Bundle Public Board 28 November 2019

1 09:30 - Patient/Staff Story / Stori Claf/Staff

Working Collaboratively to Improve Vocational Outcomes for Individuals Accessing The Early Intervention in Psychosis Service (Collaborative work between HDdUHB, MIND Cymru and DWP)

Winner of the NHS Wales Awards 2019 for Working Seamlessly across the Public and Third Sector

Presenter: Joe Teape

Early Intervention in Psychosis Employment Specialist Worker Project Presentation - Public Board November 2019

2 09:45 - Public Forum / Fforwm Cyhoeddus

2.1 Open Agenda for Responding to Questions Raised in Advance by Members of the Public / Agenda Agored er mwyn ymateb i gwestiynau a godwyd o flaen llaw gan aelodau'r cyhoedd

Presenter: Chair

Public Questions and Response - Board 28th November 2019

3 09:50 - Governance / Llywodraethu

3.1 Apologies / Ymddiheuriadau

Presenter: Chair

3.2 Declaration of Interests / Datganiad o Ddiddordeb

All

3.3 Minutes of the Public Meeting held on 26 September 2019 / Cofnodion y Cyfarfod Cyhoeddus ar 26 Medi 2019

Presenter: Chair

Unapproved Board Minutes 26 September 2019

3.4 Matters Arising & Table of Actions from the Meeting held on 26 September 2019 / Materion sy'n Codi a Thablo Gamau Gweithredu o'r cyfarfod ar 26 Medi 2019

Presenter: Chair

Table of Actions from Health Board Meeting in Public held on 26 September 2019

3.5 Report of the Chair / Adroddiad y Cadeirydd

Presenter: Chair

Chair's Report November 2019

3.6 Report of the Chief Executive / Adroddiad y Prif Weithredwr

Presenter: Steve Moore

Chief Executive's Report November 2019

Appendix A - Register of Sealings November 2019

Appendix B - Consultation Report November 2019

3.7 Report of the Audit & Risk Assurance Committee / Adroddiad y Pwyllgor Archwilio a Sicrwydd Risg

Presenter: Paul Newman

ARAC Update Report November 2019

3.7.1 Standing Orders/Standing Financial Instructions / Rheolau Sefydlog/Cyfarwyddiadau Ariannol Sefydlog

Presenter: Joanne Wilson

LHB Revised Standing Orders

Appendix 1 - WHSSC Model Standing Orders 2019

Appendix 2 - EASC Model SOs Reservation and Delegation of Powers

4 10:20 - Strategic Issues / Materion Strategol

4.1 Health & Care Strategy Update / Diweddariad ar Strategaeth Iechyd a Gofal

Presenter: Dr Philip Kloer

SBAR Health & Care Strategy Update November 2019

4.2 Bronglais General Hospital: Delivering Excellent Rural Acute Care / Ysbyty Cyffredinol Bronglais: Darparu Gofal Acíwt Gwledig Rhagorol

Presenter: Dr Philip Kloer

SBAR Delivering Excellent Rural Acute Care: A Strategy for Bronglais

4.3 Winter Preparedness 2019/20 / Parodrwydd Gaeaf 2019/20

Presenter: Joe Teape

SBAR Winter Preparedness November 2019

Winter Plan 2019/2020

4.4 NHS Delivery Unit (DU) Audit on Primary Mental Health Services for Children and Adolescent Mental Health Services (SCAMHS) / Archwiliad Uned Gyflawni'r GIG ar Wasanaethau Iechyd Meddwl Sylfaenol ar gyfer Gwasanaethau Iechyd Meddwl Plant a'r Glasoed (SCAMHS)

Presenter: Joe Teape

SBAR Delivery Unit Audit SCAMHS November 2019

4.5 Major Trauma Network Update / Diweddariad Rhwydwaith Trawma Mawr

Presenter: Steve Moore

SBAR Major Trauma Network Update November 2019

Major Trauma PBC Cover Note for Boards

Final Major Trauma Programme Business Case

Appendix 1 - The Value of a Major Trauma Network - An Evidence Based Review

Appendix 2 - Wales Trauma Network Predicted Data Activity

Appendix 3 - Major Trauma Services - Quality Indicators

Appendix 4 - Service Model Overview Major Trauma Network

Appendix 5 - Service Model Rehabilitation

Appendix 6 - Process for Non Financial Option Appraisal Exercise May 2015

Appendix 7 - Outcome of Non Financial Option Appraisal for Major Trauma Centre June 2015

Appendix 8 - Major Trauma Independent Panel High Level Draft Financial Information

Appendix 9 - Isochrone Map - Major Trauma Scenarios - UHW as MTC

Appendix 10 - Isochrone Map - Major Trauma Scenarios - Morriston as MTC

Appendix 11 - Expert Review South Wales Major Trauma System February 2017

Appendix 12 - Consultation Plan Version 2

Appendix 13 - Major Trauma Consultation Report for Boards v1a (FINAL) 160318

Appendix 14 - Major Trauma Recommendations following Professional Peer Review

Appendix 15 - Informatics Approach

Appendix 16 - MTC Business Case V6 301019

Appendix 17 - Landing Pad Advice

Appendix 18 - TU Configuration

Appendix 19 - Final Major Trauma Network ToR October 2018

Appendix 20 - Trauma Network Governance Sub Committee TOR FINAL 12th June 2019

Appendix 21 - Example MTC Dashboard August 2018

Appendix 22 - Example TU Dashboard August 2018

Appendix 23 - PROMs Sample Report

5 11:20 - Delivering the Here and Now / Yma, Nawr

5.1 Report of the Quality, Safety & Experience Assurance Committee / Adroddiad y Pwyllgor Sicrwydd Ansawdd, Diogelwch a Phrofiad

Presenter: Professor John Gammon

QSEAC Update Report November 2019

5.2 Working to Improve the Health of Vulnerable Groups / Gweithio i Wella Iechyd Grwpiau Agored i Niwed

Presenter: Sarah Jennings

SBAR Working to Improve the Health of Vulnerable Groups

Appendix 1 - Homeless and Vulnerable Groups Update

Appendix 2 - Sensory Loss Update

Appendix 3 - Carers Report for WG - Updated September 2019

Appendix 4 - Syrian Refugees Update

Appendix 5 - Armed Forces Covenant Update

5.3 Public Services Ombudsman for Wales – Annual Letter 2018/19 / Ombwdsmon Gwasanaethau Cyhoeddus Cymru – Llythyr Blynyddol 2018/19

Presenter: Mandy Rayani

SBAR PSOW Annual Letter November 2019

HDdUHB PSOW Annual Letter 2018/19

5.4 Funded Nursing Care Fee Increases 2019/20 and 2020/21 / Cynnydd Ffioedd Gofal Nyrsio a Ariennir 2019/20 a 2020/21

Presenter: Jill Paterson

SBAR FNC Fees November 2019

5.5 Report of the Business Planning & Performance Assurance Committee / Adroddiad y Pwyllgor Sicrwydd Cynllunio Busnes a Pherfformiad

Presenter: David Powell

BPPAC Update Report November 2019

5.6 Mid-Year Review of the Annual Plan 2019/20 / Adolygiad Canol Blwyddyn o'r Cynllun Blynyddol 2019/20

Presenter: Karen Miles

SBAR Mid Year Review Annual Plan 2019/20

5.7 Integrated Performance Assurance Report – Month 7 2019/20 / Adroddiad Sicrwydd Perfformiad Integredig – Mis 7 2019/20

Presenter: Karen Miles
Please note in relation to this item: to access its full functionality, the main IPAR report and run charts will need to be opened separately

SBAR IPAR Month 7 2019/20

IPAR Month 7 2019/20

Run Charts Month 7

Performance Overview Matrix Month 7

5.8 HDdUHB Well-being Objectives Annual Report 2018/19 / Adroddiad Blynyddol Nodau Llesiant BIPHDd 2018/19

Presenter: Sarah Jennings

SBAR Well-being Objectives Annual Report 2018/19

WBFGA Annual Report 2018/19

5.9 Report of the Finance Committee / Adroddiad y Pwyllgor Cyllid

Presenter: Michael Hearty

Finance Committee Update Report November 2019

5.10 Finance/Turnaround Update – Month 7 2019/20 / Diweddariad Cyllid/Trawsffurfio – Mis 7 2019/20

Presenters: Huw Thomas/Andrew Carruthers

SBAR Finance and Turnaround Update Month 7 2019/20

6 13:00 - Committee Update Reports / Adroddiadau Diweddaru Pwyllgorau

6.1 Committee Update Reports / Adroddiadau Diweddaru Pwyllgorau

SBAR Committee Update Reports November 2019

6.1.1 Board Level Committees Update Report / Adroddiad Diweddaru Pwyllgorau Lefel Bwrdd

MHLAC Update Report November 2019

CFC Update Report November 2019

PCAC Update Report November 2019

HCSDG Update Report November 2019

UPB Update Report November 2019

6.1.2 In Committee Board / Bwrdd Y Pwyllgor

In-Committee Board Update Report November 2019

6.1.3 HDdUHB Advisory Groups / Grwpiau Cynghori BIPHDd

HPF Update Report November 2019

SPF Update Report November 2019

SRG Update Report November 2019

6.2 HDdUHB Joint Committees & Collaboratives / Cyd-bwyllgorau a Grwpiau Cydweithredol BIPHDd

SBAR HDdUHB Joint Committees and Collaboratives Update Report November 2019

Joint Committees and Collaboratives Update

6.3 Statutory Partnerships Update / Diweddariad ar Bartneriaethau Statudol

SBAR Statutory Partnerships Update November 2019

7 13:10 - For Information / Er gwybodaeth

7.1 Annual Presentation of Nurse Staffing Levels for Wards Covered Under Section 25B of the Nurse Staffing Levels (Wales) Act 2016 / Cyflwyniad Blynyddol o Lefelau Staff Nyrsio ar gyfer Wardiau a Gwmpesir o dan Adran 25B Deddf Lefelau Staff Nyrsio (Cymru) 2016

Presenter: Mandy Rayani

SBAR Annual Presentation of Nurse Staffing Levels November 2019

7.2 Annual Reports/ Adroddiadau Blynoddol

7.2.1 NHSBT Organ Donation: Review of Actual and Potential Deceased Organ Donation 01/04/2018 – 31/03/2019 / Rhoi Organau GThGIG: Adolygiad o'r Sefyllfa Wirioneddol a'r Sefyllfa Bosibl o ran Rhoi Organau gan Bobl Farw 01/04/2018 – 31/03/2019

Presenter: Joe Teape

SBAR HDdUHB Organ Donation Annual Report 2018/19

Detailed Report - Actual and Potential Deceased Organ Donation 2018/19

Action Plan Organ Donation and Transplantation Wales 2019/20

7.2.2 Community Health Council (CHC) Annual Report / Adroddiad Blynyddol Cyngor Iechyd Cymruned (CIC)

Hywel Dda Community Health Council Annual Report 2018/2019

Cyngor Iechyd Cymuned Hywel Dda Adroddiad Blynyddol 2018/2019

7.3 Board Annual Workplan / Cynllun Gwaith Blynyddol Y Bwrdd

Board Work Programme 2019-20

8 Date and Time of Next Meeting / Dyddiad ac amser y cyfarfod nesaf

9.30am, Thursday 30th January 2020, venue TBC

9 In Committee Session / Sesiwn Y Pwyllgor

Motion to exclude the public from the meeting in accordance with the provisions of section 1 (2) and (3) of the Public Bodies (Admissions to Meetings) Act 1960
Cynnig i eithrio'r cyhoedd o'r cyfarfod yn unol â darpariaeth Adran 1 (2) a (3) o Ddeddf Cyrff Cyhoeddus (Derbyniadau i Gyfarfodydd) 1960

Royal College of Occupational Therapists

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda University Health Board
Early Intervention in Psychosis Employment Specialist Worker Project

What did we do?

- Liaise with Department for Work and Pensions and local employers
- Brought employment providers together to identify gaps in provision
- Individual Placement and Support (IPS) identified as most effective and evidence based 'back to work' approach
- IPS training
- Mind successful in Third Sector tender
- Work in partnership with Mind to set up project
- Occupational Therapist (OT) developed Project pathway
- Operational Manual developed by OT and reviewed with Mind

Hywel Dda University Health Board
Early Intervention in Psychosis Employment Specialist Worker Project

Why did we do it?

- Majority of young people want to find or return to work
- National Institute for Health and Care Excellence (NICE)
- Access to income, social contact and a role - identity
- Maintaining and returning to work is highly beneficial to people's mental and physical health
- Better/improved quality of life
- Routine and structure –help people to remain healthier for longer
- Hope and optimism for the future, positive Team

Royal College of Occupational Therapists

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda University Health Board
Early Intervention in Psychosis Employment Specialist Worker Project

What difference does it make?

- Outcomes 2018/19 for 32 referrals received - 71.9% of individuals have accessed work, education or training
- Young person – “helped me with motivation and focus”
- Family – “fantastic support, the Employment Specialist Worker (ESW) deserves a medal”
- Early Intervention in Psychosis (EIP) staff – “really good, frees us up to do other clinical work”
- Winning the NHS Wales Awards 2019 – Working Seamlessly across the Public and Third Sector
- The Future: Success will influence provision of in-work support across wider adult mental health service

Hywel Dda University Health Board
Early Intervention in Psychosis Employment Specialist Worker Project

Next Steps

- Explore options for working with Department of Work and Pensions to support individuals accessing secondary mental health services
- Identify opportunities to roll out IPS model across secondary services as part of Transforming Mental Health
- Prepare business case for introduction of IPS in secondary Mental Health (MH) services and present to Business Planning & Performance Assurance Group (BP&PAG)
- Explore options for enabling OTs to support individuals in work or towards a return to work in primary MH services

Royal College of Occupational Therapists

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda University Health Board
Early Intervention in Psychosis Employment Specialist Worker Project

Other considerations

- We know that “Good Work is Good for you” (Black, 2009)
- Current Drivers for Employment support – Together for Mental Health, A healthier Mid and West Wales, Wellbeing of the Future Generations Act
- Health and Work Champions have been trained within the OT workforce cross sectors to ask the “work question”
- OT in Vocational Rehabilitation needs to be embedded in Primary Care – Current pilot in collaboration with Royal College of Occupational Therapists (Challenge Fund) has been very successful in Pembs
- Currently OTs are based in secondary Mental Health Services and not routinely in primary care. Often individuals will have fallen out of work by the time they enter secondary services.

PUBLIC FORUM – QUESTIONS AND RESPONSES

Question 1.a)
Name
Mr Bill Parker
Question
My limited understanding is that there are financial sanctions which the Board can impose in the event of breaches in dental contract delivery. If my understanding is correct can you confirm that monies have been refunded to the Board and whether they have been applied to other dental services provided by the Board?
Response from Jill Paterson - Director of Primary Care, Community and Long Term Care
As stated in previous information provided, the financial sanctions detailed within the regulations of the 2006 contractual framework have been actioned against each of the contracts that underperformed during 2018/19. Where funding has been recovered on a recurrent basis, plans are in place to reapply this funding into other dental services provided throughout the Health Board. However, as noted within the previous response, there are a number of reasons as to why funds may not be reapplied to dental services: "However, it is not always possible for the following reasons, the recovery of funds are non-recurrent and under accounting rules cannot be carried forward to the next financial year, and depending on the financial values involved investment would be subject the EEA Procurement Law and will be subject to a tender process which can take up to 5 months to enact."

