated to their local hospital for ongoing care and rehabilitation if required. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.** It should be noted that patients are already transferred to UHW from across the whole region for some highly specialised services and there are arrangements in place to support families where appropriate. This will be considered further as part of the overall implementation of the network and development of the Major Trauma Centre. **A new charity-funded building providing accommodation and facilities for families whose children are receiving treatment in UHW has recently been opened. Some accommodation is also available on the UHW site for families of adult inpatients.**
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST)	EMRTS/Air Ambulance does not operate 24/7 and cannot operate at night.	At present, the Emergency Medical Retrieval Transfer Services (EMRTS) and Wales Air Ambulance operate a 12-hour service from 8AM to 8PM. If during this time it is dark, the Wales Air Ambulance charity helicopters are able to transfer patients between hospitals where approved landing sites with lights are available. Otherwise a specialist car known as a rapid response vehicle will attend the scene of the incident. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority. **Future operational arrangements of EMRTS and the Wales Air Ambulance will be reviewed during implementation. This will include consideration of both demand and cost/benefit, taking into account any additional survival benefit associated with additional operational hours. Operational hours will be reassessed in the light of this assessment. Further advice about operational procedures will also be taken during implementation, informed by experience elsewhere in England and Wales.** Any constraints in coverage will apply irrespective of the location of the Major Trauma Centre.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST) (continued)	The impact of the major trauma network on the WAST and EMRTs.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. WAST and EMRTS presented at the Independent Panel and outlined the impact the Major Trauma Centre would have on them if located at either Morriston Hospital or UHW. If the proposal is supported, **EASC as the commissioner for Welsh Ambulance Service trusts will do detailed modelling work which will form part of their future commissioning intentions from health boards**. **As part of the next phase, further work will be undertaken to develop pathways and the commissioning framework**. From an emergency standpoint, these patients already exist and are already managed by WAST and EMRTS/Wales Air Ambulance on a day to day basis. The actual increase in ambulance work is only likely to reflect the small number of patients who travel a short additional distance to reach an Major Trauma Centre, rather than being taken to their local hospital.
	Accessibility of air ambulance when Swansea based helicopter is committed elsewhere.	This is already a constraint and would remain so however trauma services are configured.
	May need to re-assess the way in which ambulance calls are currently prioritised given that the proposal will rely on patients being transferred on occasions from one hospital to another within the network.	**This will form part of the implementation plan.**
Lack of evidence	Is there sufficient evidence to demonstrate that the current situation disadvantages patients? Major trauma is rare and has been treated well in the present centres.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Consultation process	Politically motivated decision.	Arrangements for an Independent Panel of experienced experts in the field of major trauma (predominantly from outside Wales) were agreed by health boards January 2017 (see section 3.3). The Independent Panel undertook its deliberations and developed its recommendations free from political interference. The decision to consult on the recommendations was taken by health boards and health boards will make final decisions, informed by the report of the consultation.
	The terms of the consultation, might be seen as implying a level of approval by NHS Wales of the recommendations of the expert group. Would have been more appropriate if the public had been invited to comment upon how the expert group had assessed the pros and cons of three options – Bristol, UHW and Morriston.	The report of the Independent Panel was considered by boards in public in September 2017. Boards accepted the recommendations subject to formal public consultation. The use of the Major Trauma Centre in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a Major Trauma Centre located within the region. This ruled out the option of relying on services from the Bristol Major Trauma Centre. The 2015 option appraisal workshop included health boards and the Welsh Ambulance Service Trust. Patient representatives from voluntary and charity support groups from across the region were invited. The CHCs were also invited to observe. A consultation exercise has been conducted that meets the requirements of the applicable Welsh Government guidance.
	Final details for the consultation only became clear in October, concern not widely publicised and great reliance on social media and Christmas period.	The timescale for the consultation was agreed with CHCs. A period of 12 weeks (as opposed to the required eight) was adopted to allow for the impact of the Christmas period.
	Roles of two sites not clearly defined in layman's terms.	The roles of the Major Trauma Centre and trauma units were clearly described in the consultation material.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Consultation process (continued)	Concern about whether the consultation has been genuine and extensive and has complied with the Gunning principles.	In line with the Gunning principles, the consultation process was reviewed against consultation and engagement guidance by health boards and CHCs at mid point. No further changes were advised. Conscientious consideration was given to the outcomes of the consultation process at all relevant times.
	Insufficient information to base a decision on the location of the Major trauma Centre.	Web page provided the technical documents considered by the Independent Panel. All the relevant criteria on which to base the decision were made clear during the consultation process.
	Not enough publicity has been given to the public meetings or the consultation. Request for extension/rerun of consultation process due to poorly advertised/attended public meetings.	Health boards ran a public meeting in each district. Individuals/organisations were able to respond to the consultation via Freepost, online, email. Each health board agreed the local arrangements with its local CHC.
	Should be a decision of the population.	A formal public consultation was undertaken from 13 November 2017 until 5 February 2018, in conjunction with CHCs and in accordance with Welsh Government guidance.
	Further information would have been welcome in relation to the geographical spread of incidents resulting in major trauma in recent years and how well the network is working in North Wales.	It is considered that the information provided during the consultation was adequate.

8

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Role of the Independent Panel	Concern that the independent panel was not independent and not in touch with patients.	Arrangements for an Independent Panel of experienced experts in the field of major trauma were agreed by health boards in January 2017. Panel members were selected to provide specific professional expertise It was not part of the role of the panel to be representatives of patients. CHCs were observers at the meeting of the Independent Panel (see section 3.3 for additional information about the Independent Panel and its composition).
	Terms of reference were too limited, requiring the Independent Panel to assess the current clinical capabilities of two hospitals. They should have advised whether South Wales needs to have an Major Trauma Centre and if so to assess where this would be best located in order to complement existing range of Major Trauma Centres in England and so strengthen the major trauma coverage for populations within England and Wales as a whole.	An option appraisal in 2015 agreed that, to support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a major trauma centre located within the region. This ruled out the option of relying on services from the Bristol major trauma centre. The potential for a dual site solution was considered, but subsequently eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.
Needs based decision	Should look at the needs of the community, current services and demographics.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Independent Panel considered evidence compiled across the life of the project, including travel, demographics and service provision.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Social and economic impact	No political guidance was given regarding the wider strategic direction e.g. should broader economic and social considerations have been taken into account and should welsh government have chosen to see any major trauma centres sites in south Wales as needing to complement existing chain of Major Trauma Centres operated by NHS England – upon which Welsh residents currently rely.	This was out of the scope of the consultation.
	There are concerns about the social and economic impact of further investment in Cardiff at the expense of other areas.	
Decision making process	Were the options considered subject to a Health Impact assessment (HIA) as part of the work carried out by the panel in arriving at its recommendations. Suggestion that one is carried out before recommendations are progressed.	An Equality Impact Assessment was carried out as part of the consultation process. The establishment of a major trauma network will contribute to the delivery of aims of the Wellbeing of Future Generations (Wales) Act 2015, by supporting the delivery of a 'healthier Wales' and the goal to "develop a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood".

8

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Implementation of the Major Trauma Network	Concerns about why it has taken this long to develop proposals for a Major Trauma Network for the region.	This was out of the scope of the consultation.
	Whatever service results it is fully accessible for people who are deaf or have hearing loss. The care they receive and co-produce is as dignified and clinically optimal as that of a hearing person. Currently a stream of work going around on accessibility for people with sensory loss in each health board and it is a priority each health board reports back to WG on.	Requirements for equality of access apply to all services. **During implementation work will be undertaken to ensure that the specific needs of those with protected characteristics, including the deaf and hard of hearing, are identified and addressed**.
	There is a need to ensure that the therapy professions are appropriately involved in the implementation of the network.	Implementation will need to involve professional bodies, as appropriate.
	The Royal College of Midwives should be part of the major trauma network.	

8

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Key Themes	**Area for consideration**	**Information for boards (specific mitigations in bold)**
Implementation of the Major Trauma Network (continued)	There is a need to ensure that there is excellent communications between professionals and with the public during the implementation and delivery of the network.	The need for a clear communication strategy is accepted and will be included as part of implementation plans.
	Delays in repatriation may be exacerbated by the increased numbers of patients coming to UHW if it were the Major Trauma Centre.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. **Health boards will need to agree and implement a patient flow policy which supports 'automatic acceptance' at the centre and 'repatriation' as soon as possible.**
	There is a need to ensure that digital solutions are used where possible.	The need to make appropriate use of technology in implementing the Major trauma Network is accepted.
	There is a need to ensure that implementation proceeds quickly once the decision has been made.	**An appropriate and measured implementation plan will be developed.**
	Effectiveness of moving to the model advocated will need to be monitored. Has consideration been given to deriving an appropriate methodology by which this can be done should the network be established. It would be necessary to assess the effectiveness based on outcomes.	The rationale outlined by the Independent Panel has been reconsidered and endorsed. **TARN is an outcome based monitoring tool, used for management of major trauma across England and Wales. All health boards subscribe to this**.

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Supporting Documents

Supporting Document 1	Initial Equality Impact Assessment (EqIA)	Supporting Document 1 - EqIA.p
Supporting Document 2	Board Report - January 2017	Supporting Document 2 - Board
Supporting Document 3	Independent Panel Terms of Reference	Supporting Document 3 - Indep
Supporting Document 4	Independent Panel Agenda	Supporting Document 4 - Indep
Supporting Document 5	Independent Panel Report	Supporting Document 5 - Expert
Supporting Document 6	Board Report – September 2017	Supporting Document 6 - Board
Supporting Document 7	Consultation Plan	Supporting Document 7 - Consu
Supporting Document 8	Details of Public Meetings	Supporting Document 8 - Detail
Supporting Document 9	Consultation Mid Way Review	Supporting Document 9- Consu

8

NHS Wales Health Collaborative	Major Trauma Network – Report on Consultation for Boards	Paper Ref:

Supporting Document 10	Collaborative Executive Group Paper – January 2018	Supporting Document 10 - Colla
Supporting Document 11	Numerical and Thematic Analysis of Consultation Responses	Supporting Document 11 - Num
Supporting Document 12	Analysis of Consultation Responses Against Framework	Supporting Document 12 - Analys
Supporting Document 13	Post Consultation Equality Impact Assessment (EqIA)	Supporting Document 13 - Post

8

NHS WALES HEALTH COLLABORATIVE

A MAJOR TRAUMA NETWORK FOR SOUTH AND WEST WALES AND SOUTH POWYS

EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT

Revised – October 2017

About this document

This technical document has been produced to provide background evidence to support information provided within the NHS Wales Health Collaborative public consultation on the development of a major trauma Network for South and West Wales and South Powys.

This document is meant as a reference guide, it does not provide exhaustive detail. It aims to provide an overview of our findings to date about what groups within our population may be affected by our proposals and in what way. It is a living document and will be added to by information gathered during consultation and ongoing through all stages up to and including delivery of services where actual impact will be monitored.

1. Background

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 south Wales. 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 Service Trust (WAST), Emergency Medical Retrieval and Transfer Service (EMRTS) and Welsh Health Specialist Services Committee (WHSSC). North Wales is already part of the West Midlands Major Trauma Network with the major trauma centre in North Staffordshire. North Powys also participates in the West Midlands Major Trauma Network

The 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 wide stakeholder group and supported by all Health Boards. The standards for major trauma have been written by the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute for Clinical Excellence (NICE) and say what services should be available for a patient with 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 say what services should be in a major trauma centre, trauma units, and how the network should work.

1.2 The case for change

'Major Trauma' 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). Less than 0.2% (2/1000 patients) of the people attending their local emergency department will have a major trauma. In 2016/2017 in South Wales, approximately 1,234 people attended a local emergency department with a major trauma, compared with 617,000 people attending emergency departments in total (www.statswales.gov.wales). Major trauma cases are complex and due to the small number it is a challenge for hospital staff to maintain their highly specialist skills in trauma care. w. The data used to develop the proposed service model is based on 2014 TARN (The Trauma Audit and Research Network) data. The data available at this time did not cover all south Wales hospitals and Emergency Medical Retrieval and Transfer Service (EMRTS) was not in place and therefore was likely to under-represent the true number of major trauma patients in the region, however it should be noted that numbers are still small.

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 talk about poor care and outcomes received by patients resulting from a lack of trauma networks.

As a result of these reports, England has established trauma networks across its region. North Wales is part of the west Midlands major trauma network and the major trauma centre for the region is in Stoke, North Staffordshire. South Wales is the only region across England and Wales that is not part of a major trauma network nor has access to a designated

major trauma centre. Scotland has made progress in identifying the key components of its trauma network and is moving toward implementation. Across South Wales, major trauma cases are currently managed through informal arrangements across the health boards, with some more complicated cases either admitted directly or transferred to the bigger regional centres – mostly University Hospital of Wales or Morriston Hospital. While this clearly benefits patients, it does not have the proven advantages of an established major trauma network.

A 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 and in general includes one major trauma centre (MTC) and several trauma units (TUs) spread across the region. Where there is a major trauma network, it is expected that more patients will survive and make a full recovery, irrespective where in the region they suffer a major trauma.

An established major trauma network can have a significantly positive impact on the population in the region. The key benefits of developing the major trauma network are expected to include:

- Fewer people die: Evidence shows that severely injured patients are 15%-20% less likely to die if they are admitted to a major trauma centre (Clinical Advisory Group, 2010)
- 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 will enable access to be optimised to services to 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 will receive
- Hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. The major trauma

network will facilitate 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.

1.3 Impact on workforce

Establishing a major trauma network also has significant benefits for the individual organisations who 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 through closer working with the highly specialist clinicians and other staff at the major trauma centre
- A network with a clearly identified major trauma centre and trauma units is likely to have a positive impact on recruitment across the network
- The establishment of a network is likely to receive support from the Deanery, meaning it is more likely that trainee doctors will be allocated to hospitals across the network to undertake their training
- Services are delivered within a clinical network which allows improvement to be made through an integrated, whole system approach, resulting in standardisation of services and improved patient outcomes & experience
- 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.

1.4 Equality And Human Rights

Under the Equality Act 2010 we have a legal duty to pay due regard to duties to eliminate discrimination, advance equality and foster good relations between those who share protected characteristics and those who do not.

This means that we need to take into account the needs of people from different groups within our populations who might be affected by our proposals. We must take reasonable and proportionate steps wherever

possible to eliminate or mitigate any identified potential or actual negative impact or disadvantage. Developing a major trauma network also gives us the opportunity to identify and enhance any potential positive impact on protected groups. The Equality Act 2010 gives people protection from discrimination in relation to the following "protected characteristics"[1]

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

The Human Rights Act 1998 also places a positive duty to promote and protect rights for all. In Wales, we also have a responsibility to comply with the Welsh Language (Wales) Measure 2011 and All Wales Sensory Loss Standards for Accessible Communication and Information for People with Sensory Loss. We will take all our legal duties into consideration when we make decisions around developing a major trauma network.

[1] Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

Equality Impact Assessment (EqIA)

In Wales, we are required under the Public Sector Equality Duties to undertake Equality Impact Assessments (EqIAs) which will assist us to consider how the decisions we make affect people from protected groups in different ways.

We recognise that consideration of the needs of protected groups helps us to develop and deliver cost-effective services and person-centred care, ensuring that people are treated fairly and equitably.

EqIA is an ongoing process running throughout the course of the decision making process, from the start through to implementation and review. It requires us to consider how the development of a major trauma service, 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?

EqIAs require analysing impacts on the basis of the above protected characteristics. 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 and engagement with key stakeholders 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.

While socio-economic status is not a protected characteristic under the Equality Act 2010, 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.

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 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.

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.

A literature review was carried out as a first stage of gathering evidence to inform the EqIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders to develop the service model.

2.1 Potential impacts on protected characteristic groups?

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. However, evidence suggests that should you suffer a major trauma, you are more likely to survive and make a full recovery if you are in a region where there is a major trauma network, regardless of how far you are away from the major trauma centre.

Evidence suggests there are a number of protected groups who may be likely to suffer a major trauma.

2.1.1 Gender

Men are at far higher risk of experiencing major trauma than women. The NCEPOD report[2] 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.

8.1

Young men are at greater risk of being involved in major trauma accidents, typically arising from moving vehicles, tools or work.

2.1.2 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)[3].

There is evidence, 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)[4] 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.

Teenagers and young adults are more likely to need hospitalisation from injuries than other age groups.

[2] Trauma: who cares? A report of the national confidential enquiry into patients outcomes and deaths (NCEPOD) (2007)
[3] NHS Clinical Advisory Groups Report: Regional Networks for Major Trauma (2010)
[4] The changing face of major trauma in the UK *Emerg Med J* 2015;**32**:911-915

Children under the age of 15 only account for a very small percentage of major trauma and deaths as a result of major trauma.

Potential impact –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 have 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 in an age-appropriate setting

Young people may 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. When treating children, the service model will additionally follow the standards and criteria outlined for children's services[5].

2.1.3 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 people from Black, Asian and other Ethnic Minority backgrounds 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[6].

Potential Impact - 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 their first language. Cultural issues are also important to take into account and a toolkit is available for this purpose.

2.1.4 Disability

Major trauma is the national leading cause of disability for those under 45 years of age. The improved number of survivals in young adults and

[5] http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf).
[6] Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)

reduced incidences of disability resulting from major trauma 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)[7].

Potential Impact - 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 provision of appropriate equipment across boundaries and within social care sector. As well as physical disability, there is a need to consider learning disabilities and mental health. Communication needs in these client groups may be more challenging and care should be adapted accordingly, for example, where there is a need for BSL interpretation services.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss[8] that apply directly to emergency and unscheduled care (in addition to primary care and other secondary care services) and these outline the staff training requirements, communication systems and equipment and patient needs information which should be provided by health boards. BSL interpreters will be required for the deaf community.

2.1.5 Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

2.1.6 Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

2.1.7 Religion or belief (including lack of belief)

[7] Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)
[6] All Wales Standards for Communication and Information for People with Sensory Loss 2013)

Potential impact - staff need to 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[9]. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered. As previously a comprehensive cultural awareness toolkit is available for this purpose.

2.1.8 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 transgender (LGBT) patients in Wales report significant barriers to health and social care services[10]. 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. Inappropriate assumptions are also made about 'next of kin' if they are in a same sex relationship. 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.

8.1

Potential Impact - There is a need to ensure that patients' 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 staff and their patients. Health boards should continue to seek to make progress in this area.

2.1.9 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.

Potential Impact - In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015[19] Trans* people must be accommodated in line with their gender expression. This applies to toilet facilities, wards,

[9] http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp
[10] http://www.stonewallcymru.org.uk/our-work/research/have-your-say

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. 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 Gender Recognition Certificate 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.

2.1.10 Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure 2011. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. Whilst we recognise that Welsh and English are Wales' official languages, Wales has many different voices. Like two-thirds of the world's population many people in Wales are bilingual or multilingual. This is particularly important in traumatic situations where people are more likely to need to communicate in their first language.

Potential impact - Service users who prefer to communicate in the medium of Welsh may be required to access highly specialist services which do not have sufficient Welsh speaking staff (this may also be the case for languages other than English). 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.

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. However it is important to recognise groups of other individuals who have suffered life changing conditions that may benefit from community through the medium of welsh. Research has shown these groups cannot be treated safely and effectively except in their first

language (Welsh Language Services in Health, Social Services and Social Care, 2012)[11]. Our consideration of equality takes account of this.

2. Next Steps

The needs of protected groups will continue to be an ongoing consideration during the consultation process and when implementing the consultation plan, health boards will need to ensure that venues for the public events are accessible and the NHSWHC will need to ensure that information can be provided in a variety of required alternative formats in order to maximise opportunities for participation.

Through the next phase of consultation we will consider what people may tell us about how they will be affected by the proposals in relation to their protected characteristics so that we may seek to eliminate or mitigate any potential disadvantage.

We will continue to update the assessment of impact by taking into account feedback given to us during the consultation.

The health boards will be fully informed of the outcome of the assessment and results will be published for public scrutiny.

[11] More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

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Briefing Paper
Major Trauma

Author: Rachel Jones, Programme Director, Strategic Planning

Date: 9th January 2017	**Version:** 1

Publication/ Distribution:

Abertawe Bro Morgannwg University health Board
Aneurin Bevan, University Health Board
Cardiff & Vale University Health Board
Cwm Taf, University Health BoardHywel Dda University Health BoardPowys Teaching Health Board

Purpose and Summary of Document:

This paper asks for Health Board to note the process agreed to deliver on making a recommendation for a preferred location of a major trauma centre to cover the region of south Wales, west Wales and south Powys.

The Board/Committee are asked to

Approve		**Discuss**		**Receive**	**X**

Public Health Wales	

1 Introduction

This paper is to provide an overview of the proposed process to identify a preferred location for the major trauma centre (MTC) for south Wales, west Wales and south Powys.

2 Background

An independent panel of specialists from across trauma and rehabilitation services in the UK has been commissioned to review the information available and will make a recommendation on the preferred location for a MTC in the region.

3 Assessment

3.1 The Independent Panel

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 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 and will include experts in key specialities that are essential for managing patients with severe multiple injuries as well as rehabilitation.

3.2 Expectations of the Candidate MTCs

The candidate MTCs are Morriston Hospital, Swansea and University Hospital of Wales, Cardiff. This was confirmed as part of a non financial option appraisal which took place in June 2015 and involved clinicians from across the region. The outcome of the options appraisal was approved by the Collaborative Board in August 2015.

Formal invitations have been sent to the candidate Health Boards, outlining the expectations of the panel in terms of the information provided prior to and on the day.

Each candidate MTC is invited to bring a small team of representatives, including their trauma and rehabilitation lead, to present to the Panel and answer any questions or issues which may arise. The candidate MTCs will be expected to talk about their current services and how they will address the provision of specialist services, including:

- Neurosurgery
- Plastics
- Interventional radiology
- Paediatrics
- Cardiothoracics
- Maxillo-facial
- Critical care capacity
- Rehabilitation

Public Health Wales	

They will also be expected to address their proposals for the service on day one, medium term and longer term and make reference to how relatives and carers will be supported. Each Candidate MTC will also be required to present their TARN data and discuss their response to the major trauma self assessment document.

The major trauma self assessment document is a set of quality indicators 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. It is expected that the candidate centres have this information available. They have been advised that no evidence is required to support their answers at this stage, but they should be prepared to discuss their answers during the Panel and may be required to provide supporting evidence at a later stage.

3.3 Structure of the day

Alongside the presentations from the Candidate Health Boards, Public Health Wales will be invited to present on the public health context in which the work is being taken forward and EMERTS/WAST are invited to present on activity levels, current experience when presenting at accident and emergency at either of the candidate sites and the anticipated challenges should either site be identified as the MTC. Members of the forum will be given the opportunity to question the candidate sites on aspects of their presentation in order to facilitate openness and transparency.

3.4 Stakeholder representations

It is proposed that the forum comprises representatives from across the health service in the region alongside other key stakeholders and will include representation from the following:

- Clinical representative from Aneurin Bevan, Cwm Taf, Hywel Dda and Powys Health Boards
- Public Health Wales
- Representation from Health Board Chairs
- Community Health Councils
- EMRTS and WAST
- WHSSC
- EASC

Welsh Government will also be offered the opportunity to have an observer at the event.

Public Health Wales	

3.5 Engagement and consultation

The aim of the Independent Panel process is to assist the Health Boards to identify a preferred option for the development of a Major Trauma Centre for south Wales which will thenh be the subject of full public consultation.

Alongside the process to identify a preferred option will be a period of wide stakeholder engagement which will focus on raising awareness and understanding of the need for the development of a MTC and the benefits to patients.An engagement document is being developed which will support the process and which will be distributed through established networks within the Health Boards and CHCs.

The engagement process and supporting document will articulate the public benefits, including health outcomes, irrespective of where the MTC is located. Prior to any decisions being made about implementation, a full public consultation exercise will be undertaken by each of the constituent health boards, together with their local Community Health Council in line with Welsh Government guidance.

3.6 Next Steps

Following the Independent Panel event, the independent experts will further review all the evidence provided and presented on the day. Professor Moran as Chair of the Panel will then present a report back to the NHS Wales Collaborative Leadership Group making a recommendation on the preferred location of the MTC for the region.

The recommendation will be then presented to the Health Boards whose populations are affected by the development of the MTC for decision to proceed to public consultation. The Health Boards involved will be:

- Abertawe Bro Morgannwg UHB
- Aneurin Bevan UHB
- Cardiff and Vale UHB
- Cwm Taf UHB
- Hywel Dda UHB
- Powys tLHB

Betsi Cadwalader UHB is not included on the basis that North Wales patients have major trauma services provided from within the neighbouring English Regions.

Each Health Board will be required to consider and agree the recommendation through their individual governance arrangements and make the decision to proceed to public consultation in their Board meeting in public.

On the assumption that agreement is reached by each of the constituent Health Boards to consult on the preferred option arising from the independent panel

process, a full consultation exercise will commence. This is anticipated to take place over the Summer months.

The outcome of the public consultation process will be brought together through the Collaborative Leadership Forum and then reported back through constituent Health Boards through their public meetings for decision. This is likely to be late summer / early autumn 2017.

It should be noted that the decisions to both consult on a preferred option and to ultimately make a decision on the establishment of a Major Trauma Centre to serve the population of south Wales, west Wales and south Powys are reserved for Boards through their individual governance arrangements.

4 Recommendation

The Board is asked to:

- **Note** the arrangements for the Independent panel to consider the evidence regarding the establishment of the proposed Major Trauma Centre
- **Note** the process to bring forward a recommendation of a preferred option for public consultation

Document 1

Major Trauma Independent Panel

Background briefing

Purpose

This briefing paper provides members of the Independent Panel with background information in support of the meeting being held on 21st February, outlines the additional documentation which panel members will receive, and sets the context for the day. The outputs of the work to date will inform the Independent Panel meeting; this is outlined below. The panel will consider the information and presentations on the day, and will identify a recommendation for the preferred location of the major trauma centre

Introduction

The NHS Wales Health Collaborative, on behalf of the south Wales health boards (Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf, Hywel Dda and Powys) and Welsh Ambulance Services NHS Trust, has been leading a project to develop a model for a major trauma network for the region. In May 2014, the South Wales Health Collaborative Board approved the establishment of project management arrangements to take forward planning proposals. A wide range of work has been completed to support this process across two phases of work, which are detailed in this report.

Process to date

A Project Board and Clinical Reference Group were established, to develop a detailed service model which sets out the standards and requirements for the establishment of a major trauma centre, supporting trauma units and a model for rehabilitation operating within a formal network arrangement.

The first phase of the project concluded in June 2015 with a non-financial option appraisal process to consider the options for delivery of a major trauma centre for south Wales, south Powys and west Wales. This process concluded there should be a one site major trauma centre in South Wales either at Morriston Hospital in Swansea or at the University Hospital of Wales, Cardiff.

The second phase of the work considered the process for reaching a decision on the location of the one centre, supporting trauma units and the model for rehabilitation. This phase of the project is currently being delivered and the outcome of this work will be a suite of information to enable recommendations to Boards on the location of a major trauma centre, which comprises the following:

- The clinical, workforce and financial Impact of a major trauma centre at either of the two shortlisted options
- Review and confirmation of location/designation of trauma units
- Confirmation of Ambulance transfer times/Emergency Medical Retrieval & Transfer Service (EMRTS) Cymru to assess the relative accessibility of both options

- Model for rehabilitation
- Equality impact assessment
- Engagement and consultation requirements

Three rehabilitation workshops have been held and a wide range of stakeholders have been engaged in the work from health boards, Welsh Ambulance Services, local authorities, third sector, patient organisations and patient representatives. This work has focused on the development of a service model for major trauma rehabilitation and the supporting infrastructure and communication requirements to enable the smooth transition of major trauma patients through the pathway, in order to maximise recovery outcomes. The model focuses on the provision of care at three levels – level 1 specialist rehabilitation in current designated units (Rookwood Hospital, Cardiff and Neath Port Talbot Hospital), level 2 rehabilitation at major trauma units, and level 3 rehabilitation in the community setting. Local discussions are ongoing with health boards to identify the requirements for implementation, ensuring alignment with any current models of rehabilitation in place across hospitals and out into the community.

Activity

Major trauma represents a very small proportion of total emergency workload with current and predicted demand (actual and candidate major trauma) at circa 1000-1500 cases per annum or around 0.2% of total A&E activity. The development of a comprehensive Major Trauma Network, a designated Major Trauma Centre and Units does not undermine the viability of the current A&E units across south and mid Wales but will ensure that the most serious cases are admitted for definitive treatment to the MTC with minimum delay or where necessary are appropriately stabilised for onward transfer. A comprehensive approach to rehabilitation will also ensure those patients who require specialist rehabilitation receive it in a timely manner and will be repatriated to local services for ongoing support at the earliest opportunity.

The MTC Project Board have agreed that the baseline activity for each of the current centres should be based on 2014 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 NWIS on the basis of predicated incidence, LSOA population and travel time. The model assumes a proportion of 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**

Panel members will receive a presentation from Public Health Wales as part of the contextual information on the day regarding the demography and geography of Wales. This will be further supported by presentations from the Welsh Ambulance Services NHS Trust (WAST) and the Emergency Medical Retrieval and Transfer Service (EMRTS) regarding travel times and current service provision.

Information in support of the day

To ensure that panel members are aware of the context of the Independent Panel and the work done to date, this document has set out some background information. It will also be accompanied by a suite of documentation, and this is outlined below:

- Agenda for 21st February
- Terms of reference for the Independent Panel
- Panel member biographies
- List of attendees
- Service models developed for the acute major trauma service and rehabilitation
- Service specification for major trauma service
- Equality Impact Assessment – revised January 2017
- Report of the non-financial option appraisal workshop held on 3rd June 2015
- Completed Major Trauma Quality Indicators return from both health boards
- List of services at both candidate MTC sites

In addition, Abertawe Bro Morgannwg UHB Cardiff and Vale UHB, as the two candidate health boards, have been asked to present on the day on the following:

1. How will the Health Board as the MTC address/provide the following service requirements:
    - Neurosurgery
    - Plastics
    - Interventional radiology
    - Paediatrics
    - Cardiothoracics
    - Maxillo-facial
    - Critical care capacity
    - Rehabilitation
2. How will the MT service be developed and what are the staffing issues that will need to be considered?
3. How will trauma ward provision be addressed?
4. What will the service look like on day one, medium term and longer term?
5. How will relatives and carers be supported in the MTC?

Conclusion

This briefing has set out the background information for panel members in support of the Independent Panel meeting. It provides an overview of the additional documentation members will receive in advance of the day, and sets out the information members can expect to receive at the meeting.

Major Trauma Independent Panel

21st February 2017
10am – 4.30pm
Sytner BMW Lounge, SSE Swalec Stadium, Cardiff. CF11 9XR

10.00am	Arrival and refreshments	
10.30am	Welcome and introduction • Aims of the day • Welsh Government context • Declaration of interests • What is major trauma?	Mr Bob Hudson Frances Duffy Prof Chris Moran
11.00am	Overview of demographics and geography in South and West Wales	Mr Hugo Cosh Public Health Wales
11.30am	Pre-hospital care and patient transport: presentation from Welsh Ambulance Services NHS Trust (WAST)	Dr Brendan Lloyd WAST
11.45am	Pre-hospital care and patient transport: presentation from Emergency Medical Retrieval and Transfer Service (EMRTS)	Dr Dindi Gill EMRTS
12.00pm	Presentation from Cardiff and Vale UHB regarding proposals for a Major Trauma Centre at University Hospital of Wales, Cardiff	C&V Reps
1.00pm	Lunch	
1.45pm	Presentation from Abertawe Bro Morgannwg UHB regarding proposals for a Major Trauma Centre at Morriston Hospital, Swansea	ABM Reps
2.45pm	Coffee break	
3.15pm	Observations on the discussions and opportunity for further questions from panel	All
4.15pm	Summary of the day and next steps	Mr Bob Hudson
4.30pm	Close	

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.

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 more 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

GIG CYMRU NHS WALES Cydweithrediad lechyd 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

8.6

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.

8.6

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.

8.6

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

8.6

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 2.2 Clinical standards	 3 5
3. Service Model 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	7
4. Workforce	15
5. Specialised, tertiary & networked services	16
6. Key performance Indicators	16
7. References	16

8.6

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

8.6

	• 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

8.6

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.

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.

8.6

	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.

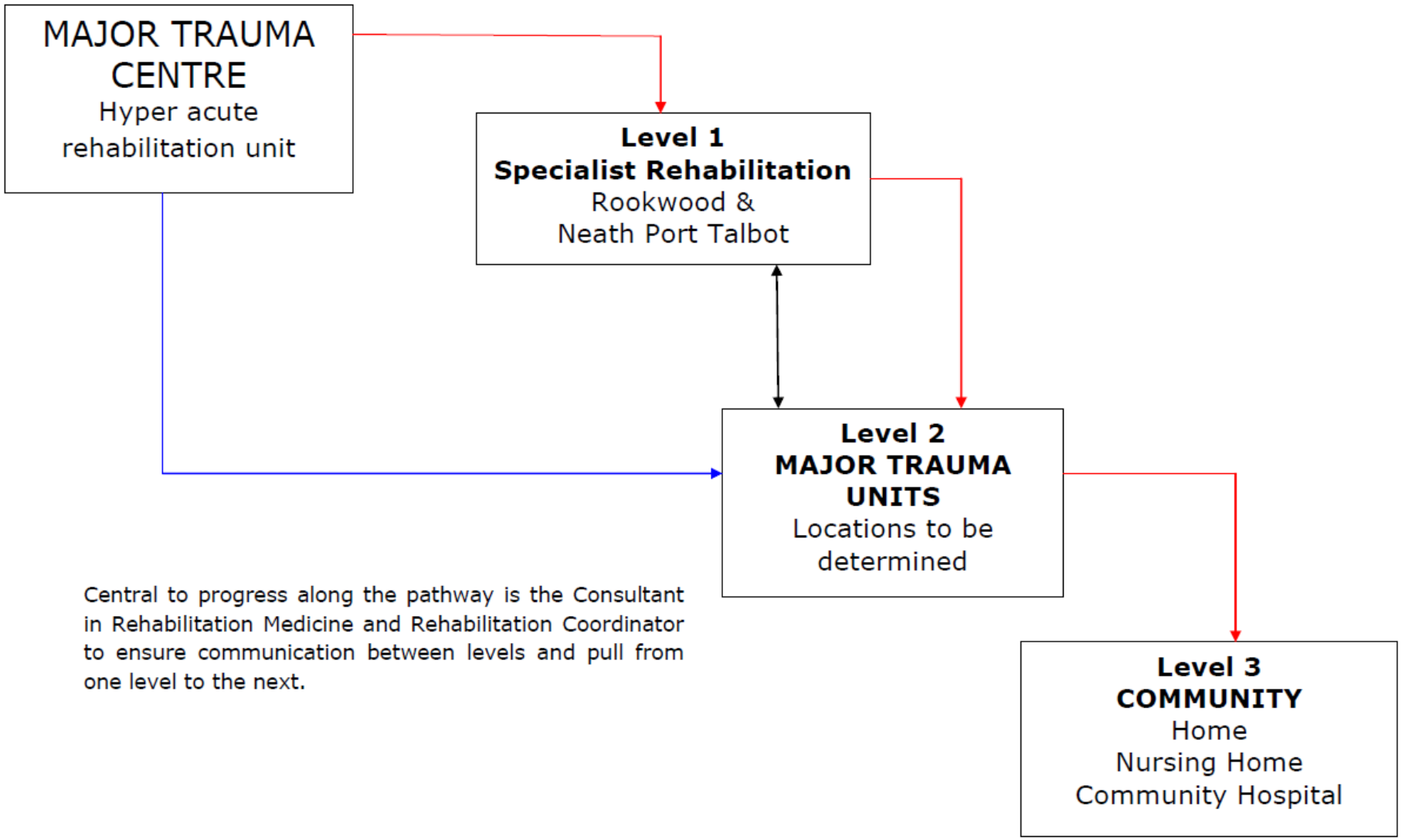
Rehabilitation phase (ongoing specialised and local rehabilitation)

• 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.

8.6

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 5–Process for Non-financial Option Appraisal

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!**

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Appendix 5–Process for Non-financial Option Appraisal

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!**

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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**

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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

8.6

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.

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

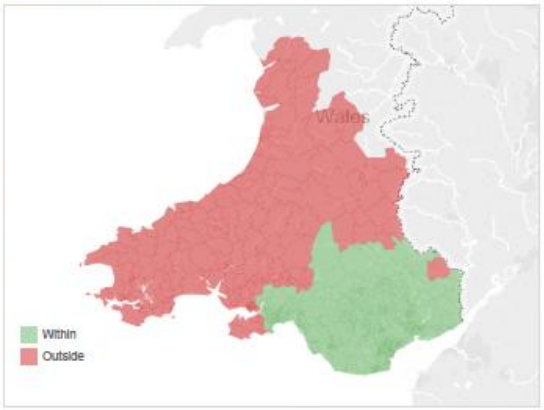
Choose Major Trauma Centre(s)
University Hospital Of Wales

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

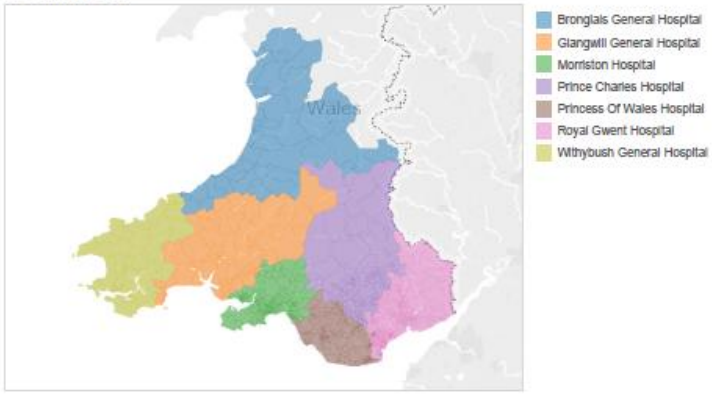
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	13	23	14	11	24	430	12	536
Candidate Major Trauma	11	16	28	16	13	28	477	14	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

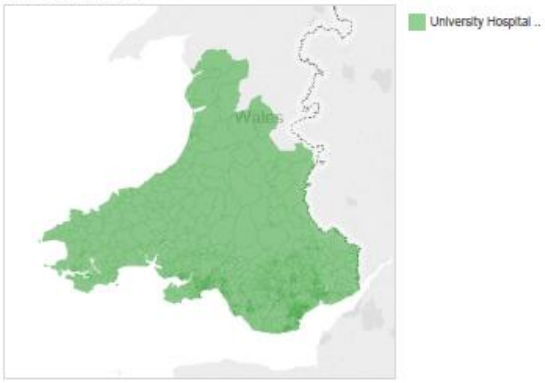


	Population	% Population
Within	1,886,846	80.09%
Outside	468,929	19.91%

TU Catchment



MTC Catchment



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Appendix 9b–Isochrones Maps
Major Trauma Scenarios – Morriston as MTC

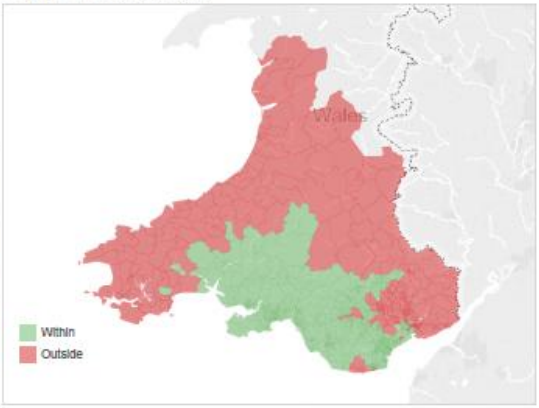
Choose Major Trauma Centre(s)
Morriston Hospital

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

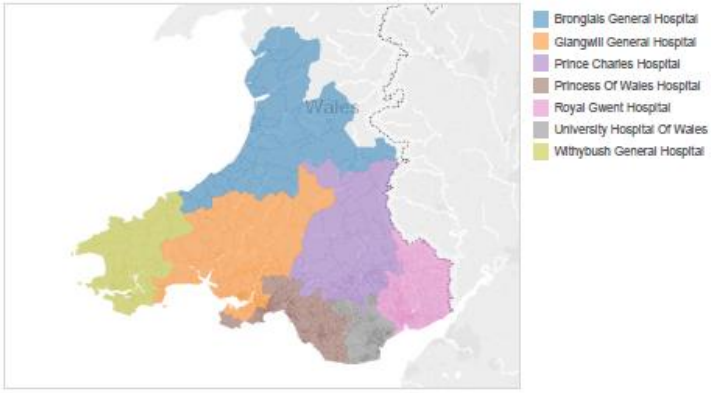
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	11	422	15	15	38	29	12	553
Candidate Major Trauma	11	13	460	18	18	46	35	14	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

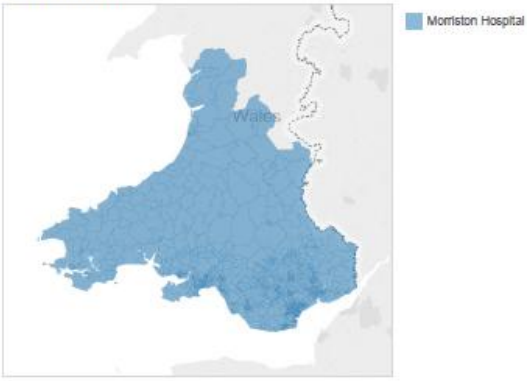


	Population	% Population
Within	1,612,535	68.45%
Outside	743,240	31.55%

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.

8.6

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)

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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.

Works Cited

Emergency Medical Journal, 2015. The changing face of major trauma in the UK. Volume 32, pp. 911-915.

Equality Act, 2010. Race, Sex, Gender Reassignment, Disability, Religion, belief/non belief, Sexual orientation, Age, Pregnancy and Maternity, and Marriage and Civil Partnerships.

European Convention on Human Rights, n.d. *Article 2: The Right to Life,* s.l.: s.n.

European Convention on Human Rights, n.d. *Article 8: The Right to Respect for Private and Family Life,* s.l.: s.n.

GMC Guide, Working With Doctors Working For Patients 2013

Human Rights Act, 1998. s.l.:s.n.

King's Fund, 2014. *The reconfiguration of clinical services: what is the evidence?,* s.l.: s.n.

Longley, P. M., 2012. *The best configuration of hospital services for Wales: a review of the evidence,* s.l.: Welsh Institute for Health and Social Care.

National Audit Office, 2010. *Major Trauma Care in England,* s.l.: s.n.

National Clinical Advisory Group, 2010. *Regional Networks for Major Trauma,* s.l.: s.n.

National Confidential Equiry into Patients Outcomes and Deaths, 2007. *Trauma: who cares?,* s.l.: s.n.

NHS East Midlands, 2010. *Integrated Impact Assessment for Region-Wide Service Redesign,* s.l.: s.n.

NHS Centre for Equality and Human Rights (CEHR) 2015 *It's just Good Care: A Guide for Health Staff Caring for People Who are Trans**

NHS England, 2012. *Standard Contract for Major Trauma (all ages) D15/S/a,* s.l.: s.n.

NHS England, 2013. *Standard Contract for Major Trauma Services,* s.l.: s.n.

NHS Wales, 2009. *Organisational Change Policy,* s.l.: s.n.

NICE guideline, 2016. *Major Trauma: Assessment and Initial Management,* s.l.: s.n.

Social Exclusion Unit, 2003. *Transport and Social Exclusion: Making the Connections,* s.l.: s.n.

Stonewall, 2015 Unhealthy Attitudes**:** The treatment of LGBT people within health and social care services

Stonewall Cymru, Have Your Say 2015

The British Society for Rehabilitation Medicine Standards Framework, n.d. s.l.: s.n.

Trauma Audit and Research Network, n.d. s.l.: s.n.

United Nations Convention in the Rights of the Child, n.d. s.l.:s.n.

Welsh Government, The All Wales Standards for Communication and Information For People with Sensory Loss , 2013

Welsh Institute for Health and Social Care, 2012. s.l.:s.n.

Welsh Language Services in Health, Social Services and Social Care, 2012. *Strategic Framework: More than just words,* s.l.: s.n.

Welsh Language Wales Measure, 2011. s.l.:s.n.

YouGov, 2011. *Welsh Confederation Survey.* s.l.:s.n.

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 individual 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 individual 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		Individual 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 committment 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 support 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 insufficient 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	

8.6

Major Trauma Network Consultation Plan

Author: Rachel Hennessy, Programme Director

Date: 13th November 2017	**Version:** 4

Publication/ Distribution:

- www.publichealthwales.org/majortraumaconsultation

Purpose and Summary of Document:

This document summarises the plan for the proposed consultation on major trauma.

8.7

Public Health Wales	

1. Introduction

This paper sets out the framework to support a consultation exercise on the provision of a major trauma network for South and West Wales and South Powys, hereafter referred to as South Wales. People living in North Wales benefit from Betsi Cadwaladr UHB being part of the West Midlands major trauma network that supports the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the West Midlands major trauma network. South Wales is the only region of England and Wales that does not have a major trauma network or have access to a designated major trauma centre. This means that if you suffer a major trauma in south Wales, you are likely to have poorer outcomes and are at greater risk of death.

The development of the 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. A developing 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.

The work to develop proposals for a major trauma network has been done in collaboration with health boards across the region, Welsh Ambulance Service Trust, Emergency Medical Retrieval and Transfer Service and also involved third sector and Community Health Councils.

2. Background/context

In late 2014, the Health Collaborative was asked by the Chief Executive Officers 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. The service model for major trauma services for adults and paediatrics was developed by the clinical reference group in line with the standards for major trauma and approved by the Project Board in May 2015. In June, a non financial option appraisal was undertaken which identified the need for a major trauma network with a major trauma centre based in the region to support the population.

Building on this work, approval was given for an Independent Panel to review the evidence available and advice on the development of the major trauma network and to recommend a preferred location for the

Public Health Wales	

major trauma centre. The recommendations from the Independent Panel have been reviewed through the Collaborative governance arrangements (Collaborative Executive Group and Leadership Forum) and the benefits for the population of South and West Wales and South Powys associated with developing a major trauma network fully considered. Health boards have considered and agreed in principle to the recommendations and for a period of consultation, in their public Board meetings in September.

Health boards in Wales are required to work with their local Community Health Council to engage and consult with the local population on matters of substantial service change. Given that the proposal to develop a major trauma network is about enhancement of existing 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. 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. Further advice has been sought from the Community Health Councils on the process and length of a consultation.

3. Scope of Consultation

To ensure the consultation process is meaningful, consideration needs to be given to key messages to be shared with the public and the evidence available to support the proposed development of a major trauma network.

The key messages include:

- 'Major Trauma' can be defined as multiple and serious injuries that could result in disability or death. These might include serious head injuries, multiple injuries cause by road traffic accidents, industrial accidents, falls, mass casualty events, attempted suicide, knife and gunshot wounds
- A major trauma network is a group of hospitals, emergency services and rehabilitation services, that work together to make sure a patient receive the best care for life threatening or life changing injuries
- You are more likely to survive and make a full recovery if you have a major trauma in a region where there is a major trauma network, regardless of how far you are aware from the major trauma centre
- Good trauma care involves getting the patient to the right place at

Public Health Wales	

the right time for the right care; having the seriousness of the injury identified as early as possible ideally at the scene of the incident; with detailed investigation taking place immediately on arrival at the trauma unit

- A major trauma network normally has one major trauma centre supported by a number of trauma units. Rehabilitation is a key component of the major trauma network and is an essential part of good trauma care and good patient outcomes
- A local emergency department does not routinely receive patients who suffer a major trauma. You will continue to go to the local emergency department if you are seriously ill or have an injury which does not need the highly specialist services
- An independent panel of expert clinicians working in major trauma were asked to look at the evidence and provide advice on the best hospital site for the major trauma centre. The Independent Panel produced a report making the following recommendations:
  - The rapid development of a major trauma network for South and West Wales and South Powys with a clinical governance infrastructure
  - The adult and children's major trauma centres should be co-located on the same site
  - The major trauma centre should be located at University Hospital of Wales, Cardiff
  - Morriston Hospital, Swansea should become a large trauma unit and should have a leadership role for the major trauma network
  - A clear and realistic timetable for the activation of the trauma network should be set
- The remaining trauma units (if any) will need to be identified by individual health boards for their local population
- Once the location of the major trauma centre has been agreed, further work will be required to identify the full costs of the major trauma centre and the trauma units.

In light of the key messages, the consultation will ask people to respond to three questions:

1. Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?
2. Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?

8.7

Public Health Wales	

3. If we develop a major trauma network for South and West Wales and South Powys is there anything else we should consider?

4. Consultation Plan

This section of the document outlines the objectives of the proposed consultation, the stakeholders, proposed method of consultation and the proposed consultation and post consultation phase. A detailed table outlining the proposed events will be developed and attached.

4.1 Objectives

The consultation plan outlines the methods and proposed process for the consultation that will support delivery of the following objectives:

- Ensure awareness and information about the consultation reaches the majority of our key stakeholders, by the close of the consultation exercise
- Provide a full range of opportunities, taking account of accessibility, for our staff and key stakeholders to give their views by the close of the consultation exercise
- To raise awareness to the general public of the consultation and provide opportunities for feedback.

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4.2 Stakeholders

There are a number of stakeholders which will need to be considered in this consultation and a variety of methods which will be employed. A stakeholder mapping exercise has been undertaken and a detailed list of stakeholders is attached. Key stakeholder groups will include the following:

NHS Wales Staff	This includes: board members; general practice; dentist; optometry; pharmacy; commissioners; Welsh Ambulance Services Trust; Emergency Medical Retrieval Transfer Service and staff working across the NHS in south and west Wales and south Powys region.
Community Health Councils	Health boards will undertaken consultation with their local community health council in line with guidance

Public Health Wales	

	(Regulation 27 of 'The Community Health Councils Constitution, Membership and Procedures Wales')
General public	Health boards will be responsible for undertaken consultation with the general public within their region, which will include public meetings in each district.
National bodies/organisations	A list of national bodies/organisations will be drawn up by the health Collaborative and a copy of the consultation and supporting documents will be sent to these organisations by the Health Collaborative. This includes: Local Medical Committee; Local Optometry Committee; Local Pharmacy Committee and Local Dental Committees; Royal Colleges.
Third sector	Third sector organisations will be engaged through the Wales Council for Voluntary Action (WCVA) by the Health Collaborative and through local County Voluntary Councils (CVCs) by the engagement leads.
Local authorities and elected members (Councillors, Assembly Ministers, Members of Parliament)	Local authorities, through the Welsh Local Government Association (WLGA); Welsh Assembly Cabinet Members; Children's Commissioner; Older Persons Commissioner will be engaged by the Health Collaborative. Health boards will engage with Town and Community Councils.
People with protected characteristics	An Equality Impact Assessment (EqIA) has been undertaken to consider how the major trauma proposal impacts on individuals with protected

Public Health Wales	

	characteristics. Groups with the following protected characteristics will be engaged with which include: Welsh Language group; equality groups; 50+ forum; women's equality network Wales; Lesbian and Gay Christian Movement Cymru; Welsh Refugee Council and Black Voluntary Sector Network Wales (BVSNW).
Other Stakeholders	This will include a number of specialist groups who may have an interest in major trauma: universities; Police; Fire service; search and rescue. Health Boards will also engage with other stakeholders including; youth councils; carers groups and GPs. In line with Guidance on Engagement and Consultation on changes to Health Services, this will include as a minimum • Stakeholder Reference Group • the Health Professional Forum • the Partnership Forum • Public Services Board • Regional Partnership Boards

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4.3 Consultation methods

A number of methods of engagement will be employed throughout the consultation.

Launch of consultation	Subject to approval by health boards in their public board meetings in September the consultation will commence 13th November 2017. Health boards, Welsh Ambulance Service Trust, Emergency Retrieval and Transfer Services, Welsh Government, Community Heath Councils will receive an email briefing providing the start date for the consultation and confirming closing date. Following launch of the consultation, all documentation will be made available via public health Wales website at

Public Health Wales	

	www.publichealthwales.org/majortraumaconsultation and a press release/briefing will be compiled by the Health Collaborative prior to launch day and shared with Welsh Government, health boards (engagement, Communication leads, planning leads), Community Health Councils.
Distribution to NHS Wales staff	Staff will be directed to the consultation documents via the Public Health Wales website at www.publichealthwales/majortraumaconsultation There is no expectation regarding cascading of this information, therefore accessing information on the website will be at the discretion of individuals.
Distribution of consultation document to National organisations	The consultation document will be shared with national organisations by the Health Collaborative via email and hard copies provided where requested. Groups will be signposted to local public meetings to be held by health boards across the region.
Distribution of consultation documents to local organisations	Consultation documents will be shared through local health board networks on line and hard copies provided where appropriate.
Public sessions	Public sessions will be held across each Health Board. A list of planned activity is attached to this document. Details on the proposed public sessions will be available on the website www.publichealthwales.org/majortraumaconsultation and also available on individual health board websites.
Presentation	A PowerPoint presentation will be compiled and made available for health boards to show at public events.
Animated film	A short film will be produced which will outline the key elements of the consultation. This will be made available on the websites, alongside other consultation documentation and will be available to show at public events.
Questionnaires	Hard copies of the surveys can be returned to a freepost address or scanned and returned via a dedicated email address. This will be coordinated by the Health Collaborative

Public Health Wales	

Online response	Individuals or organisations can respond to the consultation questions online at www.publichealthwales.org/majortraumaconsultation
Frequently Asked Questions	An initial list of frequently asked questions will be available as a technical document on the website. This list will be updated on a weekly basis pending further frequently asked questions.
Social Media	Social media may be used where health boards already use this method of engagement with the public. Questions or queries which relate to an area of interest for the wider public or the development of the wider major trauma network, should be referred to the Health Collaborative to log and coordinate a response, which will then be uploaded to the FAQs.

4.4 Consultation Phase

It is anticipated that the consultation period should last a period of 12 weeks subject to agreement with the Community Health Council's and approval at public health board meetings.

Assuming a consultation period of 12 weeks, the consultation will commence 9am, Monday 13th November and end 9am Monday 5th February 2018.

The consultation document and supporting consultation pack will be cascaded by the Health Collaborative to key stakeholders as identified in the attached stakeholder analysis and Health Board engagement leads.

The Health Collaborative will be responsible for ensuring the consultation document and supporting documentation is uploaded to the Public Health Wales website.
Health Board engagement leads will be responsible for ensuring the consultation is signposted on their health board website and the documentation is made available across their region.

There will be a period of planned activity, led by health boards in each region. This will provide the opportunity for staff, stakeholders and the wider public to find out more about the proposals for a major trauma network in South Wales as well as providing opportunities to feedback on the proposals in the consultation document.

8.7

Public Health Wales	

A list of representatives to lead planned events will need to be agreed. It is anticipated that WAST and EMRTs representatives will participate in the planned activity alongside health boards. Health boards will also identify a clinical lead and executive lead to take forward the public sessions.

Administrative support to public sessions will be supported by individual health boards. Feedback from each event will be captured on a standardised meeting record sheet to ensure consistency across Health Boards. Notes will be shared and agreed between the health boards and local Community Health Councils prior to being sent to the NHS Wales Health Collaborative to log. Notes from other local meetings will be sent directly to the NHS Wales Health Collaborative to log.

Emerging themes from the planned events will be identified by the Health Collaborative and shared with engagement and Community Health Councils leads.

A formal review meeting will be scheduled for approximately six weeks into the consultation to review response to the consultation and address any issues of concern. This will be coordinated by the NHS Wales Health Collaborative and include the health boards and Community Health Councils chief officers.

Where there is interest from the media, the Health Collaborative will coordinate formal responses as appropriate, engaging with Welsh Government and Health Board Communication leads. Queries relating to local context and issues will be addressed through individual health boards communication leads. A Press Strategy has been developed and shared with individual health boards.

3.5 Post consultation Phase

The NHS Wales Health Collaborative will receive and log responses to the consultation. This will be shared with health boards and the Community Health Councils for consideration and response.

Responses will be analysed by the NHS Wales Health Collaborative and themes identified. This information will be shared with Community Health Councils to enable production of a formal response.

A report will be produced which will include the findings of the consultation. This will be considered by health boards in their public Board

Public Health Wales	

meeting in March 2018.

3.6 Timelines

The consultation period is anticipated to last for a period of 12 weeks, commencing 9am Monday 13th November 2017 to 9am Monday 5th February 2018. A final report, detailing the response to the consultation will be produced for consideration by health boards in public meetings in March 2018.

4. Risks

The consultation on major trauma spans several organisations and regions across south Wales and is therefore complex in nature. There are a number of risks associated with delivering the planned range of activity within the identified time frame.

- Ensuring consistency in delivery of key messages across the region, where there are differing local priorities
- Opposition from one or a number of stakeholders
- Media interest
- Adverse publicity
- Misunderstanding regarding key messages, principles or emerging recommendations
- Confusion with any other potential stakeholder consultation processes which may run concurrently, for example thoracic services
- Availability of adequate resource to manage and run a comprehensive consultation process at health board and from within the Health Collaborative.

A risk register has been developed and will continue to be reviewed and updated throughout the course of the consultation.

8.7

Health Board	Title	Template received	06/11/2017	13/11/2017	20/11/2017	27/11/2017	04/12/2017	11/12/2017	18/12/2017	25/12/2017	01/01/2018	08/01/2018	15/01/2018	22/01/2018	29/01/2018
Cwm Taf University Health Board	Rhondda Valleys Public Forum	X		15/11/2017 09:30											
Cwm Taf University Health Board	Hospital Medical Staff Committee	No		17/11/2017											
Cwm Taf University Health Board	Cynon Valley Public Forum	X			22/11/2017 09:30										
Cwm Taf University Health Board	Local Medical Committee	Meeting cancelled			23/11/2017										
Cwm Taf University Health Board	Taff Ely Public Forum	X				27/11/2017 1pm									
Cwm Taf University Health Board	Merthyr Tydfil Public Forum	X				29/11/2017 2pm									
Cwm Taf University Health Board	Working in Partnership Forum	No										11/01/2018			
Cwm Taf University Health Board	Health, Social Care & Wellbeing Forum	No					06/12/2017 circ. Electronically								
Cwm Taf University Health Board	Equality & Welsh Language Group	No						13/12/2017							
Cwm Taf University Health Board	Stakeholder Reference Group	Meeting cancelled						14/12/2017 cancelled							
Cwm Taf University Health Board	CHC Service Planning Committee	HC Development session - no template completed										12/01/2018			
Cwm Taf University Health Board	Medical Leadership Forum	Meeting cancelled												24/01/2018	
Cwm Taf University Health Board	Healthcare Professionals Forum	Virtual sharing of infomration													
Cwm Taf University Health Board	Meeting withstaff directly involved with trauma services	No attendees													
Cwm Taf University Health Board	Health Board	No template completed													31/01/2018
Cardiff and Vale University Health Board	Joint UHB Stakeholder Reference Group and Healthcare Professionals Forum	X				30/11/2017 09:30 - 12									
Cardiff and Vale University Health Board	UHB Local Partnership Forum	X						13/12/2017 10-12							
Cardiff and Vale University Health Board	Cardiff and Vale CHC members via full CHC council meeting											08/01/2018 6 -7pm			
Cardiff and Vale University Health Board	General Public - Vale	X										09/01/2018 6:30 - 8pm			
Cardiff and Vale University Health Board	General Public - Cardiff	X										10/01/2018 6:30 - 8pm			
Cardiff and Vale University Health Board	Cardiff Public Services Delivery Board				24/11/2017										
Cardiff and Vale University Health Board	Vale Public Services Delivery Board					30/11/2017									
Cardiff and Vale University Health Board	Staff engagement	X													
Abertawe Bro Morgannwg University Health Board	Disability Reference Group									29/12/2017 12pm					

Abertawe Bro Morgannwg University Health Board	Stakeholder Reference Group			17/11/2017 10am											
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Swansea	X					04/12/2017 2 - 6:00pm								
Abertawe Bro Morgannwg University Health Board	Public Meeting - Swansea	X					04/12/2017 6 - 8pm								
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Neath	X					05/12/2017 2 - 6:00pm								
Abertawe Bro Morgannwg University Health Board	Public Meeting - Neath	X					05/12/2017 6 - 8pm								
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Port Talbot	X						12/12/2017 2 - 6:00pm							
Abertawe Bro Morgannwg University Health Board	Public Meeting - Port Talbot	X						12/12/2017 6 - 8pm							
Abertawe Bro Morgannwg University Health Board	Stakeholder Reference Group											10/01/2018 10am			
Abertawe Bro Morgannwg University Health Board	ABM Youth														
Abertawe Bro Morgannwg University Health Board	Bridgend Equality Forum	X			22/11/2017 2pm										
Abertawe Bro Morgannwg University Health Board	Swansea Bay LGBT Forum												17/01/2018 2pm		
Abertawe Bro Morgannwg University Health Board	CHC Members					28/11/2017 10am									
Abertawe Bro Morgannwg University Health Board	CHC Members													23/01/2018 10am	
Abertawe Bro Morgannwg University Health Board	Local Advisory Medical Group				23/11/2017 6:30pm										
Abertawe Bro Morgannwg University Health Board	Public Drop In Session - Bridgend	X							19/12/2017 2 - 6:00pm						
Abertawe Bro Morgannwg University Health Board	Public Meeting - Bridgend	X							19/12/2017 6 - 8pm						
Abertawe Bro Morgannwg University Health Board	Traumatic Brain Injury Service	X													
Hywel Dda University Health Board	Public Drop in Session - Haverfordwest	x						12/12/2017 3-7pm							
Hywel Dda University Health Board	Public Drop in Session - Carmarthen	x						13/12/2017 3-7pm							
Hywel Dda University Health Board	Public Drop in Session - Aberystwyth	x											16/01/2018 3-7pm		
Powys Teaching Health Board	Drop in Session			16/11/2017 10 - 12:30											
Powys Teaching Health Board	Drop in Session					27/11/2017 & 28/11/2017 All day events									
Powys Teaching Health Board	Drop in Session	x									05/01/2018 10 - 12:30				
Powys Teaching Health Board	Drop in Session	x										09/01/2018 10 - 12:30			
Powys Teaching Health Board	Drop in Session	x										12/01/2018 10 - 12:30			
	Brecknockshire Committee	X													
Powys Teaching Health Board	Full council meeting of the CHC											09/01/2018			
Aneurin Bevan University Health Board	Public Meeting - Newport											08/01/2018			
Aneurin Bevan University Health Board	Public Meeting - Caerphilly	: to lack ration										09/01/2018			

8.8

Aneurin Bevan University Health Board	Public Meeting - Monmouthshire	cancelled due of pre-regist										11/01/2018			
Aneurin Bevan University Health Board	Public Meeting - Blaenau Gwent												15/01/2018		
Aneurin Bevan University Health Board	Public Meeting - Torfaen														

8.8

GUIDANCE FOR ENGAGEMENT AND CONSULTATION ON CHANGES TO HEALTH SERVICES
SECTION 5: SUBSTANTIAL CHANGE

A key issue to be determined as to whether formal consultation is required is whether the change is substantial or not. It is expected that staff who lead on citizen engagement will work closely with their counterparts in other LHBs and the Trusts to promote consistency in dealing with such cases. As part of this analysis, the CHC and other stakeholders, in assessing proposals and participating in discussions about consultation, should be conscious of the potential to compromise the LHB's ability to maintain a full service for the whole population it serves	In discussion with CHCs the proposal for a major trauma network is subject to a period of consultation to last 12 weeks.
Where it appears likely that a formal consultation could take place, it is proposed in future that this should be conducted on a two stage basis. The first stage is for NHS organisations to undertake extensive discussion with all the key stakeholders, to include: • the Stakeholder Reference Group • the Professional Forum • the Partnership Forum • the Community Health Council • the Local Service Board • staff and their representative bodies • other key partners as appropriate. The purpose of these discussions will be to explore all the issues, to refine the options and to decide and agree on which questions will be set out in the consultation. Only when it is satisfied that this first stage has been properly conducted, should the NHS organisation proceed to formal consultation	Prior to the decision to go to consultation, work was undertaken in collaboration with key stakeholders. In June 2015 a workshop led by clinicians looked at the options available to support a major trauma network in south Wales. The workshop comprised representatives from the Health Boards and Welsh ambulance services Trust (WAST). Patient representatives were invited through the third sector support groups and geographical coverage was sought. CHCs were also invited in an observer capacity. Following this workshop a period of engagement was planned and documentation was developed. However, this was delayed and instead a single period of consultation was taken forward. To facilitate the decision on the preferred location of the site for the major trauma centre an independent, expert clinical panel was commissioned to review the available evidence and provide advice on the best facility to locate the major trauma centre for the region. Representatives from across the health service in the region alongside other key stakeholders were invited to attend the panel. This included: Clinical representatives from Aneurin Bevan, Cwm Taf, Hywel Dda and Powys Health Boards; Public Health Wales; Welsh Government; Community Health Council; Emergency Medical Retrieval Transfer Service (EMRTS); WAST; Welsh Health Specialist Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC). The development of the consultation documentation and questions was done in collaboration with health boards and the community health

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	councils. The initial questions were revised on discussion and agreement by the community health councils.
A formal consultation period of a minimum of 6 weeks should be sufficient in most cases if the issues have already been fully explored during the first stage and if the CHC agrees.	The major trauma consultation period is for 12 weeks, 13th November 2017 – 5th February 2018
A number of issues should be considered right at the start, because they will impact on decisions to be taken at various stages throughout the formal consultation process. These include: • what is the respective responsibility of each of the local NHS organisations? • has there been any previous consultation carried out on the same or a previous related or similar issue, e.g. for local authority services? • who should be consulted, on what and how? • will these issues affect users of other NHS services in particular those with sensory loss and disabilities? • are there issues affecting other Welsh or English areas? • what resources are needed and available? • how will any conflict/complaints be dealt with? • how will the outcome feed into the decision making process? • when and how will decisions be made? • how will results be fed back to patients, staff and citizens who have been involved, either directly or indirectly? will they be published through the media to inform a wider public? • what evaluation of the consultation is going to be undertaken, and how? • when to complete a full equality impact assessment • what is the timetable for both the involvement and consultation process? • what is the impact on associated services?	The majority of these issues are covered within the consultation document and a number of additional supporting documents • Consultation plan • Media and communication plan • Equality Impact Assessment These documents have been developed in conjunction with engagement leads from individual health boards, WAST and EMRTS and have been viewed by the CHCs. The Health Collaborative will be responsible for ensuring the consultation document and supporting documentation is uploaded to the Public Health Wales website and distributed to national organisations. Health Board engagement leads will be responsible for ensuring the consultation is signposted on their health board website and the documentation is made available across their region. Public sessions will be held across each health board. A stakeholder mapping exercise has been undertaken and a detailed list of stakeholders produced. The consultation documents have been by the Health Collaborative and to local organisations through local health board networks. The major trauma consultation period ends 5th February 2018. During the consultation the NHS Wales Health Collaborative will receive and log responses and this will be shared with health boards and the Community Health Councils for consideration and response. Responses will be analysed by the NHS Wales Health Collaborative and themes identified. This information will be shared with Community Health Councils to enable production of a formal response. A report will be produced which will include the findings of the consultation. This will be considered by health boards in their public Board meeting in March 2018.

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	Processes have been agreed for sharing responses to the consultation, media enquiries and information from public sessions. The Health Collaborative team have been identified as the point of information in the consultation documents and will be collating and analysing the responses.

In managing the process, the Welsh Assembly Government will expect that:
• senior clinicians will take a lead role in presenting and supporting the proposed change;
• the NHS body leading the consultation will work in partnership with its counterparts in other local NHS bodies
• NHS bodies will invest sufficient resources to manage the process from start to end effectively, openly and transparently; and
• the Local Service Board partners will be fully involved to ensure that proposals are seen and addressed within the context of the "whole system" of public service provision.
	The NHS Wales Health Collaborative has:
	• worked with Health Board engagement, communication and equality leads and with Community Health Councils
	• public sessions are being led by clinical and managerial representatives in each area supported by representatives from WAST and EMRTS
	• production and translation of consultation document is being undertaken by the Health Collaborative for use throughout the consultation.
	• There will be communication with:
	  • Stakeholder Reference Group
	  • the Professional Forum
	  • the Partnership Forum
	  • Local Service Board

Consultation documents should: • explain why change is necessary and provide clear evidence; • include a clear vision of the future service; • explain the consequences of change or of maintaining the status quo, on quality, safety, accessibility and proximity of services • include information on outcomes for patients and service users; • in the case of changes relating to hospitals, demonstrate how services will in future be provided within an integrated service model; • set out clearly evidence for any proposal to concentrate services on a single site; • include the evidence of support from clinicians for any proposed change; • in the case of changes prompted by clinical governance issues, show how these have been tested through independent review;	The consultation document outlines the case for change and recommendations of an Independent Panel. It has been signed off by all Health Boards and is supported by a number of additional documents • Consultation plan • Media and communication plan • Equality Impact Assessment • Technical documents available on the website www.publichealthwales.org.uk/majortraumaconsultation Inc. FAQs and Risk Register cover the majority of these issues The service model for a major trauma network was developed through a clinical reference group. An Independent clinical panel was appointed to make further recommendations based on clinical expertise. Once the location of the major trauma centre has been agreed, further work will be required to identify the full costs of the major trauma centre and the trauma units.

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• show which options were considered during the engagement phase - the NHS needs to ensure that, if a preferred option is specified, this will not be seen as a 'fait accompli'; • explain any risks and how they will be managed; • give a clear picture of the financial implications of the different proposals; • spell out who will be affected by the proposed changes and how their interests are being protected; • explain how any change and benefit will be evaluated after implementation; • be available in a range of formats, such as "Easy Read", large print, Braille and BSL or audio; • be signed off by the Board • set out how sustainable staffing levels are to be achieved.	A video of Professor David Lockey, Transitional Lead for the South Wales Neonatal Network is available on the website and has been shared with engagement leads for presenting at public and other meetings The consultation document is bilingual and available in • Easy Read • Braille • Audio • BSL There is also a contact email and phone number should other formats be required.
The NHS body should develop media contacts and work with them to explain the changes and their impact in ways in which citizens will understand. The process of consultation should be genuine and transparent. There should be an open discussion with citizens, NHS staff, staff representative and professional bodies, stakeholders, third sector and partner organisations right through the process.	A media and comms plan has been produced and a log of media enquiries and cuttings updated on an ongoing basis. All media enquiries are being managed centrally through the Health collaborative in line with the agreed media plan. Prior to commencing the consultation, a press briefing was issued to local press across the region. The consultation document has been distributed electronically by the Health Collaborative to national organisations. Health Boards have distributed the document to an agreed set of local organisations. Public sessions will be held across each Health Board. There will also be communication with: • Stakeholder Reference Group • the Professional Forum • the Partnership Forum • Local Service Board
The primary task of CHCs is to assess the impact of proposed changes on health services not to take a partisan role. If a CHC considers that there are other options to the proposal to be consulted upon by the responsible NHS body it should inform the NHS body at the earliest stage. The NHS should provide assistance to the CHC in considering such options.	Advice was sought from the CHCs on the process, the consultation questions and length of a consultation. The consultation questions were amended on guidance from the CHCs.
At the end of the consultation period, the CHC should have the opportunity to consider all comments received and record its own observations on	The Health Collaborative will receive and log responses to the consultation. This information will be shared with health boards and the CHCs for

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them.	consideration and response.
If the CHC agrees to the proposals in the consultation, the NHS body may proceed to implement its proposals subject to any other approvals or consents that may be required. The Welsh Assembly Government, local Assembly Members, the local council(s) and local Members of Parliament should be informed of this and a notice inserted in the local press informing the public that the proposals are to be implemented following CHC agreement. In normal circumstances it is considered that this stage should be reached within 4-6 weeks after the end of the public consultation period.	Not applicable at this stage
Where a CHC is not satisfied that proposals for substantial changes to health services would be in the interests of health services in its area or believes that consultation on any such proposal has not been adequate in relation to content or time allowed, it may take further action as set out in Section 7 below.	Not applicable at this stage
NHS bodies should consider with CHCs how well the consultation process worked and whether it met the expectations of those who participated in it. They should assess this against the measures identified at the planning stage. They should also give feedback to stakeholders about the results of consultation.	Not applicable at this stage

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National Principles for Public Engagement in Wales – this is supported by the Major Trauma Consultation Plan

Engagement is effectively designed to make a difference Engagement gives a real chance to influence policy, service design and delivery from an early stage.	Engagement questions developed and agreed in conjunction with CHCs.
Encourage and enable everyone affected to be involved, if they so choose The people affected by an issue or change are included in opportunities to engage as an individual or as part of a group or community, with their views both respected and valued.	Prior to commencing the consultation, a press briefing was issued to local press across the region. The consultation document has been distributed electronically by the Health Collaborative to national organisations. Health Boards have distributed the document to an agreed set of local organisations. Public sessions will be held across each Health Board. There will also be communication with: • Stakeholder Reference Group • the Professional Forum • the Partnership Forum Local Service Board English and Welsh websites developed. Public sessions being held across the region.
Engagement is planned and delivered in a timely and appropriate way The engagement process is clear, communicated to everyone in a way that's easy to understand within a reasonable timescale, and the most suitable method/s for those involved is used.	Major trauma consultation plan developed in conjunction with health board engagement leads. Timescale for consultation in outlined in consultation document, consultation information, board papers.
Work with relevant partner organisations Organisations should communicate with each other and work together wherever possible to ensure that people's time is used effectively and efficiently.	Work on the consultation document, consultation plan and supporting information has been developed in conjunction with health board engagement leads, CHC to ensure consistency. EMRTS/WAST providing additional support to public sessions.
The information provided will be jargon free, appropriate and understandable People are well placed to take part in the engagement process because they have easy access to relevant information that is tailored to meet their needs.	Consultation document has gone through 'plain English' and achieved a crystal mark. Easy read version has been commissioned and published. Alternative formats are available on the website and at request. The consultation document is bilingual and available in • Easy Read • Braille • Audio • BSL

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	As EqIA has been completed which has been used to underpin the consultation plan
Make it easier for people to take part People can engage easily because any barriers for different groups of people are identified and addressed.	Responses are welcomed via email, hard copy or through on line form available on the website.
Enable people to take part effectively Engagement processes should try to develop the skills, knowledge and confidence of all participants.	As above
Engagement is given the right resources and support to be effective Appropriate training, guidance and support are provided to enable all participants to effectively engage, including both community participants and staff.	Engagement leads are leading the process through health boards Health Collaborative is providing support, facilitation and developing central consultation documents and collating responses.
People are told the impact of their contribution Timely feedback is given to all participants about the views they expressed and the decisions or actions taken as a result; methods and form of feedback should take account of participants' preferences.	A report will be written with the response to the consultation and made available for health board meetings in March 2018. Health Boards will keep CHCs exec and full councils informed on the consultation progress The final report will be published on the Public Health Wales website following Health Board meetings in March 2018.
Learn and share lessons to improve the process of engagement People's experience of the process of engagement should be monitored and evaluated to measure its success in engaging people and the effectiveness of their participation; lessons should be shared and applied in future engagements.	A mid way review is being undertaken to review current response to the consultation and identify any changes, further work required in the second phase of the consultation. It is anticipated a document outlining lessons learned will need to be produced on completion of the consultation phase.

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Major Trauma Network Consultation Proposed framework for making recommendations

Author: Rachel Hennessy, Programme Director

8.10

Date: January 2018	**Version:** 0

Publication/ Distribution:

- Executive Group

Purpose and Summary of Document:
This paper outlines the processes, which have taken place leading up to the major trauma consultation and presents the framework that will be used to guide Health Boards through the recommendations being made following the period of consultation on the proposed development of a major trauma network for South Wales.

The Board/Committee are asked to

Approve	**X**	**Discuss**		**Receive**	

1. Introduction

This paper outlines the processes, which have taken place leading up to the major trauma consultation and recommends a framework that will be used to guide Health Boards through the decision-making processes in relation to the recommendations made by the Independent Panel for a major trauma network for South Wales and the proposed location of the major trauma centre. .

2. Background

In late 2014, the Health Collaborative were 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). The service model for major trauma services for adults and paediatrics was developed by the CRG in line with the standards for major trauma and approved by the Project Board in May 2015. In June 2015, a non-financial option appraisal was undertaken which identified the need for a major trauma network with a major trauma centre based in South Wales to support the population of South and West Wales and South Powys.

North Wales and North Powys, were excluded from the project. Betsi Cadwalder is already part of the West Midlands Major Trauma Network with patients in North Wales having access to the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the West Midlands Major Trauma Network via the trauma unit in Shrewsbury.

Building on this work, an independent panel of specialists from across trauma and rehabilitation services in the UK were commissioned by the Collaborative Board, on behalf of Health Boards, to review the information and evidence available and make a recommendation on the preferred

location of a Major trauma centre in the region. A formal report to health boards in January 2017 asked them to note the arrangements for the Independent Panel, the expectations from the panel and to note the process to bring forward a recommendation for public consultation (appendix 1. Appendix 2 and 3 are the terms of reference for the Independent Panel and a list of the evidence considered.) This was supported by all health boards.

The Independent Panel took place in February 2017. Following the event, the independent experts further reviewed the evidence provided and presented on the day and provided a formal report to the Health collaborative. The independent panel report made the following recommendations:

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- A major trauma network for South Wales with a clinical governance infrastructure should be quickly developed
- The adults' and children's major trauma centres should be on the same site
- The major trauma centre should be at University Hospital of Wales, Cardiff
- Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network
- A clear and realistic timetable for putting the trauma network in place should be set.

Health Boards formally received a copy of the Independent Panel report, and their recommendations for consideration at their board meetings in September 2017. Health boards were asked to agree in principle to the recommendations from the Independent Panel, and in doing so; agree to a period of consultation on the recommendations of the Independent Panel. All health boards agreed to these recommendations and a twelve-

week period of consultation commenced 13th November 2017 and is due to conclude 5th February 2018.

The main consultation document, response form and covering letter was written by the Health Collaborative and formally approved by health boards. The Consultation questions were formulated with guidance from the CHC. In line with guidance and best practice, the document was available in a variety of formats. An English and Welsh website was developed and accessed via Public Health Wales. A number of planned sessions are being led by health boards in each region, supported by WAST and EMRTS to provide the opportunity for staff, stakeholders and the wider public to find out more about the proposals as well as providing opportunities to feed back. People and organisations are encouraged to respond to the consultation using email, online via the website or to return their response using a FREEPOST address.

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Following the consultation, the responses will be analysed by the health collaborative and a recommendation made to the Collaborative Leadership Forum for consideration at its meeting on 21st February for onward consideration by the constituent health boards in March 2018.

3. Framework for making the recommendations

Health Boards have already agreed (as outlined above) that the basis for public consultation would be the recommendations made by the Independent Panel.

The consultation questions were developed in conjunction with health boards and CHCs and asked respondents (individuals and organisations) to consider the following three questions:

- Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys? (give a reason)
- Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel? (give a reason)
- If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?

Respondents were asked to either: agree; disagree; neither agree nor disagree, and give a reason for their answer.

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It is always challenging to evaluate the narrative provided in consultation responses to demonstrate that due consideration has been given to all views presented. This is further complicated by the need to determine whether the rationale underpinning the response has already been considered by the independent panel in generating their recommendation for consultation in the first place.

It is therefore proposed that a systematic framework is adopted to analyse the responses to the consultation, which is intended to support the Collaborative Leadership Forum in considering the recommendation that will be made to Health Boards for decision in March 2018. The proposed framework (Attachment 4) will assist the evaluation of consultation responses against the recommendations of the Independent Panel with a view to deciding whether they are accepted as the basis for future service redesign and development.

The proposed framework would require the consultation responses to be considered in line with 5 key steps as follows:

Step 1.

For each question on the consultation response form, responses will be collated and divided into:

- Agree
- Neither agree nor disagree
- Disagree

Where responses 'agree' or 'neither agree nor disagree' with a question, no further analysis will be undertaken.

Further consideration will need to be given to the response from individuals who disagree with a consultation question.

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Responses, which disagree with the recommendation, will progress to Step 2 of the analysis.

Step 2.

Where there is a reason given for disagreeing with the recommendations of the independent panel, those reasons will be further grouped into two categories:

- Reasons considered by the Independent Panel in arriving at their recommendation
- Reasons **not** considered by the Independent Panel in arriving at their recommendation

Issues that were considered by the Independent Panel, and identified as either not material to the clinical outcomes of a patient will not be considered further.

Issues, which not considered by the Independent Panel will progress to Step 3 of the analysis.

Step 3.

An assessment will be made of any issue progressing to this stage of the analysis to determine if the concern raised has any direct impact on the decision about the establishment of the network or location of the Major Trauma Centre

- If not, then no further consideration will be given to the issue
- If there is a direct correlation with the proposal then the analysis will progress to Step 4.

Step 4.

If an issue raised has not been addressed by the independent panel and directly relates to the development of a major trauma network, it will be necessary to consider if there are any reasonable steps that can be taken to mitigate the issue.

- Where it is possible to put in place mitigating actions, these will need to be identified and included as evidence to be presented to Boards to factor into their decision-making
- Where no clear mitigating actions can be identified, the issue will progress to Step 5 of the analysis.

Step 5.

Where an issue raised cannot be mitigated, the analysis will need to include any further information that might be helpful to Boards in their decision making.

Consideration of other methods of responding to the consultation

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Similar consideration will need to be given to any other issues or themes evolving from general responses to the consultation and feedback from public sessions and social media, and the same methodology will need to be applied.

4. Timeframes for Consultation

Appendix 5 outlines the proposed timeframes for responding to the consultation. It is anticipated that following the conclusion of the consultation, the initial response to the consultation will be considered by the Leadership Forum.

The Community Health Councils will then receive the response to the consultation to discuss the findings and recommendations. This will be considered by the Executive Group for each CHC and will then ratified by full committee.

It is anticipated that a formal briefing will then be required for Assembly Members. Following discussion with the CHC Chief Officer representative at the regular engagement team meeting, he has confirmed the preference for a formal briefing to the wider CHC prior to the report being considered by individual Health Boards as the statutory bodies.

Health Board meetings are scheduled to take place in March, whilst the majority are scheduled for 29th March, Aneurin Bevan and Powys are scheduled for 21st March. Correspondence is taking place with Board Secretary to look at either aligning board meetings or setting an exceptional meeting to consider the response to the major trauma consultation.

5. Conclusion

The methodology for generating the preferred location for the Major trauma centre for South Wales and the development of the wider network, was approved by all constituent Health Boards as being the Independent Panel process with the recommendations from the Independent panel forming the basis for consultation

This process was agreed as an objective recommendation based on the available evidence as assessed by impartial experts in the field of major trauma. In arriving at their decisions, health boards will need to consider how stakeholders have responded to the consultation and whether any of the consultation responses raise concerns about the recommendations made by the Independent Panel that cannot be mitigated and which would therefore materially impact on their ability to endorse the recommendations made.

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To support health boards in considering the response to the consultation the proposed framework will provide a clear basis against which consultation responses have been considered and enable health boards to make a clear decision for responding in relation to the recommendations made by the Independent Panel.

6. Recommendation

The Executive Group are asked:

- To agree to use the proposed framework to support making a recommendation on the implementation of a major trauma network for South Wales
- To agree to use the proposed framework to support making a recommendation on acceptance or otherwise of the recommendations made by the Independent Panel.
- To note the timeframe following the consultation.

- To note the requirement by CHCs for a formal briefing following the consultation.
- To determine whether a formal briefing for Assembly Members should take place following the consultation

Appendix 1.	January 2017 Public Board Paper	MT public Board paper - January 2017.
Appendix 2.	Independent Panel Terms of Reference	Document 3 - Terms of Reference Indepen
Appendix 3.	Agenda for Independent Panel event List of evidence considered by the independent panel	Doc 2 - Final Agenda for Independent Pane Major Trauma Independent Review C
Appendix 4.	Framework for making a recommendation	MAJOR TRAUMA - APPENDIX - DECISION
Appendix 5.	Timeframe for responding to consultation	Proposed draft response timeline 221

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NHS Wales Health Collaborative	Supporting Document 11 – Numerical and Thematic Analysis of Consultation Responses

Major Trauma Consultation
Numerical and Thematic Analysis of Responses

8.11

Author: Jacqui Davies, Planning Manager

Date: 13 March 2018	**Version:** 1 (Final)

Purpose and Summary of Document:

This document contains a detailed numerical and thematic analysis of the responses received during the consultation on proposals for a major trauma network for South and West Wales and South Powys.

The paper contains an analyses of:

- the written responses received to the consultation questions (Section 2)
- the views expressed at stakeholder meetings, including formal public meetings (Section 3)
- social media comments (Section 4)

An equality monitoring analysis is also provided (Section 6).

1 Overview

There were 1,041 consultation responses received from across the region, and 254 members of the public engaged in conversation on social media (with potential overlap between these two groups).

Of the 1,041 responses, 999 directly answered the consultation questions asked. During the consultation period 24 stakeholder meetings were reported to the Collaborative.

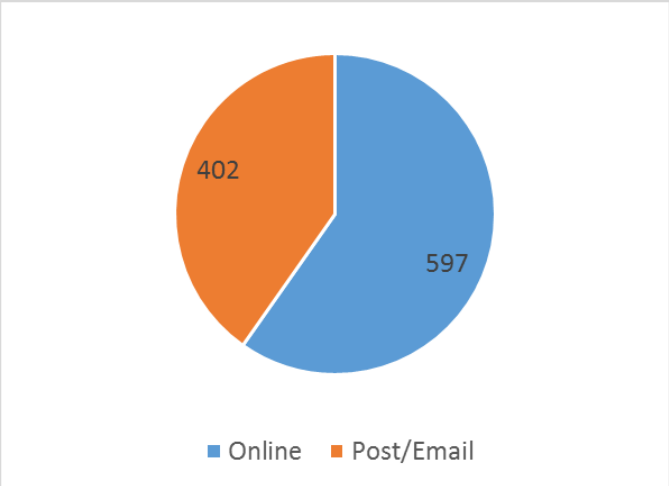
Comments received through all of the above means were considered on an equal footing.

2 Response to questions

2.1 Format of responses received

A total of 999 responses were received directly answering the questions asked.

60% (597) of the responses were submitted online through the Major Trauma Consultation webpage and 40% (402) were received either through post or email.