PUBLIC FORUM – QUESTIONS AND RESPONSES

Question b)
Name
Bill Parker
Question
How many vacancies for dentists are there across Hywel Dda, how many of these are in surgeries operated by Integrated Dental Holdings?
Response from Jill Paterson - Director of Primary Care, Community and Long Term Care
The Health Board does not currently hold this level of information. As previously noted, under the current contractual Regulations, there is no requirement for the dental practice to notify the Health Board of issues relating to their workforce. The Health Board will request information in terms of any issues that may impact contract delivery such as workforce; however, the gravity of any recruitment issue will vary in each dental practice and therefore may not have a significant influence on the NHS contract delivery.

PUBLIC FORUM – QUESTIONS AND RESPONSES

Question c)
Name
Bill Parker
Question
How long have the quarterly high level meetings to which you refer in your response to my question to the September board meeting, been taking place?
Response from Jill Paterson - Director of Primary Care, Community and Long Term Care
As previously stated, since January 2017.

PUBLIC FORUM – QUESTIONS AND RESPONSES

Question d)
Name
Bill Parker
Question
When was development of the plan for future delivery of services in respect of the practices involved (also mentioned in your response from the September 2019 Board meeting) commenced and when is it expected that the plan will be implemented?
Response from Jill Paterson - Director of Primary Care, Community and Long Term Care
The plan has been ongoing since our initial meeting in 2017 and has no end date, as it is dependent on the success of recruitment to ensure improved delivery of services.

PUBLIC FORUM – QUESTIONS AND RESPONSES

Question 2.)
Name
Bill Parker
Question
How many patients attended each of the Hywel Dda A&E units as result of community acquired pressure ulcers during July, August, September and October? If possible please show total for each month at each hospital?
Response from Mandy Rayani – Executive Director of Nursing, Quality and Patient Experience
The clinical coding department capture data where the primary reason for admission is pressure ulcers. Unfortunately, like most Health Boards, there is a backlog for clinical coding at this present time and therefore we do not currently hold this information for July, August, September and October 2019. We are able to provide, outside of this meeting, as a Freedom of Information response and at a date when the information is recorded, the data you have requested. Can you please advise if you would prefer your request to be dealt with under the Freedom of Information Act.

PUBLIC FORUM – QUESTIONS AND RESPONSES

Question 3.)
Name
Bill Parker
Question
How many profiling beds are currently installed in patients households in each of the Hywel Dda counties?
Response from Jill Paterson - Director of Primary Care, Community and Long Term Care
There are 221 beds in individuals' homes in Ceredigion; There are currently 611 beds in individuals' homes in Carmarthenshire, and an additional 50 mattresses; There are approximately 460 hybrid mattresses within individuals' homes in Pembrokeshire, unfortunately at this present time the Health Board cannot provide information on profiling beds due to issues with accessing the electronic system.

COFNODION Y CYFARFOD BWRDD IECHYD PRIFYSGOL
HEB EU CYMERADWYO/UNAPPROVED
MINUTES OF THE UNIVERSITY HEALTH BOARD MEETING

Date of Meeting:	**9.30AM, THURSDAY 26TH SEPTEMBER 2019**
Venue:	**Y STIWDIO FACH, CANOLFAN S4C YR EGIN, COLLEGE ROAD, CARMARTHEN SA31 3EQ**

Present:	Miss Maria Battle, Chair, Hywel Dda University Health Board Mrs Judith Hardisty, Vice-Chair, Hywel Dda University Health Board Mr Owen Burt, Independent Member Professor John Gammon, Independent Member Cllr. Simon Hancock, Independent Member Ms Anna Lewis, Independent Member Mr Mike Lewis, Independent Member Mr Paul Newman, Independent Member Mr David Powell, Independent Member Ms Delyth Raynsford, Independent Member Mr Steve Moore, Chief Executive Mr Joe Teape, Deputy Chief Executive/Director of Operations Mrs Lisa Gostling, Director of Workforce & Organisational Development Mrs Ros Jervis, Director of Public Health Dr Philip Kloer, Medical Director and Director of Clinical Strategy Mrs Karen Miles, Director of Planning, Performance & Commissioning Ms Mandy Rayani, Director of Nursing, Quality & Patient Experience Ms Alison Shakeshaft, Director of Therapies & Health Science Mr Huw Thomas, Director of Finance
In Attendance:	Mrs Joanne Wilson, Board Secretary Mr Michael Hearty, Associate Member Ms Jill Paterson, Director of Primary Care, Community & Long Term Care Ms Sarah Jennings, Director of Partnerships and Corporate Services Mr Andrew Carruthers, Turnaround Director Dr Kerry Donovan, Chair, Healthcare Professionals Forum Ms Donna Coleman, Chief Officer, Hywel Dda Community Health Council Mr Sam Dentten, Deputy Chief Officer, Hywel Dda Community Health Council Ms Hilary Jones, Chair, Stakeholder Reference Group Mrs Annmarie Thomas, Programme Lead for Medical Workforce Utilisation (part) Mr Peter Skitt, County Director Ceredigion (part) Ms Rachel Hennessy, Director, Service Planning, NHS Wales Health Collaborative (part) Dr Helen Munro, Consultant in Sexual Health (part) Dr Jo McCarthy, Consultant in Public Health Microbiology (part) Mr Phil Jones, Wales Audit Office (observing) Ms Clare Moorcroft, Committee Services Officer (Minutes)

PM(19)146	**PATIENT STORY**	
	The Chair, Miss Maria Battle, welcomed everyone to her first meeting as Chair of Hywel Dda University Health Board (HDdUHB). Miss Battle introduced Mrs Annmarie Thomas who would be presenting the Patient Story, which represents the most important voice of all; noting that, in this particular case, the patient is also a member of staff. Mrs Thomas	

thanked the Board for the opportunity to attend, and outlined her patient experience in being diagnosed with Guillain–Barré syndrome (GBS) and the presentation and progression of symptoms which had led to this diagnosis. Mrs Thomas emphasised that she had followed the 'Choose Well' guidance, electing to seek a GP appointment rather than present to A&E. From the GP, she had been referred and admitted to Prince Philip Hospital (PPH), with an immediate diagnosis of GBS. Mrs Thomas outlined her personal experience in terms of symptoms of GBS. These had resulted in hospital stays of 1 week on AMAU at PPH, 3 weeks at Morriston and 2 weeks on Ward 3 PPH, followed by the need for 24/7 care by family for a further 2 months at home. This had provided Mrs Thomas with a wide ranging experience of various parts of the NHS as a patient.

Key patient experience reflections included a greater appreciation of the impact of agency staffing, which Mrs Thomas had only understood from a corporate viewpoint previously. It was emphasised that, whilst there are examples of very good care from agency staff, there are also issues around continuity of care. From a patient viewpoint, patient handover is better at the bedside rather than, for example at a nurses' station, as handover within sight and sound of the patient makes them feel more reassured and safer. One of the locations in which Mrs Thomas had been treated had offered an insight into the impact of drug and alcohol related admissions on staff and other patients. Mrs Thomas' experience had highlighted the importance of education and training for doctors and other healthcare professionals, and she indicated that she would be happy to speak to these groups about her experience. The importance of volunteers in offering 'an extra pair of hands' in clinical environments was also recognised. Members heard that Physiotherapy plays a fundamental role in facilitating earlier discharge. Mrs Thomas stated that the lack of a treatment room on a ward had resulted in a difficult experience for her in terms of dignity and respect; and emphasised the importance of retaining space for such rooms when considering plans for new builds and capital developments.

With regards to mealtimes, Members heard that all parts of the meal are delivered at the same time, which can be overwhelming for patients who are struggling to eat, and means that hot food is likely to go cold. Whilst recognising that making changes would involve additional staff time, Mrs Thomas suggested that this be reviewed, as it would potentially offer benefits in terms of improving patient nutrition. Mrs Thomas had experienced a number of ambulance transfers, and noted the impact of the timings of these and the importance of coordination with bed availability. In considering the role of visitors, Members were reminded that many visitors are capable of offering additional assistance to frail patients, for example at mealtimes. Outlining the support she had received from work colleagues, both past and present, Mrs Thomas emphasised that the positive impact of this should not be underestimated. A particularly significant event had been the care shown by a GP Trainee who had treated Mrs Thomas at PPH and had subsequently visited her in his own time after she had been transferred to Morriston. Visits and support from the Health Board's Chaplain had also meant a great deal. A consultant with whom Mrs Thomas had previously worked on a specific issue had offered to provide lifts to and

from work; an unsolicited act of kindness which had been much appreciated. Finally, Mrs Thomas highlighted the significance of being able to participate in a phased return to work and in fundraising. Referencing the GP Trainee, Dr Napoleon Lorin, mentioned earlier, Members heard that Dr Lorin had been nominated for and received an Employee of the Month award. Mrs Thomas stated that the impact on recipients of such awards should not be underestimated, whilst suggesting that the concept could be refreshed.

In terms of her recovery from GBS, Mrs Thomas suggested that this is a result of her personal determination and the role of the physiotherapy department. Whilst subject to a number of limitations, Mrs Thomas had been keen to return to work; and she emphasised that there are reasonable adjustments which employers can make to help people in this regard and aid their recovery. As mentioned earlier, Mrs Thomas had wanted to undertake charitable work to 'pay back' for the care she had received, and had chosen physiotherapy as an appropriate recipient. A significant number of fundraising events and initiatives had been undertaken, which are currently on target to raise approximately £8k by the end of the year. An Active Passive Trainer has been purchased at a cost of around £5k, which is already making a significant difference in terms of patient recovery and motivation, and having a positive impact on staff. Frailty staff have been trained in its use, lessening the burden on physiotherapy staff. In reflecting on her experience from the viewpoint of an HR professional, Members heard that Mrs Thomas had needed to rely heavily on her parents for day to day care after her husband had returned to work, following the 3 days special leave he had been permitted as a Public Sector worker. It was suggested that the UHB should review their Carers Policy to ensure that it is both fit for purpose and compassionate in considering staff wellbeing. Mrs Thomas thanked the UHB for facilitating a phased return to work in her case, and concluded her presentation by emphasising the importance of investing in the wellbeing of the workforce. This does not necessarily involve financial support or provision of services; it is also about compassionate leadership and small acts of kindness, which cost nothing.

Mr David Powell thanked Mrs Thomas for her powerful presentation, from which can be taken a number of positives. Mr Powell noted and endorsed, however, the need to consider patient privacy and dignity when planning new facilities. Ms Delyth Raynsford was also grateful to Mrs Thomas for sharing her story, and enquired how the UHB can improve services to offer more support to families and carers. Mrs Thomas stated that she is lucky in that she has a supportive and capable family, with a mother who is sufficiently confident to drive her to hospital appointments, etc. Hospital parking is, however, an issue and the feasibility of patient 'drop-off zones' should perhaps be considered. Mrs Thomas suggested that HDdUHB could set itself an ambition to lead Wales in terms of its Carers Policy. . Members heard that Mrs Thomas had met a number of agency staff during her hospital stays, and had taken every opportunity to try to encourage them to join the UHB on a permanent basis and to discuss any potential concerns with the individuals. A phased return to work in this instance had been an obvious and straightforward option. Mrs Gostling offered to draw up

	proposals around potential changes to the UHB's Carers Policy, in conjunction with Mrs Thomas. Miss Battle thanked Mrs Thomas for her powerful and humane story, which had identified a number of potential areas for improvement. These included: • Converting agency staff; • Agency staff usage at night; • Transport between hospitals; • Enabling patients to eat their meals; • The benefits of equipment such as the Active Passive Trainer; • Drop-off zones at hospital sites and car parking; • Carers Policy; • Flexibility for staff; • Valuing and celebrating employees. *Mrs Thomas left the meeting.*	**LG**

PM(19)147	**PUBLIC FORUM**	
	Miss Battle advised of several questions received from two members of the public for the Public Forum section of the meeting, indicating that copies of the questions and the responses had been provided to members of the public present and to Board Members. These had already been published on the University Health Board website and formal letters of response would be provided.	**MB**

PM(19)148	**INTRODUCTIONS & APOLOGIES FOR ABSENCE**	
	Apologies for absence were received from: • Mr Jonathan Griffiths, Pembrokeshire County Council Director of Social Services • Mr Mansell Bennett, Chair, Hywel Dda Community Health Council	

PM(19)149	**DECLARATION OF INTERESTS**	
	Ms Raynsford declared that, with regard to item PM(19)157, she is a resident of Aberaeron and will be a patient of the GP Practice within Porth Gofal.	

PM(19)150	**MINUTES OF THE PUBLIC MEETING HELD ON 25TH JULY 2019**	
	RESOLVED – that the minutes of the meeting held on 25th July 2019 be approved as a correct record.	

PM(19)151	**MATTERS ARISING & TABLE OF ACTIONS FROM THE MEETING HELD ON 25TH JULY 2019**	
	An update was provided on the table of actions from the Public Board meeting held on 25th July 2019.	

PM(19)152	**MINUTES OF THE ANNUAL GENERAL MEETING HELD ON 30TH JULY 2019**	
	RESOLVED – that the minutes of the Annual General Meeting held on 30th July 2019 be approved as a correct record, subject to the addition of Mrs Karen Miles' apologies.	**CM**

PM(19)153	REPORT OF THE CHAIR	
	Miss Battle introduced her report on relevant matters undertaken as Chair since the previous Board meeting, stating that she was honoured to have been appointed as Chair of HDdUHB, and thanking everyone she had met thus far for welcoming her. Miss Battle suggested that an important role of the Chair is to be visible and to listen to staff, patients and patients' families; and indicated that she had been impressed by the dedication of staff witnessed to date. Miss Battle paid testament to the contribution of her predecessors as Chair and Interim Chair, Mrs Bernardine Rees and Mrs Judith Hardisty. Members heard that the two key priorities for the UHB are Transformation and performance improvement. Miss Battle intends to work in various locations across the region, including within the community. With regard to the location for today's Public Board meeting, it was noted that the usual venue in Ceredigion had not been available, and that other venues were not able to offer the webcasting facilities required. In addition to the awards outlined in the report, Members heard that HDdUHB had won all three of the NHS Wales Awards for which it had entered: **Delivering higher value health and care** Implementing Healthy Footsteps a Partnership Approach with Podiatry and the Education Programme for Patients (EPP) in Hywel Dda **Empowering people to co-produce their care** The Learning Disabilities Dream Team **Working seamlessly across the public and third sector** Hywel Dda UHB; MIND Cymru; Department of Work and Pensions – Working Collaboratively to Improve Vocational Outcomes for Individuals Accessing The Early Intervention in Psychosis Service All of these awards are for innovative projects, and the UHB should be proud of these achievements. Attention was drawn to the re-appointment of Cllr. Simon Hancock and Mr Mike Lewis as Independent Board Members. Finally, Miss Battle emphasised that it had been inspiring to meet a number of the UHB's new apprentices, and commended the UHB for its Apprenticeship Programme. Cllr. Simon Hancock was delighted to note the UHB's successes in the NHS Wales Awards, highlighting that one of the winners was the Learning Disabilities Charter, which had been presented to Board in July 2019 and formally launched at the Pembrokeshire County Show. Cllr. Hancock stated that the Charter has been extremely well received, with many organisations having signed up to it.	
	The Board: • **SUPPORTED** the work engaged in by the Chair since the previous meeting and **NOTED** the topical areas of interest; • **RATIFIED** the decision made by the In-Committee Board and **CONFIRMED** its approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea; subject to the additional assurances that the areas highlighted within Appendix B, have or will be delivered.	