Of the 402 responses received either through post or email:

- 141 (35.1%) used formal consultation responses forms
- 126 (31.3%) were on a standardised template
- 116 (28.9%) were on a standardised email
- 12 (3.0%) were in a standardised letter
- 7 (1.7%) were independent responses

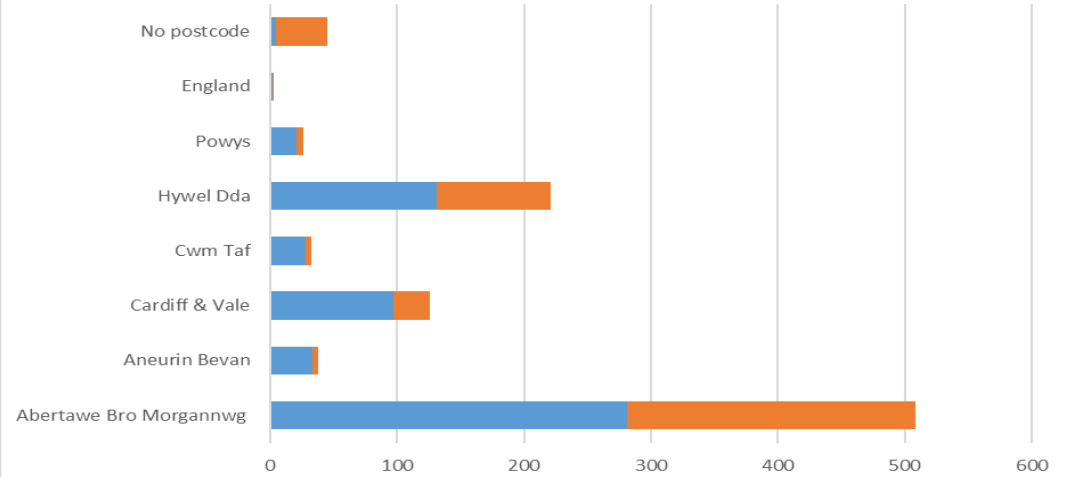
Whilst the majority of responses were in English, 15 Welsh responses were received and two used 'easy read' English.

2.2 Distribution of responses by area

Illustrated below is the distribution of the 999 responses directly answering the consultation questions:

- 73.5% of responses were from West Wales
- 19.6% of responses were from South Wales
- 2.6% of responses were from Powys
- 4.2% of responses were from England/No postcode

	Online	Post/Email	Total
Abertawe Bro Morgannwg	281	230	**511**
Aneurin Bevan	33	5	**38**
Cardiff & Vale	97	29	**126**
Cwm Taf	28	4	**32**
Hywel Dda	131	93	**224**
Powys	21	5	**26**
England	2	2	**4**
No Postcode	4	34	**38**
Total	**597**	**402**	**999**



	Abertawe Bro Morgannwg	Aneurin Bevan	Cardiff & Vale	Cwm Taf	Hywel Dda	Powys	England	No postcode
Online	281	33	97	28	131	21	2	4
Post/Email	227	5	29	4	90	5	1	41

254 people submitted standardised responses, either in the form of a template, an email or a letter.

2.3 Organisational responses

A total of 100 responses were said to be representing the views of organisations. However, nine were discounted as they had listed the organisation as either "NHS" or an individual health board (not consultees). The organisations referenced are as illustrated below:

Abertawe Bro Morgannwg	Aberavon Constituency Labour Party ABMU Local Medical Advisory Group Brackla Dental Surgery Briton Ferry Town Council Cilybebyll Community Vouncil Hawthorn Court Care Ltd, Swansea Llanfair Grange Care Home Llanfair Surgery Morgannwg LMC Ogmore Constituency Labour Party Pencoed Town Council Primary Care Communities Unit ABMU Socialist Health Association, Cymru Wales Stroke Association Swansea Council Swansea Council for Voluntary Service The Old Vicarage Nursing Home, Neath The Vale of Neath Practice Three Cuffs Dementia Care Home ABMU Brain Injury Service UNITE Retired Members Swansea Area Branch
Cardiff & Vale	Care & Repair Cardiff and the Vale Barry Town Council Royal College of Anaesthetists Glamorgan Voluntary Services (GVS) Vale of Glamorgan 50+ Strategy Forum Simon Thomas AM Occupational Therapy Service Cardiff and Vale UHB The Chartered Society of Physiotherapy (CSP) in conjunction with the Association of Trauma and Orthopaedic Chartered Physiotherapists (ATOCP) Royal College of General Practitioners Cardiff 50+ Forum Royal College of Nursing Wales
Cwm Taf	RGH Hospital Medical Staff Committee, Cwm Taf University Health Board Heads of Nursing Forum, Cwm Taf Health Board National Orthotic and Podiatry Standing advisory group Physiotherapy Service Cwm Taf UHB
Powys	Old Radnor Community Council DYFI U3A Tawe Uchaf Community Council Glascwm Community Council Presteigne and Norton Town Council Felinfach Community Council
Hywel Dda	Specialist Neurological Occupational Llanelli Town Council Llanelli Rural Council Mid and West Wales Fire and Rescue Service Llandyfaelog Community Council Cylch Ferwig Llandysilio-go-go Community Council Llanllwchaearn Community Council Mynachlog-ddu and Llangolman Community Council Jobcentre Plus, Haverfordwest Carmarthen Town Council Llangeodmor Community Council Llanrhian Community Council Mathry Community Council Clwb Gwawr Llandeilo HM Coastguard Division 5 Wales & NI St Oswalds VA School Cylch Methrin Cei Newydd Cylch Methrin Crymych Gelli Mor Ltd Cwtsh Y Clos Nuersery Cylch Meithein San Cler Blaenmarlais Care Ltd Cylch Meithrin Felinfoel Tenby Town Council Shelter Cymru Rural Issues Freystrop Community Council Narbeth Surgery Cyngor Cymuned Beulah Ceredigion Cenarth Community Council Carmarthenshire Federation WI Eglwyswrw Community Council Dinas Cross Community Council Clwb Gwawr Glannau Teifi llangeitho Community Council Cyngor Tref, Ceredigion Cyngor ?? Llangunnor Community Council Cardigan Hospital and Community League of Friends 75 or over Llanfar-ar-y-Bryn Community Council Headway Pembrokeshire Committee
England	The Disabilities Trust/ Brain Injury Rehabilitation Trust The Royal College of Emergency Medicine Wales (RCEM Wales) Headway - the brain injury association BMA Cymru Royal College of Surgeons of Edinburgh Royal College of Anaesthetists Welsh Board S Wales Police

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2.4 Responses to consultation questions

Question 1 - Do you agree or disagree that a major trauma network should be established for South and West Wales and South Powys?

- 92.8%* of respondents agreed with the proposition that a major trauma network should be established for South and West Wales and South Powys
- 4.0% disagreed
- 2.7% neither agreed nor disagreed
- 0.5% did not provide any response

* This includes 242 respondents who used a standard 'template' response and who answered 'Yes' to the question (rather than answering 'agree' or 'disagree')

		Agree	Disagree	Niether agree nor disagree	No Response	Total
Abertawe Bro Morgannwg	Online	261	14	5	1	**281**
	Post	224	4	2	0	**230**
	Total	**485**	**18**	**7**	**1**	**511**
Aneurin Bevan	Online	30	1	2	0	**33**
	Post	4	1	0	0	**5**
	Total	**34**	**2**	**2**	**0**	**38**
Cardiff & Vale	Online	88	8	1	0	**97**
	Post	25	2	2	0	**29**
	Total	**113**	**10**	**3**	**0**	**126**
Cwm Taf	Online	27	1	0	0	**28**
	Post	3	0	1	0	**4**
	Total	**30**	**1**	**1**	**0**	**32**
Hywel Dda	Online	119	5	7	0	**131**
	Post	89	1	3	0	**90**
	Total	**208**	**6**	**10**	**0**	**224**
Powys	Online	16	1	4	0	**21**
	Post	4	1	0	0	**5**
	Total	**20**	**2**	**4**	**0**	**26**
England	Online	2	0	0	0	**2**
	Post	2	0	0	0	**2**
	Total	**4**	**0**	**0**	**0**	**4**
No Postcode	Online	4	0	0	0	**4**
	Post	29	1	0	4	**34**
	Total	**33**	**1**	**0**	**4**	**38**
Total	**Online**	**547**	**30**	**19**	**1**	**597**
	Post	**380**	**10**	**8**	**4**	**402**
	Total	**927**	**40**	**27**	**5**	**999**

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Respondents were also invited to provide a narrative supporting their decision.

The main reasons for **agreeing** with the proposition contained in Question 1 are set out below:

Theme	
Access (208 references to)	Access to best possible care
	Availability of all major services and expertise on one site
	Best patient outcomes
Recognised need for a MTN (92 references to)	Needed in South Wales
Equity (40 references to)	Equity across the UK
	Equity across Wales
Evidence based (17 references to)	Based on evidence
Current Provision (11 references to)	A strategic solution to the problems experienced with the current arrangements and infrastructure
	Benefit existing emergency departments
	Consideration of the existing framework
	Free up other hospital facilities
	MTC and network well overdue for Wales
	Natural development
	Need for formal plan
	Reduce strain on local A&E departments
	Uncertain of current service provision
Current reliance on England (3 references to)	Currently Wales has no MTC, but relies upon services from NHS England e.g. Bristol.
	Currently the nearest trauma unit is Bristol
	Bristol too far away so lives may be lost
Communication and Engagement	Improved communication between HBs
Other comments generally supportive of network proposals	Unaware MTN not already established
	Agree with Panel recommendations
	Recruitment and retention
	Best use of public service resources
	Essential/sensible/well founded
	Needed to augment other hospitals
	Spread the diversity of specialisation throughout Wales
	Supportive of advantages
	The area should have its own infrastructure to form a major trauma network
	Best Practice
	Trauma Networks make a difference

Other comments generally supportive of network proposals (continued)	We need to be working together
	Widely reachable
	Would provide an industry leading service to South Wales
	Has the potential to recognise and build on existing good practice
	Has the potential to formalise and develop the relationships between the teams and services that contribute to the outcomes delivered along the major trauma care pathway
	Has the potential to ensure that all staff and carers contributing to the major trauma care pathway are supported to maintain and develop competencies and have access to the resources they need to deliver consistently high quality care
	Has the potential to relate a community of practice that can support the ongoing development of the existing trauma workforce, offer quality practice-based learning opportunities to develop the trauma workforce of the future, and produce high quality research outputs that address questions arising from practice in this area
	Looks like wide consultation and examination of the issues
	If an independent expert panel has considered the evidence and made that recommendation I will agree with them, subject to funding being available.

A number of respondents who **agreed** with the proposition in Question 1 went on the make comments that were not direct justifications of their agreement. Almost all of these comments related to the proposed location of the Major Trauma Centre:

- 22 responders who agreed with the proposition in question 1 went on to make comment indicating that they thought there should be an MTC in Morriston/Swansea
- 8 further responders indicated that easy access is needed from West Wales
- 8 further responders indicated that Cardiff is too far away from West Wales to be the location of the only MTC in the region
- 13 responders either suggested that South East Wales should receive major trauma services from Bristol or believed that was already the current position
- 4 responders indicated that there should be improved trauma services in South Powys
- 3 responders indicated that there should be an MTC further West than Swansea

Two responders had concerns that the concentration of expertise at the major trauma centre might deplete the current trauma capabilities of the local units

Of those responders **disagreeing** with the proposition in Question 1:

- 6 responders made comments indicating that there should be two or more MTCs covering the region
- 4 further responders indicated that the MTC should be in Morriston/Swansea
- 4 further responders indicated that UHW is too far away to serve West Wales
- 2 further responders expressed concerns about the accessibility of services to West Wales

Other reasons for **disagreeing** with the proposition contained in Question 1 are set out below:

Responses
Additional funding needs to be allocated to allow hospitals to operate effectively
Disbelieve the significant amount of evidence quoted
Disruption of established skilled teams
Emergency services cannot all be centralised
Hospital in Wales are at a pressure point where you are just going to create a bigger problem
Insufficient evidence to suggest poor care at present
Major trauma is rare and has been treated well in the present centres
Need a MTN that covers all of Wales
Removing major trauma from West Wales will damage all other complex care teams
Service should be for the WHOLE of Wales
South Wales is big enough to need more than one centre
The physical infrastructure at any of the hospitals would not be able to cope unless there is radical thought as to what moves out of any of the hospitals that will be involved in the network
There is a need for specialist units with the right teams for life saving treatment
Travelling long distances could be unrealistic and detrimental to the health of the injured
We should invest in the trauma services available in Bristol
A major trauma network should not be established if it is designed to substitute effective ongoing A&E services within 60 minutes of communities in south west Wales. A major trauma unit must only be considered as an additional service

Question 2 - **Do you agree or disagree that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel?**

- 34.5% of respondents agreed
- 49.3% disagreed
- 14.3% neither agreed nor disagreed
- 1.8% did not provide any response

The table below illustrates the distribution of responses received:

		Agree	Disagree	Niether agree nor disagree	No Response	Total
Abertawe Bro Morgannwg	Online	77	141	60	3	**281**
	Post	13	205	5	4	**227**
	Total	**90**	**346**	**65**	**7**	**508**
Aneurin Bevan	Online	28	2	3	0	**33**
	Post	3	1	1	0	**5**
	Total	**31**	**3**	**4**	**0**	**38**
Cardiff & Vale	Online	74	12	11	0	**97**
	Post	22	5	2	0	**29**
	Total	**96**	**17**	**13**	**0**	**126**
Cwm Taf	Online	21	2	5	0	**28**
	Post	2	1	1	0	**4**
	Total	**23**	**3**	**6**	**0**	**32**
Hywel Dda	Online	44	47	39	1	**131**
	Post	41	34	11	4	**90**
	Total	**85**	**81**	**50**	**5**	**221**
Powys	Online	10	6	4	1	**21**
	Post	5	0	0	0	**5**
	Total	**15**	**6**	**4**	**1**	**26**
England	Online	2	0	0	0	**2**
	Post	1	0	0	0	**1**
	Total	**3**	**0**	**0**	**0**	**3**
No Postcode	Online	0	3	1	0	**4**
	Post	2	34	0	5	**41**
	Total	**2**	**37**	**1**	**5**	**45**
Total	**Online**	**256**	**213**	**123**	**5**	**597**
	Post	**89**	**280**	**19**	**13**	**401**
	Total	**345**	**493**	**142**	**18**	**999**

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The expertise and independence of the Independent Panel were the main reasons for **agreeing** with the proposition in Question 2, as illustrated below:

Theme	
Independent Panel (75 references to)	Fairer and no hidden agendas or possibility of other influence
	Reassurance that the decisions are being made for the benefit of the people
	Ability to consider the clinical issues effectively
	Balanced and informed views
	Best people to make the decision
	Best way to get results
	Carefully considered the options
	Clear process, lines of governance and transparency
	Evidence based
	Expertise
	Fairest outcome
	Follows a democratic process
	Given the work that has been done to reach this conclusion the answer is categorically yes
	Independent view
	Non political
	This report has not thought out lightly
	Unbiased Panel
	Why have an independent otherwise
	UHB's are signed up to IP decision
	Wide consultation and examination of the issues
Access (4 references to)	Availability of specialist services on UHW site
	Availability of the best resources, staff and having good access
	Greater provision of care across south wales
Location (4 references to)	
Existing Services (3 references to)	Cardiff has neurosurgery and the paediatrics hospital to support the service and excellent transport links.
	Obvious and probably only choice available to build on the current facilities and skilled workforce.
	Siting is at UHW where most tertiary services are based currently including tertiary Paediatric surgery, neurosurgery
Other	MTN beneficial to south wales

A number of respondents who **agreed** with the proposition in Question 2 went on the make comments that were not direct justifications of their agreement:

- 8 respondents made comments indicating that they understood that the Independent Panel had not yet produced its recommendations
- 4 respondents expressed general concerns about access
- 3 respondents disagreed with the recommendation the only MTC in the region should be at UHW

The main theme emerging from the reasons for **disagreeing** with the proposition in Question 2 related to location. 249 respondents disagreed with the panel's claim that:

"Neither Morriston Hospital or University Hospital of Wales as a major trauma centre would have any significant advantage over the other in terms of geography. Cardiff is within an hour of Bristol's Major Trauma Centre. This means that the Major Trauma Centre should be in Swansea not Cardiff"

Theme	
Independent Panel (20 references to)	Council leaders and AM's should have been included
	Decision seems to be made already
	Decision should be made by those in the medical profession with 1st hand experience
	Disadvantages residents in West wales
	Do not believe the panel have given sufficient recognition to the impact of the geography of Wales and appreciated just how poor the road network is outside of the M4 corridor, particularly to West Wales
	Don't trust the independent panel
	How independent is the IP?
	Independent Panel has poor knowledge of current issues
	It should take all recommendations into account from wherever they are received
	Make-up and qualifications of the IP
	Panel is not seeing the wider future picture
	Do not agree with recommendation of IP
Location (390 references to)	Disagree with the panel's claim that "Neither Morriston Hospital or University Hospital of Wales as a major trauma centre would have any significant advantage over the other in terms of geography." Cardiff is within an hour of Bristol's Major Trauma Centre. This means that the Major Trauma Centre should be in Swansea not Cardiff
	Do not agree with the location for the MTC
	Major trauma centre should be in Morriston
	Too close to Bristol
	Trauma centre should be on the same site as thoracic surgery
	Proximity to SCCC
	Neither hospital have all specialisms in place

Location (continued)	Existing pressures at Morriston and UHW
	Needs to be a major trauma services in South Wales that gives equal access to all patients in South Wales The plans to centralise the MTC in Cardiff will negatively impact on many other surgical and non-surgical service west of Cardiff
	Footprint of UHW site
Needs based decision (14 references to)	Should look at the needs of the community current services and demographics
	Should be based on NHS need, budgets and live saving timeframes
	Should be what's best for most of the population of South Wales
	Should be based on population opinion
Other	Wider consultation needed
	Emergency services cannot all be centralised
	Political choice
	poorly thought out
	putting lives at risk
	Elevating one alone to the status of trauma centre will almost inevitably result in the down-grading of the other
	Recruitment of a range of general medical posts may be affected so that GP services may also be affected

Question 3 – If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?

and

Question 4 – Do you have any other comments?

The following are the main themes arising from responses to Questions 3 and 4:

- Many respondents took the opportunity to restate and/or expand on their views that:
  - the MTC should be in Morriston/Swansea
  - the MTC should not be at UHW
  - there should be more than one MTC in the region
  - parts of the region should use Bristol (and/or other English centres) as their MTC

- In implementing the network, there is a need to ensure that:
  - improvements are made in EMRTS, air ambulance services and ambulance services to ensure the time taken to transfer patients to the MTC is minimised on a 24/7 basis

  - the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the MTC, parking etc.
  - there are adequate facilities at sites in the network other than the MTC
  - there is an adequate focus on rehabilitation (including minimising waiting times)
  - there is access to 24/7 interventional radiology at the MTC
  - appropriate decisions are made about the location of trauma units
  - there is excellent communications between professionals and with the public during the implementation and delivery of the network
  - the therapy professions are appropriately involved in the implementation of the network
  - digital solutions are used where possible
  - implementation proceeds quickly once the decision has been made

8.11

- There are concerns about:
  - equity of access in West Wales and other rural areas
  - the impact on existing services at the location of the MTC through additional workload
  - the network's ability to ensure adequate staffing and adequate training for staff
  - the availability of adequate funding to implement the network
  - the downgrading of services away from the MTC
  - the ability to recruit and retain staff away from the MTC
  - the capacity of estates, facilities and support services at UHW, particularly in relation to the situation at Morriston
  - lack of co-location with thoracic surgery
  - the potential for the burns unit to move to Cardiff
  - the social and economic impact of further investment in Cardiff at the expense of other areas
  - this being part of a wider agenda to move services from Swansea to Cardiff
  - why it has taken this long to develop proposals for a major trauma network for the region
  - the degree to which the consultation has been genuine and extensive

- Further information would have been welcome in relation to:
  - how well the network is working in North Wales
  - the geographical spread of incidents resulting in major trauma in recent years

2.5 Narrative submissions

In addition to the above responses, 42 narrative submissions were received during the consultation period. Of which 12 were responses on behalf of organisations, illustrated below:

Aberavon Constituency Labour Party
Blaehonddan Community Council
Ciybebyll Community Council
Glascwm Community Council
Hearing Loss Cymru
Older People Commissioner for Wales
Pencoed Town Council
Presteigne and Norton Town Council
St Dogmaels Community Council
Tawe Uchaf Community Council
The Royal College of Midwives
The Royal College of Pathologists

8.11

The following table illustrates the emerging themes from these submissions:

Theme	
Access	Whatever service results it is fully accessible for people who are deaf or have hearing loss. The care they receive and co-produce is as dignified and clinically optimal as that of a hearing person. Currently a stream of work going around on accessibility for people with sensory loss in each health board and it is a priority each health board reports back to WG on
	Importance of continuing cross border services into England for residents of East Radnorshire who are long distances from proposed units and presently access much of their hospital care in England
Financial resources	Additional financial resources need to be made available to prevent health boards from suffering further financial pressure
MTN Structure	UHW and Morriston should have equal status
	RCM should be part of the major trauma network (leading cause of death in people under the age of 45)

MTN Structure (continued)	Concern model proposed is more of hub and spoke model rather than what may be understood by a network
	Has consideration been given to the provision of sufficient number of ITU beds. Has this been modelled?
	How will proposals work given the configuration of burns & plastics and neurosurgery?
	Are there any plans to have a trauma unit within Powys? Powys is sadly lacking any major medical unit or A&E department
Population based	Consideration should be given to the disposition of population throughout the region and not only in urban areas
Consultation Process	Insufficient information to base a decision on the location of the MTC
	Extension/rerun of consultation process due to poorly advertised/attended public meetings
	Were the options considered subject to a Health Impact assessment (HIA) as part of the work carried out by the panel in arriving at its recommendations? Suggestion that one is carried out before recommendations are progressed
	Information received on engagement and consultation with older people
Current Service Provision	Develop a new department for neurosurgery and paediatric major trauma aligned to a centre in Morriston
	How will the recent decision to centralise thoracic surgery in Morriston impact?
	Fear Burns & Plastics unit move from Swansea
Workforce Requirement	Negative impact on recruitment and retention in Morriston
	Important to understand the implications for attracting doctors in training to Wales as a result of the proposals and to quantify if this means trainee posts being relocated from some hospital sites
	Adequate training, staffing, resources to support air ambulance if they need to make further/longer journeys
	Need for additional staff resources will need to be considered. Need to ensure rotas are drawn up and suitably staffed. Seek assurance this has been modelled

Location of MTN	Geographical position of Swansea
	Has consideration been given to the alternative proposition of joining south east Wales to a major trauma network centre located in Bristol with more western parts of south wales served by a major trauma network that is based on a major trauma centre located in Swansea
	Proximity to Bristol
Travel Times	Vital response time for victims from western end of region cannot be safely met by locating MTC at Cardiff
	Travel times
	Need to be within one hours drive of treatment
	Road links in Swansea and links to M4 mid south Wales
Impact on EMRTS/ Air Ambulance	Accessibility of air ambulance when Swansea based helicopter to committed elsewhere
	Has appropriate consideration been given to the provision of sufficient ambulance capacity and has this been modelled to support the decision
	May need to re-assess the way in which ambulance calls are currently prioritised given that the proposal will rely on patients being transferred on occasions from one hospital to another within the network
Implementation of MTN	Effectiveness of moving to the model advocated will need to be monitored. Has consideration been given to deriving an appropriate methodology by which this can be done should the network be established? It would be necessary to assess the effectiveness of the network on outcomes from the moment of trauma occurring rather than simply the time of arrival at the relevant hospital
Infrastructure	Appropriate infrastructure and resources will need to be provided. Modelling work should be undertaken in sufficient detail ahead of taking a decision to progress with the proposed trauma network and not left to be worked out until after the decision has been taken. This will need to cover what facilitates are resources will need to be provided at UHW. It may also need to be determined if other facilities/services may need to be relocated to free up space for facilities required for the MTC. This should be understood before any decision is finalised
	Capacity to expand at Morriston Pressure on UHW for mainstream treatment
	Swansea has a purpose built helipad

Communication	The need for a clear communication strategy once a decision is taken on the way forward. Effective programme for informing communities in region how the proposals will work and what they will mean to them in practice.
Other	Unanswered questions relating to social and welfare aspects for patients and relatives

3 Stakeholder meetings

During the consultation period a total of 17 public meetings and/or drop in sessions were held across South and West Wales and South Powys. In addition, the Collaborative received feedback from a further seven meetings.

3.1 Public meetings

A total of 242 people attended public meetings, attending as health board employees, local residents, representatives of organisations, local councillors and Assembly Ministers.

- In ABM 4 people attended 4 meetings
- In Cardiff & Vale 26 people attended 2 meetings
- In Cwm Taf 134 people attended 4 meetings
- In Hywel Dda 47 people attended 3 meetings
- In Powys 31 people attended 4 meetings

Consistent with approaches in other Health Boards, Aneurin Bevan University Health Board organised five public meetings which were to be clinically led and managerially supported (one per Unitary Authority area). Only five people registered across all five proposed meetings, three of whom were staff, one a local councillor and one a member of the public. In agreement with the Aneurin Bevan Community Health Council, all five individuals were contacted, talked through the document, sent the video and offered a direct conversation with a lead clinician for any questions. As a result, there was no attendance at the public meetings and they were cancelled. Despite cancellation, members of staff from the health board attended each venue at the relevant time in case any members of the public turned up without registering. No further attendees presented.

Abertawe Bro Morgannwg

Number of public meetings/ drop in sessions	4
Dates	4 – 19 December 2017

Venues	
Number of attendees	4
Chaired by	Information not provided
Presentation by	Hamish Laing, Medical Director Joanne Abbott-Davies, Assistant Director of Strategy Sian Harrop-Griffiths, Director of Strategy
In attendance	Information not provided

Attendees were at 'drop-in' sessions, where they were provided with information about the consultation. Attendees were asked if they preferred to feedback at the meetings or subsequently submit written responses. All agreed to submit written responses.

Cardiff & Vale (C&V) University Health Board (UHB)

Number of public meetings/ drop in sessions	2
Dates	9th & 10th January 2018
Venues	Cardiff & Barry
Number of attendees	26
Chaired by	Malcolm Latham (CHC member) Alan Brown (CHC, Vice Chair)
Presentation by	Graham Shortland (Medical Director) Leigh Davies (Deputy Clinical Lead for Major Trauma) Abigail Harris (UHB Director of Strategy and Planning) Melissa Rossiter (UHB Clinical Lead for Major Trauma)
In attendance	David Rawlinson (Clinical Informatics Manager, EMRTS) Len Richards (UHB Chief Executive) Linda Donovan (UHB Head of Strategic and Service Planning) Anne Wei (Strategic Planning and Partnership Manager) Daniel Price (CHC Deputy Chief Officer) Wendy Orrey (CHC Business Manager) Jonathan Whelan (WAST Assistant Medical Director and EMRTS Consultant)

	Bob Tooby (WAST Assistant Director of Operations) Maria Battle (UHB Chair) Rebecca David (EA to Director of Strategy and Planning)

In response to Question 1 - Establishment of a Major Trauma Network for South and West Wales and South Powys, a number of issues were discussed including:

- Not with-standing the increased survival rates though establishing a MT Network, whether the anticipated costs of this development are being considered in comparison to other ways of spending the money to support other patient groups, comparing years of quality life added
- Concern raised about the Ambulance Service not taking notice of the cards that provide instructions on how to deal with a patient
- How a single MTC, covering a wide geographical area, will take the needs of families into consideration including accommodation, such as newly opened at the Children's Hospital for Wales
- Whether the plans build in room for increased numbers coming to an MTC, as the figures in the presentation and documentation show that the numbers expected to come to an MTC have already increased since the issue was first looked at
- The proportion of people ending up in a Major Trauma Centre MTC) as compared to being dealt with in other trauma units
- The numbers coming to an MTC in the presentation suggest that there might be 3 or 4 patients coming a day, and this would not happen evenly across every day. So when an MTC is operational, how staff are occupied if they are not dealing with a major trauma
- How the location of a single centre for Thoracic Surgery will relate to the MTC
- Support the proposals but query whether there is funding to pay for the developments
- Funding for what might need to be an increase in the number of air and road ambulances to support more transfers within a MT Network
- Why Wales is so far behind the rest of the UK in establishing a MT Network
- Concerned that it is such a complicated system that it won't work and that smaller hospitals often provide the best care
- Whether the development of Trauma Units will lead to the closure of minor hospitals that might be seen as 'surplus to requirements'
- How successful we will be in securing funding for this development.

Issued discussed with regards Question 2 - whether the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel, include:

- Issues for UHW as a specialist centre in managing to repatriate patients to local hospital, given historical problems with getting other hospitals to take patients back
- The numbers of people expected to come to a Major Trauma Centre (MTC) and the impact on capacity at UHW
- Meeting the needs of the next of kin whose family are being cared for in the MTC
- The importance of training of staff across the Network so that when patients go back to their local hospital, staff of all disciplines have the necessary skills to deal with the patients
- Whether the frustrating experience of long delays in repatriation might be exacerbated by the increased number of patients coming to the UHW if it was the MTC
- The importance of looking at what services could come off the UHW site, recognising that travel to the site was a problem, in particular those relying on public transport.

Cwm Taf

Number of public meetings/ drop in sessions	4
Dates	15th – 29th November 2017
Venues	Rhondda and Cynon Valleys, Taf Ely and Merthyr Tydfil.
Number of attendees	134
Chaired by	Community Health Council
Presentation by	Allison Williams, Chief Executive, Ruth Alcolado, Deputy Medical Director Lisa Williams, Clinical Director, Trauma & Orthopaedics
In attendance	Informed not provided

Those who attended the public meetings were in support of the established of a Major Trauma Network but questioned the location of the Major Trauma Centre.

The audience felt there were a number of issues that needed consideration should a Network be established, these included:

- Call for greater multi-agency working to support successful implementation of the Network e.g. the road network is crucial in ensuring patients get to the MTC in a timely manner.

- How many Air Ambulances do we currently have? During what hours can they fly? What happens at night in the proposed model if you need to be transferred to the Major Trauma Centre?
- Where will the Trauma Units be?
- What changes will be required to WAST and EMRTS in order to implement the Network and how will these be funded?
- Will you increase the number of ambulances in operation or reduce waiting times for ambulances outside A&E in order to ensure there are sufficient ambulances available?
- Will EMRTS be able to operate at night and in fog?
- If EMRTS can't fly at night, then patients from West Wales would have a very long journey by ambulance to Cardiff
- What about the "Golden Hour"? There is so much traffic on the road – do we need more funding for EMRTS so that we're not reliant on ambulances on the road?
- Do we need motorbike ambulances?

In addition, a number of additional comments/Questions were asked:

- Suggestion that a similar approach is taken to the Children's Hospital for Wales and the Noah's Ark appeal to raise money to support the development of the Network. Felt we couldn't rely solely on NHS funding
- Welsh Government support for the proposal was queried and how WG are engaging in the project to ensure it is delivered
- Air Ambulances should be funded from core NHS budget not reliant on a charity
- Will the burns service move from Morriston if the Major Trauma Centre is at UHW?
- How is EMRTS funded?
- Why are we reliant on charitable funding for such an important service?
- The thoracic surgery engagement is based on a similar case. Is that why they're being considered at the same time? Will those services be based in the same place?
- Is everything in place in UHW to manage major trauma? If there's minimal additional activity to go to UHW then why do we need to develop the Network and the Major Trauma Centre?
- Will the Major Trauma Centre at UHW be a new build?
- Do ambulance have a police escort to aid quicker travel?

- Is the Major Trauma Network about wider services and rehabilitation? This would make it a better quality service.
- If 1,200 patients per day are affected has does this equate to 2 per day at the Major Trauma Centre?
- Are the surgeons working exclusively in the NHS or are some also doing private work?
- Why are we so behind in this area? All other regions have a Major Trauma Centre.
- What's the budget for the Network? Will it call on already stretched resources or will Welsh Government identify additional funding?
- Will there be any know on implications for Prince Charles Hospital?

Hywel Dda

Number of public meetings/ drop in sessions	3 drop in sessions
Dates	12th December - 18th January 2018
Venues	Haverfordwest, Carmarthen and Aberystwyth
Number of attendees	47
Chaired by	Information not provided
Presentation by	
In attendance	

Across the three sessions there was broad agreement that a Major Trauma Network should be established for South and West Wales and South Powys and people felt that it long overdue. However, there was a view that basing it on UHW, Cardiff was too far East and that the preferred option would be to base the service on Morriston, Swansea.

In respect of whether development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel, Concerns were raised related to:

- the long term viability of Swansea as a major centre if Cardiff is selected
- services in Cardiff seem to have extremely limited understanding of the issues of rurality and difficulty of patients and relatives to travel to Cardiff
- the independence of the "Independent Panel"
- the effect on the ability of A&E Department in Cardiff to cope with the volume of work

Those present raised a number of issues that should be considered should a Network be developed this included:

- Family support

- Travel and Accommodation for relatives
- Concern was expressed that Swansea, Burns and Plastics Unit would be transferred to Cardiff/UHW as an enabler and would therefore further degrade local services in the West.
- In developing a Major Trauma Network further delay should be avoided.
- The MTN should include Paediatric Trauma.
- EMRTS would need expansion to 24/7 capability for inter-hospital transfers.
- Supporting hospitals would require considerable expansion and staffing and capability to rule in/rule out at locality level to avoid swamping the Trauma Centre.
- Dangers of reduction of services and quality of services with removal of resource
- "Stabilisation" in Glangwili General Hospital is a worry
- Worries that there is a lack of 24/7 advance pre-hospital service
- Doubts that there will be an ability for Withybush General Hospital to stabilise patients too unwell to go direct to UHW
- Given the proposed expansion of Morriston, will the decision over MTC to Cardiff prevent this?
- 24 hour Air Ambulance provision to make Major Trauma Network work for rural health boards such as Hywel Dda
- Effective networking to enable local ongoing rehabilitation and what will be the arrangements for rehabilitation.

In addition, a number of additional comments/Questions were asked

- Will this affect A&E 24 hour availability?
- Distance to travel
- 12 hour air ambulance. Who pays?
- Worried about cost
- Availability of beds in Cardiff
- Hywel Dda context – not explained
- Cynicism that this won't result in cuts in local services
- Does UHW really have the capacity to expand (real estate!!) for the influx?
- Why can't Bristol contribute to the Network – meaning Swansea could be MTC?
- Why can't Withybush helipad be used at night? Why does the airport need to be used?

- Major concerns about sub-centralisation of services to Glangwili (they won't cope)
- Is this a stepping stone to removal of Cardiothoracic Surgery from Swansea in favour of Cardiff?!
- Concerns over timing of consultation – over Christmas, likelihood of engagement lower!
- Is there capacity at UHW? (number of beds etc.)
- How is rehabilitation and social care to be commissioned? – People are stuck in hospital
- EMRTS 24/7?
- What happens next in the consultation process?
- What are the timescales for the introduction of the network?
- Concerns about the difficult traffic access to UHW
- Want clarity regarding geographical boundary between the North Wales network and the South Wales network
- What discussions have there been between the Trauma Network and the Mid Wales Collaborative?
- Has the Ambulance services been engaged since the beginning?
- Concern that Cardiff has not got capacity? But neither does Morriston
- Cardiff need to make it work
- Will the Major Trauma Centre have any consequence for other services?
- A&E targets are not good in Cardiff

Additional Comments were also submitted from the CHC:

- If the Major Trauma Centre is to be moved even further south access is vital and so I spoke to a representative from EMRTS who confirmed there are three Air Ambulance Helicopters in Wales operating 8am – 8pm, but this is limited in the winter months by darkness. The Air Ambulance does from time to time call on the Coastguard 'Sea King' helicopter to fly at night or in poor weather conditions when the Air Ambulance (AA) is unable to fly. The Air Ambulance can only operate between certain hospitals at night.
- All three of the AA helicopters have a consultant on board and I was reassured that the patient depending on the trauma i.e. head injuries would naturally go to Cardiff, Burns would go to Morriston and some to Stoke where the patient would receive the best treatment. This person thought this would not change if the Major Trauma service was to move to Cardiff. North Wales Health Board use Stoke, Alder Hay (Children's), Liverpool Trauma Hospitals so they are not really affected by this consultation apart from patients on the South Border and Powys patients.

- If the Major Trauma service was moved to Cardiff I feel Hywel Dda patients would be affected the most, not only would the Welsh Government need to properly fund the Air Ambulance 24/7 but also ensure there were always consultants on board. If there is poor weather or during the night (currently) the Air Ambulance does not run and therefore transfer times are hugely increased with an additional hour travel time on top of an already very long journey from the remoteness of North Mid & West Wales.
- I was told that the Welsh Air Ambulance pilots are training to fly at night and this will be complete by the end of 2018, however without funding from WG and the assurance of employing consultants on a 24 hour rota this will increase travel times by ambulance (if available) greatly.
- If the Major Trauma Unit does move to Cardiff then Morriston should retain its Burns Trauma unit and Welsh Government will have to provide proper funding for WELSH AIR AMBULANCE and CONSULTANT'S 24/7 in my opinion.
- Bristol Trauma unit is very close to Cardiff and would this affect patients being flown there in the future?

Powys

Number of public meetings/drop in sessions	3 drop in sessions
Dates	5th – 12th January 2018
Venues	Ystradgynlais, Brecon and Crickhowell
Number of attendees	31
Chaired by	Information not provided
Presentation by	
In attendance	

At each of the sessions there was agreement and support for the development of a major trauma network for South and West Wales and South Powys.

Whilst the benefits of locating the Major Trauma Centre at the University Hospital of Wales were recognised, there were concerns that some services may be lost or downgraded at Morriston, having an impact on patients follow up appointments, waiting times and whether staff may be downgraded or moved to another location. There was particular reference to the Burns and Plastics Unit.

At one session it was felt strongly that the major trauma centre could be situated in Morriston particularly when there is already a major trauma centre in Bristol. Reference was also made to the need for west Wales to get its own major trauma centre.

A number of issues that needed consideration should a Network be established were raised by the audience, these included:

- Will repatriation/ step down to the major trauma unit be smooth enough to help with flow?
- Which exact geographical area will the network cover, it is difficult to plan more until we know that?
- The opportunities to develop the real estate are better at Morriston than they are at UHW.
- The helipad at Morriston should be upgraded to accommodate larger choppers.
- is there enough money to develop a major trauma centre and to maintain it 24/7/365?
- who will have the overall say on whether this scheme is approved, surely this will sit higher than the NHS Wales Collaborative?
- it is a long way to travel from south west Wales and some areas of south Powys to Cardiff. Public transport can be difficult and timely to access but from some areas in south Powys, public transport links are non existent, from here it is proven that it is more difficult to travel to the University Hospital of Wales than it is to Morriston Hospital
- will there be facilities in place at the major trauma centre for families to stay on site?
- will there be adequate allocated parking to ensure that families are able to park easily given the nature of their visits
- Are there enough staff to run this service in one place or will they need to relocated?
- There needs to be a clear plan of how existing A&E units will be maintained.
- It is well documented on the news and social media how stacked up ambulances are at our hospitals; will this get worse if this service is consolidation to UHW?

A number of additional comments/Questions were also asked:

- Based on the information in the consultation document, it sounds like the decision has already been made.
- Given that the major trauma consultation comes on the back of the future shape of thoracic surgery services in South Wales engagement period, this feels that there is a bigger plan already in place and we are slowly being 'drip fed' information for a plan that has already been agreed and is based in University Hospital Wales.
- There seems to be lots of stuff missing from the consultation document.

- It feels like the Ystradgynlais valley is being 'stitched up' and will lose vital services in Morriston that the valley people have campaigned hard for, particularly burns and plastic services.
- Currently, how many Powys patients receive treatment at major trauma centres?
- Why does everything have to happen in Cardiff?
- Can the consultation period be extended?
- Can we have a public meeting with senior representatives from NHS Wales Collaborative, ABMUHB, PTHB.
- Will Morriston be downgraded?
- Will the SCCC have any impact on the major trauma centre?
- It comes across that you have been very ambiguous in the consultation document.
- In future, please share relevant/ current health issues like this in local newspapers.
- In regard to the difficulties that could be experienced for families in travelling from South Powys to the major trauma centre, Crickhowell Volunteer Bureau has in excess of 30 volunteers, all of whom drive on a regular basis. The team support WAST on a Mon-Fri 9-3 basis but could consider 24/7 coverage to ease the pressure on patients and their families; there are other community car schemes available across Powys who may also be open to operating 24/7 to cover emergencies.
- Can arrangements be put in place for improved transport, accessibility, overnight accommodation etc. when loved ones spend a long time in recovery a long way from him - particularly as family and friend contact can aid recovery.
- Location of MTC a less critical issue then the location of the Trauma Units and the rehabilitation pathway - health boards in South Wales must work together to agree a pattern of TUs that serves the whole of South Wales and not just individual Health Board resident populations, particularly as Powys does not have an acute hospital within the health board area
- Poor road infrastructure in rural mid Wales
- Geography and coverage of the proposed network not clearly defined - what is "South Powys" and where does it finish? Is there a clear strategy for trauma network coverage for the whole of Wales.
- Role of EMRTS and Air Ambulance is critical and could be strengthened further.
- Why is the proposed MTC located so far south rather than somewhere more accessible to more of South Wales.

3.2 Other meetings

As a minimum and in accordance with consultation guidance the following groups received information on the consultation process either via an established meeting, electronically or in hard copy and were invited to participate in the consultation process:

- Public Services Board
- Working in Partnership Forum
- Healthcare Professionals Forum
- Stakeholder Reference Group

Abertawe Bro Morgannwg

Meeting Title	Bridgend Equality Forum
Date	22nd November 2017
Number of attendees	13
Presentation by	Joanne Abbott-Davies, Assistant Director of Strategy.

8.11

During the forum individuals/constituent organisations agreed to submit comments direct on the consultation. They enquired whether UHW are still charging for parking as they felt this may have an effect on where is should be based as it may put people off.

Meeting Title	Traumatic Brain Injury Service
Date	16th January 2018
Number of attendees	14
Presentation by	No formal presentation was provided but the major trauma video was played.

The Group agreed that a major trauma network should be established for South and West Wales and South Powys, supporting the concept of a MTN because it will improve mortality rate - although this needs to be accompanied by investment in services to enable people with severe disability and their families to have a long-term quality of life.

However, they did feel additional information is required to inform this judgment and that the infrastructure required to successfully implement the rehabilitation network is currently lacking in South West Wales.

Additionally, the Group agreed, in principle that the development of the major trauma network for South and West Wales and South Powys should be based on the recommendations from the independent panel but further information on funding is needed.

Should a Network be developed they group felt there were a number of issues to be considered:

- There are concerns about the lack of medical leadership and poor resources for neuro-rehabilitation in South West Wales. In order for the model to succeed the network needs access to medical leadership from a Consultant Neurologist based at Morriston Hospital.
- This model does not take into account road travel from the furthest areas of South West Wales and South Powys to the proposed Centre at Cardiff (UHW) – this will continue to be a challenge for patients and families. There is minimal difference in travel times for patients travelling from West Wales to Cardiff or Bristol. How will traffic movement be managed? Need to consider the logistics of travelling by road to Cardiff at peak times, as well as travel costs, support, parking costs for families visiting patients at UHW.
- Are there sufficient ambulances available? More investment required and the funding available is unclear. There are concerns about the pressure for ambulance crews to provide "pre-hospital" or "roadside" care – more medical staff on-road to give assistance? Does this form part of the model?
- There are currently problems with discharge planning for patients repatriated from the Specialist Neuro-rehabilitation Unit at Neath Port Talbot Hospital to local district general hospitals and into the community (ABMU & HD). These issues have been ongoing for many years and there is a danger of re-creating these problems on a larger scale at Morriston Hospital.
- It will be important that patients are repatriated onto an appropriate ward with the correct skill mix and staff who understand and have knowledge of complex brain injury, as well as other injuries. There is a general lack of knowledge and understanding of head injury. There is a difference in "medically safe" for discharge and "safe" for discharge (and communication with relatives is key to safe discharge)
- Communication is currently poor between hospitals, GPs and neuro-rehabilitation services across South Wales.
- Investment will be required to improve clinical systems between Health Boards and Trauma Centres/Units. These costs need to be factored into the model.
- There are significant gaps in community neuro-rehabilitation services covering ABMU and HDUHB. There are long waiting times and the service in ABMU only has the resources to accept patients with moderate/severe brain injuries with active rehabilitation goals (not patients with severe brain injuries who require long-term psychosocial support). There are insufficient resources to provide any hospital in-reach services and patients are likely to wait several months post discharge to access specialist community neuro-rehabilitation.

- There will need to be investment in MDT community resources to deal with the increase in complex patients anticipated with the implementation of the network, otherwise there will be problems with delayed discharges and re-admissions.

A number of additional questions were asked:

- Where is the Financial Information? There is no cost-benefit analysis available in this consultation document to make an informed opinion on the model proposed.
- Who were the members of the Independent Panel that made the decision to locate the MTC in Cardiff?
- What is meant by Critical Mass? How was this calculated? How was it assessed? What guidelines were used for monitoring/assessing patients living in rural area?
- Where is the funding for implementing the Network coming from? Will the current financial problems impact on this?
- Insufficient information on rehabilitation within document.
- Where is the business plan?
- How will this new service be staffed given the problems with multidisciplinary recruitment in this speciality?
- Why was there no-one from the TBIS involved in any pre-consultation discussions? In ABMU there have been no brain injury specialists or expert patients involved in shaping this model.
- Issues specific to the Traumatic Brain Injury Service based at Morriston
- 60% of Trauma cases involve head injury.
- TBIS currently do not have medical staff within the MDT at Morriston. This cover was mainly provided by the Consultant in A&E but he recently retired and the post has not been replaced.
- The main medical problem post TBI is epilepsy but the current pathway to access neurology is problematic as many patients have to be referred back to the Consultants in Rehabilitation Medicine and they have to refer patients to Neurology.
- TBIS has an established business plan to include Neurology sessions in the community service. To date this plan has not been funded but funding neurology as part of a hospital in-reach neuro rehabilitation service will be crucial to the implementation of this trauma model for South West Wales. Having neurology embedded in the specialist community neuro rehabilitation team is consistent with the in-reach community model in North Wales.
- The ABI service in ABMU has the lowest MDT resources per population in Wales. If the current service has a long waiting list – what will be the

impact of the new trauma services? Complex brain trauma patients often require input for the rest of their lives.

- There is no designated lead/ward for brain injuries at Morriston. Services are fragmented and chaotic. Many patients fall through the net and are unable to advocate for themselves. There are problems with repatriation of patients from Cardiff – patients can be placed anywhere within ABMU, this has implications for other patients and staff. Few staff have the experience and knowledge of the neuro behavioural problems that can occur with a TBI. This may have implications for managing risk.
- Since Neurosurgery moved to Cardiff circa 2009 the cases of unsafe early discharges have increased. There is a waiting time to access TBIS. This service does not have the resources to intervene at short notice or in a crisis.
- There is a general lack of expertise in this specialist area across South West Wales (postcode lottery) and a historical under investment in services. It is highly likely that there will be problems recruiting.
- There are also concerns about the delayed discharges and occasionally inappropriate admissions to the Specialist Inpatient Neuro rehabilitation Unit at Neath Port Talbot Hospital. This causes problems for the patients/families and community teams. These challenges may be compounded if a Trauma Unit is developed before the problems are resolved.

Cardiff & Vale

Meeting Title	Stakeholder Reference Group and Healthcare Professionals' Forum
Date	30th November 2017
Number of attendees	9
Presentation by	Leigh Davies, Deputy Clinical Lead for Major Trauma Abigail Harris, Director of Strategy and Planning

There was agreement with the establishment of a Network and it was felt that:

- The sooner the network is in place the better because of the reduced morbidity and 20% predicted increase in survival rates
- The financial costs are far outweighed by the societal benefits of introducing the network
- Although the creation of a network will be an additional cost, if morbidity rates are reduced as a consequence then long term costs may actually decrease. Getting the right treatment quickly and starting rehabilitation early will reduce long term disability.

- More emphasis should be given to the establishment of the network rather than the issue of the location of the centre, as the service model is about the whole patient pathway.

There was also agreement that the Network should be established on the recommendations of the Independent Panel noting that these have come from an independent panel of experts who have experience of what works and what benefits result from establishing a network.

The group felt that the following needed to be considered should the Network be developed:

- An evaluation process should be agreed and described.
- Transport issues will have to be addressed for people visiting patients in the major trauma centre. It was noted that the panel had not considered access for visitors to be a major consideration in recommending the location of the major trauma centre as in principle patients would remain in the centre for as short a time as possible before transferring to other parts of the network.
- The Third Sector must be included as key partners in the network as they will have a big role to play in rehabilitation.
- The ability of the Welsh Ambulance Services NHS Trust (WAST) to support the running of the network is crucial

Meeting Title	Local Partnership Forum
Date	13th December 2017
Number of attendees	14
Presentation by	Jenny Thomas (Consultant in Rehabilitation) Melissa Rossiter (Clinical Lead for Major Trauma) Leigh Davies (Deputy Clinical Lead for Major Trauma) Abigail Harris (Director of Strategy and Planning)

In respect of question 1 there was discussion on the need for work on detailed costs and plans to be developed depending on the outcome of consultation. Other issues raised relating to:

- cost of developing networks in England
- anticipated national approach to commissioning
- opportunities for reorganising existing resources
- the fact that this would not all represent new work for C&V UHB as a lot of polytrauma patients require neurosurgery and already come to UHW, so this is an opportunity to consolidate what they're already providing.

Questions asked relating to Question 2 include:

- Whether any capital work that would be needed to establish a Major Trauma Centre at UHW would be part of discussions with Welsh Government about the redesign/rebuild of UHW.
- How establishment of a Major Trauma Centre at UHW would affect staffing.

Meeting Title	Staff Engagement Session
Date	13th December 2017
Number of attendees	59
Presentation by	Jenny Thomas (Consultant in Rehabilitation) Melissa Rossiter (Clinical Lead for Major Trauma) Leigh Davies (Deputy Clinical Lead for Major Trauma) Abigail Harris (Director of Strategy and Planning)

8.11

A number of issues were discussed:

- How quickly a Major Trauma Centre (MTC) would be operational if approved following consultation.
- The impact of establishing a MTC at UHW on other specialities and their involvement in work to date and on implementation going forward.
- The funding arrangements and how the UHB could be assured that it would receive the appropriate remuneration for all the additional work.
- Whether becoming an MTC would lead to recruitment of more trauma surgeons and anaesthetists or whether there was an expectation that existing teams would pick up the work.
- The impact of establishing an MTC on support structures and whether there would be additional resources to ensure adequate capacity particularly in overstretched teams such as physiotherapy.
- The nature of the proposed network lead role for Morriston.
- The additional patients UHW might expect to see if it became the MTC.
- How the development of an MTC would impact on theatre and critical care capacity and whether it would require a remodelling of ward environments.
- What was happening on moving elective work off the UHW site.
- The feasibility of repatriating children in light of the changes taking place as a result of the South Wales Programme which is bringing more specialist children's services to Cardiff.
- Whether an MTC would be a specific new building.

Cwm Taf University Health Board

The relevant stakeholder groups were invited to respond directly to the consultation process using the variety of response mechanisms available and therefore any responses will be included within section 2.4 of this report

Hywel Dda UHB

Meeting Title	Stakeholder Reference Group
Date	10th November 2017
Number of attendees	22
Presentation by	Dr Phil Kloer, Medical Director

Issues raised include:

- The document is only 10 pages long. It does not look to provide full detail for such a big issue.
- What money will the Health Board need to contribute towards this Major Trauma Centre? Would Welsh Government help the Health Board?
- Aberystwyth are overreliance on the Air Ambulance. The patient is transported by air to hospital however family/carers are about 4-5 hours behind and at times arrive too late. How can you help those individuals left behind?

8.11

Powys Teaching Health Board

Meeting Title	Brecknockshire Committee
Date	24th January 2018
Number of attendees	11
Presentation by	Matthew Dorrance, Chair Dr Karen Gully, Medical Director Mandy Mills, Engagement Officer

Questions asked by the Committee include:

- There has been a lot of talk around downgrading District General Hospitals and creating the SCCC. How does this proposal fit in with the other proposals?
- Will it be in a separate place?
- Cardiff is 25/30 miles away from Bristol (Frenchay), is it that the location is convenient for the consultants, and that's fine if it is the case but what about Burns and Plastics at Morriston. The Ystradgynlais do have concerns about this?
- What is the role of the Police given that they will often be involved in major trauma?
- What about NAS (National Air Support)?

- Will the staffing levels be a plentiful supply of clinicians?
- Will this affect the coordination?
- What role are the CHC playing in the consultation?
- Could you explain how important it is for patients to have these centres of excellence.

4 Social media

In addition, 254 members of the public engaged in conversation on Facebook and Twitter relating to the consultation (18 in Hywel Dda initiated conversations/threads and 236 in ABMU initiated conversations/threads). Whilst a number of individuals used these conversations to express their views on the proposal, the conversations were also used by individuals to promote and confirm that they had completed a formal questionnaire to respond to the consultation. The key themes identified from the social media conversations were considered in line with the agreed framework.

Theme	
Location of MTC	Unhappy with proposals for the MTC in the south of Wales (Swansea or Cardiff)
	All major towns need this located at their A&E
	Interested to see if the plans for Hywel Dda have been taken into account, with the proposed closures it is likely to put added stress on other major hospitals in the area.
	Why shouldn't it come to West Wales? - Carmarthen would be better for West Wales
	West Wales suffers whilst Carmarthen has major hospitals close by
	Why not change Neath Port Talbot hospital to major trauma/orthopaedic unit leaving Morriston, Singleton and Bridgend to deal with the rest. Neath is a beautiful hospital with not a lot or no A&E
	Morriston should be the Major Trauma Centre • easily accessible by road/close to motorway • excellent surgeons • covers burns • probably more land to expand than at UHW • more central for West Wales • easy to get to from north Wales

Location of MTC (continued)	In London, they have trauma units in most of their hospitals. Time is important. It would mean a lengthy journey from Bridgend, It is important for Wales to have their own trauma unit. It would save a lot of lives Response from individual: People need to understand the difference between MTC and TU. There are only 4 MTCs in London serving 12 million. Wales has a population of 3 million
	Why can't there be two major trauma hospitals in Wales?
	People of South West Wales need to be treated locally
	Cannot believe in 2018 we do not have a trauma unit
	Wales cannot support 2 Burns & Plastic or 2 neurosurgery dept. or PICU someone will have to move.
	Proximity of Bristol: • There is a trauma centre in Bristol Cardiff & East Wales can easily access. • Why have two major trauma units so close together • Wales was looked at in isolation and did not include the hospitals in Bristol
Current Service Pressure	Morriston cannot cope with the demands on A&E as it is and if POW is moved then it will only make things worse
	Neither site could cope with the extra traffic. They need to improve roads and parking first
Current Service Provision	Aberystwyth needs a nurse led walk in centre
	Concern unable to staff Hywel Dda at present
	Upgrade Bronglais; we need better hospitals to cope with treatments, operations and emergencies before major trauma units sited mils away Response from individual: The major trauma unit is separate to A&E. this is to concentrate expertise. Plastics already go to Morriston, brain injuries to Cardiff. There is no way we could have this expertise in Bronglais
	Morriston doesn't have enough neurosurgeons. Major trauma patients need them the majority of the time. Cardiff has neurosurgeons

8.11

Current Service Provision (continued)	All this for an event that may never happen. We have patient needing operations now that should be the priority
	How does this help stroke patients needing urgent treatment. Response from individual: MTCs don't treat strokes, thrombolysis is carried out in all DGH. You cant pack all DGS with tertiary specialists
	Neurosurgery needed back in Morriston. Paediatric HDU as well
	If the proposed closure of Withybush and Glangwilli go ahead there will be a lot of deaths
Access and support for families	Not just about the patient but their family – parking at UHW/Expenses for relatives
Consultation process	General enquiries regarding the time and location of the public meetings - why hold the public session in the week and not weekend days - Not enough publicity given to this consultation
	Difficulties responding to the online consultation
	It has already been decided
	All these consultations are costing money. If it's not broke why are you fixing it?
	Discussion thread regarding completion and submission of consultation forms
Financial resources	Is it necessary? This money could be better spent improving services in existing premises
Political Decision	Political argument from a London-centric point of view
Other	Cutting bed and centralising specialities does not work for the benefit of the population
	Are we having a helicopter for this service wherever it is located
	get rid of all management and bring back ward matrons

5 Receipt of late/damaged responses

- Following closure of the consultation a further 13 responses were received in the post and 6 via email. These have not been included in the analysis.
- The Collaborative received notification from Royal Mail of failure to deliver a package. However, the date documented was outside of the consultation window.
- An empty, damaged envelope was received.

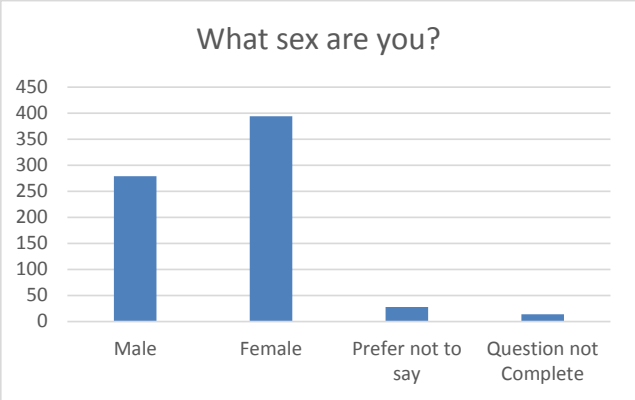
6 Equality monitoring

Equality monitoring questions accompanied the formal consultation response forms as well as the online response questionnaire. There were 715 completed equality monitoring forms returned as part of the consultation process.

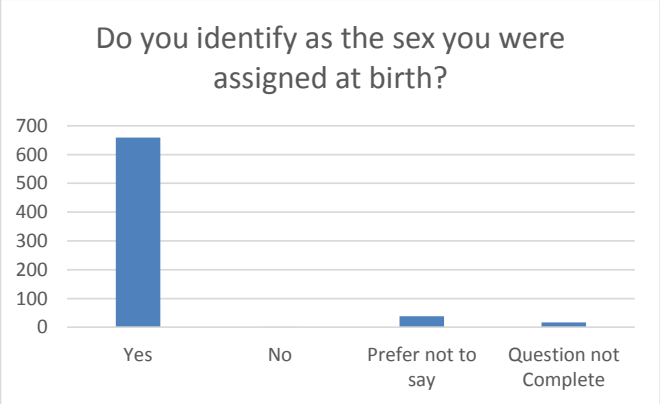
Category	Number of Respondents
16 to 24	17
25 to 34	85
35 to 44	117
45 to 54	148
55 to 64	141
65 to 74	109
75 or over	45
Prefer not to say	38
Question not complete	15
Total	715

8.11

NHS Wales Health Collaborative	Supporting Document 11 – Numerical and Thematic Analysis of Consultation Responses

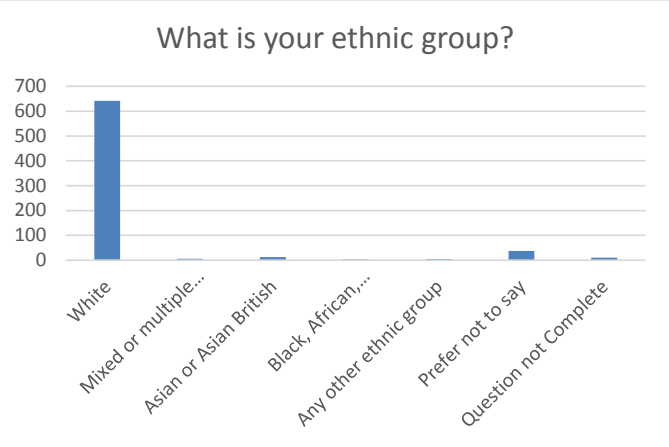


Category	Number of Respondents
Male	279
Female	394
Prefer not to say	28
Question not complete	14
Total	715



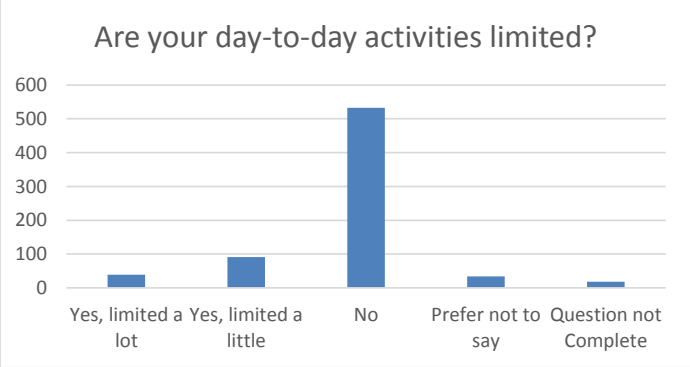
Category	Number of Respondents
Yes	659
No	1
Prefer not to say	38
Question not complete	17
Total	715

NHS Wales Health Collaborative	Supporting Document 11 – Numerical and Thematic Analysis of Consultation Responses



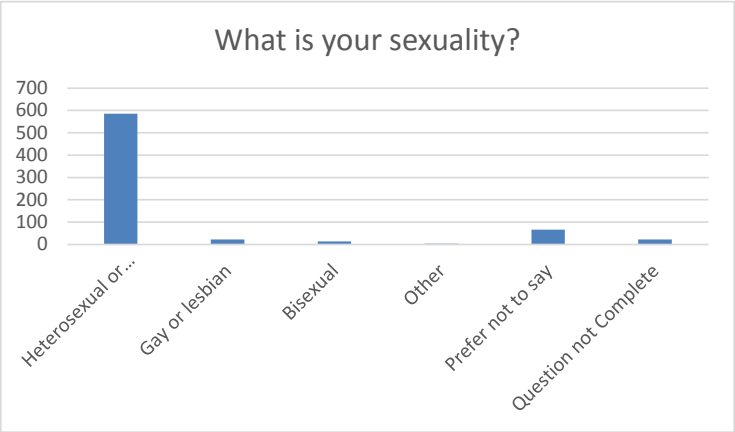
Category	Number of Respondents
White	642
Mixed or multiple ethnic groups	6
Asian or Asian British	12
Black, African, Caribbean or Black British	3
Any other ethnic group	5
Prefer not to say	37
Question not complete	10
Total	715

8.11



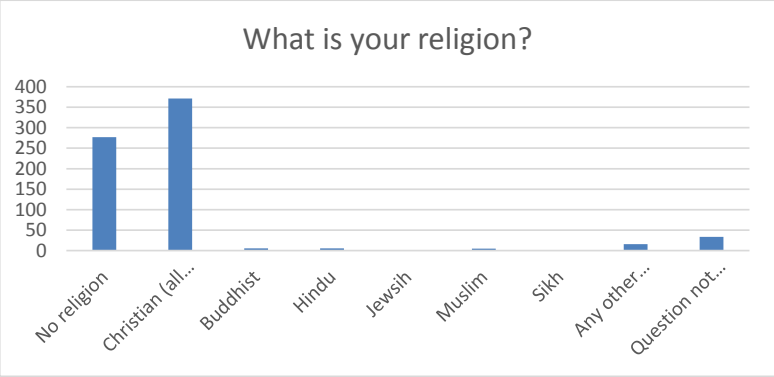
Category	Number of Respondents
Yes, limited a lot	39
Yes, limited a little	91
No	533
Prefer not to say	34
Question not complete	18
Total	715

NHS Wales Health Collaborative	Supporting Document 11 – Numerical and Thematic Analysis of Consultation Responses



Category	Number of Respondents
Heterosexual or straight	586
Gay or lesbian	23
Bisexual	14
Other	3
Prefer not to say	66
Question not complete	23
Total	715

8.11

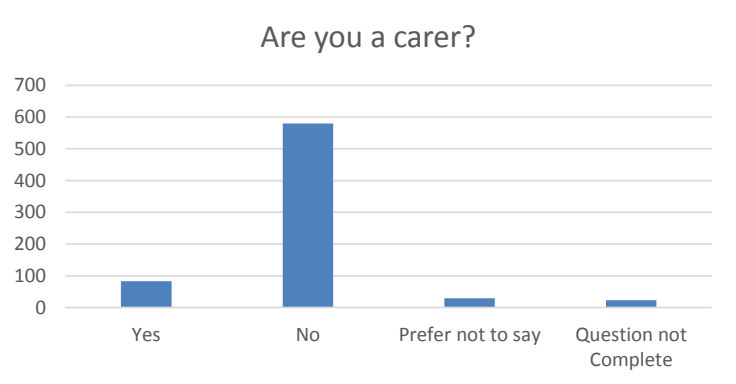


Category	Number of Respondents
No religion	277
Christian (all denominations)	371
Buddhist	6
Hindu	6
Jewish	0
Muslim	5
Sikh	0
Any other religion	16
Question not complete	34
Total	715

NHS Wales Health Collaborative	Supporting Document 11 – Numerical and Thematic Analysis of Consultation Responses

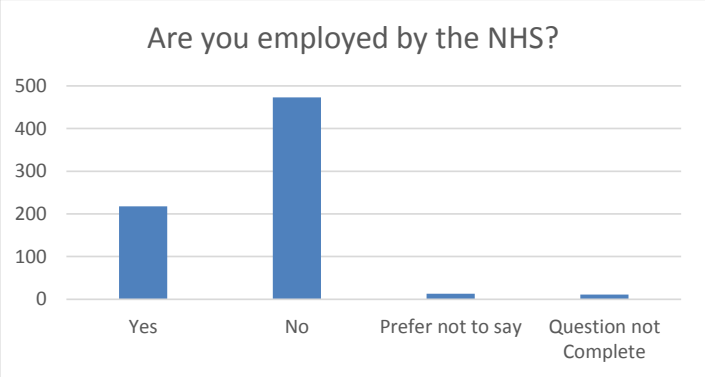
Category	Number of Respondents
Yes	139
No	530
Prefer not to say	30
Question not complete	16
Total	715

8.11



Category	Number of Respondents
Yes	83
No	580
Prefer not to say	29
Question not complete	23
Total	715

NHS Wales Health Collaborative	Supporting Document 11 – Numerical and Thematic Analysis of Consultation Responses



Category	Number of Respondents
Yes	218
No	473
Prefer not to say	13
Question not complete	11
Total	715

8.11

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Major Trauma Consultation
Analysis of Responses against Framework

8.12

Author: Rachel Hennessy, Programme Director

Date: 16 March 2018	**Version:** 1a (Final)

Purpose and Summary of Document:

A framework for analysis of the consultation responses was developed to assist health boards in their decision making process. Consultation responses were analysed in accordance with the framework. This paper contains the resulting analysis of:

- comments made in response to consultation questions 1, 2 and 4 (Sections 1, 2 and 3)
- comments made in public meetings (Section 4)
- comments made in other formal groups and meetings (Section 5)
- other consultation responses received (Section 6)

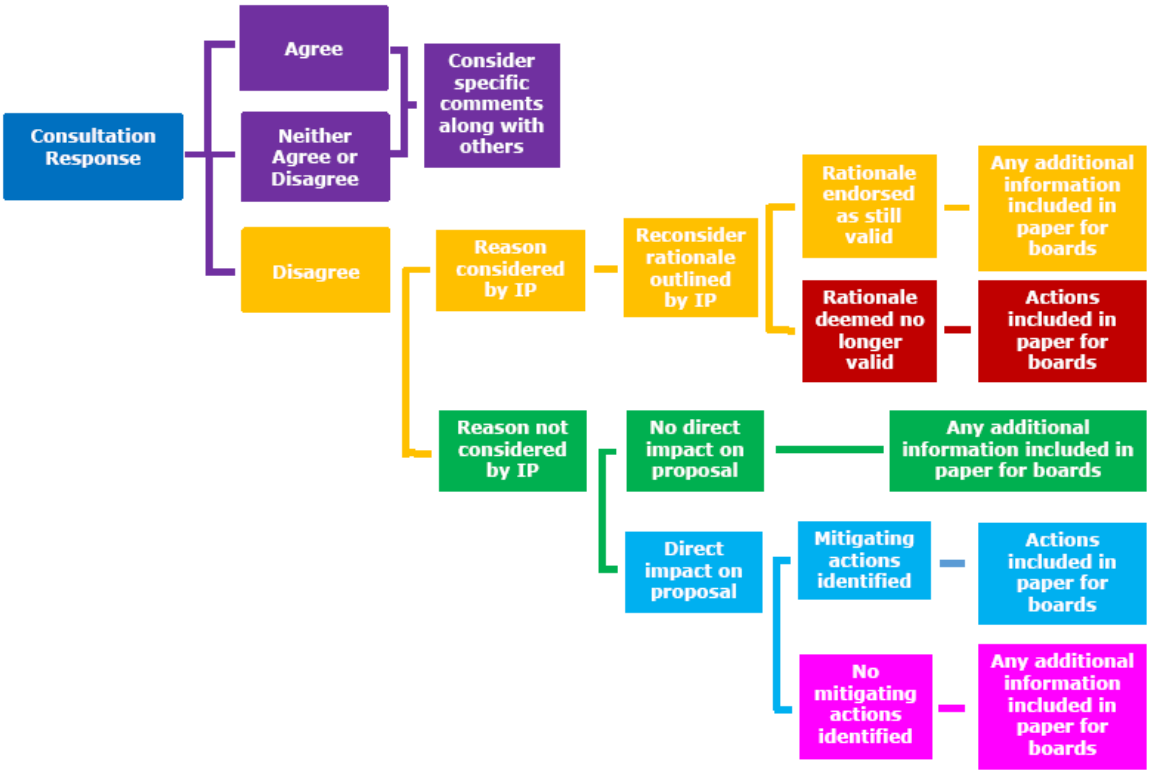
NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Introduction

The Independent Panel considered an extensive suite of information prior to making their recommendations. As a result, health boards agreed, at their board meetings in September 2017, that the basis of the consultation would be the recommendations of the Independent Panel. The framework for analysis of the consultation responses was developed to assist health boards in their decision making process and an initial version was agreed at the Collaborative Executive Group (formerly the Collaborative Board) in January 2018.

In February 2018, in considering the initial analysis of responses using the framework, the framework was modified to require that, in cases where recommendations had been challenged for reasons already considered by the Independent Panel, the Panel's rationale should be reconsidered and either endorsed as still valid or deemed to be no longer valid.

The framework is illustrated graphically below:



In applying the framework, care was taken to ensure that all comments made were considered on an equal footing regardless of the format in which they were submitted.

1 Consultation Question 1

The reasons given by individuals/groups for not agreeing with question 1 have been collated into themes outlined below and considered in line with the agreed framework.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Major trauma network (MTN) structure	The development of Trauma Units will lead to the closure of minor hospitals that might be seen as 'surplus to requirements'.	No	Direct	Yes	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency (A&E) units in North Wales, despite the fact that the Major Trauma Centre (MTC) is based in Stoke on Trent. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the MTC or receive initial treatment at a trauma unit before being transferred to the MTC. **The importance of local access, particularly for the frail and elderly, has been reinforced by the responses received and it is recognised that this should form an important consideration in relevant service models in the future.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Major trauma network (MTN) structure (Continued)	Need a major trauma network that covers all of Wales.	No	Indirect	Yes	North Wales participates in the West Midlands major trauma network and accesses the MTC in North Staffordshire. Patients in North Wales access a large number of their services from England, due to their highly specialist nature, and will continue to do so. **The regions will work closely together so they can share best practice and learn from each other. There will be a major trauma and critical care network board which will include both North and South Wales.**
	South Wales is big enough to need more than one centre.	No (but considered by the 2015 option appraisal)	Indirect	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	Travelling long distances could be unrealistic and detrimental to the health of the injured.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the MTC was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the MTC.
Access and proximity to Bristol	There should be investment in the trauma services available in Bristol.	No (but considered by the 2015 option appraisal)	Indirect	N/A	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
Lack of evidence	Is there sufficient evidence to demonstrate that the current situation disadvantages patients?	Yes	N/A	N/A	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.
	Major trauma is rare and has been treated well in the present centres.	Yes	N/A	N/A	

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision	Location of a single centre for Thoracic Surgery will need to relate to the MTC.	No	Indirect	No	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site rather than the current two. A subsequent recommendation was made by an independent panel that that the site should be Moriston Hospital. The panel specifically considered the issue of colocation. The issue of colocation of the MTC and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the MTC.
Existing infrastructure	Physical infrastructure of any of the hospitals would not be able to cope unless there is radical though as to what moves out of any of the hospitals involved in the network.	No	Indirect	Yes	**Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site. Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure (Continued)	Physical infrastructure of any of the hospitals would not be able to cope unless there is radical though as to what moves out of any of the hospitals involved in the network. (Continued)	No	Indirect	Yes	**Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.** In addition, it should be noted that the development of a major trauma network in the region will be taking place in the context of the fact that that Cardiff and Vale and Abertawe Bro Morgannwg University Health Boards are broadly committed to working together to maximise the benefits of two regional /specialist centres in South Wales with a formal partnership between the two health boards being established. **Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.** Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Financial resources	Whether the anticipated costs of this development are being considered in comparison to other ways of spending the money to support other patient groups, comparing years of quality life added.	No	Indirect	N/A	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process.
Workforce requirements	How staff will be occupied if they are not dealing with a major trauma.	No	Direct	Yes	The MTC will meet the service specification set for staffing. It would be up to the MTC how they achieve this. **The majority of staff involved in initial trauma care would have other duties in the hospital from which they can be rapidly released when a trauma is admitted.** **As in other MTNs it is likely that some substantial or even full time roles would be required to manage trauma patients - e.g. major trauma practitioners who coordinate and review major trauma patients in the MTC on a daily basis.**

2 Consultation Question 2

The reasons given by individuals/groups for not agreeing with question 2 have been collated into themes outlined below and considered in line with the agreed framework.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	There should be more than one centre.	No (but considered by the 2015 option appraisal)	Indirect	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).
Access and proximity to Bristol	Proximity of South East Wales to Bristol – people living in South East Wales have access to the Network in Bristol.	No (but considered by the 2015 option appraisal)	Direct	No	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	Disagree with the location of MTC – the MTC should be in Swansea/Morriston. Report does not take into account travel times from West Wales and South Powys to Cardiff.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre. Providing this service on-site is a minimum requirement. The Independent Panel considered iscochrone models of travel times for Morriston Hospital and UHW. There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.
Strategic direction for Wales	Report fails to take into consideration access to English MTCs.	No (but considered by the 2015 option appraisal)	Indirect	Yes	The 2015 option appraisal agreed that, to support a population of approximately two million, the network would need to be supported by a major trauma centre based within the region. **All major trauma networks in England and Wales maintain appropriate links with one another**.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing Infrastructure	Existing pressure on Morriston Hospital and UHW • Exiting pressure on UHW in relation to capacity required for the MTC. • Morriston has already purchased further land which could accommodate the MTC	No	Direct	Yes	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if the University Hospital of Wales (UHW) becomes the MTC. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients. **Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service:** • **a front door Emergency Unit service with a major trauma team leader available 24/7** • **increased critical care capacity in line with modelling for additional major trauma activity** • **additional theatre capacity** • **creation of a polytrauma unit.** **There are plans being developed to address each of these, dependent on the outcome of consultation. Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and internal service reconfiguration programme at UHW.**

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing Infrastructure (Continued)	Existing pressure on Morriston Hospital and UHW • Exiting pressure on UHW in relation to capacity required for the MTC. Morriston has already purchased further land which could accommodate the MTC (Continued)	No	Direct	Yes	**This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site.** **Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.** **Cardiff and Vale UHB is also working closely with other health boards on arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	Access and support for families.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked at the Independent Panel to outline how they would address support for families. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.**
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST)	The impact of the major trauma network on the WAST and EMRTs.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. WAST and EMRTS presented at the Independent Panel and outlined the impact the MTC would have on them if located at either Morriston Hospital or UHW.
	EMRTS/Air Ambulance does not operate 24/7 and cannot operate at night.	No	Direct	No	At present, the Emergency Medical Retrieval Transfer Services (EMRTS) and Wales Air Ambulance operate a 12-hour service from 8AM to 8PM. If during this time it is dark, the Wales Air Ambulance charity helicopters are able to transfer patients between hospitals where approved landing sites with lights are available. Otherwise a specialist car known as a rapid response vehicle will attend the scene of the incident.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST) (continued)	EMRTS/Air Ambulance does not operate 24/7 and cannot operate at night. (continued)	No	Direct	No	Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority. Future operational arrangements of EMRTS and the Wales Air Ambulance are currently under review. Any constraints in coverage will apply irrespective of the location of the MTC. Further advice about operational procedures will be taken during implementation, informed by experience elsewhere in England and Wales.
Consultation process	Politically motivated decision.	No	N/A	N/A	Arrangements for an Independent Panel of experienced experts in the field of major trauma (predominantly from outside Wales) were agreed by health boards January 2017 (see section 3.3 of the main report). The Independent Panel undertook its deliberations and developed its recommendations free from political interference. The decision to consult on the recommendations was taken by health boards and health boards will make final decisions, informed by the report of the consultation.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Role of the Independent Panel	Concern that the independent panel is not independent and not in touch with patients.	No	N/A	N/A	Arrangements for an Independent Panel of experienced experts in the field of major trauma were agreed by health boards in January 2017. Panel members were selected to provide specific professional expertise It was not part of the role of the panel to be representatives of patients. CHCs were represented at the meeting of the Independent Panel (see section 3.3 for additional information about the Independent Panel and its composition).
Population based decision	Should be a decision of the population.	No	N/A	N/A	A formal public consultation was undertaken from 13 November 2017 until 5 February 2018, in conjunction with CHCs and in accordance with Welsh Government guidance.
Needs based decision	Should look at the needs of the community, current services and demographics.	Yes	N/A	N/A	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Independent Panel considered evidence compiled across the life of the project, including travel, demographics and service provision.
Patient flow	Delays in repatriation may be exacerbated by the increased numbers of patients coming to UHW if it were the MTC.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. **Health boards will need to agree and implement a patient flow policy which supports 'automatic acceptance' at the centre and 'repatriation' as soon as possible.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Transport and infrastructure requirements	Road infrastructure and public transport requirements.	No	Indirect	Yes	There are various patient transfer options that will be used with the proposed major trauma network. Travel times were considered by the Independent Panel. Public transport is not a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport. Nevertheless, it is recognised that there will be an impact on families and carers who might have to travel further while the patient is being treated in the Major Trauma Centre. It is important to note, however, that patients would typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.**

3 Consultation Question 3 and 4

The comment made in response to questions 3 and 4 have been collated into themes outlined below and considered in line with the agreed framework.

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	The MTC should be in Morriston/Swansea The MTC should not be at UHW	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The panel decided that providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site as the major trauma centre was the main factor in deciding where to base the major trauma centre. Providing this service on-site is a minimum requirement. The Independent Panel considered iscochrone models of travel times for Morriston Hospital and UHW. There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Major Trauma Network structure	There should be more than one MTC in the region	No (but considered by the 2015 option appraisal)	Indirect	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).
	There is a need to ensure that appropriate decisions are made about the location of trauma units	No	Direct	Yes	The implementation of the network, including the redevelopment of the whole pathway of care is as important than the location of the MTC. The Independent Panel was asked to make a recommendation on the location of the MTC only, and not the trauma units. Identifying the MTC location first is helpful in informing where to locate the units. The remaining trauma units will need to be identified by individual health boards for their local area. **There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered (e.g. in Powys).** **The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.**

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Access and proximity to Bristol	Parts of the region should use Bristol (and or other English centres) as their MTC	No (but considered by the 2015 option appraisal)	Indirect	N/A	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
Role of the Emergency Medical Retrieval Service (EMRTS) and Ambulance Service (WAST	There is a need to ensure that improvements are made in EMRTS, air ambulance services and ambulance services to ensure the time taken to transfer patients to the MTC is minimised on a 24/7 basis	No	Direct	No	At present, the Emergency Medical Retrieval Transfer Services (EMRTS) and Wales Air Ambulance operate a 12-hour service from 8AM to 8PM. If during this time it is dark, the Wales Air Ambulance charity helicopters are able to transfer patients between hospitals where approved landing sites with lights are available. Otherwise a specialist car known as a rapid response vehicle will attend the scene of the incident. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority. Future operational arrangements of EMRTS and the Wales Air Ambulance are currently under review. Any constraints in coverage will apply irrespective of the location of the MTC. Further advice about operational procedures will be taken during implementation, informed by experience elsewhere in England and Wales.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	There is a need to ensure that the relatives of patients are adequately supported, in terms of provision of information, transport, accommodation at the MTC, parking etc.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked at the Independent Panel to outline how they would address support for families. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.**
Existing service provision	There is a need to ensure that there are adequate facilities at sites in the network other than the MTC	No	Direct	No	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency units in North Wales. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the MTC or receive initial treatment at a trauma unit before being transferred to the MTC.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision (Continued)	There is a need to ensure that there is access to 24/7 interventional radiology at the MTC	No	Direct	Yes	**Interventional radiology is being addressed on a regional basis between Cwm Taf, AB UHB and C&V UHB. A plan has been developed to establish a 24/7 rota. This includes some additional appointments, one of which has already been made (start date August 2018). A Business Case is being developed for a hybrid theatre to support the interventional radiology work. In addition to this there is currently work ongoing in Cardiff to finalise the capital plan for an additional single plane interventional suite in order to ensure that there is sufficient room time available across the working week to support regional working.** **At the point where the major trauma centre is in place there will need to be considerations as to how the rota works to ensure immediate availability of the appropriate staff. This will include extending the on call arrangements for the nurses and radiographers, which has been identified as part of the major trauma case.**

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location	There are concerns about equity of access in West Wales and other rural areas	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Panel considered the geography of Wales and concluded that transfer time to the MTC was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network. With the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the MTC.
Existing infrastructure and services	There are concerns about the impact on existing services at the location of the MTC through additional workload	No	Direct	Yes	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if the University Hospital of Wales (UHW) becomes the MTC. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients. **Cardiff and Vale UHB has identified four critical enablers that would support the delivery of a major trauma service:** • **a front door Emergency Unit service with a major trauma team leader available 24/7** • **increased critical care capacity in line with modelling for additional major trauma activity**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure and services (Continued)	There are concerns about the impact on existing services at the location of the MTC through additional workload (Continued)	No	Direct	Yes	• **additional theatre capacity** • **creation of a polytrauma unit.** **There are plans being developed to address each of these, dependent on the outcome of consultation.** **This work is being progressed within the context of an overall refurbishment and internal service reconfiguration programme for the UHW site. This will be subject to submission of a Business Case to Welsh Government. Cardiff and Vale UHB is also developing a Clinical Services Plan which will include consideration of what services could move off the UHW site to University Hospital Llandough. Any proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.** **Cardiff and Vale UHB is also working closely with other health boards on arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce	There are concerns about the network's ability to ensure adequate staffing and adequate training for staff There are concerns about the ability to recruit and retain staff away from the MTC	No	Indirect	Yes	**A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.** A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Financial resources	There are concerns about the availability of adequate funding to implement the network	No	Indirect	N/A	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process.
MTN structure	There are concerns about the downgrading of services away from the MTC	No	Direct	Yes	North Wales already participates in a major trauma network. This has not resulted in services being pulled out of the three major accident and emergency (A&E) units in North Wales, despite the fact that the Major Trauma Centre (MTC) is based in Stoke on Trent. If a hospital is not a dedicated trauma unit, the implementation of a major trauma network will not result in any changes to the range of services it currently provides for patients. Most hospital emergency departments treat just one major trauma patient a week, so the change will not impact significantly on their work. Only patients who need the highest level of specialised care will go to the MTC or receive initial treatment at a trauma unit before being transferred to the MTC.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure (Continued)	There are concerns about the downgrading of services away from the MTC (Continued)	No	Direct	Yes	**The importance of local access, particularly for the frail and elderly, has been reinforced by the responses received and it is recognised that this should form an important consideration in relevant service models in the future**
Existing infrastructure	There are concerns about the capacity of estates, facilities and support services at UHW, particularly in relation to the situation at Morriston	No	Indirect	Yes	Cardiff and Vale UHB is working closely with other health boards on the following: • **A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment**. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public. • **Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure	There are concerns about the capacity of estates, facilities and support services at UHW, particularly in relation to the situation at Morriston	No	Indirect	Yes	Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.
Existing service provision	There are concerns about lack of co-location with thoracic surgery	No	Indirect	No	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site (Morriston Hospital), rather than the current two. The issue of colocation of the MTC and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the MTC.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Existing service provision (Continued)	There are concerns about the potential for the burns unit to move to Cardiff	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together. Burns and plastics is already a regional service provided from Morriston Hospital.
Social and economic impact	There are concerns about the social and economic impact of further investment in Cardiff at the expense of other areas There are concerns about this being part of a wider agenda to move services from Swansea to Cardiff	No	Indirect	No	This was out of the scope of the consultation.
Consultation process	There are concerns about the degree to which the consultation has been genuine and extensive	No	Indirect	No	The consultation process was reviewed against consultation and engagement guidance by health boards and CHCs at mid point. No further changes were advised. Conscientious consideration was given to the outcomes of the consultation process at all relevant times.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Consultation process (Continued)	Further information would have been welcome in relation to how well the network is working in North Wales	No	Indirect	No	It is considered that the information provided during the consultation was adequate.
	Further information would have been welcome in relation to the geographical spread of incidents resulting in major trauma in recent years	Yes	Indirect	No	
Implementation of the Major Trauma Network	There is a need to ensure that there is an adequate focus on rehabilitation (including minimising waiting times)	Yes	Direct	No	The need to develop appropriate and robust rehabilitation pathways as part of the implementation of the Major Trauma Network is accepted.
	There is a need to ensure that there is excellent communications between professionals and with the public during the implementation and delivery of the network	No	Indirect	No	The need for a clear communication strategy is accepted.
	There is a need to ensure that the therapy professions are appropriately involved in the implementation of the network	No	Indirect	No	Implementation will need to involve professional bodies, as appropriate.
	There is a need to ensure that digital solutions are used where possible	No	Indirect	No	The need to make appropriate use of technology in implementing the Major trauma Network is accepted.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Implementation of the Major Trauma Network (Continued)	There is a need to ensure that implementation proceeds quickly once the decision has been made	No	Indirect	No	An appropriate and measured implementation plan will be developed.
	There are concerns about why it has taken this long to develop proposals for a major trauma network for the region	No	Indirect	No	This was out of the scope of the consultation.

4 Responses from public meetings

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	The location of the trauma units and rehabilitation pathway is more critical than the location of the MTC.	No	Direct	Yes	The implementation of the network, including the redevelopment of the whole pathway of care is as important than the location of the MTC. The Independent Panel was asked to make a recommendation on the location of the MTC only, and not the trauma units. Identifying the MTC location first is helpful in informing where to locate the units. The remaining trauma units will need to be identified by individual health boards for their local area. **There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered (e.g. in Powys).** **The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.** The need to develop appropriate and robust rehabilitation pathways as part of the implementation of the Major Trauma Network is accepted.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Clarity required over the exact geographical location of the major trauma network – relates to Powys.	Yes	Indirect	No	At the boundaries of the network, ambulance crews will assess patients and, if the services of a Major Trauma Centre are required, patients will be taken by ambulance or helicopter to an appropriate Major Trauma Centre, which may be the proposed centre in South Wales or one in England.
	Impact of the MTC and MTN on other hospital sites including SCC, Morriston, Prince Charles Hospitals.	No	Indirect	No	Fewer than 1% of the treatment provided in emergency departments is major trauma.
Existing services	Waiting times for neuro surgery are too long.	No	Indirect	Yes	Waiting times for Neurosurgery are longer than we want them to be but have been steadily reducing since the Summer supported by improved repatriation and some additional theatre capacity at UHW (201 patients were waiting over 36 weeks at the end of August, down to 81 at the end of January). **The service has plans to reduce waiting times further through 2018/19, with the support of WHSSC. A review of Neurosciences is due to conclude shortly which will inform longer term planning.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing services (Continued)	Difficulties with moving patients into community settings within Cardiff and Vale.	No	Indirect	Yes	Other than through improving survival, the implementation of the major trauma network will not impact on the need for care in community settings in Cardiff and Vale. **Patients will be repatriated to their home health board before requiring community based care.**
	The waiting time for residents needing local emergency department services if the Major Trauma Centre comes to the University Hospital of Wales or Morriston Hospital.	No	Direct	No	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing services (Continued)	Need to look at what services could come off the UHW site, recognising that travel to the site was a problem.	No	Direct	Yes	**Cardiff and Vale UHB is working closely with other health boards on a review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals.** This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.
	Concern that Burns and Plastics will be moved from Morriston.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Whilst it is not critical that the burns and plastic centre is on the same site as the major trauma centre, it is important that UHW and Morriston Hospital work together.
	Clear plan of how existing A&E units will be maintained.	No	Direct	No	Fewer than 1% of the treatment provided in emergency departments is major trauma. The implementation of the recommendations for a major trauma network will not change the role of local emergency units that are not designated as trauma units within the network.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Role of EMRTS/WAST	Role of EMRTS and air ambulance needs is critical and needs to be strengthened.	Yes	Direct	Yes	**As part of the next phase, further work will be undertaken to develop pathways and the commissioning framework.**
	The impact on ambulances if the service is consolidated to UHW.	Yes	Indirect	No	From an emergency standpoint, these patients already exist and are already managed by WAST and EMRTS/Wales Air Ambulance on a day to day basis. The actual increase in ambulance work is only likely to reflect the small number of patients who travel a short additional distance to reach an MTC, rather than being taken to their local hospital.
Patient flow	Delays in repatriation/step down resulting in issues with patient flow.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. **Health boards will need to agree and implement a patient flow policy which supports 'automatic acceptance' at the centre and 'repatriation' as soon as possible.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Financial resources	Need to consider if there is enough money to develop the MTC and ensure cover 24/7 365 days.	Yes	Direct	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Proposed financial information was provided by both candidate sites. **WHSSC has been identified to lead the development of a commissioning framework for the major trauma network. Detailed capital costs will be developed for inclusion in the business case to Welsh Government.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	Staffing available to support the proposal or will they need to relocate.	No	Indirect	Yes	**A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.** A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	Need to ensure that there is adequate allocated parking to ensure that families are able to park easily and facilities at the MTC for families to stay on site.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. The Independent Panel requested candidate sites to answer this question. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.**
Transport and road infrastructure requirements	Need for improved public transport.	No	Indirect	Yes	There are various patient transfer options that will be used with the proposed major trauma network. Travel times were considered by the Independent Panel. Public transport is not a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport. Nevertheless, it is recognised that there will be an impact on families and carers who might have to travel further while the patient is being treated in the Major Trauma Centre. It is important to note, however, that patients would typically only spend a short period of time in the MTC itself, before being repatriated. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.**

5 Responses from other formal groups/meetings

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN Structure	More emphasis should be given to the establishment of the network rather than the location of the MTC and identifying the location of the trauma units as soon as possible to provide reassurance to the public.	No	Direct	Yes	The implementation of the network, including the redevelopment of the whole pathway of care is as important as the location of the MTC. The Independent Panel was asked to make a recommendation on the location of the MTC only, and not the trauma units. Identifying the MTC location first is helpful in informing where to locate the trauma units. **The remaining trauma units will be identified by individual health boards for their local area, although there will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered.** **The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Access and proximity to Bristol	Locating the service at UHW appears illogical from a geographical (travel time perspective) when Bristol is such a short distance from Cardiff.	No (but considered by the 2015 option appraisal)	Direct	N/A	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
Existing service provision	Significant gaps in community neurorehabilitation across the region (ABM).	No	Indirect	No	Community neuro-rehabilitation will need to be addressed. This issue does not call into question the recommendations of the Independent Panel.
	Problems with hospital flow, communication and discharge processes from regional neurorehabilitation unit based at Neath port Talbot Hospital. Need for significant investment into an in-reach community rehabilitation service.	No	Indirect	No	This issue will need to be addressed. This issue does not call into question the recommendations of the Independent Panel.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision	How are problems with interventional radiology being addressed.	No	Direct	Yes	**Interventional radiology is being addressed on a regional basis between Cwm Taf, AB UHB and C&V UHB. A plan has been developed to establish a 24/7 rota. This includes some additional appointments, one of which has already been made (start date August 2018). A Business Case is being developed for a hybrid theatre to support the interventional radiology work. In addition to this there is currently work ongoing in Cardiff to finalise the capital plan for an additional single plane interventional suite in order to ensure that there is sufficient room time available across the working week to support regional working.** **At the point where the major trauma centre is in place there will need to be considerations as to how the rota works to ensure immediate availability of the appropriate staff. This will include extending the on call arrangements for the nurses and radiographers, which has been identified as part of the major trauma case.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Infrastructure requirements	Should discussion around capital work for UHW be considered as part of wider discussions with Welsh Government regarding the redesign of UHW.	No	Indirect	Yes	**Cardiff and Vale UHB has already had initial discussions with Welsh Government on proposals on a refurbishment and expansion internal service reconfiguration programme at UHW. This includes consideration of issues in the immediate future as well as finding longer term strategic solutions on the UHW site. A Business Case will be submitted to Welsh Government later this year, reflecting a phased development plan.**
Financial resources	Need for detailed costs and to understand what money will health boards contribute towards the MTC and how WG will support this.	No	Direct	Yes	**WHSSC has been identified to lead the development of a commissioning framework for the major trauma network. Detailed capital costs will be developed for inclusion in the business case to Welsh Government.**
	National approach to commissioning, new SLAs, recognising that this would not be all new work for C&V.	No	Direct	Yes	**WHSSC has been identified to lead the development of a commissioning framework for the major trauma network.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	The impact of the MTC and the MTN on the ability to recruit and retain staff across the network, training requirements, placements for defence, improve skill sets, rotation of staff across sites.	No	Direct	Yes	**A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.** A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites. Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and support for families	Support for families of patients being transferred by air ambulance who will arrive 4-5 hours later.	No	Direct	Yes	**Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.** **A new charity-funded building providing accommodation and facilities for families whose children are receiving treatment in UHW has recently been opened. Some accommodation is also available on the UHW site for families of adult inpatients.**
Transport and road infrastructure requirements	Transport issues will need to be addressed for people visiting the MTC.	No	Indirect	Yes	Patients will typically only spend a short period of time in the MTC itself, before being repatriated. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.**
Insufficient information	Insufficient information about the plans and investment available to support this development. More detail to inform how the panel felt this could be delivered, infrastructure changes and additional investment in staff.	No	Indirect	Yes	**If the proposals are agreed, he next level of detail will be developed as part of detailed implementation plans.**

6 Additional responses to the consultation (social media, letters and emails)

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Location of MTC	Geographical position of Swansea.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Information considered by the Independent Panel included the geography and demographics of Wales and the panel concluded that transfer time to the MTC was not the most important driver of the positive outcomes resulting from the implementation of a major trauma network The Independent Panel concluded that with the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the major trauma centre.
	Swansea has a purpose built helipad.				
	Road links in Swansea and links to M4 Mid South Wales.				
	Capacity to expand at Morriston.				
	Vital response time for victims from western end of region cannot be safely met by locating MTC at Cardiff, services should be within the 'golden hour' - within one hours drive of treatment.				
	Consideration should be given to the disposition of population throughout the region and not only in urban areas.				

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Proximity to Bristol	Locating the service at UHW appears illogical from a geographical (travel time perspective) when Bristol is such a short distance from Cardiff. The population of the south east have access to the MTN and centre in Bristol. Has consideration been given to the alternative proposition of joining south east Wales to a major trauma network centre located in Bristol with more western parts of south wales served by a major trauma network that is based on a major trauma centre located in Swansea. Should be a formal relationship with Bristol network.	No (but considered by the 2015 option appraisal)	Indirect	No	The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.
MTN structure	There could be a strong argument for either West Wales Mid Wales or Valleys body to take on the leadership role but this appears not to have been explored.	No	Indirect	No	As the most major unit that was not recommended to be the location of the MTC, Morriston was recommended by the Independent Panel to have leadership role. The rationale of the Independent Panel has been reconsidered and endorsed.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Why not change Neath Port Talbot hospital to major trauma/orthopaedic unit leaving Morriston, Singleton and Bridgend to deal with the rest. Neath is a beautiful hospital with not a lot or no A&E. Carmarthen would be better for West Wales. All major towns need this located at their A&E.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Morriston Hospital in Swansea and University Hospital of Wales, Cardiff were the only two hospitals in the region that could maybe meet the criteria for a major trauma centre. This is due to the specialist nature of the service and the need for it to be located with other specialist services.
	Further clarity required regarding the exact scope and number of trauma centre [units] - is not clearly described in the consultation document. Are there any plans to have a trauma unit within Powys? Powys is sadly lacking any major medical unit or A&E department.	No	Direct	Yes	**The remaining trauma units will need to be identified by individual health boards for their local area.** Powys secures its secondary care services from neighbouring District General Hospitals. **Powys tHB will work with each of these health boards and trusts in relation to trauma unit provision. Powys tHB will also be focusing on the provision of rehabilitation services for people as close to their home as possible.** **The Wales Critical Care and Trauma Network will assist by supporting assessments of candidate units against the criteria for a trauma unit contained in national standards and guidelines.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Advice from the group be further tested by 1. Assessing the reliance of an England and Wales chain of MTUs comprising Morriston rather than UHW 2. looking further at the accessibility indicators for both road and air conveyed patients from S Wales if Morriston was relied upon.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Information considered by the Independent Panel included the geography and demographics of Wales. The Independent Panel concluded that there should be an MTU within the region and that his should be at UHW.
	UHW and Morriston should have equal status.	Yes	Direct	No	The potential for a dual site solution was considered in the option appraisal conducted in June 2015, but was eliminated based on the fact that the critical mass for sustainability (a population of approx. two million) could not be delivered through such an arrangement (see section 3.2 of the main report).
	Concern model proposed is more of hub and spoke model rather than what may be understood by a network.	No	Indirect	No	The model proposed adopts the arrangements used by major trauma networks across England and Wales.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
MTN structure	Has consideration been given to the resources and facilities required including ITU beds, IT infrastructure, support services e.g. radiology	No	Direct	Yes	Morriston Hospital and UHW provided high level costs for each site to meet the designation criteria for a MTC. **If supported, UHW will develop a detailed business case which will include an assessment of the resources available and what is required to deliver a major trauma centre. Any additional resources required will be required over a period of time.**
	How will proposals work given the configuration of burns & plastics and neurosurgery.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together. Burns and plastics is already a regional service provided from Morriston Hospital. Neurosurgery is already a regional service provided from UHW. Patients are already managed across the two sites relating to their primary needs.
Existing service provision	May be unclear to the general public the level of accident service hospitals across South Wales presently offer in respect of serious injuries.	No	Indirect	Yes	**To accompany any implementation plan and information for the public on the use of the MTC and major trauma network, clear guidance will be provided outlining the range of Accident and Emergency services available throughout the region.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision (Continued)	Moving neurosurgery back to Morriston hospital to sit alongside burns unit would not be a major problem if other factors were judged to be more strategically important. Develop a new department for neurosurgery and paediatric major trauma aligned to a centre in Morriston.	No	Indirect	No	The location of neurosurgery at UHW was previously the subject of a formal consultation based on the best available evidence.
	Fear that accident services to west of Bridgend will increasingly struggle to recruit senior consultants and nursing staff leaving West Wales hospitals.	No	Indirect	Yes	**A workforce plan, including any arrangements for staff rotation across the network, will be developed as part of the business case for the major trauma centre and network.** The establishment of the network will improve the ability of NHS Wales to recruit and retain relevant staff.
	Importance of continuing cross border services into England for residents of East Radnorshire who are long distances from proposed units and presently access much of their hospital care in England.	No	Direct	Yes	**The consultation proposed that where patients currently access the trauma units in England, they will continue to do so**.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing service provision	Concern that Burns and Plastics will be moved from Morriston.	Yes	Indirect	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. There are Networks where plastics and neurosurgery are not co-located. It will be important for both hospitals to work together.
	How will the recent decision to centralise thoracic surgery in Morriston impact.	Yes	Indirect	No	In 2016, the Welsh Health Specialised Services Committee (WHSSC) requested the Royal College of Surgeons to conduct an independent invited service review into the provision of thoracic surgery services in South Wales. The final report was delivered to WHSSC in January 2017 and recommended that thoracic surgery services in South Wales be concentrated on one site (Morriston Hospital), rather than the current two. The issue of colocation of the MTC and thoracic surgery services was explicitly considered by the thoracic service review. The thoracic surgery specification for Wales, developed during late 2016 and subject to a consultation, does not require colocation with the MTC.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Existing service provision	Interested to see if the plans for Hywel Dda have been taken into account, with the proposed closures it is likely to put added stress on other major hospitals in the area.	No	Indirect	No	Such plans may impact on the future configuration of Accident and Emergency units, but will not be material in relation to the overall recommendations of the Independent Panel.
	Upgrade Bronglais; we need better hospitals to cope with treatments, operations and emergencies before major trauma units sited miles away.	No	Indirect	No	View to be shared with Hywel Dda Health Board.
	Aberystwyth needs a nurse led walk in centre.	No	Indirect	No	View to be shared with Hywel Dda Health Board.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure	Not clear the impact on UHW, it is already a congested site, this may increase pressure on UHW for mainstream treatment for the local population.	No	Direct	Yes	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients. **Cardiff and Vale UHB is working closely with other health boards on the following:** • **A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients with a major trauma who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure (Continued)	Not clear the impact on UHW, it is already a congested site, this may increase pressure on UHW for mainstream treatment for the local population. (Continued)	No	Direct	Yes	• **Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work. Existing protocols such as in neurosurgery, are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.**
	Morriston Hospital has acquired further land upon which additional clinical capacity can be placed and already has it helicopter landing site within its grounds.	No	Indirect	No	This observation does not call into question the rationale of the Independent Panel in recommending that the MTC should be at UHW. UHW has an existing helipad which provides direct access to the Emergency Unit without the need for an additional transfer. Cardiff and Vale UHB has recently been granted a 24/7 landing licence by the Civil Aviation Authority.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Existing infrastructure (Continued)	Neither Morriston or UHW could cope with the extra traffic. Morriston cannot cope with the demands on A&E as it is and if Princess of Wales were to move then it will only make things worse	No	Direct	No	Fewer than 1% of the treatment provided in the emergency department is major trauma and this will not significantly change with the estimated additional patients expected if UHW becomes the major trauma centre. Approximately 60% of trauma cases need support for head injuries, and as the only neurological centre in Wales, UHW is already taking many of these patients.
Infrastructure requirements	Appropriate infrastructure and resources will need to be provided. Modelling work should be undertaken in sufficient detail ahead of taking a decision to progress with the proposed trauma network and not left to be worked out until after the decision has been taken. This will need to cover what facilitates are resources will need to be provided at UHW. It may also need to be determined if other facilities/services may need to be relocated to free up space for facilities required for the MTC. This should be understood before any decision is finalised.	No	Direct	Yes	Morriston Hospital and UHW provided high level costs for each site to meet the designation criteria for a MTC. **If supported, UHW will develop a detailed business case which will include an assessment of the resources available and what is required to deliver a major trauma centre. Any additional resources required will be required over a period of time.**

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Access and Support for Families	It is not just about the patient but also their family: e.g. Cost of parking at UHW/Expenses for relatives.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Candidate centres were asked to outline how they would address support for families at the Independent Panel. **Appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the MTC.**
Strategic direction for Wales	No political guidance was given regarding the wider strategic direction e.g. should broader economic and social considerations have been taken into account and should welsh government have chosen to see any major trauma centres sites in south Wales as needing to complement existing chain of MTCs operated by NHS England – upon which Welsh residents currently rely.	No	Indirect	Yes	Out of scope - Wales is a devolved nation.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Scope of Independent Panel	Terms of reference were too limited – effectively requiring the Panel to assess the current clinical capabilities of two hospitals. They should have advised whether South Wales needs to have a MTC and if so to assess where this would be best located in order to complement existing range of MTCs in England and so strengthen the major trauma coverage for populations within England and Wales as a whole.	No	Direct	Yes	An option appraisal in 2015 agreed that, to support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by a major trauma centre located within the region. This ruled out the option of relying on services from the Bristol major trauma centre. The potential for a dual site solution was considered, but subsequently eliminated based on the fact that the critical mass for sustainability could not be delivered through such an arrangement.
Data issues	Data about incidence and volumes of major trauma shows equal activity at Morriston and UHW.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed.
	Travel time data needs to be in the public domain in much more detail.	Yes	Direct	No	The rationale outlined by the Independent Panel has been reconsidered and endorsed. Travel time was not the primary consideration in recommending UHW as the MTC.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Financial resources	Additional financial resources need to be made available to prevent health boards from suffering further financial pressure.	No	Direct	Yes	Proposed financial information was provided by both candidate sites. **WHSSC has been identified to lead the development of a commissioning framework for the major trauma network.** **Detailed capital costs will be developed for inclusion in the business case to Welsh Government.**
	The financial and opportunity cost of creating a south wales unit for what is a small number of people who may receive a higher level of care than they presently get from Bristol because of their distance from Bristol needs to be weighed against all other current unmet demands upon existing scarce NHS resources.	No	Indirect	No	The clinical benefits for patients having access to a major trauma network have been clearly demonstrated. In launching this consultation, health boards are already committed to ensuring the patients of South and West Wales and South Powys who experience a major trauma have access to equitable, appropriate care to meet their specialist needs. The matters being consulted on relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on trauma will be subject to further scrutiny through the commissioning process. The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2 of the main report). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	Additional staff resources will need to be considered; rotas need to be drawn up and suitably staffed. Needs to be reassurance this has been modelled.	No	Direct	Yes	**A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.** A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites. Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements	Adequate training, staffing, resources to support air ambulance if they need to make further/longer journeys.	No	Direct	Yes	**If the proposal is supported, EASC as the commissioner for Welsh Ambulance Service trusts and Emergency Medical Retrieval and Transfer Service will identify detailed training requirements for the workforce. This will then be part of the commissioner intentions for the service.**
	Important to understand the implications for attracting doctors in training to Wales as a result of the proposals and to quantify if this means trainee posts being relocated from some hospital sites; possible loss of trainees from Morriston should the MTC go to UHW.	No	Direct	Yes	**A workforce plan, including any arrangements for staff rotation across the network, will need to be developed as part of the business case for the major trauma centre and network.** A network provides real opportunities for greater sharing and training across the region. One of the responsibilities of a major trauma centre is education, with plans being developed to share information, run joint study days and move of staff around the network to support professional development. The experience in England has shown this is hugely beneficial to recruitment, as staff are attracted to the opportunities provided by working in a network. The establishment of a network will give consideration to the needs of the whole system and the importance of giving trainee doctors, nurses and the professions allied to medicine the opportunity to rotate and learn across the sites.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Workforce requirements (Continued)	Important to understand the implications for attracting doctors in training to Wales as a result of the proposals and to quantify if this means trainee posts being relocated from some hospital sites; possible loss of trainees from Morriston should the MTC go to UHW. (Continued)	No	Direct	Yes	Another benefit is that currently military clinicians/nurses in training cannot work in a non-networked system so NHS Wales does not benefit from their involvement in Wales. This will change if a MT network is developed.
Impact on EMRTS/Air Ambulance	Accessibility of air ambulance when Swansea based helicopter to committed elsewhere.	No	Direct	No	This is already a constraint and would remain so however trauma services are configured.
	Has appropriate consideration been given to the provision of sufficient ambulance capacity and has this been modelled to support the decision.	No	Direct	Yes	EMRTS presented at the Independent Panel. Most patients already require transfers by ambulance or a rapid response vehicle. WAST has considered the impact of the changes from the proposal. If the proposal is supported, **EASC as the commissioner for Welsh Ambulance Service trusts will do detailed modelling work which will form part of their future commissioning intentions from health boards**.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Impact on EMRTS/Air Ambulance (Continued)	May need to re-assess the way in which ambulance calls are currently prioritised given that the proposal will rely on patients being transferred on occasions from one hospital to another within the network.	No	Indirect	Yes	**This will form part of the implementation plan.**
Decision making Process	Were the options considered subject to a Health Impact assessment (HIA) as part of the work carried out by the panel in arriving at its recommendations. Suggestion that one is carried out before recommendations are progressed.	No	Direct	No	For consideration at next stage of the project. The establishment of a major trauma network will contribute to the delivery of aims of the Wellbeing of Future Generations (Wales) Act 2015, by supporting the delivery of a 'healthier Wales' and the goal to "develop a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood".

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Consultation process	SHA concerned the terms of the consultation, might be seen as implying a level of approval by NHS Wales of the recommendations of the expert group. This perception is aided by the apparently unintended public release of the conclusions of the expert group. Would have been more appropriate if the public had been invited to comment upon how the expert group had assessed the pros and cons of three options – Bristol, UHW and Morriston.	No	Indirect	No	The report of the Independent Panel was considered by boards in public in September 2017. Boards accepted the recommendations subject to formal public consultation. The use of the MTC in Bristol was considered in the option appraisal conducted in June 2015 (see section 3.2). To support a population of approximately two million (deemed to be the critical mass for sustainability) the network would need to be supported by an MTC located within the region. This ruled out the option of relying on services from the Bristol MTC. The 2015 option appraisal workshop included health boards and the Welsh Ambulance Service Trust. Patient representatives from voluntary and charity support groups from across the region were invited. The CHCs were also invited to observe. A consultation exercise has been conducted that meets the requirements of the Welsh Government guidance.
	Final details for the consultation only became clear in October, concern not widely publicised and great reliance on social media and Christmas period.	No	Indirect	NO	The timescale for the consultation was agreed with CHCs. A period of 12 weeks (as opposed to the required eight) was adopted to allow for the impact of the Christmas period.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Consultation process (Continued)	Roles of two sites not clearly defined in layman's terms.	No	Indirect	No	The roles of the MTC and trauma units were clearly described in the consultation material.
	Concerns regarding the Gunning principles.	No	Direct	Yes	In line with the Gunning principles, the consultation process was reviewed against consultation and engagement guidance by health boards and CHCs at mid point. No further changes were advised. Conscientious consideration was given to the outcomes of the consultation process at all relevant times.
	Insufficient information to base a decision on the location of the MTC.	No	Direct	Yes	Web page provided the technical documents considered by the Independent Panel. All the relevant criteria on which to base the decision were made clear during the consultation process.
	Unanswered questions relating to social and welfare aspects for patients and relatives.	No	Indirect	No	To be considered as part of implementation. Requirements are set out in a Welsh Health Circular, as for other tertiary services.
	Not enough publicity has been given to the public meetings or the consultation. Request for extension/rerun of consultation process due to poorly advertised/attended public meetings.	No	Direct	No	Health boards ran a public meeting in each district. Individuals/organisations were able to respond to the consultation via Freepost, online, email. Each health board agreed the local arrangements with its local CHC.

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	Area for consideration	Considered by IP	Direct/indirect impact	Mitigation Yes/no	Information for boards (Specific mitigation in bold)
Consultation process (Continued)	Information received from the older persons commissioner on engagement and consultation with older people.	No	Direct		Information noted. Consultation process was considered to be appropriate.
Implementation of the MTN	Whatever service results it is fully accessible for people who are deaf or have hearing loss. The care they receive and co-produce is as dignified and clinically optimal as that of a hearing person. Currently a stream of work going around on accessibility for people with sensory loss in each health board and it is a priority each health board reports back to WG on.	No	Indirect		Requirements for equality of access apply to all services.
	The Royal College of Midwives should be part of the major trauma network (as trauma is the leading cause of death in people under the age of 45).	No	Indirect	No	Implementation will need to involve professional bodies, as appropriate.

8.12

NHS Wales Health Collaborative	Supporting Document 12 – Analysis of Consultation Responses against Framework

Key Themes	**Area for consideration**	**Considered by IP**	**Direct/indirect impact**	**Mitigation Yes/no**	**Information for boards (Specific mitigation in bold)**
Implementation of the MTN	Effectiveness of moving to the model advocated will need to be monitored. Has consideration been given to deriving an appropriate methodology by which this can be done should the network be established. It would be necessary to assess the effectiveness of the network on outcomes from the moment of trauma occurring rather than simply the time of arrival at the relevant hospital.	Yes	Indirect	Yes	The rationale outlined by the Independent Panel has been reconsidered and endorsed. **TARN is an outcome based monitoring tool, used for management of major trauma across England and Wales. All health boards subscribe to this**.
	The need for a clear communication strategy once a decision is taken on the way forward. Effective programme for informing communities in region how the proposals will work and what they will mean to them in practice.	No	Indirect	No	The need for a clear communication strategy is accepted.
Other	Are we having a helicopter for this service?	Yes	Direct	No	The Emergency Medical Retrieval and Transfer Service (EMRTS), are supported by the Air Ambulance and have been included through the project

8.12

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NHS Wales Health Collaborative

Major Trauma Network for South and West Wales and South Powys

Equality Impact Assessment Evidence Document

Post Consultation Analysis

Author: Rachel Hennessy, Programme Director

Date: 13 March 2018	**Version:** 1 (FINAL)

Purpose and Summary of Document:

This technical document has been produced to provide background evidence to support information provided within the NHS Wales Health Collaborative public consultation on the development of a major trauma Network for South and West Wales and South Powys.

This document is meant as a reference guide, it does not provide exhaustive detail. It aims to provide an overview of our findings to date about what groups within our population may be affected by our proposals and in what way. It is a living document and will be added to by information gathered during consultation and ongoing through all stages up to and including delivery of services where actual impact will be monitored.

This document builds on the initial EqIA developed prior to the consultation and includes the post consultation analysis and considers findings from the consultation exercise which commenced 13th November 2017 and concluded the 5th February 2018.

1 Background

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 south Wales. 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 Service Trust (WAST), Emergency Medical Retrieval and Transfer Service (EMRTS) and Welsh Health Specialist Services Committee (WHSSC). North Wales is already part of the West Midlands Major Trauma Network with the major trauma centre in North Staffordshire. North Powys also participates in the West Midlands Major Trauma Network

The 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 wide stakeholder group and supported by all Health Boards. The standards for major trauma have been written by the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute for Clinical Excellence (NICE) and say what services should be available for a patient with 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 say what services should be in a major trauma centre, trauma units, and how the network should work.

1.1 The case for change

'Major Trauma' 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). Less than 0.2% (2/1000 patients) of the people attending their local emergency department will have a major trauma. In 2016/2017 in South Wales, approximately 1,234 people attended a local emergency department with a major trauma, compared with 617,000 people attending emergency departments in total (www.statswales.gov.wales). Major trauma cases are complex and due to the small number it is a challenge for hospital staff to maintain their highly specialist skills in trauma care. w. The data used to develop the proposed service model is based on 2014 TARN (The Trauma Audit and Research Network) data. The data available at this time did not cover all south Wales hospitals and Emergency Medical Retrieval and Transfer Service (EMRTS) was not in place and therefore was likely to under-represent the true number of major trauma patients in the region, however it should be noted that numbers are still small.

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 talk about poor care and outcomes received by patients resulting from a lack of trauma networks.

As a result of these reports, England has established trauma networks across its region. North Wales is part of the west Midlands major trauma network and the major trauma centre for the region is in Stoke, North Staffordshire. South Wales is the only region across England and Wales that is not part of a major trauma network nor has access to a designated major trauma centre. Scotland has made progress in identifying the key components of its trauma network and is moving toward implementation. Across South Wales, major trauma cases are currently managed through informal arrangements across the health boards, with some more complicated cases either admitted directly or transferred to the bigger regional centres – mostly University Hospital of Wales or Morriston Hospital. While this clearly benefits patients, it does not have the proven advantages of an established major trauma network.

A 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 and in general includes one major trauma centre (MTC) and several trauma units (TUs) spread across the region. Where there is a major trauma network, it is expected that more patients will survive and make a full recovery, irrespective where in the region they suffer a major trauma.

An established major trauma network can have a significantly positive impact on the population in the region. The key benefits of developing the major trauma network are expected to include:

- Fewer people die: Evidence shows that severely injured patients are 15%-20% less likely to die if they are admitted to a major trauma centre (Clinical Advisory Group, 2010)
- 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 will enable access to be optimised to services to 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 will receive
- Hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. The major trauma network will facilitate 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.

1.2 Impact on workforce

Establishing a major trauma network also has significant benefits for the individual organisations who 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 through closer working with the highly specialist clinicians and other staff at the major trauma centre
- A network with a clearly identified major trauma centre and trauma units is likely to have a positive impact on recruitment across the network
- The establishment of a network is likely to receive support from the Deanery, meaning it is more likely that trainee doctors will be allocated to hospitals across the network to undertake their training
- Services are delivered within a clinical network which allows improvement to be made through an integrated, whole system approach, resulting in standardisation of services and improved patient outcomes & experience
- 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.

2 Equality and Human Rights

Under the Equality Act 2010 we have a legal duty to pay due regard to duties to eliminate discrimination, advance equality and foster good relations between those who share protected characteristics and those who do not.

This means that we need to take into account the needs of people from different groups within our populations who might be affected by our

proposals. We must take reasonable and proportionate steps wherever possible to eliminate or mitigate any identified potential or actual negative impact or disadvantage. Developing a major trauma network also gives us the opportunity to identify and enhance any potential positive impact on protected groups. The Equality Act 2010 gives people protection from discrimination in relation to the following "protected characteristics"[1]

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

The Human Rights Act 1998 also places a positive duty to promote and protect rights for all. In Wales, we also have a responsibility to comply with the Welsh Language (Wales) Measure 2011 and All Wales Sensory Loss Standards for Accessible Communication and Information for People with Sensory Loss. We will take all our legal duties into consideration when we make decisions around developing a major trauma network.

3 Equality Impact Assessment (EqIA)

In Wales, we are required under the Public Sector Equality Duties to undertake Equality Impact Assessments (EqIAs) which will assist us to consider how the decisions we make affect people from protected groups in different ways.

We recognise that consideration of the needs of protected groups helps us to develop and deliver cost-effective services and person-centred care, ensuring that people are treated fairly and equitably.

EqIA is an ongoing process running throughout the course of the decision making process, from the start through to implementation and review. It requires us to consider how the development of a major trauma service, operating within a major trauma network structure for south Wales, south

[1] Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

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?

EqIAs require analysing impacts on the basis of the above protected characteristics. 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 and engagement with key stakeholders 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.

While socio-economic status is not a protected characteristic under the Equality Act 2010, 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.

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 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.

A literature review was carried out as a first stage of gathering evidence to inform the EqIA, which identified potential impacts of the proposal on protected characteristic groups. There was also engagement with stakeholders to develop the service model.

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.

3.1 Potential impact on protected characteristic groups?

This section of the document, recognises the potential impact on protected characteristic groups prior to the consultation exercise and 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. However, evidence suggests that should you suffer a major trauma, you are more likely to survive and make a full recovery if you are in a region where there is a major trauma network, regardless of how far you are away from the major trauma centre.

Evidence suggests there are a number of protected groups who may be likely to suffer a major trauma.

3.1.1 Gender

Men are at far higher risk of experiencing major trauma than women. The NCEPOD report[2] 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.

[2] Trauma: who cares? A report of the national confidential enquiry into patients outcomes and deaths (NCEPOD) (2007)

Young men are at greater risk of being involved in major trauma accidents, typically arising from moving vehicles, tools or work.

3.1.2 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)[3].

There is evidence, 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)[4] 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.

Teenagers and young adults are more likely to need hospitalisation from injuries than other age groups.

8.13

Children under the age of 15 only account for a very small percentage of major trauma and deaths as a result of major trauma.

Potential impact –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 have 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 in an age-appropriate setting

Young people may 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. When treating children, the service model

[3] NHS Clinical Advisory Groups Report: Regional Networks for Major Trauma (2010)
[4] The changing face of major trauma in the UK *Emerg Med J* 2015;**32**:911-915

will additionally follow the standards and criteria outlined for children's services[5].

3.1.3 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 people from Black, Asian and other Ethnic Minority backgrounds 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[6].

Potential Impact - 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 their first language. Cultural issues are also important to take into account and a toolkit is available for this purpose.

3.1.4 Disability

Major trauma is the national leading cause of disability for those under 45 years of age. The improved number of survivals in young adults and reduced incidences of disability resulting from major trauma 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)[7].

Potential Impact - 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

[5] http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf).
[6] Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)
[7] Integrated impact assessment for region-wide service redesign: NHS East Midlands (2010)
[6] All Wales Standards for Communication and Information for People with Sensory Loss 2013)

ensure the provision of appropriate equipment across boundaries and within social care sector. As well as physical disability, there is a need to consider learning disabilities and mental health. Communication needs in these client groups may be more challenging and care should be adapted accordingly, for example, where there is a need for BSL interpretation services.

There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss[8] that apply directly to emergency and unscheduled care (in addition to primary care and other secondary care services) and these outline the staff training requirements, communication systems and equipment and patient needs information which should be provided by health boards. BSL interpreters will be required for the deaf community.

3.1.5 Marriage and civil partnership

No impacts upon this protected characteristic are anticipated.

3.1.6 Pregnancy and maternity

No impacts upon this protected characteristic are anticipated.

3.1.7 Religion or belief (including lack of belief)

Potential impact - staff need to 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[9]. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered. As previously a comprehensive cultural awareness toolkit is available for this purpose.

3.1.8 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 transgender (LGBT) patients in Wales report significant barriers to health and social care services[10]. 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. Inappropriate assumptions are also made about 'next of kin' if they are in a same sex relationship. This makes LGBT people feel anxious about accessing health or social care and

[9] http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp
[10] http://www.stonewallcymru.org.uk/our-work/research/have-your-say

creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks.

Potential Impact - There is a need to ensure that patients' 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 staff and their patients. Health boards should continue to seek to make progress in this area.

3.1.9 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.

Potential Impact - In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015[19] Trans* people must be accommodated in line with their 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. 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 Gender Recognition Certificate 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.

3.1.10 Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure 2011. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. Whilst we recognise that Welsh and English are Wales' official languages, Wales has many different voices. Like two-thirds of the world's population many people in Wales are bilingual or multilingual. This is particularly important in traumatic situations where people are more likely to need to communicate in their first language.

Potential impact - Service users who prefer to communicate in the medium of Welsh may be required to access highly specialist services which do not have sufficient Welsh speaking staff (this may also be the case for languages other than English). 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.

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. However, it is important to recognise groups of other individuals who have suffered life changing conditions that may benefit from community through the medium of welsh. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)[11]. Our consideration of equality takes account of this.

4 The Consultation process

A consultation plan was written to ensure there was a consistent approach to the consultation across the region and to provide a full range of opportunities taking account of accessibility for staff and key stakeholders to give their views and equality of opportunity to respond.

In developing the consultation plan consideration was given to the variety of methods which would need to be employed to give equality of opportunity to stakeholders to respond to the consultation. In order to facilitate this, standard documentation was produced and made available in a variety of formats including: easy read in English and Welsh; British Sign language; audio English and Welsh; sub titled presentation; and Braille.

The main consultation was produced as a bilingual document and a crystal mark was achieved which recognised the achievement of plain English in the document.

Alongside the main consultation document which was available electronically or via hard copies, the follow other methods for sharing information during the consultation were employed:

A website for the consultation was developed and accessed via Public Health Wales at the following address:

www.publichealthwales.org/majortraumaconsultation.

[11] More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

There is both an English and Welsh website. The consultation document and supporting documents were available on the website in a variety of formats as detailed above.

An animated short film was produced outlining the key elements of the consultation. This was filmed in English and Welsh with BSL overlaid.

The Clinical Lead for Major Trauma also provided a session talking about major trauma, the benefits and proposed model. His session was also available with Welsh translation.

Across the consultation period, each health board scheduled public meetings in each district within their region. This was to provide the opportunity for staff, stakeholders and the wider public to find out more about the proposals for a major trauma network in South Wales as well as providing opportunities to feedback on the proposals in the consultation document. The presentation was available in English and Welsh and British Sign language interpreters were made available where required. A series of additional meetings took place with other professional/recognised groups.

People and organisations are encouraged to respond to the consultation using the following methods: Hard copy via a FREEPOST address; Email via a generic email address; or online in their preferred language of choice.

Social media (Facebook and Twitter), was used by health boards to promote the consultation and public meetings. Hywel Dda and Abertawe Bro Morgannwg UHB also engaged in wider discussions via social media.

Prior to the formal launch of the consultation, a bilingual press release was sent under embargo to local media across the region. A further press release was issued to local media at the mid-point of the consultation reminding the public of the consultation and the date by which to respond. Requests were made from several local radio stations, as well as BBC Wales for interviews with the Transitional clinical Lead for Major Trauma.

5 Outcome from consultation

On conclusion of the consultation, the responses received and equality monitoring forms were collated and analysed. The responses to the consultation and analysis will be available on the public consultation website at:

www.publichealthwales.org/majortraumaconsultation

There were a total of 1041 response to the consultation received from across the region.

Seventeen public meetings were scheduled across the region and a total of 242 people attended comprising health board employees, local residents,

local councillors, an assembly minister and representatives of other organisations. Feedback received in these meetings was captured and analysed and considered on an equal footing with all other responses.

In addition, 254 members of the public engaged in conversation on Facebook and Twitter relating to the consultation (18 in Hywel Dda UHB initiated conversations/threads and 236 in Abertawe Bro Morgannwg UHB initiated conversations/threads). Whilst a number of individuals used these conversations to express their views on the proposal, the conversations were also used by individuals to promote and confirm that they had completed a formal questionnaire to respond to the consultation. The key themes identified from the social media conversations were considered on an equal footing with other responses.

Alongside the response to the consultation proposal, there were 715 completed equality monitoring forms received. On analysis of the equality monitoring forms, for each 'protected characteristic' there were a small number of respondents who left each question blank. There were also a number of equality monitoring forms received from organisations, which ticked multiple responses to a single question (e.g. where an age category was required, several age brackets were identified). These forms were acknowledged but were not included in analysis of the monitoring form returns.

8.13

Outlined below is an overview of the response to the equality monitoring forms.

- Age: Age of respondents ranged from the lowest age bracket 16-24 to 75 or over, with the majority of respondents identifying as 45-54 age bracket (141).
- Gender: The response from individuals identifying as female (394) was slightly higher than the number of individuals identifying as male (279).
- Race: Respondents identified as predominately white (642) with a small number of respondents identifying as Asian or Asian British, Black, African, Caribbean or Black British, Mixed or multiple ethnic groups or another ethnic group (26).
- Disability: Majority of respondents identified as not having their day to day activities limited (533). A number of individuals did identify as having day to day activities limited a little (91) or a lot (39).
- Religion or belief: Majority of respondents identified as Christian (371). A small number of respondents identified as Buddhist, Hindu, Muslim or other religion (33). A large number identified as no religion (277).

- Sexual orientation: Respondents predominantly identified as heterosexual or straight (586) with a small number identifying as gay or lesbian, or bisexual (37).
- Welsh language: Majority or respondent identified as non Welsh speaking (530) and (139) identified as Welsh speaking

As recognised earlier in this document, the EqIA notes that while socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, which impact on their ability to access health services.

Analysis of the consultation responses identified the following areas which may affect individuals identifying with low economic status and as such consideration needs to be given to how these can be mitigated for this group of individuals: major trauma network infrastructure; road infrastructure and public transport; and access and support for families;

- Major trauma Network Infrastructure – The need to consider the establishment of the wider network, including the location of trauma units and the development of rehabilitation pathways, rather than the location of the Major Trauma Centre was emphasised in the consultation. The structure of the proposed network is likely to impact on this group of individuals.

The implementation of the network, including the redevelopment of the whole pathway of care is as important than the location of the Major Trauma Centre. It is proposed that patients will typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated to a trauma unit closer to home for ongoing care and rehabilitation if required.

To support this, it is accepted that appropriate and robust rehabilitation pathways will need to be in place as part of the implementation of the Major Trauma Network.

The Independent Panel was asked to make a recommendation on the location of the Major Trauma Centre only, and not the trauma units. Identifying the Major Trauma Centre location first is helpful in informing where to locate the units. The remaining trauma units will need to be identified by individual health boards for their local area. There will need to be appropriate collaboration between health boards to ensure that all populations within the network are appropriately covered by trauma units (in line with national standards and guidelines).

- Road infrastructure and public transport is likely to impact on this group of individuals, in particular for those living a distance from the major trauma centre. It is recognised that the proposals for a major trauma centre at University Hospital Wales, may mean some individuals will live a distance from the Major trauma centre.

However, patients will be taken to the major trauma centre by 'blue light ambulance' or the air ambulance and would typically only spend a short period of time in the Major Trauma Centre itself, before being repatriated to a trauma unit closer to home as soon as possible. Therefore public transport should not be a major consideration in the location of the Major Trauma Centre, as trauma patients would not use public transport.

However, in order to mitigate the impact the location of the major trauma centre appropriate arrangements will need to be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre to support families and carers.

- Access and support for families and carers, including parking, accommodation and information (including translation into Welsh and other languages), at the major trauma centre is an area likely to impact on this group of individuals.

It is recognised that there is a need to ensure that the relatives of patients are adequately supported and informed during the time at the major trauma centre. it is accepted that in order to mitigated the impact on families and carers, appropriate arrangements for supporting families and carers will be developed and implemented as part of the overall implementation of the network and development of the Major Trauma Centre.

8.13

In the current service model for Wales, some patients are already transferred to UHW from across the whole region for some highly specialised services and there are arrangements in place to support families where appropriate. This will be considered further as part of the overall implementation of the network and development of the Major Trauma Centre.

In addition, a new charity-funded building providing accommodation and facilities for families whose children are receiving treatment in UHW has recently been opened. Some accommodation is also available on the UHW site for families of adult inpatients.

There were a number of responses received from individuals/organisations representing individuals with protected characteristics such as representative of the deaf and hard of hearing and the Older persons Commissioner for Wales. These responses referenced the importance of giving consideration to the needs of individuals with protected characteristics, ensuring the service that is implemented is fully accessible and the care received and opportunities for the involvement in co-production are equitable across all stakeholders.

6 Next Steps

The needs of protected groups will continue to be an ongoing consideration during the planning and implementation phase of the project and Health boards will need to ensure that stakeholders are engaged throughout, venues for the public events are accessible and information is provided in a variety of required alternative formats in order to maximise opportunities for participation wherever required.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT	
Name of Meeting : Board Meeting	**Date of Meeting :** 29.03.18

Executive Lead : Executive Nurse Director
Author : Assistant Director Patient Safety and Quality - 029 2184 6117
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

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 where available
- 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 areas of current concern and AGREE that the current actions being taken are sufficient

9

SITUATION

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from January to end of February 2018.

BACKGROUND

The development of an integrated Patient Safety Quality and Experience report, presents an opportunity for greater triangulation and analysis of information. It summarises the 'looking, listening and learning' that is undertaken on a daily basis across the UHB, enabling Clinical Boards and the Corporate Nursing Team to identify areas of good practice but also to identify emerging trends and issues that require action in order to improve safety and quality of services.

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

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

ASSESSMENT

The Board should be advised that there are currently a number of quality and safety issues that remain of concern and continue to receive a high level of focus and monitoring.

Serious Incident reporting – there has been an increase in reporting during February 2018 when the UHB reported 25 SIs. This rate of reporting has not been seen since March 2017, but is due largely to the increase in the reporting of pressure damage. This has happened as a result of the UHB being identified as an under-reporter of pressure damage, when compared with peers across Wales. A considerable amount of work is being undertaken across the UHB to improve the quality of pressure damage assessment, reporting and undertaking root cause analysis, so that a reliable baseline can be established and we can identify if this damage is healthcare acquired. WG is due to publish related guidance, which may allow us to report retrospectively if an investigation determines that it was healthcare acquired and avoidable. Until this guidance is available, the Board should anticipate an increasing trajectory of reporting, as we take steps to improve the quality of the reporting of pressure damage in community settings.

Gastroenterology - we continue to report SIs related to Endoscopy services. These relate mainly to access to the service – delays in urgent and routine endoscopies and patients who are being lost to follow up –particularly in our surveillance patient group. The situation is being closely monitored by the Clinical Board and there is input from the Corporate Operations and Patient Safety team to support the Clinical Board in delivering the necessary improvements. The Quality, Safety and Experience Committee (QSE) received a detailed paper in February 2018. The UHB has received in-year funding to improve waiting times and has agreed with Welsh Government that any additional capacity would need to be balanced across clinical priorities and would, therefore, be used to both reduce the volume of urgent and routine patients waiting greater than eight weeks and also patients overdue their surveillance endoscopy. The additional capacity has been secured through our existing private providers on an outsourcing arrangement and also a new provider on an insourcing arrangement. The outsourcing capacity commenced at the beginning of January 2018 and the insourcing arrangement commenced on 27th January 2018. With this additional in-year activity in place, it is anticipated that waiting times across all categories of endoscopy patients, including surveillance, will reduce significantly by the end of March 2018. The Board should note, however, that the number of Serious Incidents as a result of long waiting times in endoscopy is likely to increase as we identify those patients when the backlog is reduced.

We will be surveying patients who did not attend recent endoscopy appointments to determine if there are any reasons for non-attendance that can be addressed.

The QSE Committee is monitoring the issue and a further report is being presented to the forthcoming April 2018 committee.

Patient Safety Impact due to the current operational pressures. – The Board will note from the detailed performance reports that the activity and demand across all of our services has seen our services under considerable pressure. This has led to staff, in line with good governance, reporting concerns about patient care via datix and directly to the Executive Team. Some of this reporting of clinical incidents has led to us reporting serious Incidents to Welsh Government. The details of these incidents are in the body of the report

The UHB continues to work closely with the Welsh Ambulance Services Trust (WAST), to jointly investigate any serious incidents reported by either organization. A recent meeting was held between the Executive Nurse Director and members of the patient safety teams from the UHB and from WAST, to clarify the current position and to agree reporting processes and working arrangements. A paper providing and overview of current WAST related serious incidents involving Cardiff and the Vale UHB, was presented to the Management Executive on 5th March 2018 and this will be updated and presented to the April 2018 QSE Committee.

All incidents reported by the Emergency Units are being monitored and reported by exception, to the weekly Executive Concerns meeting.

Patient Falls

In-patient falls continue to be the most frequently reported patient safety incident. It is anticipated that this will continue to feature as a commonly reported patient safety incident while balancing the risk of rehabilitating and mobilizing patients who would otherwise start to 'de-condition', Although the majority of patients, do not experience major harm, approximately one patient a week experiences a serious injury from an in-patient fall. The aim of the UHB Falls Prevention Strategy will be to focus on community based interventions to prevent falls and unnecessary hospital admissions and for in-patient falls, will focus on education and training of staff with an ambition to reduce the number of injurious in-patient falls on a year by year basis.

A range of performance indicators which span the healthcare system have recently been agreed. These will be presented to and monitored by the UHB Falls Delivery Group.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT
January – February 2018

Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

During January and February 2018, the following Serious Incidents and No Surprises have been reported to Welsh Government:

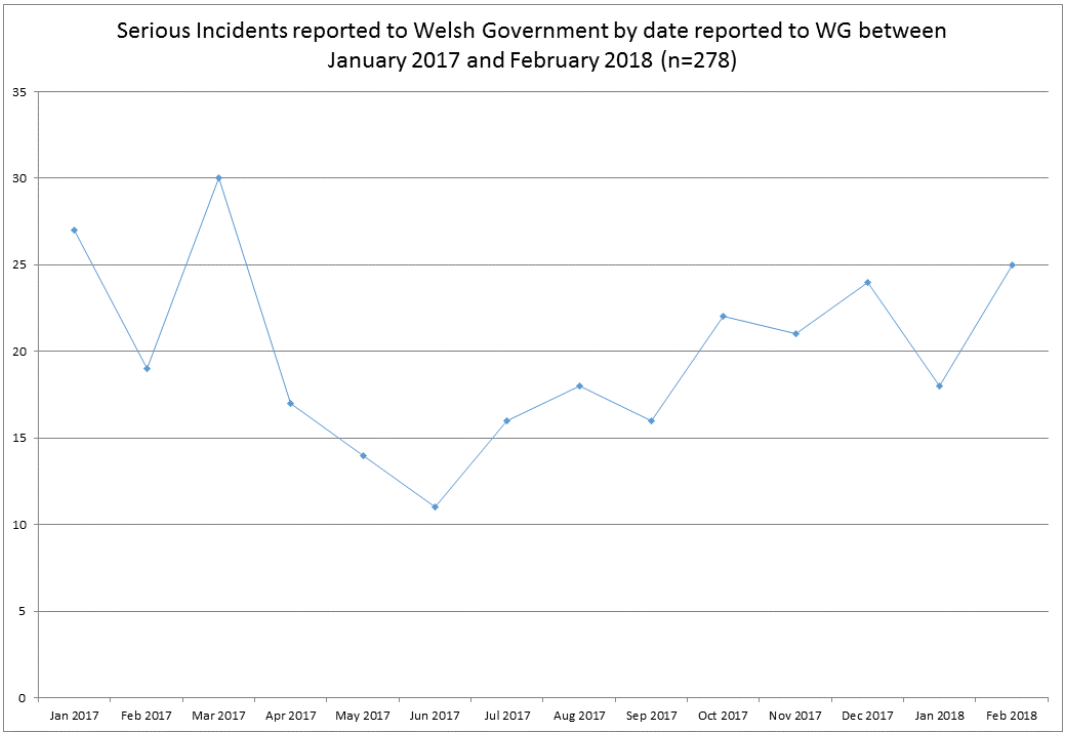
Serious Incidents		
Clinical Board	**Number**	**Description**
Children and Women	1 1	• Medication intended for administration via an epidural was commenced intravenously. The error was identified very promptly and no harm came to the patient. • A case of shoulder dystocia has been reported by Obstetrics.
Dental	0	• Not applicable.
Executive Nurse	1	• Incident reported where the Procedural Response to Unexpected Death in Childhood (PRUDIC) process has been instigated.
Medicine	14 9 3 1	• Grade 3 or 4 healthcare acquired pressure damage. • Falls where the patient sustained significant injury. • Patients delayed in having diagnostic or surveillance procedures in Gastroenterology. • Concern regarding the management of a patient who presented with sepsis and subsequently died.
Mental Health	1 3	• Fall where the patient sustained significant injury. • Unexpected deaths of patients known to Mental Health services, including Addictions services.
Primary Care and Intermediate Care	1	• Grade 3 or 4 healthcare acquired pressure damage.
Specialist	2 1	• Grade 3 or 4 healthcare acquired pressure damage. • Concern has been raised regarding the length of time a patient has waited for pituitary surgery.
Surgery	1 1	• The UHB has retrospectively reported an incident to WG as a clinical negligence claim is progressing for an Ophthalmology patient where it is reported that there were delays in treatment of the patient. • A patient's anticoagulation medication was not recommenced in a timely manner whilst the

	1 2	patient was in hospital and this caused the patient harm. • A patient received a botox injection into an unintended site. This does not constitute a Never Event but WG has asked the Delivery Unit to work with the UHB on this investigation process for assurance purposes. • Grade 3 or 4 healthcare acquired pressure damage.
Total	**43**	

No Surprises		
Clinical Board	**Number**	**Description**
Clinical Diagnostics and Therapeutics	1	• A member of staff has been arrested by the police following serious allegations regarding medicines.
Executive/ Miscellaneous	1 1	• A patient who has been in liaison with the Concerns Department raised her concerns further with the media. It relates to surgery undertaken some years ago. • A Nursing and Midwifery Council hearing was due to proceed. It related to health consultations with staff members.
Medicine	1 1 1	• A patient known to the Gastroenterology Directorate raised concerns regarding his care with the BBC. • An outbreak of flu/respiratory symptoms temporarily affected several wards. • A Nursing and Midwifery Council hearing was due to be held. It related to a previously reported SI and Coroner's case.
Primary Care and Intermediate Care	1	• A member of staff employed by another organisation was scheduled to attend a Court hearing. It related to a UHB patient who lived in supported accommodation managed by this other organisation.
Specialist	1	• A patient group raised concerns with a media outlet regarding historic blood scandal issues.
Total	8	

A total of 43 Serious Incidents were reported during this period. This contrasts with 45 Serious incidents reported in November and December 2017. The graph below demonstrates the trend in SI reporting over the last 12 months:

Graph 1 below demonstrates the trend in SI reporting over the last 12 months;



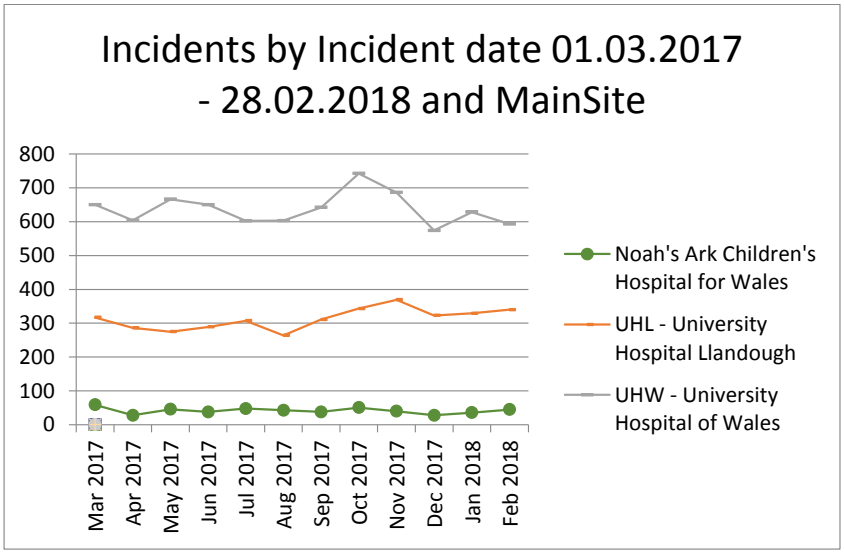
While the UHB had begun to see a decrease in the number of SIs being reported during the first 6 months of 2017, a request from WG to increase the reporting of Grade 3 and 4 pressure damage has seen an overall steady increase in the number of SIs being reported.

How do we compare to our Peers?

There is no updated information available from Welsh Government (WG) since the last data that was presented to Board in the January 2018 report. Benchmarking data is provided by WG on a 6 monthly basis and is due in at the end of the October 2017 – March 2018 period.

Graph 2 below, demonstrates the total number of patient safety incidents reported on to the UHB's Datix risk management system by main sites over the last twelve months. As would be anticipated, 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 Patient Safety Team continues to monitor the incident reporting rates across the sites.

Graph 2



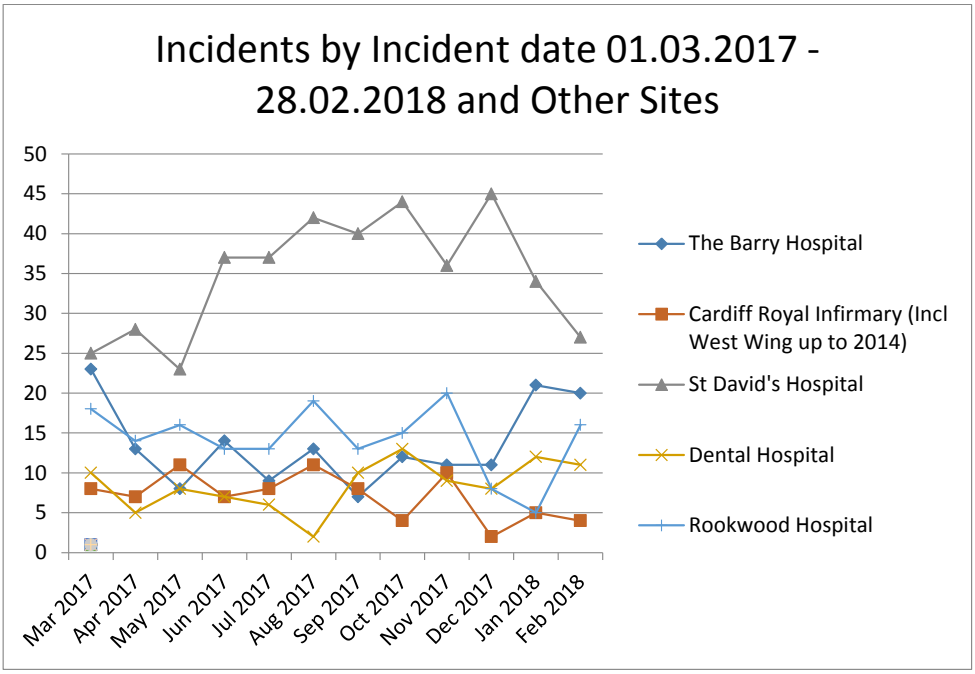
There are no significant changes to trends in reporting.

Graph 3, demonstrates the patient safety incidents reported onto the UHB's Datix risk management system by other sites over the last twelve months. The lower volume of incidents reported reflects the size and activity levels at the sites.

The Board was advised in November 2017, of an unexpected increase in falls at St David's Hospital. Graph 3 demonstrates that rates of incident reporting at St David's Hospital are now returning to anticipated levels having been monitored recently due to increased levels of reporting. In January and February 2018, there were 18 and 11 patient accidents/falls respectively. Several patients have fallen more than once, with a maximum of 4 incidents of falls reported each in two patients. No serious injuries were sustained by patients.

In addition, incident reporting levels following the transfer of the Iorwerth Jones Centre to UHL have also been monitored as there initially appeared to be an increase in reported incidents. A lower number of incidents has been reported in January and February 2018 with 19 reported incidents. 10 of these incidents were patient accidents/falls. Several patients fell more than once, with a maximum of 2 incidents of falls each reported in three patients. No serious injuries were sustained by any of the patients.

Graph 3



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Never Events

All Wales position

Updated information available from Welsh Government regarding the position across Wales on Never Events, will be available at the end of the reporting period from October 2017 – March 2018.

No new Never Events have been reported by the UHB during this reporting timeframe.

What are we doing about it?

The UHB currently, has 2 Never Events open with WG.

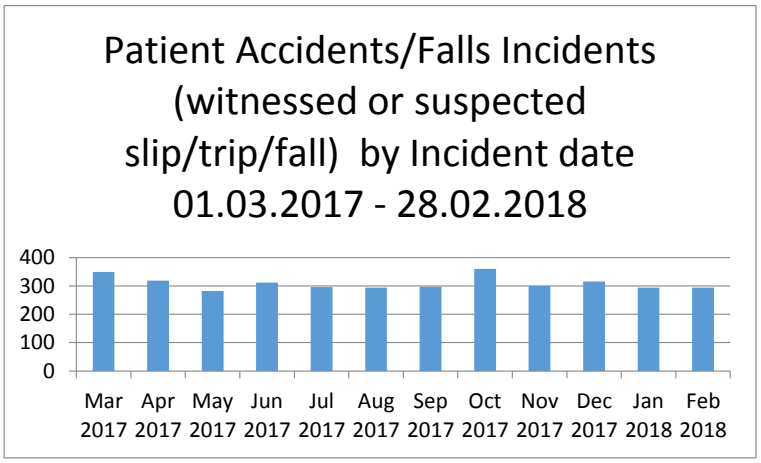
The Dental Clinical Board have an over-arching improvement plan in place for the prevention of Never Events and have currently concluded the investigation of two incidents from the previous reporting period. New improvements will include:

- The introduction of a second check for the correct identification of teeth, by registered Dental nurses
- Review and revision of student and staff departmental information
- Revised procedures for the supervision of students in outreach clinics

Patient Falls

How are we doing?

Patient falls continues to be a frequently reported patient safety incident. The following table indicates the number of patient accidents/falls reported between March 2017 and February 2018.



The majority of falls continue to result in no significant injury to patients. The UHB is monitoring the trend of falls over the winter period as previous increases at this time have been noted. In January and February 2018, 10 falls were deemed to require reporting to WG due to significant injuries being sustained by patients. In the same period last year we reported 13 such incidents. On investigation it was determine that one of these incidents had not resulted in any significant injury to the patient and the UHB has submitted a closure form to WG.

An incident occurred in February 2018 in the Medicine Clinical Board at UHL whereby a patient tragically died having sustained a head injury following an inpatient fall. This case is currently under investigation internally and the Patient Safety team will work closely with the Clinical Board and Her Majesty's Coroner to prepare for the inquest.

How do we compare with our Peers?

There is currently no reliable All Wales benchmarking data available.

What are we doing about it?

The Falls Strategy Implementation Lead has commenced in post in January 2018. A falls strategy is in development. The Falls Delivery Group is now well embedded with a good level of multi-agency, multidisciplinary and pan Clinical Board representation. It is anticipated that the Falls baseline assessment, Strategy and improvement plan will be agreed at the next meeting in May 2018.

The Strategy Lead has led the development of a falls prevention fuel tank animation which was launched on 26th February 2018 to coincide with Falls Prevention Awareness Week. The video was supported by 1000 Lives, the National Taskforce for Falls and Ageing Well in Wales and is part of the national Steady on Stay SAFE campaign. Further information can be viewed on the link provided: http://www.cardiffandvaleuhb.wales.nhs.uk/news/47667

A current community based initiative features the pilot of an inter-generational project which encourages young children to invite their grandparents to a special assembly focusing on Falls Prevention.

Regulation 28 reports

No Regulation 28 reports were issued to the UHB by Her Majesty's Coroner in the current reporting timeframe.

Outcomes of internal and external inspection processes

How are we doing?

Internal observations of care

24 unannounced internal inspections were undertaken in January and February 2018. These were undertaken across five Clinical Boards, and all 24 inspections were undertaken as part of the planned programme of unannounced inspections.

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 at the time of the inspections and a written report is submitted to the Director of Nursing for that Clinical Board; of note, what is considered good practice in one area, might be an area requiring improvement in another.

Key findings for January and February have shown:

- Continued improvements with medicines management noted over the year, but continued attention is required to ensure that all medicines fridges and cupboards are locked when not in use.
- There has been increased evidence of good leadership and team working e.g. observation of good communication between different disciplines, positive comments from staff relating to leadership on the ward and calm, organised ward areas.
- Good provision of activities for patients especially those within mental health services, that included games rooms with facilities such as a football table, pool table, table tennis facility and board games; a mini gym room was also ready for patient use,
- Patients are complimentary about the care they received

Areas for improvement include:

- Variation in the standard of completion of documentation:

  - comprehensive completion of risk assessment in some areas
  - examples of good evaluation of care
  - little attempt to individualise care plans in some areas with no care plans in place
- Lack of storage space.
- Delay in maintenance requests being actioned.

What are we doing about it?

The UHB has appointed a Lead Nurse to support the introduction of the All Wales electronic -nursing documentation. Outputs from this are anticipated in 12 months time, but it will provide an opportunity for a complete review of current practices.

A monthly report detailing all findings relating to medicines management continues to be provided to the Nurse Advisor for Medicines Management. Key messages and learning for staff are included in the bi-monthly Medication Safety Executive newsletter.

Monthly reports of the findings of inspections are provided as part of the Clinical Board Directors of Nursing Professional Nursing review with the Executive Nurse Director.

Storage space will continue to be an issue but can be addressed through refurbishment programmes and new builds. Infection, prevention and control audits of clinical areas, reinforce messages with regards to unnecessary clutter.

The issues in relation to delays in maintenance requests have been raised with the Estates Manager.

External inspections

Healthcare Inspectorate Wales (HIW), carried out inspections to Daffodil Ward on the Llanfair Unit in January 2018 and also a Mental Health Act monitoring visit to Beech Ward. On the whole both visits were very positive and no immediate assurance issues were identified.

In January 2018, the UHB also received a draft report following a National Thematic review of Adult Community Mental Health services across Wales. In Cardiff and the vale UHB, the visit was carried out at the Links, which is the oldest and largest of the eight CMHTs that provide multi-disciplinary and community based mental health care and social services within the area of Cardiff and the Vale of Glamorgan.

In particular the report highlighted the poor environment and a number of health and safety, fire, security and environmental actions which have been identified in the service's own health and safety risk assessments. Actions identified in these assessments require implementation to ensure risks are being appropriately managed and to ensure the building is fit for purpose. Sustainable plans for the CMHT being run in an appropriate environment, are

being put in place and a business case, to secure capital investment for a new build, have been submitted to Welsh Government.

The report also highlighted, again, the need to review and manage the caseloads of psychiatrists and Community Psychiatric Nurses (CPNs). At the time of the inspection the caseload of The Links was 520 open and active cases, which had significantly reduced since 2014. This reduction has been achieved through a concerted effort by staff at the CMHT, working closely with their GP colleagues, combined with a proactive case load management system, adopted by the CMHT manager, Community Psychiatric Nurse (CPN) lead and the Social Work manager. However, HIW have still highlighted the need for the UHB to ensure that psychiatrist caseloads are safe and manageable. This is significant because it was a key issue highlighted in the MR L Homicide review in 2014. The report and improvement plan will be presented at the April 2018 QSE Committee (pending publication by HIW), and assurance on this particular issue will be required.

Patient Experience

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

How are we doing?

Real Time

The number of routine 'real time' paper surveys completed each month across our Clinical Boards during January and February has been **1085** and **1094** consecutively. The patient satisfaction scores from the National Surveys distributed across the UHB during January and February were 91% and 89% consecutively, which is similar to the previous reporting period. . The majority of qualitative comments received were in relation to a positive experience and include:

It can be difficult to evidence outcomes as the majority of comments relate to behaviours, for example:

> My mother is no longer able to communicate but as a family we are very grateful for the care she has received and are impressed by the efficient dedication of the staff as well as their great empathy. It makes this difficult time more bearable.

> Very positive experience overall, staff made a great effort to make me feel comfortable regarding my transgender identity despite admitting they don't have extensive knowledge of trans healthcare which is greatly appreciated.

This is the first time I have had to stay in hospital in many years. I had heard horror stories from people who had stayed and expected the worst. How wrong I was. I am so amazed how professional and compassionate all the staff are at UHW. They are all a credit to their profession. I felt I was the most important patient they ever had there. I would like to thank everyone on behalf of my family for taking such care of me.

However there are also examples of 'you said – we did'

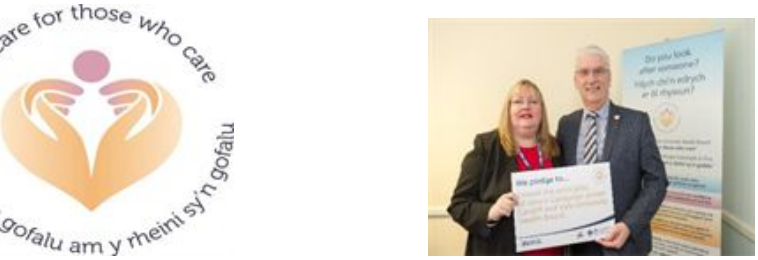
I would like to go out a bit more of the time	Ward Sister to review patients leave and if appropriate will arrange extra staff to accommodate
As B4 patients do not venture outside the ward, would it be possible for someone to buy a paper for me in the morning?	Discussion have been held with RVS Trolley Service to see whether this can be accommodated

Within the qualitative feedback, patients often tell us they are bored, an example being:

'Need a bit more entertainment'.

Boredom and loneliness continues to feature in patient experience feedback. In addition to Arts and Craft volunteers, an Arts and Craft Group was set up at University Llandough Hospital. It is initially facilitated by the Patient Experience Macmillan Information and Support Facilitator; but will be sustainably supported by Health Board volunteers. This group is for patients, carers and those wishing to attend from the community are also welcomed.

On 20th February a pilot of the 'principles of John's Campaign' was launched at St Davids Hospital. The co-founder of the campaign Dr Julia Jones was in attendance. The pilot involves seven wards areas across four hospital sites. A brand has been developed, signifying hands around a person, supported by the message that '***we care for those who care'*.**



The Principles of the Campaign include:

1. **Priority** – early identification of carers;
2. **Principles** – ensuring a carer voice, and that they are informed and communicated with;
3. Our **Promises** - that carers are welcome and that they can continue their caring role of they wish e.g. in mealtimes, personal care and medicines management etc;
4. Finally carers **Please** – respect other patients privacy, ward issues and tell us if you need our help and support.

Proactive and Reactive

Outpatients Kiosk

The outpatient's kiosk was introduced to the UHB in May 2017 and is a means of gathering feedback from patients, relatives, friends and carers.

Since placing the kiosk in the department on 3rd May 2017, we have had 1080 surveys completed, both full and partial. Of these, 859 (80%) are by patients, 164 (15%) by relatives/friends/loved ones and 57 (5%) by carers/helpers.

The most recent report includes feedback from 1st January – 20th February 2018, during which time we had 131 survey completions. Patients continue to complain that they have difficulty in parking and in a third of cases this makes them late for appointments. It should be noted, however, that since the commencement of the survey this has been an improving picture. A small percentage of patients continue to experience difficulties in finding their clinic and this has also made them late for their appointment. Again, of those patients surveyed, it is pleasing to note that 60% reported clinics running to their scheduled times and when a clinic was running late in 55 % of clinics patients were informed regarding the reason for the delay.

We have now completed this outpatient kiosk survey phase and will be implementing a more targeted approach in coming months. The new survey questions have been agreed and will be uploaded onto a portable kiosk for testing. The kiosk will then

stay for a period of time in a specific clinic area e.g. two weeks, before moving onto the next.

Ward Feedback Kiosks

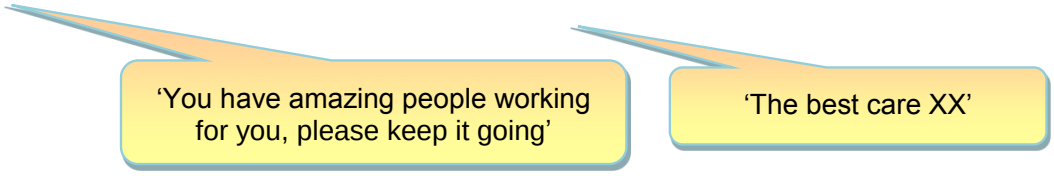
The ward feedback kiosks were introduced to the wards in June 2017 and are a means of gathering real time feedback from patients, relatives, friends, carers and staff. The survey tools, currently loaded on the kiosks, are available in both English and Welsh. During each survey period, the kiosk remains on its designated ward for one week. A detailed report is then sent to the area at the start of the following week. If there are any areas noted for improvement these are highlighted to the ward and the Patient Experience Team will follow up on any actions noted.

In addition to this, the kiosk can be opportunistically placed in an area where concerns have been raised, as a means of responding quickly and gaining a sense of any potential quality and safety issues from patient and staff feedback.

To date, 32 areas have been surveyed at UHW and 33 areas at UHL. The table below gives a breakdown of which areas have been surveyed since January's Board report, number of surveys completed in each area and the percentage of those completed by patients, relatives/friends/carers and staff.

Basic findings *(based on data from 1st Jan – 4th Mar 2018)*

- Overall 525 surveys have been completed, 295 (56%) by staff, 70 (13%) by relatives/friends/carers and 160 (30%) by patients. However, this distribution does vary depending on ward, please see table above.
- 95% of surveys were completed in English, 5% completed in Welsh.
- 84% of patients felt safe whilst in our care
- 66% of patients thought staff were always kind and caring towards them and 64% of relatives/friends/carers thought staff were always kind and caring towards the patient. 53% of staff, believed that patients thought staff were always kind and caring.
- 81% of patients felt they were involved when decisions were made about their care/treatment,.
- 67% of patients rated their care as excellent and 60% of relatives/friends/carers rated the care the patient received as excellent. Incidentally, only 44% of staff believed that patients rated the care they received as excellent.
- On the whole comments left by patients and relatives/friends/carers were positive and were in relation to the care received and staff. However, there were some negative comments regarding the ward environment/facilities, and patient rights.



- Comments left by staff centered mainly around understaffing issues. However, there were some positive comments made around team work and staff.

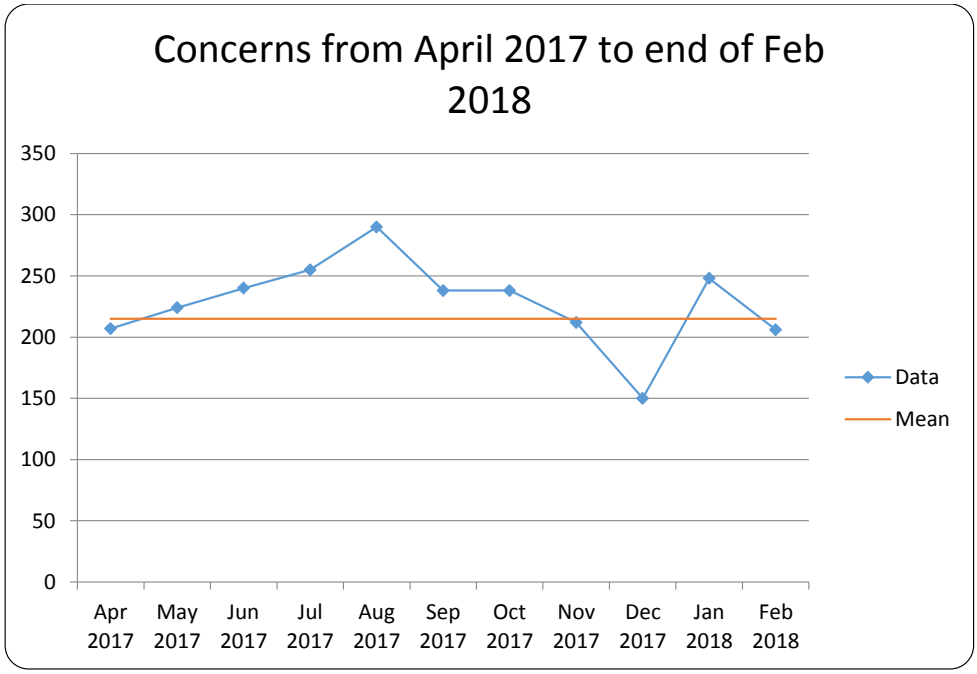
Balancing

Complaints

The UHB receives approximately 2,600 concerns per year; this is set in the context of approximately 1.8 million patient contacts Since 1st April 2017, the UHB has received 2,505 concerns, 62% of those were managed through our informal process, with less than 2% being converted to a formal complaint (instances where the Clinical Board has not been able to resolve the concerns raised in a timely manner or the complainant is unhappy with the informal response).

Graph 4 shows the number of concerns (formal/informal) reported over the last 11 months:

Graph 4



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There was a rise in informal concerns in July 2017, which were in relation to out-patients appointment waiting times. There were however no particular themes or trends. It should be noted, that the UHB always experiences a rise in the number of formal complaints received and this is evident again in 2018. The number of contacts with complainants is noticeably increased over this period. Normally, we can anticipate an improving trajectory and we will continue to monitor this.

During January and February, there has been a focus across the Clinical Boards to improve the 30 day response time. This has had a very positive outcome as the latest overall Health Board performance in response to 30-day concerns is 74% in comparison to 55% reported in the last Board report.

During January and February, the Health Board received 449 complaints, 60% of those were managed through the informal process, and the overall informal response time is 93%.

Surgery Clinical Board continue to receive the highest number of formal and informal concerns; during January and February, Surgery Clinical Board managed 74% of their concerns informally. We are anticipating a decrease in the volume of informal concerns logged with Surgery, as a high percentage related to a delay in Ophthalmology Outpatient Appointments and the Clinical Board have taken a number of actions to address this, including, introduction of a Nurse Led Clinic for patients who meet a specific criteria and can be seen by a nurse. This has reduced the backlog of patients waiting to receive a follow up appointment. THE UHB will continue to monitor this position.

Compliments

During the period 1st April 2017– 28th February 2018, the Health Board logged 552 compliments. Medicine Clinical Board continues to receive the highest volume of compliments, particularly within the Emergency, Medicine Directorate. Following the recent adverse weather conditions it has been pleasing to note a significant increase in the number of compliments received for our staff and volunteers who overcame significant difficulties to be able to provide care for our patients.

How do we compare to our Peers?

At present there is no new All Wales data available regarding concerns or compliments. Generally across the four quadrants there is little reliable benchmarking data available with the exception of Ombudsman reports.

We have noted an increase in the number of cases for investigation, with 2 new cases in January and 6 new cases in February.

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

The latest Ombudsman casebook can be found here and this provides an All Wales perspective.

What are we doing?

All complaints and patient feedback provide us with an opportunity to make changes to improve services. The following are examples of action that the UHB has taken following concerns raised by patients and their families:

You Said	We Did
Informal concerns were raised about cancelled appointments for botox clinics to treat muscular disorders	We organised additional evening clinics to see and treat 200 patients
Concerns about Communication with patients and families using ALAS were noted as a theme	The service have reviewed the communication pathway to maintain a log of inter professional communication to ensure that families are kept fully informed
2 incidents were noted where people fell outside the medicentre due to a fault with the walkways uneven paving.	The redress leads identified that the area was managed by the university and following contact with them the fault was quickly rectified

FINANCE REPORT FOR THE PERIOD ENDED 28th FEBRUARY 2018	
Name of Meeting : Board Meeting	**Date:** 29th March 2018

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 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 February 2018 is a deficit of £25.502m comprised of the following: • (£2.823m) favourable budget variance; • £28.325m planned deficit (11/12th of £30.900m).
Quality, Safety, Patient Experience impact: This report details financial performance against the 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 operational plan;
- The scrutiny of financial performance undertaken by the Finance Committee;
- The month 11 position which is £2.823m less than the profiled deficit within the financial plan;
- The identification of a full £35m savings programme.

The Board is asked to:

- **NOTE** that the UHB has an one year operational plan that has a planned deficit of £30.900m for the year;
- **NOTE** that the UHB has reduced its forecast year end deficit by £4m in month to £26.900m;
- **NOTE** the £25.502m deficit at month 11 which includes a planning deficit of £28.325m and budget underspends of (£2.823m);
- **NOTE** that the UHB has written to Welsh Government to confirm a reduction to the cash assistance required by the UHB in line with the reduction the forecast year end deficit.

SITUATION

Following a review of expected outturn for the remainder of the year and confirmation of the month 10 position which was nearly £1.5m better than planned, the UHB's

year-end forecast improved to a deficit of £26.9m. The reduction in the forecast deficit was within the range outlined to the Board in the December Finance Report and the forecast deficit is now £4m better than the planned deficit of £30.9m.

The £4m improvement to the UHB's year-end forecast is underpinned by the following savings:

- A £1.8m non recurrent underspend against delegated budgets;
- Clarification of the required recurrent contribution for the Welsh Risk Pool (WRP) which is £1m less that the WRPs planning assumption;
- A £1.2m recurrent surplus on the UHB's Hepatitis C drugs budget;

Following confirmation of the month 11 position and a review of expected income and expenditure for the final month of the year the UHB's remains on course to deliver its revised forecast year-end deficit of £26.9m

BACKGROUND

The UHB submitted a financial plan to Welsh Government on 10th March 2017 which had a deficit of £45.873m. The plan was reconsidered by the UHB at its Board meeting on the 25th May 2017 where it was agreed to work towards a stretch target to deliver a position no worse than the £30.9m forecast position in 2016/17.

The opening underlying deficit position was £54.5m and whilst the UHB has worked towards delivering a £30.9m deficit, many of items needed to achieve this are non recurrent. The UHB's assessed underlying deficit to be carried forward into 2018/19 has fallen by £3.1m in the year to date and is currently assessed at £51.4m. The UHB is applying further pressure on the underlying deficit with the objective of reducing the figure carried forward to 2018/19 to £49m.

This report has been prepared against the 2017/18 planned deficit of £30.9m. A summary of this plan and the revised forecast is provided in table 1.

Table 1: Revised Operational Plan 2017/18 @ February 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 @ December 2017	14,973
Financial Plan with Stretch Target: surplus / (deficit)	**-30,900**
WRP revision to required contribution	1,000
Surplus on Hep C budget	1,200
Improvement in forecast delegated budget position	1,800
Forecast Outturn (£m)	**-26,900**

ASSESSMENT AND ASSURANCE

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

Table 2: Finance Dashboard @ February 2018

Finance Dashboard								
Finance Indicators	Statutory Target	Standard	Performance		In Month	Year to Date	Month 11 Full Year Forecast
			In Month	Year to Date	RAG Rating		
Remain within revenue resource limit - Variance Adv/(Fav)	Yes	£0	£1.244	£25.502			
Reduction in underlying deficit c/f to 18/19 (£54.5m b/f to 17/18)		£0	(£1.0m)	£51.382m			
Variance against unapproved 2017/18 £30.9m deficit plan		£0	(£1.331m)	(£2.823m)			
Pay expenditure (actual versus Plan)		£0	(£0.216m)	(£2.352m)			
Non-Pay Expenditure (Actual versus Plan)		£0	(£1.117m)	£0.377m			
Income (actual versus Plan)		£0	£0.002m	(£0.848m)			
Remain with CAPEX resource limit	Yes	£0	n/a	(£1.909m)			
Creditor payments compliance 30 day Non NHS		95%	93.80%	92.40%			
CRP Green / Amber status - Delegated Targets @ Feb 28th		100% Green		100%			

Month 11 Cumulative Financial Position

The UHB reported a deficit of £25.502m at month 11 as follows:

- (£2.823m) favourable budget management variance;
- £28.325m planned deficit (11/12th 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 28th February 2018

Income/Pay/Non Pay	In Month			Year to Date			Full Year		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Forecast £m	Variance (Fav)/Adv £m
Income	(116.279)	(116.277)	0.002	(1,061.643)	(1,062.491)	(0.848)	(1,283.645)	(1,283.645)	0.000
Pay	51.014	50.798	(0.216)	540.303	537.950	(2.352)	589.864	589.864	0.000
Non Pay	67.839	66.723	(1.117)	633.311	633.687	0.377	724.681	724.681	0.000
Variance to Draft Plan £m	2.575	1.244	(1.331)	111.970	109.147	(2.823)	30.900	30.900	0.000
Planned Deficit	(2.575)	0.000	2.575	(28.325)	0.000	28.325	(30.900)	0.000	30.900
Total £m	(0.000)	1.244	1.244	83.645	109.147	25.502	(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 @ February 2018

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	(83.636)	(83.636)	0.000	(690.704)	(690.704)	0.000
Non Cash Limited Expenditure	(1.534)	(1.534)	0.000	(17.887)	(17.887)	0.000
Accomodation & Catering	(0.230)	(0.192)	0.039	(2.232)	(2.133)	0.099
Education & Training	(3.196)	(3.185)	0.011	(34.704)	(34.797)	(0.093)
Injury Cost Recovery Scheme (CRU)	(0.189)	(0.145)	0.044	(2.076)	(2.217)	(0.141)
NHS Patient Related Income	(22.659)	(22.618)	0.041	(253.699)	(254.196)	(0.497)
Other Operating Income	(4.005)	(4.209)	(0.204)	(50.251)	(51.099)	(0.849)
Overseas Patient Income	(0.010)	(0.012)	(0.002)	0.104	(0.023)	(0.127)
Private Patient Income	(0.101)	(0.042)	0.059	(1.219)	(0.787)	0.432
Research & Development	(0.720)	(0.705)	0.015	(8.975)	(8.647)	0.328
Total £m	(116.279)	(116.277)	0.002	(1,061.643)	(1,062.491)	(0.848)

An in month deficit of £0.002m and a cumulative surplus of £0.848m is reported against income budgets.

Accommodation and catering income is again below target in month due to a shortfall in canteen and vending machine income.

The in month deficit reported against the Injury Cost Recovery Scheme follows a fall in the number of notified new cases and the withdrawal of 2 high value claims in February.

The majority of the in month favourable variance reported against other operating income relates to the expected allocation of NHS Wales Shared Service Partnership savings which are in in excess of planning assumptions.

Both the in month and cumulative underperformance against private patient income targets again relate to Specialist Services. The reduction in income will in part be offset by a corresponding reduction in costs.

The reported cumulative deficit against R & D income is primarily due to the reduction in Welsh Government funding.

Pay

Pay budgets continue to show sound performance with a year to date underspend of £2.352m. Table 5 highlights that this is favourable performance compared to a month 11 overspend of £0.827m in 2016/17.

Table 5: Analysis of fixed and variable pay costs

	2016/17 Total Spend £m	2016/17 Month 1 to Month 10 £m	2017/18 Month 1 to Month 10 £m	2016/17 Month 11 £m	2017/18 Month 11 £m	2016/17 Cum. to Month 11 £m	2017/18 Cum. to Month 11 £m
Basic	502.093	415.194	425.825	42.023	43.245	457.217	469.070
Enhancements	23.635	19.179	19.822	2.640	2.679	21.819	22.501
Maternity	4.136	3.477	3.443	0.295	0.299	3.772	3.742
Protection	0.743	0.621	0.567	0.060	0.052	0.680	0.619
Total Fixed Pay	**530.607**	**438.472**	**449.657**	**45.016**	**46.275**	**483.488**	**495.932**
Agency (mainly registered Nursing)	9.017	6.830	6.683	0.771	0.978	7.601	7.661
Nursing Bank (mainly Nursing)	14.249	10.934	11.677	1.297	1.301	12.231	12.978
Internal locum (Medical & Dental)	2.105	1.759	3.523	0.178	0.384	1.937	3.907
External locum (Medical & Dental)	9.547	7.889	5.768	0.784	0.585	8.673	6.353
On Call	2.154	1.718	1.774	0.233	0.260	1.951	2.033
Overtime	6.072	4.927	4.472	0.398	0.466	5.324	4.938
WLI's & extra sessions (Medical)	3.549	2.812	3.599	0.351	0.550	3.163	4.149
Total Variable Pay	**46.693**	**36.869**	**37.495**	**4.011**	**4.523**	**40.880**	**42.018**
Total Pay	**577.301**	**475.341**	**487.152**	**49.027**	**50.799**	**524.369**	**537.950**
Pay Budget	**576.692**	**474.168**	**489.288**	**49.373**	**51.014**	**523.541**	**540.303**
Budget Variance (Fav)/Adv £m	**0.609**	**1.173**	**(2.136)**	**(0.345)**	**(0.216)**	**0.827**	**(2.352)**

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

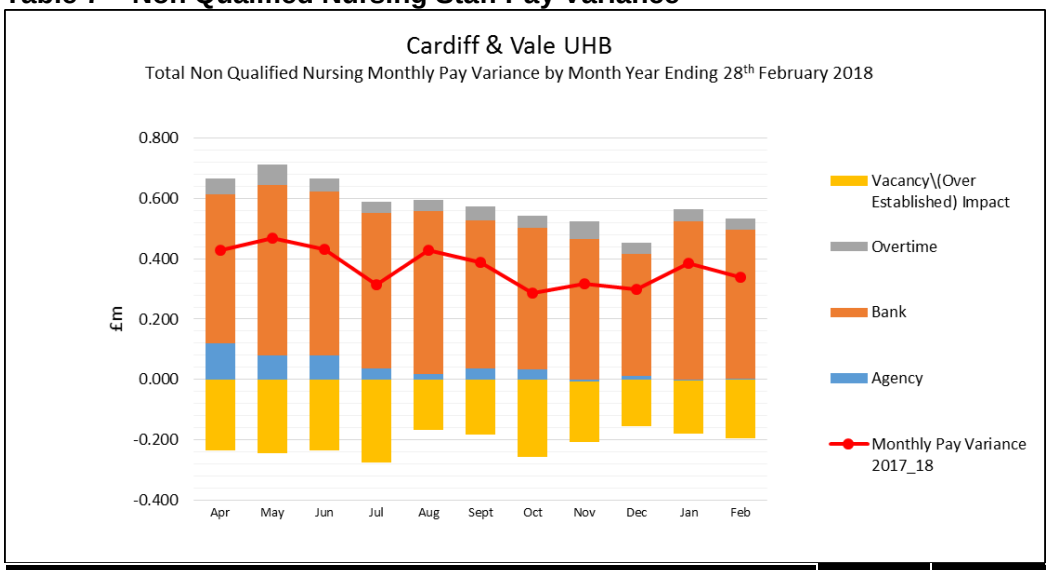
An analysis of pay expenditure by staff group is shown in Table 6.