PM(19)154	REPORT OF THE CHIEF EXECUTIVE	
	Mr Steve Moore welcomed Miss Battle as Chair, and presented his report on relevant matters undertaken as Chief Executive of HDdUHB	

	since the previous meeting. Mr Moore highlighted the significant challenges around out of hours services, and advised that an update will be provided as part of the full report on winter planning for 2019/20 to the next meeting. Targeted Intervention discussions with Welsh Government (WG) continue, and the UHB will continue to update WG as regards progress on various matters. Members' attention was drawn to the appended progress update on the Quality Assurance (QI) Framework. Mrs Ros Jervis provided further information the Tuberculosis (TB) outbreak, reminding Members that a great deal of work has taken place to date. This issue has appeared in the local news again recently, due to the UHB sending out results letters to those tested in the most recent screening round. The screening clinics have not been open access; attendance is by invitation only. It had not been possible to screen everyone required during the first phase in June 2019, therefore a second phase had taken place in September 2019, which nearly 800 people had attended. Findings from the second phase had been as follows: no active cases of TB; 128 latent cases of TB, making a total of 204 latent cases. Mrs Jervis explained that latent TB is not infectious and that, whilst treatment is not urgently required, it is recommended. Those individuals who are affected are being invited to attend outpatient clinics for further discussion of results and treatment. Approximately 100 people will need a repeat blood test, as their result had been inconclusive. It was suggested that there are opportunities for prevention work, including a vaccination programme. Mrs Jervis acknowledged that this is a worrying time for those affected, emphasising that support and advice is available, and that it is a priority for the UHB and Public Health Wales (PHW) to bring the outbreak under control. Referencing the Llanelli Wellness Village update, Professor John Gammon noted the gap analysis of skills required for the workforce. With Swansea University no longer being a partner, Professor Gammon observed that the report does not indicate how the project will manage issues around pre-registration and post-registration training for healthcare professionals. Mrs Karen Miles acknowledged this concern, advising that there have been discussions with the Llanelli Wellness Village project manager, who has committed to meet with Dr Philip Kloer, Mrs Gostling and Ms Alison Shakeshaft next week, to work through these issues. Mrs Miles committed to provide an update to the next Board meeting.	**JT** **KM**
	The Board: • **RECEIVED ASSURANCE** that the QI Strategic Framework is being implemented as planned, and that the approach adopted is resulting in active and enthusiastic engagement from across the organisations; • **ENDORSED** the Register of Sealings since the previous report on 25th July 2019; • **NOTED** the status report for Consultation Documents received/ responded to.	

PM(19)155	**REPORT OF THE AUDIT & RISK ASSURANCE COMMITTEE**	
	Mr Paul Newman, Audit & Risk Assurance Committee (ARAC) Chair, outlined the ARAC update report, highlighting those areas of concern ARAC wished to bring to the Board's attention.	

	Referencing discussions outlined on page 3 regarding discharging patients; Miss Battle stated that, having examined the Integrated Performance Assurance Report (IPAR) and spoken to staff, she had concerns regarding the number of patients in HDdUHB hospitals who are medically optimised. In view of this, Miss Battle requested that this issue be considered a Board level matter going forward. Mr Newman explained the background to ARAC's discussions on the Wales Audit Office report, and the committee's focus in this regard. Mr Joe Teape advised that, whilst ARAC had requested a response, the Wales Audit Office report is intended for Board consumption, noting that the document had been previously shared with all Board Members. It is intended to 'regroup' and focus attention on specific areas, with a further update to be provided to ARAC. Miss Battle suggested that a focus on this area will assist in terms of the IPAR and will have an impact elsewhere, for example on A&E pressures.	**JT**
	The Board **NOTED** the ARAC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern together with actions being taken to address these.	

PM(19)156	**HDdUHB DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2018/19**	
	Mrs Jervis introduced the HDdUHB Director of Public Health Annual Report for 2018/19, emphasising that the organisation has been on an unprecedented journey during the past few years, which includes adoption of a Health & Wellbeing Framework. The report is retrospective as well as forward-looking, and Mrs Jervis thanked her team for their work in interpreting her vision. Hard copies have been circulated, and the team is currently working on an interactive version. Members' attention was drawn particularly to the following: The shift in approach to Population Health; The move to 3 Strategic Goals; Legislation in Wales which supports the UHB's ambition; Aspirations for a social model for health; Commitment to co-design of services. Mrs Jervis reminded Members that the Health & Wellbeing Framework was approved by the Board in January 2019. The report includes examples of how the Wellbeing Lens has been used for specific projects. Ultimately, the aim of the report is to inspire hope, with all stakeholders working together to face the significant challenges ahead. Ms Anna Lewis congratulated Mrs Jervis on the report, and the focus and energy it demonstrates. Ms Lewis suggested that further improvements could be made by an increased interaction between strategic global health and quality improvement and population health. Also, that steps should be taken to reach seldom heard groups. In terms of questions, Ms Lewis enquired regarding the equivalent of a capital scheme in population health; and what the UHB is doing to consider whether the way in which it works helps or hinders its population health ambitions. In response to the first query, Mrs Jervis recognised that these are challenging times in which to consider resource reallocation. It is important, however, to 'get the basics right' in terms of population health; including work around smoking cessation and alcohol and substance misuse. These are key population health risk factors to tackle. In addition, the following should be areas for focus: • Transformation/sustainable change;	

- The early years/the first 1000 days;
- Preventing adverse childhood experiences;
- Teaching/encouraging emotional resilience;
- Mobilising change;
- Tackling obesity.

Referencing earlier discussions, Mrs Jervis also emphasised the need to consider the health and wellbeing of the HDdUHB workforce, reminding Members that these individuals are the local population. They are often carers, for children and/or elderly relatives, and concerted change is required to address their needs. As this is a different approach, and change does not happen on its own, an infrastructure is required to mobilise the movement for change. Population health does not just mean health improvement; it also involves health protection. The latter is an extremely important domain of population health, and the UHB needs to consider how it can be strengthened. With regard to the second query, whilst there are not 'barriers' as such to implementing a population health approach, the infrastructure or human resource to do so does not currently exist. With regard to QI, Members heard that the job description for the new Public Health consultant includes a significant focus on quality and safety. Referencing the suggestion regarding seldom heard groups, Ms Sarah Jennings emphasised that the UHB is working with its partners in this regard. There has been substantial progress in reaching people who are seldom heard, including those who would not normally attend engagement events for example. These individuals are often the most frequent users of the UHB's services, whilst being least heard. Within the Strategic Equality Plan, Members will note the example of 16 partners consulting once with seldom heard groups, including carers, with the findings subsequently adopted by all 16 partners. It was emphasised that individuals within these groups are often distrustful of bodies such as the UHB, and that the involvement of Third Sector organisations is vital in such work. Ms Jennings concluded by highlighting Mrs Jervis' commitment to 10,000 conversations about health and wellbeing with local people; noting that these will not all be in village halls – a number will be in people's homes.

Ms Jill Paterson endorsed the positive comments regarding the report made by other Members. Referencing the statement on page 13 around the need to 'Move to new ways of measuring whether we have made a difference', Ms Paterson emphasised the importance of this. It is not always possible to utilise traditional outcome measures, and the organisation must consider other mechanisms to evaluate change. Mrs Jervis agreed, stressing that there is a need for the organisation to be 'bold and brave'. Whilst health indicators and performance measures offer benefits in specific applications, there are other instances where using targets can 'miss the point'. New measures can and should be co-designed with others. These may include formats such as patient stories; however, it is not for the UHB to dictate how to measure impact or success. Mr Owen Burt was pleased to see the narrative in respect of hard to reach groups. Noting reference to a drug and alcohol prevention summit, Mr Burt enquired whether further information is available. Mrs Jervis explained that, in general, alcohol and substance misuse has only a treatment focus and recovery focus. There needs to be a focus on prevention. No date for the summit has been identified as yet; however,

	the list of invitees will be broad and will include the Area Planning Board and stakeholders. Cllr. Hancock enquired whether PHW has strong advocacy channels to WG, for example in suggesting setting minimum prices for alcohol. Mrs Jervis confirmed that there is a strong network in this regard, which is wider than PHW, although they are key contributors. This network meets regularly with WG, with Mrs Jervis attending. A greater emphasis on prevention is certainly being championed. Ms Jennings advised that the Wales Audit Office has recently completed a review of HDdUHB's progress with regards to the Wellbeing of Future Generations, which will be considered by ARAC at its next meeting and which will be useful going forward. Mr Moore noted that this is the first Director of Public Health report since adoption of the Health & Care Strategy, which imbues an added importance The UHB is also committed to continuing engagement with the local population – both those groups which are heard regularly and those which are seldom heard. It is vital now for concepts and proposals to be translated into formal action plans for the next three years, and for the Board to be held to account for progress.	
	The Board **DISCUSSED** the report, **NOTED** the content and **COMMITTED** to join with the Director of Public Health to create a movement for change with a focus on wellbeing and staying well.	

PM(19)157	**FOCUS ON HEALTHCARE SERVICES IN CEREDIGION**	
	Miss Battle welcomed Mr Peter Skitt, County Director for Ceredigion, to the meeting. Mr Teape presented the Focus on Healthcare Services in Ceredigion report, explaining that the opening of Porth Gofal in Aberaeron represents a momentous occasion, it being the first Integrated Care Centre to open. Mr Teape thanked Mr Skitt, Ms Jina Hawkes and Mr Matthew Willis for their contribution to this project. Mr Skitt echoed these thanks, reminding Members also of the Cardigan Integrated Care Centre, and advising that teams will be operational in both buildings by the end of the year. Mr Skitt emphasised that staff in the County are extremely dedicated and that they have been fortunate in that the local population has worked with the UHB to develop proposals. Members were shown a video describing the format and benefits of the multi-disciplinary team approach utilised within Porth Gofal. Mr Skitt explained that the Integrated Care Centre will also incorporate other services, including ambulance services and public health, which will offer further opportunities for integration and collaboration. Overall, there has been an investment of £25m across the two centres in Ceredigion. Members heard that both have a long history; Aberaeron has been at least 10 years in the planning, and the Cardigan project was first envisaged in 1957. Mr Skitt advised that a different format had been applied to the County report being presented, which reflects the message that there are different ways to approach issues and different ways to deliver care. The focus had been on what the local population feel they need, and there had been overwhelming support for combining GP services with other health services; this had offered significant opportunities. Ms Paterson commended the report and the work undertaken by the County team, particularly in achieving integration of GP services with other healthcare services. As Members are aware, Ceredigion faces a	

	number of challenges in terms of sustainability; there is a need to change the way in which patients access care and for patients to accept that they may not always see the traditional practitioners they have previously. Mrs Judith Hardisty welcomed the report and stated that she had been pleased to visit both buildings recently. The transformation and improvements made were substantial. The GPs touring the centre with Mrs Hardisty were extremely impressed with the facilities and possibilities offered, and the Integrated Care Centres are great examples of what the UHB is attempting to achieve. There are key comments at the end of the SBAR relating to how these centres demonstrate the Health & Care Strategy in action. Mrs Hardisty concluded by offering her congratulations to the team on progress to date and looked forward to the official opening of both centres. Mr Skitt explained that the centres have seen significant investment in digital infrastructure to facilitate agile working arrangements, and that IT colleagues have been extremely supportive in this regard. Professor Gammon noted the commitment to seamless provision of Mental Health services, with the intention to make centres a 'one stop shop' for mental health assessments. This was particularly welcome, especially in view of the discussions around challenges in Mental Health scheduled for later on the agenda. Mr Sam Dentten stated that the Community Health Council (CHC) are excited by the opportunities offered by Integrated Care Centres, which illustrate how changes outlined in the transformation agenda can become reality. Mr Dentten emphasised, however, that change – no matter how positive – can be challenging for people; and encouraged the UHB to utilise the opening of the centres to involve the local population and introduce them to new models of care. Mr Skitt assured Members that there is a Communications Group, which is developing a communications strategy around the new centres, and that stakeholder groups include community representatives. Miss Battle thanked all of those involved, and looked forward to seeing the centres opened and fully operational.	
	The Board **NOTED** and **DISCUSSED** the report.	

PM(19)158	**DEVELOPMENT OF A NEW CHEMOTHERAPY DAY UNIT AT BRONGLAIS GENERAL HOSPITAL**	
	Mr Teape introduced the Development of a New Chemotherapy Day Unit (CDU) at Bronglais General Hospital (BGH) report, advising Members that this has been a long-standing issue. Patients are currently receiving care in open areas, which are not fit for purpose. The UHB has learned from the experience of developing and opening the Pembrokeshire Haematology and Oncology Day Unit at Withybush General Hospital (WGH), and Members noted that the same planning team has been involved with the BGH project. Mr Teape explained that, to facilitate the BGH CDU project, Y Banwy Ward would need to be re-located. This has been a source of concern and is an area of risk, with the need to ensure that Porth Gofal and changes at BGH are operational before this can be enacted. Whilst there is also a need to close the gap in terms of funding; Mr Teape suggested that this is low risk, based on the fundraising history. Miss Battle enquired regarding the timescale for re-location of Y Banwy Ward, and Mrs Mandy Rayani advised that the target timescale is by the end of the financial year at the latest. Members were informed by Ms	

	Jennings that the wording of the recommendation considered by the Charitable Funds Committee (CFC) had been revised, as follows: **CURRENT** Subject to the development being approved by Board, the Charitable Funds Committee is also asked to: • APPROVE the development of a fundraising appeal under the umbrella of Hywel Dda Health Charities for a new Chemotherapy Day Unit at Bronglais Hospital, in anticipation of this scheme being approved by Board in September 2019. **REVISED** • APPROVE the development of a fundraising appeal under the umbrella of Hywel Dda Health Charities for a new Chemotherapy Day Unit at Bronglais Hospital, subject to confirmation of the availability of the proposed location for the development (following the pilot of the shared care model with Y Banwy and Enlli Ward). Cllr. Hancock advised that CFC Members had visited the current BGH Chemotherapy Day Unit on 14th June 2019. Whilst the quality of care offered is exceptional, the current environment is not suitable. CFC is, therefore, keen to support this project. Members heard that Miss Battle has recently visited the WGH Haematology and Oncology Day Unit, which should be commended for the dignified care setting it provides.	
	The Board **APPROVED** the re-location of the Chemotherapy Day Unit to Y Banwy Ward, together with the process and detailed schedules in the attached Business Case and timelines/funding assumptions identified in the report, subject to a caveat that the fundraising campaign will commence once the re-location of Y Banwy Ward has taken place.	