Table 6: Analysis of pay expenditure by staff group @ February 2018

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	1.913	1.825	(0.088)	20.833	20.168	(0.665)
Management, admin & clerical	5.722	5.641	(0.080)	63.343	62.392	(0.950)
Medical and Dental	13.181	12.976	(0.205)	139.527	138.380	(1.148)
Nursing (registered)	15.521	15.486	(0.035)	162.180	160.309	(1.871)
Nursing (unregistered)	4.171	4.510	0.339	42.858	46.942	4.084
Other staff groups	7.634	7.599	(0.036)	80.761	80.367	(0.394)
Scientific, prof & technical	2.871	2.760	(0.111)	30.800	29.391	(1.409)
Total £m	51.014	50.798	(0.216)	540.303	537.950	(2.352)

The in month underspend of £0.216m against pay budgets is broadly consistent with the trend established in the first ten months of the year. Part of the in month overspend against nursing is due to relatively high levels of sickness on medical wards. The majority of the nursing overspend continues to be a consequence of the additional cost of cover for vacant posts on medical wards.

Table 7 – Non Qualified Nursing Staff Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.001	0.403
Bank	0.495	5.505
Overtime	0.037	0.496
Adverse Impact	0.533	6.404
Vacancy\(Over Established) Impact	(0.194)	(2.320)
Total Pay Variance - Unqualified Nursing (Fav)/Adv £m	0.339	4.084

Table 7 demonstrates that the majority of adverse variance against non-qualified nursing assistants is due to an overspend of £5.505m on bank staff which is partly offset by an underspend against established posts. The in month overspend of £0.339m is less than the average monthly overspend for the year to date of £0.371m.

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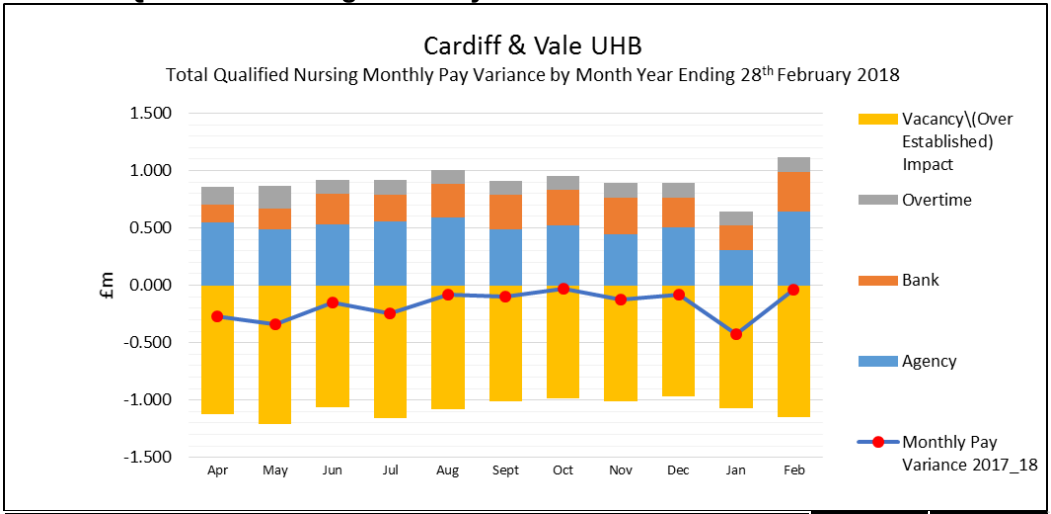
Table 8 - Qualified Nursing Staff Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.642	5.630
Bank	0.344	2.869
Overtime	0.130	1.463
Adverse Impact	1.116	9.963
Vacancy\(Over Established) Impact	(1.150)	(11.833)
Total Pay Variance - Qualified Nursing (Fav)/Adv £m	(0.035)	(1.871)

Table 8 confirms that expenditure on established qualified nursing posts is significantly less than budget. The overall trend for the year to date is moving towards broadly balanced monthly budgets. The reported variance in January was skewed by the confirmation of non recurrent Invest to Save funding from Welsh Government which was applied to support nursing posts.

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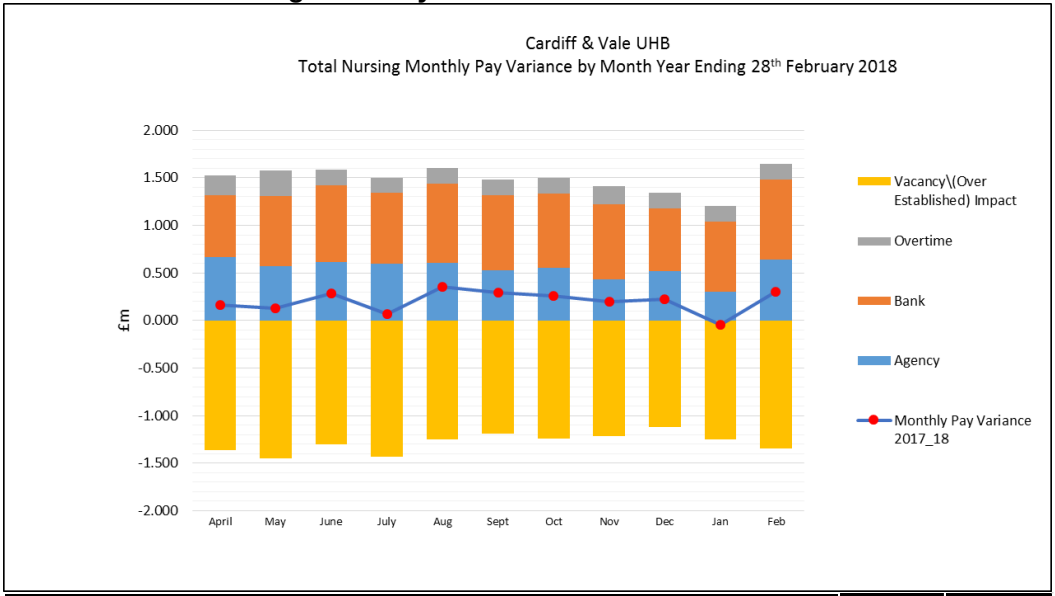
Table 9 - Total Nursing Staff Pay Variance

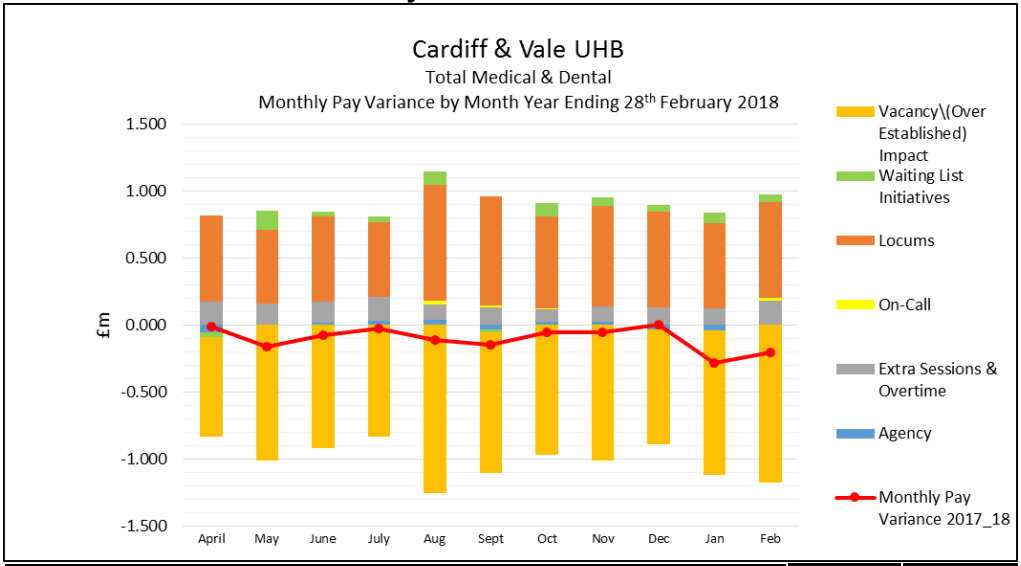


Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.643	6.033
Bank	0.839	8.374
Overtime	0.167	1.960
Adverse Impact	1.649	16.366
Vacancy\(Over Established) Impact	(1.345)	(14.153)
Total Pay Variance - (Fav)/Adv £m	0.304	2.213

Table 9 shows that the expenditure against substantive nursing posts for the year to date is less than budget as reported by a £14.153m surplus against established posts. However the combined £16.366m 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 £1.148m at month 11.

Table 10 - Medical & Dental Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.003	(0.039)
Extra Sessions & Overtime	0.178	1.557
On-Call	0.023	0.074
Locums	0.708	7.551
Waiting List Initiatives	0.060	0.608
Adverse Impact	0.973	9.751
Vacancy\(Over Established) Impact	(1.178)	(10.898)
Total Pay Variance - Medical & Dental (Fav)/Adv £m	(0.205)	(1.148)

Non Pay

Table 11 highlights an in month underspend of £1.117m and a £0.377m cumulative overspend against non pay budgets.

Table 11: Non Pay Variance @ February 2018

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	8.070	8.248	0.178	86.835	87.500	0.666
Commissioned Services	15.581	15.946	0.365	149.584	149.813	0.229
Continuing healthcare	7.615	7.710	0.095	56.355	56.921	0.566
Drugs / Prescribing	13.132	12.114	(1.018)	137.361	135.770	(1.590)
Establishment expenses	1.168	1.140	(0.029)	10.231	10.069	(0.161)
General supplies & services	0.603	0.686	0.083	5.056	5.710	0.654
Other non pay	7.236	6.450	(0.786)	29.800	30.756	0.956
Premises & fixed plant	2.987	3.052	0.065	33.664	33.022	(0.641)
Primary Care Contractors	11.447	11.377	(0.070)	124.425	124.124	(0.301)
Total £m	67.839	66.723	(1.117)	633.311	633.687	0.377

The in month overspend against clinical services and supplies represents 2% of the in month budget.

The adverse in-month movement against commissioned services reflects a deterioration in LTA expenditure, the WHSCC risk share on further C&V provider LTA over-performance, a high number of CAMHS Tier 4 admissions and a provision for WHSSC activity growth.

The in month overspend against Continuing Healthcare (CHC) partly reflects the net increase of 17 non mental health cases in month. The additional NHS funded nursing fees costs arising from the judgement of the Supreme Court are now included within the UHB's 2017/18 forecast deficit.

A number of high cost NCSO price concessions have now expired leading to an in month underspend against primary care prescribing costs. In addition the UHB recognised a significant level of savings against Hepatitis C drugs in month following confirmation of actual dispensing volumes and costs.

Other non-pay includes the additional costs resulting from the outsourcing of the neuro-interventional radiology service which are now estimated to be £0.583m for the year to date. The UHB's Director of Finance has met with the WHSCC Director of Finance to discuss whether additional income will be provided by WHSCC under the current LTA framework and there is an expectation that the issue will be concluded in March and that WHSSC will risk share these costs.

Also included in other non pay is a £1.697m contribution to the stretch target due to planned underspends in delegated budgets

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 months to 28tf February 2018 by Clinical Board is shown in Table 12.

Table 12: Financial Performance for the period ended 28th February 2017

Clinical Board	M10 Budget Variance £m	M11 Budget Variance £m	In Month Variance £m	Cumulative % Variance
Clinical Diagnostics & Therapies	0.373	0.459	0.086	0.47%
Chidren & Women	0.427	0.425	(0.003)	0.47%
Capital Estates & Facilities	(0.412)	(0.403)	0.009	(0.68%)
Dental	(0.011)	(0.007)	0.004	(0.02%)
Executives	(0.276)	(0.318)	(0.042)	(0.89%)
Medicine	0.323	0.149	(0.175)	0.14%
Mental Health	(0.364)	(0.475)	(0.111)	(0.71%)
PCIC	(2.091)	(2.303)	(0.212)	(0.82%)
Specialist	(0.508)	(0.641)	(0.134)	(0.46%)
Surgery	0.239	0.063	(0.176)	0.05%
Central Budgets	0.807	0.230	(0.577)	0.17%
SubTotal	**(1.492)**	**(2.823)**	**(1.331)**	**(0.25%)**
Planned Deficit	25.750	28.325	2.575	2.47%
Total	**24.258**	**25.502**	**1.244**	**2.23%**

All primary delegated budget holders are now reporting an underspend with the exception of the Medicine, Children and Women, Surgery and the CD&T Clinical Boards.

In month performance by the Medicine Board improved, however, pressures on nursing budgets remained. Underperformance in PICU and NICU alongside premium costs of medical cover and nursing costs are pressures in the Children and Women Clinical Board. The cumulative deficit reported by the Surgery Clinical Board fell by £0.176m in month. The overspend reported by the CD&T Clinical Board is due to the 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 produced recovery plans in order to achieve a balanced year end outturn. The only Clinical Board that is now forecasting an overspend is CD&T due to the exceptional non-recurring costs in interventional neuroradiology. Without this cost pressure, the Clinical Board has a balanced plan. **The expectation now is that all Clinical Boards will deliver their latest forecast position and assurances have been received that this will be achieved.**

Savings Programme

The UHB set a 1.5% recurrent savings target of £13m and a 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 and agreed a £14.973 stretch plan leading to an overall savings target of £35.001m

At month 11 the UHB has identified £39.001m savings to deliver against the £35.001m savings target as summarised in Table 13 and is detailed in **Appendix 1**.

Table 13: Progress against the 2017/18 Savings Programme at Month 11

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Over-programming) £m
Total £m	35.001	39.001	4.000

For the year to date £32.4m (83.0%) of savings are profiled into the position and these have been delivered. It should be noted that a number of identified corporate schemes are profiled into the last month of the year.

Underlying Financial Position

A key risk to the UHB is its c/f deficit from 2017/18 into 2018/19. The recurrent underlying deficit in 2016/17 b/f into 2017/18 was £54.5m. The assessed deficit c/f into 2018/19 is currently £51.4m as shown in Table 14.

Table 14: Summary of Underlying Financial Position

	2017/18 Plan £m	Forecast Position @ Month 11	
		Non Recurrent £m	Recurrent Position £m
Opening Underlying Deficit	**54.533**	**0.000**	**54.533**
Income	**(23.414)**	**0.000**	**(23.414)**
Cost pressures less mitigating actions	**34.782**	**5.861**	**40.643**
Less CIPs	**(35.001)**	**14.621**	**(20.380)**
Deficit	**30.900**	**20.482**	**51.382**

The UHB is pursuing further recurring efficiencies with the objective of reducing the carried forward underlying deficit into 2018/19 to £49m. A large part of this will be making recurrent budget underspends within Executive Directors delegated budgets.

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Balance Sheet

The Balance sheet is shown in **Appendix 3.**

The increase in reported value of property, plant and equipment reflects the impact of the Valuation Office Agency's valuation of the UHB's Estate as at 1st April 2017. The carrying value now also reflects the transfer of Llantwit Major Health Centre from Abertawe Bro Morgannwg Health Board which was completed in February 2018.

The main reason for the increase in trade debtors is the increase in amounts due from the Welsh Risk Pool. 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**.

Welsh Government wrote to the UHB on 14th December 2017 to confirm that it will provide up to a maximum of £29.389m strategic cash only support to Cardiff & Vale UHB in 2017/18. As a consequence of the £4m reduction to the UHB forecast deficit in January the level of strategic cash assistance required by the UHB has also fallen by £4m from that previously requested. The UHB has therefore written to Welsh Government to confirm the Strategic Cash Assistance required is therefore now £4m less at £25.389m. The UHB has also requested £1.599m cash assistance for working balance movements.

The UHB has therefore requested total cash assistance of £26.988m (£25.389m strategic cash only support & £1.599m working balances cash assistance).

Public Sector Payment Compliance

The UHB's cumulative performance to the end of December improved by 0.1% in month to 92.4%. As previously reported the poor performance to date is linked to the transition to the All Wales Nursing Agency Contract. The UHB expects performance in this area to gradually improve following the introduction on the 1st August 2017 of an automated ordering & receipting process. This roll out began on 1st August 2017 and as at 28th February 2018 the UHB's eight biggest suppliers were all part of this process, with seven of the companies hitting a compliance rate of over 94% in month which is significantly better than 6 months ago. In addition, the UHB is piloting a "No Purchase Order, No Pay" policy within corporate departments with the long term intention of rolling the policy out across the UHB and improving the efficiency of invoice payments. Furthermore all Clinical Boards have formally been reminded that

the UHB expects all invoices received to either be authorised or receipted on Oracle within 3 days of receipt. It is expected that the combination of remedial actions will produce a steady improvement.

Capital Resource Limit (CRL)

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

Table 15: Progress against Capital Resource Limit @ February 2017

	£m
Planned Capital Expenditure at month 11	25.831
Actual net expenditure against CRL at month 11	23.922
Variance against planned Capital Expenditure at month	(1.909)

The UHB anticipates to fully expend its CRL by the year end.

Financial Risks

The UHB is forecasting a £26.9m year-end deficit which is £4.0m less than its Operational Plan.

The NHS Funded Nursing Care (FNC) financial risk has now been accommodated within the UHB forecast and the risk around NCSO drugs has now largely gone. In addition Welsh Government has confirmed funding for PACS.

Therefore the only outstanding material risk relates to the performance of neonatal intensive care against the WHSSC contract. The UHB in on track to make good part of the year to date underperformance. Due to the stepped marginal cost in this contract however, if this is not achieved it will result in a £0.8m income reduction.

Key Concerns & Recovery Actions

At month 11, the key concerns and challenges are set out below:

1. Concern- Budget overspends at month 11;

   Action – All Clinical Boards have confirmed expected year end outturn through a detailed forecasting exercise and escalation process. All Clinical Boards have balanced plans except CD&T due to the exceptional non-recurring costs in interventional neuroradiology.

2. Concern – Key financial risks;

   Action – Further savings have been identified to mitigate against these and therefore the UHB has greater assurance of delivering its forecast position.

3. Concern – Underlying Deficit.

Action – Further work is being taken forward to reduce the recurrent cost base in order to minimise the c/f underlying deficit into 2018/19.

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's draft 2017/18 financial plan aimed to achieve a £30.9m deficit. Following a review in January the UHB revised and improved its year-end forecast by £4m to a deficit of £26.9m. The cumulative underspend against the UHB plan increased by a further £1.331m in February from £1.492m to £2.823m providing the UHB with assurance that it remains on course to meet the revised forecast deficit of £26.9m.

At the beginning of 2017/18 the UHB had a brought forward underlying recurrent deficit of £54.5m. This has now reduced to £51.4m and the UHB is aiming to reduce this further so that underlying deficit carried forward into 2018/19 is circa £49m.

The UHB will continue to share progress being made with Welsh Government and 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 eleven months to the end of February is a deficit of £25.502m. This is made up of a budget plan deficit of £28.325m and a favourable variance against plan of £2.823m.

Appendix 1

2017-18 Part Year Effect Month Ending February 2018

Identified Savings	17-18 Target	Granular Identified Green	Clinical Board Amber	Clinical Board Pipeline Red	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000
Corporate Execs	681	941	106	72	1,046	-365
Specialist Services	2,400	2,636	311	324	2,947	-547
Capital Estates and Facilities	1,244	1,355	0	0	1,355	-111
Surgery	2,357	2,401	118	35	2,520	-163
PCIC	3,323	3,327	226	450	3,553	-230
Mental Health	1,395	1,433	0	0	1,433	-38
Children & Women	1,775	1,675	147	420	1,822	-47
Dental	400	408	0	10	408	-8
CD&T	1,880	1,890	0	163	1,890	-10
Medicine	1,878	1,879	0	157	1,879	-1
Clinical Board Forecast			4,541		4,541	-4,541
Corporate Schemes	17,668	15,108	500	234	15,608	2,060
Total Savings	**35,001**	**33,053**	**5,949**	**1,864**	**39,001**	**-4,000**

2017-18 Full Year Effect Month Ending February 2018

Identified Savings	17-18 Target	Granular Identified Green	Clinical Board Amber	Clinical Board Pipeline Red	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000
Corporate Execs	501	609	87	16	696	-195
Specialist Services	1,800	1,365	450	324	1,815	-15
Capital Estates and Facilities	933	933	60	420	993	-60
Surgery	1,768	1,794	170	86	1,964	-196
PCIC	2,493	3,239	275	160	3,514	-1,021
Mental Health	1,047	1,047	0	0	1,047	0
Dental	300	88	0	20	88	212
Children & Women	1,331	946	425	723	1,371	-40
CD&T	1,382	1,382	0	163	1,382	0
Medicine	1,408	1,702	0	594	1,702	-294
Corporate Schemes	17,668	7,275	953	0	8,228	9,440
Total Savings	**30,631**	**20,380**	**2,420**	**2,505**	**22,800**	**7,831**

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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**	**109,803**	**96,177**	**113,911**	**110,746**	**115,938**	**122,659**	**151,174**	**1,355,190**
Identified savings	-618	-1,481	-2,972	-1,757	-2,739	-2,898	-4,741	-3,568	-3,326	-3,141	-5,136	-6,624	-39,001
Unidentified savings required for stretch target													
Total savings required	**-618**	**-1,481**	**-2,972**	**-1,757**	**-2,739**	**-2,898**	**-4,741**	**-3,568**	**-3,326**	**-3,141**	**-5,136**	**-6,624**	**-39,001**
Net costs	**102,626**	**100,073**	**107,341**	**107,324**	**107,851**	**106,905**	**91,436**	**110,343**	**107,420**	**112,797**	**117,523**	**144,550**	**1,316,189**
Income (phased as per budget plan)	98,952	98,579	104,814	104,728	105,337	104,301	88,882	107,862	105,687	110,716	116,279	143,152	1,289,289
Net surplus/ (deficit)	**-3,674**	**-1,494**	**-2,527**	**-2,596**	**-2,514**	**-2,604**	**-2,554**	**-2,481**	**-1,733**	**-2,081**	**-1,244**	**-1,398**	**-26,900**

Notes

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

Gross costs in October are abated by a £15.275m credit in respect of impairments and depreciation as a consequence of an adjustment required to the carrying value of the UHB's estate following receipt of the District valuers 5 yearly report on the estate. The October spike in savings reflects management action to recover a VAT claim c £1.5m.

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 £20.6m of AME Donated Depreciation\Impairments profiled into month 12 and the expected settlement of LTAs

Savings profiled to Month 11 & 12 include £1.2m Hepatitis drug savings; £1m savings on the planned contribution to the Welsh risk Pool and £1.8m savings against delegated budgets.

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Appendix 3

BALANCE SHEET AS AT 28th FEBRUARY 2018

	Opening Balance 1st April 2017	Closing Balance 28th February 2018
Non-Current Assets	**£'000**	**£'000**
Property, plant and equipment	628,042	640,519
Intangible assets	1,601	1,478
Trade and other receivables	42,437	42,727
Other financial assets		
Non-Current Assets sub total	**672,080**	**684,724**
Current Assets		
Inventories	15,129	15,972
Trade and other receivables	137,493	201,355
Other financial assets	0	0
Cash and cash equivalents	881	6,289
Non-current assets classified as held for sale	1,815	0
Current Assets sub total	**155,318**	**223,616**
TOTAL ASSETS	**827,398**	**908,340**
Current Liabilities		
Trade and other payables	157,516	146,021
Other financial liabilities	0	0
Provisions	102,277	163,017
Current Liabilities sub total	**259,793**	**309,038**
NET ASSETS LESS CURRENT LIABILITIES	**567,605**	**599,302**
Non-Current Liabilities		
Trade and other payables	10,207	9,720
Other financial liabilities	0	0
Provisions	44,615	42,727
Non-Current Liabilities sub total	**54,822**	**52,447**
TOTAL ASSETS EMPLOYED	**512,783**	**546,855**
FINANCED BY: **Taxpayers' Equity**		
General Fund	399,057	432,640
Revaluation Reserve	113,726	114,215
Total Taxpayers' Equity	**512,783**	**546,855**

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Appendix 4

CASH FLOW FORECAST AS AT 28th FEBRUARY 2018

	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	79,642	71,292	73,102	82,767	65,128	72,858	73,876	880,213
WG Revenue Funding - Non Cash Limited (NCL)	1,830	1,830	1,150	1,410	1,610	1,815	1,375	1,720	1,605	1,620	1,630	1,530	19,125
WG Revenue Funding - Other (e.g. invoices)	2,360	2,360	2,506	2,361	2,361	2,331	2,356	2,356	2,878	5,280	2,498	5,953	35,600
WG Capital Funding - Cash Limit	9,000	2,000	1,000	2,100	3,900	2,950	0	4,200	375	3,325	5,200	7,113	41,163
Sale of Assets	0	9,152	0	0	0	0	212	550	0	0	0	0	9,914
Income from other Welsh NHS Organisations	47,076	17,644	41,554	29,101	31,459	41,273	25,977	32,259	39,530	26,020	31,674	36,264	399,831
Other - (Specify in narrative)	11,438	3,599	7,579	5,630	8,324	6,620	9,018	6,738	5,850	8,488	5,898	8,435	87,617
TOTAL RECEIPTS	**149,044**	**96,943**	**144,167**	**106,988**	**114,740**	**134,631**	**110,230**	**120,925**	**133,005**	**109,861**	**119,758**	**133,171**	**1,473,463**
PAYMENTS													
Primary Care Services : General Medical Services	5,249	4,042	8,318	3,992	3,986	6,294	4,142	4,059	6,769	4,242	4,008	6,768	61,869
Primary Care Services : Pharmacy Services	153	124	144	112	125	135	121	101	215	484	344	167	2,225
Primary Care Services : Prescribed Drugs & Appliances	15,528	2	15,095	4	7,945	16,115	3	7,429	16,189	3	7,767	7,769	93,849
Primary Care Services : General Dental Services	1,734	1,877	1,908	1,936	1,720	1,806	1,845	1,793	1,768	1,839	1,904	1,719	21,849
Non Cash Limited Payments	1,986	2,196	1,910	2,173	2,105	2,125	2,135	2,174	2,201	2,094	2,023	2,174	25,296
Salaries and Wages	45,715	47,104	47,578	46,857	46,825	46,822	46,626	47,425	47,459	47,086	47,613	47,986	565,096
Non Pay Expenditure	41,188	43,621	48,892	44,051	45,352	44,772	49,641	44,931	40,770	46,476	41,863	52,227	543,784
Capital Payment	9,738	1,925	1,323	1,802	3,587	2,322	2,277	3,052	2,773	2,439	3,008	9,169	43,415
Other items (Specify in narrative)	15,801	2,891	17,084	2,836	9,095	16,775	2,913	8,717	17,075	3,025	9,268	10,600	116,080
TOTAL PAYMENTS	**137,092**	**103,782**	**142,252**	**103,763**	**120,740**	**137,166**	**109,703**	**119,681**	**135,219**	**107,688**	**117,798**	**138,579**	**1,473,463**
Net cash inflow/outflow	11,952	(6,839)	1,915	3,225	(6,000)	(2,535)	527	1,244	(2,214)	2,173	1,960	(5,408)	
Balance b/f	881	12,833	5,994	7,909	11,134	5,134	2,599	3,126	4,370	2,156	4,329	6,289	

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Appendix 5

PROGRESS AGAINST CRL AS AT 28th FEBRUARY 2018

Approved CRL issued March 3rd 2018 £'000s	41,975

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	3	2	(1)	3	3	0
Rookwood Emergency Works	733	617	(116)	1,445	946	(499)
Relocation of Central Processing Unit	0	0	0	0	0	0
Neonatal Phase 2	11,989	11,990	1	15,935	15,935	0
Primary Care Fees	18	8	(10)	125	125	0
Gamma Cameras	485	339	(146)	672	339	(333)
Anti Ligature Works	172	80	(92)	500	400	(100)
CRI Wards 14 and 14(a)	1,281	1,022	(259)	1,601	1,601	0
Genomics	426	171	(255)	1,060	1,060	0
Implementation of WIFI	250	0	(250)	600	600	0
National Clinical Information Systems	50	0	(50)	448	198	(250)
Modular Theatre Llandough	1,802	1,807	5	1,697	1,807	110
Interventional Radiology Suite UHW	0	0	0	1,500	1,500	0
ICF-Mental Health Barry Hospital	0	8	8	198	248	50
Cyber Attacks Equipment	0	0	0	180	180	0
WEDINOS Equipment	0	0	0	431	431	0
Imaging Equipment	0	0	0	100	100	0
Sub Total	**17,209**	**16,044**	**(1,165)**	**26,495**	**25,473**	**(1,022)**
Discretionary:						
I.T.	451	371	(80)	1,110	1,360	250
Equipment	803	519	(284)	1,949	2,854	905
Statutory Compliance	1,701	1,606	(95)	2,845	2,845	0
Estates	13,647	13,362	(285)	18,293	18,160	(133)
Sub Total	**16,602**	**15,858**	**(744)**	**24,197**	**25,219**	**1,022**
Donations:						
Ronald McDonald House, Oakgrove Foundation & Endowments	5,728	5,728	0	6,465	6,465	0
Sub Total	**5,728**	**5,728**	**0**	**6,465**	**6,465**	**0**
Asset Disposals:						0
West Wing	1,750	1,750	0	1,750	1,750	0
The Former Filling Station at Llandough	10	10	0	10	10	0
CRC Credits Surrendered	212	212	0	212	212	0
Longcross House	280	280	0	280	280	0
Sub Total	**2,252**	**2,252**	**0**	**2,252**	**2,252**	**0**
CHARGE AGAINST CRL	**25,831**	**23,922**	**(1,909)**	**41,975**	**41,975**	**0**
PERFORMANCE AGAINST CRL (Under)/Over £'000s		**(18,053)**			**0**	

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PERFORMANCE REPORT
Name of Meeting : Board Meeting **Date of Meeting :** 29 March 2018
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

11

SITUATION

The full Performance Report sets out the UHB's performance against Welsh Government (WG) Delivery Framework and other priority targets up to February 2018 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 (January = 21, March = 23/58) and is making satisfactory progress towards delivering a further 23 (January = 23, March =13).

Since the last report one measure has improved to amber:

#15 – The proportion of formal complaints responded to within 30 days has increased steadily from 43% to 55% in December and is presently at 74%.

Six measures have deteriorated. These are:

#1 The UHB is now unlikely to achieve the 75% standard for vaccination within the community, despite a marked improvement in uptake of the influenza virus compared with last year,. Our present rate is 70.8% for the over 65 year population and 49% for the high risk population aged <65.

#28 – Performance against the first and second of the four stroke bundles has fallen from 43% and 95% to 23% and 90% respectively. It is expected that as a UHB we demonstrate sustained continuous improvement.

#43 – The proportion of episodes coded within 30 days fell to 94.9% in December. The expected standard is 95%.

#54 – The number of patients waiting over 12 hours to be admitted, discharged or treating within the Emergency Unit increased to 290 in February. The WG standard is that no patient waits over 12 hours, whilst the UHB's delivery trajectory was to limit the number to a maximum of 175 during quarter 4.

#59 – The cumulative 12 month annual rate of sickness absence deteriorated to 5.04%, the highest rate. The UHB's IMTP improvement trajectory sought to deliver a reduced rate of 4.2% for the 12 months to March 2018.

#61 - The proportion of ambulance handovers completed within 15 and 60 minutes of arrival reduced to 31% and 71% respectively in February. The Welsh Government standard is 60% and 100% respectively, whilst the UHB's improvement trajectory was to deliver performance against the 60 minute handover rate of circa 84%.

#62 – The number of patients whose care is delayed increased to 46 at the census date in February 2018 from 38 in December. The objective is to deliver a 10% reduction on the March 2017 census position, (which was 46 patients).

There are now 19 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. Performance data can be accessed via http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/322147.

Policy Objective	Green	Amber	Red	Score
Delivering for our population	8	10	2	13/20
Delivering our service priorities	2	2	2	3/6
Delivering sustainably	7	7	11	10.5/25
Improving culture	1	4	4	3/9
Total	18	23	19	29.5/60

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 and delayed transfers of care
- GP Out of Hours services
- Stroke
- Cancer
- Elective access including dementia and diagnostic waiting times and postponed admissions
- Healthcare Acquired Infections
- Staff sickness

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.

ASSESSMENT

1) MENTAL HEALTH

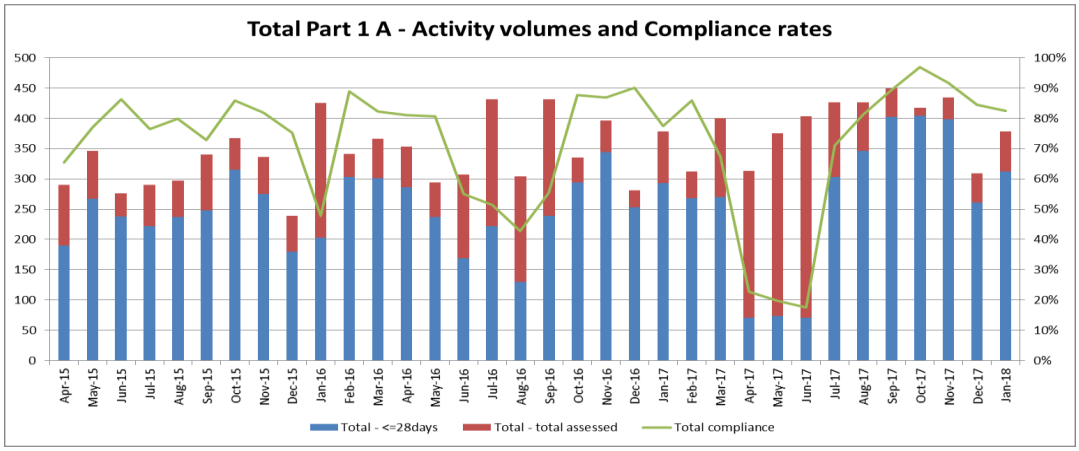
How are we doing?

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

Overall 83% of service users seen in January 2018 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%.

Whilst overall the UHB was compliant with the Welsh Government's standard, there has been a significant deterioration in access into the Children's and Adolescents' service, where compliance has fallen from 86% in October down to 36% in February.

Both the adult and older people's services achieved the standard of 80%, delivering 93% and 88% respectively. Referral volumes received by the adult and older people's services over the 2017 calendar year averaged almost 900 per month, a slight increase on the previous year. However as noted in the risk section of this report, CAMHS demand, measured by resource required to meet the need, has almost doubled in 18 months, during which time the service has struggled to achieve a full establishment of staff to provide the service.



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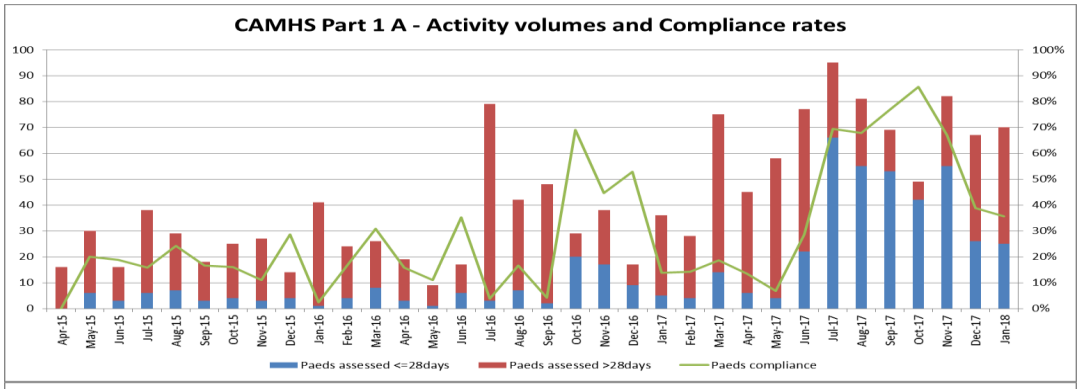
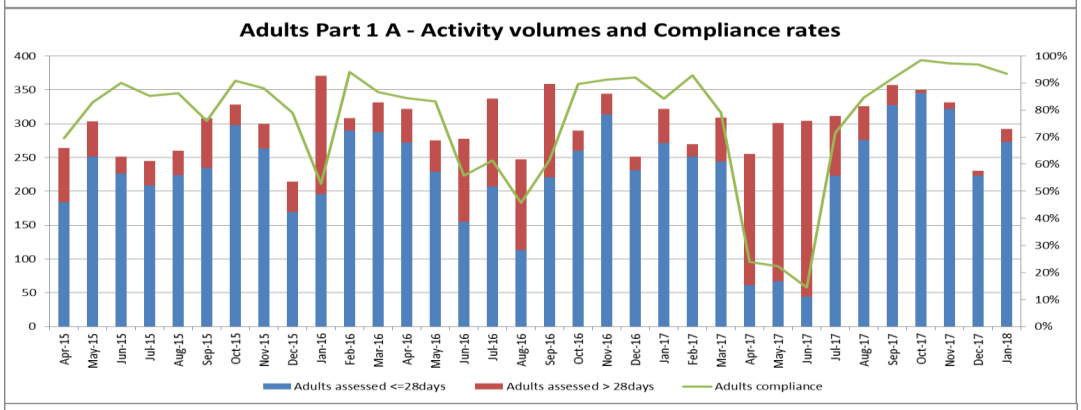
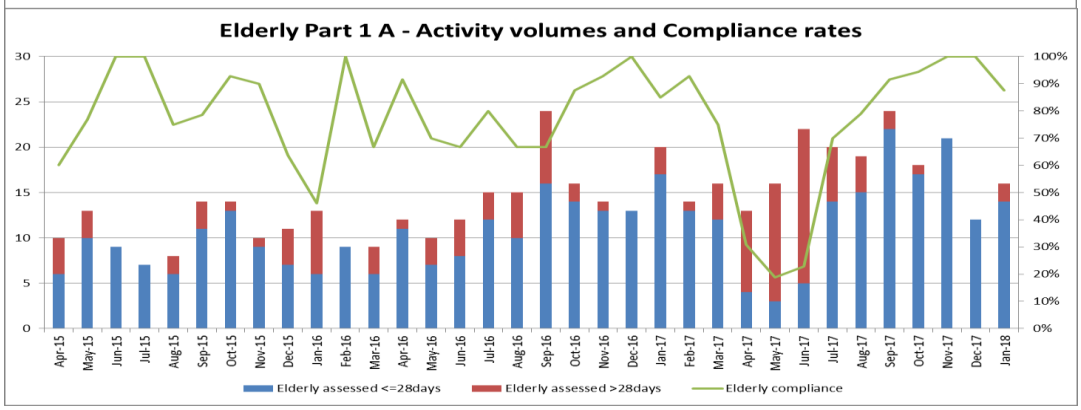






Part 1b: Overall 79% of service users started a therapeutic intervention following assessment by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of their assessment against a standard of 80%**.**

Part 2: Overall 90.1% of LHB residents had a valid Community Treatment Plan completed at the end of November. Performance remains above the standard of 90%.

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?

The UHB's level of performance is similar to that of other Health Boards in Wales, as per the data for December 2017:

December 2017	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	80.5%	80.8%	90.0%	100.0%
ABM	65.3%	70.4%	89.4%	100.0%
AB	80.8%	83.2%	90.4%	100.0%
BCU	80.9%	81.8%	89.3%	100.0%
C&V	84.5%	86.0%	90.0%	100.0%
CTaf	84.8%	83.3%	87.5%	100.0%
HDda	86.8%	86.4%	93.9%	100.0%
Powys	85.7%	77.7%	91.0%	100.0%
Rank	4/7	2/7	4/7	-/7

What are the main areas of risk?

Whilst the number of referrals into the adult mental health system has started to plateau, demand for the Children and Young Peoples service continues to increase rising from c. 300 hours work per month in the Summer of 2016 to 550-600 in January 2018. 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. This is presently materialising due to vacancies and sickness absence.

A further reputational risk facing the board is associated with the delivery standard for part 1b: "commencement of therapy". The standard is not sensitive to the group-based model used by the organisation for proving many of the interventions. Group based interventions being less effective when there are breaks in their delivery. Consequently groups are scheduled to be completed prior to the holiday periods, resulting in variation in performance against a monthly access indicator. Discussions within the community of practitioners which advises WG are scheduled to take place shortly to consider the options.

What actions are we taking?

The Child and Adolescent service are delivering the following actions which it is anticipated will result in the position being recovered by the end of March:

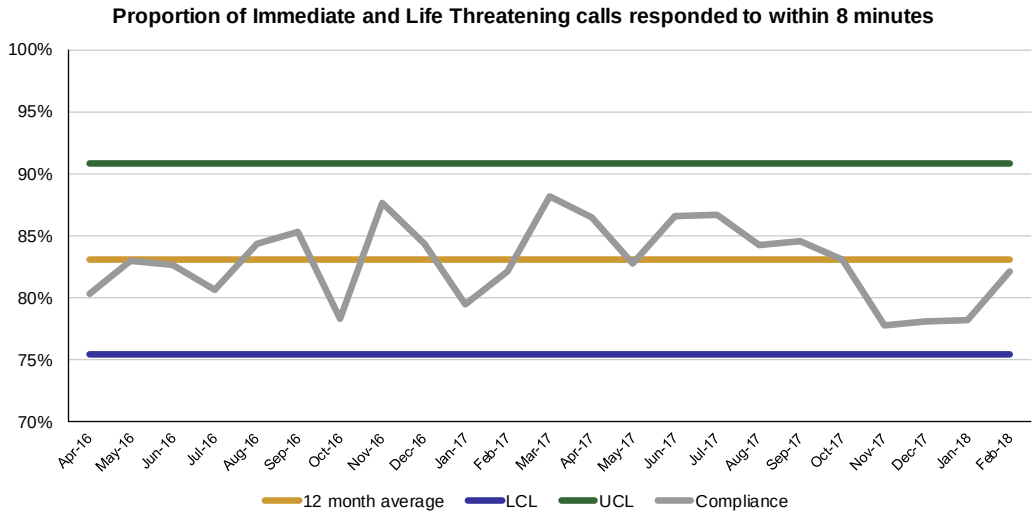
- Pre appointment screening introduced and telephone triage in place where appropriate. This tends to be for older young people.

- Senior staff member in the CYP team prioritising telephone assessment for Young People 16 -17 year olds (7 in this age range awaiting assessment as of 12th January)
- Working with Adult PMHSS to use bank options for young people 17 plus. 7 young people fall into this age range and need to be assessed before 24th January so we have sourced 4 bank shifts (2 each shift)
- Additional support sourced from part time staff member in Cwm Taf CAMHS to do a clinic on a Friday afternoon. 3 cases until the end of March.
- Additional clinics being undertaken by a Child Psychologist as extra hours (22 cases seen in last 3 months)
- Evening clinics being planned to run dependent on availability of bank staff between now and year end.
- New staff starter 0.5 WTE in February and offer to be made to candidate on the reserve list from last interviews for a 0.5 post, this will leave the service with only a 0.5 vacancy.

In respect of part 1b, a service plan for delivery of the Matrics Cymru, which has resulted in an increased level of demand for a wider variety of specific one-to-one psychological interventions, is being considered.

2) UNSCHEDULED CARE

The proportion of immediate and life threatening calls responded to within 8 minutes remains stationary around a mean of 83%, above the Welsh Government target of 70%.



In respect of ambulance handover delays, performance in February had fallen to 31% for patients handed over within 15 minutes and 71% of patients handed over

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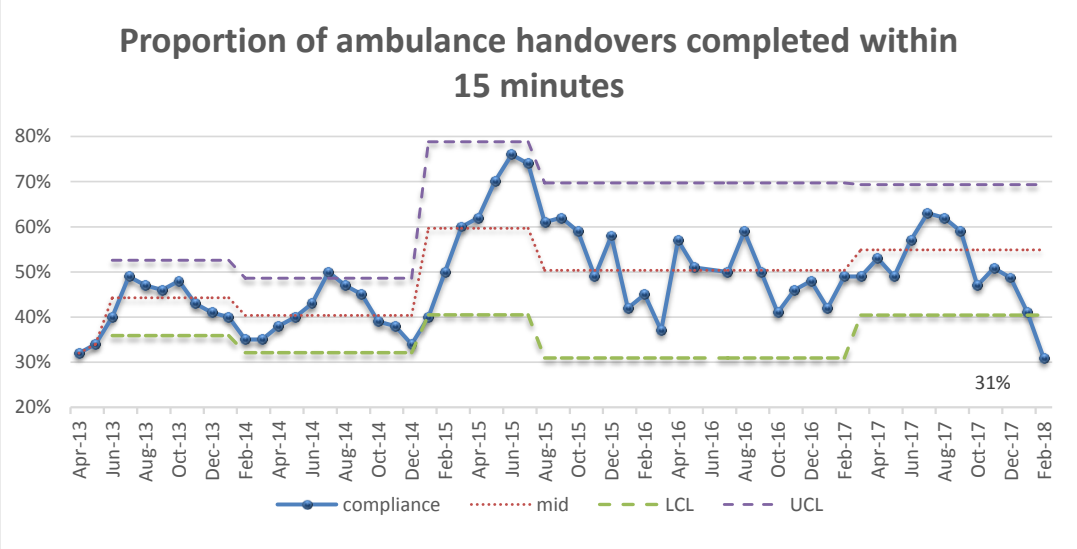
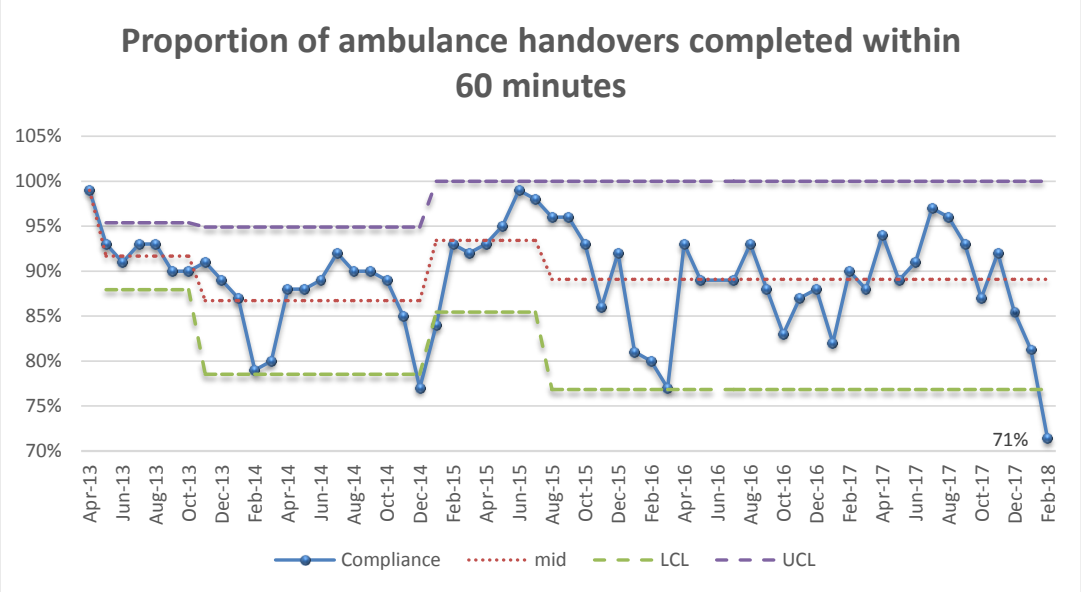
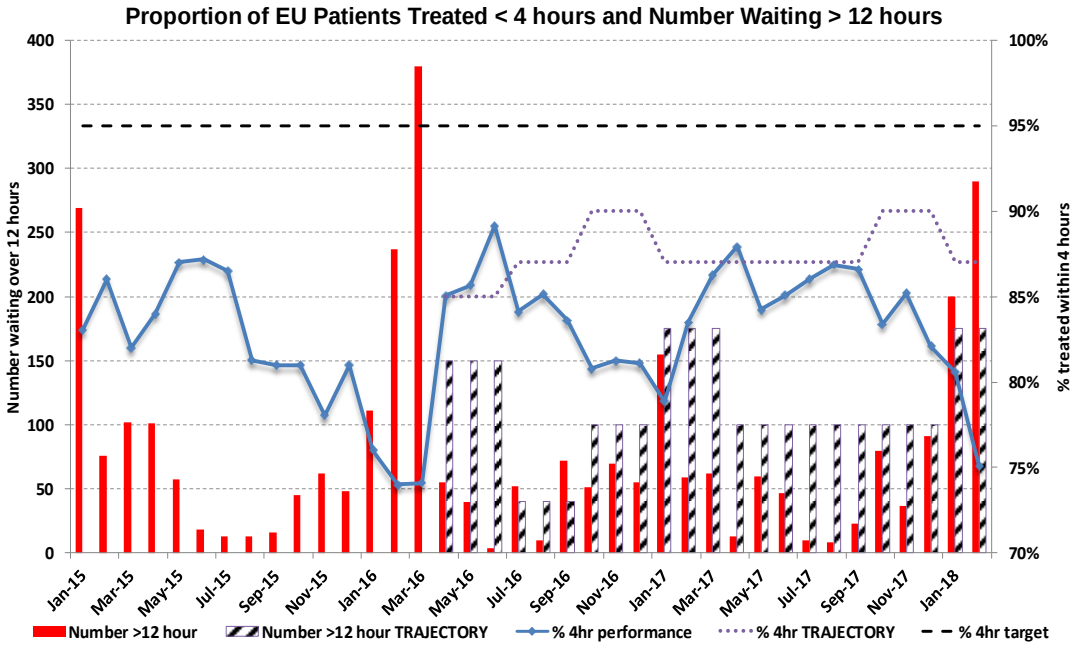
within an hour. Performance in this area is highly volatile, suggesting the service lacks resilience.





The proportion of patients admitted, discharged or transferred within 4 hours fell in February to 75.1%, against the WG expected level of performance of 95% and the UHB's IMTP trajectory of 87%. The number of patients waiting in excess of 12 hours increased to 290, which is above the IMTP trajectory of 175 and in excess of WG's standard of zero. 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.



At the February 2018 census point, the UHB recorded that 46 patients had their care pathway delayed as per formal WG rules. The number of bed days attributed to patients whose care was delayed was 972 in the month, equating to 35 beds per day. This continues the downward trend and meets the Welsh Government's expectation to deliver continuous reduction.

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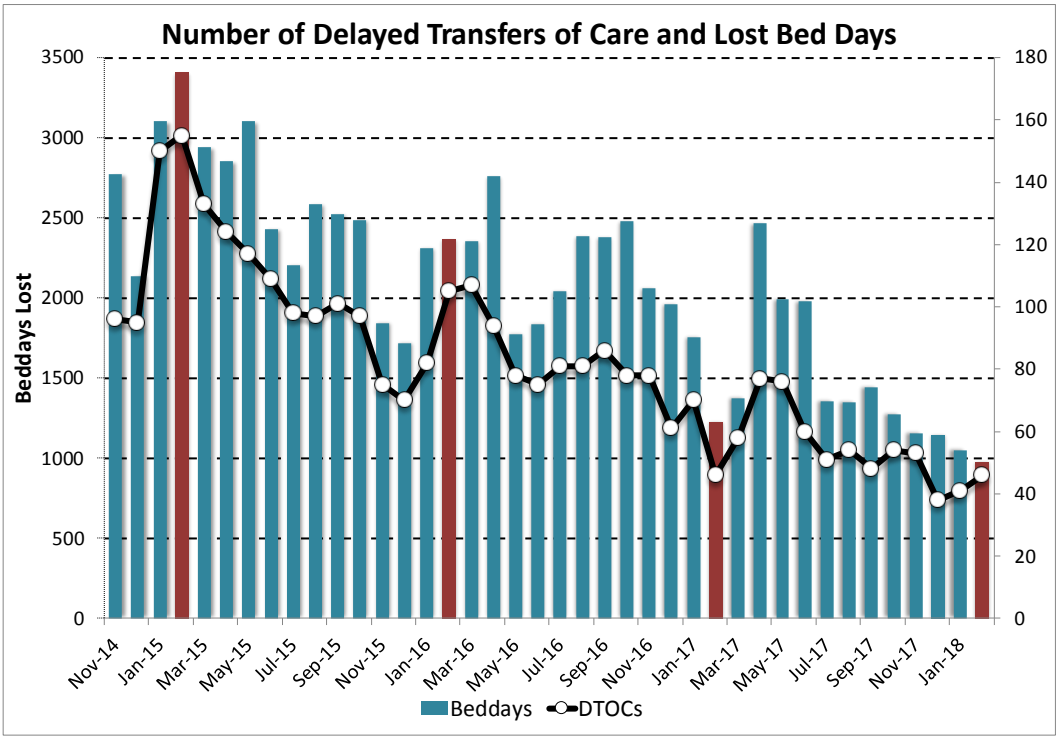

How do we compare with our peers?

The latest performance data available indicates that C&V performs within or better than the Welsh average.

Month	Jan-18	Jan-18	Jan-18	Jan-18
HB	4 Hour	Patients >12Hrs	Red Call<8 Minutes	Ambulance Waits>1 Hr
ABM	76.1%	924	66.1%	1030
AB	76.7%	726	71.1%	503
BCU	72.7%	1820	70.0%	1598
C&V	80.6%	200	78.2%	430
CT	79.3%	731	67.3%	11
HD	83.2%	710	65.2%	287
Wales	78.0%	5111	69.7%	3951
C&V Rank	2/6	1/6	1/6	3/6

The UHB has the 4th 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. Recognising that for the past 5+ years, the UHB has been the worst performer in this area, this position would indicate that the levels of improvement made by the UHB in improving the discharge process and our approach to integrated care are relatively far better than those seen in other Health Boards

January-18		Wales	ABM	AB	BCU	C&V	CT	HDda	Powys	C&V Rank
No. of DTOCs per 10,000	Non Mental Health (Age 75+)	142.7	120.7	179.9	159.6	150.2	126.0	79.9	185.3	4/7
	Mental Health (all Ages)	3.2	6.2	1.8	2.8	2.5	2.8	2.8	3.2	2/7

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 the UHB has put in place a number of additional schemes across the whole system as part of its Winter Plan. In addition, we progressed a number of further schemes with the additional Welsh Government Winter monies. All of the schemes are predicted on ensuring the quality and safety of services is maintained. These include:

- Additional Senior Decision makers at key times, including weekends and out of hours to help both maintain the flow at the front door and on wards to maximise discharges
- Tactical deployment of additional bed capacity, flexing bed capacity up and down in response to demand and operational pressures
- Maximising our integrated models of care – CRT; Integrated discharge team; Increased capacity for Residential Discharge to Assess services
- Increased GP OOH resilience in line with demand
- Robust procedure in place for the management of infectious incidents and outbreaks, including the isolation and cohorting of patients admitted with respiratory infections, D&V or flu. When necessary, we have increased our IP&C support and advice over 7 days a week
- Dedicated clinical team to focus on the management of outliers
- Continued joint working with WAST to develop and implement new EU attendance avoidance pathways e.g. gynaecology, mental health, ACS
- A 6 week Hospital Avoidance Pilot commenced on 26th February, a joint project between WAST and the UHB. The scheme involves an Emergency Nurse Practitioner, OT and Physiotherapist supporting a paramedic to identify suitable patients who could be managed in their own home or residential/nursing home. The aim is to reduce the number of admissions to the Emergency Unit

Planning for the Easter Period has commenced, with all Clinical Boards currently finalising their plans to meet the unscheduled care challenges during and directly after Easter. The plans include maintaining bed capacity, securing senior clinical decision makers, ensuring experienced members of Clinical Board teams are available over the period and other general resilience and escalation measures.

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 February, the UHB achieved the following:

- 8 areas were reported as Green (5 reported for December)
- 1 areas was reported as Amber (2 reported for December)
- 8 areas were reported as Red (10 reported for December)

	Demonstrates that a standard has been achieved		Total Contacts= 9899				Total Contacts= 8978			
	Demonstrates that a standard is within 10% of being achieved		Total Clinical Contacts Recorded on Adastra = 8532				Total Clinical Contacts Recorded on Adastra = 7781			
	Demonstrates that a standard has **not** been achieved		**Jan-18**				**Feb-18**			
	Demonstrates volumes only									
Standard	**Description**	**Target**	Total	Result	Score		Total	Result	Score	
Telephone Services										
Telephone Calls	Number of calls answered within set timeframes	95% ans. in 60 seconds	8969	7769	87%		8289	6675	81%	
		100% ans. in 120 seconds	8969	8353	93%		8289	7314	88%	
Abandoned Calls	Number of callers who abandon their attempt after 60 secs.	No more than 5%	8969	189	2%		8289	276	3%	
Handling	% of calls recording the correct patient demographic information	100% Correct	8969	8969	100%		8289	8289	100%	
Telephone Triage Services										
Urgent Triage	Number of urgent calls, logged & returned within set timeframes	98% triaged within 20 minutes	2694	1964	73%		2474	1672	68%	
Routine Triage	Number of routine calls, logged & returned within set timeframes	98% triaged within 60 minutes	3870	2684	69%		3629	2451	68%	
Immediate Life Threatening (ILT) Conditions										
Referral	Number of life threatening conditions identified	100% within 3 minutes	264	264	100%		210	210	100%	
Home Visiting										
Home Visits	The number and percentage of home visits	No target	8532	616	7%		7781	561	7%	
HV P1 (Emergency)	The number of face to face contacts within one hour	75% seen within one hour	16	7	44%		9	8	89%	
	The number of face to face contacts within two hours	100% seen within two hours	16	14	88%		9	9	100%	
HV P2 (Urgent)	The number of face to face contacts within two hours	98% seen within two hours	219	142	65%		218	156	72%	
HV P6 (Less Urgent)	The number of face to face contacts within six hours	98% seen within six hours	381	249	65%		334	209	63%	
Primary Care Centre Appointments										
PCC	The number and percentage of PCC attendances	No target	8532	2397	28%		7781	2294	29%	
PCC P1 (Emergency)	The number of face to face contacts within one hour	75% seen within one hour	7	6	86%		4	3	75%	
	The number of face to face contacts within two hours	100% seen within two hours	7	7	100%		4	4	100%	
PCC P2 (Urgent)	The number of face to face contacts within two hours	98% seen within two hours	296	206	70%		318	248	78%	
PCC P6 (Less Urgent)	The number of face to face contacts within six hours	98% seen within six hours	2094	2019	96%		1972	1908	97%	
Transmissions										
Transmissions	The number of reports sent to GP Practice by OOH	100% by 9am	10241	10241	100%		8938	8938	100%	
Other Data										
Rota	Shift fill rate (reported in hours)	100% of shifts filled	4607	3599	78%		3488	2752	79%	
Complaints/Incidents										
Complaints	Total number of complaints received & number upheld	No target		8				1		
Compliments	Total number of compliments received	Volume only		4				3		
Significant Events	Total number of significant events recorded	Volume only		1				0		
Serious Incidents	Total number of serious incidents recognised	Volume only		0				0		

Call volumes have reduced from the peak observed in December and are broadly in line with demand experienced in January and February of 2017. The proportion of shifts filled has increased back up to 79% from 72% in December.

The proportion of home visits for patients prioritised as “emergency” which were provided within 1 hour continues to fluctuate wildly, between limits of 41% and 97%. The mean performance is 69% compared with the Welsh Government’s delivery standard of 75%.

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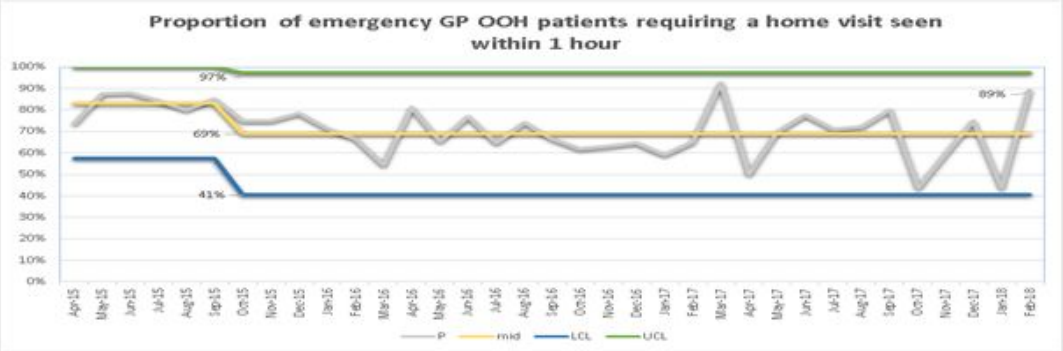
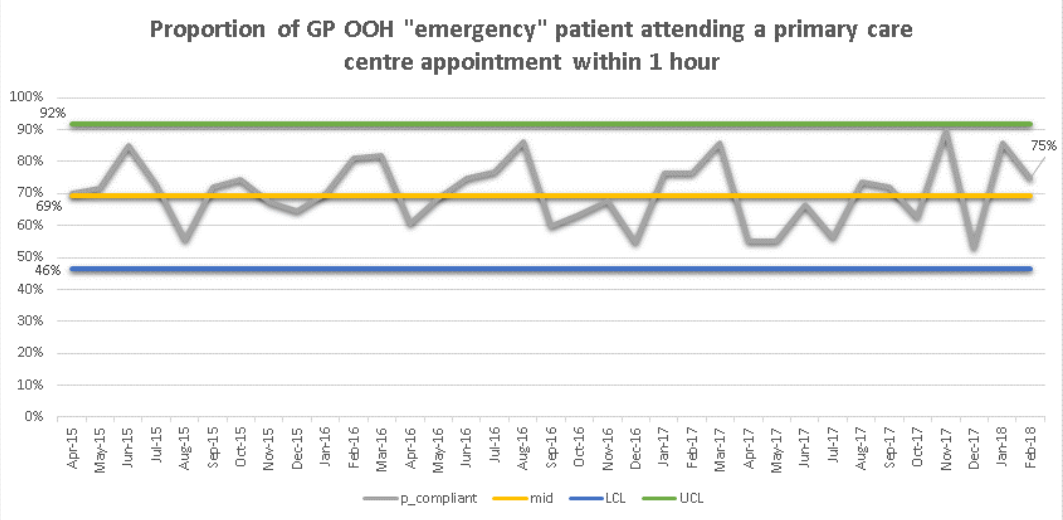


The proportion of primary care centre appointments provided within 1 hour for those prioritised as “emergency” was 75% in February. Performance has remained within the same process control limits for the past 34 months.



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How do we compare with our peers?

Welsh Government have chosen to publish comparative data for 2 of the indicators relating to the timeliness of urgent triage and the timeliness of consultations for urgent patients. It is understood that organisations are in a state of transition in terms of their reporting, prior to the new definitions, presently used by C&V, being uniformly applied across Wales from April.

It is also understood from data incorporated within previous service presentations that C&V categorise almost 100% more calls as urgent than the other Health Boards. This is the result of a clinical decision taken following a serious clinical incident within the service.

Dec-17	ABM	AB	BC	C&V	CT	HD	Powys	C&V Rank
%Urgent calls logged & patient started definitive clinical assessment <=20 mins of call being answered	No data	84%	58%	61%	57%	55%	98%	3/6
% very urgent patients seen<= 60 mins following clinical assessment	No data	66%	50%	74%	71%	33%	70%	1/6

What are the main areas of risk?

The two areas of concern are:

- An ability to provide home visits within 20 minutes for all areas of Cardiff and Vale when considering the geographical area covered and the variation in average travel times across our dense urban areas.
- The ability to attract staff onto the roster at certain times of the week and the subsequence reliance on bank staff, who provide less certainty as to their availability.

What action are we taking?

A process to look at changing the skill mix and rostering of the multi-disciplinary team providing the service has begun. As part of this:

- A 3 month pilot to examine the effectiveness of deploying a Paediatric Advanced Nurse Practitioner and a triage nurse with a background in Paediatrics has commenced.
- Exploring, with the University, opportunities to deploy Advanced Paramedic in the out of hours service in the future.
- A 3 month pilot to examine the potential to use clinical practitioners including those with a paramedic background to complement the capacity to provide home will start in April
- A clinical practitioner staffing bank is being set up with the intention of having access to additional capacity on a flexible basis.
- Options for improving the career progression of the clinical practitioners is being considered, as a means of recruiting and retaining high quality individuals.
- Joint working arrangements have been established with Cardiff University to provide mentorship and exposure to the Out of Hours service for students undertaking the “Advanced Clinical Practice” qualification.

4) STROKE

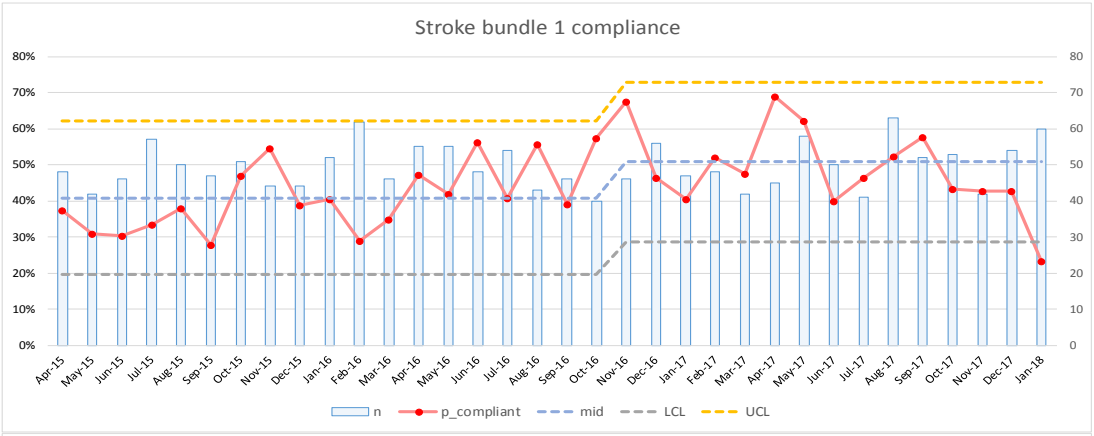
How are we doing?

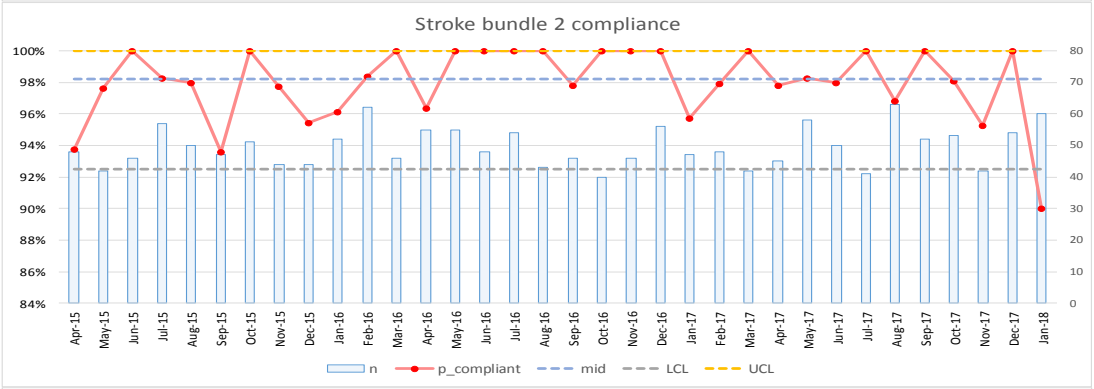
The expectation on the UHB is to demonstrate continuous improvement over the course of the year with the objective of achieving the SSNAP UK average by the end of the financial year. (SSNAP is the audit tool used throughout the UK to record detailed data on stroke patients treated in hospitals).

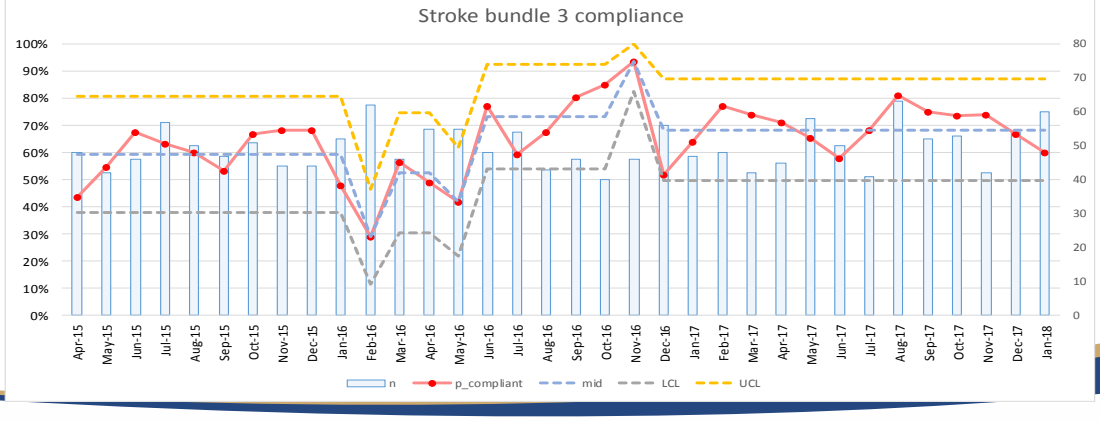
The Welsh Government has chosen four areas within the Quality Improvement Measures (QIMs) to focus on for All-Wales benchmarking. There is a target for three of them, whilst an improvement trend is required for the other.

WG benchmarking standard		IMTP trajectory	UHB in Jan-18
4 Hour QIM	Direct Admission to Acute Stroke Unit within 4hours	60%	21%
12 Hour QIM	CT Scan within 12 hours	96%	90%
24 Hour QIM	Assessed by a Stroke Consultant within 24 hours	89%	80%
45 Minute QIM	Thrombolysis Door to Needle within 45 minutes	Improve	14%

Trends in performance in delivering the full bundles are shown below. These indicate that there have been significant deteriorations in performance against the 4 and 12 hour bundles:







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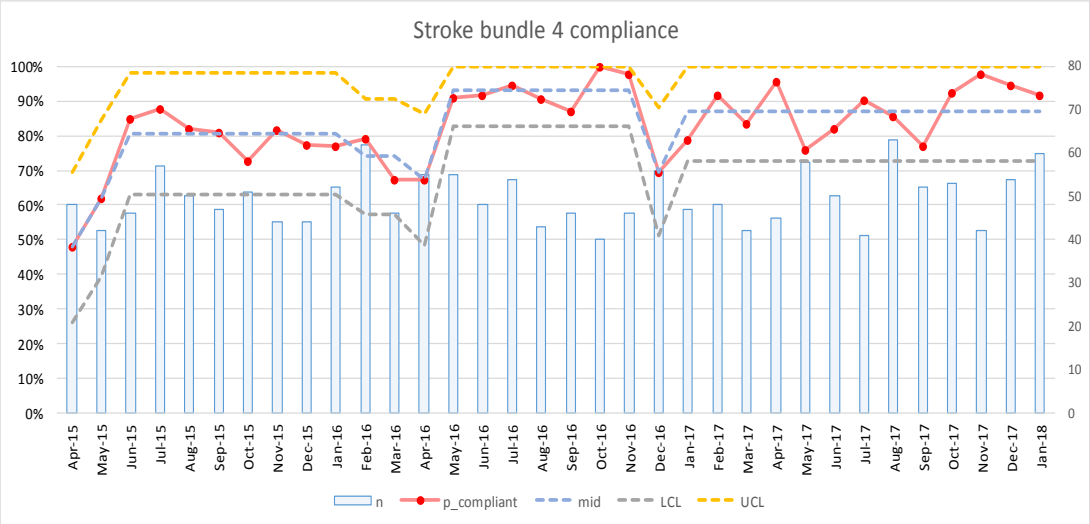


The following table shows the UHB's performance against all of the QIMs:

Stroke Care Performance Indicators	*Jan-17*	*Feb-17*	*Mar-17*	*Apr-17*	*May-17*	*Jun-17*	*Jul-17*	*Aug-17*	*Sep-17*	*Oct-17*	*Nov-17*	*Dec-17*	*Jan-18*
1. Access													
1a - Percentage of All Stroke Patients Thrombolysed	17.0%	20.8%	16.7%	17.8%	17.2%	10.0%	7.3%	15.9%	19.2%	11.3%	9.5%	14.8%	11.7%
1b - Percentage of Eligible Stroke Patients Thrombolysed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2. Time													
2a - Thrombolysed Patients with Door-to-needle <=30 mins	12.5%	10.0%	0.0%	0.0%	10.0%	40.0%	0.0%	20.0%	20.0%	0.0%	25.0%	12.5%	0.0%
2b - Thrombolysed Door-to-needle <=45 mins	37.5%	40.0%	14.3%	12.5%	10.0%	40.0%	33.3%	40.0%	30.0%	0.0%	25.0%	12.5%	14.3%
2c - Thrombolsyed Patients with Onset-to-Needle <=90 mins	12.5%	0.0%	0.0%	0.0%	10.0%	20.0%	0.0%	10.0%	10.0%	0.0%	0.0%	0.0%	0.0%
2d - Thrombolysed Patients with Pre and Post Thrombo NIHSS	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	66.7%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%
72 Hour Pathway Care KPIs													
1. Within 4 Hours Care KPI	40.4%	52.1%	47.6%	68.9%	62.1%	40.0%	46.3%	52.4%	57.7%	43.4%	42.9%	42.6%	23.3%
1a - Direct Admission to Acute Stroke Unit	43.2%	53.3%	46.2%	67.5%	62.3%	42.6%	50.0%	52.5%	57.1%	44.9%	48.7%	45.1%	21.4%
1a - TRAJECTORY for above	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%
1b - Swallow Screening	76.7%	74.5%	75.0%	82.9%	81.5%	63.8%	71.8%	71.7%	76.0%	66.0%	70.0%	73.6%	50.0%
2. Within 12 Hours Care KPI	95.7%	97.9%	100.0%	97.8%	98.3%	98.0%	100.0%	96.8%	100.0%	98.1%	95.2%	100.0%	90.0%
2a - CT Scan	95.7%	97.9%	100.0%	97.8%	98.3%	98.0%	100.0%	96.8%	100.0%	98.1%	95.2%	100.0%	90.0%
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%
3. Within 24 Hours Care KPI	63.8%	77.1%	73.8%	71.1%	65.5%	58.0%	68.3%	81.0%	75.0%	73.6%	73.8%	66.7%	60.0%
3a - Assessed by a Stroke Consultant	74.5%	89.6%	92.9%	86.7%	86.2%	76.0%	78.0%	95.2%	92.3%	92.5%	73.8%	77.8%	80.0%
3b - Assessed by a Stroke Nurse	97.9%	89.6%	95.2%	95.6%	93.1%	90.0%	97.6%	96.8%	92.3%	88.7%	92.9%	88.9%	78.3%
3b - TRAJECTORY for above	88.0%	88.0%	88.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
3c - Assessed by One of OT, PT, SALT	72.3%	87.5%	81.0%	84.4%	75.9%	72.0%	85.4%	85.7%	82.7%	81.1%	100.0%	90.7%	88.3%
4. Within 72 Hours Care KPI	78.7%	91.7%	83.3%	95.6%	75.9%	82.0%	90.2%	85.7%	76.9%	92.5%	97.6%	94.4%	91.7%
4a - Formal Swallow Assessment	41.7%	82.4%	76.9%	85.7%	73.7%	65.0%	82.4%	82.6%	75.0%	89.5%	100.0%	96.0%	95.7%
1a - TRAJECTORY for above	84.0%	84.0%	84.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
4b - OT Assessment	100.0%	93.3%	90.0%	100.0%	86.3%	94.0%	93.9%	92.9%	93.8%	91.3%	97.4%	94.0%	92.6%
4c - Physiotherapy Assessment	100.0%	97.9%	95.2%	100.0%	94.3%	98.0%	97.3%	95.0%	93.9%	100.0%	100.0%	98.1%	98.1%
4d - SALT Communications Assessment	88.9%	96.7%	90.9%	95.7%	75.0%	76.9%	90.9%	84.2%	78.8%	93.9%	100.0%	100.0%	100.0%
Patients Treated per Month	47	48	42	45	58	50	41	63	52	53	42	54	60

How do we compare with our peers?

The latest available benchmarking data across Wales is for January 2018, indicating that the UHB's relative performance has deteriorated against 3 of the 4 bundles.

HB	ABM	AB	BCU	C&V	CT	HD	Wales	C&V Rank
4 Hours	32%	39%	40%	21%	50%	60%	40%	6/6
12 Hours	93%	97%	90%	90%	100%	100%	95%	5/6
24 Hours*	Not reported due to data change							
Door to Needle <= 45 Minutes	0%	10%	0%	14%	20%	57%	17%	3/6

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.

What actions are we taking?

4hr Target:

- 90-day transformation programme is underway; 1wte senior nurse and 0.6wte management time has been dedicated to stroke.
- Stroke Escalation Plan has been developed
- Daily huddle established to review breaches within the last 24hrs and plan for the 24hrs ahead
- Review the Code Stroke 2 pilot pathway - the aim is to reduce the number of inappropriate calls to the stroke team
- In the process of developing an educational plan for wards in UHW and UHL to highlight the Code Stroke process for inpatients who stroke
- SOP has been developed for patients on Stroke Rehabilitation Centre who do not require stroke specific rehabilitation / do not have rehab potential
- SOP has been developed for patients on A6s and SRC who were admitted as medical outliers, stroke mimics or who are palliative who no longer require stroke specific input
- Implemented weekly MDT and IDS discharge planning meetings for medically fit patients on SRC – our ALOS on SRC has halved since these meetings have been implemented

Thrombolysis:

- Code Stroke 1 pathway was process mapped and a pilot is being implemented to further embed elements of the Helsinki Model – commenced 12.03.18. Aim is to reduce the “door to needle” time
- Root Cause Analysis forms are being completed at weekly breach meetings for patients who have breached the 45 min target.

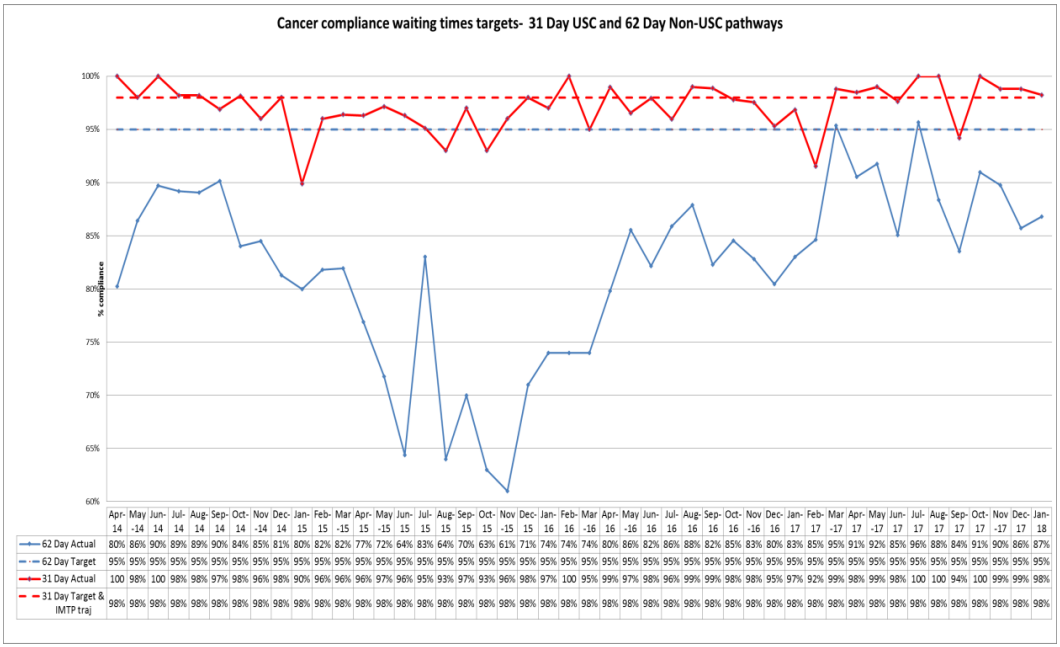
5) CANCER

How are we doing?

The UHB met the Non-USC 31 day target in January for the fourth consecutive month, with reported performance 98.25%.

Reported performance against the USC 62 day target in January was 86.79%, a 1% improvement on last month but below the UHB's IMTP trajectory. There were 14 breaches in month, of which 7 (50%) related to GI.

Year to date, we continue to show improvement over the previous three years



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	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	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
62 Day Actual	80%	86%	90%	89%	89%	90%	84%	85%	81%	80%	82%	82%	77%	72%	64%	83%	64%	70%	63%	61%	71%	74%	74%	74%	80%	86%	82%	86%	88%	82%	85%	83%	80%	83%	85%	95%	91%	92%	85%	96%	88%	84%	91%	90%	86%	87%
62 Day Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
31 Day Actual	100	98%	100	98%	98%	97%	98%	96%	98%	90%	96%	96%	96%	97%	96%	95%	93%	97%	93%	96%	98%	97%	100	95%	99%	97%	98%	96%	99%	99%	98%	98%	95%	97%	92%	99%	98%	99%	98%	100	100	94%	100	99%	99%	98%
31 Day Target & IMTP traj	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Single Cancer Pathway (SCP)

The UHB continues with implementation of the SCP. The main issues for the UHB were outlined in a previous brief. The UHB had submitted a bid to the Wales Cancer Network for Project Management Support for 2018-19

How do we compare with our peers?

In December 2017, the UHB was 1 of 3 Health Boards compliant with the 98% delivery standard for the 31 day non-USC pathway. No health boards delivered the 95% 62 day USC standard.

Dec 2017	ABM	AB	BCU	C&V	CT	HD	Wales	C&V

								Rank
Non USC	94.0%	95.4%	99.3%	98.8%	100%	94.3%	96.8%	3/6
USC	82.4%	89.9%	88.0%	85.7%	87.3%	90.1%	87.2%	5/6

What are the main areas of risk?

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

- GI continues to be the single biggest issue for the UHB. Whilst the issues are fully understood, these are multi-factorial. Actions to address these are being progressed - see actions being taken section below.
- We continue to treat patients in turn or according to their clinical priority but remain aware that our backlog of untreated patients waiting > 62 days fluctuates and remains too high. The UHB needs to further reduce the backlog across all tumour sites to be assured of continuous improvement and achieving the levels of performance set out in our IMTP.

What actions are we taking?

The UHB remains committed to maintaining and sustaining improvement. As reported above, the single biggest challenge for the UHB is GI. The issues are multi-factorial with a range of actions, therefore, being progressed:

- Pathway redesign project in GI – Process mapping has shown that pathway redesign is required to ensure all patients can be seen and treated within 62 days, particularly those that require multiple diagnostics. This work, along with reducing clinical variation, is being taken forward by the GI Pathway Improvement Project Team. Led by the by Medical Director, this has full clinical and managerial engagement.
- Reduction in waiting times – The UHB continues with implementation of its endoscopy plan to reduce the backlog and balance demand and capacity, thereby improving patient experience and access to endoscopy services. WG improvement monies for 2017/18 and in particular additional capacity through insourcing (commenced 27th Jan) are supporting the Directorate in balancing waiting times and clinical urgency
- Strengthening tracking – Tracking resource between Clinical Boards (Surgery and Medicine) is now aligned with a joint weekly meeting in place. To further strengthen tracking and expediting of patients through the GI pathway, the Cancer Services team are progressing with automating feeds and bringing GI onto the UHB's cancer tracking IT system (Tentacle). It is anticipated that this will be live in March 2018.
- A direct telephone booking process has been trialled and full implementation is now being for USC endoscopy appointments. In addition direct booking for endoscopy from outpatient clinic appointments is now in place.

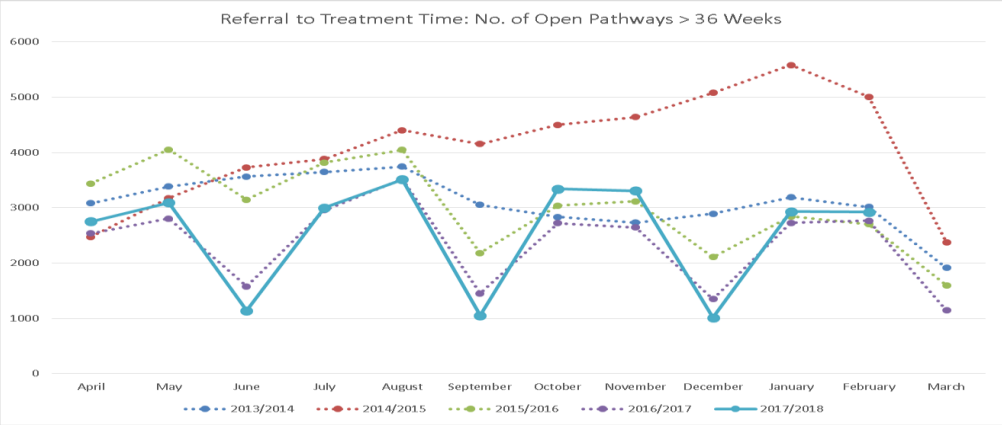
In addition:

- Enhanced performance management arrangements remain in place, including monthly Cancer Challenge and Support meetings with Clinical Boards chaired by the Chief Executive Officer
- All Directorates have been asked to secure additional capacity, where possible, between now and the end of March, to bring activity forward, thereby both improving timeliness of access and experience for patients and performance. Patients continue to be tracked at both Directorate and UHB level, with actions escalated as appropriate.