PM(19)159	**MAKING MALNUTRITION MATTER BUSINESS CASE**	
	Mr Skitt left the Board meeting. Ms Alison Shakeshaft presented the Making Malnutrition Matter Business Case, outlining the background to this proposal. There are two associated risks on the Risk Register, with multiple mitigating actions put in place. There is, however, a fundamental lack of dietetic service capacity to manage malnutrition. A Business Case presenting various options had been considered by the Executive Team on 22nd July 2019. Whilst Option 2 was the preferred option, the Executive Team had taken the decision to address the highest risk area, supporting Option 3. Ms Shakeshaft advised that the service is in the process of recruiting to posts through a two year phased process, as it is unlikely to be able to fill the required number immediately. The report is presented to Board for ratification of the proposed approach. Mr Powell emphasised that the nutrition of patients in the UHB's care is a fundamental responsibility, and expressed concern that this should even be an issue. Mr Powell noted that the Board is being asked to approve Option 3, rather than Option 2; and indicated that he would rather a commitment to the preferred option, even if this was phased. Ms Shakeshaft explained that, whilst the Executive Team had agreed there was a need to tackle the issue in its entirety, a pragmatic approach was required in the first instance, to address the area of greatest risk. It was emphasised that this was not 'closing the door' on issues in the	

community. Whilst the latter offers the best potential for improvement, it is currently the lowest risk. Mrs Hardisty was also concerned that the community issues are being set aside, highlighting that GPs, Primary Care Clusters and the Integrated Care Fund (ICF) offer potential in this regard, including possible sources of funding. Mrs Hardisty felt that proposals send the wrong message, and suggested that the Executive Team re-examine this issue, and consider alternative approaches and resourcing. It was noted that the costs of risks are not quantified, for example quality of care to patients, clinical risk, costs of hospital care. Ms Shakeshaft advised that the UHB has a very active nutrition and hydration group, and assured Members that actions to address this issue are in train. There is, for example, already a robust screening tool in use in the UHB's hospitals – the limiting factor is ability to act upon the findings of this tool. However, in the community there is a lack of awareness of the importance of nutrition and hydration, and no active screening in place. One of the tasks for one of the Task & Finish Groups will be to consider implementing self-screening within outpatient clinics, which will inevitably have an impact on referrals. Ms Shakeshaft emphasised that this is not solely a nutrition and dietetics service issue, there needs to be education of the wider service.

Mr Newman had understood from the report that the reason for not following Option 2 was primarily financial; however, discussions today suggest that the reason is to do with recruitment. If the latter, and this is a phasing issue, it was suggested that it could be addressed by adopting Option 2 over a longer implementation period. Mr Newman requested clarification regarding the rationale for selecting Option 3, and whether this relates to recruitment issues or finances. In response, Ms Shakeshaft stated that an element of both is involved. Option 2 incurs a recurrent cost of £600k per year, and the service has suggested that the UHB would probably experience difficulties in recruiting the relevant staff, with this needing to be phased. Mr Newman welcomed this clarification, and indicated that he would be more sympathetic to the proposals if there is a future commitment to Option 2. Ms Raynsford enquired what steps are being taken to involve the Hotel Services department to consider alternative ways to provide nutritious food. Also, how doctors, nurses, families and carers can be engaged.

Mrs Rayani assured Members that a multi-disciplinary approach is being applied to this issue, adding that the UHB has recently revisited its Nutrition and Hydration Policy. There is a focus on what visitors can do to improve the process and social aspect of mealtimes, with the latter also being important to patient wellbeing. Members heard that an unintended consequence of the Protected Mealtimes Policy had been to remove carers & family members from clinical areas at mealtimes; this is being revisited. Mrs Rayani advised that the standard of nutrition and hydration within both hospitals and the community and how this might be improved is a matter of considerable and ongoing debate for the nursing team. Members also heard that, as part of the Holding to Account process, there has been 'check and challenge' with catering staff regarding the standard of meals. Overall, there is a significant amount of engagement with various parties, including the multi-disciplinary teams. This also includes Pharmacy colleagues, who are involved in prescribing supplements where required. In terms of the community, nutrition and

	hydration form part of the significant work being undertaken around infection prevention and control and pressure damage. This includes a focus on hydration to reduce the incidence of urinary tract infections, and a focus on the importance of good nutrition in reducing pressure damage. Further consideration must be given to how the UHB works with the local population to emphasise the importance of nutrition and hydration. Dr Kerry Donovan suggested that the approach being proposed seems 'at odds' with the UHB's strategy of transformation, focus on community-based care and avoiding hospital admissions. Mr Moore emphasised that the UHB is aware of the challenges across its Therapies services, with Ms Shakeshaft having achieved a great deal since appointment. Mr Moore suggested that the language being used, with consideration of 'options' in isolation, is causing issues. The UHB's priority had been to take immediate action, due to the urgency around specific areas of risk; however, this does not preclude or undermine a future commitment to community services. Mr Moore would request that the Board approve taking the most urgent step in the first instance by agreeing to increase dietetic staffing in acute sites. The UHB will then ensure that Option 2 is brought in on a phased basis, as part of a three-year plan, the pace of which will probably be dictated by ability to recruit, rather than by finances. Members noted that implementation of Option 2 will commence from April 2020.	
	The Board: • **CONSIDERED** and **APPROVED** Option 3 within the 'Making Malnutrition Matter' Business Case, to increase dietetic staffing for the acute hospital sites over a two year period, in order to address the extreme risk associated with Risk 654 to reduce it to tolerance level, at an associated revenue impact of £113k for 2019/20 and £329k from 2020/21 onwards. This being on the understanding that the community-based elements of Option 2 be incorporated into a phased three-year plan, starting in April 2020; • **CONSIDERED** the recommendation for the community malnutrition elements of the business case to be considered through the Transformation Fund process.	

PM(19)160	**MAJOR TRAUMA NETWORK**	
	Mrs Miles outlined the Major Trauma Network report, emphasising that this area should be regarded as a 'work in progress', with all current workstreams detailed in the report. It is anticipated that the Board will see a conclusion to this matter in November 2019. The report outlines the local decision-making and recruitment planning which has been required; with regard to the latter, it should be recognised that the UHB will be in competition with other Health Boards. Mr Dentten reminded Members that the CHC has a statutory role in those instances when the UHB makes changes to its services. Accordingly, the CHC has developed a response to the Major Trauma proposals which reflects its involvement over several years. The CHC's recommendations are included in its response; however, to summarise, the CHC feels that the UHB should work towards becoming part of the Major Trauma Network and welcomes proposals that rehabilitation be delivered closer to patients' homes. The CHC is concerned, however, that designating Glangwili General Hospital (GGH) as Hywel Dda's	

	Major Trauma Unit could impact on the roles of WGH and BGH. Mr Dentten emphasised that there is still a great deal of concern among the local population around access to urgent care, whether this be Major Trauma care or not. It was suggested that it is unreasonable for people to have to live with such concerns, even if these are based on misapprehensions. Mr Dentten felt that the UHB should undertake more work within the community to address these anxieties. Mr Powell noted the capital requirement of £1.25m for 'Landing Pad' beds, and that the UHB are approaching WG for this funding. Mr Powell enquired whether, in view of the urgency involved, consideration should be given to utilising monies from the Discretionary Capital Programme (DCP). Mrs Miles explained that organisations are currently in the phasing stage, and that further evaluation by the Major Trauma Network and local clinicians is required. This probably will not be complete until 2020. It is likely that there will be space requirements; and resourcing requests will be fast tracked if possible. Mrs Miles did not feel that it would be of benefit to pursue the DCP route at this point in time. Dr Donovan thanked all of those involved for their work, including the clinicians, acknowledging that certain posts need to be in place in order to progress the Major Trauma proposals. Members were reminded that development of a Major Trauma Network will result in more survivors, which will, in turn, increase demand on rehabilitation services. In view of this, Dr Donovan enquired whether there is a commitment to review and address deficiencies in Therapies. Ms Shakeshaft assured Members that the UHB recognise this as a key issue; with neuro-rehabilitation in particular being a significant challenge. The UHB will need to give further consideration to how it gets the best out of the resources it already has. Dr Donovan also highlighted that people who have experienced major trauma and head injuries will need to adjust while they recover. Psychology service provision also needs to be considered as part of this. Mr Moore confirmed that the organisation is aware of requirements in this regard, and will be developing a comprehensive rehabilitation services plan going forward. Miss Battle noted the CHC feedback regarding the need for ongoing communication with the public; and advised that staff at WGH A&E have expressed concerns around the impact of changes on their ability to retain clinical skills. With regard to the latter, Mrs Miles confirmed that the UHB is committed to offering all its trauma staff, across all sites, opportunities to ensure that they retain their skills. Dr Philip Kloer acknowledged that more work needs to be undertaken to discuss training requirements with staff. In the case of Major Trauma, patients may be in WGH or BGH for the first part of their treatment, or may be conveyed straight to GGH or the Major Trauma Centre at Cardiff under certain circumstances. Responding to the suggestion that further communication with the public is required, Dr Kloer reiterated the UHB's commitment to ongoing engagement, agreeing that staff need to be visible on a continuing basis. Whilst recognising public concerns, Dr Kloer emphasised that additional services and service plans will be coming online, including a 24/7 Emergency Medical Retrieval and Transfer Service (EMRTS) from spring 2020.	
	The Board: • **NOTED** progress made in the implementation of the MTN and **SUPPORTED** the path of travel in relation to:	

	○ The critical posts for Day One, Year One and in particular the Q4 costs 2019/20 of £70,232 and FYE up to £515,289; ○ The potential for a requirement for a capital scheme to deliver Landing Pad beds at a potential cost of £1.252m; ○ The annual costs for the new MTN, which are being developed as part of the PBC, will need to be included in the 2020/23 3-Year Plan; ○ In year costs 2019/20 totalling £165,500 to support the set-up of the MTC. • **COMMENDED** the extensive work carried out to deliver the successful engagement process in relation to the MTN and Glangwili Hospital's position as interim Trauma Unit and **THANKED** the University Health Board's lead clinicians and partner organisations for their involvement and commitment to the Programme.	

PM(19)161	**RECONFIGURATION OF SEXUAL ASSAULT REFERRAL CENTRES (SARCs) ACROSS SOUTH, MID AND WEST WALES**	
	Ms Rachel Hennessy and Dr Helen Munro joined the Board meeting. Members were advised that all Health Boards are considering the same paper at their Public Board meetings. Mrs Rayani introduced the Reconfiguration of Sexual Assault Referral Centres (SARCs) across South, Mid and West Wales report, advising that this represents the culmination of six years' work. Ms Rachel Hennessy suggested that the report is self-explanatory and very detailed, and drew Members' attention to the 14 recommendations therein. Ms Hennessy emphasised the commitment to work with local Community Health Councils, with a meeting scheduled for October 2019. There is also joint engagement with the Police & Crime Commissioners. Mr Mike Lewis acknowledged the work which has been undertaken, noting that proposals represent a considerable improvement on current arrangements. Referencing Recommendation 2, regarding paediatric out of hours services, Mr Lewis enquired whether there is a longer-term vision to increase the number of centres from one for all of the region. Dr Helen Munro explained that this is a challenging issue. The service provided, for both adults and children, needs to be both sustainable and safe; this requires a 'critical mass' of cases which allows medical professionals to maintain their clinical skills. There are currently insufficient paediatric cases in the Dyfed Powys area to ensure a safe and sustainable service. Whilst there is an ambition for an out of hours day service in Swansea, this would be dependent on the ability to staff such a service. Mr Burt emphasised the importance of the Third Sector in accessing people who are potentially at risk; whilst suggesting that the short-term contracts which are often utilised can cause issues for such agencies. Ms Hennessy advised that the Third Sector has been involved from the outset, and that their input has been crucial to the success of this project. The service has evolved, which has produced the need to utilise short-term contracts; however, the intention is for a structure to be implemented which allows longer-term contracts and commitments. It should be noted that there is a commitment to funding current services, which means that there is no risk to the existing service provision. Ms Raynsford noted that the report makes no mention of a commitment to the Welsh Language or other languages. With patients/victims using the service potentially being under duress, it is likely that their preference	

	would be to communicate using their first language. In response, Ms Hennessy suggested that she anticipates more extensive discussions and development of a detailed specification, whilst emphasising that a commitment to the Welsh Language has been identified. Clarification of the increased funding commitment for HDdUHB was sought, with Members noting that the figure is £38k. Miss Battle thanked Ms Hennessy and Dr Munro for their contribution, commending the project for putting the voice of service users at its heart. *Ms Hennessy and Dr Munro left the Board meeting.*	
	The Board: • **APPROVED** the overarching model for SARC services within South, Mid and West Wales, as follows: 1. There should be two paediatric hubs (Swansea and Cardiff) providing in-hours services for children up to their 16th birthday. Training and recruitment of staff will be required and a costed optional appraisal to identify appropriate accommodation in Swansea that meets forensic standards and standards for children's services 2. There will be one paediatric hub (Ynys Saff SARC) that will provide services out of hours for children across the region up to their 16th birthday, 3. Children 16-17 will have their forensic examination undertaken by an FME at the appropriate local SARC Hub at all times. This will be subject to evaluation and review moving forward. 4. There will be a commitment to developing appropriately trained paediatricians to undertake forensic medical examination for children presenting at the paediatric SARC hubs. It is anticipated this will take 3-5 years due to training requirements 5. There is a commitment to developing pathways for children up to their 16th birthday, who live in North Powys to attend for service in Colwyn Bay, North Wales, if they require a forensic medical examination 6. There will be a single adult hub in South East Wales, at Ynys Saff SARC, Cardiff which will provide services to the populations of South East Wales. SARC Spokes for the region will be in Risca and Merthyr Tydfil. Ynys Saff SARC Hub will also act as a spoke for Cardiff and Vale region. 7. There will be a single adult SARC hub in South West Wales provided in Swansea, which will provide services to the population of South Dyfed Powys region and Swansea. Swansea SARC Hub will also act as a SARC spoke for the Swansea region. 8. There will be a single adult SARC hub in Dyfed Powys provided in Aberystwyth, which will provide service to the population of Mid and West Wales. SARC Spokes for the region will be in Newtown and Carmarthen. Aberystwyth SARC Hub will also act as a SARC spoke for the Aberystwyth region 9. There will be a commitment from Police organisation to move towards a single provider for FME services across the region. This will be phased over 3-5 years due to existing contractual arrangements 10. There will be a commitment from Health organisations and police organisations to developing an NHS provided FME service throughout Wales. This will require a commitment to formal	

	training of healthcare professionals and recognition within job plans for trainers and trainees on a regional basis. This will also require commitment to management of new/existing contracts with private providers to support the training of clinicians. Funding will need to be clearly identified to support the training and running of an NHS provided model. It is anticipated this will take 5-10 years due to training requirements. 11. There will be a formal joint procurement process (health and police), led by NHS Wales to appoint the hubs and spokes across the regional service model. Consideration will need to be given to ensuring there is flexibility in the process to meet local population needs alongside the core requirements of the new service model 12. An All Wales SARC Delivery Network is established, comprising an Operational Delivery group and a joint Commissioning Board with a lead commissioning organisation. 13. A Lead commissioning organisation from health is appointed to establish and manage the contracts and commissioning framework as part of the Delivery Network 14. C&V UHB is formally appointed to host the Operational Delivery Group as part of the Delivery Network • **APPROVED** the proposal to move forward with implementation of phase 1; • **APPROVED** the proposed costs of £92,056 as Hywel Dda UHB's contribution to phase 1 of the SARC Model; • **SUPPORTED** the proposal to move forward with phase 2 and 3 – the development of costed service models for the spokes and FME services.	

PM(19)162	**REPORT OF THE QUALITY, SAFETY & EXPERIENCE ASSURANCE COMMITTEE**	
	Professor John Gammon presented the Quality, Safety & Experience Assurance Committee (QSEAC) update report, emphasising that the need to focus on mitigations and actions taken to address quality and safety issues is made explicit to sub-committees. This is in order to ensure that QSEAC is provided with sufficient information and assurance, and can escalate those areas where there is insufficient assurance. Professor Gammon stated that QSEAC welcomed in particular the funding for additional Aseptic Units; work on Stage 2 Mortality Reviews; and Patient Experience Charter work. The final draft of the latter is due to be considered at the next meeting. In terms of matters which QSEAC wish to bring to the Board's attention, Members heard that there are issues around training assessors for the Liberty Protection Safeguards, which have replaced the Deprivation of Liberty Safeguards; QSEAC will be monitoring this area. The Committee has concerns relating to infection prevention, which Professor Gammon suggested be discussed as part of the IPAR agenda item. QSEAC's other main concerns, lack of capacity in Nutrition and Dietetics and Mental Health & Learning Disabilities fragilities and risks, have been and are to be discussed separately by Board. Miss Battle thanked Professor Gammon for his report, welcoming the fact that a number of the substantive issues identified by QSEAC appear on the Board agenda as stand-alone items.	

	The Board **NOTED** the QSEAC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern together with actions being taken to address these.	

PM(19)163	**FRAGILITY OF MENTAL HEALTH SERVICES**	
	Mr Teape introduced the Fragility of Mental Health Services report, explaining that this is a development of the report discussed by QSEAC. Members heard that the risks outlined within the report are not 'new' to the service, which has been working to address them for some time. There is close management and oversight of risks, with monthly meetings to consider a range of indicators across Mental Health & Learning Disabilities (MH&LD). Despite the challenges, there are a number of excellent initiatives taking place within the directorate, which can be overlooked when focusing on the issues. For instance, HDdUHB leads in Wales in terms of listening to those with lived experience. Professor Gammon welcomed the report, which details the mitigations taken in response to risks and addresses QSEAC's concerns. Professor Gammon suggested, however, that it would be helpful for Members to have an understanding of the risks and potential consequences for patients. There are also workforce issues to consider, including how this should be redesigned to meet needs. For instance, it was suggested that the UHB should be considering how to upscale the advanced practitioner roles, now that the benefits and impact of these are clear. Mr Teape advised that this issue was discussed at the Transforming Mental Health (TMH) meeting on 25th September 2019. One of the directorate's lead nurses is an Advanced Practitioner and an Approved Clinician. A number of nurses are keen to develop their skills, and Mr Teape agreed that this is an area requiring active expansion; it is hoped that progress will be made by the end of this calendar year. Mrs Hardisty emphasised that, from her discussions with staff and managers within the MH&LD directorate, it is clear that there is huge commitment and enthusiasm. Mrs Hardisty queried whether certain of the elements of the TMH model can be brought forward, and what is required to increase pace in this regard, suggesting that this be discussed in detail outside the meeting. Members heard that the directorate has been successful in piloting and implementing projects; for example, the Recovery Forum which – whilst on a small scale – receives excellent feedback. Such a project would not require much investment/commitment to upscale. It was also suggested that the UHB should be more ambitious in terms of the numbers of advanced practitioners. In summary, Mrs Hardisty felt that, whilst there are a great deal of challenges, staff in the service are working incredibly hard and should be provided with the support they require. Mr Dentten reported that the CHC has seen a small but noticeable number of complaints from Mental Health service users. It is intended to launch a survey on World Mental Health Day on 10th October 2019, the findings of which will be shared with the UHB. Mr Dentten noted the suggestion within the paper to bring forward implementation of certain of the original TMH proposals and stated that, where this is happening due to operational pressures rather than the phased plan, the CHC would like to be provided with more detail. Referencing concerns around the visibility of quality and safety metrics, Mr Newman felt that it would be useful for relevant Board level	

	committees such as QSEAC to receive enhanced information on the quality and safety of services. Professor Gammon suggested that Board recognise that staff within this particular area are trying to transform services at the same time as they are maintaining the current service model and the sustainability of the current model. This places them under severe pressure and presents significant challenges. Mr Moore agreed, noting that Mental Health is in the position where the rest of the UHB's services will be soon; dealing with both day to day service delivery, together with transformation. Members were informed that the Executive Team have been discussing how it deploys corporate resources in terms of priorities in the short, medium and longer-term, noting that there will be potentially difficult discussions at Board regarding the future focus. It was agreed that a report outlining this work, to include the three transformation programmes, together with what actions are being brought forward, would be presented to the next meeting. This would consider the broader issues, including how both transformation and delivery of current services is being supported. Miss Battle requested that the patient safety and voice of the patient aspect are monitored by QSEAC. Members were reminded that every part of the TMH programme has involved service users and those with lived experience of services. West Wales Action for Mental Health and the CHC have both been active stakeholders from the beginning of the process, and there are no plans to change this approach. Miss Battle suggested that it would be useful for examples of this involvement to be included in the next report to QSEAC.	**SM** **MR** **JT**
	The Board: • **NOTED** the fragility of certain areas that are covered within the report and **TOOK AN ASSURANCE** that the MH&LD Directorate is taking all possible actions to mitigate the current risks; • **NOTED** that, where possible, the Health Board will progress with earlier implementation of elements of the TMH model; • **AGREED** that a further report be presented to the next meeting, to include the issues outlined above.	

PM(19)164	**HDdUHB SEASONAL INFLUENZA PLAN 2019/20**	
	Dr Jo McCarthy joined the Board meeting. Mrs Ros Jervis welcomed Dr Jo McCarthy, who presented the Seasonal Influenza Plan 2019/20 report, outlining the proposed vaccination focus for the upcoming year. This will be around children aged 2-3 years; individuals under 65 years of age at clinical risk, including pregnant women; and UHB staff. The UHB has doubled its number of Flu Champions; and has provided additional training to these individuals, which has been tailored to address previous questions and feedback from staff. Dr McCarthy advised that the various Quality Assurance measures to be employed are detailed within the report, and emphasised that the Influenza Plan is very much a dynamic document, which will evolve throughout the season. Members were thanked for their positive feedback regarding the plan and were informed that Flu vaccinations will be available following today's meeting. Miss Battle commended the report and plan. *Dr McCarthy left the Board meeting.*	
	The Board:	

	• **CONSIDERED** and **SUPPORTED** the positive, assets-based approach taken to the development and implementation of the Influenza Vaccination Improvement Plan this year which ensures a focus on collective responsibility for an improvement in uptake rates for the prevention of respiratory illness across our workforce and other eligible population groups. • **NOTED** that the approach to be taken this year is in line with the Health and Well Being Framework for Hywel Dda (Our Future Generations: Living Well) as approved by the Board in January 2019 with its focus on working with our population in order to understand vaccine hesitancy where it occurs and focus on a positive, assets based approach to improving the health of our communities.	

PM(19)165	**REPORT OF THE BUSINESS PLANNING & PERFORMANCE ASSURANCE COMMITTEE**	
	Mr Powell outlined the Business Planning & Performance Assurance Committee (BPPAC) update report, drawing Members' attention to the UHB's Major Incident Plan, which appears as the next agenda item. This document has been through various approval processes and any queries addressed prior to approval by BPPAC; it is now presented to the Board for ratification. In terms of concerns which BPPAC will continue to monitor and manage, Mr Powell highlighted the Health and Safety Executive (HSE) inspection, the findings of which had focused on violence and aggression, moving and handling and asbestos. There are concerns that the UHB is not being proactive regarding these findings, and risks being served with an improvement notice. There are also costs associated with the HSE having to conduct a revisit. By way of an update, Mr Teape explained that the information provided to BPPAC was derived from the Health & Safety and Emergency Planning Sub-Committee update report. The formal findings of the HSE inspection, which have not yet been received, will also be conveyed via the Board reporting structure. Members heard that two new posts are to be recruited: a Health & Safety Manager and a Violence & Aggression Manager, and an interim action plan has been developed to address concerns raised by the HSE. Mr Teape added that these issues are being discussed and monitored by both BPPAC and ARAC.	
	The Board **NOTED** the BPPAC update report and **ACKNOWLEDGED** the key risks, issues and matters of concern together with actions being taken to address these.	

PM(19)166	**HDdUHB MAJOR INCIDENT PLAN 2019/20**	
	The Board **APPROVED** the updated Major Incident Plan 2019/20.	

PM(19)167	**INTEGRATED PERFORMANCE ASSURANCE REPORT – MONTH 5 2019/20**	
	Mrs Miles presented the Integrated Performance Assurance Report (IPAR) for Month 5 of 2019/20, with Members invited to raise any issues and queries arising from the report. Professor Gammon highlighted the issue of waits for diagnostics and therapies treatments, noting that the UHB has previously received additional funding to address Referral to Treatment (RTT) times. Whilst	

Professor Gammon understood that a sustainable model is being developed, he queried whether this is having an impact, in view of the already increasing trajectory in waiting times. Secondly, Professor Gammon enquired whether there are plans for targeted interventions to address current 'hotspots' in terms of the healthcare acquired infections C.difficile, E.coli and S.aureus. In response to the first query, Mr Teape emphasised that this has been a challenging month across all sites. Members were assured, however, that there are plans to get back on course in target areas. Mr Teape explained that there is funding in the budget on a recurrent basis to address RTT, and that the three year plan will address this going forward. With specific regard to therapies, there are new Physiotherapists joining the organisation on a substantive basis. Miss Battle requested a broad outline of the plans to get the UHB back on course mentioned above. Mr Teape stated that the intention is to bring RTT breaches back down from 506 to zero; detailed exception reports have been prepared and there is no one issue causing the current breaches. For therapies, substantive staff are coming on-line and waits will go back to zero. In terms of diagnostics waits, endoscopy is back in balance and cardiology waits are expected to be back in balance, with some outsourcing necessary. Also in relation to diagnostics, the UHB has moved to a single RADIS system in Radiology, and work is taking place with the Informatics team to ensure that the correct scripts are being run to accurately report breaches. In regards to delayed follow-ups, a rapid improvement is expected due to ongoing validation work and the impact of outpatient transformation work. In combination, it is anticipated that these will allow the UHB to meet its commitment to Board and WG around RTT targets. Mr Teape emphasised that the most significant challenge currently is in unscheduled care, which is experiencing an extremely difficult period. The team are planning to focus activity on a smaller number of actions which can be progressed at pace.

Referencing infection rates, and the increase in E.coli specifically, Mrs Rayani believes that this is related to the heat during July and August 2019; the run chart indicates a drop in cases until that time. Mrs Rayani suggested that E.coli infection rates need to be considered and analysed over a longer period; there was an overall reduction last year, however it is recognised that the organisation is not where the Board would want it to be. The UHB is working hard to address all infection rates, particularly C.difficile. WGH is a specific area of concern, although this relates to the community rather than the hospital setting. Various actions are being taken, including antibiotic prescribing practice, with specific clinicians identified and interventions being made. In response to a query regarding the deterioration in performance around Delayed Transfers of Care (DTOCs), Mr Teape advised that this had also featured during discussions at ARAC. The actions being taken are set out in the report; specific concerns/issues are reablement capacity, packages of care availability and availability of care home and step-down beds in Carmarthenshire and Pembrokeshire. Concerns had been previously expressed that the escalations raised through Local Authority partners were not necessarily effective in producing additional capacity, as they tend to be reacting to specific cases. A more strategic/long-term view is required, with this needing to be an area of focus. It is hoped, however, that the Intermediate Care Resource being put in place via the

Transformation Fund investment will result in positive impact, with all three counties actively recruiting additional resource.

Ms Lewis enquired to what extent the UHB understands the knock-on impact for people, in terms of clinical outcomes and patient experience, of not receiving care within the anticipated timescale. Mr Teape replied that a number of reports have been prepared on this topic for QSEAC. The WG Delivery Unit have also undertaken a national report. The UHB is undertaking specific work around follow-up appointments, particularly delayed follow-ups, and is exploring how these might be classified using risk factors. Ms Lewis queried whether there is more the organisation can do in this regard, to improve the patient experience and manage expectations. It was highlighted that there is a psychological impact involved in waiting for appointments and treatment. Members heard that one of the Quality Improvement projects focuses on communication with patients. It was acknowledged, however, that the organisation can and should do more, particularly around proactive communication, which would not necessarily require major investment. This is an area where showing increased kindness and consideration could make a material difference. Mr Michael Hearty expressed concern regarding Consultant Job Plan numbers, suggesting that this performance is not satisfactory, particularly for an organisation undergoing transformation, and that job plans should be regarded as an expectation of staff. Dr Kloer clarified that the figures in the report relate to up-to-date job plans, assuring Members that 100% of consultants have a job plan. Performance in this regard is impacted partly by timing, and partly by the move to an electronic job planning system. Dr Kloer emphasised that the risks in this area are recognised. The original target was 90% of consultants and Specialty and Associate Specialist (SAS) doctors. Major progress has been made recently with a number of the larger specialties, which represents a significant development. Dr Kloer assured Members that the commitment made to ARAC of 90% completeness and currency in job plans in-year remains the objective.