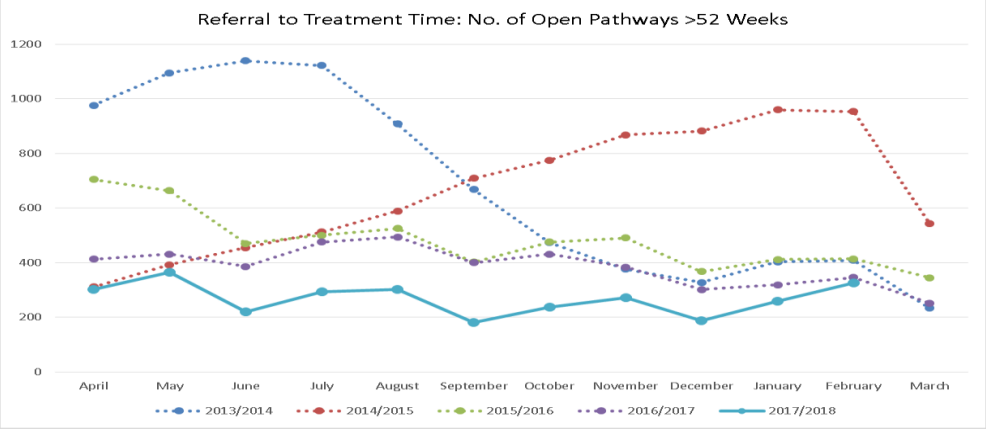
6) ELECTIVE ACCESS

How are we doing?

The UHB has marginally improved on its position from January and is expecting to meet its target for year end.



There has been an increase in the numbers of our longest waiting patients; there were 326 patients waiting greater than 52 weeks (259 in January).



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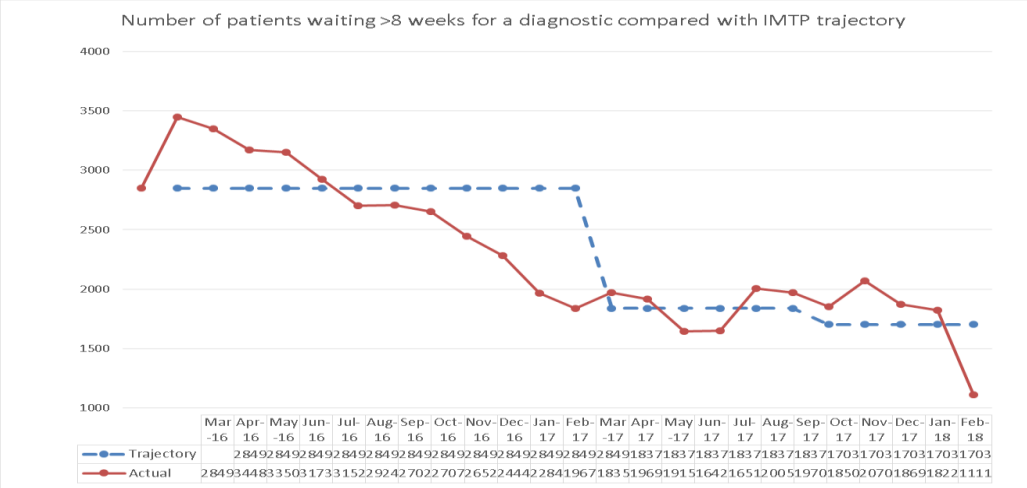
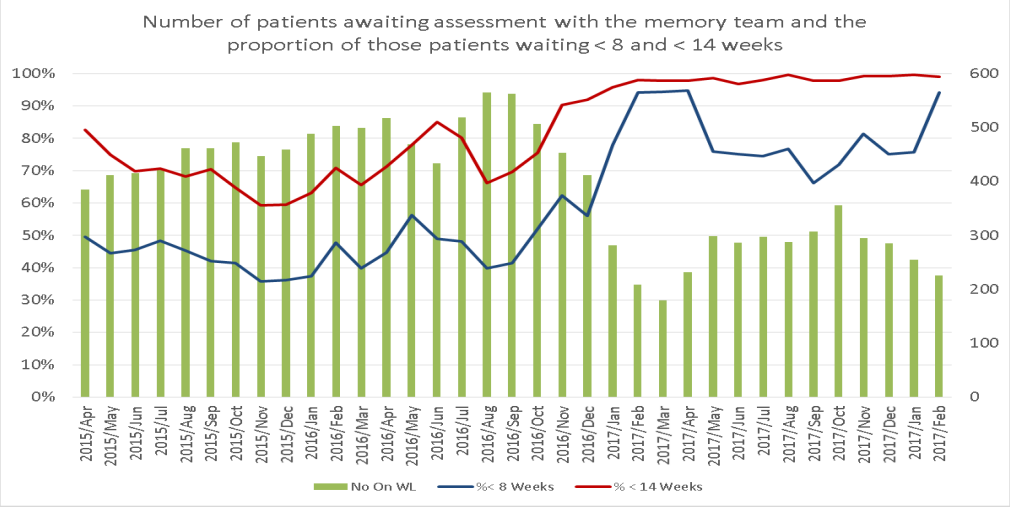
There were 11,558 patients waiting in excess of 26 weeks on an elective referral to treatment time pathway at the end of February, equating to 86% of patients waiting under 26 weeks. This performance meets the 86% improvement trajectory submitted in the annual plan.

The February position for the number of patients waiting more than 8 weeks for a diagnostic test is 1,111; this exceeds the IMTP target by nearly 600. This has largely been possible as a result of the in-souring of gastroenterology services this quarter.



At the end of February 2018, 99% of patients requiring a memory assessment were waiting less than 14 weeks, against a standard of 95%. The number of patients waiting less than 8 weeks, improved from 75%% in December to 94% in February 2018. Since October 2017 GP-led clinics have been reinstated to stabilise the waiting list and reduce the worsening trajectory. This has reduced the waiting times down to a present maximum of 10-12 weeks.



How do we compare with our peers?

The All-Wales waiting time position at the end of October 2017, shown below, indicates that Cardiff & Vale ranked 5th for the % of patients waiting less than 26 weeks, 3rd for the lowest number of patients waiting in excess of 36 weeks and 7th for the number of patients waiting in excess of 8 weeks for a diagnostic.

As at 31/12/16	Wales	ABM	AB	BC	C&V	CT	HD	Powys	C&V Rank
% < 26 weeks - RTT	86.0%	85.3%	89.2%	79.8%	84.7%	85.8%	83.2%	100%	5/7
No. > 36 weeks - RTT	19446	4716	1607	10365	1012	994	3309	0	3/7
No.>8 weeks diagnostic	9134	0	1510	1123	1869	1676	0	1	7/7

What are the main areas of risk and how are we mitigating them?

A key risk remains elective procedure cancellations as a result of both bed and critical care pressures, with a further snow warning given for the weekend of the 16th March.

The Health Board lost a significant amount of activity due to the snow and is currently off track in meetings its' year end targets of 800 for patients waiting in excess of 36 weeks, and 998 patients waiting in excess of 8 weeks for a diagnostic.

Whilst some of the RTT position has been recovered through commissioning of additional WLIs, there are still a number of other recovery plans that will need to be realised for the Health Board to meet its target. The key ones are additional activity from ophthalmology insourcing (commences 17th March); and further additional WLI activity for a number of specialties.

The reported diagnostic position for February 2018 was 1111 patients waiting greater than eight weeks. This represents a 41% reduction since the end of the last quarter and is in line with additional activity commissioned from the Welsh Government improvement monies. Recovery plans to address the loss of activity associated with the snow are continuing to be put in place to bring the Health Board back on plan. These include additional endoscopy lists over the Easter bank holiday and commissioning radiology activity from external providers.

7) HEALTHCARE ACQUIRED INFECTIONS

How are we doing?

Welsh Government Reduction Expectations 2017/18

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.

The numbers of cases recorded up to the end of Februaryr within the UHB is shown below alongside a straight line trajectory for delivery.

Target Organism	Total Allowable for 2017/18	Month 11 target	Apr-Feb 2018
C. difficile	126	115	115
***S. aureus* (Total)**	96	88	140
E. coli	290	266	316

Included within the *S. aureus* total were 14 MRSA cases against a target of zero.

Position as at the end of February:

C. difficile: With one month to go the UHB are now on target to achieve the reduction expectation for *C. difficile.* We must have fewer than 11 cases of *C. difficile* during March to achieve the required target. As at 12th March there have been 3 cases of *C. difficile* confirmed across the Health Board.

***Staph. aureus* blood stream infections*:* The** UHB can no longer achieve the *Staph. aureus* bacteraemia reduction expectation. We have increased our numbers of *Staph. aureus* bacteraemia against the previous year and have also seen more cases of MRSA bacteraemia than last year.

***E.coli* blood stream infections:** The UHB are now unable to achieve the reduction expectation for *E.coli* bacteraemia by end of March 18. It is however likely that we will be able to demonstrate a reduction in cases compared with 2016/17. We will need to ensure that we continue the work to reduce this burden of disease during 2018/19.

How do we compare with our peers?

***C. difficile, S. aureus* bacteraemia and *E. coli* bacteraemia monthly commentary, up to Feb 18**

Reduction expectation summary (Apr 17 - Feb 18)

Number and rate of *C. difficile, S. aureus* bacteraemia and *E. coli* bacteraemia per 100,000 population by health board, Apr 17 - Feb 18

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	243 (+118)	50.17	183 (+87)	37.78	486 (+164)	100.35
AB UHB	201 (+68)	37.60	137 (+36)	25.63	420 (+95)	78.57
BC UHB	254 (+89)	39.89	185 (+58)	29.05	485 (+59)	76.17
C&V UHB	115 (=0)	25.65	140 (+52)	31.23	316 (+50)	70.49
CT UHB	54 (=0)	19.79	95 (+41)	34.82	254 (+72)	93.11
HD UHB	143 (+52)	40.73	121 (+51)	34.46	415 (+180)	118.19
All Wales	1042 (+304)	36.58	865 (+297)	30.36	2390 (+487)	83.90

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

As can be seen from the above summary Cardiff & Vale HB and Cwm Taf HB are on target to achieve the reduction expectation for *C. difficile* by end March 2018. No other Health Board is on target to deliver on any of the HCAI reduction expectations

for 2017/18.

2017/18 FY summary (Apr 17 - Feb 18)

Number and rate of *C. difficile*, MRSA bacteraemia, MSSA bacteraemia and *E. coli* bacteraemia per 100,000 population by health board, Apr 17 - Feb 18

More cases than Apr 16 – Feb 17
Same cases as Apr 16 – Feb 17
Fewer cases than Apr 16 – Feb 17

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		*E. coli* bacteraemia	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
ABM UHB	243	50.17	19	3.92	164	33.86	486	100.35
AB UHB	201	37.60	15	2.81	122	22.82	420	78.57
BC UHB	254	39.89	38	5.97	147	23.09	485	76.17
C&V UHB	115	25.65	13	2.90	127	28.33	316	70.49
CT UHB	54	19.79	10	3.67	85	31.16	254	93.11
HD UHB	143	40.73	9	2.56	112	31.90	415	118.19
P THB	21	17.36	0	0.00	1	0.83	3	2.48
V NHST	11	N/A	0	N/A	3	N/A	11	N/A
All Wales	**1042**	**36.58**	**104**	**3.65**	**761**	**26.71**	**2390**	**83.90**

* Rate per 100,000 population

When the number of cases seen in April 17 to February 2018 is compared with the same period in 2016/17 it can be seen that Cardiff and Vale has seen a reduced number of cases of *C. difficile* and also fewer cases of *E.coli* BSI, *Staph. aureus* BSI (MRSA & MSSA) cases have increased compared with 2016/17 figures.

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

Once the Welsh Health Circular is received from Welsh Government providing detail of the improvement goals to be achieved by end March 2019 we will need to develop an organisational plan to address the requirements for 2018/19.

Otherwise our planned work remains as highlighted below.

***C. difficile**:* Work to reduce *C. difficile* through focussing on hotspots, improving early isolation of patients with diarrhoea, improving treatment and adhering to antimicrobial prescribing guidance appears to be making a difference to our numbers of cases month on month. We need to understand what is making the difference and ensure that the good work is spread across the whole organisation and sustained, so that our numbers of *C. difficile* cases continue to decrease.

Staphylococcus aureus: As a UHB we are refreshing our approach to reducing this burden of infection focussing on medical device management and implementation of ANTT across the Health Board and more focussed work in the community related to wound management and prevention of infection in substance misusers. With regard to the increases in MRSA bacteraemia, we need to reverse the upward trend in cases urgently, and through clinical boards, will bring back a focus on not tolerating cases of MRSA and preventable infections.

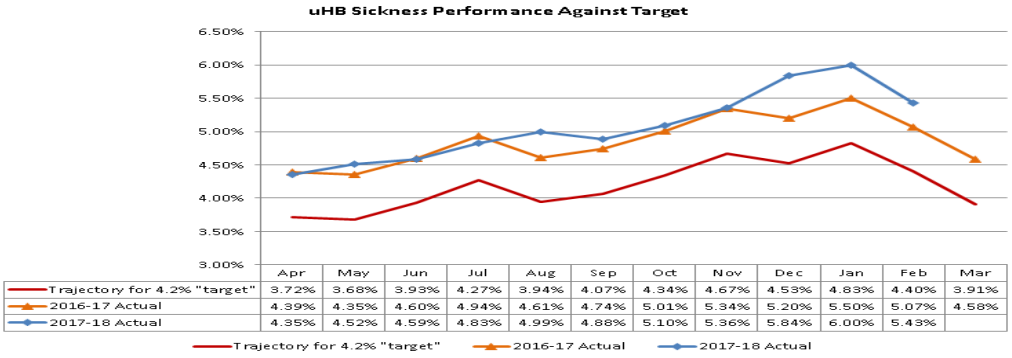
E.coli: Our figures for *E.coli* blood stream infections are lower in April 17 to February 2018 vs the same period in 2016/17. It was a challenging new target introduced this year and one which the UHB cannot now achieve by the end March 2018. However, tracking our cases month on month has shown the significant burden of infection that is related to *E.coli* blood stream infections and we have seen some improvement. As this target is linked to the UK Antimicrobial Resistance Strategy commitment to reduce Gram negative blood stream infections by 50% by 2020/21 there will be further pressure to make improvements over the coming years.

A significant burden of *E.coli* blood stream infection presents from the community, but even so, it is estimated that a significant proportion of these cases are healthcare associated and therefore potentially preventable. We have started a UTI improvement group through the PCIC clinical board to take forward work in the community to improve the management of UTI and urinary catheters in the community with a view to that feeding into reductions in *E.coli* BSI. This work needs to continue and to move from pilot work to spreading good practice and improvements in UTI prevention and management across the broader healthcare services of the Health Board as soon as possible.

8) Staff Sickness

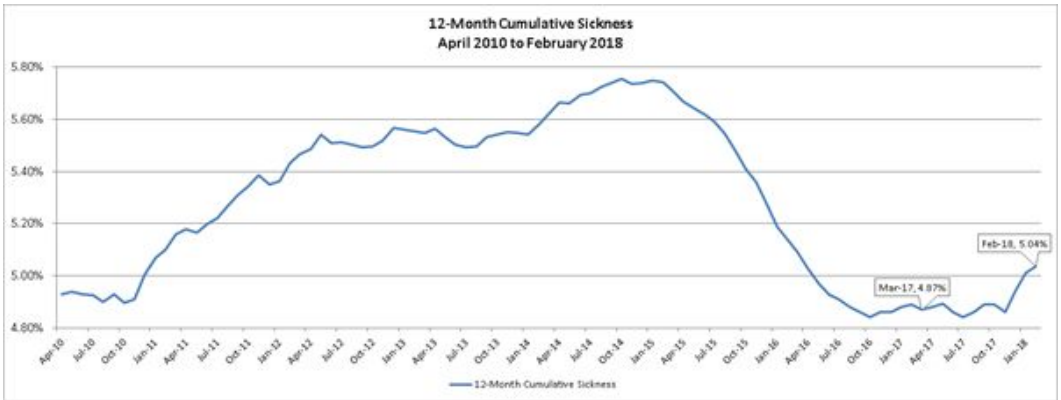
How are we doing?

In February absence rates due to sickness equated to 5.43% of planned working hours (capacity). This is 1% higher than the seasonal delivery trajectory required for the UHB to deliver on its 4.2% improvement target.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory for 4.2% "target"	3.72%	3.68%	3.93%	4.27%	3.94%	4.07%	4.34%	4.67%	4.53%	4.83%	4.40%	3.91%
2016-17 Actual	4.39%	4.35%	4.60%	4.94%	4.61%	4.74%	5.01%	5.34%	5.20%	5.50%	5.07%	4.58%
2017-18 Actual	4.35%	4.52%	4.59%	4.83%	4.99%	4.88%	5.10%	5.36%	5.84%	6.00%	5.43%	

The 12 month cumulative rate of sickness has increased above 5% for the first time since April 2016 to 5.04% by the end of February. This level of absence equates to 639 whole time equivalents being absent every calendar day, or each whole time equivalent having 18 days sickness per annum. The actual direct cost of this level absence being assessed as £19.2m, £3.6m above the UHB's annual plan.



How do we compare with our peers?

For the 12 months up until October, the UHB had sickness rates comparable with the better levels of performance seen in the other HBs

	ABM	AB	BC	C&V	CT	HD	Powys	C&V Rank
Oct-17	5.6%	5.2%	4.9%	4.9%	5.5%	4.9%	4.7%	4/7

What are our key areas of risk?

The ability to provide safe, high quality services to meet our population's needs and expectations within the resources available is dependent on the having sufficient levels of staffing with the right competencies and training in work at the right time. Higher levels of staff absence threaten service sustainability and can wider system inefficiencies.

What actions are we taking to improve?

The overall aim for Health and Wellbeing in C&V UHB is to embed a proactive, holistic and sustainable approach to maximising attendance within C&V. The Health and Wellbeing Advisory Group sets the strategic Direction of Health and Wellbeing at work for all staff and encourages and endorses a culture of Health and Wellbeing for staff in line with the Gold and Platinum Corporate Health Standard.

The Health and Wellbeing Group are refreshing and re-enforcing our Time to Change Plan which tackles mental health discrimination and stigma and encourages our employees to talk about mental health experiences.

We have adopted and are both promoting and encouraging the use of the New Health and Wellbeing guidance tools developed by NHS Wales staff working in collaboration with Trade Unions. The guidance signposts staff to information and resources to enable them to make better choices with regards to their own health and wellbeing and that of others.

Mental Health Champions (Time to Change) and Health & Wellbeing Champions (via Health and Wellbeing Advisory Group) are currently being recruited which will make a positive long term difference to all our staff.

The UHB's Maximising Attendance Group is continuing to lead on operational attendance management, providing a focus on:

- whole system problem-solving of attendance management issues
- Monitoring and early appropriate response to changes in performance in attendance
- Adoption of good and emerging practice from the national Attendance Management and Health and Wellbeing Groups

RECOMMENDATION:

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

DRAFT UHB INTEGRATED MEDIUM TERM PLAN (IMTP) 2018-21	
Name of Meeting : Board Meeting	**Date of Meeting :** 29th March 2018

Executive Lead : Director of Planning
Author : Deputy Director of Planning
Caring for People, Keeping People Well : 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

ASSURANCE AND RECOMMENDATION

ASSURANCE on the development process for the UHB 2018/21 Integrated Medium Term Plan is provided through:

- Continued routine formal dialogue through the Welsh Government targeted intervention process

The Board is asked to:

- **NOTE –** the current position regarding the development of the 2018/21 Integrated Medium Term Plan

12

SITUATION

The draft IMTP was submitted to Welsh Government on 31st January following the last Board meeting on 25 January. Ongoing discussion with Welsh Government have been taking place regarding the plan and formal feedback was received on 13 March 2018.

At this stage the UHB is not in a position to submit an approvable plan for formal submission to Welsh Government by 29th March 2018. Further dialogue will take with Welsh Government in particular in relation to our financial and performance commitments in the next three year period.

It remains the case, supported by Welsh Government that 'Shaping Our Future Wellbeing' provides the right strategic direction and the organisation is making progress in achieving its long term aims.

BACKGROUND

The draft plan had been developed with a strong focus on re-establishing a sustainable service, workforce and financial platform over the next three years whilst ensuring that the UHB continues to make progress in delivering the strategy described in Shaping Our Future Wellbeing.

The Draft IMTP for 2018/21 was broadly well received by Welsh Government, with a recognition of the progress made in recent years. Welsh Government acknowledged the draft plan had a clear narrative aligned to our strategic direction, demonstrated the principles of the Future Generations and Wellbeing Act and set out our collaborative role in working with regional partners.

The emphasis in the draft plan was on maintaining commitment to our strategic objectives whilst delivering some very challenging improvements to service productivity, efficiency as well as significantly reducing our costs through robust grip and control and through our transformation programme. This draft plan requires some difficult choices in the investments we make as a commissioner and a provider of care. It is particularly in these areas of performance and finance where further discussion with Welsh Government is required.

In relation to performance, we are revising our modelling and trajectories. Our performance trajectories in the draft plan submitted in January were based on a realistic assessment of historic performance, which has seen improvement in each quarter, and the financial envelope available. However there is a need to push further and faster in our performance.

We will further engage with Welsh Government over our proposed performance trajectories and the finance required for delivery of improved performance in particular in relation to RTT and diagnostics.

ASSESSMENT

The strategic context is provided by Shaping Our Future Wellbeing remains correct and the broad approach of our plan is correct. Further discussions will take place with Welsh Government over coming weeks and we will keep the Board informed.

Note – The full IMTP can be found in a standalone document both on the "boardbooks" system and our website.

DEVELOPING "THE CARDIFF AND VALE WAY" TRANSFORMATION (making better systems) AND IMPROVEMENT (making systems better)	
Name of Meeting : Board	**Date of Meeting:** March 29th 2018

Executive Lead : Executive Director Public Health/Deputy CEO
Author : Dr Sharon Hopkins 029 2074 8886
Caring for People, Keeping People Well : Transformation underpins the sustainability element of the UHB's strategy "Shaping our Future Wellbeing"
Quality, Safety, Patient Experience impact : Transformation is aimed at improving quality safety and experience for patients, staff and communities
Health and Care Standard Number : 1,3,7
CRAF Reference Number: 1.1,3.1,5.1,5.7,6.7 and 10.1
Equality and Health Impact Assessment Completed: Linked to SOFW and not specifically undertaken at this stage

ASSURANCE AND RECOMMENDATION

ASSURANCE

- The development of the approach to transformation is described
- Health Systems Management Board signs off the projects included in the transformation programme and monitors through highlight reports
- The next phase of development is outlined with seven key strands being taken forward.

The **BOARD** is asked to:

APPROVE

- The continued central role of Shaping Our Future Wellbeing
- The approach to transformation (making better systems) of continuing learning and development

AGREE

- To actively support the next phase of development to implement 'seven strands' in developing the 'Cardiff and Vale Way', incorporating the learning from Canterbury.

14

SITUATION

The UHB has been developing its approach to transformation (making better systems) whilst continuing to drive 'relentless good management' practice and continuing service improvement (making systems better). All three elements are necessary and need to continue. Good management practice gives us a strong base on which to progress, continuous improvement is necessary to

ensure we are continually learning, developing and making things better[1] for people. However we need to actively develop the Cardiff and Vale transformation approach and secure a step change in understanding, ownership, engagement and pace impacting communities, partners, primary care, secondary and tertiary care.

BACKGROUND

The UHB recognized that the first step to sustainability was to develop a clear vision and strategy, this resulted in 'Shaping our Future Wellbeing' 2015 – 2025. Our strategy advocates a population approach considering all we do through a community lens. The strategy supports integrated partnership working, understanding that sustainability will be predicated on an integrated approach with public sector and third sector partners. We have recognized that international evidence on achieving sustainable transformation requires the vision and the direction set to be *'adhered to* ', whilst recognizing that the pathway to achieving the vision may change.

International learning from organisations who have successfully transformed tells us that in addition to a clear vision and strategic direction key factors are:

- A sustained orchestrated approach with oversight (light touch)
- Clinically led design teams with clinical ownership
- Strong focused leadership development through well-developed internal programmes
- A standard approach to design, analysis, improvement and management – ie 'Virginia Mason way'; the Canterbury way'
- An internal support resource
- A well-developed measurement system

We know that SoFW requires clear milestones which should be articulated in the three year rolling IMTP and whilst progress has been made our milestones are not yet fully developed. To support this, strategic level key outcome and performance indicators are required, whilst we have an outline set this work has not completed.

The start

In 2015/16 a focused approach to transformation began, working on driving out variation alongside development work on a descriptor of a 'perfect locality and some defined work on decreasing the length of stay for people waiting longest in our hospital beds. The UHB worked with three Big Improvement Goals (BIG) from September 2015 to November 2017, with a strong communication campaign. The plan was to be supported by an external experienced partner, requiring Welsh Government support. However the intended partnership was not realized and limited the progress made. During this time a well received and engaged refresh of our values and behaviours was completed. Our learning from this period was that:

[1] Making things better for people (community, patients and staff)– quality , experience, activity , efficiency and effectiveness

- The values into behaviours work offers a very strong base to work from
- Whilst three priority areas allowed focus they didn't engage the majority of staff
- The challenge of winning staff commitment and ownership and turning that into sustained change of practice was under-estimated
- Persisting with the agreed programme and ensuring visibility through-out the UHB required significantly more attention than anticipated
- The ubiquitous belief that new resource was required to enable improvement hampered progress

Phase two
In November 2016, driven by a worsening financial position, the UHB agreed that it needed to ensure it could demonstrate 'grip and control ' of its everyday operations through relentless good management driving efficiency and managing allocated budgets. This was run through the senior leadership teams as a programme called 'Turning the Curve', which emphasized decision making based on a balance of impact on *quality, activity and resource*. It utilised benchmarking and proactive risk sharing and management across the UHB. At this time the senior teams were clear that external consultancy support was not a key to success, recognizing that there is huge talent in our staff and partners which 'just' needs to be harnessed. This potential remains unrealized. The UHB led through 'Turning the Curve', stopped the deterioration in its financial position and delivered its agreed end of year financial deficit (2016/17).

Phase three
From April 2017 the conversation turned to consideration of a sustainable approach to secure an improving financial picture whilst working to deliver SOFW, securing quality and activity improvement for our communities. The decision to broaden the focus for transformation and improvement activity sought to build on previous direction, success and failure. The focus was and remains:

- using clinically agreed pathways to remove variation and ensure high standards
- decreasing out-patient visits on all hospital sites
- improving length of hospital stay for people (to best benchmarks)
- increasing theatre productivity

Given the desire to utilise internal talent and strong clinical leadership, a 'virtual' clinical transformation team was put in place between July and November 2017 with expert managerial, improvement, analytics, digital, finance, OD and project management support. This was to work in an agile way. A light governance structure, an programme and methodology was devised with a view that this would develop and change as we learned how to achieve transformation (*making better systems*) within the UHB so that agility. As an example the role of the new 'Transformation Board' was transferred to the Health Services Management Board in November 2017 to secure the active ownership of the Clinical Board senior leaders. The programme currently has 7 projects in progress (highlight reports available).

Phase four
From July 2017 our CEO introduced a serious consideration of application of international learning on achieving sustainable transformation, into Cardiff and Vale. In particular, the experience of the Canterbury Health Board who visited us in September 2017, began to be looked at in depth. The Canterbury Health Board resonates hugely with our vision and our circumstances and the CEO led a brief visit to Canterbury in November 2017 to extend our learning. We have been exploring their approach and the transferrable learning to support a step change in how we achieve transformation. The CEO set out a proposal for next steps in his paper 'Learning from Canterbury – Proposed Next Steps - December 2017.

ASSESSMENT AND ASSURANCE

The learning

There has been good learning from Canterbury which has given us clear direction on how we can continue to shape our transformation approach. It is clear that whilst we have a good vision and strategy this is not yet embedded far enough throughout the UHB so that everyone is clear how their everyday work can contribute to achieving that vision. Canterbury have built a '*one system, one budget*' ethos into how they have embedded their vision.

We have yet to take a truly population outcomes based approach ensuring that primary care and the need for resilient communities is the lens through which we undertake redesign. Our work on sustainable models for General Practice, clusters and localities needs to serve community needs and drive the shape of the system has to be strengthened.

In developing the 'Cardiff and Vale way' our model of clinically led change could be strengthened utilising some of the 'Alliancing principles' demonstrated in Canterbury. A multiagency and disciplinary approach in which the centrality of the patient or person drives the conversation about service change with the professional leaving their organisation and professional allegiances out of the room.

Canterbury's use of a single health pathways tool to enable clinically agreed pathways to set the standard and to be visible to everyone has demonstrably improved care for people and decreased variation. It has effectively enabled an integrated primary and secondary approach. Although we have many agreed pathways they are not easily accessible or routinely used to drive standards.

The sophisticated use of information to drive decision making which is easily accessible and designed around the clinical need was notable. This was one area that colleagues from Canterbury said with hindsight they would have developed earlier.

Leadership and skills development is aligned with the desired culture (values and behaviours) and vision through a defined approach, locally developed and delivered.

Translation – to the what
In beginning to translate the learning so far to define the 'Cardiff and Vale way', building on elements we already have that are supported by evidence of successful sustained transformation, there are seven strands emerging. These need to be taken forward through an orchestrated programme owned by the Executive and Senior leadership teams and engaging the whole organization. These are in essence enablers or tools to secure new systems, which are designed to become the way we do business and therefore sustainable.

1. Secure a pathways approach and methodology (underway)

2. Secure a refreshed programme for accessible information for clinical staff (including the necessary platform) to drive improvement (underway)

3. Review the programme to secure a digitally enabled organisation and workforce

4. Develop Cardiff and Vale Alliance approach which integrates with partner organisations

5. Develop the 'Cardiff and Vale approach' to management and leadership
(including the learning partnership alliance with Canterbury) which will support culture change and build capability and capacity.

6. Secure the model for primary care to drive a population outcomes approach for the system, enabling sustainability for general practice

7. Embed our vision (SoFW), values and behaviours.

Outlining the how
In moving to the next phase of our transformation programme, the transformation resource will be consolidated into a single resource team to enable best use of expertise within the UHB. Active demonstration of full executive leadership and ownership sees that each strand will have an Executive Sponsor.

The measures of success of the programme will see the 'dial turning on the four areas:

- using clinically agreed pathways to remove variation and ensure high standards
- decreasing out-patient visits on all hospital sites
- improving length of hospital stay for people (to best benchmarks)

- increasing theatre productivity

The detailed projects within each strand are being identified through the methodology already agreed ie benchmarking and service issues. For example the identification of top ten areas which will deliver most benefit through pathway implementation. The process has to accommodate absolute clarity on intended outcome, measures and be accompanied by detailed modelling to quantify impact on the WG targets and the four 'dial' measures. There is work to be done to secure the detail on how each element will be delivered, who will be responsible and the timeline.

Whilst we are putting all of this in place, we know that it has to align with and support the requirement for continuing improvement against Welsh Government targets (quality, activity and finance) with the aim of achieving compliance by the end year three (2020/21). Project content has to be able to flex to support urgent operational issues, as the methodologies and approaches (the seven threads) just become the way we do business. The granular pathways and projects testing and developing new systems will have to be able to deliver on the operational issues of today. Modelling work on expected outcomes and benefits will have to be completed and in doing this we will be drawing on the Canterbury experience alongside others who are actively utilising these tools for systems change.

The transformation approach will work with in the current resource envelope however will seek to secure resource from the Welsh Government Transformation fund in particular to support two areas the population outcome primary care model work and the accessible information for clinical staff to drive improvement. The approach will continue to increase realisation of capability within the organisation.

Not forgetting
Clearly there is much service improvement work already underway and this will continue. There are also regional projects underway (thoracic, Major Trauma Centre); work on the future of UHL and UHW; SoFW in the community; capital and estates developments and programmes under the auspices of the Regional Partnership Board and the Public Services Boards. All of these elements are necessary pieces of our jigsaw, in moving towards our vision. They will be informed by the approach we are taking to transformation as the tools and methods become business as usual.

The Parliamentary review findings and recommendations have informed our approach as have the discussions on value based health care driving towards outcomes.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Annual Audit Report 2017 – Cardiff and Vale University Local Health Board

Audit year: 2017

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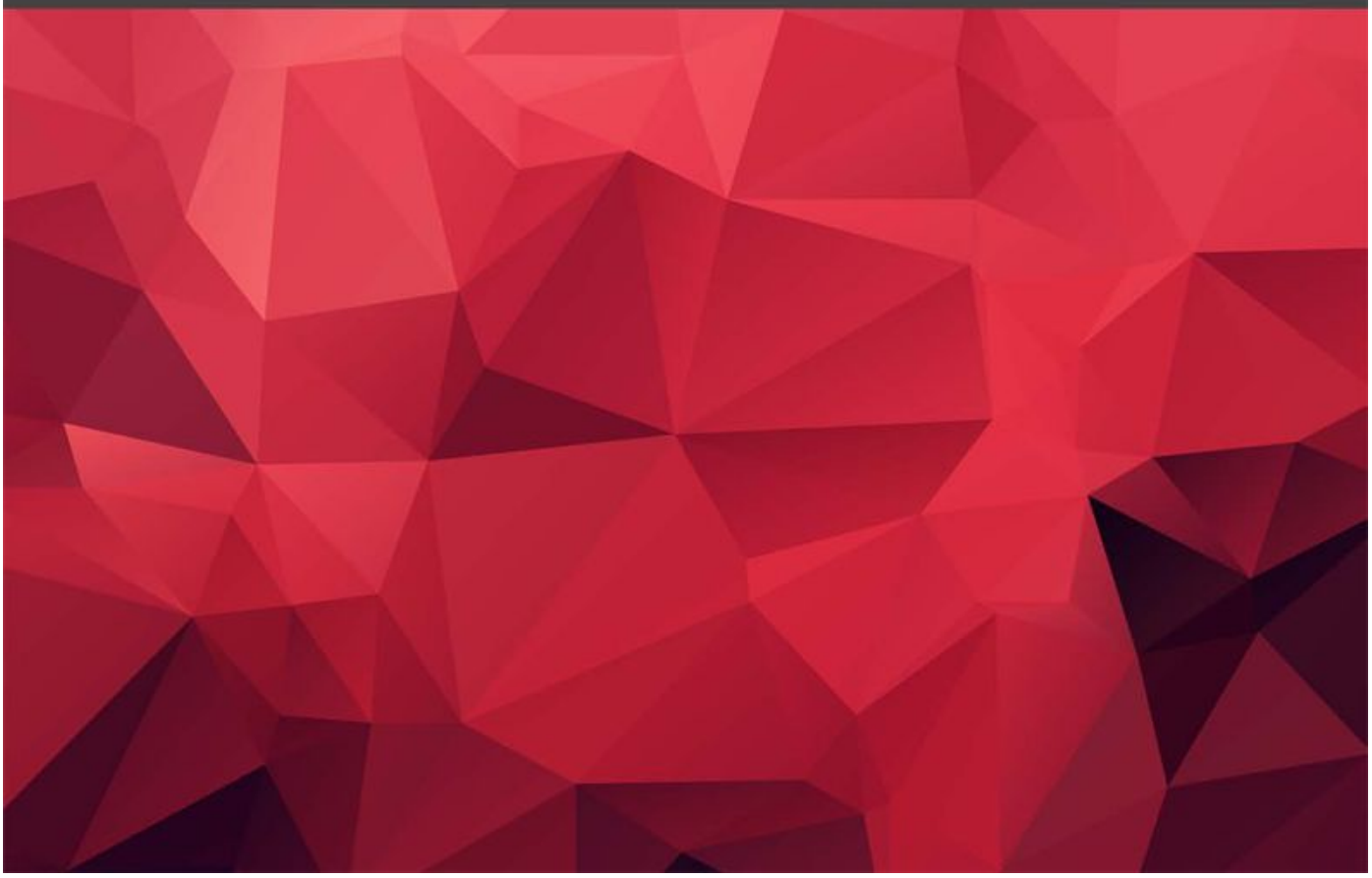

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

The team who helped me prepare this report comprised Anne Beegan, Mark Jones, Dave Thomas and John Herniman.

Contents

Summary report 4

Detailed report

About this report 8

Section 1: audit of accounts 9

While I issued an unqualified opinion on the 2016-17 financial statements being true and fair and properly prepared, I issued a qualified regularity opinion and a substantive report, and in doing so I brought a number of issues to the attention of officers and the Audit Committee 9

Section 2: arrangements for securing efficiency, effectiveness and economy in the use of resources 12

The Health Board now has effective arrangements in place to support the planning and monitoring of savings, but is facing an increased deficit position for the three-year period ending March 2018 13

Operational arrangements are generally effective but there are weaknesses in Board oversight and assurance, and it is unlikely that the new data protection regulations will be met in time 15

The Health Board has responded well to the issues raised in my public interest report that highlighted governance failings around the awarding of certain HR contracts and the appointment of a Director 20

My performance audit work has identified some positive arrangements whilst also identifying some opportunities to secure better use of resources in a number of key areas 21

Appendices

Appendix 1 – reports issued since my last annual audit report 28

Appendix 2 – audit fee 29

Appendix 3 – significant audit risks 30

15

Summary report

Summary

1 This report summarises my findings from the audit work I have undertaken at Cardiff and Vale University Health Board (the Health Board) during 2017. I did that work to discharge my responsibilities under the Public Audit (Wales) Act 2004 (the 2004 Act) in respect of the audit of accounts and the Health Board's arrangements to secure efficiency, effectiveness and economy in its use of resources.

2 My audit work focused on strategic priorities and the significant financial and operational risks facing the Health Board, and which are relevant to my audit responsibilities. The separate reports I have produced during the year have more detail on the specific aspects of my audit. We discuss these reports and agree their factual accuracy with officers before presenting it to the Audit Committee. My reports are shown in Appendix 1.

3 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report, which we presented to the Audit Committee on February 27, 2018. The Board will receive the report at a subsequent Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange wider publication of this report. Following Board consideration, we will make the report available to the public on the Wales Audit Office website.

4 My audit work can be summarised under the following headings.

Section 1: audit of accounts

5 I issued an unqualified opinion on the Health Board's 2016-17 financial statements being true and fair, and properly prepared. I issued a qualified regularity opinion because the Health Board failed to meet its financial duty to manage revenue expenditure within its resource allocation over the three-year period, exceeding its cumulative revenue resource limit of £2.5 billion by £50.5 million.

6 Alongside my audit opinion, I placed a substantive report on the Health Board's financial statements, which explained the financial duties placed on the Health Board by the NHS Finance (Wales) Act 2014, and the reasons the Health Board did not meet those duties for 2016-17. Section 2 of this report has more detail about the financial position and financial management arrangements.

7 While I did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the financial statements, there were some important weaknesses that I brought to the attention of officers and the Audit Committee, which require management action. These issues relate to improving accounting practices and financial reporting, and the quality of the draft Annual Governance Statement.

15

Section 2: arrangements for securing efficiency, effectiveness and economy in the use of resources

8 I have examined the Health Board's financial planning and management arrangements, its governance and assurance arrangements, and its progress on the improvement issues identified in last year's Structured Assessment. I did this to satisfy myself that the Health Board has made proper arrangements for securing efficiency, effectiveness and economy in the use of its resources. I have also undertaken Performance Audit reviews on specific areas of service delivery. My conclusions based on this work are set out below.

The Health Board now has effective arrangements in place to support the planning and monitoring of savings, but is facing an increased deficit position for the three-year period ending March 2018

9 Key findings from my review of the Health Board's arrangements for planning and delivery of financial savings are as follows:

- savings for 2017-18 are well managed, but historical under achievement of savings targets and recent overspends against resource limits means that the Health Board is forecast to have a cumulative increasing deficit position of £61 million by March 2018;
- the planning of savings is aligned to the Health Board's three-year planning cycle and delivery is supported by corporate services, however, there is scope to revisit the allocation of targets to take advantage of areas with greater savings opportunities; and
- there are strong scrutiny and monitoring arrangements of financial savings at Board, committee and operational levels, and good mechanisms for learning lessons.

Operational arrangements are generally effective but there are weaknesses in Board oversight and assurance, and it is unlikely that the new data protection regulations will be met in time

10 Key findings from my review of the Health Board's governance and assurance arrangements are as follows:

- strategic planning is generally effective and increasingly joined up across the organisation, however scrutiny of delivery remains a gap at Board and committee level, despite close monitoring at an operational level;
- the Health Board's organisational structure continues to mature with steps being taken to improve joint working across the organisation, though concerns about corporate governance capacity remain;
- the Board and some of its committees are not providing sufficiently rigorous and consistent oversight, partly due to turnover in membership, and until the

two new committees are fully established, there are risks to assurance on performance and planning;

- the Health Board recognises that risk management needs to improve and is reviewing operational and corporate risk management processes, however due to capacity issues within the corporate governance team this will be a slow process;
- the Health Board's information governance arrangements are not yet developed enough to effectively implement the new General Data Protection Requirements (GDPR) by May 2018;
- operational performance management is robust and comprehensive, but Board and committee oversight is as yet ineffective;
- the Health Board has not yet made effective use of the NFI to detect fraud and overpayments; and
- the Health Board has made mixed progress against my previous structured assessment recommendations and its arrangements for tracking progress against recommendations from our other audit work still need to be improved.

The Health Board has responded well to the issues raised in my public interest report that highlighted governance failings around the awarding of certain HR contracts and the appointment of a Director

11 For the first time in relation to a Health Board, I used my powers under the Government of Wales Act 2006 (Paragraph 19 of Section 8) to report publicly in respect of fundamental weaknesses that I identified in the Health Board's governance and decision-making arrangements.

12 My public interest report highlighted significant governance failures in relation to the award of three contracts for HR consultancy services and the subsequent appointment of a Director. Following the publication of my report, the Health Board responded positively and identified clear actions for improvement. The Audit Committee and Board are overseeing implementation of the actions, with good progress being made.

My performance audit work has identified some positive arrangements whilst also identifying some opportunities to secure better use of resources in a number of key areas

13 Key findings from my performance audit reviews are as follows:

- workforce and estates are increasingly supporting the goals of the Health Board, though informatics is struggling to keep pace;
- whilst operationally the radiology service is well managed, there are risks to the current and future service delivery because of a lack of strategic and business planning, increasing demand, reporting backlogs, aging equipment, and recruitment and retention issues;

- the Health Board has strengthened the governance of GP out-of-hours but performance is mixed and risks remain in relation to the sustainability of the service;
- in respect of discharge planning arrangements, the Health Board has robust improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services;
- the Health Board is not effectively monitoring all of my previous recommendations however my follow up work has identified that the Health Board has made progress in addressing my recommendations on the management of follow-up outpatients;
- collaborative commissioning arrangements have helped drive some important changes for emergency ambulance services in Wales; however, the maturing arrangements require greater commitment from some partners; and
- collaborative arrangements for managing local public health resources do not work as effectively as they should.

14 We would like to thank the Health Board's staff and members for their assistance and co-operation during the audit.

Detailed report

About this report

15 This Annual Audit Report 2017 to the Board members of the Health Board sets out the findings from the audit work that I have undertaken between January and December 2017.

16 I undertake my work at the Health Board in response to the requirements set out in the 2004 Act[1]. That act requires me to:

a) examine and certify the accounts submitted to me by the Health Board, and to lay them before the National Assembly;

b) satisfy myself that the expenditure and income to which the accounts relate have been applied to the purposes intended and in accordance with the authorities which govern it; and

c) satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

17 In relation to (c), I have drawn assurances or otherwise from the following sources of evidence:

- the results of audit work on the Health Board's financial statements;
- work undertaken as part of my latest structured assessment of the Health Board, which examined the arrangements for financial management, governance and assurance;
- performance audit examinations undertaken at the Health Board;
- the results of the work of other external review bodies, where they are relevant to my responsibilities; and
- other work, such as data-matching exercises as part of the National Fraud Initiative (NFI) and certification of claims and returns.

18 I have issued a number of reports to the Health Board this year. The messages contained in this annual audit report represent a summary of the issues presented in these more detailed reports, a list of which is included in Appendix 1.

19 The findings from my work are considered under the following headings:

- section 1: audit of accounts
- section 2: arrangements for securing economy, efficiency and effectiveness in the use of resources

20 Appendix 2 presents the latest estimate on the audit fee that I will need to charge to cover the actual costs of undertaking my work at the Health Board, alongside the original fee that was set out in the 2017 Audit Plan.

21 Finally, Appendix 3 sets out the significant financial audit risks highlighted in my 2017 Audit Plan and how they were addressed through the audit.

15

[1] Public Audit (Wales) Act 2004

Section 1: audit of accounts

22 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2016-17. These statements are the means by which the organisation demonstrates its financial performance and sets out its net operating costs, recognised gains and losses, and cash flows. Preparation of an organisation's financial statements is an essential element in demonstrating appropriate stewardship of public money.

23 In examining the Health Board's financial statements, I am required to give an opinion on:

- whether they give a true and fair view of the financial position of the Health Board and of its income and expenditure for the period in question;
- whether they are prepared in accordance with statutory and other requirements, and comply with relevant requirements for accounting presentation and disclosure;
- whether that part of the remuneration report to be audited is properly prepared;
- whether the other information provided with the financial statements (usually the annual report) is consistent with them; and
- the regularity of the expenditure and income in the financial statements.

24 In giving this opinion, I have complied with my Code of Audit Practice and the International Standards on Auditing (ISAs).

While I issued an unqualified opinion on the 2016-17 financial statements being true and fair and properly prepared, I issued a qualified regularity opinion and a substantive report, and in doing so I brought a number of issues to the attention of officers and the Audit Committee

The Health Board's draft financial statements were properly prepared, materially accurate, and provided to me on time, although there is scope for some further improvement

25 The draft financial statements were submitted on the Welsh Government's deadline of 28 April 2017. There was clear evidence that the financial statements had been subject to good quality assurance checks by both the relevant Health Board officers and the Audit Committee, prior to their submission for audit.

26 I did not encounter any significant difficulties during the audit. I received information in a timely and helpful manner and I was not restricted in my work. The Health Board prepared a detailed closedown plan for 2016-17, which incorporated my audit requirements. This approach helped the preparation and audit of the

financial statements by the target date set by the Welsh Government. I continue to work closely with the Health Board to identify areas where further improvement can be made for 2017-18.

27 I am required to report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee and its Board on 1 June 2017. The Board approved the audited financial statements that day, which I subsequently certified on 7 June 2017.

28 Exhibit 1 summarises the key issues set out in my report to the Audit Committee, as those charged with governance.

Exhibit 1: issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Provision for continuing healthcare costs	The 2016-17 financial statements disclose that over 204 'phase 3' continuing healthcare claims have been received by the Health Board, for which the assessment process remains incomplete (last year we reported that there were over 240 such cases). The Powys Teaching Health Board continues to review these cases on behalf of all NHS Wales organisations, but its progress is slow. The claims may result in significant additional costs to the Health Board, and we have a growing concern that many cases are still not reviewed sufficiently to allow an assessment of possible and probable costs.
The record keeping of plant and equipment assets	Previous audit work had highlighted instances where the Health Board had not consistently used its process for labelling equipment-based assets with a unique identification reference. This year's audit found similar errors, reaffirming my view that the Health Board's recording of its equipment assets is weak.
Accruals for goods and services received not yet invoiced	Previous audit work had highlighted that many of the Health Board's purchase orders are old and are likely to be invalid. For 2015-16, I had estimated that around £1.7 million of these accruals were more than a year old. I established that in response to my audit recommendations, the Health Board had strengthened its review of the accruals and in doing so had cancelled many of them. However, I established that despite this work by the Health Board, there was still some £1.476 million of the accruals for goods and services received prior to 31 March 2016 (ie over a year old).

Issue	Auditors' comments
Annual Governance Statement	Previous audit work had highlighted concerns over the poor quality of the draft Annual Governance Statement (AGS) submitted for my audit, which required numerous amendments. This year I have found that while the Health Board had sought to improve the preparation of its AGS, the preparation process commenced quite late and as a result, incomplete versions of the AGS were submitted for audit, which did improve during the audit due to the input and oversight of the Health Board's new Head of Governance.
Reports generated from the Oracle ledger	As reported the previous year, the automated accounts-payable system feeder is continuing to produce spurious entries in the ledger, which greatly inflate both debit and credit postings.
Related party disclosures	Related party returns are required annually from each member of the Board, in order to inform the disclosures required in the financial statements. Despite the Health Board's repeated attempts, it had been unable to obtain a return from its former Chief Executive, who had left the Health Board in November 2016. In the absence of a return, the Health Board therefore needs to ensure that returns are complete, including for any senior staff that leave during the year.

29 As part of my financial audit, I also undertook a review of the Whole of Government Accounts' return. I concluded that the counterparty consolidation information was consistent with the financial position of the Health Board at 31 March 2017 and the return was prepared in accordance with the Welsh Government's instructions.

30 My separate audit of the 2016-17 Charitable Funds' financial statements is complete, with my findings reported to officers. The audited financial statements were considered by the Charitable Funds' trustees on 25 January 2018 and were certified on 26 January.

The Health Board breached its revenue resource limit for the three-year period to 31 March 2017, which resulted in my qualification of the regularity opinion

31 The Health Board breached its revenue resource limit by spending £50.5 million over the £2.5 billion that it was authorised to spend in the three-year period 2014-15 to 2016-17. This excess spend of £50.5 million constitutes irregular expenditure. I therefore issued a qualified regularity opinion.

32 Alongside my audit opinion, I placed a substantive report on the Health Board's financial statements, which explained the financial duties placed on the Health

Board by the NHS Finance (Wales) Act 2014, and the reasons the Health Board did not meet those duties for 2016-17.

33 Over the same three-year period, the Health Board did not breach its capital resource limit of £167.1 million. The Health Board underspent against this limit of some £217,000.

My work did not identify any material weaknesses in the Health Board's internal controls relevant to my audit of the financial statements, although there are some weaknesses which require management action

34 I reviewed the Health Board's internal controls that I considered relevant to the audit to help me identify, assess and respond to the risks of material misstatement in the financial statements. However, I did not consider them for the purposes of expressing an opinion on the overall operating effectiveness of internal control. On that basis, my review did not identify any significant deficiencies in the Health Board's internal controls, and I have set out my main observations and recommendations (which the Health Board have accepted) within Exhibit 1 above.

35 Further to the Exhibit 1 recommendations, my Engagement Lead issued a separate report to the Health Board's finance officers, which sets out the less significant issues arising. I will consider the progress made by the Health Board in implementing the recommendations as part of next year's audit.

Section 2: arrangements for securing efficiency, effectiveness and economy in the use of resources

36 I have a statutory requirement to satisfy myself that NHS bodies have proper arrangements in place to secure efficiency, effectiveness and economy in the use of their resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- reviewing the Health Board's planning and delivery of financial savings and their contribution to achieving financial balance;
- assessing the effectiveness of the Health Board's governance and assurance arrangements through my structured assessment work, including a review of the progress made in addressing structured assessment recommendations made last year;
- assessing the application of data-matching as part of the National Fraud Initiative (NFI);
- specific use of resources work on radiology services, GP out-of-hours services and discharge planning; and

- assessing the progress the Health Board has made in addressing the recommendations raised by previous audit work on the management of follow-up outpatients and reviewing the Health Board's arrangements for tracking progress against external audit recommendations.

37 I have also undertaken performance audit work that has examined the governance arrangements within the Emergency Ambulance Services Committee, and the collaborative working arrangements between local public health teams and Public Health Wales NHS Trust.

38 The main findings from the work referenced above are summarised under the following headings.

The Health Board now has effective arrangements in place to support the planning and monitoring of savings, but is facing an increased deficit position for the three-year period ending March 2018

39 In addition to commenting on the Health Board's overall financial position, my structured assessment work in 2017 has considered the actions that the Health Board is taking to achieve financial balance and create longer-term financial sustainability. I have assessed the corporate arrangements for planning and delivering financial savings in the context of the overall financial position of the organisation. I have also reviewed progress made in addressing previous structured assessment recommendations relating to financial management. I summarise my findings below.

Savings for 2017-18 are well managed, but historical under achievement of savings targets and recent overspends against resource limits means that the Health Board is forecast to have a cumulative increasing deficit position of £61 million by March 2018

40 Historically the Health Board has set ambitious annual savings targets. Although it has achieved significant amounts of savings, the Health Board has not achieved its annual targets and target levels have gradually reduced over time. Since 2015 the savings target has become more realistic and in 2016-17 in particular, although it had not identified all of the required savings schemes at the start of the year, the Health Board almost achieved its £26 million savings

41 For the three-year period 2014-17, the Health Board however failed its duty to spend within its financial allocation, overspending its allocation by £50.5 million. The Welsh Government did not approve the Health Board's three year integrated medium term plan (IMTP) and for 2017-18, the Health Board has been working to an annual operating plan.

42 In 2016-17, the Health Board applied a delegated savings target of 3% to each of its nine clinical and service boards, but only two met the target. In recent years, the proportion of recurring savings had been high but in 2016-17, the proportion fell to

50% of all savings. Non-pay and medicines management accounted for over half of the target savings.

43 In 2017-18, the Health Board has a savings target of £35 million, and a planned annual deficit of £30.9 million. This planned deficit is a slightly worsened position on the reported deficit for 2016-17. At month six, the Health Board was on target to deliver its savings target and the in-year planned deficit position. Due to historical spend, the three-year rolling deficit for 2015-18 however is forecast at £61 million, which is £10 million worse than the cumulative deficit to the 31 March 2017. Despite improved in-year delivery against savings targets and the overall financial position, the level of savings being identified and subsequently achieved however is not yet sufficient to reduce a growing cumulative deficit.

The planning of savings is aligned to the Health Board's three-year planning cycle and delivery is supported by corporate services, however, there is scope to revisit the allocation of targets to take advantage of areas with greater savings opportunities

44 The Health Board has a top-down approach to savings planning, meaning the corporate finance team sets a Health Board wide target, which is applied equally across the clinical and service boards. Service areas are responsible for identifying individual savings schemes, and planning and delivering these through their cost improvement plans.

45 The Health Board introduced its 'turning the curve' programme in the latter part of 2016-17. This has provided a platform to address the Health Board's financial issues. Although this programme is under review, the Health Board continued to strengthen its financial governance arrangements by introducing a new Finance Committee and developing a Cost Improvement Programme (CIP) tracker. The tracker is a planning and monitoring tool and used to monitor progress.

46 Savings planning is aligned with the Health Board's IMTP planning cycle; with a requirement for clinical and service boards to develop their savings plan over a three-year period. There is a flat rate approach to savings and CIP performance suggests that savings targets are achievable. However, the flat line approach means that opportunities to identify areas with a greater potential to save more are missed, and there is now scope for the Health Board to identify higher targets to areas where there is greater potential to save more.

47 Finance and workforce functions are integrated within clinical and service boards, and play a key role in developing the IMTP and savings plans. Other support functions such as informatics also support the clinical and service boards. The Health Board has five crosscutting themes, which are supported by the Programme Management Office. The Health Board has also recently set up a Transformation Board, which recognises that service transformation is required to make longer-term savings.

There are strong scrutiny and monitoring arrangements of financial savings at Board, committee and operational levels, and good mechanisms for learning lessons

48 The Health Board has a Finance Committee, which meets monthly. This committee receives a detailed report on the Health Board's latest financial position, including delivery against savings targets by clinical and service board. This report is also presented to the Board, which meets bimonthly.

49 Delivery of savings at a clinical and service board level is monitored on a weekly basis, and issues discussed at monthly executive level performance reviews. The Chief Executive chairs these reviews, which include all executive directors. Escalation arrangements are in place if CIP delivery for a clinical or service board is off-track. Directorates also monitor their savings plans and report up to clinical and service board meetings. Crosscutting themes are monitored through the crosscutting steering group.

50 The Health Board has a number of mechanisms for sharing ideas and learning lessons at various operational levels. The Health Board is also represented well at national level forums.

Operational arrangements are generally effective but there are weaknesses in Board oversight and assurance, and it is unlikely that the new data protection regulations will be met in time

51 My structured assessment work has assessed the Health Board's governance and assurance arrangements. This included the effectiveness of the board and its governance structures and the progress made in addressing previous structured assessment recommendations and improvement issues. My findings are set out below.

Strategic planning is generally effective and increasingly joined up across the organisation, however scrutiny of delivery remains a gap at Board and committee level, despite close monitoring at an operational level

52 The Health Board failed its statutory duty to have an approved three-year integrated medium term plan, and, for the second year running, has been working to an annual operating plan. Initial drafts of the 2017-18 plan included an increased planned deficit position. The Board finally agreed the 2017-18 plan in May 2017 with the revised planned deficit position of £30.9 million.

53 The Board receives regular updates on IMTP planning and development, but there are gaps in scrutiny at Board and committee level in relation to delivery of the plan. The committee responsible for scrutinising delivery was stood down in May 2017, and the new Strategy and Engagement Committee is still in its infancy. There are, however, increasingly better links between the plan and the Health Board's financial position, and there is robust monitoring of the delivery of the plan at an operational level through the executive level performance reviews.

The Health Board's organisational structure continues to mature with steps being taken to improve joint working across the organisation, though concerns about corporate governance capacity remain

54 During the year, the Health Board did not make any fundamental changes to its organisational structure, although it now has a full executive team in place. The new Chief Executive joined in July 2017 with a new Director of Workforce and Organisational Development following in October. At the time of our structured assessment fieldwork, the Health Board was about to appoint a substantive Chief Operating Officer.

55 In recognition of the fact that the clinical board structure can promote silo working, the executive team has taken action to promote increasing cross-organisational working, particularly through the executive level performance reviews. Corporate services work across the clinical boards, with finance and workforce resources embedded within each of the clinical boards. However, other support functions are not as embedded although integrated working is improving.

56 The corporate governance team plays an active role in providing challenge and support to the executive team and the wider organisational structure. Even though a new Head of Corporate Governance was appointed in April 2017, our previously reported concerns around team capacity remain

The Board and some of its committees are not providing sufficiently rigorous and consistent oversight, partly due to turnover in membership, and until the two new committees are fully established, there are risks to assurance on performance and planning

57 The Health Board experienced a significant turnover of independent members (IMs) during 2017. Seven new IMs have been appointed, although a further two IMs were due to leave at the end of December 2017. This level of turnover has posed risks to Board continuity, although outgoing IMs have provided legacy statements and extended support to ensure a smooth transition. Of the seven new IMs, only one has had previous NHS board experience, placing increasing pressure on the Health Board to get the new IMs up to speed through its Board development programme.

58 Our observations of Board and some of its committees[2] indicate that the level of scrutiny and challenge varies, as does committee administration. The Finance Committee and the Quality, Safety and Experience Committee are two of the better run committees. The previous People, Planning and Performance (PPP) Committee was disbanded in May 2017, and two new committees were established. However, these committees (Strategy and Engagement Committee,

[2] As part of our structured assessment work, we observed the Board and the following committees – Finance Committee, Quality Safety and Experience Committee, Strategy and Engagement Committee, Resources and Delivery Committee and Audit Committee

and Resources and Delivery Committee) have only held two meetings and are still in their infancy. The time lag between standing down the PPP committee and establishing the new committees has introduced risks around gaps in Board assurance.

59 Papers and minutes for committees are generally well written. However, the Chief Executive and Chair have recognised that discipline around papers in relation to quality and size needs to improve, in order to support more effective scrutiny and review of information.

The Health Board recognises that risk management needs to improve and is reviewing operational and corporate risk management processes, however due to capacity issues within the corporate governance team this will be a slow process

60 The Health Board's combined Corporate Risk and Assurance Framework (CRAF) is currently under review. The CRAF has been in place for four years, however the Health Board recognises that risk management needs to improve to give better assurance to the Board.

61 The CRAF is a live document and is clearly laid out, but risks are not yet aligned to the corporate objectives, the risks lack clarity, are not reducing as a result of mitigating action and a number were assigned to the previous PPP committee for some months after it was disbanded.

62 A risk management workshop was held in May 2017 and improvement actions have already started, including improved reporting of risks. The Health Board aims to launch a new version of the CRAF in 2018, alongside a wider review of the risk management policy. This is a substantive piece of work but capacity to undertake it is limited.

The Health Board's information governance arrangements are not yet developed enough to effectively implement the new General Data Protection Requirements (GDPR) by May 2018

63 The Health Board has made progress in addressing recommendations from the Information Commissioner's Office 'limited assurance' review but the majority of actions remain ongoing, despite the need for these to be addressed ahead of the GDPR coming into force in 2018.

64 The Health Board has recognised the legislative changes and what other actions are required in readiness of the GDPR but progress in addressing these actions has been slow. Compliance with information governance training is well below the target of 85% and response times to information requests are slow. The Health Board's information governance strategy also needs to be aligned to the national digital strategy. The Health Board has a small information governance team and its ability to meet the GDPR effectively will be challenging within the timescales.

Operational performance management is robust and comprehensive, but Board and committee oversight is as yet ineffective

65 The Health Board has strong performance management arrangements. The executive team holds all clinical and services boards to account through regular performance review meetings, which are focused, and well organised. As well as holding to account, the review meetings offer support and encouragement, and provide opportunities to discuss national issues and cross-board working. Comprehensive performance dashboards support the performance review meetings.

66 At Board level, the new Resources and Delivery Committee is responsible for providing assurance on performance and workforce. However, the information reported to the committee is less detailed than that reported to Board, which focuses on priority targets or performance areas that have deteriorated. More information should be made available to the committee to support its scrutiny function and improve its effectiveness in providing assurance to the Board.

The Health Board has not yet made effective use of the NFI to detect fraud and overpayments

67 The NFI is a biennial data-matching exercise that helps detect fraud and overpayments by matching data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. It is a highly effective tool in detecting and preventing fraud and overpayments, and helping organisations to strengthen their anti-fraud and corruption arrangements.

68 Participating bodies submitted data to the current NFI data matching exercise in October 2016. We released the outcomes of the exercise to participating bodies in January 2017. The Health Board is a mandatory participant in NFI.

69 In January 2017, the Health Board received 9,980 data-matches through the NFI web application. Data-matches highlight anomalies which when reviewed can help to identify fraud and error. Whilst we would not expect organisations to review all data-matches, some of the matches are categorised as 'recommended matches'. These are matches considered to be of high risk and therefore recommended for early review. We identified 851 'recommended matches' for the Health Board.

70 The NFI web-application, which records the findings of the Health Board's review of its data-matches, shows that as at 20 November 2017, the Health Board had only reviewed 11 of the data-matches. I recognise that the Health Board has experienced delays in the NHS Wales Shared Services Partnership identifying a suitable contact to lead on the creditor matches, which account for the majority of the NFI matches. I also recognise that it was the intention of the local counter fraud service to review the remainder of the matches during quarter four of 2017-18. In discussion with the Health Board, I am assured that both the NHS Wales Shared Service Partnership and the local counter fraud service are now giving the data-

matches the appropriate attention. The Health Board is due to provide data for the next NFI exercise (NFI 2018-19) in October 2018.

The Health Board has made mixed progress against my previous structured assessment recommendations and its arrangements for tracking progress against recommendations from our other audit work still need to be improved

71 The Health Board has made mixed progress in addressing the recommendations in last years structured assessment work. Of the 12 recommendations, two are complete and seven are in progress, but not complete. The Health Board has made limited progress against three recommendations.

72 In addition to reviewing the actions taken to address my 2016 structured assessment recommendations, I also considered the effectiveness of the Health Board's wider arrangements to respond to my audit recommendations. External audit recommendations are tracked through the Audit Committee which meets every 1-2 months. This includes Wales Audit Office recommendations as well as those from other inspectorates.

73 This year my team found that external recommendations tracking arrangements are disjointed. There is a separate tracker report for recommendations made by the Wales Audit Office and other external inspections. The Wales Audit Office tracker shows which committee will be providing assurance and monitoring the recommendations. However progress against individual recommendations is not shown, there are no end dates and the status of all recommendations is 'ongoing'. The external inspections tracker is cumbersome and confusing, many items do not show completion dates and completed actions remain on the tracker.

74 The lack of robust and clear recommendations tracking arrangements will obstruct effective monitoring and prevent the Health Board from identifying key issues identified across audit and inspection bodies. In 2016, I recommended the Health Board strengthen tracking arrangements for external audit recommendations, to date this recommendation has not been progressed. Little progress has been made but the corporate governance team is in the very early stages of reviewing tracking arrangements. As part of this review, the team plans on reviewing the policy for handling reports coming into the organisation, to ensure it has greater oversight of external reviews and recommendations. This piece of work is being led by the Head of Corporate Governance, however, as raised in paragraphs 56 and 62, I have concerns about the capacity within the corporate governance team to complete this work.

The Health Board has responded well to the issues raised in my public interest report that highlighted governance failings around the awarding of certain HR contracts and the appointment of a Director

75 I identified a number of fundamental weaknesses in the governance and decision-making arrangements over the award of three contracts for HR consultancy services. I reported my findings publicly on 17 July 2017. I prepared this report in accordance with Paragraph 19 of Schedule 8 to the Government of Wales Act 2006. This provides that if I think that it would be in the public interest to bring to the public's attention a matter coming to my notice in the course of an examination of auditable financial statements, I may prepare a report on that matter.

76 The matter under consideration first arose in 2016 through my audit of the Health Board's 2015-16 financial statements. As the audit of the consultancy contracts progressed, I identified certain other matters, which I judged were in the public interest. To date, this has been the only instance where the Auditor General for Wales has issued a 'public interest report' in respect of a Welsh NHS body.

77 The key findings from the report were:

- the way in which the Health Board 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;
- 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; and
- the process followed by the Health Board 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.

78 Following the publication of my report the National Assembly's Public Accounts Committee considered my findings, with evidence from the Health Board's Chair and Chief Executive Officer. I am pleased that since issuing the report, the Health Board has responded positively and in doing so has developed a detailed action plan, and is making good progress to implement it.

My performance audit work has identified some positive arrangements whilst also identifying some opportunities to secure better use of resources in a number of key areas

Workforce and estates are increasingly supporting the goals of the Health Board, though informatics is struggling to keep pace

79 My Structured Assessment work has reviewed how a number of key enablers of efficient, effective and economical use of resources are managed. My key findings are summarised in Exhibit 2.

Exhibit 2: progress in implementing audit recommendations in specific service areas

Issue	Summary of findings
Workforce planning	Approaches for recruitment, retention and supporting workforce management are generally effective, and while some aspects of training and development present challenges, the Health Board is taking steps to tackle them During the year, the Health Board had a number of recruitment successes, although some professional groups and specialties remain hard to recruit. Despite this, agency spend is low. The Health Board implemented a number of successful initiatives to support workforce productivity and these are now having a positive impact. Sickness absence rates are also reducing. However, turnover of staff is higher than the average for Wales, and the length of time to recruit is also above the average. Compliance with mandatory training and performance appraisals also needs to improve, with both medical and non-medical appraisal rates falling short of the 85% target. Work is underway to improve access to training and, since the appointment of the new Director of Workforce and Organisational Development, there has been an increased focus on training and appraisals at performance management reviews.

Issue	Summary of findings
Estates and assets	The Health Board has continued to focus its attention on estates. A recent internal audit review of how it is managing compliance with statutory requirements provided 'reasonable assurance'. The risks associated with backlog maintenance are slowly reducing, although the level of significant risks that the Health Board is carrying remains high, with the majority of this risk associated with the main University Hospital of Wales (UHW) site in Cardiff. The Health Board has taken steps to develop a series of estates management plans which articulate how the Health Board intends utilising its estate over the next ten years.
ICT and use of technology	The Health Board faces a number of challenges in its arrangements for the use of information technology, deployment of national IT systems and securing appropriate resources to deliver the informatics strategic outline programme. The Health Board has developed its informatics strategic outline programme (SOP) for 2016-2021 although Welsh Government capital and revenue funding was not sufficient to cover the SOP intentions. The Health Board continues to have an ageing IT systems infrastructure and the need to replace legacy IT systems. The Health Board has been making prioritised investments under its 'keeping the lights on' capital programme, albeit that capital funding is constrained. These investments have helped maintain IT systems whilst waiting for the deployment of the national IT programme, although some systems are likely to be passed their 'end-of-life' date by the time the national IT systems are rolled out. The low level of investment on IT infrastructure and informatics resources increases the risk of potential threats arising from cyber-attacks. As yet, the Health Board does not have a dedicated IT security officer. The Health Board measures IT KPIs but these focus mostly on the performance of the IT service desk and call resolution.

Whilst operationally the radiology service is well managed, there are risks to the current and future service delivery because of a lack of strategic and business planning, increasing demand, reporting backlogs, aging equipment, and recruitment and retention issues

80 My work on radiology services found that patients have good access to in and out of hours radiology services, with a robust system in place to ensure referrals are correctly prioritised. While the time patients have to wait for their radiological examination has fallen, waiting time targets however are still not being met consistently. Despite a backlog, reporting is not outsourced and radiographers are under-utilised. Clinical performance is regularly audited, discussed and fed back to staff; however, there are concerns about staff participation because of capacity issues. Processes are in place to monitor and learn from complaints and incidents, however patient and staff feedback highlights long standing environmental concerns, which are not being addressed.

81 Steps are being taken to try to reduce service pressures, but clinical advances and external factors, such as demand from other health board areas and public health campaigns, continue to increase demand. Whilst clear referral guidance is in place, my team found that referring clinicians are unaware of it, and although the service is taking positive steps to reduce inappropriate referrals, the lack of an e-referral system is a risk. However, the service has a good system to manage waiting lists and appointment slots.

82 Radiology staffing levels have grown at a slower rate than the rest of Wales and this is complicated by significant local and national recruitment and retention challenges. The radiology workforce profile generally compares favourably with the rest of Wales, although there are limitations on the staffing comparisons due to the tertiary nature of the service and difficulties accounting for complexity. Staffing constraints hinder training opportunities and compliance with statutory and mandatory training is poor. Compared to Wales, there is an above average number of scanners, with longer operating hours, and whilst there is potential to further optimise weekend usage, this may cost the service more.

83 The Health Board does not have a radiology strategy nor detailed operational and workforce plans, however, the service is taking steps to address this. The management structure and lines of accountability are clear, and the service is well represented on Board committees and sub-committees. However, in recent years, the service has overspent against its budget and missed its savings target, and whilst finance performance reports are clear, remedial actions are not included. Despite equipment at or reaching the end of life expectancy, and frequent breakdowns, there is no equipment replacement programme in place. Generally, radiology ICT systems do not serve the Health Board's needs, and radiology performance is regularly reviewed at corporate and management level, however the performance dashboard needs to be strengthened and used to its full potential.

The Health Board has strengthened the governance of GP out-of-hours but performance is mixed and risks remain in relation to the sustainability of the service

84 My work found that the Health Board does not have a GP out-of-hours strategy but is planning change to the service through an action plan and a new business case. There are good arrangements for clinical and operational leadership of the GP out-of-hours service; and the Health Board has strengthened the way it monitors GP out-of-hours performance and learns from incidents but the approach to clinical audit and patient feedback is limited.

85 The service has increased its skill mix but remains fragile because there is no workforce plan and there are frequent problems filling shifts. The Health Board's expenditure on GP out-of-hours has decreased and in 2015-16, its spending was the lowest per contact in Wales. Since our fieldwork, the Health Board has increased funding for GP out-of-hours services.

86 The Health Board works in a range of ways to inform the public about out-of-hours services but there is scope to improve signposting from its website and practice answerphone messages. The service answers calls more quickly than other services in Wales and whilst there appear to be no call terminations, there may be inaccuracies in the data. Timeliness of call-backs to patients remains one of the service's most stubborn problems with performance remaining below the all-Wales average. Timeliness of home visits and appointments is mixed compared with the average performance across Wales. Problems with data consistency make it difficult to compare referral patterns and whilst the out-of-hours service does not have a directory of services, it does have protocols with emergency departments.

In respect of discharge planning, the Health Board has robust improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services

87 My work identified that the Health Board has developed clear plans for improving discharge planning with partners. The Health Board has a well-developed draft discharge policy, reviewed with partners, however patient and carers have not been involved in its review. The recently revised discharge pathways are comprehensive and form part of the draft discharge policy.

88 The Health Board has dedicated discharge resources, which are multi-agency and multi-disciplinary but these are available weekdays only. There is scope to improve staff training and raise awareness of policies, pathways and access to information about community services.

89 There are clear lines of accountability and regular scrutiny of discharge planning performance, which includes partners. Board members generally feel informed about discharge planning performance, with action being taken to develop further the range of information available. Performance is improving but it is too early to comment on whether this is linked to improvements in discharge processes.

The Health Board is not effectively monitoring all of my previous recommendations however my follow up work has identified that the Health Board has made progress in addressing my recommendations on the management of follow-up outpatients

90 In addition to reviewing the effectiveness of the Health Board's arrangements to manage and respond to recommendations made as part of my audit work as discussed in paragraphs 71-74, I have reviewed the extent to which progress is being made against audit recommendations through the Health Board's own tracking arrangements.

91 My work has found that whilst the Audit Committee considers the initial action plan at the time the report is finalised, subsequent consideration of my reports at the most appropriate committee can be slow, and progress updates are not always reported. This has in part been due to the disbanding of the PPP committee and the subsequent gap before setting up the new Resources and Delivery Committee.

92 Where progress has been reported, it is not clear from the updates the extent to which my recommendations have been completed. I have therefore been unable to take a view on the Health Board's progress against my previous recommendations, using its own tracking arrangements.

93 During the last 12 months, I have undertaken detailed follow-up audit work to assess the progress that the Health Board has made in addressing concerns and recommendations arising from previous audit work in specific areas of service delivery. The findings from this follow-up work are summarised in Exhibit 3.

Exhibit 3: progress in implementing audit recommendations in specific service areas

Area of follow-up work	Conclusions and key audit findings
Progress update of follow-up outpatients	The Health Board has made progress in addressing the recommendations made in our 2015 report, and, with the Outpatient Transformation Programme (under the remit of the Planned Care Board), is well placed to meet all recommendations.

Collaborative commissioning arrangements have helped drive some important changes for emergency ambulance services in Wales; however, the maturing arrangements require greater commitment from some partners.

94 My review of the all-Wales arrangements for commissioning emergency ambulance services found that the Emergency Ambulance Services Committee (EASC) has helped drive some important changes, such as the development of the CAREMORE®[3] model. However, structures and roles to secure accountability for

[3] The CAREMORE® model is a 'made in Wales' commissioning method. Its registered trademark belongs to Cwm Taf University Health Board on behalf of NHS Wales.

emergency ambulance services are unclear. I found that there is scope to clarify the roles of EASC, the Welsh Government and the Chief Ambulance Services Commissioner in relation to emergency ambulance service performance, finance and service modernisation. In addition, although the formation of EASC has supported all-Wales ownership of emergency ambulance services, my team identified that EASC needs to do more to drive through service transformation. In addition, the sub-group structure, which underpins EASC, lacks clarity and purpose, which is affecting attendance by health board staff and the ability of the subgroups to make a meaningful contribution.

95 Partners support the commissioning model but the pace with which health boards are driving the necessary changes to enable it to work as intended varies, and the model does not consider regional or cross-border activity. My work identified that there is a general willingness of WAST and health boards to work together to improve ambulance services, but the level of ownership of emergency ambulance performance and pathway modernisation by health boards is variable, with the predominant focus on the latter stages of the ambulance pathway, such as, ambulance handovers. I reported that WAST is properly responding to agreements set out by EASC, however, health boards' compliance with and level of understanding of the requirements set out in CAREMORE® vary.

96 My work found that commissioning arrangements are underpinning some improvements to emergency ambulance services. The introduction of the new clinical response model is supporting partners to achieve Welsh Government performance targets, with the potential for further performance improvements from other recently agreed initiatives. Planned service changes and performance monitoring of partners are now increasingly aligned with the Ambulance Patient Care Pathway (referred to as the five-step model). However, more consistency is needed across health boards and it is too soon to say if this is having an impact. There is a significantly improved and broader set of measures, which focus on activity and performance through the Ambulance Quality Indicators. However, partners are not yet doing enough to fully understand patients' outcomes and experience when receiving emergency ambulance care.

Collaborative arrangements for managing local public health resources do not work as effectively as they should

97 My review of collaborative arrangements between Public Health Wales NHS Trust (the Trust) and health boards for managing local public health resources found that effective collaboration in relation to health improvement work is dependent upon consensual leadership, which is not always evident. In the overall public health system, a broad range of people and organisations contribute to protecting and improving health and wellbeing, and reducing health inequalities in Wales. No one organisation is wholly responsible for achieving improvements in population health and wellbeing but achievement is predicated on effective collaboration.

98 While it may not be desirable to identify a single system leader, there does need to be greater clarity over respective roles of the different stakeholders within the system. My work found that there is a lack of meaningful dialogue between the Trust, local public health teams and Directors of Public Health about respective roles, responsibilities and an agreed framework about what work is best done collectively.

99 Currently, there is an absence of effective arrangements to ensure that value for money is being secured from the resources allocated to local public health teams. Meetings do not take place between the Trust and Directors of Public Health to discuss how resources to improve health and wellbeing are used and whether they deliver the intended benefit. My work also found a lack of robust methods for allocating or changing resources of local public health teams. Instead, ad hoc discussions take place as vacancies arise.

100 My work found that arrangements are in place to support professional registration of staff deployed across local teams, but more clarity is needed on how this is used to demonstrate professional competence and career progression. New arrangements are also helping to strengthen appraisal processes and personal development planning but more needs to be done to assess the collective development needs of local public health teams.

101 Mechanisms for communicating and sharing information between the Trust and local public health teams are underdeveloped. There is no standardised approach for sharing intelligence about what works well, and what different players were doing at both a national and local level. My work also found a lack of arrangements for co-ordinating work developed or delivered locally or nationally, and communicating information to the same-shared partners.

102 I have noted the collective and collaborative management response that has been prepared by the Trust, Health Boards and Welsh Government to my findings. I intend to undertake further work in 2018 to assess the progress that has been made to address the concerns identified above.

Appendix 1

Reports issued since my last annual audit report

Exhibit 4: reports issued since my last annual audit report

Report	Date
Financial audit reports	
Audit of Financial Statements Report	May 2017
Opinion on the Financial Statements	June 2017
Performance audit reports	
Radiology Services	February 2017
Emergency Ambulance Services Commissioning	April 2017
GP Out-of-Hours Services	September 2017
Collaborative Arrangements for Managing Local Public Health Resources	October 2017
Progress update of follow-up outpatients	October 2017
Review of Discharge Planning	November 2017
Structured Assessment 2017	January 2018
Other reports	
2017 Audit Plan	February 2017

Exhibit 5: performance audit work still underway

Report	Estimated completion date
Progress update of medical equipment	February 2018
Review of Primary Care	June 2018
Cross-cutting review of the Integrated Care Fund	October 2018

Appendix 2

Audit fee

The 2017 Audit Plan set out the proposed audit fee of £420,652 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in accordance with the fee set out in the plan.

Appendix 3

Significant audit risks

Exhibit 6: significant audit risks

Significant audit risk	Proposed audit response	Work done and outcome
The Health Board has a duty to ensure that robust accounting records and internal controls are in place to ensure the regularity and lawfulness of transactions.	My audit team will test accounting records and internal controls relevant to the audit to ensure accuracy, regularity and lawfulness of transactions.	My team reviewed accounting records, assessed internal controls, and did not identify any material issues to report.
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk in accordance with International Standards on Auditing 240.	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions that the audit identifies, which may potentially be outside the normal course of business.	My team reviewed a number of the accounting estimates and a sample of transactions that included journal entries. I did not identify any issues to report.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk in accordance with International Standards on Auditing 240.	My audit team will consider the Health Board's income streams and assess whether there is a risk of material misstatement due to fraud related to revenue recognition. Where we determine that such risks do exist we will undertake specific testing.	My audit team considered the Health Board's income streams. No additional risks were identified.

Significant audit risk	Proposed audit response	Work done and outcome
Based on our review of the Health Board's financial reporting and our discussions with senior officers, it seems highly likely that the Health Board will spend in excess of its revenue resource allocation. The month 9 position shows a year-to-date deficit of £25.2 million and forecast a year-end deficit of £30.9 million. Under the NHS Finance (Wales) Act 2014, local health boards ceased to have annual resource limits with effect from 1 April 2014. Instead, 2014-15 and 2015-16 became the 'transitional' first two years under the new statutory financial duty not to exceed a rolling three-year resource limit. Accordingly, there could not have been any breach of a statutory resource limit in either of those two individual years. With effect from the 2016-17 financial year onwards, the provisions of the 2014 Act require me to compare the Health Board's cumulative expenditure for the year of account and the previous two years with the corresponding three-year resource limits for both revenue and capital.	My audit team will continue to monitor the Health Board's financial position for the 2016-17 financial year, and also for the cumulative position for the three years to 31 March 2017. This review will also take into account the impact of any relevant uncorrected misstatements over those three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2016-17 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.	The Health Board did not meet its three-year revenue resource allocation. As reported within Section 1 of this report, I therefore qualified my regularity opinion on the 2016-17 financial statements. I placed a substantive report on the financial statements explaining the Health Board's performance against its statutory duties under the NHS Finance (Wales) Act 2014, and my audit qualification.

Significant audit risk	Proposed audit response	Work done and outcome
The current financial pressures on the Health Board, around its revenue and capital expenditure, and cash spend; increase the risk that management judgements and estimates could be biased in an effort to report within the financial limits put in place by the Welsh Government.	My audit team will identify those areas of the financial statements that they judge to be prone to reporting bias, and undertake focused audit testing where appropriate.	My team reviewed a number of management's key judgments and estimates. I did not identify any material issues to report. My Audit of Financial Statements Report did however report the Health Board's continued poor progress in examining and assessing the estimated cost of its 'phase 3' continuing healthcare claims.
There is risk around the calculation and disclosure of the Health Board's payment performance against the targets set out in the Welsh Government's Public Sector Payment Policy (PSPP). The Health Board's month 9 reporting forecasts significant pressure on its cash position at year-end, with a year-end cash shortfall of £18.0 million. This shortfall of cash could potentially increase creditor payment times and impact on payment performance.	My audit team will audit the PSPP disclosures and consider any implications that the cash pressures have on the Health Board's target. The auditors of NHS shared services will undertake some of this audit work.	The audited financial statements reported that the Health Board did not meet the Welsh Government's targets, which require the Health Board to pay 95% of creditors within 30 days of delivery. By number, the Health Board paid 59.7% of its NHS creditors, and 94% of its non-NHS creditors, within the 30 days' target. As I had done the previous year, in my Audit of Financial Statements Report I explain that the disclosed payment-performance percentages are potentially misstated due to the way that the Health Board reports its invoices in dispute.

Significant audit risk	Proposed audit response	Work done and outcome
The timetable for producing and certifying the annual report and accounts is demanding. The 2016-17 financial year is the second year of implementing HM Treasury's three-part reporting that is based on: a Performance Report, Accountability Report and Financial Statements. The Welsh Government has reviewed the requirements and logistics for 2016-17, with this year's requirements set out in the current consultation draft the 2016-17 Manual For Accounts. The Health Board will need to put in place appropriate arrangements to prepare the accountability report at the same time as the financial statements and ensure adequate working papers are provided for audit on a timely basis.	My audit team will work closely with Health Board staff to monitor progress, and seek to resolve any issues of timing as soon as possible so that the accounts certification timetable can be met. The Health Board's Annual Governance Statement is disclosed within the Accountability Report. My audit is required to review the governance statement to ensure that it complies with HM Treasury and Welsh Ministers' guidance. As part of my audit work, I will review the statement to ensure that it is consistent with audit results, and my knowledge and understanding of the Health Board.	I audited the Accountability Report with satisfactory results. In my Audit of Financial Statements Report, I acknowledged that some improvements had been achieved for 2016-17, although I also set out the need for the earlier preparation of the Accountability Report for 2017-18.

Significant audit risk	Proposed audit response	Work done and outcome
The annual accounts are compiled under International Financial Reporting Standards (IFRS) and NHS Manual for Accounts. The Health Board must have a full understanding of these requirements, keeping up to date with changes and ensuring that risks and issues are identified and dealt with appropriately. Specific risk areas include: • estimates, particularly for the continuing health-care provision and primary care expenditure; • capital developments, with complex accounting requirements; • significant transactions with related parties; • the consideration and approval of contracts valued at more than £1 million; and • accuracy and completeness of the Remuneration Report, including exit packages and changes to Executive Members during the year.	My audit team will audit the financial statements with particular focus on these risk areas, by undertaking focused testing. With regard to the Remuneration Report, we are aware that during 2016-17 there has been a number of changes to the Health Board's executive roles and the officers appointed to certain posts. My audit team will examine these changes. The audit testing will include whether the appropriate authorisations are in place, and whether the disclosures within the Remuneration Report are accurate.	I assessed the Health Board's arrangements and carried out appropriate testing. While my findings were generally satisfactory, I raised a number of recommendations for improvement in my Audit of Financial Statements Report.

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AUDIT OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD'S CONTRACTUAL RELATIONSHIPS WITH RKC ASSOCIATES LIMITED AND ITS OWNER	
Name of Meeting: Board	**Date of Meeting:** 29 March 2018

Executive Lead: Chief Executive
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
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 progression of the Action Plan provided
- Ongoing monitoring by the Audit Committee
- Internal Audit review

RECOMMENDATION

The Board is asked to:

- **NOTE** the contents of this report

SITUATION

Further to the critical report of the Auditor General for Wales dated July 2017 relating to the UHB's contractual relationships with RKC Associates Ltd and its Owner, the UHB developed a comprehensive action plan to make the necessary further improvements to ensure no similar incidents of this kind occur in the future.

BACKGROUND

This report contains the updated version of the Action Plan. The Audit Committee continues to monitor the Action Plan and received a progress report at its February meeting.

Following the attendance of the Chair and Chief Executive at the Public Accounts Committee (PAC) in September 2017, an update on the implementation of the Action Plan is due to be provided to the PAC in April 2018.

ASSESSMENT AND ASSURANCE

The Action Plan reflects the progress that has been made since the last report to the Board.

The Corporate Governance Department met with Wales Audit Office on 20 January 2018 and it was acknowledged that good progress has been made, whilst being mindful that improving the culture completely within the Health Board will be a longer term goal, but is essential if we are to avoid similar incidents occurring in the future.

Internal Audit has also reviewed the progress made against the Action Plan and provided a finding of Substantial assurance. Three recommendations for improvement were made by Internal Audit, these were accepted and responded to as part of the report presented to the February Audit Committee.

Of the 26 actions contained within the Action Plan, only 4 now remain outstanding. The updates provided in the Action Plan provide assurance that good progress is being made in relation to these outstanding actions.

Two actions have been amended as partially complete acknowledging that even though the reviews have been completed, approval of an updated policy and development of a scrutiny checklist will fully complete these actions and provide robust assurance.

Full closure of the Action Plan was intended for March 2018, it is clear that the following 3 actions will not be concluded by this stage:

- Full implementation of the no purchase order no payment system – the initial target set was overambitious given the size of the organization;
- Development of an internal protocol providing a system for senior leaders to raise concerns – following recent discussions between Corporate Governance, the UHB Chair and Nurse Director, and taking account of the observations of the PAC regarding culture, it is considered that more work is required around this and the re-launch of the Procedure for NHS Staff to Raise Concerns. A Working Group has therefore been established to include Corporate Governance, Corporate Nursing, and WOD to take this forward and a report is to be presented to the UHB Management Executive on 26 March 2018.
- Circulation of a bulletin to the UHB Board and throughout the UHB reinforcing the Nolan principles of Good Governance – finalization of this communication will form part of the Working Group's agenda.