Mrs Hardisty observed that performance around Delayed Follow-ups appears to be taking a retrograde trajectory; and enquired whether the organisation is addressing the issue of which patients should be followed-up, and whether consultant practice should be changed. Mrs Hardisty stated that a number of clinicians have suggested that this topic needs to be discussed, and discussed in all specialties, to ensure that the UHB follows best practice in this regard. Members heard from Mr Teape that, by the end of September 2019, every specialty has been tasked to define the criteria for what it will and will not follow-up, as part of the outpatient improvement work. Referencing earlier comments around prioritisation of resources, including corporate resources, Dr Kloer suggested that this area is one which could benefit from increased support. It involves large numbers of patients, and has significant impacts for those patients, including psychological and clinical risks. Dr Kloer acknowledged that there is variability within specialties and between specialties, agreeing with Mrs Hardisty's viewpoint. Members were assured, however, that there is clinical engagement in making changes with regard to Follow-ups. Mr Andrew Carruthers advised that all specialties have been requested to provide, for their top 5 high-volume pathways, what will and will not be followed-up. Real traction is

	starting to be seen in this area, and Mr Carruthers was optimistic this will result in improvements. Dr Donovan reminded Members that, behind performance figures, are clinical leaders and managers working hard to reduce waiting lists and improve patient flow. These managers are under a great deal of pressure and require support. Demands need to be balanced against their obligations to maintain staff wellbeing, morale and goodwill with performance management. Whilst it is important to make improvements for patients, particularly in teams that may be under performing, it is vital to recognise that managers must also be supported in their role to do this. Miss Battle reported that her first meeting with Independent Members (IMs) had taken place on 24th September 2019. From this, there had been a clear message regarding the absolute dedication and commitment of UHB staff, including the Executive Team. Noting the recent deterioration in urgent suspected cancer performance, Miss Battle enquired how and when this will be recovered, adding that it would be useful to include figures for the Single Cancer Pathway. Mr Teape highlighted that the backlog of cases is high, which will lead to further breaches. However, the expectation is that performance will improve to above 90% during the final quarter of the year. Swansea Bay UHB has recruited a number of new staff, which should assist with the backlog. The UHB has also received funding for a number of areas of the Single Cancer Pathway, largely around additional diagnostics capacity in endoscopy, radiology and pathology. Also for Cancer Multi-Disciplinary Team Trackers; individuals who will track cancer patients through the system and ensure that test results are expedited, etc. In addition to Single Cancer Pathway figures, Miss Battle also requested that performance in unscheduled care be drawn together in future iterations of the IPAR. There are various factors involved with unscheduled care performance, including medically optimised patients, DTOCs and community services. It was suggested that these require discussion at the Regional Partnership Board, it being a collective partnership. Miss Battle indicated that she would work with Mrs Miles and others to develop the IPAR. Miss Battle also enquired regarding confidence that the work being undertaken by KPMG will assist with improving the UHB's performance. Mr Moore stated that, whilst it was difficult to offer absolute assurance in this regard at this point, various work is ongoing. Mr Thomas indicated that, in order to improve financial performance, there is a need to improve operational performance. The organisation is still currently at the stage of diagnosing the key issues. Miss Battle concluded by recognising the significant work taking place around the organisation's performance. Although this is not necessarily where it should be, there is confidence that improvements can be made. Referencing earlier discussions, Miss Battle requested that further detail be provided at the next Board regarding the aforementioned work around prioritisation, focusing and release of resources.	**MB/KM** **SM**
	The Board **DISCUSSED** the Integrated Performance Assurance Report for Month 5 2019/20 and issues arising from its content.	

PM(19)168	**STRATEGIC EQUALITY PLAN ANNUAL REPORT 2018/19**	
	Ms Jennings introduced the Strategic Equality Plan Annual Report, reminding Members of the successful 'This is Me' Conference, co-hosted by HDdUHB and Swansea Bay UHB on 4th July 2019. Ms	

	Jennings highlighted Appendix 1 of the report, which provides a useful representation of population demographics in each county; enabling a greater understanding of local communities, their diversity, and the challenges they face. Members' attention was also drawn to the Workforce Equality Annual Report and Gender Pay Gap Report, the latter having been prepared by Mrs Gostling and her team. In preparing the report, the following key messages have been identified: • The importance of the UHB's Continuous Engagement and Consultation Framework; • Improvements to translation and interpretation services (based on positive feedback from patients and their families); • Relaunch of ENFYS, the LGBTQ+ staff network; • Refresh of diversity and inclusion training at staff induction; Ms Jennings concluded by emphasising that there is much work to do within the next three years, and assured Members that this will be factored into the UHB's 3 year plan. Cllr. Hancock suggested that the report demonstrates the great strides made in equality and diversity by HDdUHB as a Board and organisation, highlighting in particular improvements in mandatory training levels. Members were also informed that funding for two new strategic partnership and inclusion managers had been identified, together with monies to support a Diversity and Inclusion Innovation Fund. Cllr. Hancock also welcomed the provision of specialist training where required, and the relaunch of ENFYS. Whilst there is more to be done, Cllr. Hancock suggested that the Board deserves recognition for its commitment to this area. Referencing the Gender Pay Gap Report, and specifically the 'Next Steps' outlined on page 8, Ms Lewis enquired whether there are any plans to examine examples of best practice from other organisations, and whether it is intended to extend this analysis to include other pay gaps, such as those relating to disabilities. Mrs Gostling confirmed that the UHB does plan to learn from good practice elsewhere, and will be examining various sectors of the workforce to analyse pay gaps.	
	The Board: • **RECEIVED** the Strategic Equality Plan Annual Report 2018/19 for assurance on the work which has been undertaken to meet the PSED and HDdUHB equality objectives; • **NOTED** that it will receive an updated Strategic Equality Plan and Objectives 2020-2024 for approval in March 2020.	

PM(19)169	**REPORT OF THE FINANCE COMMITTEE**	
	Mr Hearty outlined the Finance Committee reports from meetings in July and August 2019, adding that there had also been a meeting on 24th September 2019. In order to achieve the Control Total set by WG, the UHB needs to deliver its savings plans and meet the directorate budgets set by the organisation. Members heard that, in terms of the first of these objectives, gaps in savings plan delivery remain; in regards to the second, directorates have forecast pressures of £5m. Mr Hearty emphasised that this represents a high risk situation, and that the Finance Committee are, therefore, only able to provide limited assurance around achievement of the Control Total. The Director of	

	Finance and other Executive Directors have been requested to supply additional information and plans outlining how they intend to achieve the required financial position.	
	The Board **NOTED** the Finance Committee update report and **ACKNOWLEDGED** the key risks, issues and matters of concern together with actions being taken to address these.	

PM(19)170	**FINANCE/TURNAROUND UPDATE – MONTH 5 2019/20**	
	Mr Thomas presented the Finance and Turnaround Update for Month 5 of 2019/20, drawing Members' attention to the additional £10m WG funding received during Month 4, which reduces the Control Total set by WG to £15m. The organisation's position is currently at £3.1m variance to plan for the year. In terms of the objectives mentioned by Mr Hearty, and specifically departmental budgets, Mr Thomas highlighted specifically challenges in unscheduled care, which included operational surge pressures and reliance on agency staff, particularly nursing staff. There has also been an increase in drugs costs in both primary and secondary care, with the pressures in primary care being due to a growth in cost, not necessarily usage. There have also been additional costs associated with the TB outbreak. The overall projection including savings risk is an adverse variance to plan of £11.5m, which would equate to a year end deficit position of £26.5m. Mr Thomas highlighted that this would have an impact not just on the current year, but recurrently. As outlined by Mr Hearty, Members heard that the Executive Team has been tasked to consider potential savings opportunities. These will include any findings from the work being undertaken by KPMG, which falls into 5 areas: controls; productivity (in secondary care in particular); potential short-term opportunities to move care into the community; services which are duplicated across sites; and service transformation (to a limited extent). KPMG's contract is due to end at the end of September 2019, and the organisation will work with them on their findings. Mr Thomas emphasised that the Executive Team is committed to responding to the challenges faced by the organisation and exploring potential opportunities for further savings. Mr Carruthers confirmed that the UHB is working closely with KPMG and is taking on board any recommendations and suggestions which can be implemented before it receives their formal findings. The organisation has been working hard to gain assurance around the risk assessment of savings schemes, which had resulted in a reduction from £6m to £3m. In terms of the savings 'gap', whilst there is no shortage of ideas for potential savings, the issue is how these can be translated into reality. Mr Carruthers reminded Members that, if improvements are made to quality and performance, financial savings will follow. The actions Board is discussing around improvements to quality and performance will drive savings delivery and delivery of the Control Total set by WG. Cllr. Hancock noted the increasing cost of unscheduled care, and enquired whether the proposed recovery plan for WGH has been fully implemented yet. Mr Teape explained that a range of actions are ongoing, including plans around the Emergency Department. Physicians have been allocated one ward each and are applying Test of Change processes. An Ambulatory Care Unit is in operation, and various other improvement work is being actively implemented. Mrs Hardisty emphasised that IMs will support initiatives and staff wherever possible,	

	whilst requesting assurance that basic principles of 'grip and control' are in place. Mr Thomas stated that two areas KPMG have reviewed to date are non pay costs and pay/workforce costs. Examples of good practice had been identified for the former; however, issues requiring increased focus regarding the latter had been identified. There is work in a number of areas which needs to be taken forward. Mr Moore emphasised that the UHB remains committed to achievement of the £15m Control Total. If this position is realised, it will be only the second time the organisation will have been able to reduce its financial deficit. It is vital for the organisation to return to plan in terms of finances, and all current work must be focused on improving quality and safety, together with delivering the required financial position. Miss Battle commended the exceptional progress made by HDdUHB last year, emphasising the need to join forces and make improvements for public and patients.	
	The Board **NOTED** and **DISCUSSED** the financial position for Month 5 2019/20.	

PM(19)171	**COMMITTEE UPDATE REPORTS: BOARD LEVEL COMMITTEES**	
	Mrs Wilson outlined the Board Level Committees update report, drawing Members' attention to those matters requiring consideration or approval by the Board and the areas of concern and risk which had been raised by the Committees.	
	The Board: • **ENDORSED** the updates and **RECOGNISED** matters requiring Board level consideration or approval and the key risks and issues/matters of concern identified, in respect of work undertaken on behalf of the Board at recent Committee meetings; • **APPROVED** the SRG's revised Terms of Reference.	

PM(19)172	**COMMITTEE UPDATE REPORTS: IN-COMMITTEE BOARD**	
	The Board **RECEIVED** the update report of the In-Committee Board meeting.	

PM(19)173	**COMMITTEE UPDATE REPORTS: HDdUHB ADVISORY GROUPS**	
	The Board **RECEIVED t**he update report in respect of recent Advisory Group meetings.	

PM(19)174	**HDDUHB JOINT COMMITTEES & COLLABORATIVES**	
	The Board **RECEIVED** for information the HDdUHB Joint Committees & Collaboratives update report.	

PM(19)175	**STATUTORY PARTNERSHIPS UPDATE**	
	The Board **RECEIVED** the Statutory Partnerships Update report and **NOTED** the progress updates for our collaborative working with each PSB and the RPB.	

PM(19)176	**HEALTHCARE INSPECTORATE WALES ANNUAL REPORT 2018/19**	
	The Board **NOTED** the Healthcare Inspectorate Wales Annual Report 2018/19.	

PM(19)177	**BOARD ANNUAL WORKPLAN**	
	The Board **NOTED** the Board Annual Workplan.	

PM(19)178	**ANY OTHER BUSINESS**	
	There was no other business reported.	

PM(19)179	**DATE AND TIME OF NEXT MEETING**	
	9.30am, Thursday 28th November 2019, Y Stiwdio Fach, Canolfan S4C Yr Egin, College Road, Carmarthen SA31 3EQ	

TABLE OF ACTIONS FROM
HEALTH BOARD MEETING IN PUBLIC
HELD ON 26TH SEPTEMBER 2019

MINUTE REFERENCE	ACTION	LEAD	TIMESCALE	PROGRESS
PM(19)146	**PATIENT STORY:** • To work in conjunction with Mrs Annmarie Thomas on proposals around potential changes to the UHB's Carer's Policy.	LG	~~November 2019~~ March 2020	The timescale for ensuring the process of implementing the Carer's Policy is likely to extend into next year.
PM(19)147	**PUBLIC FORUM:** • To provide letters of response to the questions received and to ensure that responses are available on the UHB website.	MB	September 2019	Completed.
PM(19)152	**MINUTES OF THE ANNUAL GENERAL MEETING HELD ON 30TH JULY 2019:** • To make the amendment required.	CM	September 2019	Completed.
PM(19)154	**REPORT OF THE CHIEF EXECUTIVE:** • To provide an update on OOH services to the next meeting, as part of the full report on winter planning for 2019/20; • To provide an update on discussions regarding Llanelli Wellness Village workforce issues to the next meeting;	JT KM	November 2019 November 2019	Forward planned for 28th November 2019 Public Board meeting. Provided within Health & Care Strategy Update report.

MINUTE REFERENCE	ACTION	LEAD	TIMESCALE	PROGRESS
PM(19)155	**REPORT OF THE AUDIT & RISK ASSURANCE COMMITTEE:** • To provide a discharge planning update.	JT	November 2019	Forward planned for 28th November 2019 Public Board meeting.
PM(19)163	**FRAGILITY OF MENTAL HEALTH SERVICES:** • To present to the next meeting a report outlining discussions regarding corporate resources and priorities, to include the three transformation programmes, and actions being brought forward. To consider the broader issues, including how both transformation and delivery of current services is being supported; • For QSEAC to monitor the patient safety and voice of the patient aspect of Mental Health services; • To include in the next report to QSEAC examples of service user and stakeholder involvement in the TMH programme.	SM MR JT	November 2019 December 2019 December 2019	Forward planned for 28th November 2019 Public Board meeting. Further information to be included in report from Mental Health and Learning Disabilities Quality, Safety & Experience Sub-Committee. To be included in report from Mental Health and Learning Disabilities Quality, Safety & Experience Sub-Committee.
PM(19)167	**INTEGRATED PERFORMANCE ASSURANCE REPORT – MONTH 5 2019/20:** • For the Chair to work with Mrs Karen Miles and others to develop the IPAR;	MB/KM	November 2019	Following a request to make the Board performance report more accessible for the general public and to focus on key priorities at Board level, a meeting took

MINUTE REFERENCE	ACTION	LEAD	TIMESCALE	PROGRESS
				place between the Chair and Director of Planning, Performance & Commissioning, and subsequently, the report was reformatted. The performance report is a work in progress, and will be enhanced over the coming months as further feedback is received and as the UHB responds to its priorities
	• To provide further detail at the next meeting regarding the work around prioritisation, focusing and release of resources.	SM	November 2019	As for PM(19)163, above. Forward planned for 28th November 2019 Public Board meeting.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Report of the Chair
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Miss Maria Battle, Chairman
SWYDDOG ADRODD: **REPORTING OFFICER:**	Miss Maria Battle, Chairman

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide an update to the Board on relevant matters undertaken by the Chair of Hywel Dda University Health Board (the UHB) since the previous Board meeting.

Cefndir / Background

This overarching report highlights the key areas of activity and strategic issues engaged in by the Chair and also details topical areas of interest to the Board.

Asesiad / Assessment

Chair's Action

There may be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances the Chair, supported by the Board Secretary as appropriate, may deal with these matters on behalf of the Board.

There has been one such action to report since the previous meeting of the Board, which relates to the Outline Business Case for the Cross Hands Health & Wellbeing Centre, the details of which are attached as Appendix 1 to this report.

Patient Story – Taking Forward the Issues

At the September 2019 meeting of the Board, Annmarie Thomas, who is also a member of staff, presented a powerful and moving story about her experiences as a patient. Annmarie made suggestions for improving patient experience, many of which we are taking forward.

Annmarie has joined the Employers Carers Group which is looking at proposals to strengthen the UHB's Carers Policy to ensure that it is even more compassionate and enables flexible working for staff who are carers. This is key to retention, good attendance and compassionate leadership. We will be celebrating Carers Rights Day on 21st November 2019, reaching out to staff who are carers.

Following the success of the Active Passive Trainer, which is already making a significant difference in terms of patient recovery and motivation and having a positive impact on the workload of physiotherapy staff, we are looking to purchase additional machines with charitable funds, to be sited across the UHB.

We are also looking at where we have patient drop-off zones at hospital sites, as this helps patients in getting to their appointments, with Glangwili General Hospital for example having such a facility. We will also be introducing more staff recognition awards.

Board Seminar 17th October 2019

Board Members received a presentation on Quality Improvement, including the UHB's current position and its future ambitions. Members agreed that the EQIP programme is proceeding well. The Board discussed patient safety walkrounds and agreed how important these were for quality assurance. These have been reinvigorated and increased.

The Board considered the Duty of Candour, enshrined in the Health & Social Care (Quality & Engagement Wales) Bill which will become an Act next year, and the implications for the UHB. It is proposed that careful consideration be given to training and how the Board will comply with the legal requirements. The Board also agreed to introduce a "Speaking up Safely" process to encourage staff to speak up about patient safety issues. A Task and Finish Group, 'Hywel Dda Speak Up 'has been set up to take this forward across the UHB.

Mencap presented 'Improving Lives – Cross Government Programme'. The positive work undertaken by the UHB in relation to learning disabilities was acknowledged and an invitation was extended to Mencap to contribute to a forthcoming workshop. Matters to be considered by the Board going forward include focusing on early intervention and consideration of the pathway for people in crisis.

The final item of the Board Seminar focused on the UHB's preparations for Brexit. The Board was informed of the review of risk assessments and business continuity plans having been undertaken as far as they possibly could across the organisation.

Key Meetings

I have continued to meet with front line staff across Hywel Dda, including maternity services, A&E departments, community services, palliative care, medical records, the concerns team, ward staff in all our hospitals, apprentices and managers and leaders in the three counties. I have also been meeting with patients and their families. It is important that, as a Board, we listen to our staff and patients and thank our staff for their dedication and service in these continuing challenging times.

I also attended the following meetings:

- NHS Wales Health Collaborative Leadership Forum
- NHS Chairs Meeting/Chairs Ministerial Meeting
- SARC Project Board
- Partnership Council for Wales
- All Wales Public Service Leaders' Summit
- Introductory meetings with Council Leaders
- Introductory meetings with AMs
- Vice Chancellor of Aberystwyth University
- Pembrokeshire Public Services Board
- National Primary Care Conference

Events/Visits

On 27th September 2019, I was delighted to join the Neville family at the launch and handover of a Mobile Entertainment Unit to Cilgerran Ward at Glangwili General Hospital. Merlin's Magic Wand is a children's charity that supports children facing challenges of serious illness, disability or adversity around the world, and Elly's Ward 10 Flag Appeal wrote to Merlin Entertainments asking for support and were introduced to the charity. The charity kindly offered to donate one of their Mobile Entertainment Units to a children's ward of her choice and the family chose Cilgerran Ward. We are very grateful for this gift and the continued support and generosity of the Neville family and the Ward 10 Flag appeal is much appreciated.

It was an honour, on 17th October 2019, to join in celebrating the Value & Impact of Occupational Therapy from Cradle to Grave in West Wales, in the presence of Her Royal Highness, The Princess Royal, Patron of the Royal College of Occupational Therapists. The Chair of the Royal College and the Chief Therapies Adviser for Wales were also present. Occupational Therapy has been making a difference to the lives of our population in many ways and areas. This event was an excellent opportunity to celebrate the successes of our workforce, who showcased their achievements, and to share the vital contribution of occupational therapy in transforming our services for the population of West Wales.

I am pleased to report that Aberaeron's flagship new Integrated Care Centre opened its doors to the public on 21st October 2019, bringing joined-up health and social care to local communities for the first time. In a landmark moment for the transformation of health and social care in West Wales, the centre at Minaeron will provide everything from GP appointments and clinical services which were previously provided at Aberaeron hospital, to district nursing and social care teams, third sector organisations and the Porth Gofal multi-disciplinary team. I met with all the teams who were excited at the prospect of being able to work together in such an excellent facility.

The project was funded with the support of over £3m of capital funding from the Welsh Government as part of the first phase of projects included in the Primary Care Pipeline, launched by the Health & Social Services Minister in December 2017. Additional funding of more than £400,000 was provided from the Miss Bessie Anne Jenkins Legacy Fund for the purpose of supporting healthcare services in the Aberaeron locality.

Celebrating Success/Awards

RCN Wales Nurse of the Year Awards 2019

Congratulations to our award winning nurses at the RCN Wales Nurse of the Year Awards 2019:

- Sarah Morgan, All Wales Mesothelioma UK Clinical Nurse Specialist and Senior Macmillan Lung Cancer Specialist Nurse won the Advanced and Specialist Nursing Award;
- Allyson Lloyd-Thomas, Senior Primary Care Nurse Advisor and Senior Practice Nurse won the Primary Care Nursing Award;
- Kathy Senchal, Practice Nurse was runner up in the Primary Care Nursing Award;
- Terri-Ann Patrick, Team Leader, ART, Ceredigion and Community Resource Team was runner up in the Community Nursing Award.

We are incredibly proud of you all, and all of the nursing staff across Hywel Dda University Health Board.

Workforce and Organisational Development Awards
Careers Wales Valued Partner Awards

- Gold Award Winner
- Outstanding Contribution Award Nominee

HPMA 2020 Wales Awards

- Organisational Development Team Award for excellence in the Education, Learning and Development Category.

NHS Wales Awards

We are celebrating three of our projects which made it to the finals of this year's NHS Wales Awards, organised by 1000 Lives Improvement. They were announced as winners for:

- Delivering higher value health and care
  Hywel Dda UHB - Implementing Healthy Footsteps a Partnership Approach with Podiatry and the Education Programme for Patients (EPP) in Hywel Dda
- Empowering people to co-produce their care
  Hywel Dda UHB - The Learning Disabilities Dream Team
- Working seamlessly across the public and third sector
  Hywel Dda UHB; MIND Cymru; Department of Work and Pensions - Working Collaboratively to Improve Vocational Outcomes for Individuals Accessing The Early Intervention in Psychosis Service

Nine awards were presented to organisations across Wales for their innovative work that has transformed the experience and outcomes for people in Wales.

We are also celebrating after the Community Midwives in North Ceredigion were recipients of two awards in recognition of their home birth skills. The team were recognised at this year's Maternity and Midwifery Awards for their efforts in promoting the home birth service and increasing the local home birth rate significantly. The team also won an Iolanthe Midwifery Trust award, which will allow the team to attend an "Appropriate Skills and Appropriate Places" workshop to improve home birth services.

On 26th November 2019, Welsh Government is holding the first Allied Health Professional, Healthcare Scientist and Pharmacy Conference. This new awards programme is open to AHPs, healthcare scientists and pharmacists throughout Wales, recognising and celebrating the achievements of all three professions, with 8 awards open to enter. I am pleased to report that we have had success with the following:

- One poster accepted (out of over 100 entries and only 20 shortlisted) – John Davies, Senior Physiotherapy Manager "Musculoskeletal MRI requesting is an overused resource: Can a multi-disciplinary group reduce inappropriate referrals from primary care to secondary care?"
- One presenter accepted – Paula Jeffery (Welsh Ambulance Services NHS Trust) "Advanced Paramedic Practitioners working within GP Out of Hours services in Hywel Dda University Health Board."
- One member of staff shortlisted for an award (again out of over 100 entries) – Meryl Davies, Primary Care Antibiotic Pharmacist, for Pharmacist of the Year Award.

We are immensely proud of every award winner's commitment and achievements, all of which benefit our patients across Hywel Dda.

Employee or Team of the Month
Members of staff, patients, service users and the public are invited to nominate those who have gone above and beyond the call of duty and to highlight excellent work. As I advised at the last Board meeting, it is really important that we recognise and celebrate our staff; and the employee or team of the month awards will continue and I intend to introduce more awards. I am currently reviewing the staff awards recognition scheme in general, with a view to a re-launch by the end of the year.

Independent Board Members Update
With this Board meeting, it is with regret that we see the departure of Mr David Powell as an Independent Member of the Board. During his time on the Board, David has been an exceptionally committed and pro-active Member, and his contribution to the organisation has been significant. I would like to sincerely thank David for all the work he has undertaken on behalf of the Board and wish him well for the future.

I am pleased to announce that the Minister for Health and Social Services has appointed Maynard Davies as Independent Member of the Board, Information, Communications and Technology.

Another Departure
This will also be the last Board meeting for Mr Joe Teape, Deputy Chief Executive and Executive Director of Operations, before he moves on to pastures new. During his time with us at Hywel Dda, Joe has made a significant contribution in driving this organisation forward and I would like to thank him sincerely for all the work he has undertaken and wish him well in his new post.

Argymhelliad / Recommendation

The Board is asked to:

- Support the work engaged in by the Chair since the previous meeting and to note the topical areas of interest.
- Ratify the action undertaken by the Chair on behalf of the Board, detailed in Appendix 1.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Chairman's Diary & Correspondence
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Chairman

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No impact
Ansawdd / Gofal Claf: Quality / Patient Care:	Ensuring the Board and its Committees makes fully informed decisions is dependent upon the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
Gweithlu: Workforce:	No impact
Risg: Risk:	No impact
Cyfreithiol: Legal:	No impact
Enw Da: Reputational:	No impact
Gyfrinachedd: Privacy:	No impact
Cydraddoldeb: Equality:	No EqIA is considered necessary for a paper of this type.

Appendix 1 - Register of Chairman's Actions 2019/2020

Serial No.	Requesting Department	Details of Request	Cost, where applicable	Date Issued	Date Signed by Chair
115	Planning, Performance & Commissioning	Cross Hands Health & Wellbeing Centre Approval of Outline Business Case. Capital funding is sought from Welsh government as part of the All Wales Pipeline for primary care projects. The scheme will have a revenue consequence for the Health Board, however the Board has considered the project to be a key deliverable in the future model of care as defined by the Health Board's Transforming Clinical Services programme and its subsequent Health and Care Strategy 'A Healthier Mid and West Wales; Our Future Generations Living Well'. This approval assumes the strategic funding of the capital charges by Welsh Government.	Gross Capital Cost of £25,636,939 Additional Revenue Cost £438, 345 Additional Depreciation Cost- £776,948	**23/10/2019**	**31/10/2019**

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Chief Executive's Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Steve Moore, Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sian-Marie James (Head of Corporate Office) and Yvonne Burson (Head of Communications)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to:

- Update the Board on relevant matters undertaken as Chief Executive of Hywel Dda University Health Board (the UHB) since the previous Board meeting held on 26th September 2019; and
- Provide an overview of the current key issues, both at a local and national level, within NHS Wales.

Cefndir / Background

This report provides the opportunity to present items to the Board to demonstrate areas of work that are being progressed and achievements that are being made, which may not be subject to prior consideration by a Committee of the Board, or may not be directly reported to the Board through Board reports.

Asesiad / Assessment

1. Register of Sealings

The UHB's Common Seal has been applied to legal documents and a record of the sealing of these documents has been entered into the Register kept for this purpose. The entries at ***Appendix A*** have been signed by the Chair and Chief Executive or the Deputy Chief Executive (in the absence of the Chief Executive) on behalf of the Board (Section 8 of the UHB's Standing Orders refers).

2. Consultations

The UHB receives consultation documents from a number of external organisations. It is important that the UHB considers the impact of the proposals contained within these consultations against its own strategic plans, and ensures that an appropriate corporate response is provided to highlight any issues which could potentially impact upon the

organisation. A status report for Consultation Documents received and responded to is detailed at ***Appendix B***, should any Board Member wish to contribute.

3. Listening and what we've heard

We are continuing to talk to our staff, communities and partners on multiple issues, as part of our commitment to continuously engage and benefit from the different skills, experiences and insights which working in this way offers us.

One of the highlights since my last report has been joint engagement activities on health and well-being in the Amman and Gwendraeth areas, which were delivered by the UHB and Carmarthenshire County Council. This has started the conversation around how we use and further develop Amman Valley Hospital, as well as other health and well-being services in the community. The engagement exercise has allowed us to gather information on the perceived strength and 'assets' we already have in those communities and also consider ideas for future developments and needs. We are planning more events in the area and look forward to continuing to work with this community.

We've also been delighted to see some of our partnership work come to fruition in the Ceredigion community, such as the newly opened Aberaeron Integrated Care Centre and forthcoming Cardigan Integrated Care Centre. This has been welcomed by staff, patients and the wider community, with lots of social media activity and excitement in the community itself. I was humbled to work alongside some of our estates staff and staff based at Aberaeron when they moved in, and was really impressed with what I saw, which is no doubt a much more pleasant and integrated health and care facility for that population and the staff who work from there.

We have been concerned to hear about the problems our staff have encountered with new parking enforcement at Glangwili and Prince Philip Hospitals, and potential traffic safety issues this has caused, particularly on the Glangwili site. For this reason, whilst we still ask staff to adhere to new parking arrangements to protect patient spaces at our hospitals, we have taken the decision to suspend enforcement (and refund previous fines) relating to staff parking in patient areas. This does not apply to those parked in zero tolerance zones. The suspension and cancellation of parking charge notices recognises that the plan we had developed has not had the impact we had hoped, with most staff within a 20 minute commuting distance who were asked to find alternatives to driving to work, qualifying for exemption. Whilst the suspension is in place the Executive Team and Parking Team are implementing some additional solutions, although options are limited. I have therefore met with staff on both sites to ask for their support in reducing congestion on site and doing their very best to protect parking spaces. I was heartened by the sense of responsibility to help that staff expressed at the meetings and the number of ideas coming forward. We will need to harness this and work with staff to test and implement these ideas. Everyone attending the meetings agreed that we must avoid placing stress and frustration on patients and their visitors, and that we will all need to work together to improve the situation on each site.