Therefore it is proposed that a final closure report come back to the Board, following completion of these last actions.

16

16

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: 14 March 2018

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[1] 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.

Conclusion 1 Action Plan	Lead	Completion	Update	Status
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	Aug 2017	**Complete** Training delivered on 31/08/17.	
2. Cascade the training provided at Clinical Board senior management teams and throughout the organisation to Directorate Management level.	Executive and Clinical Board Directors	Oct 2017	**Complete** Discussed at ME on 04/09/17 & cascaded.	
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	Aug 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	Sep 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	Sep 2017	**Complete** Approved by ME on 25/09/17	
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	Oct 2017	**Complete**	
7. Implement a no purchase order, no payment system to prevent the processing of manual payments.	Head of Procurement	June 2018 (original date set was Mar 2018)	Roll out has taken place in the Executive Team, UHB “no purchase order no payment” Group meets monthly & feeds into the National Group. Full implementation now expected by June 2018.	
8. Develop and cascade process guidance for off-payroll working.	Head of Procurement	Aug 2017	**Complete** Approved by ME on 14/08/17, taken to HSMB on 17/08/17 for cascading by Clinical Board Directors.	

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.

Conclusion 2 Action Plan	Lead	Completion	Update	Status
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	Sep 2017	**Complete** All training complete, refresher sessions will continue.	
2. Obtain quality management accreditation for the Procurement Department in respect of its tendering processes.	Head of Procurement	Mar 2018 (original date set was Nov 2017)	**Complete** Audit took place 15/02/18 & full ISO Accreditation awarded with no findings of non-compliance.	
3. Develop a Procurement flowchart for use by Board and Senior Managers.	Head of Procurement	Oct 2017	**Complete** Flowchart considered by ME on 11/12/17 & agreed that Executives will cascade through Management Structures.	
Audit 4. Enhance existing audit processes within the Procurement Department to verify compliance with contract procedure.	Head of Procurement	Sep 2017	**Complete** Forward programme for audit planned & training of Clinical Boards & departments to continue.	
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	Nov 2017 (original date set was Sep 2017)	**Complete** Specific audit included in 2018 plan, to look at overall progress of action plan & review in detail a sample of actions.	
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	Sep 2017	**Complete** Standing agenda item with first report received at Audit Committee on 26/09/17.	
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	Jan 2018 (original date set was Oct 2017)	**Complete** Review approved by Board on 30/11/17. Amendment made to note at the next meeting of the Remuneration and Terms of Service Committee.	

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.

Conclusion 3 Action Plan	Lead	Completion	Update	Status
Review 1. Review the procedures used to recruit Executive Directors and other Senior Managers.	Assistant Director of Workforce and Organisational Development	May 2018 (target date set Jul 2017)	**Partially Complete** Process revised & now to be reflected in the updated Recruitment and Selection Policy & Procedure which is due for approval in May 2018.	
2. Review the quality of information and its presentation to the Remuneration and Terms of Service Committee.	Chair and Director of Corporate Governance	Mar 2018 (target date set Sep 2017)	**Partially Complete** New process introduced in January 2018 whereby all papers are assured by Chair & Director of Corporate Governance prior to publication. Checklist being formulated to support this scrutiny.	
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	Aug 2017	**Complete** Process revised & now to be reflected in the updated Recruitment and Selection Policy & Procedure.	
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	Aug 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	Oct 2017	**Complete** Included in the programme for the October Board Development Day.	

Additional Improvements				
Action Plan	**Lead**	**Completion**	**Update**	**Status**
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	Jan 2018 (target date set Oct 2017)	**Complete** All Wales Procedure adopted, Working Group established to re-launch Procedure, agree underlying process & improve culture.	
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	Apr 2018 (target date set Oct 2017)	This will be developed by the above Working Group.	
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	Mar 2018	Model Standing Financial Instructions and Standing Orders being developed on an All Wales basis.	
4. Review and revise the UHB's Scheme of Delegation.	Director of Finance	Feb 2018 (target date set Oct 2017)	**Complete** Review presented to Audit Committee on 27/02/18 & Scheme of Delegation revised to include off-payroll working.	
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	Apr 2018 (target date set Oct 2017)	Draft prepared, final version delayed to ensure content aligns with outcomes of Working Group.	
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	Oct 2017	**Complete** Reports at Board, ME, HSMB, LPF. Continued dialogue with Senior Trade Union / Staff Side representatives, CEO communication placed on intranet and internet. Action plan monitored by Audit Committee.	

CARDIFF AND VALE OF GLAMORGAN WELL-BEING PLANS	
Name of Meeting: Board	**Date of Meeting** 29 March 2018

Executive Lead : Executive Director of Public Health
Author : Strategic Partnership and Planning Manager 029 2184 7730
Caring for People, Keeping People Well : The focus in the Well-being of Future Generations (Wales) Act 2015 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 plan, make decisions and deliver action with partners in line with the sustainable development principle. Improvement in population health and wellbeing will enable better use of public sector services
Quality, Safety, Patient Experience impact : Acting in accordance with the sustainable development principle 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: The Plans will help to tackle inequalities and increase community engagement. They will also contribute to the national well-being goal of a more equal Wales. There will be full Equality and Health Impact Assessments completed on the specific actions identified in the Plans.

ASSURANCE AND RECOMMENDATION

ASSURANCE

- The UHB is represented by the Chair and members of the Executive Team on the Public Services Boards (PSBs) in Cardiff and in the Vale of Glamorgan; the PSBs have overseen the development of the Plans
- UHB staff have been involved in discussions and stakeholder workshops to help shape the content of the Plans and have had the opportunity to comment on the draft Plans
- The draft Plans were considered and supported by the UHB Strategy and Engagement Committee in November 2017 during the formal consultation period

The Board is asked to:

- **AGREE** the final versions of the Plans, subject to formal collaborative sign-off by the Public Services Boards in April and publication in May 2018 that can be found on the links below:

The final draft Cardiff Well-being Plan is available in English and Welsh.

The final draft Vale of Glamorgan Well-being Plan is available in English and Welsh

SITUATION

The Well-being of Future Generations (Wales) Act places a well-being duty on Public Services Boards (PSBs) to improve the economic, social, environmental and cultural well-being of its area by contributing the achievement of the seven national well-being goals.

In order to do so, a PSB must, while acting in accordance with the sustainable development principle:

- prepare and publish a local well-being plan, which sets local well-being objectives and the steps proposed to meet them. These must be designed to maximise the Board's contribution to delivering the well-being goals within its area;
- take all reasonable steps to meet those objectives.

The local well-being plan must be published within one year of the local government elections, i.e. the first must be published by 3 May 2018 and will cover a five-year period. The PSB is required to undertake consultation for a minimum of twelve weeks. A PSB must publish an assessment of the state of wellbeing in its area no later than a year before it publishes its local well-being plan, to inform the development of the well-being plan.

In terms of approving the final local well-being plan, each statutory member of the Board must approve the Plan at a meeting of the body in question (i.e. at a meeting of the Health Board, the Fire and Rescue Authority, Full Council and the Board of Natural Resources Wales). The Plan must then be approved at a meeting of the Public Services Board.

BACKGROUND

The UHB is a full statutory member of the PSBs in Cardiff and in the Vale of Glamorgan. Both PSBs undertook consultations on draft well-being assessments in January – February 2017 under a joint regional brand of 'Let's Talk' to align with the engagement on the Population Needs Assessment (PNA) required under the Social Services and Well-being (Wales) Act 2014. The UHB Chair signposted members to the consultations on these assessments at the January 2017 Board meeting. Final well-being assessments were published in March 2017 by the PSBs in Cardiff and the Vale of Glamorgan. The draft Well-being Plans were considered at the November 2017 meeting of the Strategy and Engagement Committee and included in the Chair's report to the Board in November 2017.

ASSESSMENT

12 week consultations on the draft Well-being Plans in both areas concluded at the end of 2017. The development of Well-being Objectives for each PSB has drawn on a range of sources, including:

- local Well-being Assessments

- well-being objectives set by individual PSB member organisations (including the UHB's well-being objectives set out in our IMTP)
- discussions with Welsh Government and the Office of the Future Generations Commissioner
- multi-agency workshops
- discussions with PSB members

The draft Plans were considered by the UHB Management Executive prior to the PSB meetings which signed off the Plans for consultation. While the UHB is one of the statutory partners and was therefore involved in the preparation of the draft Well-being Plans, consultation provided an opportunity to test the objectives and proposals for priority action more widely within partner organisations and ensure alignment with the corporate plans of those organisations. The UHB therefore provided feedback on the draft Plans to the PSB teams to help shape the final versions of the Plan. The development of the UHB's IMTP has included appropriate consideration of the objectives and proposed actions in the draft Well-being Plans. The PSBs also recognise the need to work closely with the Regional Partnership Board to ensure that there is alignment of objectives and actions, along with clear accountability arrangements for taking lead responsibility on issues. In many respects, the Area Plan, approved by the UHB Board in January 2018, provides the care and support element of the Well-being Plans.

All statutory partners are required under the Act to sign off the Well-being Plans at a meeting of their respective Boards prior to final sign-off at meetings of the PSBs in April and publication in May. The final draft Well-being Plans were agreed for approval by the statutory partners at a meeting of the Vale PSB on 29 January and the Cardiff PSB on 27 February.

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UHB RESEARCH AND DEVELOPMENT (R&D) IMPLEMENTATION PLAN	
Name of Meeting; UHB Board	**Date of Meeting;** 29.3.2018

Executive Lead : Medical Director
Author : R and D Director
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: Potential resource allocation for strengthening services – see detailed plan for consideration in this paper.
Quality, Safety, Patient Experience impact : Research activity has a positive effect on patient outcomes.
Health and Care Standard Number; Standard 3.3 Research and Innovation
CRAF Reference Number 5.1 Deliver safe effective care
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE is provided by:

- The UHB R&D plan has undergone major changes with key changes and sets out rather than to just regulate the Clinical Boards, it encourages them to generate funding and resources for R&D with improved performance.

The Board is asked to:

- **APPROVE** the Research and Development Cardiff and Vale University Health Board Research and Development Implementation Plan.

SITUATION

This paper outlines the revised Cardiff and Vale University Health Board (UHB) Research and Development Implementation Plan. Included is the Executive Summary (appendix one) and detailed Clinical Board plans can be accessed via the Medical Director if required.

A series of individual meetings has been held with the Medical Director, R&D Director and each of the Clinical Board Directors/Research Leads in February 2018 to review the plan. In addition this was to inform them about the new Welsh Government (WG) Finance Policy and the implications for the UHB.

For April 2018 WG has mandated the introduction of its new R&D Finance Policy which would put the spending of all the UHB R&D non-commercial funding under the control of the R&D Director, not the Clinical Boards (CB). This would result in the removal of about £2.1m from CBs as at present this amount cannot be directly accounted for by CBs in R&D activity and is supporting normal service work. This money would come under the control of the UHB R&D Director which although it would be given straight back to CBs to undertake research is thought to be a financial risk to CBs. The UHBs R&D activity continues to fall and only releasing further investment into R&D will reverse the annual fall in WG non-commercial funding, restore our reputation as a research UHB, provide new therapies for patients in line with other university hospitals throughout the UK, make further drug/device savings through clinical trials, increase commercial income (presently £1.3m per annum, UK average for UHB £6m) and allow compliance with WG R&D Key Performance Indicators.

BACKGROUND

The UHB has historically delegated its Health and Care Research Wales (HCRW) research funding allocation to the Clinical Boards. With the move from Culyer funding to activity based funding (ABF) research funding income has fallen by £7m over the last 5 years down to £5.6m in 2017/18. Most of the UHB's previous research monies that have been lost from HCRW have been passed on to other NHS organisations within Wales who are investing this money directly in research from centralised budgets.

ASSESSMENT

The UHB has a strong R&D ethos and historical 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 and improve Research Performance key changes have been introduced in this revised implementation plan. This will enable delivery of the UHB's strategy with improved R&D performance and are summarised below:

1. Annual revised R&D implementation plans will be submitted by each of the eight Clinical Boards. The content of these will be assessed by a new R&D performance structure as described in point three. (The updated plans for each Clinical Board 2018/2019 are available from the Medical Director if required).

2. Activity Based Funding (ABF) received from HCRW will be centrally allocated over three years to the R&D office under the control of the R&D Director for future investment with the introduction of a revised financial operating policy for R&D funding, consistent with new Welsh Government policy. Investment of the above funding generated as a consequence of the change in financial policy will be used to build

research capacity over an initial three year period. In addition to funding being directed to those that are successful in research as measured by the key performance indicators there will be active consideration of how:

Clinical Boards are:

- Encouraging a joint approach between Clinical Boards for R and D funding proposals to share costs and the associated benefits from revenue.

- Supporting research active individuals not only from a traditional pool of medically trained staff but also nursing and therapies staff.

- Developing a mixed portfolio of studies enabling the more poorly resourced interventional studies to be financially underpinned by taking part in simpler large observational studies.

3. A new performance structure for the Clinical Boards which will consist of performance reports every quarter and face to face reviews (R&D Director and Medical Director) in March and September of each year with the production of an annual UHB performance report for Executives in June of each year. Key performance indicators for the Clinical Boards will include:

- The WG Performance Metrics as a minimum standard.

  1. Increase of 10% per annum of the number of HCRW Clinical Research Portfolio (CRP) studies being undertaken within the UHB;

  2. Increase of 5% per annum of the number of commercially sponsored studies being undertaken within the UHB;

  3. Increase of 10% per annum of the number of patients recruited into HCRW CRP studies being undertaken within the UHB; and

  4. Increase of 5% per annum of the number of patients recruited into commercially sponsored studies being undertaken within the UHB.

- Monitoring the number of studies that are set up but then do not recruit any patients with a waste of significant resource and effort.

- Reporting of the full benefits of R&D studies including the potential for significant drug savings to Clinical Boards.

- Increase commercial income from its present level of £1.3m per annum towards the UK average for a UHB of £6m over the next 5 years with the aim of increasing research capacity.

4. Strengthen links with Cardiff University (CU). In early 2018, CU refreshed its strategy, The Way Forward, setting out what the organisation aims to achieve over the next five years, against a number of strategic themes. These themes include Innovation and Research. A paper is currently being agreed at Executive level which sets out proposals for strengthening the partnership between Cardiff University and the UHB recognizing the inter-dependency of the working relationships between the two organisations, and the need to deliver both organisations strategic objectives over the next five years.
Currently without the development of a joint office and Clinical Trials Unit the UHB staff will not be able to make applications to the major grant giving bodies including the Medical Research Council. With closer working with CU and the Clinical Trials Unit there will be greater opportunities to secure funding from these grant giving bodies.

Cardiff and Vale University Health Board Research and Development Implementation Plan 2018/19 – Executive Section

Contents

1. Executive Summary
2. Background
3. Approach to Developing a Research Strategy
4. Executive Strategic Aims
5. R&D Office and Delivery Team Strategic Aims
6. Clinical Research Facility Strategic Aims

1`. Executive Summary

Our Mission is 'CARING FOR PEOPLE; KEEPING PEOPLE WELL'

Cardiff and Vale University Health Board has an important job to do. What we do matters because it's our job to care for people and keep them well.

Our Strategy is to achieve joined up care based on 'home first', avoiding harm waste and variation, empowering people and delivering outcomes that matter to them.

The Strategy sets out a number of objectives which contribute to four strategic themes including:

Culture: how we develop our people, work with partners, use technology to improve what we do, and enable R&D and innovation to flourish for patient and economic benefit.

Cardiff and Vale University Health Board (UHB) has a strong Research and Development (R&D) ethos and historical 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 the UHB. This implementation plan sets out to generate a structure which rather than just regulating the Clinical Boards, encourages them to generate funding and resources for R&D. To adapt to this changing funding landscape and improve performance key changes have been introduced in this revised implementation plan.

This will enable delivery of the UHB's strategy with improved R&D performance and outcomes and are summarised below:

1. Annual revised R&D implementation plans will be submitted by each of the eight Clinical Boards. The content of these will be assessed by a new R&D performance structure as described in point three. (The updated plans for each Clinical Board 2018/2019 are included in appendix one).

2. Activity Based Funding (ABF) received from Health and Care Research Wales (HCRW), Welsh Government (WG) will be centrally allocated to the R&D office over three years under the control of the R&D Director for future investment with the introduction of a revised financial operating policy for R&D funding, consistent with new Welsh Government policy. Investment of the above funding generated as a consequence of the change in financial policy will be used to build research capacity over an initial three year period. In addition to funding being directed to those that are successful in research as measured by the key performance indicators there will be active consideration of how:

Clinical Boards are:

- Encouraging a joint approach between each other for R and D funding proposals to share costs and the associated benefits from revenue.

- Supporting research active individuals not only from a traditional pool of medically trained staff but also nursing and therapies staff.

- Developing a mixed portfolio of studies enabling the more poorly resourced interventional studies to be financially underpinned by taking part in simpler large observational studies.

3. A new performance structure for the Clinical Boards which will consist of performance reports every quarter and face to face reviews (R&D Director and Medical Director) in March and September of each year with the production of an annual UHB performance report for Executives in June of each year. Key performance indicators for the Clinical Boards will include:

- The HCRW Performance Metrics (see below under Background) as a minimum standard.

- Monitoring the number of studies that are set up but then do not recruit any patients with a waste of significant resource and effort.

- Reporting of the full benefits of R&D studies including the potential for significant drug savings to Clinical Boards.

- 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 through the development of an increased research capacity.

4. Strengthen links with Cardiff University (CU). In early 2018, CU refreshed its strategy, The Way Forward, setting out what the organisation aims to achieve over the next five years, against a number of strategic themes. These themes include Innovation and Research. A paper is currently being agreed at Executive level which sets out proposals for strengthening the partnership between Cardiff University and the UHB recognizing the inter-dependency between the two organisations, and the need to deliver both organisations strategic objectives over the next five years.

Currently without the development of a joint office and Clinical Trials Unit the UHB staff will not be able to make applications to the major grant giving bodies including the Medical Research Council. With closer working with CU and the Clinical Trials Unit there will be greater opportunities to secure funding from these grant giving bodies.

2.0 Background

One of the core principles of the NHS and the UHB strategy is to bring benefits to patients through R&D and innovation. Effective R&D performance is essential if the UHB is to meet its values and 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&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 the UHB
- Exemplar as the leading Health Care provider in Wales
- Financial offset of staff costs (through provision from R&D income), drug/device savings through study participation, access to commercial income through research and trial participation
- Direct R&D income – Welsh Government.

The UHB has historically delegated its HCRW Welsh Government (HCRW WG) research funding allocation to the Clinical Boards. With the move from Culyer funding to activity based funding (ABF) research funding income has fallen by £7m over the last 5 years down to £5.6m in 2017/18. Most of the research monies previously given to the UHB from HCRW

has been passed on to other NHS organisations within Wales who are investing this money directly in research from centralised budgets.

As part of the HCRW Performance Metrics (see below), targets have been set in relation to number of research studies undertaken by the NHS organizations in Wales, and recruitment to these studies but the UHB is not presently achieving these:

- 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 has actually fallen over the last seven years and other NHS organisations in Wales who have been the beneficiaries of the new R&D monies have directly invested all their monies into R&D.

Strengthening and building the R&D culture within the UHB is priority for the organisation but there are challenges, which include:

- Competition for limited financial resources within the UHB
- 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 it is 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 resources from other NHS organizations
- External competition for Higher Education Institutions for grant funding
- Less than ideal operational collaborative working with local HEI's.

Also the funding model used by HCRW rewards simple, low impact observational studies as the funding formula is weighted as follows:

Interventional =11
Observation = 3.5
Large size = 1.

So for example three questionnaire participants attracts the same funding as one patient in a complicated cancer or critical care patient study. The UHB takes its role very seriously as a tertiary centre and is very often the only site in Wales able to offer many complicated trials. We see it as our role to offer Welsh patients these types of studies despite the funding formula not always providing adequate resources for these types of studies to cover costs. Unfortunately, the funding model has encouraged some UHBs to only take on highly remunerated studies reducing the funding pot available for more complicated studies. However, to be able to undertake the complicated – sometimes money losing - interventional studies, the UHB and its Clinical Boards need to have a mixed portfolio of studies enabling the more poorly resourced studies to be financially underpinned by taking part in simpler large observational studies.

In 2012 the UHB 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

It was decided that the Clinical Boards should be as fully autonomous as possible including the ability to develop their own plans and operational priorities including their approach to R&D.

R&D is overseen by the HCRW funded R&D Office which ensures Regulatory and Legal compliance of R&D and manages HCRW R&D key performance indicator compliance. In addition, HCRW also funds a Clinical Research Facility (CRF) and in October 2018 the previously centralised R&D delivery workforce was TUPE'd over from HCRW to the UHB with their associated funding. Traditionally the UHB ABF allocation has been top sliced to provide structural support including the R&D Office, Research Delivery staff, Pharmacy and the CRF (see section six below) but in 2017 these monies were added to the ABF funding model.

The R&D Office is headed by a Director and Manager who are managerially responsible to the Medical Director. This management structure has been strengthened by the addition of a performance manager, a delivery staff manager and the regional delivery staff manager who is “hosted” by the UHB (see section 5 below).

3.0 Approach to Developing a Research Implementation Plan

The Clinical Boards have 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 UHB R&D Implementation Plan consists of Executive, R&D Office, CRF and Clinical Board/Directorate sections. In keeping with HCRW performance metrics the UHB’s R&D Implementation Plan has to be approved by the Cardiff and Vale UHB annually. However, despite CVUHB’s R&D performance falling in terms of patient recruitment and ABF income, the previous 2 years Clinical Boards/Directorates R&D Implementation Plans were approved without significant alterations or improvement. CVUHB R&D performance/income continued to fall due to a failure of Clinical Boards/Directorates R&D Implementation Plans so in September 2017 CVUHB Executive Board rejected the R&D Implementation Plan highlighting a lack of ambition and failure to adapt to the third year of falling R&D performance and failure to implement their own R&D plans and grow R&D activity.

The UHB’s Executives wished to see a more ambitious approach to R&D to reverse our failing R&D performance protect and grow our R&D income, bring benefits to patients and under pin our values and strategy.

A letter was sent to all Clinical Board Directors, their finance teams and R&D Leads explaining the more ambitious approach to R&D. Each Board had to submit a new R&D Implementation Plan by the end of January 2018 which would be reviewed by the Medical Director and R&D Director at face to face meetings in February. At these meetings each Clinical Boards prior performance and R&D Implementation plans were reviewed with the aim of having the new plans and Executive Summary submitted for approval at the UHB Management Executive meeting in March 2018. Also at these meetings the teams were introduced to the new performance system which will consist of performance reports every quarter and face to face reviews in March and September of each year with the production of an annual UHB performance report for Executives in June of each year. This will enable the Boards to adapt their own R&D Implementation Plans over the summer ready to review at the September performance meeting and presented to the UHB Executive Board for approval and integration into the UHB’s IMTP plan during the Autumn for the following financial year.

4.0 Executive Strategic Aims Aims/Requirements to support the R&D Implementation Plan

Going forward the R&D plans for the Clinical Boards will be scrutinised and supported, to ensure a more ambitious and aggressive approach to research which aligns 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 the 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 opportunities with possible commercial exploitation.

5.0 R&D Office and Delivery Team Aims/Requirements to support the R&D Implementation Plan

The priorities for the R&D Office during 2018/19 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.
- 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 over three years.
- 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 R&D performance management system with 6 monthly performance meetings, address any areas of underperformance eg lack of staff, skills etc and the production of an R&D performance report for the UHB.
- Continue to develop the skill mix of Delivery staff and encourage and support non-medical PI’s.

6.0 Clinical Research Facility Aims/Requirements to support the R&D Implementation Plan

The priorities identified for the CRF in 2018-2019 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 tril

11

19

WHITCHURCH HOSPITAL – DISPOSAL OF SITE
Name of Meeting : Board **Date of Meeting** 29th March 2018

Executive Lead: Director of Planning
Author: Director of Capital, Estates and Facilities 029 2074 4335
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: Potential capital receipt. Disposal cost met from receipt
Quality, Safety, Patient Experience impact: This report is fundamental to the continued provision of safe and appropriate patient and staff facilities within UHB premises.
Health and Care Standard Number: Standard 2.1 Managing Risk and Promoting Health and Safety
CRAF Reference Number: 6.4
ASSURANCE AND RECOMMENDATION **ASSURANCE** is provided by :- • The UHB Board has previously received a recommendation and approved the exchange of land between Cardiff and Vale UHB and Velindre NHS Trust. • The land exchange was subject to the successful outline planning permission being granted for the development of the proposed new Velindre Specialist Cancer Center which was approved by Cardiff City Council in November 2017. The Board is asked to: • **APPROVE** the recommendation to declare the Whitchurch Hospital site surplus to requirements • **APPROVE** the recommendation to dispose of the existing Whitchurch hospital site and adjacent land transferred to its ownership previously owned by Velindre NHS Trust and seek Welsh Government approval as required

SITUATION

The UHB has previously approved a land exchange proposal between Cardiff and Vale UHB and Velindre NHS Trust. This transaction allows for the proposed Velindre Specialist Cancer Center to be developed on land known as Northern Meadows which is currently owned by Cardiff and Vale UHB.

The contract for the exchange of land has been developed between both parties and the trigger point for the completion of the transaction was the receipt of outline planning permission by Velindre NHS Trust for the proposed development. The Local Authority determined the application in November 2017, subject to the completion of the Section 106 agreement. The details of the Section 106 agreement have now been finalised which will allow for the formal Outline approval to be issued.

BACKGROUND

Cardiff and Vale UHB vacated Whitchurch Hospital in April 2016 following the completion of the Hafan Y Coed unit at University Hospital Llandough and the successful transfer of patients.

Since that time the main hospital building has been decommissioned and secured whilst the detailed discussions and contract negotiations have progressed to enable the land transfer between Cardiff and Vale UHB and Velindre NHS Trust to complete. The details of the proposed transfer were previously considered by the UHB Board and approved.

Velindre NHS Trust have subject to completion of the Section 106 agreement received outline planning permission for the proposed new Specialist Cancer Center which will now trigger the formal exchange of land between the parties.

The completion of the exchange of land will allow Cardiff and Vale UHB to declare the site surplus estate and commence the marketing for disposal.

It should be noted that the UHB continue to occupy part of the Whitchurch site, with the former Headquarters building being occupied by the Community Resource team. This building and adjacent land will not form part of the disposal. The UHB will retain part of the land for the proposed development of a Health & Wellbeing Hub for the North Cardiff locality as referenced in the ‘Shaping Our Future and Wellbeing– in the community’ Programme.

ASSESSMENT AND ASSURANCE

It is anticipated that the land exchange described will be complete by the end of March 2018 and that marketing of the old Whitchurch Hospital buildings and adjacent land could commence immediately.

The UHB have previously established a disposal team, including property surveyors, (Savills) Planning Consultant, (White Young Green) Legal Advisors (Blake Morgan) and NWSSP Property Department. A considerable amount of work has been undertaken to prepare to market the site.

With the land exchange imminent it is recommended that the UHB formally declare the site as surplus and seek approval from Welsh Government to progress its disposal as soon as possible.

20

FUNDED NURSING CARE (FNC)

Meeting: Board	**Date:** 29 March 2018
Executive Lead : Director of Corporate Governance	
Author : Director of Corporate Governance 029 2074 4230	
Caring for People, Keeping People Well – Yes Care in the Community	
Financial impact : £ actual figure or approximate-To be agreed	
Quality, Safety, Patient Experience impact : Yes	
Health and Care Standard Number 1	**CRAF Reference Number** 2,3,5,6
Equality Impact Assessment Completed: Yes / No / Not – Not Applicable	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Chief Executive Officers Group have discussed and approved the paper for circulation to Health Boards

The Board is asked to:

- **NOTE** the background provided and the legal challenges regarding FNC that have taken place over recent years;
- **NOTE** the Judgment of the Supreme Court that quashes the previous HB decisions and finds both HB and LA arguments regarding what should form the FNC rate to be incorrect, instead providing its own definition;
- **NOTE** the implications of this for HBs and LAs, including the need to uplift the FNC rate in order to ensure compliance with the Judgment;
- **NOTE and APPROVE** the recommendation that the FNC rate that is the responsibility of the HBs to fund be uplifted to £162.75;
- **NOTE** the work underway to develop processes to manage reimbursement and the need to consider the current policy model in discussions with WG.

SITUATION

20

Funded Nursing Care (FNC) refers to NHS Funding of Registered care with care homes.

This was introduced in 2001 and since that time there have been significant discussions and legal proceedings in relation to the rates to be paid resulting in a judgment being made by the Supreme Court in August 2017. The purpose of this paper is:

- To update the Board on the position regarding Funded Nursing Care (FNC) following the 2017 Supreme Court Judgment;
- To advise the Board of the work underway since the Judgment to ensure compliance;
- To seek Board approval for a revised FNC rate.

BACKGROUND

Funded Nursing Care (FNC) refers to the NHS funding of Registered Nursing care within care homes where the need for nursing care has been assessed as necessary. In 2001 Welsh Government introduced FNC and a flat rate was introduced by Welsh Government to cover this cost.

In 2007, Welsh Government transferred the FNC model to Health Boards and uplifts were provided annually in line with the general allocation uplifts from Welsh Government.

Since this time there have been considerable discussion and legal proceedings to address the concern of Providers that the rate paid had not kept pace with increasing costs.

ASSESSMENT

In 2012, recognising this concern of Providers in relation to the rates being paid, the Chief Executive Officers established a FNC Group to consider the current rate and whether this remained appropriate. This work led to the commissioning of a large study of 256 care homes and was undertaken by Laing and Buisson and a report was published in 2013.
Based on this study a staged uplift was approved to the rate over a 2 year period. However, a number of Providers were not content with this and Judicial Review proceedings commenced in 2014 and were heard in the High Court in 2015. At this time Local Authorities were mentioned as an Interested Party. The High Court found in favour of the Health Boards. Following the Court of Appeal judgment, Providers decided not to appeal to the Supreme Court. However, Local Authorities did and this hearing took place in 2017 with the Local Authorities now the Appellants.

In August 2017, the Supreme Court handed down its judgment and said the interface between Health and Social Care is a ‘difficult and controversial

policy area'. The Court provided its own view of what service should be included in the FNC rate.

The consequence of this decision has continued to be monitored closely by the Chief Executive Officers Group. In summary, the revised rate will apply from 1st April 2014 and be back dated.

The Chief Executive Officer Group has now approved a report and has requested that this be presented to all Health Boards meetings in March 2018. The report is attached and sets out in more detail the implications of the judgment and the financial implications.

FNC Paper for March HB Board

Funded Nursing Care: Update and Revised FNC Rate

1. Purpose

The purpose of this paper is to:

- Update the Board on the position regarding Funded Nursing Care (FNC) following the 2017 Supreme Court Judgment;
- Advise the Board of the work underway since the Judgment to ensure compliance;
- Seek Board approval for a revised FNC rate.

2. Background

Funded Nursing Care (FNC) refers to the NHS funding of Registered Nursing (RN) care within care homes, where the need for nursing input has been assessed as necessary. The (then) Welsh Assembly Government introduced FNC in 2001 to address the anomaly that nursing care in Care Homes was potentially chargeable. Prior to FNC being introduced, funding of nursing care in care homes was dependent upon a financial assessment, the outcome of which dictated whether the care was funding by the individual as a self –funder or by the responsible Local Authority.

Initially funded by WG, a £100 flat rate contribution covered the RN costs provided to an individual and any continence products that may be necessary. The flat rate was the equivalent of approximately 7.5 hours of RN input per resident per week, with the funding provided via a vote transfer from Local Authorities.

WG transferred the FNC model and funding to HBs in 2007. Uplifts were provided annually in line with the general allocation uplift from WG. In those years where there was no resource uplift from WG, no uplift was made to the FNC rate.

In 2012, recognising the concerns of Providers that the rate had not kept pace with increasing costs on the care sector, CEOs established an FNC Group with a remit to consider the current FNC rate and whether that remained appropriate. The Group initially undertook a small scale survey to capture the functions undertaken by a registered nurse in care homes over the course of several days. This identified significant periods of time when the registered nurse was not involved in either direct or indirect nursing duties, and led to the commissioning of a larger study of 256 care homes via Laing & Buisson. Independent Care Sector Providers were engaged with the commissioning and design of the work, via Care Forum Wales, throughout this process.

Laing & Buisson reported back in July 2013. Based on a 25% response rate their report concluded that, within the parameters set by the FNC Group, the average cost per resident was higher than that currently paid by HBs. Based upon this, HB Boards all approved a staged uplift to the rate over two years, increasing the hours funded from 7.5 hours to 7.62 hours.

3. The Legal Proceedings

Despite the work undertaken by HBs, and the uplifts subsequently made in response to the outcome of this work, a number of Providers felt that certain aspects of the RN time currently excluded by HBs should have been included in the FNC rate and therefore challenged the decisions relating to the setting of the FNC rates, initially via correspondence between Solicitors, and then via **Judicial Review** proceedings. The court proceedings were issued in September 2014 and heard in the High Court in February 2015. Local Authorities joined the proceedings as Interested Parties and supported the Providers' arguments. Welsh Government were also named as an interested party but, whilst their Counsel was present at the High Court, he took no active part in proceedings.

Despite a concession made by Health Boards during the hearing that 'stand by time' should be included in the FNC rate, the Judgment concluded that, in defining the services that they had to provide under the legislation, the Health Boards had adopted a task-based approach and restricted services to the tasks that only a registered nurse could perform. The Judge held that it was necessary to meet care home residents' needs to have a registered nurse on site at all times to deal with specific nursing and medical requirements,. The Health Boards were responsible for providing such a nurse, and responsibility was not diminished simply because the nurse might not be performing the specific tasks that only a registered nurse could perform at all times.

HBs appealed the Judgment to the **Court of Appeal** and the Hearing took place in late 2015. Again, Local Authorities were Interested Parties in support of the Providers and WG once again adopted a neutral stance and took no active part in proceedings. The Secretary of State for Health in England also intervened in the proceedings at this point in support of the HBs' arguments.

The Court of Appeal found on a 2:1 basis (one Judge adopting a neutral position) in favour of the HBs position.

Following the Court of Appeal Judgment, Providers indicated they would take no further legal action but Local Authorities sought, and were subsequently granted, permission to appeal to the Supreme Court.

The **Supreme Court** hearing took place in early 2017 with LAs now the Appellants. The Secretary of State for Health was once again an Intervener supportive of the HBs argument. WG again took no active part in proceedings. The Supreme Court handed down its Judgment in August 2017.

The Judgment describes the interface between health and social care as 'a difficult and controversial policy area'. The Supreme Court also noted that surprisingly there was little previous case law to support their deliberations.

In allowing the appeal the Supreme Court rejected the arguments of both the HBs and LAs and determined that both parties had misinterpreted s49(2). Instead, the Court provided its own view of what services should be included in the FNC rate.

The Court concluded that ""*nursing care by a registered nurse" covers (a) time spent on nursing care, in the sense of care which can only be provided by a registered nurse, including both direct and indirect nursing time as defined by the Laing and Buisson study; (b) paid breaks; (c) time receiving supervision; (d) stand-by time; and (e) time spent on providing, planning, supervising or delegating the provision of other types of care which in all the circumstances ought to be provided by a registered nurse because they are ancillary to or closely connected with or part and parcel of the nursing care which she has to provide*".

The remainder of the personal care provided by registered nurses which does not fall within the definition above is to be funded by LAs.

There is no further avenue for appeal and the decision of the Supreme Court is the final Court ruling on this matter. The Judgment applies in England as well as Wales.

Over the course of the legal proceedings, HBs have continued to make annual uplifts to the FNC rate in line with the Inflationary Uplift Mechanism previously approved by all HB Boards.

4. Revising the rate

The Supreme Court Judgment ("the Judgment") effectively quashed the decisions taken by HBs to set the FNC rate initially in 2014, and subsequent decisions uplifting the rate. The Court has determined that these decisions do not reflect the requirements of s49. HBs therefore need to retake decisions based upon those factors which the Court has determined should be included.

Work has been underway across all parties over recent months to consider how the FNC rate needs to be calculated and set. This work has involved both HBs and LG representatives and has been facilitated by WG. Professor John Bolton was commissioned by WG to consider the Judgment and the options for parties to consider as to how to meet the Court's requirements. Professor Bolton considered the Laing & Buisson (L&B) Report to be appropriate as the basis for this work, rather than the work commissioned by the Department of Health from Mazars. There are a number of reasons why the L&B model was determined the most appropriate:

- The L&B Report was undertaken in Wales and reflects the Welsh context;
- The Courts have not been critical of the methodology or findings in the L&B Report, instead they viewed the application of the findings to be incorrect;
- The L&B Report had a 25% response rate whereas the Mazars work in England had only a 10% response rate;
- The time calculated for personal care provided by the registered nurse was higher in the L&B report than the equivalent finding from Mazars. HBs have therefore opted for the higher amount;
- The Mazars work was undertaken in England and their view is the findings are not directly reproducible in Wales. A further piece of work would need to be commissioned taking several months and incurring additional costs.

Professor Bolton concluded there were two main options, both of these reflected the Court's view that HBs fund: direct and indirect RN care; stand by time; paid breaks,

registrant supervision time. The option of choice provides a 50:50 split in the costs between the HBs and LAs of the time spent on other types of care which is ancillary to, or closely connected with, nursing care[1].

5. The FNC Rate

The current FNC rate is £149.67 per person per week which is the financial equivalent of the current 8.09 hours of RN input per person, per week funded[2].

All parties[3] have supported the recommendation made by the WG led Steering Group that HBs will be responsible for an additional 0.38 hours for paid breaks and registrant supervision; and 50% of the additional 0.77 hours identified in L&B for time spent on personal/social care[4]. The remaining 50% of the personal/social care time will be borne by the LAs.

HBs are therefore responsible for an additional 0.765 hours which equates to an increase of £13.08 to the FNC rate, per person, per week; so the new FNC rate for HBs would be £162.75[5]. LAs are responsible for an additional 0.385 hours which equates to an additional £6.59 per person, per week; which will be an increase on their current rate.

Given the Supreme Court quashed the 2014 decisions taken by HB Boards, the uplift will apply from 1 April 2014 – backdating will therefore be necessary.

6. Next steps

In addition to uplifting the FNC rate, there are a number of other strands of work that will need to be progressed. These will include:

- Backdating the revised rate to 2014. Significant work has already been undertaken by finance colleagues across HBs to ensure data is available on numbers funded and the funding period – the two factors necessary to calculate the amount of backdated funding;
- Developing a process that will provide HB Boards with assurance that the factors being funded are provided to staff working within Care Homes – for example paid breaks. Work will need to be done to identify how corporate

[1] The alternative option would have required negotiation with individual LAs regarding the proportion of personal care time which is ancillary to or closely connected with nursing care. .

[2] This is made up of the 7.5 hours of funding transferred from WG in 2007 when the funding was rolled out to HBs, a further 0.12 hours uplifted post 2013 L&B report, plus an additional 0.47 hours per person, per week for stand by time which was conceded at the High Court hearing.

[3] A Steering Group established by WG with LA, HB, WLGA and NHS Confed Wales representation.

[4] This is the component that will be shared between health boards and local authorities.

[5] This is based on the current hourly rate of £17.10 per hour.

assurance can be provided without placing disproportionate demands for evidence upon Providers;
- Processes to identify and reimburse self funders who may, post Judgment, have funded some services that should have formed part of the FNC rate;
- Compliance with the Cost Order issued by the Court;
- Working with WG to consider the necessary changes to Policy that result from the Supreme Court Judgment[6]

7. Conclusion

Board members will be aware from previous papers received and considered over recent years of the legal challenges that have been underway regarding FNC.

Whilst the outcome of the Judgment in 2017 was that the Appeal was allowed, the Court clearly rejected the arguments of both the HBs and LAs and determined that both parties had misinterpreted s49(2). The Court therefore provided its own view of what services should be included in the FNC rate. This means the inclusion of paid breaks, registrant supervision time, and a proportion of the personal care that it is appropriate for the registered nurse to undertake because it is ancillary to the plan of care must be funded by HBs. The remainder of the personal care provided by registered nurses will be funded by LAs – this has been considered and an apportionment of 50:50 with LA partners has been agreed for this element only.

This paper sets out the implications of the Judgment, namely that the previous decisions have been quashed and HBs need to retake decisions that reflect compliance with the Judgment. In financial terms, this will require the HB FNC rate to rise from its current £149.67 to £162.75, and for the LAs to increase their rate by £6.69. It will be the responsibility of the HBs to fund the increase in the FNC rate only.

Processes will need to be put in place to backdate the additional requirements to 2014 along with appropriate and proportionate assurance mechanisms that the additional components identified by the Court are actually being provided. HBs will also need to identify and reimburse any self funders who may have funded some services the Court has now determined the NHS should have funded. Work is underway to develop these processes via a Technical Group. Funding for the retrospective payment has been provided to the HBs by Welsh Government.

[6] The WG estimation of 7.5hours RN time per person per week continued to be used by HBs when WG transferred responsibility in 2007. The Supreme Court has now determined that to be insufficient to meet the full responsibilities within s49.

FNC Paper for March HB Board

8. Recommendations

Board members are asked to:

- **Note** the background provided and the legal challenges regarding FNC that have taken place over recent years;
- **Note** the Judgment of the Supreme Court that quashes the previous HB decisions and finds both HB and LA arguments regarding what should form the FNC rate to be incorrect, instead providing its own definition;
- **Note** the implications of this for HBs and LAs, including the need to uplift the FNC rate in order to ensure compliance with the Judgment;
- **Note and approve** the recommendation that the FNC rate that is the responsibility of the HBs to fund be uplifted to £162.75;
- **Note** the work underway to develop processes to manage reimbursement and the need to consider the current policy model in discussions with WG.

CONFIRMED MINUTES OF A MEETING OF THE STRATEGY AND ENGAGEMENT COMMITTEE HELD ON 28 NOVEMBER 2017 – 9.00AM CORPORATE MEETING ROOM, HEADQUARTERS, UHW

21.1

Present:

John Antoniazzi	Independent Member – Capital Management, Chair
Eileen Brandreth	Independent Member – IT

In Attendance:

Len Richards	Chief Executive Officer
Abigail Harris	Director of Planning
Bob Chadwick	Director of Finance
Keithley Wilkinson	Equality Manager
Marie Davies	Deputy Director of Planning
Martin Driscoll	Director of Workforce & Organisational Development
Peter Welsh	Director of Corporate Governance
Rachel Jones	Assistant Director of Integrated Health & Social Care
Sharon Hopkins	Director of Public Health

Apologies:

Fiona Jenkins	Director of Therapies
Ruth Walker	Executive Nurse Director
Geoff Walsh	Director of Capital and Estates
Steve Curry	Interim Chief Operating Officer

Secretariat: Glynis Mulford

SE: 17/039 WELCOME AND INTRODUCTIONS

The Chair opened the meeting and welcomed everyone present.

SE: 17/040 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

SE: 17/041 DECLARATIONS OF INTEREST

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

SE: 17/042 MINUTES OF THE PEOPLE, PLANNING AND PERFORMANCE COMMITTEE MEETING HELD ON 5 SEPTEMBER 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 5 September 2017.

SE: 17/043 ACTION LOG FROM MEETING PEOPLE, PLANNING AND PERFORMANCE MEETING HELD ON 5 SEPTEMBER 2017

The Committee **RECEIVED** the Action Log from the meeting of 5 September 2017 and **NOTED** the following:

UHB 17/182: Traffic Management and Car Parking – Members were informed there were two parts to the contract process one was in regard to a technical evaluation and the second consisted of a panel with two independent members. It was suggested there should be a discussion with the panel prior to the formal meeting to talk through requirements.

ACTION: A meeting to be arranged with panel prior to formal session

SE: 17019 - 2018/19 – 2021 Commissioning Intentions and IMTP Deliverables: - To ensure patients waiting for outpatient follow-up is captured in report. **COMPLETE**

SE: 17/024 - *Food Outlets and Non Patient Catering -* Keithley Wilkinson will meet with procurement to review process. It was noted that the Equality Impact Assessment had been completed.

SE: 17/044 QUARTER TWO, 2017, 18 INTEGRATED MEDIUM TERM PLAN ASSURANCE REPORT

Mrs Abigail Harris, Director of Strategic Planning presented the report. Members were informed that the Health Board was required by Welsh Government (WG) to report quarterly on progress with implementing Integrated Medium Term Plan (IMTP). The report presented a high level summary with Clinical Boards (CBs) identifying key actions progressed in quarter 2 for each of the priorities set out in the IMTP. The focus centred on CBs actions, which were committed to in the IMTP, and the progress made. It was noted that the recent performance reviews with Clinical Boards had included an in-depth review of progress against the priorities and actions set out within their plans.

It was discussed and noted:

- The corporate document was commended for its detail and content but stated there was too much information for the Committee. It was therefore suggested for it to be filtered to enable the Committee to focus on aspects related to the strategy.
- There was a need to consider putting actions in place for years two and three and what the role of Committee would be in having a forward look.
- In response it was stated a working document had been drafted which sets out beyond the three year cycle of the IMTP. It looked at the remainder of the key milestones for delivering the strategy timeframe and analyzed the big milestones in that period. The IMTP was evolving to better reflect years two and three of the strategy.

- To report key risks to delivery to the Committee in the quarterly reports.
- The Committee should identify specific areas that were not meeting the plan and were material to long term strategy.
- If there were issues that raised concern, this should be on the risk register around the strategy and should be elevated to this meeting.
- Items should be risk related to the bigger strategy rather than it being around a small component. There was a need to be more discerning of risks against the 10 year strategy.
- In response to how risks are highlighted, it was stated the risks were identified through the performance review process and other committee functions.
- Future reports to the Committee would follow the quarter performance review.
- The executives to update the risk register and only bring items that are of significant risk, with actions, in order for the Committee to be assured that there was a plan around the risk.

ACTION: Executives to update risk register and bring to Committee significant risks and mitigating actions.

The Committee:

- **NOTED** the progress made against the key 2017/18 IMTP schemes in quarter 2 and
- **ENDORSED** this progress report to Board

SE: 17/045 UPDATE ON INTEGARTED MEDIUM TERM PLAN FOR 2018-19

Mrs Abigail Harris, Director of Strategic Planning stated the Commissioning Intentions were agreed at the last Board meeting and discussed the key deliverables document.

It was discussed and noted:

- The executive team was in process of triangulating what the Clinical Boards can achieve, what could be accomplished as an organisation and where this places the Health Board in terms of the financial plan. The position will be reviewed on 11 December 2017.
- Management Executives will meet on 18 December 2017 and will present information on the financial plan for next year.
- On 4 January 2018 the Finance Committee will discuss the plan before it is delivered to Welsh Government. An invitation to the Finance Committee will be extended to all Board members. A meeting had been arranged with Heads of Finance to go through the first cut of IMTP, where pressures will be ascertained and PODs, with financial implications, presented. This will be to have an indication of the pressures and investments and what schemes are in place to show any gaps before being submitted to Welsh Government in March.
- The IMTP was being framed as a three year plan and it was explained that the process concluded that the Health Board had an unapprovable IMTP because of the financial position and there was a need to have a one year plan. At the Targeted Intervention meeting it was made clear by Welsh Government to develop

that the UHB should develop a 3 year plan based on the performance of the Health Board this year.

- Members raised questions, as the IMTP was being developed and the consideration of financial pressures, how will the financial pressures impede or advantage our strategic direction, if we are not able to free funds in order to invest. Secondly, what would be the approach to mitigate this as there was a need to understand what this means for our strategy and how we can adapt.
- In response it was stated that freeing funds in order to invest was one of the key enablers and whilst trying to identify resource that closes the financial gap there was a need to find the balance of how this is done.
- In regard to the risks it was stated the Corporate Risk Assurance Framework (CRAF) had not been arranged against the key objectives of the strategy and there was a need to look how this could be aligned.
- It was acknowledged that capital estates presented a real barrier in delivery of service. Other fragile areas were highlighted where more control was needed to be applied.

The Committee:

- **NOTED** the update on the Integrated Medium Term Plan for 2018/19

SE: 17/046 CAPITAL PROGRAMME REPORT

Mrs Abigail Harris, Director of Strategic Planning presented an assurance report stating the condition of the estate represented a significant risk to the organisation with significant financial commitment to mitigate the risk. It was noted that there are two key sources of funding for capital, the discretionary capital budget which comes through our annual allocation and the all Wales capital programme which is accessed by submitting business cases to WG for approval.

It was noted that the first phase of the neonatal programme was complete. In relation to the latest phase asbestos had been discovered in the ground and was explained that if we slip on the capital programme the money would go back to WG and would not be returned next year. There was further discussion that this should be challenged as this was a genuine issue that could not be foreseen.

It was noted that the Director of Capital, Estates and Facilities was reviewing two capital programmes to identify any actions that could be brought forward into this year.

There had been delay in the development of CRI and Rookwood as the contractor had withdrawn and the Health Board was progressing with the new contractors. The full business case for Rookwood had been revisited and would be submitted to WG in January 2018.

ACTION: **To ensure that the scrutiny report for the next meeting assessed the impact, and mitigations in relation to the slippage on the neonatal programme**

The Committee:

- **NOTED** the report content of the report recognizing the difficulty in managing a large and complex programme of works within a limited resource
- **SUPPORTED** the approach taken to manage the competing requirements of the Clinical Boards by engaging with them through a series of workshops to agree the priorities
- **NOTED** the risks in relation to estate compliance and in particular the management of asbestos and the difficulties restricted access to plant rooms etc. can pose to maintaining engineering services to support clinical activity

SE: 17/047 NIGHT TIME ECONOMY STRATEGY

Mrs Sharon Hopkins, Director of Public Health, stated this was a partnership strategy delivered through the Partnership Board. The strategy had been developed with the local authorities and other agencies, and UHB Staff had been involved in the process. In regard to finances the Committee was assured there was no request for new resource to fund the strategy. Although ambitious, the Business District Improvement Plans will have a number of bids to increase the resource to support delivery of the strategy. The Business District Improvement Plan will not have a call directly on UHB funding and the expectation was those contributing to the funding in regard to the night time economy services will remain.

A query was raised as the approach to drink spiking was not evident in the strategy. In response it was stated that drink spiking was being dealt with through the Area Planning Board and there was dovetailing of what the definitive actions in the different services are and how this links into an overarching strategy and approach. It was stated there was a lot of work going on that would not necessarily be seen in the strategy.

The Committee:

- **APPROVED** the Night Time Economy Strategy

SE: 17/048 STRATEGY FOR REDEVELOPMENT OF UHW SITE

Mrs Abigail Harris, Director of Strategic Planning stated that a strategic plan was being developed for estates. This could not be detailed until work was completed on the Clinical Services and what was required in terms of infrastructure. The plan, at a high level, would describe the whole system service model and a significant amount of work had been done through the Transformation Board and Shaping Our Future Wellbeing in regard to what services needed to be transferred into the community. The presentation, which had also been shared with Welsh Government, was a high level summary and showed what was needed to be articulated in the Estates Strategy. This will require infrastructure in the community in regard to the Wellbeing Hubs which is being discussed at the next Board Development Session along with the condition of our estates.

There was a Strategic Outline Plan for technology which will enable the Health Board to deliver services in a different way. There had been collaboration with Primary Community and Intermediate Care Clinical Board on the primary care estates plan and the need for this to reflect implications of the Local Development Plan. In addition, there was engagement with Cardiff Council to ensure the Wellbeing Hub model dovetails with the Community Hub model. The presentation set out questions in regard to clinical service plans and was a work in progress. Discussions had started with Abertawe Bro Morgannwg (ABM) University Health Board for there to be a new approach in planning tertiary services. Members were informed the Health Board was Wales' leading teaching, research (with Cardiff University), and academic centre and to look at how this can be promoted to become a clearer feature.

It was discussed and noted:

- In regard to what our plan would be in tertiary services and working with Abertawe Bro Morgannwg UHB, there will be increasing discussion with our Board recognising they are a specialist centre and there are a number of fragile specialist services in our area. The organisation had to realize the need to play our part and have an open approach to think of our services in relation to what was being developed in our HB that complimented Abertawe Bro Morgannwg.
- In relation to SOFW in the community was a timetable for the work and business cases and there was a huge amount of work to get the business cases developed and recognized that an outside skill set was needed.
- A condition survey had been completed on all of the estates and a utilisation survey highlighted the buildings that were being used well and those that were not. As the model of our services change it has become apparent that a number of places were not being used appropriately.
- Decisions had to be made to ensure the estate was being used efficiently. The latest information on benchmarking had been received regarding the cost of heat, light and cleaning and the estates maintenance cost. This would help to inform future decisions.
- In response to whether there was enough resource in the Health Board, it was stated that the organisation worked alongside the Local Authorities (through a Public Sector Asset Board in Cardiff). They had closed a number of facilities as they were not viable and consolidated services into hubs; there had been learning from this process.
- In response to buildings that had deteriorated it was stated that the condition survey and the risk assessments undertaken ensured that no one was vulnerable. Urgent action would be taken if deemed unsafe.
- Although encouraged to see compliance was being assessed, it was raised that there was a gap in what was planned to be done and the work able to be executed. This was also in regard to assessing the estates. It was further queried whether we had prioritised areas considered to be the highest risk to be done first. In response it was stated that this would be included as part of the statutory compliance and as part of the presentation. The Committee was assured that the Director of Capital Estates and Facility was aware of the all the work that needed to be undertaken across the Health Board and there was a good system in place of knowing where this work was being resolved.

- A number of questions raised would be considered at the Board Development day to be discussed in depth.

The Committee:

- **NOTED** the verbal report

SE: 17/049 PUBLIC SERVICE BOARD WELLBEING PLANS CONSULTATIONS

Mrs Sharon Hopkins, Director of Public Health, presented the two Public Service Board Wellbeing Plans to the Committee. These plans had to be produced as a result of the Wellbeing of Future Generations (WBFG) Act. The Needs Assessment that informed the wellbeing plans had been undertaken with the local authority. A common approach to consultation was taken across the two local authorities through a programme called 'Let's Talk'. This proved successful with a good level of engagement activities and participation. From the needs assessment, priorities to address the significant needs were identified. The wellbeing plans reflected the five ways of working set out in the Wellbeing of Future Generations Act, and align with Shaping our Future Wellbeing.

Members were informed the consultation process would finish mid December 2017. The plan will be finalised and brought through the Public Service Board and partner organisations for approval.

A query and was raised in regard to children and young people and children with special needs whether the plan addressed the mental health issues. It was stated that it was covered at a strategic level. The mental health and wellbeing was a critical factor in deriving service plans, therefore the objectives were inclusive. It was assured during the development of the Population Needs Assessment mental health and children were high up in conversation.

The Committee:

- **CONSIDERED** the draft Wellbeing Plans to inform UHB feedback as part of the consultations and inform IMTP development

SE: 17/050 CARDIFF AND VALE OF GLAMORGAN AREA PLAN FOR CARE AND SUPPORT NEEDS

Mrs Rachel Jones, Assistant Director of Integrated Health and Social Care stated that there was a statutory duty on the Health Board and two local authorities to produce an area plan. The requirement for the plan was set out in the Social Services and Wellbeing (SSWB) Act. It was recognized that there was cross over with the requirement of the WBFG Act requirements. In terms of the Area Plan there was a duty on the statutory bodies for a Population Needs Assessment. The Regional Partnership Board is responsible for overseeing the area plan and the Public Service Board (PSB). There was a challenge that issues arising from the Populations Needs Assessment were not in the remit of Regional Partnership Board and therefore there

was a need to ensure collectively that nothing was being missed or falling through the gaps.

The Area Plan is a high level document with a supporting action plan. There was no statutory consultation period for the Area Plan a consultation exercise followed the Population Needs Assessment, which ends on 3 December 2017. The process will be to take an amended plan back through the RPB in the New Year; to the Board for formal approval and also the two Cabinets. One of the key themes to come out of the consultation was access to care and support and public transport. It was raised at the last RPB how to join up with the action that sits on the PSB agenda, and how to share strategies around these issues. There was a need to continue to work with PSB colleagues to ensure the two agendas were aligned.

The Committee was informed of the many interconnected and multiple plans and strategies and was keen to ensure that there was no duplication. It was suggested for a plan map to be produced showing all the plans the Health Board was work against so there was no duplication.

The Committee:

- **CONSIDERED** the draft Area Plan for Care and Support Needs to inform UHB feedback as part of the consultations and inform IMTP development

An Independent Member left the meeting therefore Committee was not quorate

SE: 17/051 THORACIC SURGERY SERVICES

The Director of Strategic Planning gave an update on the engagement process being undertaken in regard to Thoracic Surgery Services. The information came to Board to support the Welsh Health Specialised Services Committee (WHSSC) led engagement which concluded on 30 November 2017. There will be an internal WHSSC meeting to gather all of the views and comments received as part of the process; some of these have been directly fed into WHSSC. Following this process a Project Board meeting will be set up with two members of staff representing the organisation and will be making a recommendation to look at the evidence to support a single site model. An Independent Panel is waiting to be convened in regard to the recommendation from the Panel Project Board to consider all the evidence and which of the two existing sites would be the single site for South Wales. This process is due to happen in January 2018. The Health Board was being asked to submit evidence on how well we would be able to establish this. There was a need to ensure planning with regard to the outcome. In regard to Major Trauma, the Community Health Council was aware that there were two processes following different approaches, which was explained.

The Committee:

- **CONSIDERED** the questions posed in the Engagement Document
- **NOTED** the approach to local engagement to support the wider WHSSC engagement on the future of these services

- **NOTED** that specific pieces of evidence have been required by WHSSC to inform the work of potential Independent Panel recommendation on the location of a single centre

SE: 17/052 EXTRACT ON CORPORATE RISK ASSURANCE FRAMEWORK

Mr Peter Welsh, Director of Corporate Governance highlighted the current positions of risks associated with Committee stating there were no new risks. A process was underway of changing the risk register to be more meaningful and was looking at best practice outside of Wales. The intention was through Management Executive and through the Board to have a new arrangement in place next April 2018 and align risks against strategic objectives which would appropriate greater ownership.

The Committee:
- **CONSIDERED** the CRAF Update Report
- **AGREED** assignment of risks to the Committee
- **CONSIDERED** whether further assurance is required for its risks

SE: 17/053 ANY OTHER BUSINESS

There was no other business to report.

SECTION 2: ITEMS FOR INFORMATION

SE: 17/054 CORPORATE PROGRAMME TRACKER REPORT

The Committee:
- **NOTED** the overall October position of the developments as show in the Planning Programme Tracker (PPT) dashboard
- **AGREED** based on the tracker exception report, the schemes which need to be prioritised in order for further progress be made and therefore any actions required

SE: 17/055 CONSULTATION ON MAJOR TRAUMA NETWORK DEVELOPMENT

The Committee:
- **NOTED** the approach to consultation being led by the Collaborative and the local approach agreed with the Cardiff and Vale Community Health Council

SE: 17/056 INTEGRATING CARE FUND QUARTERLY REPORT

The Committee:
- **NOTED** the Quarter 2 Performance Report of the Integrated Care Fund 2017-18

AC: 17/057 REVIEW OF THE MEETING

There was nothing of note to report.

AC: 16/058 DATE OF NEXT MEETING

The next Strategy and Engagement Committee meeting is scheduled to take place at 9.00am on **Tuesday, 13 March 2018** in the Corporate Meeting Room, Headquarters, UHW

**UNCONFIRMED MINUTES OF THE
CHARITABLE FUNDS COMMITTEE MEETING
HELD AT 09.00AM TUESDAY 19 DECEMBER 2017
CARDIFF CITY STADIUM**

21.2

Members:

Akmal Hanuk	Chair
Maria Battle	Independent Member
Stuart Egan	Independent Member
Christopher Lewis	Deputy Director of Finance

Attendees:

Alun Williams	Head of Financial Services
Katie Mallam	Fundraising and Communications Manager
Mike Jones	Chair, Charitable Funds Bids Panel
Peter Welsh	Director of Corporate Governance
Simone Joslyn	Engagement Lead

Secretariat:
Leanne Miles

CFC 16/138 WELCOME AND INTRODUCTIONS

- The new Chair, Akmal Hanuk welcomed all present to the meeting and thanked Martyn Waygood for all his hard work as former Chair of the Committee.

CFC 16/138 APOLOGIES FOR ABSENCE

- Apologies for absence were noted off Angela Hughes -

CFC 16/139 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings.

- None were given.

CFC 16/140 UNCONFIRMED MINUTES OF THE MEETING HELD ON 19 SEPTERMBER 2017

- The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 19 September 2017

CFC 16/141 ACTION LOG - MEETING OF 19 SEPTEMBER 2017

- The Committee **RECEIVED** the Action Log from the meeting of 19 SEPTEMBER 2017 and **NOTED** the following:

CFC 16/121 – Benefits of colour – Enhancing the patient's mealtime experience. Evaluation at the Charitable Funds Committee in September 2018.
Peter Welsh on behalf of Joanne Jefford, Dietician, stated that their team were delighted that funds were made available for this activity and that there will be a positive evaluation at the meeting in September 2018, and to pass on their thanks and appreciation.

CFC 16/142 PROPOSAL – GVS THIRD SECTOR SMALL GRANTS SCHEME UHB 2017

Peter Welsh presented a paper on the above.
It was outlined that this is a proposal to invest a further £25,000 on a yearly basis into the health and wellbeing of the population of Cardiff and the Vale of Glamorgan by via the third sector.
Previous allocation from the Charity of £25,000 for third sector projects made a massive difference to community healthcare projects in the region.

Recommendations to the Charitable Funds are to:

- **CONSIDER** the proposal of further donations yearly of £25,000
- **AGREE** to allocate the agreed amount of funding into a community grants programme for administration by GVS.

The Charitable Funds Committee:

- **AGREED** to the recommendations listed above.

CFC 16/143 HORATIO'S GARDEN

Peter Welsh presented a paper on Horatio's Garden. It was outlined that services were due to transfer from Rookwood Hospital to Llandough in 2018. An integral

part of this service is the recovery and rehabilitation of patients after severe head and spinal injuries. The Committee was advised that Horatio's Garden is a charity that creates and professionally maintains gardens in NHS spinal centres. The UHB was contacted to see if it would be interested in working in partnership with Horatio's Garden to provide a purpose built garden at Llandough for the new unit which would be the first of its type in Wales. Peter Welsh stated that as there are external limitations at Llandough to patients due to the topography of the area. It was stated that there is potential to develop a purpose designed garden, an area of raised ground adjacent to the new unit but would involve extensive civil engineering works to level the area and make a "walled" embankment. Early indications of cost are circa £500k and is also a "guestimate". Peter Welsh also reiterated the covenant on the Rookwood site which requires income raised through the sale of Rookwood site be used for rehabilitation services at the hospital.

Peter Welsh stated that this could be borrowed and reimbursed back into the Charity's pot and this would allow Horatio's garden to progress. Maria Battle had been in touch with the Chair of the Trustees who are keen to progress purely in terms of what this would give to patients. Maria Battle stated that she, Katie Mallam and Simone Joslyn went to see patients at a spinal unit that had a Horatio's Garden, in Salisbury and that it came from a survey of patients that stated they wanted the ability to access a garden outside. A survey of staff was also undertaken but was ignored with only the patient's views taken into account. Maria Battle stated that the garden was used frequently, events were undertaken there and it was also very therapeutic plus had a tea room. For patients that couldn't leave the wards there were video recordings available of the garden and it also benefited from a world class gardener. Maria Battle stated that she would meet the next contractor to see if they will partly fund the build at Llandough as they will be on site with the machinery. Maria Battle also reiterated the money will be available once Rookwood is sold, and fully supports the proposal and stated that it's a very intelligent way of making the project happen. Simone Joslyn stated that the Added Value was integral. Because of the design of the garden in Salisbury, patients in beds and wheelchairs were able to be taken into the garden by trained volunteers. Simone Joslyn stated that this type of access should be an integral part of the design at Llandough.

Chris Lewis stated the strength of the Charity's portfolio. It has allowed us to realize some of the gains and allowed us to withdraw £700k. However Chris Lewis did state the need to be mindful of the value of the charity and how the market is performing over the next two years until the asset is realized so we don't over stretch ourselves and live within our reserves policy.

ACTION: Maria Battle/Peter Welsh to work on a paper for the Trustees meeting in January 2018 which will include more information about the gardens and address any concerns

The Committee:

- **ENDORSED:** The application to fund Horatio's garden
- **RECOMMEND:** To the full Trustees meeting in January 2018 to approve the above.

CFC 16/144 MAMMOGRAPHY SYSTEM UPGRADE (BID OVER 25K) BREAST CENTRE UHL

The Committee is asked to

- **APPROVE** the purchase of mammography equipment.

Peter Welsh presented a paper on the Breast Centre at UHL and a Procurement Report outlining a request to purchase mammography equipment. The Breast Centre is now looking for funding for additional mammography equipment that will provide 3D pictures. The application has been approved and supported by the Clinical Board and Clinical Board Director responsible. It is a major piece of equipment providing leading edge technology and service and will enhance patient experience.
Peter Welsh stated that there is over £250k in the Breast Centre Fund and the purchase will be funded through this fund.

The Committee **APPROVED** the purchase of the Mammography equipment.

CFC 16/145 NHS 70TH BIRTHDAY CELEBRATIONS

Simone Joslyn gave an oral presentation on the current state of where we are with the NHS 70th birthday celebrations. Preparations are well underway and is continuing to attend the All Wales Group and that Cardiff and Vale Health University Health Board is doing more than any other Health Board in Wales with regards to promoting birthday celebrations. Some of the projects we are getting involved in, need more exposure as they are supported mostly by the Health Charity. We are working closely with the University of Manchester who have been in Llandough collating patient stories. We have met with the commissioned artists for the celebrations and have also bagged a piece of coffee art to use and also to work with the National Theatre of Wales on some of their projects. Dietetics have become really engaged in the celebrations and will do a party on each elderly ward on the day which will encourage nutrition and the intake of fluids. A piece of work has been commissioned by a local group to the UHW site who are creating a quilt and will create 70 pieces to make it. The celebrations tie in nicely with the 100 year celebrations for Rookwood with connections to the RAF, veterans, artists and musicians. We have also been approached by the BBC and media teams around the celebrations and will liaise with the communications department to see where we are with this. With the run up to the 70th birthday celebrations, different events will be held monthly at different locations in Cardiff and Vale.
Simone Joslyn also stated that for part of the ceremony a miner's lamp will travel from Tredegar to Llandough and then make its way to Westminster and will be carried by Aneurin Bevan's granddaughter and the Tredegar town band.

Maria Battle stated that it would be worth having a report off Joanne Brandon on the communications with local radio stations surrounding the celebrations, which the majority of people in this locality listen to.
ACTION: Joanne Brandon

The Committee

- **NOTED** the oral presentation and the continued work in the celebrations.

CFC 16/146 ROOKWOOD

Chris Lewis gave a brief oral update on the situation with Rookwood. An updated paper was presented at the Trustees meeting 28 September 2017, to note that the formal application was recommended to go in nine months before the expected completion date and the move likely to be 2019/2020.
To note, there will be nothing to report for the next 12 months. Information will be brought to a Committee in the future when it becomes available.
Maria Battle asked the question regarding the closure of Rookwood, are staff being kept informed? Simone Joslyn stated that she was advised by Estates that until there was more concrete information to be given out not to send out updates regarding the closure due to the amount of messages previously given and confusion caused by these, but information that has been given out is that we do care about Rookwood and that celebrations are underway for the 100 years. This would help build relationships with the staff and start to prepare them for the closure.

The Committee:

- **NOTED** the oral presentation and that no further information regarding Rookwood will be brought to the Committee for 12 months, unless any information becomes available.

CFC 16/147 UPDATE ON POTENTIAL COMMERCIAL PARTNERSHIP DEALS

Peter Welsh gave a brief oral update on potential commercial partnership deals. The Vectis card has been distributed to employees of Cardiff and Vale University Health Board and feedback has been very positive and that a further meeting will take place when more information will become available.
A further meeting has taken place with Griffin Mill who are very positive to have this relationship in place. There will also be a further meeting with Senior Managers of Griffin Mill in the New Year to discuss further deals. Peter Welsh also outlined “Change Card”, a Charity that offers an online banking service. They provide a banking service especially to homeless people. They will provide any member of staff and their family with a bank card and bank account but stated that you cannot go overdrawn and don’t give out loans and there are also no fees

associated with it. There are also perks to the card such as money back deals. Also a donation will be made to the charity on accounts that are opened and purchases made on the card. A further meeting will be undertaken with "Change Card" and a formal proposal brought to the next Charitable Funds Committee to sign it off and to outline the benefits to the Charity in more detail. Peter Welsh stated that it has also been presented to the Local Partnership Forum and governance has been checked.
Peter Welsh also outlined that Enterprise Car Rental are also keen to work with us with a range of benefits including major discounts to rental. An introductory meeting has taken place but a further meeting is in the pipeline to discuss further benefits to NHS staff and families and are also keen to work with the Charity.

The Committee:

- **NOTED** the oral presentation

CFC 16/148 FINANCE MONITORING REPORT

Chris Lewis presented the Finance Monitoring Report of the Charity. The report showed the period to date and spending of £475k more than income generated during the period. Some legacies were received in after this period and after the report was prepared. The value of the charity decreased by £300k during this period, however it is expected to pick up in the second part of the year.
Chris Lewis referenced the investment portfolio which showed the fall in investment value to March 2017 due to the realization of £700k from the portfolio in February 2017.
To summarize the value of the Charity in the current year is £10.335m.
It was also noted that the investment broker for the Charity will be present at the next meeting in March 2018 and will give a classification of the Charity's portfolio.

The Committee:

- **NOTED** the report and the financial position of the charity.

CFC 16/149 FUNDRAISING REPORT

Katie Mallam presented the Fundraising Report of the Charity. Katie Mallam stated the current situation for the year with the income; Legacies had received an additional £150,000, donations are at £224,000, appeals at £128,000 and the lottery £109,000 for the year.

The Committee:

- **NOTED** the oral report.

CFC 16/150 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES

- Paper to be prepared on Horatio's Garden and taken to Trustees Meeting in January 2018

CFC 16/151 DATE AND TIME OF NEXT MEETING

- **Tuesday 20 March 2018 - Corporate Meeting Room, UHW 9.00am – 12.00noon**

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 24th JANUARY 2018

LARGE MEETING ROOM, HQ, UHW

Present:

Len Richards	Chief Executive
John Union	Chair (Finance Committee)
Dr Sharon Hopkins	Deputy Chief Executive
Bob Chadwick	Executive Director of Finance
Steve Curry	Chief Operating Officer
Martin Driscoll	Director of Workforce
Maria Battle	Chair
Andrew Gough	Assistant Director of Finance (Transformation & Planning)
Christopher Lewis	Deputy Director of Finance
John Antoniazzi	Independent Member

In Attendance:

Secretariat:

Paul Emmerson	Finance Manager

FC – 18/148 WELCOME AND PURPOSE OF THE COMMITTEE

The Chair welcomed everyone to the meeting.

FC – 18/149 APOLOGIES FOR ABSENCE

Apologies were received from Charles Janczewski, Ruth Walker and Abigail Harris.

FC – 18/150 DECLARATIONS OF INTEREST

The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.

FC – 18/151 MINUTES OF THE FINANCE COMMITTEE HELD ON 3RD JANUARY 2018

The Committee **RECEIVED** and **APPROVED** minutes of the meeting held on 3rd JANUARY 2018.

FC - 18/152 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log from the meeting of 3rd January 2018 and **NOTED** the following:

FC 18/142 – The month 8 in month overspend of £0.105m against establishment expenses was turned around to an underspend of £0.043m in month 9. Part of the month 8 overspend against telephone was offset and managed by underspends against other delegated budgets. Postage budgets reported a small underspend in month 9.

FC - 18/153 FINANCIAL PLANS 2018/19 to 2020/21

The Deputy Director of Finance confirmed that the Finance Section of the Draft IMTP was scheduled to be submitted to Welsh Government at the end of January. The section was included in the Committee papers and the Deputy Director of Finance guided the Committee through a presentation of the key assumptions and planning objectives set out in the IMTP**.**

The following points were highlighted:

- The UHB had made significant Cash Releasing savings in each year from 2014/15 to 2017/18, however a large proportion of the savings made were non recurrent
- Despite the level of savings achieved the UHB had reported deficits of £21.4m in 2014/15; £29.2m in 2016/17 and had a forecast deficit of £30.9m in 2017/18. A surplus of £0.010m had been achieved in 2015/16 after the receipt of £26.5m non recurrent funding from Welsh Government. This suggested that the UHB had been in a position of underlying deficit for a number of years.
- The Draft IMTP planned for continuing improvement on the assumptions that:
    - The UHB will not be required to make good any of its prior year deficits and this needed to be confirmed with Welsh Government;
    - There will be no material loss of income from SIFT and other education budgets due to the creation of HEIW and revisions to commissioning arrangements;
    - The commissioning approach from WHSSC and neighbouring LHBs does not financially destabilise the UHB;
    - The UHB can manage to deliver expected performance levels within the budget set.
- The UHB must identify an additional £5.582m recurrent saving schemes in the remainder of 2017/18 to reduce the carry forward underlying deficit to the £49m assumed in the Draft IMTP.
- The UHB is seeking additional Welsh Government funding of £4.5m to support annual population growth and £11m additional support in 2018/19 and a further £4.5m to support annual population growth and £11m additional

support in 2019/20, A further £4.5m to support annual population growth is sought in 2020/21.

A query (JU) was raised regarding the probability the UHB receiving the additional allocations identified. The Chief Executive confirmed that the Draft IMTP represented an offer to Welsh Government based on what the UHB could deliver. The provision of additional funding at the start of the year would enable the UHB to deliver sustainable investments in capacity and reach a balanced position and maintainable base in year 3. It was unclear at this stage whether the request for additional support at the beginning of the planning cycle would be acceptable to Welsh Government.

- Cost pressures included in the plan are those that are determined to be unavoidable and are forecast to total £33.3m in 2018/19; 39.7m in 2019/20 & £29.8m in 2020/21.
- Curtailing the amounts set aside for growth is a risk to the UHB. Prescribing cost pressures had been capped by £3.2m in 18/19; CHC pressures in PCIC are capped by £1.2m in 18/19; CHC has been capped in Mental Health by £1m in 18/19 FNC has been capped by £0.050m in 18/19 NICE, Velindre and WHSSC costs are best estimates at this time.

A query (JU) was raised regarding the level of cost pressures that remained to be managed Clinical Boards with particular reference to the PCIC Clinical Board. The Director of Finance confirmed that some of the outlined pressures initially identified by Clinical Boards had subsequently diminished below the levels identified in the presentation e.g. the NCSO drug price concession which placed pressure on PCIC budgets. However the UHB recognised that a significant level of financial challenge remained with Clinical Boards particularly when considered with the 3% recurrent and 1% non recurrent savings requirement. In this context material pressures would be placed on and monitored through the Risk Register.

- Investment proposals of £6.290m included in the plan were above the cap of £4.3m and therefore the UHB would need to prioritize the schemes to go forwards.
- The Efficiency Plan to support the IMTP required the UHB to achieve recurrent 3% cash releasing savings in both 2018/19 and 2019/20 and 2% cash releasing savings in 2020/21. This would be a considerable challenge and evidence suggested that the levels of savings required is at the top end of what was achievable and sustainable.
- The 3 year plan was expected to deliver a deficit of £21.9m in 2018/19; a deficit of 3.3m in 2019/20 and return the UHB to a sustainable position with a surplus of £0.9m in 2020/21.
- Approximately £11.3m of the £24.1m cost pressures identified by Clinical Boards will need to be managed by Clinical Boards in 2018/19 alongside the savings targets delegated to Clinical Boards.
- The key Financial Risks to the Plan are:

- Securing IMTP approval – The plan does not break even over the three year period 2018/19 – 2020/21, however the UHB was seeking approval for the plan on the basis of restoration of financial balance in year 3. The financial support requested from Welsh Government is a fundamental component of this plan and further discussions will be required in order to progress this.
- Achievement of the efficiency plan target – the CIP target is at the top end of what is achievable and will be supported by the Cross Cutting Steering Group and the Programme Management Office.
- Management of Cost Pressures – the UHB expects budget holders to manage all carried forward and unfunded cost pressures within their total of delegated resources. It is expected that this will be successfully achieved in 2017/18 but does pose a risk given the scale of efficiencies being sought.

The Committee then discussed the plan focussing on the evidence of delivery of the 2017/18 plan and the level of confidence that the Committee and Board should have in respect of the likelihood of savings targets being delivered. .

A query (MB) was raised regarding the level of assurance that the UHB had in respect of efficiency opportunities offered by theatre utilisation rates etc. The Chief Operating Officer confirmed that length of stay, theatre and outpatient benchmarking indicated that the UHB had the scope to reduce its cost base if opportunities were worked through the whole system and across organisational boundaries. The Deputy Chief Executive stated that the implementation of the Emergency Surgery Plan was predicated on clear clinical objectives that clinical and management teams had been motivated to deliver and that the success of the plan provided the UHB with a template for engaging the service with further opportunities.

It was noted by the independent member (JA) and the Chair (MB) that 2017/18 performance should provide the Board with some assurance that the draft plan could be delivered and that the UHB could return to a sustainable base in the 3rd year of the plan. The Committee acknowledged that pay costs represented a large proportion of the UHB's cost base and in this context savings plans would need to be underpinned by workforce plans which safeguarded performance, patient safety and delivery.

The Finance Committee Chair (JU) queried whether Welsh Government was likely to accept the UHB draft IMTP. The Chief Executive advised the Committee that the UHB's draft 3 year plan provided the UHB with a firm base for progressing capacity planning, staff/workforce development and a return to financial balance in year 3. The Chief Executive noted that the UHB and Welsh Government were discussing the level of underlying deficit that the UHB had identified as being carried forward into 2018/19 and that agreement of the level of underlying deficit moving into 2018/19 was a key assumption within the UHB's plan. The Director of Finance added that the

UHB had written to Welsh Government outlining the non recurrent savings and benefits that supported the UHB's 2017/18 forecast outturn and confirmed that the Board would only be presented with a plan based on firm foundations that the UHB could deliver.

In response to a query from the UHB Chair (MB), the Chief Executive indicated that the UHB may need to operate under a 1 year plan if a 3 year plan could not be agreed with Welsh Government. This could impact on capacity planning and the time required to return to a balanced financial position.

The Finance Committee:

- **NOTED** the work completed on the plan to date and the draft IMTP Finance section.

FC - 18/154 BENCHMARKING OPPORTUNITIES

The Director of Finance referred the Committee to the report on Benchmarking Financial Opportunities and confirmed that the UHB considered both internal and external benchmarking data from a number of sources. The headline figures in the report were significant, however the UHB should make a mature assessment of the timing and level of savings that could be delivered. Benchmarking data highlighted which areas the UHB should approach to identify savings and flagged potential opportunities to budget holders and provided a starting point for the exploration of future change in processes to deliver services.

The Director of Operations added that the UHB should target its approach to the pursuit of savings particularly if additional support was required to deliver savings.

The Finance Committee:

- **NOTED** the benchmarking work already undertaken in supporting delivery of the financial plan
- **NOTED** the next steps in driving further financial savings opportunities

FC - 18/155 FINANCE REPORT AS AT MONTH 9

The Deputy Director of Finance presented the UHB's financial performance to month 9. The UHB recorded a £22.177m deficit at the end of month 9 and remained on track to deliver a financial position within the £30.9m planned deficit.

The UHB had now incorporated the current year costs of £1m for increased NHS Funded Nursing Care (FNC) fees within its forecast position and therefore the risk associated with NHS funded nursing fees following the Supreme Court Judgement

had fallen to approximately £2.7m. The risk associated with NCSO drug concessions had also fallen in month.

The favourable budget management variance had improved in month and was now c.£1m and the overall £22.177m deficit at month 9 was made up as follows:

- (£0.998m) favourable budget management variance
- £23.175m planned deficit (9/12th of £30.900m)

The Deputy Director of Finance informed the Committee that in light of the improving financial position that the UHB would review its year-end forecast over January and consequently may be able to reduce its year end forecast by £2m - £4m to support the position across Wales. In particular the review would focus on the reduction in demand for some high cost drugs as well as seeking clarification from the Welsh Risk Pool on the UHB's expected 2017/18 contribution.

The Director of Finance confirmed that the improving financial position was due to the continuing control exercised over budgets and indicated that there was an expectation that any improvement in the UHB's forecast outturn would in part be re-provided by Welsh Government in 2018/19.

The Deputy Director of Finance drew the Committee's attention to the Finance Dash Board that indicated that the underlying deficit had fallen by £0.5m in month and that the in month creditor payment compliance rate was above target at 95.7%.

The in month income surplus was primarily due to the over-performance against NHS Patient Related Income in month 9. Cumulative performance against income targets remained favourable. Pay budgets showed a year to date underspend of £1.553m and non pay budgets reported an in month underspend of £0.592m. The Deputy Director of Finance indicated that a further meeting was scheduled with WHSCC to discuss additional income for the costs of the temporary outsourcing of the neuro-interventional radiology service and added that the UHB had already covered the additional cost incurred within its forecast position.

All Clinical Boards bar CD&T remained on track to deliver balanced year end budget.

The Deputy Director of Finance referred the Committee to table 14 of the report which indicated that the UHBs underlying financial position now stood at £54.5m which was equivalent to the underlying deficit brought forward into 2017/18. The UHB expected the underlying deficit to fall further towards the year end planning figure of £49m over the remaining months of the year.

The Committee was informed by the Deputy Director that the UHB may need to reduce its request for strategic cash assistance if the UHB reduced its forecast year end deficit.

The Deputy Director of Finance outlined the key concerns and remedial actions

around budget overspends, financial risks and the underlying deficit to the Committee and noted that there had been an in month improvement in the areas of concern.

LIMITED ASSURANCE was provided by:

- The work that has been undertaken to develop the 2017/18 operational plan;
- The scrutiny of financial performance undertaken by the Finance Committee;
- The month 9 position which is £0.998m less than the profiled deficit within the financial plan;
- The identification of a full £35m savings programme.

The Finance Committee:

- **NOTED** that the UHB has a one year operational plan that has a planned deficit of £30.900m for the year;
- **NOTED** the £22.177m deficit at month 9 which includes a planning deficit of £23.175m and budget underspends of (£0.998m);
- **NOTED** that the UHB now has a savings plan that is fully identified;
- **NOTED** the key risks that are outside the current expenditure projection that need to be managed;

FC - 18/156 COST REDUCTION PROGRAMME

The Assistant Director of Finance highlighted the following key points from the Cost Reduction Report:

- As at 30st December 2017, the UHB remained on track to deliver the £35.001m savings programme.

- Cross Cutting schemes were expected to deliver £10.5m of indicative savings in 2018/19. 2017/18 themes would continue into 2018/19 with the addition of the Efficiency Opportunities theme. Each theme was sponsored by an executive officer and would be progressed by a named project manager, implementation lead and finance lead.

- As at 31st December 2017, £3.263m of 2018/19 opportunities had been identified as Green or Amber. It was expected that the majority of schemes

(90%) would be categorised as either green or amber prior to the start of the financial year and progress would need to accelerate to achieve this.

The Finance Committee:

- **NOTED** the progress against the 2017/18 CRP target and the Cross Cutting contribution**.**
- **NOTED** the progress against the 2018/19 CRP target.

FC - 18/157 RISK REGISTER

The Assistant Director of Finance (Transformation & Planning) presented the risk register to the Finance Committee and highlighted the number of risk in each category.

The Committee was asked to endorse the removal of 3 risks from the risk register where optimum controls are in place

The Finance Committee:

- **NOTED** the risks highlighted within the risk register.
- **ENDORSED** risks to be removed from register where optimum controls are in place.

FC - 18/158 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES

No other items to bring to the main Board.

FC - 18/159 DATE AND TIME OF NEXT MEETING

Wednesday 28th February; 2.00pm; Large Meeting Room, HQ, UHW

CONFIRMED MINUTES OF THE FINANCE COMMITTEE

HELD ON 3rd JANUARY 2018

LARGE MEETING ROOM, HQ, UHW

Present:

Len Richards	Chief Executive
John Union	Chair (Finance Committee)
Dr Sharon Hopkins	Deputy Chief Executive
Bob Chadwick	Executive Director of Finance
Ruth Walker	Executive Nurse Director
Steve Curry	Chief Operating Officer
Martin Driscoll	Director of Workforce
Charles Janczewski	Vice Chair
Andrew Gough	Assistant Director of Finance (Transformation & Planning)
Christopher Lewis	Deputy Director of Finance
Akmal Hanuk	Independent Member
Abigail Harris	Director of Planning
Michael Imperato	Independent Member
Fiona Jenkins	Director of Therapies
Graham Shortland	Medical Director

In Attendance:

Secretariat:

Paul Emmerson	Finance Manager

FC – 18/136 WELCOME AND PURPOSE OF THE COMMITTEE

The Chair welcomed everyone to the meeting.

FC – 18/137 APOLOGIES FOR ABSENCE

Apologies were received from John Antoniazzi, Maria Battle, Susan Elsmore and Peter Welsh.

FC – 18/138 DECLARATIONS OF INTEREST

The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.

FC – 18/139 MINUTES OF THE FINANCE COMMITTEE HELD ON 30TH NOVEMBER 2017

The Committee **RECEIVED** and **APPROVED** minutes of the meeting held on 30th NOVEMBER 2017.

FC - 18/140 ACTION LOG FOLLOWING THE LAST MEETING

The Committee **RECEIVED** the Action Log from the meeting of 30th November 2017and **NOTED** the following:

FC 18/128 – The letter to Welsh Government of 12 July 2017 analysing key recent causes of the underlying deficit was relayed to Independent Members on 21.12.2017.

FC 18/130 – The WAO Report 'Comparative review of NHS financial reporting – Cardiff and Vale University Health Board' was circulated to Finance Committee Members on 08.12.2017.

FC 18/130 – The UHB wrote to WAO on the 05.12.2017 to confirm the actions taken in response to the WAO report; 'Comparative review of NHS financial reporting – Cardiff and Vale University Health Board'.

FC 18/132 - Draft 2018/19 – 2020/21 Financial Plan was included on the Finance Committee agenda on the 3rd January 2018.

FC 18/132 - All Board Independent Members (IMs) and UHB Executive Officers were invited to the Finance Committee on January 3rd to consider the Draft 2018/19 – 2020/21 Financial Plan in the context of the IMTP.

FC 18/133 - Risks Fin02/17, Fin04/17, Fin08/17, Fin11/17 & Fin12/17 where optimum controls are now in place have been removed from the risk register.

FC - 18/141 FINANCIAL PLANS 2018/19 to 2020/21

The Deputy Director of Finance guided the Committee through a presentation on the UHB's Financial Forecast and Outlook between 2018/19 to 2020/21.

The Committee was informed that UHB's management executive had considered 8 different scenarios in developing the High Level Financial Plan for 2018/19 and was advised of the key assumptions around the b/f underlying deficit; allocation uplift, 2018/19 CIP and investments underpinning each of the scenarios.

A query (CJ) was raised regarding the probability of the UHB receiving its full allocation as assumed in 3 out of the 8 scenarios. The Committee was informed that the level of additional funding that Welsh Government will provide to the UHB in 2018/19 was uncertain as the 2018/19 cash letter issued on the 21st December 2017

had not allocated all of the additional investment of £230 million revenue funding provided for in the 2018-19 Draft Welsh Government Budget. The UHB did expect to receive some additional funding from the residual amount left with Welsh Government and it was noted that the cash letter had already applied additional Performance Improvement and Local Service Improvement funding to 2 out of the 7 Health Boards to reflect the recurrent effect of allocation uplifts issued in 2017-18.

The Chief Executive added that the UHB was working towards presenting Welsh Government with a realistic and workable plan that would move the UHB towards a balanced financial position over 3 years. The plan would clearly indicate the annual allocation uplifts that the UHB would require to deliver the plan.

The Deputy Director of Finance indicated that the UHB's management executive had dismissed 6 of the potential 2018/19 scenarios because either the year end deficits, the percentage level of savings or the level of investments were deemed too high. The 2 scenarios that the Executive Team considered best met the UHB objective of moving towards balance whilst maintaining levels of performance and patient safety were scenarios 4 & 8.

The Deputy Director of Finance advised the committee that modelling of Scenario 4 was based on the following key financial assumptions:

- B/F underlying Deficit to 2018/19 - £49.0m
- Assume allocation Uplift -2%
- Assumed recurrent CIP -3%
- Assumed non recurrent CIP -1%
- Annual Investments £4.3m

The modelling indicated that scenario 4 would deliver a £31.0m deficit in 2018/19, a £25.7m deficit in 2019/20 and a deficit of £16.8m in 2020/21. The Committee was advised that scenario 4 did not deliver financial balance in year 3.

The presentation then moved to consider scenario 8 and the Committee was informed that this scenario was based on the same assumptions as scenario 4 bar the 2% allocation uplift. Scenario 8 assumed that the UHB would receive its full share of the Welsh Government allocation uplift in 2018/19, 2019/20 & 2020/21. The Committee was advised that scenario 8 delivered a deficit of £19.7m in 2018/19, a deficit of £8.5m in 2009/20 and an in year financial surplus of £12.7m in year 3. The Committee was advised that the risk of the UHB not receiving the full allocation was c £11m per year.

In response to a query (CJ) raised around gaps in financial plans across Wales, the Chief Executive informed the Committee that only 3 Welsh Heath Boards were currently forecasting a balanced position in 2017/18.

The committee chair (JU) asked if the assumption of receiving its full share of the allocation in 2017/18 incorporated additional funding for the differential rate of population growth observed in the Cardiff & Vale area. The Deputy Director of Finance confirmed that this was not included in the calculation and emphasized that at this stage the figures and assumptions should be seen as planning figures which would be subject to development and change. The Director of Operations noted that the impact of providing services to a population that was increasing by approximately 3,500 people on an annual basis had been factored into service requirements and that the additional funding requirement was in part required to meet the health needs of the projected increase in the population served.

A query (MI) was raised in relation to whether either scenario 4 or 8 would satisfy the statutory requirement to ensure that UHB expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years. The Committee was informed that without additional financial support from Welsh Government that neither scenario 4 or 8 met this requirement and that the UHBs accounts would be qualified if the UHB did not balance its position over a 3 year rolling period.

The Committee was asked (EB) why an option to achieve balance over a 3 year rolling period was not considered. The Committee was informed that the management executive had ruled out this option as this would require a level of savings in excess of 5% which evidence suggested would be both unsustainable and unachievable without a reduction to either level of service or patient safety. The Medical Director indicated that the proposed annual investment of £4.3m was relatively small and the Chief Executive added that both scenario 4 & 8 already placed pressure on established staff numbers going into 2018/19. The Chief Executive confirmed that the UHB would not pursue savings to the detriment of patient safety and the Nurse Director indicated that this approach had enabled the UHB to deliver in 2017/18 and establish an effective and mature relationship with Welsh Government.

The Chair asked when any reduction in established posts would materialise under scenario 8. The Chief Executive informed the Committee that changes in workforce numbers would be worked through each of the 3 years of the IMTP and that the detailed plans developed by Corporate Departments and Clinical Boards would be subject to scrutiny through the UHB's governance framework**. Any reduction in established posts would be included within the Final Draft of the UHB's 3 year IMTP which would be considered by the UHB Board before formal submission to Welsh Government.**

In response to a query (EB) on the delivery of savings at the earliest opportunity, the Director of Finance stated that the process of identifying future efficiencies and populating 2018/19 savings trackers had started in month 7 so that Corporate Departments and Clinical Boards were clear of their responsibilities in pushing the UHB towards recurrent financial balance.

The presentation moved on to consider the financial settlement identified by the 2018/19 cash allocation letter. The Deputy Director of Finance confirmed that the UHB had received an additional allocation of £13.2m out of the £230m uplift across Wales. However £4.6m had been top-sliced from the £13.2m to fund Welsh Government priorities leaving the UHB with and uplift of £8.6m (1.3%). The Committee was informed that Welsh Government had indicated that further funding would be made available for Mental Health Services and in response to a query (CJ) the Deputy Director of Finance indicated it was unclear at this stage what proportion of the funding would be allocated to the UHB.

The initial cash allocation letter indicated that Welsh Government had retained a significant amount of the additional £230m allocated to the NHS in Wales although additional allocations had been provided to Cwm Taf and Aneurin Bevan Health Boards for performance and service improvement. On this theme the Chief Executive suggested that the UHB's evolving track record of delivery should help to increase the level of confidence that Welsh Government has in the UHB which in turn should enable a transparent discussion on the additional resources required by the UHB to deliver the IMTP. The Director of Finance emphasised that the UHB must restrict investments to c £4.3m and commit to delivering the planned recurrent 3% and 1% non recurrent savings if it intended to request additional resources from Welsh Government to support the IMTP.

The Chair (JU) queried the timetable for agreement of the plan. It was agreed that a further draft would be brought back to the next Finance Committee and that an update would be provided at the next Board.

The Finance Committee:

- **NOTED** the work already completed and **AGREED** that scenario 8 should be worked up in detail and presented back to the Finance Committee on January 24th.
- **NOTED** that the outcome of the planned discussions at the Finance Committee on January 24th would inform the parameters for the IMTP to be presented to the Board in March

FC - 18/142 FINANCE REPORT AS AT MONTH 8

The Deputy Director of Finance presented the UHB's financial performance to month 8. The UHB recorded a £20.444m deficit at the end of month 8 and remained on track to stay within the planned year end deficit of £30.900m.

The risks in respect of NHS funded nursing fees had not changed in month and were still assessed at approximately £3.6m. The risk associated with NCSO drug concessions had diminished in month.

The favourable budget management variance had increased in month although the overall deficit at month 8 was still broadly in line with the plan being made up as follows:

- (£0.156m) favourable budget management variance
- £20.600m planned deficit (8/12th of £30.900m)

Performance against income targets remained favourable.

A £1.487m cumulative month 8 pay underspend and in month underspend of £0.124m was reported. Pressure against nursing budgets remained and whilst the overall trend suggested a move towards balance there was an overspend against in month and year to date nursing budgets.

A cumulative overspend of £1.610m and an in month overspend of £0.094m was reported against non-pay budgets in November. The Committee was informed that the risks around NCSO drugs and cost of outsourcing the neuro-interventional radiology service remained. In month pressures had been observed against establishment expenses and this was offset by an underspend against energy budgets.

All Clinical Boards bar CD&T remained on track to deliver a balanced year end. The CD&T Clinical Board was working to deliver the best possible position in light of the additional costs arising from the outsourcing of the neuro interventional radiology service. The Committee was informed that delivery of financial balance by the Women and Children Clinical Board was subject to hitting NICU activity target thresholds in order to secure agreed levels of funding from WHSCC.

The Deputy Director of Finance referred the Committee to table 14 of the report which indicated that the UHBs underlying financial position had not improved in month.

It was reported that Welsh Government had confirmed £29.389m strategic cash support to the UHB for 2017/18 and that the UHBs request for working balances cash assistance had been noted and that the level of support to be provided would be confirmed later in the year.

Public Sector Payment compliance had improved in month and the key concerns and remedial actions around budget overspends, financial risks and the underlying deficit were outlined to the Committee.

A number of queries in respect of the report were raised as follows:

- It was noted that an underspend of £4.8m was reported against the Capital Resource Limit at month 8. In response to a query (EB) on the likely year end position and the risk of a significant underspend the Deputy Director of Finance confirmed that the UHB expected expenditure against the capital resource limit to be broadly balanced at year end

- A query (CJ) was raised in respect of the RAG rating of the in year reduction in the underlying deficit which was marked as amber in month and for the year to date. The Deputy Director Director of Finance indicated that an amber score had been registered as there was no adverse movement in month and that there was still an expectation that the underlying deficit c/f into next year would be lower that the level b/f to 2017/18.
- A query (CJ) around the adequacy of the bad debt provision in for the Compensations Recovery Unit was raised. The Deputy Director of Finance confirmed that the UHB used a local rate subject to regular review. The local rate was higher that the nationally recommended rate.
- In response to a query (CJ) about progress on manpower planning the Director of Workforce confirmed that plans would be considered at either the February or March Resource and Delivery Committee.
- The Deputy Director of Finance agreed to inform the next Finance Committee of action to improve the budget performance against establishment and telephone expenses in response to a query (CJ) raised about what remedial action was planned.

  ACTION: DEPUTY DIRECTOR OF FINANCE

- In response to a query (CJ) on progress in securing additional income for the outsourced neuro interventional radiology service, the Deputy Director of Finance confirmed that whilst limited progress had been made in month, discussion with WHSSC was continuing. The Chair (JU) questioned whether this issue would run into 2018/19 and assurance was provided that any impact in 2018/19 would be relatively small given that the in house provision of the service had been re-established.
- In response to a question (CJ) the Deputy Director of Finance confirmed that the increase in trade receivables was linked to monies expected from the Welsh Risk Pool which in turn was matched by an increase in the UHB's provision for contributions to the Welsh Risk Pool.

LIMITED ASSURANCE was provided by:

- The work that has been undertaken to develop the 2017/18 operational plan;
- The scrutiny of financial performance undertaken by the Finance Committee;
- The month 8 position which is broadly on line with the profiled deficit within the financial plan;
- The identification of a full £35m savings programme.

The Finance Committee:

- **NOTED** that the UHB has a one year operational plan that has a planned deficit of £30.900m for the year;
- **NOTED** the £20.444m deficit at month 8 which includes a planning deficit of £20.600m and budget underspends of (£0.156m);

- **NOTED** that the UHB now has a savings plan that is fully identified;
- **NOTED** the key risks that are outside the current expenditure projection that need to be managed;
- **NOTED** that the UHB will continue to inform Welsh Government of cash assistance requirements through the monthly monitoring return

FC - 18/143 Cost Reduction Programme

The Assistant Director of Finance highlighted the following key points from the Cost Reduction Report:

- As at 30th November 2017, a full savings programme of £35.001m remained in place. The programme was being delivered evenly over the course of the year as indicated by the graph of the delivery profile included within the written report.

- Cross Cutting schemes continued to progress the development of savings with buy in and momentum from Clinical Boards. It was hoped that the number of themes could be extended in 2018/19

- As at 11th December 2017, £3.220m of 2018/19 opportunities had been identified as Green or Amber.

The Finance Committee:

- **NOTED** the progress against the 2017/18 CRP target and the Cross Cutting contribution**.**
- **NOTED** the progress against the 2018/19 CRP target.

FC - 18/144 RISK REGISTER

The Assistant Director of Finance (Transformation & Planning) presented the risk register to the Finance Committee and highlighted that the risk associated with NCSO concessions had fallen to £1.4m in month.

The Committee was asked to endorse the removal of 5 risks from the risk register where optimum controls are in place

The Finance Committee:

- **NOTE** the risks highlighted within the risk register.

- **ENDORSED** risks to be removed from register where optimum controls are in place.

FC - 18/145 Any Other Business

A question (CJ) was raised in respect of the pursuit of recurrent transformational opportunities. The Director of Public Health confirmed that the Health Services Management Board (HSMB) had taken on the role of the Transformation Board in order to secure the ownership and full involvement of all of the Clinical Boards and Corporate Departments. The HSMB meets monthly and has a dedicated section on transformation at the beginning of each agenda. Management Executive could expedite decisions coming out of the transformation Board if required.

A query (CJ) was raised in respect of the timetable for determining the liability for NHS Funded Nursing Care. The Director of Finance indicated that Welsh Government had set up a Task and Finish Group which was expected to confirm the final position before year end.

A further query (CJ) was raised in respect of UHB contingency plans for NCSO price concessions. The Medical Director stated that price concessions were agreed by the Department of Health and were difficult to predict. The UHB had no direct influence over the approval of a concession. In the event of a long term price concession, the UHB would ask the medicines management group to consider alternatives.

The Nurse Director conveyed apologies for absence for the next planned meeting.

FC - 18/146 Items to bring to the attention of the Board/Other Committees

No other items to bring to the main Board.

FC - 18/147 Date and time of next meeting

Wednesday 24th January; 9.00am; Large Meeting Room, HQ, UHW

21.4

UNCONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am ON 23 JANUARY 2018 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:

Michael Imperato	**Independent Member – Legal (Chair)**
Charles Janczewski	Independent Member (Vice Chair)

In attendance:

Charles Dalton	Head of Health and Safety
Martin Driscoll	Director of Workforce and OD
Stuart Egan	Health and Safety Staff Lead
Abigail Harris	Director of Planning (from agenda item 18/010)
Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Deputy Director of Public Health
Catherine Salter	Staff Representative (RCN)
Geoff Walsh	Director of Capital, Estates and Facilities
Peter Welsh	Director of Corporate Governance

Apologies:

Steve Allen	CHC Representative
Carol Evans	Assistant Director of Patient Safety and Quality
Mike Turner	Cardiff University Representative

Observer:

Maria Battle	Chair

Secretariat:

Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 18/001 WELCOME AND INTRODUCTIONS

Mr Imperato welcomed Maria Battle, Chair to the meeting who was attending as an Observer.

Mr Imperato also informed the Committee it was Catherine Salter, Staff Representative (RCN) last meeting and thanked her for her contribution to the Committee and wished her well for the future.

HSC: 18/002 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.

HSC: 18/003 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 24th October 2017 were **APPROVED** and **ACCEPTED** as a true record, with the exception of some minor amendments:

- HSC: 17/088 – typo –'report'
- HSC: 17/088 – the staff representative (RCN) stated at the last meeting it was agreed that the action plan with timescales would be reinstated within the Fire Safety Annual Report and this was not reflected in the minutes.

  The Director of Capital, Estates and Facilities reiterated from the last meeting that this was not straightforward but for the next meeting he would provide details of completed and outstanding actions.

  ACTION – Mr G Walsh

- HSC: 17/092 – typo – 'had been made'
- HSC: 17/097 – should read a score of 4 had been awarded.

HSC: 18/004 UPDATED ACTION LOG

The Committee **RECEIVED** the Updated Action Log from the previous meeting. The following updates were provided:

- 17/058 – the Committee Chair stated a definitive timeframe was required for the implementation of the e-datix risk module. The Director of Corporate Governance added the review of the risk management process would be completed by the end of March 2018.

  ACTION – Mrs C Evans

- 17/061 – the Deputy Director of Public Health suggested the action log was reviewed to ensure actions were appropriately reflected and more specific.

The Independent Member (Vice Chair) requested the action log included timeframes for completion.

ACTION – Miss R Daniel

HSC: 18/005 PRESENTATION ON THE RESULTS OF THE ARJO PROACT 2017 SURVEY

Sara Thomas, National Solutions Manager for Arjo UK Limited thanked the Committee for inviting her to present to them. Ms Thomas informed the Committee the 1st survey was undertaken in June 2015, the 2nd in July 2017 and the 3rd would be undertaken in November/December 2018 to determine whether the time of year had an impact on the range of inpatient mobility levels.

Ms Thomas highlighted the key findings from the survey:

- 10% of equipment was now discontinued, it may still be working well but should a fault develop it could not be repaired as the parts were no longer available.
- 4% of equipment was well beyond its lifespan.
- 10% of equipment was just beyond its lifespan.
- In respect of equipment condition – 7% was in poor condition and 28% was in a satisfactory condition.
- In respect of washable slings – 54% were well beyond their lifespan and 7% was just beyond their lifespan.
- 55 hoists will require replacing during 2018.
- 266 slings will require replacing during 2018.

The Committee Chair thanked Ms Thomas for her presentation and stated there was obviously equipment needs for the next five years and queried how this was going to be addressed. The Head of Health and Safety stated a bid for the obsolete equipment would be made from Welsh Government monies as in the previous year. The Director of Capital, Estates and Facilities advised a bid should be submitted to the Capital Management Group as a matter of urgency in order for it to be considered but to be mindful there was real pressure on discretionary capital monies.

ACTION – Mr C Dalton

Mr Imperato requested an action plan be submitted to the next meeting. Mrs Battle, Chair also requested the action plan was shared with ward staff as there was a real concern regarding the lack of equipment and also the slow process in getting equipment repaired. Mr Dalton stated he would include a communication plan within the action plan. He also added one of actions would be to review the current maintenance regime.

ACTION – Mr C Dalton

The Deputy Director of Public Health queried whether Ruth Walker, Director of Nursing had seen the results of the survey, Mr Dalton advised Mrs Carol Evans, Assistant Director of Patient Safety and Quality had been made aware of the presentation.

The Director of Therapies and Health Sciences queried whether a similar survey had been undertaken in the Community, Ms Thomas advised the Manual Handling Advisers work very closely with the 2 Local Authorities but currently no survey of this type had been conducted.

The results of the Arjo Proact 2017 Survey had been **RECEIVED** and **CONSIDERED** by the Committee.

HSC: 18/006 PEDESTRAIN SAFETY STRATEGY

The Director of Capital, Estates and Facilities provided the Committee with an oral update as to the progress being made. Mr Walsh advised information in relation to pedestrian movement was limited within other Health Boards and following liaison with the Local Authority it had been decided to engage Consultants to look at this on behalf of the Health Board. An initial meeting had taken place with the Company who were in the process of developing a brief which should be available by the end of the week.

With regards to the accident that occurred on the Medical Physics Road, Mr Walsh advised that the footpath had been segregated from the road by means of a physical barrier.

The Health and Safety Staff Lead requested the mini roundabout outside the Emergency Unit was considered as part of the brief. Mr Egan also stated he was aware of plans to restrict access to the tunnels and suggested this was prioritised as it was being reported to him that relatives were often being directed through the tunnels by Emergency Unit staff. Mr Walsh advised some modifications were required to the lifts before access could be restricted.

The Independent Member (Vice Chair) queried whether the brief would just focus on University Hospital of Wales (UHW), Mr Walsh confirmed initially UHW and then University Hospital Llandough (UHL). The Director of Corporate Governance added significant improvement had already been made to pedestrian safety in UHL.

The Committee Chair stressed a written report must be provided to the next meeting in order for the Committee to be assured this was being progressed appropriately.

ACTION – Mr G Walsh

HSC: 18/007 FIRE ENFORCEMENT AND MANAGEMENT COMPLIANCE REPORT

The Director of Capital, Estates and Facilities informed the Committee there had been an increase in the fire training figures which was pleasing to note. Mr Walsh however added the fire evacuation drill arranged for August 2017 was unable to run despite all non clinical staff being available as no clinical staff were available on the day.

The Staff Representative (RCN) commented on the positive report and queried whether the training figures could be broken down by e-learning, tutor led etc. The Head of Health and Safety advised the Learning Education Department (LED) were now able to provide better training statistics and these would be included in future reports.

ACTION – Mr G Walsh/Mr C Dalton

The Independent Member (Vice Chair) stated he was not clear what the aim was; what was the target and why some Clinical Boards were were better than others. Mr Walsh advised the target was 85%.

The Director of Workforce and OD informed the Committee his department were reviewing the statutory and mandatory training requirements and a report on the health and safety elements would be brought to the next meeting.

ACTION – Mr M Driscoll

The Chair advised she would raise the thwarted fire evacuation drill with the Chief Operating Officer.

ACTION – Mrs M Battle

The Health and Safety Staff Lead raised concerns that non clinical areas undergo a 3 yearly fire inspection but this needed to be reviewed for high risk areas. Mr Walsh assured the Committee high risk non clinical areas were being appropriately inspected.

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 by:

- Identified fire enforcement compliance and safety were being appropriately managed.

HSC: 18/008 SHARED SERVICES FIRE SAFETY AUDIT OF UNVERSITY HOSPITAL LLANDOUGH

The Director of Capital, Estates and Facilities provided the Committee with an oral update as to the status of the action plan following the shared services audit.

HSC: 18/009 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee one new event had occurred since the last meeting where a member of staff had been assaulted by a patient and was absent from work for more than 7 days. The Health and

Safety Executive (HSE) had requested information in relation to the violence and aggression risk assessment and the patient care plan, this has been provided to them and no further correspondence has ensued.

The Independent Member (Vice Chair) asked after the welfare of the member of staff and was informed they had now returned to work and offered support via the Case Management Team. The Committee Chair suggested the Case Management Team present to a future meeting the support mechanisms available to staff, this was **AGREED** and **SUPPORTED** by the Committee.

Action – Miss R Daniel

Mr Dalton stated the legionella event remained active as based on the information submitted to the Water Safety Group not all Clinical Boards were undertaking the flushing regime and therefore full assurance could not be given.

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: 18/010 HEALTH AND SAFETY IMPROVEMENT PLAN - EXCEPTION REPORT

The Head of Health and Safety informed the Committee there were currently fifteen red areas on the plan that were being actively progressed.

In respect of 7.8 Control of Contractors, the Director of Capital, Estates and Facilities stressed he was only responsible for those Contractors employed by the Capital and Estates Department and could not be responsible for those outside of his remit. Mr Dalton added a working group was established in estates for contractor control and a similar group was required for non estates contractor control. The Director of Corporate Governance advised he would be happy to lead this, scope the extent of the problem and bring a progress report back to the next meeting.

ACTION – Mr P Welsh

The Director of Planning stated it was important everyone was clear on their responsibilities when engaging and managing contractors.

In respect of 1.4 Health and Safety Management Training, the Health and Safety Staff Lead advised it was evident when undertaking workplace inspections that some Managers were not aware of what was required of them particularly in the corporate departments where they do not have the same health and safety structure as Clinical Boards. Mr Welsh advised he would

discuss with Mr Egan outside of the meeting and a workplace inspection programme be developed.

ACTION – Mr P Welsh/Mr S Egan

The Safety Representative (RCN) queried the timeframe for implementing the manager's training, Mr Dalton advised the content could be completed within one month however delivering the training would be more difficult as the department had limited resources.

In respect of 5.6 Bariatric Patient Care, Mrs Salter suggested clarity was required on who was leading on this for the Health Board as it was not clear from various discussions she'd had, Mr Welsh would raise this with the Executive Directors.

ACTION – Mr P Welsh

In respect of 2.5 Violence and Aggression Training, Mrs Salter informed the Committee Security and Emergency Unit staff were not currently compliant. Mr Dalton stated security staff had received an appropriate level of training but in order for the full joint training to take place Emergency Unit staff have to be present as the training must be clinically led. Mrs Harris suggested that as the training requires commitment from the emergency unit the deadline needs to be reviewed as April was not realistic and suggested September would be more achievable.

ACTION – Mr C Dalton

The Independent Member (Vice Chair) stated the full improvement plan requires milestones to be included so that it becomes more of a meaningful document.

ACTION – Mr C Dalton

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.

PART 2

HSC: 18/011 COMMITTEE WORK PROGRAMME FOR 2018/19

The Work Programme for 2018/19 was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/012 HEALTH AND SAFETY IMPROVEMENT PLAN (DETAILED)

The full Priority Improvement Plan was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/013 WASTE MANAGEMENT COMPLIANCE REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/014 ENVIRONMENTAL HEALTH REPORT OF AROMA UNITS, UNIVERSITY HOSPITAL OF WALES ON 17TH NOVEMBER 2017

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 4 had been awarded.

HSC: 18/015 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF SEPTEMBER 2017

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/116 SECURITY AND PERSONAL SAFETY STRATEGY GROUP MINUTES OF SEPTEMBER 2017

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/117 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The schedule was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 18/118 REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES

No items are to be bought to the attention of the Board or other Committees.

HSC: 18/119 DATE AND TIME OF NEXT MEETING

The next meeting will be held at 9.30am on Tuesday 10th April 2018 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed .....

Date .....

CONFIRMED MINUTES OF A MEETING OF THE RESOURCE AND DELIVERY COMMITTEE HELD ON 30 JANUARY 2018 – 9.00AM CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Maria Battle	UHB Chair
Charles Janczewski	Chair – UHB Vice Chair
Akmal Hanuk	Independent Member – Local Community
John Antoniazzi	Independent Member – Business Planning
Eileen Brandreth	Independent Member - ICT
Sara Moseley	Independent Member – Third Sector

In Attendance:

Abigail Harris	Director of Planning
Geoff Walsh	Assistant Director of Planning
Fiona Jenkins	Director of Therapies, Health Science and IT
Lee Davies	Assistant Chief Operating Officer
Martin Driscoll	Director of Workforce and Organisational Development
Peter Welsh	Director of Corporate Governance
Sharon Hopkins	Director of Public Health
Steve Curry	Chief Operating Officer

Observer:

Apologies:

Len Richards	Chief Executive Officer
John Union	Independent Member - Finance
Marie Davies	Deputy Director of Planning
Robert Chadwick	Director of Finance
Ruth Wales	Nurse Executive
Keithley Wilkinson	Equality Manager

Secretariat: Glynis Mulford

RD: 17/036 WELCOME AND INTRODUCTIONS

The Chair welcomed the UHB Chair and Members to the final meeting of the Committee. In regards to item 12 of the agenda, it was explained members from the Strategy and Engagement Committee were invited to discuss the role and responsibilities of the new Strategy and Delivery Committee.

RD: 17/037 MATTERS ARISING

There were no matters arising.

RD: 17/038 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

RD: 17/039 DECLARATIONS OF INTEREST

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

RD: 17/040 MINUTES OF THE RESOURCE AND DELIVERY COMMITTEE MEETING HELD ON 8 AUGUST 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 7 November 2017.

RD: 17/041 ACTION LOG FROM MEETING PEOPLE, PLANNING AND PERFORMANCE MEETING HELD ON 8 AUGUST 2017

The Committee **RECEIVED** and **NOTED** the Action Log from the meeting of 7 November 2017.

RD: 17/042 CHAIR'S ACTION – REVISED POLICY ON RECORDS MANAGEMENT

Comments were received and noted from the Executive Nurse. **ASSURANCE** was provided by adherence to the UHB Standing Orders. The policy was presented to the meeting and the Committee **ENDORSED** the action taken by the Chair.

RD: 17/043 WORKFORCE AND ORGANISATIONAL DEVELOPMENT DELIVERY PLAN OBJECTIVE REPORT – HEALTH AND WELLBEING INCLUDING SICKNESS MANAGEMENT

Mr Martin Driscoll, Director of Workforce and Organisational Development updated the Committee on the report and highlighted the following:

- Members were informed that Health and Wellbeing was embraced in the Efficient Workforce objective of the IMTP. In regard to the key metrics data, this focused on absenteeism and influenza and highlighted there was additional information available.
- In terms of the Corporate Health Standards, the Organisation achieved both gold and platinum in the final quarter of the calendar year. The Director of Workforce and Organisational Development attended the final day of the

independent assessment and was impressed with the work attained by many parts of the organisation where comments received from the assessors stated the Health Board was exemplar in the work done across the public and private sector in Wales, which was ongoing.

- The Committee recognised and commended the team with the work accomplished and was informed that the Chief Executive had written to individuals involved in the work.
- There were conversations and work around engagement being a proactive interface with initiatives to build a better health service and a healthy workforce. Discussions would be integrated into the workplace to transform conversation around employees and this should have an impact on the sickness absence performance.
- Through close governance, sickness absence performance had shown significant improvement over the past few years. It was stated that the initial target was to go down from 7% to 4% by 2017/18. This was considered too ambitious and had demonstrated this was not achievable as the Maximising Attendance Group had set itself challenging targets for reducing sickness absence. By reviewing this area with the team, a proposed absence target was set to a level that could be achieved although stretched. The Committee was informed that the sickness level currently stood at 4.9% and aimed to reduce this to 4.6% by end of year.
- In regards to the Occupational Health and Wellbeing programme there had been a considerable amount of work undertaken by the Occupational Health Team and Flu Champions in the Clinical Boards and the uptake of flu jab stood at 63%.
- The other area reviewed was the development of the Employee Assistant Programme, an external programme, which was used through the Employee Wellbeing Service, of which the majority of staff continued to use. It was reported that the UHB had engaged with an external group to support employees (Employee Assistant Programme), the Board had also continued to engage the Employee Wellbeing Service, which is longstanding and broadly trusted by the employees. It is viewed that there will not be an ongoing requirement to support two programmes of employee assistance and this position will be reviewed in March 2018.

It was discussed and noted:

- In response for more depth and understanding in regard to the independent assessment, it was explained that there was a detailed report from the Assessment Board which is a national body. They had received detailed submission packs in advance. This had been presented extensively along with the team and across the organisation, but was happy to circulate report with further information. Also, in regards to recommendations there were further targets to achieve which would be addressed.
- In looking at Maximising Attendance and what is reasonable, the revision of the targets was welcomed. Clinical Board targets would be variable in regards to how they had performed in the past. In discussion with Heads of Workforce it was deemed a fairer way of accomplishing and achieving the targets.

- Commendation was given to the team in regards to seeing how the work was coming together stating it demonstrated both a growing maturity and systems leadership within the Organisation. It was suggested that at some point in the future those departments that were achieving lesser results should seek to learn from others.
- In discussion with the operational teams, areas had been highlighted in the Organisation where they were more challenged than others. It was stated a tailored approach would be more welcome as some departments would be able to extend whereas others could only achieve the minimum. There was a need to ensure line managers were empowered and capable to discharge responsibilities around this.
- Leadership is a good indicator but would like to consider looking at a motivational level and staff morale whether this was being captured and lining up aspects of achievements. In response it was stated that Employee Service Plans will go ahead this year but returns from previous years were relatively low with low scoring. But acknowledged this was an indicator of a piece of work to undertake.

ACTION: M Driscoll to circulate the Corporate Health Standards report to Committee Members

The Committee:

- **NOTED** the update and progress of the health and wellbeing agenda

RD: 17/044 WALES ANNUAL EQUALITY STATEMENT AND REPORT

Mr Keithley Wilkinson, Equality Manager, was unable to attend the meeting. Members were informed that the paper would go forward to Board for consideration.

RD: 17/045 UPDATE ON PERSONAL APPRAISAL AND DEVELOPMENT REVIEW

Mr Martin Driscoll, Director of Workforce and OD gave a verbal update on Personal Appraisal and Development Review (PADR), stating the detail came through to the Board meeting reports. Members were informed that PADR performance was static from March 2016 to March 2018. This included medical staff which had shown marginal improvement. This was an area that had a level of traction but no progress. There was a challenge going forward for a significant piece of work to be undertaken. It was emphasized that line managers should at least once a year, discuss staff aspirations and their future and engage staff on how to take this into a different arena; for there to be wider discussion on succession planning, talent and development management. This should form the basis of information that came from appraisals. In two to three months' time a piece of work would be brought to the new Committee on what would be considered to be taken forward.

It was discussed and noted:

- This was a fundamental step in moving forward as the Board was responsible for the culture and the development of staff.
- The scrutiny was welcomed and it was acknowledged there were more PADRs being undertaken than were currently recorded on the Electronic Staff Record system. There was a need to ensure it is a valuable conversation and rewards individuals appropriately.

The Committee:

- **NOTED** the verbal update on Personal Appraisal and Development Review

RD: 17/046 MORE THAN JUST WORD (WELSH LANGUAGE)

Sara Moseley, Independent Member gave a verbal update stating that she had recently attended a meeting with the Welsh Language Commissioner to review the Annual Reporting Plan resulting in a number of specific suggestions. This was overshadowed as the Standards had not yet been published. In early observations the Independent Member had asked the team for benchmarking data against other Health Boards in regard to good practice and what was working well. It was stated for the Health Board not only to comply with the standards but to celebrate what we had in relation to diversity and the number of staff able to speak the language. There were discussions on having a creative approach and being more engaged. The team was focused in undertaking work around this area and was exploring ideas for improvements.

The Director of WOD stated that good work had been undertaken and achievements captured during the past 12 months. There was promotion of the Welsh language in terms of recruitment and induction. There were some challenges around recruitment outside of Wales. The More than Just Words strategy has a traction in the organisation and a strategic objective. Further updates will be given in new Committee.

It was discussed and noted:

- In response to whether the question is asked if employees speak Welsh, it was stated that although the question is asked it was not compulsory to answer. The Organisation had a service where staff wear lanyards for patients and visitors to identify those who can speak Welsh.
- There was a need to ensure that people who are unable to speak Welsh were not deterred by applying for posts. There was a need to look at the national and international market and for there to be a balance by looking for other skills too.
- It was highlighted that a number of items on the table were RAG rated red with dates stating not current and asked for these to be reviewed by the team.

- It was acknowledged that there was very good work ongoing across the Organisation and for this to be recognised.

ACTION: For team to review table with RAG rates that are red

The Committee:

- **NOTED** the course of action undertaken to ensure compliance to the More than Just Words Strategy and he UHB Welsh Language Scheme
- **ENDORSED** progress report to Board

21.5

RD: 17/047 POLICIES FOR APPROVAL

Business Continuity Policy

The Committee **RECEIVED** the Business Continuity Policy and the Committee was informed that Internal Audit had been looking at the procedure for some time and one of the gaps was to have an updated policy. It was acknowledged that a considerable amount of work had been undertaken.

It was discussed and noted:

- The security cyber-attack last year raised questions around business continuity and the WAO audit required Clinical Boards to have their own continuity plans in place. It was suggested that there should be a link for executive leadership in IT and this should be a defined role added into the policy. Welsh Government will be running a seminar on business continuity for executives in the near future and this should be reflected in document. The Director of Therapies and Health Science considered that as she also had a responsibility for patient safety, this should be included in the policy.
- The Strategic Partnership and Planning Manager and team had engaged with the Chief Operating Officer (COO), Chief Executive and Clinical Boards around emergency preparedness. As the scope of this document is very wide-ranging,it was recognised that having specific leads for high profile risks was important. The COO played a particular role in emergency preparedness and given the potential impact on the organisation there may be a need for particular leads allocated to particular items.
- It was highlighted that it said in the EQIA 'no action required at this stage' and queried if this was the case with such a number of actions. It was explained that each Clinical Board had to have ownership of their individual policy which fed into the broader document. This was not about service improvement but whether the Health Board could continue to function and operate if a crisis arose.
- It was suggested that the Equality and Health Impact Assessment (EHIA) on front cover of report could be reworded 'where relevant in delivering the policy an EHIA will be undertaken'.
- The real delivery and assurance centred around Clinical Boards doing the appendices in the document and for them to progress and ensure they are enacted.

ACTION: **G Walsh to discuss revising document to include Director of Therapies and Health Science around the professional and executive role in IT**

To clarify if the 'no actions required at this stage' was robust

21.5

SUBJECT to above amendments the Committee:

- **APPROVED** the BC Policy and BC Planning Guidance
- **APPROVED** the full publication of the BC policy and BC Planning Guidance in accordance with the UHB publication scheme

Employment Policy and Procedure
The Committee was informed the employment policies were a revised All Wales policy with key changes highlighted. There had been a new approach for staff to raise concerns which has been championed by Chair. The documents will be disseminated via the intranet and clinical portal.

The Committee:

- **ADOPTED** the revised All Wales Special Leave Policy
- **ADOPTED** the revised All Wales Procedure for NHS Staff to Raise Concerns
- **APPROVED** the full publication of the Policy and Procedure in Accordance with the UHB Publications Scheme

RD: 17/048 TO DISCUSS AND AGREE THE ROLES AND RESPONSIBILITY OF THE NEW COMMITTEE IN ORDER FOR THE TERMS OF REFERENCE TO BE PREPARED

The UHB Chair informed Members that a Wales Audit Office (WAO) draft report was being considered and recognized a brand new Board and the challenges this had for the Organisation. Part of the WAO report reviewed the Resource and Delivery and Strategy and Engagement Committees. In speaking to Independent Members it was recognized they had been given detailed fundamental training on the NHS and governance. There was a need to look collectively as a unitary Board to review how we seek assurance as a Board and revise our Committee structure. This will be looked at in detail at the Board Development Away Day in February.

Members were invited to provide input into the requirements needed for the new Committee and a robust discussion ensued on the role and responsibilities of the Committee. This will be discussed further at the Board Development Away Day. It was agreed that a Working Group be set up before the Board Development Day to ensure the day can be set with clear principles and parameters.

ACTION: The UHB Chair to set up Board and Committee Working Group

The Committee:

- **AGREED** to stand down the Strategy and Engagement and Resource and Delivery Committees and replace these with a new Strategy and Delivery Committee
- **SUPPORTED** Chair's Action to agree the terms of reference of this new Committee and for this to be endorsed at the Board's meeting on 29 March 2018

RD: 17/049 HIGH LEVEL PERFORMANCE DASHBOARD

The dashboard taken up to quarter three for this year was presented for information by the Chief Operating Officer. It was explained this was a view of high level indicators covering Tier 1 targets and related to the IMTP to highlight whether or not the Health Board was compliant.

There was wider discussion in understanding where the challenges should be and what appropriate scrutiny should be against these reports.

The Committee:

- **NOTED** Year to date performance for 2017-18 against key operational targets

RD: 17/050 CONTINUING HEALTHCARE REPORT

The report is required by Public Accounts Committee to be noted at the meeting. It was queried whether the report should sit with the Finance Committee.

ACTION: Chief Operating Officer to distribute missing page

The Committee:

- **NOTED** the paper

RD: 17/051 ANY OTHER BUSINESS

There was no other business to report.

21.6

UNCONFIRMED MINUTES OF A JOINT MEETING OF CARDIFF AND VALE HEALTHCARE PROFESSIONALS' FORUM AND STAKEHOLDER REFERENCE GROUP HELD ON WEDNESDAY 31 JANUARY 2018, HAFAN Y COED, UNIVERSITY HOSPITAL LLANDOUGH

Present:

Sue Bailey	Clinical Board Director for Quality, Safety and Patient Experience, Clinical Diagnostics and Therapeutics Clinical Board, UHB (Chair HPF)
Paula Martyn	Care Forum Wales (Chair SRG)
Posy Akande	Carer
Liz Fussell	UHB Volunteer
Iona Gordon	Cardiff Council
Ben Gray	Vale of Glamorgan Council
Suzanne Hardacre	Head of Midwifery
Denise Shanahan	Consultant Nurse
Karen Visser	Principal Speech Therapist

In Attendance:

Tim Davies	Emergency Management Officer, Cardiff Council
Abigail Harris	Director of Planning, UHB
Angela Hughes	Cardiff and Vale UHB, Patient Experience
Fiona Jenkins	Executive Director of Therapies and Health Science, UHB
Len Richards	Chief Executive, UHB
Anne Wei	Strategic Partnership and Planning Manager, UHB
Peter Welsh	Director of Corporate Governance, UHB
Joy Whitlock	Quality and Safety Improvement Manager, UHB
Huw Williams	Emergency Preparedness Manager, UHB

Apologies:

Sarah Capstick	Cardiff Third Sector Council
Shane Exton	Lead Cardiac Physiologist, UHB
Sheila Harrison	Acting Deputy Executive Nurse Director, UHB
Alison Kibblewhite	South Wales Fire and Rescue
Stuart Parfitt	South Wales Police
Richard Penketh	Consultant Gynaecologist, UHB
Linda Pritchard	Glamorgan Voluntary Services
Graham Shortland	Executive Medical Director, UHB
Michael Stone	Consultant Physician, UHB
Richard Thomas	Care and Repair Cardiff and the Vale
Bob Tooby	Welsh Ambulance Service NHS Trust

Secretariat: Gareth Lloyd

HPF/SRG 18/01 WELCOME AND INTRODUCTIONS

The Chairs welcomed colleagues to the meeting.

HPF/SRG 18/02 APOLOGIES FOR ABSENCE

The HPF/SRG **NOTED** the apologies.

It was **NOTED** that although not members of the HPF nor SRG, Jo Chapman, Marie Davies and Keithley Wilkinson had sent their apologies for the meeting.

HPF/SRG 18/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

HPF/SRG 18/04 MINUTES OF MEETING HELD ON 30 NOVEMBER 2017

The HPF/SRG **RECEIVED** and **APPROVED** the minutes of the meeting held on 30 November 2017.

Major Trauma Network
Anne Wei reminded the HPF/SRG that the formal Consultation period ended on 5 February 2018. At the last count, around 450 responses had been received. A significant majority of the responses support the establishment of a major trauma network for South and West Wales and South Powys and a majority also support the proposal that the development of the network should be based on the recommendations from the independent panel. Following Consultation, a report will be produced including details of the responses together with the final proposal. The report will be considered by all Health Boards in March 2018.

Traffic Management Arrangements
Abigail Harris informed the HPF/SRG that the competitive dialogue process was taking longer than anticipated. It was anticipated that the contract for management of car parking at all of the UHB's major sites would be awarded at the end of February. The contract would run from 5 June 2018 at UHW and 1 November 2018 at the other sites.

Engagement on the Future Shape of Thoracic Surgery Services
Abigail Harris informed the HPF/SRG that the engagement process had concluded during November 2017. The Project Board established by Welsh Health Specialised Services Committee had met during early January and recommended that thoracic surgery should be delivered from a single site. An independent panel had reviewed all the evidence gathered during the process and had determined that this site should be Morriston Hospital. Discussions

were ongoing regarding whether a formal public consultation was required. UHB staff were being kept fully briefed of developments.

HPF/SRG 18/05 FEEDBACK FROM BOARD

The HPF/SRG **RECEIVED** and **NOTED** the agenda of the UHB Board meeting held on 30 November 2017.

Peter Welsh drew the attention of the HPF/SRG to several issues that had been discussed at the Board meetings held on 30 November 2017 and 25 January 2018 and reminded them that all Board papers were available on the website including the Chair's and Chief Executive's Reports.

30 November 2017 Meeting

- The Patient Story came from the organ donation team who presented moving stories on multi faith issues. Last year the team had begun to observe a two minute silence in theatres prior to removing organs which staff found extremely helpful.
- There had been a significant change to the composition of the Board. There were three new Independent Members: two with a financial background and one with a legal background. The November meeting had also been the first for the new Vice Chair.
- The Board had received an update on the UHB's Integrated Winter Preparedness and Resilience Plan. Activity levels had been above those predicted which had presented a real challenge. There had not been the normally high level of discharges from hospital immediately prior to Christmas and there had been high levels of attendance at GP Out Of Hours services over the Christmas/New Year period. There had been a deterioration in ambulance delays and in the number of patients waiting more than 12 hours in the Emergency Department although the situation had improved the previous week. On a more positive note, Delayed Transfers of Care had been at their lowest ever level during December although they had increased a little during January. Overall the service was proving quite resilient.

25 January 2018 Meeting

- The Board had been notified of the appointment of the final two new Board members. Professor Gary Baxter was the new Cardiff University representative and the Independent Member for trade unions was Dawn Ward who was an occupational therapist.
- The Chief Executive had provided an update on his visit to Canterbury District Health Board (New Zealand).
- Cardiff and Vale of Glamorgan Joint Commissioning and Pooled Budgets for Older Peoples Services
- Cardiff and Vale of Glamorgan Area Plan for Care and Support Needs.

Peter Welsh explained that the Board meeting in February would be a development session at which further consideration would be given to how the Board and its Committees functioned.

HPF/SRG 18/06 DRAFT INTEGRATED MEDIUM TERM PLAN (IMTP) 2018-19

Abigail Harris explained that it was anticipated that the UHB would end 2017/18 with a financial deficit of just under £30m. This position would have been achieved through a disciplined approach to cost improvements. The underlying deficit for 2018/19 would be £50m. The UHB remained in 'Targeted Intervention' with Welsh Government (WG) because it did not have a financially balanced plan.

Abigail Harris informed the HPF/SRG that the UHB would be submitting a draft IMTP to WG that day. It would receive feedback from WG officials during February. The IMTP would then formally submit its IMTP at the end of March. It was acknowledged that the draft IMTP was too long and would need to be more succinct and provide WG with an assurance that the targets contained therein were achievable.

Members of the HPF and SRG were reminded that they were invited to an IMTP stakeholder engagement event on 19 March, further details of which would be issued during the coming weeks.

HPF/SRG 18/07 BUILDING COMMUNITY RESILIENCE TO SUPPORT PREPAREDNESS FOR EMERGENCIES

The HPF/SRG **RECEIVED** a presentation from Tim Davies and Huw Williams. They were informed that the Cabinet Office provides four examples of 'community': geographical communities, communities of 'interest', communities of 'circumstance' and community of 'practitioners'. A working definition of community resilience is 'communities and individuals harnessing local resources and expertise to help themselves in an emergency, in a way that complements the response of the emergency services.' The approach to building community resilience being developed across public services in Cardiff was then described noting that there were similar arrangements in place in the Vale of Glamorgan.

Huw Williams explained that the UHB was working with Cardiff Council and Natural Resources Wales to identify which of its premises were at risk of flood. All community councils within Cardiff were encouraged to develop a resilience plan.

It was a noted that there would be a live Rest Centre exercise in Cardiff on the 19 and 20 March 2018.

The HPF/SRG then considered three specific questions.

- What else could be done to help build community resilience to emergencies?
- How can you help us work with different communities?
- What can the UHB do to support this agenda?

It was agreed that all UHB staff could play their part in cascading the information within their own communities. It was further noted that the Patient Experience Team were working with Emergency Preparedness colleagues to look at the potential role of UHB volunteers in an emergency.

The suggestion was made that Apps could be used. TD explained that there was an 'Evac Cardiff' App and consideration was being given to developing a website.

Members highlighted opportunities for them to share information within their own groups and communities. It was agreed that members of the HPF/SRG would be sent a link to the 'Preparing for Emergencies' pack.
Action: Huw Williams/Gareth Lloyd

HPF/SRG 18/08 ACCELERATING THE IMPLEMENTATION OF SHAPING OUR FUTURE WELLBEING

The HPF/SRG **RECEIVED** a presentation from Len Richardson on how learning from Canterbury District Health Board (New Zealand) could accelerate implementation of the UHB's Shaping Our Future Wellbeing (SOFW) Strategy.

The HPF/SRG was informed that ten years ago the situation in Canterbury bore many similarities to the current situation in Cardiff and the Vale. There was an aging population which was increasing demand for health care services, a challenging financial environment and difficulties in staffing hospitals. The key features of the new model introduced in Canterbury were then described.

- A consistent and compelling vision - Canterbury DHB is world renowned for the emphasis it places on primary care and delivering care close to peoples' homes. The focus is on enabling people to take greater responsibility for their own health, for them to remain well for longer and minimise the need for admission to hospital. Every professional development course begins with reference to this vision and every opportunity is taken to reinforce it.
- Clinical engagement and empowerment. 900 health pathways have been developed since 2006 with high levels of compliance.

- A permissive and accountable culture with high levels of trust and low levels of bureaucracy. There is a single health system with a single budget provided by public, private and third sector agencies.
- Patient centred and system wide. Care is designed to be seamless for the individual with services organised around them.

The HPF/SRG then discussed the presentation. In response to an enquiry, Len Richards explained that GPs in New Zealand are independent practitioners but work collectively through three different federations. In Cardiff and Vale there are GP Clusters. Abigail Harris explained that sessions were being held with the Clusters to look at different services models.

A single budget would be key to the success of SOFW.

The HPF/SRG enquired how the transformation had been led in Canterbury. Len Richards explained that Canterbury had benefitted from a relatively stable leadership over the past ten years and staff had been recruited to the vision There were also 3-4 really engaged clinicians, mainly GPs who drove the process and built the model up from primary care.

The HPF/SRG enquired whether Cardiff and the Vale could be compared to Canterbury given, for example, the rapid increase in children in the southern arc of Cardiff. Len Richards acknowledged that there were certainly differences between the two regions and there was no question of simply replicating the Canterbury model. That notwithstanding, there were lessons to be learned that could be applied to Cardiff and the Vale.

Abigail Harris explained that the UHB proposed developing a multi-agency Health and Wellbeing Centre in each of its three Localities supported by a network of Health and Wellbeing Hubs. The UHB was also producing a high level estates strategy to reflect the need to rebuild UHW. To do this greater clarity was required regarding the future role of UHL and the likelihood was that more elective activity would have to be undertaken at UHL. There was an acknowledgement that model for commissioning from the independent sector would also have to be revised.

Abigail Harris informed the HPF/SRG that the Parliamentary Review of Health and Social Care in Wales had been published on 16 January. The Report gives support to the UHB's SOFW Strategy as it refers to putting patients at the centre and empowering them to take more responsibility for their own health. The topic for the Team Wales Event on 2 February would be on the national strategy for responding to the Report. It was agreed that the Report was a potential agenda item for a future SRG meeting.

HPF/SRG 18/09 UHB ANNUAL QUALITY STATEMENT

Joy Whitlock informed the HPF/SRG that the UHB was starting to consider the 2017/18 Annual Quality Statement (AQS). She explained that the template was provided by WG and it was not designed as a Board assurance report.

The HPF/SRG was then asked to consider some specific questions.

- Are there any specific issues that must be included this year?
- Was the balance of words and photographs in the 2016/2017 AQS appropriate?
- Do you have any good ideas for an eye catching front cover? What would grab your attention?
- Did the 2016/17 AQS contain a good balance of want went well and what did not go so well?
- Does it feel as though the 2016/17 AQS was written in an open way?

The HPF/SRFG made a number of observation.

- There could be a greater emphasis on prevention
- The narrative should consistently refer back to the SOFW Strategy which was not always the case in the previous years' AQF.
- It would be helpful if explanations of the implications for the patient were provided throughout.
- It may be difficult for some people to read all of the narrative. An interactive web page might be a better way of providing the information. Joy Whitlock explained that an electronic version of the AQS would be produced containing hyperlinks to other useful materials.
- Greater use could be made of graphs and infographics.
- Will the AQS be available in languages other than English? Joy Whitlock confirmed that a Welsh language version would be produced.

It was agreed that members of the HPF/SRG would email any further comments to Alex Scott. Gareth Lloyd agreed to provide HPF/SRG members with her contact details.
Action: Gareth Lloyd/All

HPF/SRG 18/10 NEXT MEETING OF SRG

The next meeting of the SRG will take place 9.30am-12pm, 27 March 2018, Seminar Room, Hafan Y Coed, UHL.

Peter Welsh agreed to liaise with the Chairs regarding arrangements for future joint meetings.
Action: Peter Welsh

Minutes from the Local Partnership Forum Meeting held on Thursday 8 February 2018 at 10am in Seminar Room 5, Cochrane Building, University Hospital of Wales

Present:

Mike Jones	UNISON/Chair of Staff Representatives (Co-Chair)
Martin Driscoll	Executive Director of Workforce and OD (Co-Chair)
Janice Aspinall	RCN
Catherine Salter	RCN
Peter Hewin	BAOT/UNISON
Joe Monks	UNISON
Andrew Crook	Head of Workforce Governance
Julie Cassley	Deputy Director of Workforce and OD
Joanne Brandon	Director of Communications
Abigail Harris	Executive Director of Strategic Planning
Fiona Jenkins	Executive Director of Therapies and Health Sciences
Holly Vyse	CSP/ Staff Side Secretary
Dorothy Debrah	BDA
Steve Gaucci	UNISON
Stuart Egan	UNISON/Lead Health and Safety Representative
Bob Chadwick	Executive Director of Finance (part of meeting)

Apologies:

Ceri Dolan	RCN
Sharon Hopkins	Executive Director of Public Health/Deputy Chief Executive
Peter Welsh	Director of Corporate Governance/Senior Manager UHL
Len Richards	Chief Executive
Graham Shortland	Medical Director
Steve Curry	Chief Operating Officer
Fiona Salter	RCN
Dawn Ward	BAOT/UNISON
Pauline Williams	RCN
Claire Radley	Assistant Director of OD

Secretariat:

Rachel Pressley	Workforce Governance Manager

LPF18/001 WELCOME AND INTRODUCTIONS

Mr Jones welcomed everyone to the meeting and introductions were made.

It was noted that this was Miss Catherine Salter's last meeting as she was moving on to a new role in the RCN. Mr Jones thanked her for all her work as Deputy Lead Health and Safety Representative.

Mr Jones also noted that Ms Dawn Ward had been appointed as the new Independent Member – Trade Union, and congratulated her on behalf of the Forum. Dr Jenkins added her congratulations and offered to support Ms Ward while she got settled in to her new Board role.

LPF18/002 APOLOGIES FOR ABSENCE

Apologies for absence were **NOTED**.

LPF18/003 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF18/004 MINUTES OF PREVIOUS MEETING

The Local Partnership Forum **RECEIVED** and **APPROVED** the minutes from 13 December 2017 as an accurate record of the meeting with the following exception:

- Mr Egan had been present but was missing from the list of attendees

LPF18/005 ACTION LOG REVIEW

The Local Partnership Forum **RECEIVED** and **NOTED** the Action Log.

LPF 18/006 STRATEGIC PLANNING FLASH REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Executive Director of Strategic Planning, providing a high level summary of planning developments within the Health Board.

Mrs Harris advised that discussions about a UHW rebuild had now begun in earnest, but that before a business case could be developed the specifications of UHW and UHL needed to be determined and a model clinical pathway developed. There was some urgent work needed, especially in Theatres, and this would continue in the meantime.

Conversations were also taking place with PCIC around the infrastructure of Primary Care. Mrs Harris suggested that it might be beneficial for the LPF to have a separate discussion around this at some point.
ACTION: Dr Pressley

Miss Salter asked how the developments noted in the report and Canterbury were linked, and whether the Canterbury work would cause delays. Mrs Harris advised that they were completely intertwined and that while there was plenty of time to work through the detail of the rebuild, steps would be taken to ensure that it was a flexible and responsive as possible.

LPF 18/007 LEARNING FROM CANTERBURY – PROPOSED NEXT STEPS

The Local Partnership Forum was reminded by Mrs Harris that at the previous meeting the Chief Executive had talked about a recent visit by Health Board representatives to Canterbury Health System in New Zealand. Ten years ago Canterbury had been in a very similar position to the Health Board, with financial difficulties, an aging population and a heavily hospital based system which was not sustainable. They had introduced a change programme which centred around the patient ('Agnes'), and which had brought about demonstrable outcomes including fewer visits by the elderly to the Emergency Department, fall prevention, and a reduction in admissions due to Chronic Obstructive Pulmonary Disease (COPD).

The core elements of the Canterbury Health System included a vision very similar to that described Shaping Our Future Wellbeing, clinical and frontline engagement and empowerment, and an organisational culture which was built around the concept of 'Agnes' and how things would impact on her.

Mrs Harris advised that while there are no plans to 'lift and shift' the Canterbury model (in fact some aspects were already in place or more advanced), there was a great deal which could be learnt from them.

The proposed next steps included:

- re-invigorating our vision to bring it to life for frontline staff. This was supported by a recent Parliamentary Review and the emphasis it placed,through the 'quadruple aim', on keeping the workforce happy and healthy
- a re-invigorated transformation programme
- improved technology to provide more real time data
- the development of an alliance with Canterbury, South East Sydney Health Board and Grampian NHS Trust

Mr Hewin noted that staff representatives had previously indicated their support for this programme but suggested that conversations about how to make these changes, particularly cultural changes, were needed within each of the Clinical Boards. He used the example of the continued use locum psychiatrists rather than substantive nurses or therapists to illustrate some of the cultural and organisational barriers faced. Mrs Harris agreed, and talked about the impact of staff stress on patients and the importance of compassion in leadership. A number of the Executive Team had heard Prof. Michael

West speak about this at the NHS Confederation conference the previous day and Mr Richards hoped to arrange a similar UHB session in the future.

Mr Egan asked what barriers had been identified and how they would be broken down. He built on Mr Hewin's example and asked how we would respond if the Deanery threatened our teaching status if we did not replace Consultants on a like by like basis. Mr Jones asked Mrs Harris to feed these comments back to Mr Richards for his consideration.
ACTION: Mrs Harris

Miss Salter noted that health and social care were integrated in Canterbury. Mrs Harris stated that the need for integration was reinforced by the Parliamentary Review, and indicated that there had been some progress around this through the Social Partnership Board.

Mr Jones suggested that Mr Alun Tomkinson or another member of the team who had visited Canterbury should be invited to the Staff Side meeting for more detailed discussions.
ACTION: Miss Vyse

LPF 18/008 HEALTHY WORKPLACE, HEALTHY YOU

The Local Partnership Forum **RECEIVED** and **NOTED** the report of the Lead Staff Representative for Health and Safety, outlining a new toolkit focussing on staff wellbeing called 'Healthy Workplace, Healthy You'.

Mr Egan noted that the staff were the Health Board's greatest asset and that they needed to be valued and looked after. The toolkit had been developed by the RCN and introduced by the trade unions in partnership, with support from the Health and Wellbeing Advisory Group. Mr Egan advised that there were two elements to the toolkit; organisational and personal responsibility. These covered a range of topics including work life balance, health and safety, mind, body and career. The Local Partnership Forum supported the introduction of the toolkit, and welcomed this as the first report brought to the meeting by staff rather than management representatives. Mr Driscoll advised that Mr Richards was happy to sign the Pledge for the Healthy Workplace, Healthy You toolkit.

The Forum also supported the idea of an All-Wales Menopause Policy and it was **AGREED** that a joint letter should be issued by the Co-Chairs to the Welsh Partnership Forum.
ACTION: Mr Driscoll/Mr Jones

It was noted that there were a number of instances of health initiatives being aligned with charitable causes within the Health Board. These included plans for Mr Egan and other staff to shave their heads to raise money for the Orchard at UHL, and the half marathon which Mr Richards, Miss Battle and Mr Driscoll had all entered.

LPF18/009 FINANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** a report detailing the financial position of the UHB for the period ended 31 December 2017.

Mrs Harris advised that Welsh Government had agreed that the surplus between the value and sale price of West Wing could be used against the bottom line on this occasion

LPF18/010 WORKFORCE AND OD KEY PERFORMANCE INDICATORS

The Local Partnership Forum **RECEIVED** and **NOTED** the report of Mr Martin Driscoll, Executive Director of Workforce and OD.

Mr Driscoll reported that the sickness absence position had deteriorated in December 2017 but that it was hoped that this was an outlier due to winter illness and the flu.

He advised the Forum that the Health Board were participating in a number of local and national nursing recruitment events, to promote the UHB, Cardiff and NHS Wales. A recent visit to Southampton had been very successful, with 34 people expressing an interest in working here.

Mr Egan suggested managers should be made more aware of the Stress Risk Assessment. He believed that most managers only realized that the tool existed once Occupational Health became involved, and that it was therefore used reactively. He understood that the policy was currently being reviewed and asked if staff representatives could be heavily involved in the process.

Mr Monks reminded the Forum that he had suggested on several occasions that there was too much emphasis on poor attendance and sickness management, as oppose to good attendance, and he did not believe this had had a big impact on sickness figures. He had previously put forward the idea of letters of congratulations for staff who did not take time off sick, but as far as he was aware this had never happened. He noted that there was a lot of change taking place and that staff found this stressful. It was important to do everything possible to make that feel valued and appreciated. Mr Driscoll indicated that while he had no issue with good attendance letters being sent to staff, he could not agree with Mr Monks' comments about sickness figures as they had reduced from 6% to around 4.6%

Mr Hewin asked about the external review in Paediatrics Therapies referenced in the report as he was under the impression that local decisions based on waiting lists had superseded this. Dr Jenkins believed that it had taken place and that the review was complete. Mr Hewin expressed concern about this because as far as he was aware staff representatives had

not been involved. He was also concerned about a comment in the report relating to the 'prudent use of the registered workforce' in CD&T Clinical Board. Mr Gauci agreed to find out more about this from the Head of Workforce and OD and feedback to Mr Hewin.
ACTION: Mr Gaucci

Mr Hewin also mentioned that he was aware of the restructuring process taking place within Workforce and OD and Finance asked whether this was a precursor to changes to the lead staff representative role and Clinical Board Structure. Mr Driscoll assured him that this was about the delivery of service and would not have an impact on the Clinical Board arrangements.

Miss Salter suggested that it would be useful to see more risks reported in the Workforce KIPs, particularly around statutory and mandatory training. She suggested that it was not really sufficient to report level 1 (e-learning) training for fire, manual handling etc. when so many roles required training at a more advanced level. Mr Driscoll advised that he was reviewing the workforce KPIs with his team and expected to make changes to the report from April onwards.

LPF18/011 IMTP UPDATE

The Local Partnership Forum **RECEIVED** a verbal update from the Executive Director of Strategic Planning.

Mrs Harris stated that the UHB had submitted a draft plan in January but that it was not ready for approval by Welsh Government because of the underlying financial position. Money allocated for investments had been limited, but there was a balance between continuing performance and the improvement trajectory and how much could be taken out of the system.

Mr Chadwick advised that while the deficit had been reduced slightly this year, it had been hoped that this would have been greater through transformation. A plan to achieve balance was being developed, based on a 3% recurrent and 1% non-recurrent CRP. However, even with good performance and minimal investment this was not acceptable to Welsh Government and discussions continued.

Mrs Harris advised that the IMTP was available on the UHB website and that a link would be sent out to members.
ACTION: Dr Pressley

LPF18/012 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Patient Safety, Quality and Experience Report.

LPF18/013 PERFORMANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Performance Report.

LPF LPF18/014 ANY OTHER BUSINESS

There was no other business raised.

LPF18/015 REVIEW OF THE MEETING

The Local Partnership Forum reviewed the meeting and agreed that the Healthy Workplace, Healthy You toolkit should be brought to the attention of the Board.
ACTION: Ms Ward

LPF18/016 DATE OF NEXT MEETING

Dates of meetings for 2018/9 were being arranged and would be published as soon as possible.

UNCONFIRMED MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD AT 9AM ON 13 FEBRUARY 2018 CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
Susan Elsmore	Independent Member, QSE Chair
Akmal Hanuk	Independent Member – Community
Maria Battle	UHB Chair
Michael Imperato	Independent Member – Legal
In Attendance:	
Andrew Gough	Assistant Director of Finance
Angela Hughes	Asst. Director Patient Experience
Carol Evans	Asst. Director Patient Safety and Quality
Caroline Bird	Deputy Chief Operating Officer
Clive Morgan	Deputy Director of Therapies and Health Science
Dr Graham Shortland	Medical Director
Peter Welsh	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Observers	
Len Richards	Chief Executive
Alun Jones	Deputy Chief Executive, HIW
Dr Aarij Siddiqui	Chief Registrar Medicine
Dr Kathryn James	Welsh Clinical Leadership Training Fellow
Yvonne Hyde	Senior Nurse, IPC
Apologies:	
Abigail Harris	Director of Planning
Dr Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Salter	Staff Representative
Robert Chadwick	Director of Finance
Sharon Hopkins	Director of Public Health
Stephen Allen	Chief Officer, Cardiff and Vale of Glam CHC
Steve Curry	Chief Operating Officer
Secretariat:	Julia Harper

QSE 18/001 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular, colleagues representing Executive Directors and several Observers. It was noted that colleagues from the Surgery Clinical Board would be attending from 9.30am – Dr Linda Walker, Clinical Board Director of Nursing, Mr Geoff Clark, Consultant Surgeon, Dr Richard Hughes, Consultant Anaesthetist and Mike Bond, Director of Operations.

QSE 18/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

QSE 18/003 DECLARATIONS OF INTEREST

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

QSE 18/004 MINUTES OF THE SPECIAL COMMITTEE HELD ON 6th DECEMBER 2017

The Minutes of the last meeting were **RECEIVED** and **APPROVED.**

QSE 18/005 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:

1. QSE 17/138 and 17/179 Nutrition and Catering Policy and Never Event NG Tube – The Policy was being considered at the Clinical Standards Group in March and following this would be available for consultation. It was anticipated for approval at Committee in June 2018. A timeframe for the completion of the Naso Gastric Tube Policy would be chased.
Action Dr Fiona Jenkins and Mrs Carol Evans

2. QSE 17/202 Patient Safety Walkrounds – Cllr Elsmore had written to Members about the importance of maintaining the programme for Walkrounds. These had started and were going well. The importance of writing a note of the visit was stressed to ensure actions could be followed through.

3. QSE 17/204 IPC Tier 1 – A Board Champion for Cleanliness and Hygiene would be considered at the Development Day next week.
Action – Miss Maria Battle

4. QSE 17/132 CHC Report – Work was ongoing about the role and function of the CHC. Their visit reports would be shared with the Committee to triangulate learning.

5. QSE 16/192 Critical Care Outreach/Care of Deteriorating Patients – A project structure had been put in place. No concerns had been identified from mortality figures. There were pockets of good practice and the NEWS system was used across the UHB but the response to a deteriorating score differed across the UHB.

It was agreed to consolidate the action log and provide a realistic time frame. It was also agreed to receive a short report at the next meeting, including the risk, priorities, mitigation and methodology.
Action – Dr Graham Shortland
The Resuscitation Team had managed successfully a call from the Llanfair Unit.

6. QSE 17/214 HIW Ophthalmology Thematic Review – The Executive Nurse Director advised that Management Executive had recently considered a report on waiting times and communication with patients. The Chief Operating Officer was streamlining a single plan and was personally overseeing progress, though it had to be recognised there were some very high risk areas. It was agreed to delay the update report to June so that the impact of these actions could be seen.

7. QSE 17/195 Specialist Services QSE Assurance Report – This was complete and the poem may also be used in the Annual Quality Statement.

The Chair expressed her concerns that timescales were often extended for work on items within the Action Log and this did not provide assurance. It was important for Executives to be open with the Committee and to commit to meeting the identified timeframes.

QSE 18/006 CHAIR'S ACTION TAKEN SINCE THE LAST MEETING

The Chair had nothing to report.

QSE 18/007 PATIENT STORY – SURGERY

Mr Geoff Clark, Consultant Surgeon delivered two patient stories that demonstrated both good and bad patient experience in emergency surgery.

As a result of a successful business case to support emergency general surgery, the UHB now had 2 surgical teams on call – one in theatre and one at the front door. In addition, the emergency CEPOD theatre had been enhanced. The teams covered upper GI and colorectal surgery.

The first case demonstrated that excellent communication between expert teams meant that a patient admitted in pain was diagnosed with advanced cancer very quickly, was supported when the bad news was broken, was discussed at a multi-disciplinary team meeting and was discharged with a care plan within 48 hours. All this care was provided by a consultant or specialist nurse.

The second case involved out of hours care which had not changed as a result of the business case. There was only one team with access to two theatres. A patient arrived via A&E and waited 11 hours for surgical review.

Knowing that a general anaesthetic was required, he was starved of food and drink. When it was known that he would not be able to access theatres he was discharged home, advised he could eat and was told to return in the morning. Due to poor communication, the surgeon was not aware that the second theatre was not available due to maintenance work. The first theatre was treating an emergency neuro case. The patient was finally taken to theatre at 5pm after starving all day and was "bumped" again due to another emergency neuro case. His operation finally took place at 3am the following morning. Overall the care was poor, yet the patient was so very grateful.

The Committee noted that weekend surgery was still a challenge and that there was no agreement for the SAU to open at weekends. In addition the constant need for 2 theatres was noted. The challenge was not all about money, but having sufficient staff. The establishment of 14 SPRs was running with 10 which left gaps in the rota.

The Chief Executive highlighted the need to make change easier in order to improve safety and quality and to change the culture to a "can do" attitude. This would also motivate staff and improve morale. Having just one extra pair of hands made a huge difference to performance, patient experience and morale. In terms of transforming emergency care, the key was training junior doctors in emergency surgery.

The Medical Director agreed to circulate a recent GMC case to Committee for information.
Action – Dr Graham Shortland

The Chair thanked Mr Clark for his excellent leadership and for sharing openly both good and not so good examples that focussed the mind and opened the debate across the organisation.

QSE 18/008 SURGERY SERVICES CLINICAL BOARD QUALITY, SAFETY AND EXPERIENCE REPORT

The Chair invited comments and questions on the comprehensive report.

Dr Linda Walker commented on the action taken to improve infection rates, noting that "bare below the elbow" remained a challenge, but staff were talking about it. Refurbished areas had made a big difference to the environment.

A lack of interventional radiology was an issue out of hours. A consultant appointment had been made at Cwm Taf and it was anticipated that this would be resolved by the summer. Going forward, a regional partnership approach was needed to deliver an out of hours service with 2 serious incidents being investigated. It was agreed to receive a further report in June when progress was expected to be seen.
Action – Mr Steve Curry

Whilst the mortality review system had improved, there was still a need for more work on governance and assurance systems.

Dr Walker also answered questions on smoking cessation for pre-op patients, complaints response times and telephone assessment in the evenings. Nurse recruitment was doing well, but retention was harder and not helped by the number of medical outliers that damaged staff morale. This was being addressed in conjunction with the Medicine Clinical Board and the number had been reduced from 100 to 35 outliers. A business case was being prepared to address the requirements of the Nurse Staffing Act.
It was agreed to receive a separate report on outliers at the next meeting.
Action – Mr Steve Curry

In terms of medical negligence claims, it was noted that the number was not proportionately high.

The Chair thanked the Surgery Clinical Board for attending the meeting and answering the Committee's questions.

ASSURANCE was provided by:

- The governance processes embedded in the core business of the Surgical Clinical Board and its Directorates
- Evidence of regular performance management reporting
- Independent review of the business of the Surgery Clinical Board by internal and external bodies such as Internal Audit, CHC, HIW, Welsh Risk Pool, Welsh Government

The Quality Safety and Experience Committee:

- **APPROVED** the content of this report and the assurance given by the Surgery Clinical Board.
- **NOTED** the progress and approach taken by the Surgical Clinical Board to date and planned future actions.

QSE 18/009 COMMUNITY HEALTH COUNCIL (CHC) REPORT

In the absence of the CHC Chief Officer, Mr Stephen Allen, the report was **RECEIVED** and **NOTED.**

QSE 18/010 POLICIES FOR APPROVAL

1. **PRESSURE ULCER RISK ASSESSMENT, PREVENTION AND TREATMENT**

ASSURANCE was provided by:

- Full consultation across the UHB to ensure staff implementation and its integration into UHB pressure ulcer training programmes
- The policy was in line with national and international guidelines.

- Report to Clinical Board Quality and Safety Sub Committee meetings bi-monthly where each Clinical Board investigated, via a Root Cause Analysis, all category III, IV and un-stageable pressure damage.
- Continuing to identify the various causes of pressure damage and adopting appropriate preventative methods where possible.
- Qualitative audit activity of compliance to inform risk assessments.

The Quality, Safety and Experience Committee:

- **APPROVED** The Pressure Ulcer Risk Assessment, Prevention and Treatment Policy and Procedure.
- **APPROVED** the full publication of the Pressure Ulcer Risk Assessment, Prevention and Treatment Policy and Procedure in accordance with the UHB Publication Scheme.

2. MEDICINES MANAGEMENT

The Medical Director, Dr Graham Shortland explained that this Policy would overarch the procedures contained in the Medicines Code that was approved at the last meeting.

ASSURANCE was provided by:

- Aligning UHB Practice to the All Wales Policy for Medicines Administration Recording Review and Storage (MARRS 2015).
- Monthly Medicines Metrics Audit completed by Pharmacy and reported to the Clinical Boards.
- Annual secure storage of medicines audit, reported to Clinical Boards and UHB Medicines Management Group.
- Self-Assessment against Welsh Government's MARRS Policy.

The Quality, Safety and Experience Committee:

- **APPROVED** the Medicines Management Policy subject to the provision of an Equality and Health Impact Assessment within 14 days (by 26th February) for Chair's approval.
  Action – Dr Graham Shortland
- **SUPPORTED** the provision of procedural guidance provided by The Medicines Code.
- **APPROVED** the full publication of the Medicines Management Policy and Code in accordance with the UHB Publication Scheme.
- **APPROVED** delegation of responsibility for the approval of Procedures (The Medicines Code itself) to the Medicines Management Group.
- **APPROVED** the withdrawal of a further 6 medicines management Policies/Procedures.
- **Action – Mrs Julia Harper**

QSE 18/011 REVIEW OF COMMITTEE TERMS OF REFERENCE

As part of the governance process, the Terms of Reference for the Committee were reviewed on an annual basis.

The UHB Chair advised that she had appointed two new Members to the Committee: Prof Gary Baxter as the new Committee Vice Chair and Dawn Ward.

ASSURANCE was provided by:

- Regular annual review of the Terms of Reference as well as adjustments made by the Board in November 2017.

The Quality Safety and Experience Committee:

- **APPROVED** the revised Terms of Reference of the Quality, Safety and Experience Committee for 2018 -2019.

QSE 18/012 COMMITTEE WORKPLAN FOR 2018/19

The Workplan was full, robust and aligned to the Health and Care Standards Framework, but hot topics would be added as and when necessary.

It was noted that the February Board Development session would be devoted to effective and efficient Board and Committee working and any changes made at that meeting would be incorporated as necessary.
Action – Mr Peter Welsh

ASSURANCE was provided by:

- Inclusion of items identified in the CRAF, Health and Care Standards as well as recommendations from external reports.

The Quality Safety and Experience Committee:

- **APPROVED** the Committee Work Plan for 2018 -2019 subject to the inclusion of Patient Experience Framework and Claims and Concerns.
  Action – Mrs Carol Evans
  .

QSE 18/013 WAO REPORT ON DISCHARGE PLANNING

Mrs Judith Hill attended the meeting at the request of the Audit Committee for this item. She commented on the assessment of WAO findings and the 4 recommendations with the subsequent management response that was now somewhat out of date.

It was noted that the number of delayed transfers of care (DTOC) had reduced considerably from 157 in 2016 to 43. Weekly meetings were held with patients/families and each case was carefully scrutinized. It was clear

from these meetings that staff were very familiar with the needs of their patients and understood the need for timely information.

A new clinical dashboard had recently been shared with staff to help them monitor the situation and ensure patients were allocated to the correct pathway.

Timely discharge was a risk and it was important that staff understood this in terms of patient safety, community handover and patient flow. It was appropriate for Board Members to ask questions about this during Safety Walkrounds as it was a key part of the UHB's Strategy.

The Chair thanked Mrs Hill for all her work and commented that the Council was working closely with the UHB to ensure a seamless service for patients. The DTOC position was the best it had been in 12 years.

ASSURANCE was provided by:

- The development, implementation and monitoring of improvement plans to address recommendations.
- Confirmation from the Wales Audit Office that the Health Board had robust discharge improvement plans, strong performance management arrangements and performance overall was improving but there was scope to improve ward staff training and awareness of policies and community services.

The Quality, Safety and Experience Committee:

- **CONSIDERED** the main findings of the Wales Audit Office review.
- **AGREED** that the action plan addressed the recommendations made within the Wales Audit Office report.

QSE 18/014 SAFER PATIENT NOTICE 24 - PATIENT IDENTIFICATION BANDS

The Executive Nurse Director, Mrs Ruth Walker was delighted to inform the Committee that from April 2018, funding had been allocated for an electronic system and it was anticipated that this would also save money. Fortunately no correlation to patient harm had been found in the absence of a system whilst awaiting funding. It was also pleasing that the new bar code system would be able to offer further safety possibilities in the future. Mrs Walker thanked Mrs Carol Evans for all her work on this and for sourcing the system in order for the UHB to comply with the safety notice.

ASSURANCE was provided by:

- This update on progress to address non-compliance of the UHB with Safer Practice Notice 24.

The Committee **CONSIDERED** the update provided within the paper.

QSE 18/015 INFECTION PREVENTION AND CONTROL REVISED RISK ASSESSMENT

The report had been withdrawn.

QSE 18/016 CANCER PEER RE REVIEW – HEAD AND NECK

The Medical Director, Dr Graham Shortland advised that wok had moved into the re review process. Good progress had been made and more learning had emerged. Work was underway with Surgery on ward staffing levels and skill mix, though there was a general recruitment issue in Pathology.

ASSURANCE was provided by:

- The level of scrutiny applied internally and externally to the 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.
- **AGREED** that appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.
- **AGREED** that this, and future action plans, should be made more explicit and contain timescales.
  Action – Dr Graham Shortland

QSE 18/017 CLINICAL AUDIT PLAN 2017-18 PROGRESS UPDATE

Dr Graham Shortland, Medical Director, introduced the report and thanked Carol Evans and Alex Scott for the easy read dashboard for national audits. Post audit report, there was a 3 week window to report back to Welsh Government and a report was also taken to HSMB. It was agreed that there needed to be clarity and explanation of any areas where the UHB was classed as an outlier.

It was important that local audits aligned with the UHB agenda and addressed hot spot areas.

ASSURANCE was provided by:

- Progress against the clinical audit plans.
- The assurance processes in place around the National Clinical Audits.
- The additional Local Clinical Audit activity that was registered and ongoing.

The Quality, Safety and Experience Committee:

- **NOTED** the clinical audit activity undertaken in the Clinical Boards.
- **AGREED** to consider the clinical audit process for 2018 / 2019 on the June Agenda.
  Action – Dr Graham Shortland

QSE 18/018 HEALTHCARE INSPECTORATE WALES (HIW) ANNUAL REPORT 2016-17

The Executive Nurse Director, Mrs Ruth Walker reminded Committee that as well as the Annual Report, separate individual reports from HIW were shared with Committee on a regular basis. This report addressed the action taken from the themes within the Annual Report.

ASSURANCE was provided by:

- The development and monitoring of improvement plans to address both local and national recommendations.
- Reporting and monitoring through the UHB Committees.

The Quality, Safety and Experience Committee:

- **NOTED** the Healthcare Inspectorate Wales Hospital Inspection Annual Report.
- **NOTED** the processes in place to monitor the required actions and improvements.

QSE 18/019 MANAGEMENT OF OUTPATIENT FOLLOW UPS AND ENDOSCOPY SURVEILLANCE

Mrs Caroline Bird, Deputy Chief Operating Officer advised the Committee that both areas were behind plan. Outpatient follow up had initially made good progress but this had slowed and action therefore needed to be refocussed. The PMS system was not designed to manage follow ups and staff were working with the IM&T team for other options. Unfortunately there was no clinical consensus on the management of follow ups due to the risk of the wrong patients being removed or left on the list. However, it was anticipated that a realistic view of the number of patients waiting would be available by the end of March. Following this, there would be a need to look at and change processes.

The number of patients waiting for endoscopic surveillance had deteriorated over the summer due to workforce issues. However, the opportunity had been taken to increase capacity through the use of two private hospitals and weekend insourcing at UHL. These lists appeared more efficient than the UHB's own lists and therefore there were lessons to be learned. The UHB was balancing the risk of patients waiting over 8 weeks and those awaiting surveillance.

Two further serious incidents had been received in the last week where delayed patients had been diagnosed with cancer. It was therefore important to receive a report on the lessons being learned and to ensure that risk was being balanced.
Action – Mr Steve Curry

It was noted that "spot purchase" was not helping. It would be more helpful if funding was recurrent in order to smoothly manage capacity and the growing demand.

In terms of streamlining administrative processes, it was suggested that lessons could be learned from Radiology where staff were very pleased with their booking system. It was also worth investigating DNA (did not attend) rates and whether they were lower at weekends when appointments were probably more convenient for working adults. It was agreed to look into DNA in greater detail to determine whether the service could make further improvements.
Action – Mr Steve Curry

As some patients were being failed, it was necessary for the Committee to be assured that the initiatives being taken were making a positive impact. In light of the gravity of the situation, it was agreed to receive a further comprehensive report in April.
Action – Mr Steve Curry

ASSURANCE was provided by:

- The Outpatient Follow-Up Improvement Plan was revised in July 2017, revising governance arrangements and re-focusing actions to increase the pace of improvement.
- Whilst there had been an increase in the number of patients overdue their planned surveillance endoscopy, the UHB had secured additional in-year capacity to reduce the number of patients delayed.
- There was a clinically agreed risk scoring methodology in place for patients waiting for a surveillance endoscopy.

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 at the April meeting.
  Action – Mr Steve Curry

QSE 18/020 UPDATE ON SINGLE ROOMS, ISOLATION ROOMS AND DECANT FACILITIES

In the absence of the Director of Planning, Mrs Ruth Walker advised Committee that it was recognized that the UHB had insufficient single rooms and this meant that patients sometimes spent longer in the Emergency Unit to

remain isolated. This was an ongoing challenge, but it was clear that more single rooms needed to be installed during the refurbishment process.

ASSURANCE was provided by:

- NWSSP – Specialist Estate Services Isolation Room Ventilation Inspection Report March 2017.
- Prioritisation of discretionary capital programme.
- Scrutiny at the Capital Management Group.
- Development of the UHB's estates strategic plan, the outline of which was discussed in the Strategy and Engagement Committee.

The QSE 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.

QSE 18/021 SINGLE POINT OF ENTRY FOR CHILDREN

Mrs Caroline Bird, Deputy Chief Operating Officer, advised Committee that the service model would need to change in the interim and longer term and commented on the mitigating action that had been taken to address the risk.

A working group had excluded a number of options and the choice was now down to two. Miss Battle advised that a regional planning meeting would be held later in the day and that Cwm Taf had reduced their figures downwards for paediatrics and maternity and this may affect the UHB's planning work for the service and its funding.

ASSURANCE was provided by:

- Plans for a Single Point of Entry were progressing in line with the project plan and were aligned to the developing plans for the Major Trauma Centre.
- These plans, and the interim options, were being developed with the full engagement of medical, nursing and managerial teams from the Children and Women and Medicine Clinical Boards and in consultation with the other affected Boards and services.
- The alignment of the interim plans with the SWP paediatric changes had allowed the development of options which bridged the majority of the existing financial deficit.

The Committee:

- **NOTED** the progress with the plans for a Paediatric Single Point of Entry and the options developed for the interim arrangement.

PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION

The following items were **RECEIVED** and **NOTED** for information.

QSE 18/022 WHC 045 2017 INTEGRATED GUIDANCE ON HEALTH CLEARANCE OF HEALTHCARE WORKERS AND MANAGEMENT OF HEALTHCARE WORKERS INFECTED WITH BLOODBORNE VIRUSES (HEPATITIS B AND C, AND HIV)

ASSURANCE was provided by:

- Awareness of the Welsh Health Circular and actions taken to implement necessary changes.

The Quality and Safety Committee **NOTED** Welsh Government Request and the Cardiff and Vale UHB response.

QSE 18/023 ANNUAL QUALITY STATEMENT 2017-18

ASSURANCE was provided by:

- The plan of work to support the development of the Annual Quality Statement.

The Quality, Safety and Experience Committee **AGREED** the time frame for the development of the 2017 /18 Annual Quality Statement.

QSE 18/024 MINUTES FROM CLINICAL BOARD QUALITY AND SAFETY SUB COMMITTEES

The following Minutes were received and noted.

1. **CLINICAL DIAGNOSTICS AND THERAPEUTICS – OCTOBER**
2. **MENTAL HEALTH – NOVEMBER AND DECEMBER**
3. **PRIMARY, COMMUNITY AND INTERMEDIATE CARE - NOVEMBER**
4. **SPECIALIST SERVICES – OCTOBER, NOVEMBER AND DECEMBER**
5. **MEDICINE – NOVEMBER**
6. **SURGERY – SEPTEMBER AND NOVEMBER**
7. **CHILDREN AND WOMEN – OCTOBER**
8. **DENTAL – No Minutes since September**

The Committee found it unacceptable that no Minutes had been received from Dental since September and the Chair would write to the Clinical Board.
Action – Cllr Susan Elsmore

QSE 18/025 AGENDA FOR THE PRIVATE QSE MEETING

The private agenda was published as part of the culture on openness.

QSE 18/026 ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEE

There was nothing to bring to the attention of the Board.

QSE 18/027 REVIEW OF THE MEETING

There was nothing to add to the meeting and a review would be held following the private meeting.

QSE 18/028 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 17th April 2018.

21.9

UNCONFIRMED MINUTES OF THE FIRST MEETING OF THE STRATEGY AND DELIVERY COMMITTEE HELD ON 13 MARCH 2018 AT 9AM CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
Charles Janczewski	Chair – UHB Vice Chair
Akmal Hanuk	Independent Member - Community
Dawn Ward	Independent Member – Trades Unions
Eileen Brandreth	Independent Member – ICT
John Antoniazzi	Independent Member – Business Planning
In Attendance:	
Abigail Harris	Director of Planning
Martin Driscoll	Director of Workforce and OD
Robert Chadwick	Director of Finance
Sharon Hopkins	Director of Public Health
Steve Curry	Chief Operating Officer
Apologies:	
Gary Baxter	Independent Member – University
Maria Battle	UHB Chair
Sara Moseley	Independent Member – Third Sector
Geoff Walsh	Assistant Director of Planning
Len Richards	Chief Executive
Marie Davies	
Peter Welsh	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Secretariat:	Julia Harper

SD: 18/001 WELCOME, INTRODUCTIONS AND PURPOSE OF THE MEETING

The Chair welcomed everyone to the first meeting of the new Committee and explained that this would be replacing two Committees: Strategy and Engagement and Resource and Delivery. The purpose of today's meeting was to understand the basics and what the new Committee would be responsible for and how it would achieve this.

SD: 18/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

SD: 18/003 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. Ms Eileen Brandreth explained that a short item included as any other business within the Committee papers contained her University title – Chief Information Officer. She made it clear that this item had nothing to do with her University role and was presented by her as an Independent Member of the UHB, and more specifically, as Chair of the UHB Information Technology and Governance Sub Committee.

No other interests were declared.

SD: 18/004 MINUTES OF THE STRATEGY AND ENGAGEMENT COMMITTEE MEETING HELD ON 28 NOVEMBER 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 28 November 2017.

SD: 18/005 MINUTES OF THE RESOURCE AND DELIVERY COMMITTEE MEETING HELD ON 30 JANUARY 2018

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 30 January 2018.

SD: 18/006 ACTION LOG FROM STRATEGY AND ENGAGEMENT COMMITTEE

The Committee **RECEIVED** and **NOTED** the Action Log from the meeting of 28 November 2017.

SD: 18/007 ACTION LOG FROM RESOURCE AND DELIVERY COMMITTEE

The Committee **RECEIVED** and **NOTED** the Action Log from the meeting of 30 January 2018.

An amalgamated action log from the two Committees would be produced and would include any further action from this meeting.
Action – Mrs Julia Harper

SD: 18/008 TERMS OF REFERENCE FOR THE STRATEGY AND DELIVERY COMMITTEE

The Chair invited Members to consider the draft Terms of Reference to ensure that the Committee was clear of its remit and ensure that this was not so wide that Members would be inundated with operational information. It was hoped that an update could be provided to the March Board on the progress made and that the Terms of Reference could be approved at the May or July Board meeting.
Action – Mr Peter Welsh

During a long discussion, clarification was provided on the UHB's overarching 10 year Strategy "Shaping Our Future Wellbeing" and the plans that were designed to help the UHB achieve this, namely the Integrated Medium Term Plan, the rolling annual programme as well as Clinical Board Plans and the corporate strategic plans for clinical services, estates and workforce. All these areas of work were designed to lead transformation and deliver the principles of home first, avoiding waste harm and variation, empowering people and delivering outcomes that mattered to people.

Amongst other things, Members considered the need for dashboards, key performance indicators, exception reporting and consideration of risks in order to measure and assess how the UHB was progressing towards the delivery of its Strategy. The question of everyday operational delivery was also discussed and the balance of these areas needed to be agreed and included within the Terms of Reference.

In order to progress and define responsibilities, the Chair proposed the he lead a small working group comprising the Directors of Planning and Public Health as well as the Chief Operating Officer. A revised document would then be circulated to the Committee for any last comment before the final version was presented at the next meeting.
Action – Mr Charles Janczewski

SD: 18/009 ORAL UPDATE ON SHAPING OUR FUTURE WELLBEING STRATEGY

Mrs Abigail Harris, Director of Planning tabled a high level summary that was still a work in progress, with her thoughts on how the UHB was progressing towards meeting each strand of the Strategy. Although new legislation had been introduced since the Strategy was approved, the Strategy did not need to be refreshed as changes were addressed and accommodated in the underlying plans.

Executive Directors were working on high level "bell weathers" that would indicate whether actions were sufficient to reduce inequality. It should be remembered however, that many actions and outcomes in terms of the Strategy would take several years to be seen – for example, reducing the incidence of stroke rather than just monitoring operational targets against the Stroke Measure.

It was acknowledged that this initial piece of work required further development to include an accurate baseline from which progress could be measured. It also needed timelines when it could be anticipated that progress would be seen. There was also work to do on the culture of the organization so that every worker knew that what they were doing was helping to meet the objectives of the Strategy. It was agreed that these measures would be developed.
Action – Mrs Abigail Harris

The Committee **NOTED** the good progress already made and the sticking points, particularly around sustainability. It was **AGREED** to send comments on the format and content of the report to the Director of Planning.
Action – All Committee Members and Attendees

SD: 18/010 IMPLEMENTATION OF THE FRAMEWORK FOR WORKING WITH THE THIRD SECTOR – UPDATE

Dr Sharon Hopkins, Director of Public Health gave an oral update on the work of the Steering Group that had been in existence for several years and comprised umbrella organizations. These organizations were relied upon to input, guide, engage and disseminate information. It was important that going forward, the Third Sector was a key component in UHB work as Third Sector would help deliver the UHB Strategy. The recently refreshed Framework also reflected new legislation – Future Generations Act. It was important that the Committee reflected on the added value and opportunities presented by working closely with the Third Sector.

ASSURANCE was provided by:

- A multi-agency Third Sector Strategic Alliance Steering Group, chaired by the Director of Public Health, which oversees this agenda.

The Strategy and Engagement Committee:

- **NOTED** the end of year progress in delivering the Action Plan for 2017/18 which supported implementation of the UHB Framework for Working with the Third Sector.
- **NOTED** the work underway to develop the Action Plan for 2018/19.

SD: 18/011 REVIEW OF THE PERFORMANCE REPORT – UPDATE

Dr Sharon Hopkins, Director of Public Health, reminded Committee of discussions at the Board Development Day. Until the Terms of Reference of the new Committee had been agreed, it was not possible to devise appropriate performance indicators or determine whether an outcomes framework was required, similar to the Canterbury model.

Dr Hopkins offered to meet with all Members separately to understand their expectations of the type and level of information they required.

Action – Dr Sharon Hopkins

SD: 18/012 REVIEW OF THE WORKFORCE AND ORGANISATIONAL DEVELOPMENT REPORT

Mr Martin Driscoll, Director of Workforce and OD, updated the Committee on the development of new key performance indicators. Each Clinical Board was developing indicators pertinent to them, but these would overlap including the nurturing of talent to enable delivery of the Strategy. The Committee **NOTED** the verbal update.

SD: 18/013 DEVELOPMENT OF A COMMITTEE WORK PLAN

As this was dependent on the agreement of the Terms of Reference, it was agreed to defer this item to the next meeting.
Action - Secretariat

SD: 18/014 AGREEMENT OF STANDING AGENDA ITEMS FOR THE COMMITTEE

As this was dependent on the agreement of the Terms of Reference, it was agreed to defer this item to the next meeting.
Action - Secretariat

SD: 18/015 ANY OTHER BUSINESS

Items Raised by the Chair of the Information Technology and Governance Sub Committee Following the Meeting Held on 6th March 2018

1. **GDPR -** Concern was raised that the UHB had not made sufficient progress and would not be ready to comply with the new legislation that would be introduced in May 2018.

2. **Information Governance Training –** the Clinical Boards were unable to get the right people trained in a timely manner.

3. **Information Governance Workforce –** the strain on the very small Information Governance workforce was becoming unsustainable and it was close to breaking point trying to manage a very large agenda. A temporary increase in resources had been identified to mitigate the risks in the short term.

The Committee discussed aspirations for digitalization and a digitally enabled workforce. Both immediate and transition actions were required and the

Committee noted that Management Executive had already commenced such workforce conversations and how areas described as struggling could be supported.
Whilst the UHB was not an outlier in terms of progress, the Information Commissioner had previously undertaken an audit of the UHB and remedial actions had not yet been completed. A national audit of readiness for the new legislation had recently been received and the Committee was advised of the serious fines that could be imposed for non-compliance. In response, the Committee was also reminded that for every penny of investment in one area, decisions had to be made on disinvestments elsewhere and these risks were difficult to balance.

The Committee **NOTED** the concerns and mitigating action and **AGREED** that these concerns should be highlighted at the March Board.
Action – Mr Charles Janczewski

SD: 18/016 DATE OF NEXT MEETING

The next meeting would be held at 9am on Tuesday 5th June 2018 in the Corporate Meeting Room, HQ, UHW.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

21.10

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – NOVEMBER 2017

The Welsh Health Specialised Services Committee held its latest public meeting on 28 November 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:

- JC019 – Perinatal Mental Health. The Cabinet Secretary had responded today to the recommendations from the Children, Young People and Education Committee. A paper would be brought to the January 2018 Joint Committee meeting.
- JC027 – Develop standard business case template. It was suggested that the WHSSC Team work with the Directors of Planning on this initiative.
- JC028 & JC029 – Risk sharing. A new proposal would be discussed during the 'In Committee' session of the meeting.
- JC030 – CMRI future responsibilities. Correspondence had been issued to the All Wales Cardiac Network and Local Health Boards informing them of the agreement to transfer responsibility to Local Health Boards.

Chair's Report
The content of the Chair's written report was noted.

Managing Director's Report
Members noted the content of the Managing Director's report and in particular:

- PET scanning – the All Wales PET Scanning Group had discussed the proposal to provide clinical and cost effectiveness business cases for different indications to Management Group and concluded that this would be extremely challenging, time consuming and therefore not viable. The chair of the Group, who also chaired the Clinical Oncology Sub Committee, had indicated that he would be writing to the Director General regarding this matter. The difficulties in identifying the scale of pathway savings was noted. Also, although

the proposal considered at the previous meetings was very likely to be contained within the financial envelope for 2017-18, the inability to guarantee overspend on new indications against plan for future years was acknowledged. The WHSS Team repeated that there was, however, a clear expectation of savings across pathways arising from use of PET scans for new indications and that Wales was currently lagging behind England in terms of PET scans for new indications. SL observed that the proposed new indications had already been through the prioritisation process and were ranked at the high priority end of the scale. It was noted that PET scans for non-approved indications were regularly taken through the IPFR process and that this would continue but that the number of cases had necessitated a new route, outside of the mainstream IPFR process. It was noted that NICE had already positively reviewed the benefits of PET scans for head and neck indications and it was therefore agreed to approve these indications and defer further approval at the present time. It was confirmed that there was currently sufficient PET scanning capacity for the head and neck indications.

- Inherited bleeding disorders – the WHSS Team clarified that the project would be aligning resources between Local Health Boards and WHSSC, rather than bringing all provision under WHSSC.

Wales Neonatal Standards – Third Edition 2017

Members received a paper that provided an overview of Local Health Boards' baseline assessments against the Third Edition of the Standards and proposed that the Welsh Health Collaborative consider the Standards and advise on the process for their approval given its governance role for the Neonatal Network. It was noted that the Welsh Government would hold Health Boards accountable against the revised Standards following their launch. It was confirmed that the revised Standards were similar to the English standards, which would be important to PtHB, as it worked to both. The paper also proposed that WHSSC works with Reginal Planning Boards to develop an integrated plan for neonatal cots across south Wales; this would be done in the context of the overall model rather than on cot occupancy in isolation.

Members noted and supported the recommendations as set out in the paper.

Development of the WHSSC Integrated Commissioning Plan (ICP) 2018-21

Members received a paper that outlined the timeline for the development and submission of the ICP 2018-21, together with the development work involved in the process. This year the WHSS Team had involved Directors of Planning and their teams, in addition to Management Group, to ensure that the ICP was aligned to Health Board IMTPs; it was suggested that

this would be very important going forward. It was noted that the timeline was very tight but the WHSS Team felt more comfortable with this than the prior year because the view of Management Group members was more aligned on this occasion.

21.10

Members noted the development work undertaken to date and the timeline for development and submission of the ICP.

Integrated Performance Report
Members received the report for September 2017, which provided a summary of the key issues arising and detailed the actions being undertaken to address areas of non-compliance.

CAMHS in BCUHB, together with Paediatric Surgery and Neurosurgery at CVUHB continued to be in stage 3 escalation with Bariatric Surgery at ABMUHB at stage 4.

Financial Performance Report
Members received the finance report for Month 7 2017-18 noting a year to date overspend of £737k with a forecast underspend to year-end of £259k for WHSSC.

HRG4+ reporting had been discussed with Welsh Government. Actual HRG4+ costs were being reported as incurred but were being excluded from year end forecasts with contingency plans developed in case agreement is not achieved with NHS England. The previous week NHS England had agreed to take the matter away and give it further consideration. Whilst there was no certainty, it was hoped that a response would be forthcoming during December 2017. PtHB and WHSSC were aligned in not signing contracts with English providers but some Health Boards had signed contracts where local benefits applied.

Up to a further £2m of reserves may be available for release if the related matters were favourably resolved.

A clear view of the 2017-18 year end and roll forward position would be presented in the Finance Report to the January Joint Committee meeting.

Joint Sub Committees and Advisory Groups
Members noted the update reports from the following joint sub committees and advisory groups:

- Audit Committee - It was reported that considerable work had been done by the WHSSC Team on the Risk Management Framework but that the Committee didn't feel it received assurance on management of the risks without sight of the individual risk on a page summaries but members understood why this detail was missing.

- All Wales Individual Patient Funding Request Panel – A Review of a Panel decision by ABUHB had decided not to uphold the grounds submitted for the Review and therefore allowed the Panel decision to stand.
- Quality & Patient Safety Committee
  - Annual Report appended
- Welsh Renal Clinical Network – An apology was received for the nature of the report that had been submitted (in draft form) but its content was confirmed as accurate
- NHS Wales Gender Identity Partnership Group
  - Annual report appended

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 26 September 2017
at Health and Care Research, Castlebridge 4,
Cowbridge Road East, Cardiff

21.10

Members Present

Vivienne Harpwood	(VH)	Chair
Lyn Meadows	(LM)	Vice Chair
Marcus Longley	(ML)	Independent Member
Chris Turner	(CT)	Independent Member/ Audit Lead
Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB(part meeting)
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB (via Videoconference)
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB
Stuart Davies	(SD)	Director of Finance, WHSSC
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC

Associate Members

Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee
John Williams	(JW)	Chair of Welsh Renal Clinical Network

Apologies:

Alexandra Howells	(AH)	Acting Chief Executive, Abertawe Bro Morgannwg UHB
Sian Lewis	(SL)	Managing Director, WHSSC
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Tracey Cooper	(TC)	Chief Executive, Public Health Wales
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust

In Attendance

Shakeel Ahmad	(SA)	Associate Medical Director (Neurosciences & Complex Conditions), WHSSC
Andrew Champion	(AC)	Assistant Director Evidence, Evaluation & Effectives, WHSSC
Sian Harrop-Griffiths	(SHG)	Executive Director of Strategy, Abertawe Bro Morgannwg UHB
Sharon Hopkins	(SH)	Executive Director of Public Health/ Deputy Chief Executive, Cardiff and Vale UHB
Claire Nelson	(IL)	Acting Assistant Director of Planning, WHSSC
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC

The Meeting opened at **9.30am**

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JC17/045 **Welcome, Introductions and Apologies**
The Chair formally opened the meeting and welcomed members and the public.

JC17/046 **Declarations of Interest**
Dr Chris Turner declared an interest in relation to item 10, Risk Management Framework Alternative Augmentative Communication (AAC) Service as a Governor of Cardiff Metropolitan University, as it was the University that had been commissioned to undertake the evaluation of the AAC service.

The interest was noted; no action was required.

JC17/047 **Patient Story**
Members received a presentation of two patient stories relating to Motor Neurone Disease; a patient voice, and a family member's perspective.

Members heard how the disease had affected the individuals in their daily lives and the moment at which the diagnosis was made. Members learned about the significant impact Alternative Augmentative Communication technology had on those with the disease, how it had enabled them to have a voice after losing theirs to the disease, and supported a family in spending quality time together.

The Chair thanked the contributors and requested a formal letter of thanks be sent on behalf of the Committee.

Action
- **Chair to send formal letter of thanks to the two contributors**

Members **resolved** to:
- **Note** the patient stories

JC17/048 **Accuracy of Minutes of the meeting held 25 July 2017**
Members reviewed and approved the minutes of the meeting held on 25 July 2017 as a true and accurate record.

Matters Arising
JC17/034 – Perinatal Mental Health
Members received an update noting that that a meeting had been arranged to discuss the feedback from the Joint Committee meeting and review the options appraisal paper and wider evidence. It was noted that a Workforce Group had been established and was scheduled to meet on 13 October 2017 to review the broader model. Members were advised that Health Board Representatives had been invited to attend the meeting. Members were reminded of the inquiry into Perinatal Mental

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Health Services and the political interest to find a solution in Wales.

It was noted that a revised options paper would be presented to the WHSSC Joint Committee in January 2018.

JC17/049 **Action Log**
Members reviewed the action log and received the following updates.

JC011/012/013- Provision of Specialised Neurosciences in NHS Wales
Members noted that work was progressing on development of the strategy, that these actions would be rolled into the output on the Neurosciences Strategy and it was anticipated that the paper would be presented in March 2018.

JC014/015/016/017 were picked up and addressed within the main agenda items.

JC17/050 **Report from the Chair**
It was noted that this was the inaugural meeting for Professor Harpwood as the new Chair of WHSSC, and as such there were no formal items on which to update Members.

Members noted that the Chair had held meetings with members of staff and other stakeholders and looked forward to working with the WHSSC team.

JC17/051 **Report from the Acting Managing Director**
Members received a report from the Acting Managing Director; the following areas were highlighted:

SL thanked SD for his contribution over the last year as Acting Managing Director and providing stability and leadership for WHSSC.

Members received an overview of the key areas of focus for the organisation over the next few months including; internal reconfiguration and building teams. This also involved taking forward the recommendations of the Culture Review. Members noted that a recent 'temperature check' evidenced positive change within the organisation. It was noted that a paper on the recent review of the Management Group would be presented at a future Joint Committee meeting for consideration.

Members noted that SL had held meetings with a number of stakeholders as part of the work to progress the development of a Strategy for WHSSC.

Neonatal Transport

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Work was continuing around reviewing risks associated with the service and funding allocations for the service. Members were informed that the work to date had identified a number of more complicated issues than initially anticipated. It was noted that the Neonatal Transport service was to be reviewed as part of the prioritisation process for the 2018-19 ICP.

It was noted that, in the context of considering schemes for the 2018-19 Plan, it was anticipated that there would be a more challenging financial environment which would require tougher decision making based on available evidence. It was therefore requested that the Joint Committee was given visibility of any issues arising to be fully sighted. In regard to neonatal services, it was suggested that there was a requirement to understand exactly what service provision was needed and whether any alternatives were available to meet that need.

All Wales Blood Service Programme
The programme closure report had been received by WHSSC and was circulated with the meeting papers for information.

Members **resolved** to:

- **Note** the content of the report
- **Receive** the All Wales Blood Service Programme Closure report

JC17/052 **Thoracic Surgery Review: Project Update**

Members received a report which provided an update on progress, consider the timescales for decision making and sought approval for the processes and documentation underpinning the final decision by the Joint Committee regarding the number and location of future services in south Wales.

Members received an overview of the engagement process noting that the engagement documents had been circulated to each Health Board for consideration at their respective Board meetings. The information was also submitted to the Community Health Councils (CHCs). Ultimately the CHCs would determine whether there was a requirement to undertake a formal consultation process.

It was noted that there would be a two phase decision making processes. Phase 1 to determine whether the service should be delivered over one or two sites and Phase 2 to determine the location of the service should the decision be taken that it should be on one site.

Members noted that a second timeline had been circulated to members, this was further to feedback received from engagement leads that the original timeline was too ambitions and that additional time was required to allow a proper and robust process to be followed.

It was noted, given that there had been a substantial length of time since the project was established, that the Project Board had re-reviewed the

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process documentation and re-approved it at the last Project Board meeting. It was noted that CVUHB had requested a change to the wording in the engagement document and that it had been agreed that this would be reflected in the Frequently Asked Questions document which was being produced.

Members received an overview of the decision making process and members were asked whether they were content for the Project Board to sign off on the criteria that the Independent Panel would use to develop a recommendation, or whether this should be referred back to the Joint Committee – it was agreed to reserve this to the Joint Committee to provide consistency of process with the Neonatal work and also to ensure that there was open challenge and scrutiny. It was further agreed that the criteria could be considered at a virtual meeting of the Joint Committee during December 2017.

A question was raised around the definition of an independent panel and the level of independence of its members. It was noted that the Panel would consist of representatives from the NHS in north Wales as non-conflicted and knowledgeable of NHS service provision in Wales, and expert representation from NHS England. Members were advised that the model would follow that of the Neonatal Workforce project undertaken last year, as it was felt that the process was successful and supported by the CHCs.

It was suggested that a 'process on a page' be developed to clearly outline the key points for decision and who was involved. It was noted that this would assist in providing a greater level of assurance to Health Boards around process and governance and identify where input was required from Health Board.

Action
Process on a page to be developed to clearly outline the process and those involved at key points.

A discussion was held around the alternative timeline, and what point in the process value for money and affordability would be considered. It was noted that SD was leading on the work around value for money and that this would be embedded at every stage of the process, it was confirmed that the alternative timeline would involve the Joint Committee taking a decision at its meeting on 30 January 2018 that would be reported to the Boards of Health Boards at their March 2018 meetings.

A question was raised around the data used to map travel times for patients when considering phase one options and ensuring consideration of proportion of population. It was noted that a number of travel patterns were being considered including those used for the major trauma centre for non-elective cases.

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Action

- **Phase 2 criteria to be presented to Joint Committee for approval at virtual meeting during December 2017**

A question was raised as to whether the CHCs had reviewed the alternative timeline and whether they were supportive. It was agreed that SL would send the revised timeline to the CHCs for information.

21.10

Action

- **SL to send revised timeline to CHCs for information.**

GD joined the meeting

Members resolved to:

- **Note** the update to the Thoracic Surgery Review Project
- **Approve** the alternative timeline for the decision process
- **Approve** the Engagement Documentation
- **Agree** that the sign off of the criteria to be used by the Independent Panel is undertaken by the WHSSC Joint Committee.

JC17/053 **Positron Emission Tomography (PET) Policy development**

Members received a paper that presented a business case which mitigated the financial risk associated with proposed changes to the PET policy as recommended by the All Wales PET Advisory Group (AWPET). The proposal was principally based on funding the PET expansion for new indications from the predicted over provision for PET scans in the 2017-20 ICP.

AC presented the paper noting that this had not been previously considered within the ICP as no new interventions were considered. It was noted that PET had been highlighted via the ICP Risk Management Framework and that there was a strong evidence base that the expansion of the PET policy for new indications would result in clinical and cost benefits within Health Boards for patients who were more appropriately managed following successful PET scans but it was difficult to achieve visibility of this.

Members were advised that the Management Group had considered a draft business case in July 2017 and supported the proposal for in-year development subject to receipt of assurances from Welsh Government regarding financial underwriting. A formal response was awaited from Welsh Government but informal indications suggested there would be support for the proposal but that financial underwriting might not be forthcoming.

Members noted the detail provided within the report and the work undertaken by the AWPET, differences between England and Wales and the anticipated levels of activity. It was also noted that current contract

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for PET would be reviewed as part of the ICP development for next year.

A question was raised in relation to the evidence for clinical and financial impact to support the changes to criteria and indications. It was noted that NICE had modelled this for some indications (e.g. head and neck) but the modelling was resource heavy and took considerable time to develop. Members noted that work had been carried out on different elements of the process which had been taken through Management Group prioritisation and clinical impact assessments with the risk assessment element presented to the WHSSC Joint Committee.

A discussion followed around understanding where PET was being used as an alternative to other diagnostic tools and the cost savings, concerns relating to growth in demand if additional criteria/indications were approved, and the potential of an over spend against the ICP provision in either 2017-18 or the following year. It was noted that the proposal included a significant level of uncertainty in this regard

Members acknowledged there was a clear under provision of services in Wales and the associated issues. A further discussion was held around the funding arrangements and consideration needed around how any cost savings created within the wider health care system should be utilised.

Members wished to see clinical evidence that an increase in PET scans for new indications would result in clinical and cost benefits elsewhere in the patient pathway prior to approving the proposal and asked for this to be channelled through Management Group in the first instance.

Action

- **WHSSC Team to present to Management Group with the clinical evidence that an increase in PET scans for new indications will result in clinical and cost benefits elsewhere in the pathway; review the proposed eight new PET indications as a priority and liaise with Cancer Network to support this (AC)**
- **Update WG and stakeholders. (AC)**

Members resolved to

- **Note** the information within the report and the current risk to patients, providers and commissioning Health Boards; and
- **Note** the support from Management Group to fund the PET policy expansion out of the current PET provision in the WHSSC ICP 2017-20, subject to assurances from Welsh Government.
- **Defer approval** of the proposal to fund the PET policy expansion out of the current PET provision in the WHSSC ICP 2017-20, referring it to Management Group for consideration of ;

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JC17/054 **Risk Management Framework – Alternative Augmentative Communication (AAC) Service**

Members received a paper which provided a summary of the current position of the All Wales Alternative Augmentative Communication Service, the risks as detailed within the ICP Risk Management Framework and the identified mitigation.

It was noted that a letter of support had been sent to WHSSC from the Wales Neurological Alliance, a third sector organisation supporting all Neurological Conditions.

Members were reminded of the announcement from Welsh Government in June 2016 at which time recurrent funding for staffing was provided however funding for equipment was secured on a non-recurrent basis. Members noted that in September 2016 the Joint Committee supported the extension of the evaluation period for the specialist AAC service until 2017/18, when a full year of service data would be available, and approved the carrying forward of any under spend on non-recurrent budget which was primarily used for the AAC equipment.

It was noted that the funding for equipment was due to expire in Autumn 2017. The WHSSC team and Management Group had carried out a risk assessment within the ICP Risk Management Framework which identified AAC as having one of the highest risks from a patient perspective, as identified in section 3.0 of the report.

It was reported that an informal indication had been received from Welsh Government that equipment funding may be made available for the remainder of the current financial year but this was yet to be formally confirmed.

It was noted that the evaluation report was expected back from Cardiff School of Health Sciences at Cardiff Metropolitan University for presentation to the Committee in November 2017.

Members were presented with an overview of the options set out within the report and were asked to agree an option to progress in order to mitigate the identified risks within the AAC service.

A discussion was held around the original tripartite funding arrangements for the service as it spanned Health, Social Care and Education. It was acknowledged that the right mechanism needed to be identified for this as a regional partnership and it was suggested that the equipment element could be added to the Joint Equipment Inventory given the broader context of the service assisting three domains.

Members agreed to Option 4: Collectively Escalate to Welsh Government. It was suggested that a letter be sent to the Director General of Health and Social Services/Chief Executive, NHS Wales.

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Members resolved to:

- **Note** the current risks to the All Wales Alternative Augmentative Communication service as outlined in the Risk Management Framework and the mitigations that have been identified to date.
- **Agree** to progress Option 4

JC17/055 **Adult Cystic Fibrosis service: Update**

Members received a paper which presented a summary of the current position with regarding the adult Cystic Fibrosis services for mid and south Wales, the risks to the sustainability of this service, and the potential for a commissioning decision regarding the revenue requirements to address these.

It was noted the Cystic Fibrosis service was provided by a dedicated unit which had seen an increase in demand and there was now a need for investment for both facilities and staffing. Members were informed that the service would soon reach capacity and be unable to accommodate new referrals. This would mean that new referrals would be sent to units in England; however it was noted that there were issues with English providers, with Birmingham advising that they were no longer able to accept referrals from Welsh patients. Members noted that a peer review, undertaken by the Cystic Fibrosis Trust in 2015, identified the unit in Wales as having one of the lowest bed bases per patient in the UK.

Members were informed that CVUHB were developing a capital business case for increased inpatient beds at the CF unit and to provide en-suite accommodation for all. A proposal for the required revenue for additional staffing was submitted as part of the ICP process for 2017-18, however it was not funded.

It was noted that there was Welsh Government interest in the service.

Management Group reviewed the risks and case for change in September 2017; when it suggested that further work was needed to develop the business case from CVUHB.

It was suggested that consideration be given to the potential for other models (e.g. greater community based care).

Members discussed the process in place for accepting/reviewing business cases. It was noted that a different approach was being taken in that in the first instance a case for change is to be identified and then a more guided business case will be developed. Members requested that Management Group develop a standard business case template which could be use for all business cases and provide a consistent approach.

Members supported the case for change and agreed that Welsh Government should be briefed on the prospective need for new revenue funding in support of the capital business case being developed by

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CVUHB. The business case for change would consider alternative models for delivering the service including outpatient and/ or community services.

Action

- **WHSSC team to work with Management Group to develop a standardised template for Business Cases outlining what should be included.**

21.10

Members resolved to:

- **Note** the ongoing risks to patient care associated with the adult CF service at CVUHB, as discussed at the September Management Group workshop
- **Note** that the service will soon reach capacity and be unable to accommodate new referrals, meaning new patients referred to centres in England
- **Support** the case for change in order to mitigate the current risks within the service.

JC17/056 **Risk Sharing Update**

Members received a paper which provided an update on implementing proposals to move the neutralisation date from the end of 2011-12 to 2013-14 and set out the latest modelling together with the issues and questions raised by the Finance Group.

Members noted the discussions held by the Finance Group at their meeting on 20 October 2017, during which it was recognised that the proposal to move the neutralisation date was considered a reasonable 'best fit' position. It was noted that the impact of this was considered and it was recognised that running the numbers at any point in time led to huge volatility in the financial impact based on relatively small numbers of high cost services/episodes of care.

Members noted the detail provided in relation to the individual Health Boards and that there had been a material shift for some Health Boards. Members were asked whether they wanted the Finance Group to continue working through the number to see if there was a way to create a better balance of risk in the system.

A discussion was held around: the likelihood of being able to achieve a point at which all Health Boards would agree, the preference held by members of the Finance Group for an activity based share, and the concerns around the challenge for individual Health Boards on the financial outcome.

Members discussed the rationale behind the principles previously established, the process to this point and the impact on the wider system. It was suggested that consideration be given to approaching Welsh Government to ensure that it was sighted on the purpose of the work of

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the Finance Group and align with the wider system perspective.

It was agreed that an activity based share was desirable but might be unachievable if the financial impact was excessive on a small number of Health Boards and that the Finance Group should have a final attempt to resolve this, also that advice should be sought from Welsh Government on the final option.

Action:

- **Finance Group to reconsider an activity based approach as a final attempt to resolve the issues before the next meeting of the Joint Committee. (SD)**
- **Advice to be sought from Welsh Government around the final option for risk sharing approach. (SD)**

Members resolved to:

- **Note** the impact assessment and the nature of the queries raised by the Finance Group;
- **Consider** options for the next steps; and
- **Receive assurance** that the technical queries raised are being worked through and will be reported to the next Finance Group.

JC17/057 **Cardiac Magnetic Resonance Imaging (CMRI) – future planning responsibilities**

Members received an update on the collective commissioning work completed by WHSSC in respect of CMRI and a recommendation to transfer the responsibility for further planning and implementation to Health Boards with support from the All Wales Cardiac Network.

Members noted the update, approved the adoption of the CMRI Service Specification by Health Boards and agreed the transfer of responsibility from WHSSC. It was suggested that this work could be taken forward through the Regional Planning Boards. Correspondence was to be sent to the All Wales Cardiac Network and Health Boards on behalf of the WHSSC Joint Committee informing them of the agreement to transfer responsibility to the Health Boards.

Action:

- **Correspondence to be sent to the All Wales Cardiac Network and Health Boards on behalf of the WHSSC Joint Committee informing them of the agreement to transfer responsibility to the Health Boards.**

Members resolved to:

- **Note** the collective commissioning work completed by WHSSC;
- **Approve** the adoption of the CMRI Service Specification by Health Boards; and
- **Approve** the recommendation to confirm that WHSSC has

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completed its role in collective commissioning for this service and to transfer the responsibility for further planning and implementation to Health Boards, supported the All Wales Cardiac Network.

JC17/058 **Development of the Integrated Commissioning Plan 2018-21: Commissioning Intentions**

Members received the paper which outlined the Commissioning Intentions that had been drafted to inform the development of the WHSSC three year ICP for Specialised Services 2018-21.

Members noted that the plan remained largely unchanged and that the ICP Risk Management Framework was developed to support the consideration of schemes for inclusion, which included ministerial priorities. It was noted that the three domains of Safe, Sustainable and Effective were the key areas of consideration and that it was anticipated that once the quality team was established a greater focus on quality would be provided to support the review of the demand and capacity trends and enhance service monitoring.

A query was raised in relation to the apparent lack of detail provided within the report around value based commissioning. It was noted that although value based commissioning was not expressly mentioned it was part of WHSSC's assessment process; also that WHSSC would be working with Health Boards to look through their Integrated Medium Term Plans (IMTPs) to inform both the IMTPs and the ICP in relation to specialised services.

It was suggested that, due to the way they were constructed, the commissioning intentions felt more like principles. It was noted that it was anticipated that between now and next year these would evolve.

Members resolved to:

- **Approve** the WHSSC Commissioning Intentions to inform the development of the WHSSC Integrated Commissioning Plan 2018-21.

JC17/059 **Restructuring of Staffing Models within the Welsh Health Specialised Services Team**

A paper was received that informed members of a planned staffing restructure within the WHSSC Team that included the establishment of a Quality Assurance Team on a cost neutral basis.

Members approved the cost neutral staffing restructure without the need to seek approval for specific changes.

Members resolved to:

- **Support** the proposed staff restructuring which addressed the recommendations of the Good Governance Institute and Healthcare

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Inspectorate Wales Reviews through the cost neutral establishment of a Quality Assurance Team within the Directorate of Nursing; and
- **Approve** the future cost neutral staff restructuring without the need to seek approval for specific changes.

JC17/060 **Governance for Clinical Networks**

Members received a paper that made recommendations to facilitate regularisation of the governance and accountability arrangements for the Child and Adolescent Mental Health and Eating Disorders and Neonatal clinical networks that transferred to the NHS Wales Health Collaborative (the Collaborative), hosted by Public Health Wales, on 1 October 2016. The paper further recommended the formalisation of the ongoing relationship between the five clinical networks managed by the Collaborative and WHSSC.

Members recognised the importance to ascertain clarity around the relationships between WHSSC and the clinical networks to ensure the right advice was received to support the commissioning process.

Members approved the recommendations with a target implementation date of 1 January 2018.

Members resolved to:
- **Note** the information presented within the report; and
- **Approve** the recommendations.

JC17/061 **Integrated Commissioning Plan (ICP) 2017-18 Risk Management Framework**

Members received an update on the implementation of the ICP Risk Management Framework which highlighted schemes that required further review, risk mitigation and escalation in line with the requirements of the Framework. It was noted that the report to the November 2017 meeting would include development of the 2018-21 ICP.

Members were advised that WHSSC had submitted a letter to Welsh Government seeking additional funding from the £50m identified as available. A discussion was held around the Welsh Government expectation that bids would be received from providers and that WHSSC were supportive of these. The discussion continued around population and equity issues; members supported SD liaising with Welsh Government for clarification on bids from providers and commissioners. It was noted that the WHSSC request was targeted toward funding to reduce waiting times for various specialised services.

Action
- **Clarification to be sought from Welsh Government regarding the availability of additional funding for commissioners. (SD)**

CONFIRMED

Members resolved to:

- **Note** both the 'Extreme' and 'High' risk rated schemes requiring further review, risk mitigation and escalation.

JC17/062 **Integrated Performance Report**

Members received the report for June 2017, which provided a summary of the key issues arising and detailed the actions being undertaken to address areas of non-compliance.

The most significant change related to CAMHS OoA placements due to reduced capacity at the north Wales facility which was now in stage 3 escalation, together with Paediatric Surgery and Neurosurgery at CVUHB.

Members resolved to

- **Note** current performance and the action being undertaken to address areas of non-compliance.

JC17/063 **Financial Performance Report**

Members received the finance report for Month 5 2017-18 noting a year to date over spend of £1,109k with a forecast under spend to year-end of £2,082k, which primarily related to a release of £2,000k of Balance Sheet reserves. The year to date position included around £2,500k of HRG4+ costs for English contracts; however, the year-end forecast included a partial adjustment to HRG4+ costs due to some positive conversations with NHS Improvement.

Members noted that Welsh Government was now fully engaged with HRG4+ situation. A question was raised around when a resolution may be achieved. It was noted that this was still unclear, it was anticipated that further information would be available towards the end of October 2017.

Members resolved to:

- **Note** the current financial position and forecast year-end position.

JC17/064 **WHSSC Joint Committee Annual Self Assessment**

Members received a paper that provided information relating to the Joint Committee's annual self assessment.

Members noted the information provided in the report and supported consideration by the Chair and Committee Secretary of a 'development day' and/ or an induction programme.

Action:

- **Chair and Committee Secretary to review options for a development day for the Joint Committee and induction programme for members.**

CONFIRMED

Members resolved to:

- **Note** the information presented within the report; and
- **Support** consideration by the Chair and Committee Secretary of a 'development day' and/or induction programme.

21.10

JC17/065 **Reports from the Joint Sub-committees and Advisory Group Chairs**

Members received the following report from the Joint Sub-committees and Advisory Group chairs:

Sub Committees

Audit Committee
Members noted the update from the meeting held 11 September 2017.

All Wales Individual Patient Funding Request Panel
Members noted the update from the meeting held 30 August 2017, and received the 2016-17 Annual Report of the Chair of the Panel.

Integrated Governance Committee
Members noted the update from the meeting held 15 August 2017, and received the 2016-17 Annual Report of the Committee Chair.

Quality and Patient Safety Committee
Members noted the update from the meeting held 26 September 2017. Members noted that the Committee had refocused its attention on quality rather than activity performance and sought to adopt a whole pathway approach. It was noted that there had been a reinforcement of Independent Member input.

Members received and approved the revised Quality and Patient Safety Committee Terms of Reference, subject to a further review of the quorum, as it was felt that a quorum comprising two members might be too few.

Action:

- **Review quorum of the Quality and Patient Safety Committee. (CK/KS)**

Welsh Renal Clinical Network
Members noted the update from the meeting held 7 August 2017 and received the 2016-17 Annual Report of the Network Chair.

WHSSC Management Group
Members noted the update from the meeting held 31 August 2017.

Advisory Groups

NHS Wales Gender Identity Partnership Group

CONFIRMED

Members noted the update from the meeting held 21 August 2017.

Wales Child and Adolescent Mental Health Services and Eating Disorder Network
Members noted the update from the meeting held 1 September 2017 and received the 2016-17 Annual Report of the Network Chair.

21.10

Members noted that the Network was undergoing a transition following the move to the Collaborative. It was noted that the Children, Young People and Education Committee were considering CAMH Services and that the Network would be submitting evidence to the meeting of this Committee.

JC17/066 **Items of Any Other Business**

Wales Gender Identity Partnership Group

Tracy Myhill, Chair of the NHS Wales Gender Identity Partnership Group joined the meeting to present the work carried forward by the Group in relation to the development of an All Wales Interim Gender Pathway.

Members noted that there had been a significant increase in the number of stakeholders now involved with the Group, of which there were now 13 who provided a strong and passionate voice.

Members were provided with an overview of the political pressure around this work and the scope of work being developed by the group since the announcement by Welsh Government in August 2017. It was anticipated that the pathway would enable more patients to be treated in Wales, with only more complex cases requiring attendance at the London Clinic. This would reduce duplication and improve patient experience.

It was noted that CVUHB had submitted a bid to host the Gender Team for consideration by the Welsh Government. It was anticipated that the interim service would be established from Autumn 2017 and would support the development of expertise within primary care. The interim service would consist of expert GPs funded via a Welsh Enhanced Directed Service Contract.

Members noted that it was expected that the majority of Welsh patients would be repatriated by March 2018 and when work on a longer term pathway would commence. Support was sought from members for WHSSC to continue to oversee the interim pathway model until such time that project was in a position to be handed back to the Collaborative drive forward the longer term model.

A discussion was held around the commissioning model for the service and whether an indicative business case was available and it was requested that the project plan be presented to the Joint Committee in November 2017.

CONFIRMED

Action

- **Project plan for the Interim Gender Pathway to be presented at the November 2017 Joint Committee Meeting.**

A query was raised around the provision of services for children and young people and it was noted that the foregoing arrangements were for the adult pathway. A pathway for children and young people was to be considered separately, however it was noted that Tavistock and Portman NHS Foundation Trust operated an outreach service in Cardiff and discussions were ongoing around opportunities to expand this service. It was noted that NHS England had published a consultation on Gender Services for Children that was due to close week commencing 2 October 2017.

JC17/067 **Date and Time of Next Meeting**

It was confirmed that the next meeting of the Joint Committee would be held on 28 November 2017 at 1.30pm

The public meeting concluded at approximately **12.50pm**

Chair's Signature: ……

Date: ……

CONFIRMED

	Paper Ref: **LF-1802-01**
NHS Wales Health Collaborative Leadership Forum	Minutes 11/12/17

21.11

NHS Wales Collaborative Leadership Forum

Minutes of Meeting held on 11 December 2017

Author: Mark Dickinson	**Version:** 0a

Members present	Ann Lloyd (Chair), Chair, Aneurin Bevan UHB Maria Battle, Chair, Cardiff & Vale UHB Andrew Davies, Chair, Abertawe Bro Morgannwg UHB Huw George, Deputy Chief Executive, Public Health Wales (for Tracey Cooper) Steve Ham, Chief Executive, Velindre NHS Trust Judith Hardisty, Vice Chair, Hywel Dda UHB Alex Howells, Acting Chief Executive, Abertawe Bro Morgannwg UHB Chris Jones, Chair, HEIW Rosemary Kennedy, Chair, Velindre NHS Trust Marcus Longley, Chair, Cwm Taf Steve Moore, Chief Executive, Hywel Dda UHB Judith Paget, Chief Executive, Aneurin Bevan UHB Len Richards, Chief Executive, Cardiff & Vale UHB Patsy Roseblade, Director of Finance, WAST, for Tracey Myhill Carol Shillabeer, Chief Executive, Powys tHB Allison Williams, Chief Executive, Cwm Taf UHB Jan Williams, Chair, Public Health Wales
In attendance	Mark Dickinson, NHS Wales Health Collaborative Jane Green, Welsh NHS Confederation
Apologies	Tracey Cooper, Chief Executive, Public Health Wales Gary Doherty, Chief Executive, Betsi Cadwaladr UHB Mick Giannasi, Chair, WAST Vivienne Harpwood, Chair, Powys tHB

	Peter Higson, Chair, Betsi Cadwaladr UHB Bob Hudson, Director, NHS Wales Health Collaborative Tracy Myhill, Chief Executive, WAST Bernadine Rees, Chair, Hywel Dda UHB Vanessa Young, Welsh NHS Confederation

Introductory remarks and confirmation of Chair	**Action**
Ann Lloyd (AL) introduced the meeting. AL reported that, as Viv Harpwood (VH) now has additional commitments and demands on her time, VH has decided not to take on the role of Chair of the Collaborative Leadership Forum, as previously agreed. The meeting, therefore, confirmed AL as the new Chair of the Collaborative Leadership Forum. Chris Jones (CJ) noted that, as Chair designate of HEIW (a special health authority), he was no longer technically a member of the Forum, as the terms of reference specify the membership to be the chairs and chief executives of health boards and trusts. It was **agreed** that, as many issues within the remit of the Forum have significant workforce implications, the terms of reference should be revised to include both the Chair and Chief Executive of HEIW. The revised terms of reference will be brought back to the next meeting for formal approval.	**MD**

Minutes of previous meeting	**Action**
CJ, as Chair at the time of the previous meeting, introduced the minutes of the meeting held on 20 September 2017. The minutes were reviewed for accuracy and the following changes were noted: • On p8, the fourth bullet point should say "What functionality is still required" • On p9, the following sentence (and related attributed action) should be deleted "It was agreed that JP will act on behalf of the Collaborative Leadership Forum to sign off the consultation material" Subject to the above changes, the minutes were approved as a correct record.	

	Paper Ref: **LF-1802-01**
NHS Wales Health Collaborative Leadership Forum	Minutes 11/12/17

21.11

Matters arising from previous meeting	**Action**
The following matters arising were discussed: *Publication of minutes* Mark Dickinson (MD) and Allison Williams (AW) reported back that, following discussions with board secretaries, it was proposed that the minutes should not be routinely published on a Collaborative website, but should be formally reported back to individual boards, by which means they would enter the public domain as board papers. It was noted that this would require the Forum to be clear when issues are to be discussed in a 'closed session', so that the relevant sections of minutes can, in turn, be reported back to closed sessions of boards. It was also noted that all minutes were within the scope of the Freedom of Information Act and, subject to any valid exemptions, would need to be disclosed, if requested. This proposal was **agreed** and MD will ensure that approved minutes are sent to board secretaries for reporting to boards. *Escalation process* AW noted that, whilst an escalation process is set out in the Forum's terms of reference, this involves Welsh Government, but has never been formally endorsed by Andrew Goodall or other officials. It was **agreed** that AW and AL will discuss this further as part of wider discussions about the future of the Collaborative and will bring proposals back to the next meeting for discussion. *Possible use of SIFT funding to support the Imaging Academy* CJ reported that HEIW is in discussion with Welsh Government about SIFT coming within the scope of HEIW. CJ noted that there had been a previous review of SIFT, but that the recommendations had not been fully implemented. *Retirement of Director* AW reported that, having approached some individuals who had not been interested, expressions of interest are now being sought from executives across NHS Wales, on the basis of a secondment of 12 months. This time period reflected the fact that it was not yet clear where the Collaborative might be positioned in the system in future. AW confirmed that she is not entirely confident that someone appropriate will come forward. Executive directors are stretched and we need someone of appropriate calibre, experience and level of seniority.	**MD** **AW/AL**

AW further reported that she will be discussing contingency plans with chief executives next week and that, in the meantime, she will be providing direct support for a month after Bob Hudson steps down on 31 December. On this basis she will be meeting the Collaborative senior management team for discussions later this week. It was noted that this is not a sustainable solution. Jan Williams (JW) asked whether the role could be opened up across health and social care. AW responded that we need someone who can grasp the current agenda, which is very health service focused, as quickly as possible. CJ asked whether there is clarity as to what the 'must dos' for the Collaborative currently are. AW responded that she will be looking at the work plan with BH and his team. A lot of work with the networks can continue to roll forward, whilst the current work on major trauma and SARCs will be ending, leaving some capacity. AW undertook to bring the work plan back to the group to ensure the line of sight and to allow choices to be made, as necessary.	**AW** **AW**
Sexual Assault Referral Centres	**Action**
AW introduced the paper on SARCs, noting that this had become a reputational issue for the health service with some partners. There had been a bit of a hiatus, although this had not been entirely driven by the NHS. The content of the paper indicated significant progress is being made and that the right people are involved in constructive discussions. There is a clear commitment from Cardiff and Vale to undertake the role of lead provider, as defined by the recent work. Maria Battle (MB) added that the recent multi agency meeting had been very constructive, with frank discussion, and that the three police forces and Police and Crime Commissioners had spoken with one voice. AW noted that in recent correspondence and discussions, there has been a conflation of the issues around health board SLAs with New Pathways and the implementation of the new regional model for SARCs.	

It was **agreed** that there is a need to resolve the New Pathways SLA issues as quickly as possible and, in particular for health boards to: • ensure payments are made to New Pathways under this year's SLAs, taking into account the need to be assured of delivery, as per the content of the SLAs • ensure that SLAs with New Pathways for 2018/19 are negotiated and agreed as soon as possible	**21.11** **All HB CEs**
It was also **agreed** that the outstanding accommodation issues in Swansea need to be resolved. Alex Howells (AH) reported that this is being progressed and that a meeting on this had taken place with the police at the end of the previous week.	**AH**
It was also **agreed** that the Cardiff and Vale led implementation group, as described in the paper, needs to be put into place quickly to take forward the next steps. This requires the release of resources to enable the necessary posts to be filled.	**LR CEs**
CJ noted that the non-signing of third sector SLAs had not been an issue that had been escalated to all chairs. AW responded that, as the actual value of the SLAs was very small, this would not normally be escalated to chairs.	
Judith Paget (JP) noted that Aneurin Bevan had never had an SLA with New Pathways and would be putting into place a commissioning approach, with clarity over the flows of resources.	
CJ was very concerned that since the last meeting, where concerns were expressed, not enough progress had been made. There is a need to ensure we do not get into a similar position again, where we are playing catch up with important relationships.	
JW described the paper as being very helpful, but asked if there could also be a 'learning piece' produced by the Collaborative Team, describing how this became a reputational issue and providing lessons that can be applied, both for the remaining life of the Collaborative and in other contexts, to ensure we do not end up getting into the same situation again. It was **agreed** that such a report should be produced.	**AW/BH**
AW drew attention to the fourth bullet point on page 7 of the report, in relation to forensic medical examiners (FMEs). The	

FME role is currently the responsibility of the police. There are, however, anxieties over governance and the issue is likely to be progressed by the police, including consideration as to whether the FME role should become an NHS responsibility. This is a bigger issue than in relation to SARCs alone and there will be a need to consider the issues carefully as there are risks associated with both transfer and non-transfer of the role. JW noted that, in her previous role, she had dealt with many cases where people had been held in custody when they should have been under the care of the NHS. There is, however, a gap in the Government of Wales Act 2006 that prevents the NHS from providing the FME role. Pressure from the group could help to get this addressed. Carol Shillabeer (CS) reported that she had recently met the Children's Commissioner, who was now more satisfied with progress over SARCs, but is also interested in the FME issue being progressed. It was **agreed** that there is a need to support a joint piece of work, to be instigated by the police, on the FME issue. It was **agreed** that BH should write to the police forces and Police and Crime Commissioners to signal our willingness to participate actively in such a review. MB stressed the importance of focusing any review on the needs of the women and children who require the services and on the impact of any change on them. There is a need to ensure that they can be dealt with as sensitively and quickly as possible. CJ noted that the FME role also includes getting and assessing evidence, which needs to be considered separately from the clinical care and support to victims that FMEs provide. Ensuring justice is an important consideration, alongside the care of individuals. AL asked that previous health board responses to the earlier Children's Commissioner's letter should be shared with the group and this was **agreed**. It was also **agreed** that AL should write separately to the Children's Commissioner to provide assurance that the SARC issue is being taken seriously and is being progressed.	**21.11** **BH** **CEs** **AL**

Andrew Davies (AD) noted that, in the light of the problems that had arisen with the development of the SARC, an assurance process for all programmes be established. This was **agreed**.	**BH**
AL asked that a paper outlining the timing and content of phase 2 be circulated as soon as possible.	**BH**
Major Trauma	**Action**
AW introduced the paper and drew particular attention to the timetable in appendix 4. Scheduling differences in each health board mean that the feedback received so far is not necessarily representative. There remains a need to encourage people to respond.	
LR noted that the paper refers to preconceived ideas and questioned how we are trying to correct these. AW replied that this would be an 'ongoing drip feed exercise', including reassurance about what is not going to change.	
CJ asked for reassurance that the risk register is up to date. AW indicated that she thought it was, but **agreed** to check with the team.	**AW**
CJ asked about how the risks of not having a major trauma network were being dealt with. After discussion, it was **agreed** that there is a need for these risks to be made fully explicit in the papers that will go to boards following the end of the consultation.	**AW/BH**
It was **agreed** that the conclusions of the review to be conducted at the midway point of the consultation will be circulated to the group.	**AW/BH**
JP noted that some of the responses received are clearly based on inaccurate information and asked whether any attempts were being made to provide correct information in such circumstances and to provide responders with an opportunity to reconsider their views in the light of this. AW replied that his was not happening, but **agreed** to raise this as a suggestion for the team to consider. It was also **agreed** that the FAQs should be updated to address new questions raised to try to rectify any misunderstandings.	**AW/BH** **AW/BH**

Patsy Roseblade (PR) pointed out that the percentages on page 9 of the report were open to misinterpretation if put into the public domain in their current form. Andrew Davies (AD) noted that, whilst numbers attending public meetings were low, there was a considerable amount of social media traffic related to the issue. This illustrated that we are currently bound into using the wrong tools for consultation and engagement exercises of this sort. There is a need to consider what a modern engagement exercise should look like, as digital engagement can lead to the sorts of meaningful conversations that are impossible in public meetings. AW supported this view and noted that there is a need to have a conversation with government on how we do this, particularly for cross organisation issues. AL added that this will become an increasingly significant issue as regional planning develops. It was **agreed** that a workshop should be organised in the new year to look at modernising engagement practices in Wales and to refer any subsequent recommendations for change to the DG.	
Clinical Networks and Regional Planning	**Action**
AW introduced the paper, noting that it provided, for information, an overview briefing of work currently ongoing in relation to the clinical networks, which Mark Dickinson (MD) has been leading. AW commented on the complexity of the current arrangements for networks, implementation groups and multiple other programmes and disease specific groups. In total, this involves a significant amount of management and clinical leadership time and effort. AD suggested that a 'pause and review' would be very helpful at this stage. A lot of recent reviews had ignored interdependencies between clinical services, whilst ever-increasing specialisation was driving up costs. CJ expressed satisfaction with the reports on individual networks, but stressed the need to be talking about the interdependencies with Andrew Goodall as there is currently too much fragmentation and duplication.	

AL agreed that there is need to consider why we are doing all of this and the impact it is having. We have the opportunity to streamline. Steve Moore (SM) referred to the multiple groups just in the single topic of imaging, but noted that having a number of networks brought together in the Collaborative had helped. AW added that there are still new things being announced, with the latest being a perinatal mental health network. AW suggested that there is a need to open a debate with Welsh Government about this prior to the reporting of the Parliamentary Review. CS expressed her view that the perinatal issue can be resolved within existing structures and that, through work already started, we can get a better overall NHS Wales grip of mental health. JW suggested that there is an urgent need to assess how much planning capacity we require, how much we have and where we need it. The current arrangements are all disconnected and vastly expensive in terms of time. AL agreed with this and the need to map what we currently have. It was **agreed** to discuss this matter further in a meeting later in the day.	**All**
Arrangements for next meeting	**Action**
It was noted that the next meeting, which had been scheduled for March, will now be held in late February, to allow time for the report on the major trauma consultation to be considered and approved, prior to discussion by boards. The date and time will be confirmed soon.	**MD**

AGENDA ITEM 1.4

21.12

EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON
28 NOVEMBER 2017 AT THE HEALTH AND CARE RESEARCH WALES
CASTLEBRIDGE 4, CARDIFF

PRESENT

Members:

Prof Siobhan McClelland	Chair
Mr Stephen Harrhy	Chief Ambulance Services Commissioner
Dr Tracey Cooper	Public Health Wales
Mr Gary Doherty **(Via VC)**	Chief Executive, Betsi Cadwaladr UHB **(in part)**
Mr Steve Moore	Chief Executive, Hywel Dda UHB
Mrs Carol Shillabeer	Chief Executive, Powys tLHB
Mrs Allison Williams	Chief Executive, Cwm Taf UHB

In Attendance:

Mrs Patsy Roseblade	Deputy Chief Executive, WAST
Mr Glyn Jones	Director of Finance, Aneurin Bevan UHB
Mr Julian Baker	Director, National Collaborative Commissioning
Mr Stuart Davies	Director of Finance, EASC & WHSSC
Ms Joanne Abbott-Davies **(Via VC)**	Assistant Director Strategic Planning, Abertawe Bro Morganwwg UHB
Mr Shane Mills	National Collaborative Commissioning Unit.
Mr Robert Williams	Committee Secretary / Board Secretary Host Body
Mr Ross Whitehead	Assistant Chief Ambulance Services Commissioner

AGENDA ITEM 1.4

		Action
Part 1. PRELIMINARY MATTERS		
EASC 17/69	**WELCOME AND INTRODUCTIONS** Professor McClelland (Chair) welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. In commencing the meeting, the Chair reminded Members of the need to ensure that they all had read the Committee's papers and that contributors also take this into account when presenting items. In light of limited attendance and Mr Doherty having to leave the meeting late morning, an issue of quorum was raised and the Chair revised the sequencing of agenda items to ensure the meeting was quorate for key agenda items requiring a decision.	
EASC 17/70	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Ms Alexandra Howells, Abertawe Bro Morgannwg UHB; Mr Steve Ham, Velindre NHS Trust; Ms Judith Paget, Aneurin Bevan UHB; Mr Len Richards, Cardiff & Vale UHB, Ms Tracy Myhill, Welsh Ambulance Services NHS Trust. Professor McClelland expressed her ongoing concerns about the level of attendance of some Committee Members, despite having written to some Health Boards and raised her concerns with the All Wales Chairs. Whilst noting some of the related circumstances that influenced attendance at today's meeting Professor McClelland reiterated the expectation of the Cabinet Secretary for Health, Well-Being and Sport and made reference to previous criticisms raised by Wales Audit Office and Internal Audit.	
EASC 17/71	**DECLARATIONS OF INTERESTS** There were no additional interests, to those already declared.	

AGENDA ITEM 1.4

EASC 17/72	**MINUTES OF THE MEETING HELD ON 26 SEPTEMBER 2017** Members **CONFIRMED** the minutes of the meeting held on 26 September 2017, subject to the correction of some minor typographical errors.	*Committee Secretary*
EASC 17/73	**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. **EMRTS** The Chief Ambulance Services Commissioner confirmed that he was still awaiting confirmation of a date for the Gateway review, which is anticipated for early in 2018. **Health Care Professional (HCP) Calls** The Chief Ambulance Services Commissioner reported that he had attended the recent meeting of the Chief Operating Officers (COOs) and is planning to attend the December meeting of the All Wales Medical Directors. Mr S M Harry provided an update on feedback from the COOs meeting, with a particular focus on closer working between Welsh Ambulance Services Trust (WAST) staff and hospital Bed Managers, to better coordinate patient flow. The meeting also discussed options around Direct access and capturing related data. Mr Harrhy explained that the main issue for discussion with Medical Directors relates to boarding, which usually is not an issue, but requires a clinically led conversation. The CASC confirmed that he would also be attending the all Wales Directors of Primary Care meeting next month, to discuss with them the alignment of the above work and management of patient flow within Primary Care. Following discussion, the CASC agreed to develop a more detailed update on progress, providing a verbal update to the January 2018 meeting with a more detailed written update to the March 2018 meeting and also ensure the related discussions align appropriately with the Integrated Medium Term Planning / Commissioning intentions process.	CASC *CASC*

21.12

AGENDA ITEM 1.4

	Non Emergency Patient Transport (NEPTS) Members **NOTED** that the quality and assurance framework, signed off by WAST, was only awaiting Chair of EASC signature. **Memorandum of Understanding (MoU)** Members **NOTED** that there was an outstanding action, linked to a recommendation within the Wales Audit Office report and management response. The issue to address within the update relates more about the relationships with Welsh Government and WAO are being kept up to date. Members suggested that we take the revised MoU, following consideration of progress by the Joint Committee in January, to the March 2018 Board meeting rounds, along with any final amendments to the revised Governance Framework, an item for consideration later in the business of the meeting. **Hear and Treat** Members **NOTED** that Welsh Government had indicated their intention to fund arrangements for Hear & Treat. The CASC agreed to send a letter of confirmation outlining the funding arrangements to Members. Mrs P Roseblade and Mr S Davies confirmed that a letter explaining the approach to allocations had been received. Mrs A Williams asked that confirmation is provided on the funding approach and specific arrangement to ensure all interested parties are clear on the approach. The Committee **RESOLVED** to: • **NOTE** the Action Log and the updates provided.	*Chair* *CASC* *CASC*
EASC 17/74	**MATTERS ARISING** Mr S Harrhy thanked Members for confirming the agreed way forward and additional funding to support the EASC commissioning function. **Primary Care** Mrs A Williams sought clarity on the action identified to her, referred to in the minutes with regards Primary Care Reference Group. The CASC explained that this related to Unscheduled Care Board and the all Wales Primary Care Directors meeting and sharing the pilot work being progressed in Cwm Taf, which he had discussed further with Mr J Palmer.	

21.12

AGENDA ITEM 1.4

Part 2. ITEMS FOR APPROVAL / ENDORSEMENT		
EASC 17/75	**TERMS OF REFERENCE FOR REVISED EASC SUB GROUPS** The Chief Ambulance Services Commissioner, presented the proposed revised Terms of Reference for the new EASC Sub Groups, which were agreed at the September meeting of the Joint Committee. The CASC provided the context and reminded Members of related discussions held at the last meeting of the Joint Committee in discussing the WAO Management response. Mrs A Williams, whilst supportive of the establishment of the revised sub group structure reiterated her general concerns about the intended number of members on the group (27) and if all nominations were received and attended would be challenging to manage. Members in **NOTING** the point raised agreed that the revised structure should run for at least 6 months and see how it works. Dr T Cooper commented on the role Public Health Wales could support in relation to Health Intelligence data / information, which was welcomed. Clarity was sought on how will the Planning, Development (not Delivery) & Evaluation Group (PDEG) interface with WASTs own internal development arrangements. In response the CASC explained that it was complementary to WASTs internal processes. Mr G Evans queried, in relation to commissioning intentions, the relative maturity of the sub groups to take related work forward and inform the agreed direction of travel. Mrs J Abbot-Davies confirmed that Ms S Harrop-Griffiths will represent ABM UHB on the PDEG and that she had also suggested providing recommendations on the EASC commissioning intentions should be within the Terms of Reference. In considering the 'draft' Terms of Reference for both the Planning, Development & Evaluation Group and the Joint Management Assurance Group, members raised the following key issues:	*TC*

21.12

AGENDA ITEM 1.4

	Professor McClelland in referencing her ongoing concerns about commitment and attendance of members at the Joint Committee considered this was also a feature of the approach to the sub group arrangements. Reference was made to Cardiff & Vale UHB not being represented at the meeting today and the general poor level of attendance to date at the sub groups. The Chair sought comments and views from those Members present. Members in acknowledging the issues raised by the Chair provided a number of observations and contributory factors in response, but accepted the criticisms made and the valid concern raised by the Chair and recognised the need for improvement. Members considered that it was not an issue of will or commitment but one more aligned with capacity and that for those organisations in targeted intervention, that presented additional challenges and demands. The Chair in noting the comments made, reminded Members that EASC is a statutory Sub-Committee of Member Health Boards and that it would be difficult to progress some of the challenges of the WAO report findings if we haven't got consistent commitment and engagement from member Boards at Joint Committee and sub group level. In considering whether there was anything else Members could agree to make it easier to deliver what was recognised as an important agenda, the CASC considered the right level and consistency of membership, particularly in the Sub Groups and regular attendance, can make a big difference in being able to progress related work. The Committee **RESOLVED** to: • **APPROVE**, subject to making the proposed minor amendments referenced above, the Terms of Reference and Membership for the Planning, Development & Evaluation Group and the Joint Management Assurance Group and would be reviewed in 6 months time.	

21.12

AGENDA ITEM 1.4

EASC 17/76	**ALIGNMENT OF EASC COMMISSIONING INTENTIONS FOR EMERGENCY AMBULANCE SERVICES WITH INTEGRATED MEDIUM TERM PLANS** The Director, National Collaborative Commissioning, presented the report which summarised the work progressed to date in developing Joint Committee commissioning intentions. Mr J Baker explained some of the context and reasoning for the developed intentions which were summarised in the supporting appendices to the report. Members **NOTED** that there had been extensive engagement and raised the following related issues; Mrs A Williams suggested that on Figure 1, tables 1a, 1b and 2 are the highest priorities for sequencing and for taking forward with Planners in relation to Integrated Medium Term Plans. Mr J Baker noted the suggestion and advised that in planning terms there was recognition that table 3 is work in progress. On resourcing Mrs A Williams outlined the direction we are being given by Welsh Government via the allocation letter, including top slicing on Paramedic Band 6 and Hear & Treat, these are large investments of resource and it's unclear to Members at present, what the return is on this significant level of investment. The CASC made reference to related discussions and more detailed questions that WAST, as providers, will have to answer, including on the former for example, how upskilled paramedic staff positively impact on the significant variability of conveyancing to hospital rates and we will take this via PDEG and JMAG. The money is now recurrent as per allocation letter. As WAST have an approved IMTP and are a commissioned organisation the ability to disinvest and reinvest resources following appropriate evaluation can be progressed in 2018/19. Members confirmed that WAST would be treated in a similar way to all NHS organisations in relation to uplifts and cost reduction expectations. Mrs Shillabeer suggested the approach was very NHS focused, although a lot of work is being developed with	

21.12

AGENDA ITEM 1.4

	partners and this was confirmed as being referenced within Table 3. Mrs Shillabeer also sought clarity on IMTP expectation, which she was happy to address outside the meeting, as Powys have some flexibilities in approach. Dr T Cooper sought clarity on the recording of activity and performance within WAST in respect of time to answer calls. The CASC advised that the percentage of calls responded to within a particular time frame is reported by WAST. Mrs Roseblade confirmed that WAST do have more data internally than what is reported and that there were, until recently, issues with looping calls across BT lines, which had been addressed. In response to a query Members **NOTED** that WAST also have a deployment Plan that is routinely reviewed. Members discussed the importance of ensuring more of a shift left in the patient pathway, with increased focus and activity on steps 1 and 2 and the importance that this is more appropriately reflected within commissioning intentions but also organisations IMTPs. Mr S Harrhy suggested that this may be better considered within a development session of the Committee. Mr S Moore emphasised the importance of ensuring local dimensions were also factored into what understandably is a national commissioning approach. Members also considered that there was a need to ensure intent on performance expectation and consistency of approach across Wales, working through this on a collaborative basis. Mrs Roseblade suggested that there is a lack of reference to hospital handover delays, which needed to be added. Members felt it would be helpful if the document was updated to reflect today's conversations and that updated guidance was shared with Planning Directors. Members were content to **APPROVE** the document and asked that Mr Harrhy's covering letter is absolutely clear on the resourcing, recognising we are also concerned about the quality, safety and experience of patients	

21.12

AGENDA ITEM 1.4

	included within the covering letter. The CASC agreed to ensure the balance was right within the covering letter. The Committee **RESOLVED** to: • **APPROVE** the Commissioning Intentions alignment process with IMTPs, subject to reflecting some of the helpful comments provided in discussion.	*DNCC*
EASC 17/77	**NON EMERGENCY PATIENT TRANSPORT SERVICES COMMISSIONING UPDATE** The Director, National Collaborative Commissioning, presented the report which summarised the work progressed to date in taking forward the NEPT commissioning arrangements. Mr J Baker explained the approach to date in developing and taking forward the plurality model including the related context and reasoning for the developed intentions which were summarised in the supporting appendices to the report. Members **NOTED** that there had been extensive engagement and discussions and that work would continue with providers on enacting the plurality model, which would be a requirement of at least one Health Board and Members **NOTED** that it will be Cardiff & Vale UHB on a true novation basis by 31 March 2018. Mrs C Shillabeer raised an issue of branding and whether we had taken on board or reflected patient/carer views. PTS / PCS (patient care services). Mrs Roseblade explained that part of the business case was to develop a new brand, which is consistent with what the Cabinet Secretary had been referring to. Members **NOTED** that the approach to date had been developed within WAST using an acronym already in use, which would need to be used on an interim basis, even if the intention going forward is to engage with the public for a more longer term approach. Mrs Roseblade confirmed that WAST had engaged with patients at the time of developing the business case. The Committee **RESOLVED** to: • **NOTE** the report. • **APPROVE** the principles to support successful delivery of the Assurance Framework and enactment of the plurality model.	

21.12

AGENDA ITEM 1.4

	• **APPROVE** the continuation of the NEPTS DAG with regular reporting to EASC. • **APPROVE** that the NEPTS Quality & Delivery Assurance Framework are signed by the Chair of EASC and the CASC on behalf of EASC, and by the WAST Chair and CEO on behalf of WAST, to become operational from 1 November 2017.	
Part 3. KEY ITEMS FOR DISCUSSION		
EASC 17/76	**CHAIR'S REPORT** The Chair informed Members that her planned appraisal with the Cabinet Secretary had been postponed and was being rearranged. The Chair made reference to discussions with the Chair of WAST and where the Cabinet Secretary had raised the Amber 95th percentile category. The Chair confirmed that the all Wales NHS Chairs have a scheduled meeting with the Cabinet Secretary on 11 December 2017.	
EASC 17/77	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** Mr Harrhy, Chief Ambulance Services Commissioner (CASC), presented an update on matters contained within his written report, which included: • **EMRTS** The CASC will be doing some further related work on EMRTS which will need to be brought back to the Joint Committee, following consideration of the NHS and Charitable factors that influence this area of work. Members **NOTED** that a Major Trauma public consultation event was held yesterday. Members felt it was important to ensure any consideration of a requirement for a 24 hour service, needs full consideration of the evidence base that may not justify it. Members felt an agreed consistent form of words would be helpful to exchange in the consultation. Mr S Moore made reference to some of the associated Hywel Dda issues in the context of their developing Clinical Services Strategy, particularly in the context of the management of ill children in mid Wales, which	

AGENDA ITEM 1.4

	currently makes the assumption that a 24 hour service is not in place. Mr S Harrhy agreed to speak with Mr B Hudson and separately Mr S Moore on the related issues raised by Members. • **Service Change** Members **NOTED** the agreed approach to taking forward discussions on potential service change across different parts of NHS Wales and any related implications for Ambulance Services. • **Integrated Performance Report** Members **NOTED** the work being progressed to develop an integrated performance report which will align with Health Board and WAST reports. The intention is to provide health boards with bespoke reports which will enable them to identify opportunities for improvement in joint working with WAST and also ease pressure on the prehospital element of unscheduled care. Members **RESOLVED** to • **NOTE** the report. (11:30am Mr G Doherty left the meeting) Members **NOTED** that the remainder of the meeting was not quorate as only 3 Chief Executive Health Board Members were present, although the business of the meeting had been adjusted to take account of Mr Doherty having to leave.	CASC
EASC 17/78	**RECRUITMENT AND RESOURCING POSITION UPDATE** The Chair explained the background to the request that generated the report and the links to recent media interest in related WAST staffing issue, following which Professor McClelland had requested an update to Joint Committee, as the matters reported had not been raised by exception to the Committee. Ms P Roseblade, Deputy Chief Executive, WAST presented the report and outlined the approach adopted by WAST in the summer, when progressing its 'big bang' recruitment event, where the number and quality of candidates supported WAST to over recruit its core establishment and make better use of existing resource,	

AGENDA ITEM 1.4

	which included reductions in overtime and off contract provider support. Members **NOTED** the update and following discussion welcomed the reported improved efficiency in the deployment of workforce resource as a consequence of WAST's successful recruitment and the reduced dependency on overtime and private providers. Members considered it was important to avoid 'boom and bust' workforce planning even if we over train paramedics in Wales, we could perhaps work together to address clinical workforce re-modelling in a broader space, ensuring we don't de-skill paramedics from their core role. Mrs Roseblade explained that despite over recruiting, due to the quality of candidates, there were around 26 candidates that weren't offered posts, which Members suggested consideration of an alternative approach subject to development of alternative care models that we may choose to roll out across other parts of Wales. E.g. MIUs; GP OoHs. Members suggested the WAST Workforce Director take into a conversation with the NHS Wales Directors meeting. The CASC explained the alignments of the commissioning intentions and the evaluation of pilots, in discussion with Health Boards, which puts NHS Wales in a better place to take such approaches forward. There was also alignment with the community paramedic conversation but important that this is in the right space. The Chair asked specifically what was happening on sickness and absence management. Important to remember the level of investment that had been made by Members and its intention being to reducing overtime, reducing sickness and completing in some parts of NHS Wales (AB UHB and BC UHB specifically) staff rosters, as the report doesn't draw out previously agreed arrangements. In response Mrs Roseblade reported positively on staff sickness reductions but recognised there was more to do on completing roster reviews. The Chair welcomed the inference that WAST feel now that they do have sufficient resource and emphasised the need to progress the Demand & Capacity work and improving efficiency of appropriate deployment of the right response.	

21.12

AGENDA ITEM 1.4

	Many of these issues will be picked up in ongoing discussions with WAST colleagues as commissioning intentions are further developed. Members **RESOLVED** to; • **NOTE** the pro-active management of resourcing levels, including the recruitment to funded paramedic establishment levels**.**	
EASC 17/79	**IMPLEMENTATION AND BENEFITS REALISATION OF BAND 6 PARAMEDICS IN WALES** Ms P Roseblade, Deputy Chief Executive, WAST presented the report and the progress being made in partnership with Staff representatives to deliver and implement the agreement. Ms Roseblade confirmed that progress had been made on development of the role profile. To date a number of paramedic staff had indicated that they do not wish to progress to the new Band 6 role. A more individualised approach to Personnel Development Review and appraisal, with return on investment more likely to be apparent from year 2 onwards as paramedics who do adapt to the revised competencies and framework will need some time to complete the transition. The Chair reported that she was keen to ensure the benefits realisation plan is considered and developed further through the work of the PDEG in advance of it coming back to Joint Committee in order that change and anticipated benefits are tangible. Members suggested that there were likely to be some more immediate benefits that could be realised even in year 1 and it was important to ensure if possible that these are grasped. Dr T Cooper raised the related Clinical Governance implications and added responsibilities on individuals and different clinical risks and pressures being managed, which Mrs Roseblade confirmed that the Medical Directorate will review and also have input into inform the self-assessments.	CASC

21.12

AGENDA ITEM 1.4

	CASC made reference to resource set aside to train staff and felt it was important to align this with other training requirements e.g. major trauma centre / networks, to avoid duplication and mitigate any separate resourcing requests. The Chair emphasised the importance of more clarity and detail on the realisation of benefits, as it's a large investment via the Commissioners and it was important to ensure the investment also informed service improvements. Members **RESOLVED** to • **NOTE** the report.	
EASC 17/80	**COMPUTER AIDED DISPATCH SYSTEM (CADS)** Ms P Roseblade, Deputy Chief Executive, WAST presented the report and the progress being made with implementation of the new Computer Aided Dispatch System (CADS). Ms Roseblade declared her Senior Responsible Officer (SRO) role in the project. Members **NOTED** the report presented by Mrs Roseblade and noted that there was an element of familiarisation and whilst still early days, overall the implementation had been considered very successful, but will be subject to more formal evaluation. Staff involvement and feedback from the project was also very positive. Members **NOTED** and raised concerns about Red 1 performance in some parts of Wales, including Powys tLHB and Hywel Dda UHB. Ms Roseblade outlined the actions being taken to address the performance issues in those parts of Wales. Members **NOTED** that generally the CADS was working effectively although understandably there had been some related teething issues e.g. auto allocation alignment with the Welsh geography. Members recognised that whilst there was likely to be some impact and congratulations were conveyed to all staff involved in implementing such a significant project, it was difficult to support the recommendation within the report, that there was no service impact, as clearly there was some.	

21.12

AGENDA ITEM 1.4

21.12

	The CASC explained that overall performance across NHS Wales is likely to be 6% down, although recognised it was important to ensure what element of the performance deterioration aligned with the CADS implementation and it was important to ensure the right balance with related communication about these matters. Members **AGREED** to take the detail through the JMAG meeting and **NOTED** that the CASC, WAST and Welsh Government had scheduled a meeting next week to discuss related matters further. Members **RESOLVED** to • **NOTE** the report.	CASC
EASC 17/81	**CLINICAL RISK ASSURANCE REVIEW UPDATE** Mr S Mills, Clinical Director, National Collaborative Commissioning Unit, presented the report which summarised progress on work undertaken with WAST in responding to the outcomes of the Clinical Risk Assurance Review which was undertaken in 2016/17 and reported in May 2017. The clinical team of EASC continue to work closely with colleagues at WAST to address the issues raised within the review. Mr Mills made reference to the positive work and progress made but recognised there were some actions outstanding linked to the need to progress clinical leadership changes. Members **NOTED** the report and the reported improvements and agreed to receive a further update in 6 months on conclusion of the outstanding actions. Members **RESOLVED** to; • **NOTE** the report and the reported progress made.	
EASC 17/82	**HEALTHCARE PROFESSIONAL CALLS AND COMMUNITY PARAMEDICS UPDATE** Mr Ross Whitehead, Assistant CASC, presented the report, the purpose of which, was to update Members on progress with the management of health care professional calls and the rollout of community paramedic schemes, since discussion at the last meeting of the Committee.	

AGENDA ITEM 1.4

	Members **NOTED** the detailed discussion which took place at the last meeting of the Committee and the further related actions, which before January 2018, will be reported into the conclusion of the review work, which the Unscheduled Care Board has asked to receive updates on. Members **RESOLVED** to; • **NOTE** the report.	CASC
EASC 17/83	**AMBULANCE QUALITY INDICATORS (Quarter 3)** The Report of the Chief Ambulance Services Commissioner was **received**. Mr Ross Whitehead presented some of the key issues raised within the report and provided an overview of the highlights over the last quarter. Members **NOTED** the recognition of EASC re importance of Stats Wales and access to the Stats Wales resource to make better use of the reported data. Meetings have taken place with NWIS to make better use of the data. CASC confirmed intention to use the JMAG meeting to consider and discuss the Ambulance Quality Indicators (AQIs), their development and reporting. Dr T Cooper offered the support of Public Health Wales statisticians if required. The Chair emphasised the importance of Health Boards being sighted on the AQIs and were using them within their performance monitoring arrangements. Members **RESOLVED** to; • **NOTE** the Report.	
EASC 17/84	**JOINT COMMITTEE RISK REGISTER** Mr Robert Williams, Committee Secretary (Board Secretary Host Body) presented the report and updated Members on the development of the Risk Register and related changes. Members **NOTED** the addition of a risk associated with Major Trauma and implications on EMRTS, recognising the current ongoing public consultation.	

AGENDA ITEM 1.4

	Members **NOTED** the changes highlighted within the report and supporting appendices. Mrs P Roseblade suggested a conversation take place outside the Committee, with the Committee Secretary, in order to better understand the approach being taken in development and presentation of the Risk Register. Members **RESOLVED** to • **NOTE** the report and **ENDORSE** the updated Risk Register.	*Committee Secretary*
EASC 17/85	**MONTH 7 FINANCE REPORT** Mr S Davies presented an update on the Month 7 EASC Finance position. Members **NOTED** that there was no significant under or over spends to report and that the reported position was balanced, with a projected year end break even position being reported. Members **RESOLVED** to: • **NOTE** the Month 7 finance update.	
Part 4. GOVERNANCE & ASSURANCE		
EASC 17/86	**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 Meeting 25 September 2017. • Quality Assurance and Improvement Panel (QAIP), Action Notes from the meeting held on 14 September. • EMRTS Delivery Assurance Group, Chair's Summary from 19 September 2017 • Planning, Development & Evaluation Group (PDEG) Chair's Summary from 16 November 2017. Members **RESOLVED** to: • **NOTE** the Sub Group summary updates and Minutes received.	
EASC 17/87	**EASC IMTP 2017-20** Members received for information a copy of the final draft 2017-2020 EASC Integrated Medium Term Plan.	

AGENDA ITEM 1.4

EASC 17/88	**FORWARD PLAN** Members received and **NOTED** the forward plan. In considering the item, it was **AGREED** that matters raised in relation to Mental Health is added to the March 2018 meeting. Service Change, deferred today, will now take place in January 2018 meeting.	*Chair / CASC / Committee Secretary*
OTHER MATTERS		
EASC 17/89	**DATE AND TIME OF NEXT MEETING** The time and date of the next Joint Committee meeting was scheduled to commence at 13:30am on Monday 29 January 2018, at Castlebridge 4, Health &Care Research Wales, Cardiff.	*Committee Secretary*

Signed …… (Chair)

Date ……

21.12

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Professor Siobhan McClelland
Lead Executive Directors	Health Board / Trust Chief Executives
Author and contact details.	Robert.Williams@wales.nhs.uk
Date of last meeting	29 January 2018

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 via the following link: EASC Joint Committee Meeting Agenda & Papers 29 January 2018

Members met in workshop session, prior to the commencement of the meeting, to discuss regional and national service change options and their potential impact on Emergency Ambulance Services Commissioning and also a summary review of proposals received to date from Health Boards with regards the additional £10m recently announced by the Cabinet Secretary to support operational winter pressures.

COMMITTEE MEMBER ATTENDANCE

The Chair reiterated her ongoing concerns regarding some Chief Executives commitment to and attendance at Joint Committee, as required by the standing orders of the Joint Committee. Professor McClelland confirmed that she would write to the Chairs of the 2 Health Boards and 1 NHS Trust, where attendance by the Chief Executives had not been sufficient. She would also consider escalating concerns into Welsh Government.

INTEGRATED PERFORMANCE DASHBOARD

Members reviewed and discussed the developing draft integrated performance dashboard and considered areas where the related work could be strengthened. Members welcomed the dashboard, which will be developed further, taking into account the latest Ambulance Quality Indicators (AQIs) for consideration at the March 2018 meeting of the Joint Committee.

CHAIR'S UPDATE

The Chair confirmed that she had participated in her appraisal with the Cabinet Secretary for Health & Social Services. The Cabinet Secretary recognised the progress EASC had made over the last 18 months and **NOTED** the further areas of work that it was focusing on going forward.

Professor McClelland confirmed that she would not be seeking re appointment as Chair of EASC when her current term ended in March 2018.

The Chair asked that information provided by WAST to NHS Wales Chairs meeting is shared with Members as a consequence of its alignment with the work of EASC.

CHIEF AMBULANCE SERVICES COMMISSIONER (CASC) UPDATE

Mr Stephen Harrhy, CASC, provided an update to the Joint Committee on progress with the following key matters:

- **Winter Pressures**

Members **received** an update from the CASC on discussions that had taken place with Health Board and WAST Chief Executives and Chief Operating Officers on the current management of winter pressures and resilience of related winter plans.

21.12

In discussing the particularly challenging period over recent weeks, activity levels in parts of the urgent and emergency care system have been, at times, unprecedented and well above what could realistically have been predicted. Practitioners from across all services are demonstrating a huge commitment to high quality patient care and many services in parts of Wales continue to function very well. Members discussed the significant pressures on WAST and Health Boards and their related impact on performance and handovers.

Specifically in relation to Emergency Ambulance Services:

- NHS management information shows that Red or 'life threatening' incidents for emergency ambulance services in December were the highest since the new clinical response model was introduced and 54% higher on New Year's Eve when compared to last year.
- NHS management information shows that the Welsh Ambulance Service responded to the highest recorded number of Red calls in December 2017.
- NHS management information also show there was a further 29% increase in Red demand on 1 January when compared to last year.
- NHS management information shows there was also a 23% increase in Amber incident on 31 December when compared to two years ago (and 9% up on last year).
- Despite this, management information shows Red performance for December 2017 was 70%.

Members **NOTED** the additional £10m funding recently announced by the Cabinet Secretary and the intended use of the resource which Health Boards and WAST were compiling proposals against.

- **Amber Calls**

Members **received** an update from the CASC on work being progressed via a Task & Finish Group to further review and develop a request from the Cabinet Secretary for Health & Social Care, following the publication of the PACEC review (Public and Corporate Economic Consultants Limited, released on 20 April 2017) that EASC and the CASC consider the learning from the PACEC report but also take the opportunity to be innovative. In particular, the Cabinet Secretary suggested that the review could provide an opportunity to 'use clinical advice and evidence as a guiding principle to keep the model under constant review' and that he was encouraged by the:

> *'opportunities to improve patient care by making the best use of alternative community services that can provide a more suitable response than an ambulance intervention and conveyance to hospital'*.

The Task and Finish Sub-Group of the Clinical Prioritisation Assessment Software Group met to discuss the review of the individual AMBER codes. At this meeting approximately 20 AMBER codes were reviewed and amendments made to the ideal response configuration.

Whilst these codes account for a relatively small proportion (approx. 7%) of the total AMBER code set they account for approximately 100,000 AMBER incidents (approx. 40% of AMBER Incidents) per annum.

21.12

As such it was felt by the Task and Finish Sub-Group that it would be unwise to make any further changes to other AMBER codes without evaluation of the amendments made to these largest volume codes. A secondary review day has been agreed in early March to undertake this evaluation.

The March Committee meeting will receive a closure report on the recommendations of the PACEC review. This report will include assurance on how the model will be under continual review in line with the developing evidence base and trigger factors for ad-hoc reviews.

- **Non Emergency Patient Transport Services (NEPTS)**

Members **received** an update from the CASC on progress with commissioning of NEPTS, which in summary included the following;

- Following the submission of schedules for implementation from 1 November 2017, the operational schedules have been updated to reflect the most up to date HB information.
- WAST informatics and management teams continue to work on the population of data in the quality indicators report template. Further detailed consideration required to identify sources for new reporting data.
- All known HB data has been clearly set out in the schedules. Discussions are ongoing with Velindre and Welsh Renal Clinical Network. However, as discussions progress it still appears that there are some discrepancies within health boards. WAST will maintain a log of all queries/changes to form part of the transfer agreement at point of transfer. WAST have arranged for the NHS Wales Shared Services Partnership, Audit and Assurance Service to undertake an audit and provide a level of assurance on the current situation.
- Process for transfer of work developed. Proposal that Cardiff and Vale will be the first health board to transfer – intention to transfer at the start of the next financial year.
- An operational and process review of each of the 5 welsh non-emergency patient transport bookings centres has been undertaken. The review identifies how each booking centre operates and what information is shared with patients. The review also addressed each centres ability to capture performance data in-line with the NEPTS 5 steps quality indicators.
- A joint research project between WAST, Betsi Cadwaladr UHB, Wrexham and Gwynedd Local Authorities (LAs) is ongoing as part of the Innovate to Save Fund supported by Welsh Government and NESTA. Initial outcomes show that better integration would result in releasing capacity for WAST and LAs, initially in the Lleyn peninsula. The Research and Development will complete in January 2018.

21.12

WAST INTEGRATED MEDIUM TERM PLAN 2018-2021
Members **received** and **NOTED** a summary update on work undertaken by WAST to progress its 2018-21 IMTP. The Chair asked that the 'draft' WAST IMTP, which had not been provided to Joint Committee, as it was being considered during this week by the WAST Board, be distributed to Members in order to consider any comments on the 'draft' to feedback via the CASC to WAST.

As the plan hadn't been included with the cover report, it was not possible at this stage to provide Commissioner support.

EASC INTEGRATED MEDIUM TERM PLAN 2018-2021
Members **received** and **NOTED** progress with development of the EASC 2018-21 IMTP which reaffirmed agreed commissioning intentions, which were discussed in some detail at the November meeting of the Committee.

GOVERNANCE & ASSURANCE
Members received sub group Chair reports and related minutes, including;

- Non-Emergency Patient Transport Services (NEPTS) Action Notes 23 October 2017
- Non-Emergency Patient Transport Services (NEPTS) Chairs Summary 27 November 2017
- Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery Assurance Group Minutes 19 September 2017
- Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery Assurance Group Chairs Summary 10 January 2018
- Joint Management Assurance Group (JMAG) Action Notes 14 November 2017
- Joint Management Assurance Group (JMAG) Chairs Summary 10 January 2018

WALES AUDIT OFFICE REPORT AND MANAGEMENT RESPONSE
Members **received** and discussed generally good progress against the Management Action Plan and **NOTED** actions outstanding. Members **NOTED** that the Memorandum of Understanding between CASC, EASC, WAST and Welsh Government and the CASC Job Description had been delayed beyond their originally intended completion date and it was hoped that both would be resolved by the March meeting.

FINANCE REPORT
Mr S Davies presented the Month 7 EASC Finance report, which was **NOTED** by Members.

JOINT COMMITTEE RISK REGISTER
The Committee **received**, reviewed and **endorsed** the updated Joint Committee Risk Register. Members suggested consideration of a workshop discussion on the approach to risk from a commissioner perspective, which if time allowed would feature in the March meeting.

FORWARD WORK PROGRAMME
The Committee **received** and **noted** the Committee Forward Work Programme, which would be updated further 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. • Members would receive a copy of the WAST 'Draft' IMTP and submit any comments to the CASC.
Matters requiring Board level consideration and/or approval
• It is important that generally Boards are aware at Board level and as appropriate, 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 March 2018 meeting, in addition to the routine items that feature at every meeting of the Joint Committee, the following agenda items will be considered for workshop discussion: o Risk Register / Risk Appetite from a Commissioner lens (Development discussion) o Demand & Capacity o Mental Health

Committee minutes submitted (insert √)	Yes	√	No	
Date of next meeting	**27 March 2018**			

PRIVATE MEETING OF THE BOARD

29 MARCH 2018

AGENDA

PART 1: PRELIMINARIES		
1	Welcome and Introductions	Oral
2	Apologies for Absence	Oral
3	Declarations of Interest	*Chair*
4	To approve the Minutes of the Private Board meeting held on 25th January 2018	*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	Transforming Cancer Services in SE Wales Programme – OBC New Velindre Cancer Centre	*Director of Planning*
9	Tender for Parking and Traffic Management	*Director of Planning* *To follow*
PART 3: MINUTES FROM PRIVATE COMMITTEES FOR INFORMATION ONLY		
10.1 .2 .3	WHSSC Joint Committee Briefing - November RATS Minutes – December Quality Safety and Experience – February	*L Richards* *M Battle* *S Elsmore*
PART 4: FINAL - CLOSURE AND FUTURE MEETINGS		
11	Review of the Meeting	Oral
12	Date of the next meeting : Thursday 31st May 2018	