I have also been privileged to hear about many staff awards and recognition and continue to be very proud to be Chief Executive of an organisation that has such extraordinary and dedicated staff. Staff in Pembrokeshire, as well as some of our partner organisations, patient representatives and volunteers, swept up several awards at the Western Telegraph Health and Care Awards. Our diabetes consultant Dr Sam Rice, based at Prince Philip Hospital, also won the first ever NHS Wales Outstanding Contribution for Services in Diabetes at the Quality in Care Diabetes Awards. Our Occupational Therapy staff were championed and pleased to showcase their work to Royalty when Princess Anne, Patron of the Royal College of

Occupational Therapists attended our OT showcase day. The event was a huge success in demonstrating the value OT offers our patients and communities. There have likely been other awards and achievements by our staff and I thank them all for their hard work and commitment to the local NHS.

Equally, I have been really proud to hear from some of our staff who feel valued in their work as part of a video series our workforce team co-ordinated to celebrate World Values Day. As an organisation, we want to go further in valuing our staff and creating a value-based culture. We also celebrated our uniqueness in a video about our diverse workforce and this was well received by staff and the public, and we hope has gone some way to demonstrate and celebrate our diversity.

4. Strategic Issues

The following information is to update and advise Members of recent strategic issues affecting the UHB and NHS Wales:

Update on the Targeted Intervention Meetings held on 27th September 2019 and 31st October 2019

Members of the Executive Team and I met with the Chief Executive NHS Wales and members of his senior team, Welsh Government (WG), as part of our Targeted Intervention (TI) status on 27th September 2019 and 31st October 2019.

The following matters were discussed:

27th September 2019

(i) Performance

- Although it was agreed that the focus of the meeting would be finance and planning, WG was concerned about the recent dip in Cancer performance, which was due partly to the need for tertiary care for over half the patients waiting for treatment. The UHB confirmed that additional capacity had been sourced and that previous good performance in this area is expected to be seen by Quarter 4.
- There was also some concern that the recent pension changes had impacted on the UHB's ability to maintain clinical support to its Emergency Departments, although clinical staff had been willing to be flexible in supporting services despite this.

(ii) Finance and Turnaround

- WG was seeking assurance that the UHB could reach its Control Total (£15m), and particularly wanted the UHB to be clearer on its achievable plan. WG suggested fortnightly updates with the Finance Delivery Unit and asked the UHB to identify the savings plans and demonstrate how these will achieve the proposed target at the next TI meeting.
- KPMG colleagues also attended the meeting and were grateful to the UHB for its support and its openness; WG was pleased to see the organisation being open and transparent in its approach. KPMG felt that there remained an over reliance on an agency and locum workforce and that the UHB needed to make a bigger shift from acute services to primary care. There were also pockets of innovation and practice that could be applied across the whole of the UHB.
- It was acknowledged that the Clinical Strategy and the Transformation Fund would support this direction of travel, with the UHB's core team being realigned to focus on and support current delivery, to ensure delivery of the savings schemes.

(iii) Annual Plan 2019/20

- The UHB felt that it was in a strong position to have a 3-year plan, by moving ahead with delivery of the Health & Care Strategy.

- In addition, the Executive Team had both individual and corporate objectives focused on delivering the Health & Care Strategy through a 3-year plan.
- This will be tested by the Board to ensure that quality, workforce and finances are aligned fully. WG was encouraged by the focus on planning.

In conclusion, WG reiterated the importance of focusing on the opportunities within the UHB to move into a more positive and sustainable position.

31st October 2019

(i) Performance

- WG acknowledged that all Health Boards in Wales had challenges in meeting the Referral to Treatment times target, and urged the UHB to contain its slight dip in performance in this area. On a positive light, there was a reduction in the waiting times for diagnostics and therapies, and the appointment of a consultant for gynaecological cancers in Swansea Bay UHB.
- It was also acknowledged that Unscheduled Care services, particularly in the south of the UHB, were under pressure due to both demand on the service and staffing shortages in A&E. There was concern about the potential negative impact on staff and on patient experience.
- The improvement in the UHB's Complaints performance was welcomed, with the UHB now being in one of the top two organisations in NHS Wales.

(ii) Finance and Turnaround

- WG expressed disappointment that the UHB was not in the financial position it had hoped it would be at this point in the financial year, and recommended that the UHB kept a weekly control over the financial deficit with five months left to see incremental improvements. WG agreed to facilitate support from the Financial Delivery Unit and KPMG to identify any further savings.
- WG was seeking assurance that the UHB Board was aware of and considering what actions needed to be taken to meet the Control Total for 2019/20 and planning for 20120/21.
- The UHB was urged to work with its partners in utilising the Transformation Funds as soon as possible, as a driver for implementing a shift from hospitals into the community.

(iii) Planning

- The UHB's strategic approach was acknowledged, with a request that the UHB provides a clear timeline to demonstrate the start of the strategic elements.
- WG sought assurance that the UHB had a Financial Strategy working alongside its planning process to provide them with confidence that the strategic objectives would be delivered in 2020/21.

<u>Brexit</u>

Following EU leaders granting a 'flextension' of Article 50 until 31st January 2020 and subsequently MPs voting to hold a general election on 12th December 2019, the immediate risk of a 'no deal' outcome has passed. However, planning arrangements for the health and social care sector continues. Until a Withdrawal Agreement is accepted by UK Parliament the risk remains for the UK to leave without a deal at the end of January 2020. In response to these developments, Operation Yellowhammer daily situation reporting requirements have again ceased (having commenced on 21st October, 2019).

On 31st October 2019, the Director General Health and Social Services issued a letter to health and social care Chief Executives, explaining what the extension means for planning arrangements together with his expectations for Health Boards during this time. Through our Brexit Steering Group, the UHB will continue to meet these expectations, and maintain the

required enhanced level of preparedness. Supporting our workforce remains a key priority and we are continuing to provide encouragement and support to our EU staff to apply for the settled status scheme.

Give a Gift
Hywel Dda Health Charities has launched its annual Christmas ***Give a Gift Appeal***. The Give a Gift Appeal aims to brighten the lives of children and young people with life-limiting and life-threatening conditions across Carmarthenshire, Ceredigion and Pembrokeshire. The Give a Gift Appeal encourages our local communities to purchase a gift from a selection of items which have been carefully chosen by our clinical teams that will be of benefit to the children and young people that we care for at home, in hospital and in the community.

The Give a Gift wish list can be found by visiting: www.hywelddahealthcharities.org.uk/giveagift

5. Operational Issues

The Twilight Sanctuary, Llanelli
One of the first projects from the Transforming Mental Health programme has become operational in Llanelli. The Twilight Sanctuary is open Thursday to Sunday from 6pm to 2am, to offer a place of sanctuary for adults at risk of deteriorating mental health, when other support based services are closed. It will provide an easily accessible facility based in the centre of Llanelli that provides a warm and caring environment for individuals and their carers who require support with their mental health during the much needed out of hours period.

Transfer of responsibility for the Stop Smoking Wales Service from Public Health Wales NHS Trust to Local Health Boards
On 1st October 2019, Public Health Wales (PHW) transferred the responsibility for the delivery of the Stop Smoking Wales (SSW) service to Health Boards in Wales. As a result of the transfer, the UHB will be responsible for the planning, organisation and delivery of all face-to-face smoking cessation services within Carmarthenshire, Pembrokeshire and Ceredigion.

To retain the specialist expertise in the service, those PHW employees currently providing face-to-face services were transferred to the UHB, with recurrent WG funding. PHW will continue to provide the 'once-for-Wales' functions in the Help Me Quit system, including marketing, workforce training and development, and quality assurance and improvement, to support local delivery. System leadership will continue to be provided by the Tobacco Control Strategic Board.

Health & Safety Executive
Following an inspection by the Health and Safety Executive (HSE) in July 2019, on 4th October 2019, the UHB received a Report from the Health and Safety Executive (HSE) that identified 13 Material Breaches and 8 Improvement Notices. The HSE has requested confirmation of the action taken on each of these contraventions by 1st May 2020. If the UHB fails to meet this deadline, further enforcement action will be considered (a breach of the Health and Safety at Work etc Act 1974 is a criminal offence).

The Report highlighted the following themes:

(i) Improvement Notices
- Compliance with the UHB's Violence and Aggression and Manual Handling policies: the HSE found evidence that aspects of both policies were not being followed, for example, Risk Managers' Health and Safety responsibility awareness, assessments,

violence and aggression training, and handling/pushing/pulling excessively heavy weights;
- Manual handling of health records and laundry bags; and
- Preventing and controlling injuries to employees and others from the use of medical sharps.

(ii) Material Breaches
- Lone working;
- Violence and aggression relating to A&E departments in Withybush and Glangwili Hospitals;
- Violence and aggression relating to the conveyance of Mental Health patients;
- Manual handling relating to South Pembrokeshire hospital porters;
- Lifting Operations Regulations having an effective recording system, for all lifting equipment requiring a thorough examination; and
- Management of contractors.

To improve health and safety awareness amongst the workforce, the Health, Safety and Security Team will be appointing an additional Health and Safety Adviser who will deliver training to UHB staff. Co-ordination of compliance will be undertaken by three Control Groups: Moving and Handling; Violence and Aggression; and Accident Investigation. Additional Task and Finish Groups have been established for the miscellaneous topics, including Lifting Operations, Sharps Safety and Control of Contractors. Progress will be monitored by the Health and Safety and Emergency Planning Sub-Committee.

Fire Enforcement Notice Withybush General Hospital

On the 8th August 2019, the Mid and West Wales Fire and Rescue Service (MWWFRS) undertook an inspection at Withybush General Hospital (WGH), and as a result issued an Enforcement Notice. This required specific works to be undertaken by the 30th November 2019, but noted an opportunity to apply for an extension if required.

In response, the UHB has established a Control Group meeting on a fortnightly basis to identify and implement the improvements needed to comply with the notice, chaired by the Director of Estates, Facilities and Capital Management. This Control Group has developed an action plan, which has been shared regularly with the MWWFRS to give assurance that the UHB is actively implementing the improvements needed at pace. However, as there are some elements of the action plan that will take longer to deliver, the UHB will be applying for an extension to the deadline. Throughout this process, the UHB has worked closely with the MWWFRS and been assured that they are fully satisfied with the actions to date and have indicated that an extension will be granted, but will need to consider the period against the future works planned.

The UHB is also in discussions with WG on the Capital funding needed to continue with this programme of improvements, together with the appropriate procurement requirements.

Flu Vaccines

There have been a number of new initiatives undertaken as part of the 2019/20 flu campaign; however, there have been challenges this season around vaccine supply. There is a national shortage of children's nasal vaccine (fluenz/LAIV), which has meant that many surgeries across Wales have had to delay vaccination clinics for 2-3 year olds and under 18s at risk. Due to the LAIV vaccine supply issues, the schools programme has also been suspended nationally between 4th and 18th November 2019.

The UHB is working closely with schools and GPs to minimise the impact of vaccine delays, liaising regularly with surgeries to ensure they are kept up to date with latest developments,

and rescheduling vaccine sessions at all affected schools. QIVe is the vaccine ordered by many surgeries for their under 65s at risk, and has been ordered for our staff. Unfortunately, the main supplier of QIVe also had supply issues, delaying the launch of the staff campaign and compounding frustration across primary care colleagues already struggling with LAIV supply issues.

To mitigate the impact of delayed QIVe supply early in the season, patients and staff were directed to community pharmacy for vaccination when necessary and the UHB purchased additional alternate vaccine for staff to ensure no staff member requesting a flu vaccine was turned away.

Llwynhendy TB Outbreak – Update

Phase 2 of the response to the TB outbreak took place at the beginning of September 2019 (Monday 2nd September until Friday 13th September 2019) with a series of TB screening clinics based at Prince Philip Hospital. Due to a very positive response by the community, the demand for screening in the open access clinics in Phase 1 (June 2019) was very high and we were unable to see everyone or complete screening for all those who attended at that time. Screening clinics for the second phase were held specifically to accommodate those we didn't see or those we only partially screened in Phase 1. These clinics were managed by invitation/appointment only.

Main findings and key messages from Phase 2:

- No cases of active TB have been identified through Phase 2 of the screening exercise. This means that no active cases of TB have been identified through the community screening programme (Phase 1 and 2) to date.
- 128 cases of latent TB infection were identified through Phase 2 of the screening exercise. This means that, in total, 204 cases of latent TB have been identified through the community screening programme to date.
- Latent TB is not infectious and cannot be passed to other people, and people who have a latent form of TB do not need urgent treatment. However as treatment is recommended to prevent them from developing active TB disease, those identified as having latent TB infection will all be invited to discuss their treatment options. Those who tested negative for latent TB who were under the age of 36 at the time of screening have been invited for BCG vaccination.
- The Outbreak Control Team have reviewed all the data and information available and are now developing their plans for future action.

Argymhelliad / Recommendation

The Board is invited to:

- **Endorse** the Register of Sealings (**Appendix A**) since the previous report on 26th September 2019; and
- **Note** the status report for Consultation Documents (**Appendix B**) received/responded to.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable

Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce Support people to live active, happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Chief Executive's meetings (internal, external and NHS Wales wide), diary and correspondence
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Any issues are identified in the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Any issues are identified in the report.
Gweithlu: Workforce:	Any issues are identified in the report.
Risg: Risk:	This report provides evidence of current key issues at both a local and national level, which reflect national and local objectives and development of the partnership agenda at national, regional and local levels. Ensuing that the Board is sighted on key areas of its business, and on national strategic priorities and issues, is essential to assurance processes and related risks.
Cyfreithiol: Legal:	Any issues are identified in the report.
Enw Da: Reputational:	Any issues are identified in the report.
Gyfrinachedd: Privacy:	Not Applicable

Cydraddoldeb: **Equality:**	• Has EqIA screening been undertaken? Not on the Report • Has a full EqIA been undertaken? Not on the Report

Appendix A: Register of Sealings from 5th September – 4th November 2019

Entry Number	Details	Date of Sealing
254	TIR (Tenant Internal Repairing) Lease (New Build) relating to GMS Premises on the Ground Floor at Minaeron Integrated Health Care Centre, Aberaeron between Hywel Dda University Local Health Board and Dr Helen Herbert, Dr David Evans and Dr Tom Havard	20/09/2019
255	Lease in respect of Building 1, St David's Park, Jobs Well Road, Carmarthen to accommodate the Integrated Autism Service between Hywel Dda University Health Board and Carmarthenshire County Council	20/09/2019
256	Call off Contract for Regional Project Manager at Cross Hands Community Hub between Hywel Dda University Local Health Board and Mace Limited	20/09/2019
257	Parent Company Guarantee for the Project Manager Relating to Cross Hands Community Hub between Hywel Dda University Local Health Board and Mace Group Limited	20/09/2019
258	Call Off Contract for Regional Cost Adviser at Cross Hands Community Hub between Hywel Dda University Local Health Board and Gleeds Cost Management Limited	20/09/2019
259	Call Off Contract for Regional Supply Chain Partner, Cross Hands Community Hub, between Hywel Dda University Local Health Board and Willmott Dixon Construction Limited	20/09/2019
260	Parent Company Guarantee for the Supply Chain Partner for Cross Hands Community Hub between Hywel Dda University Local Health Board and Willmott Dixon Construction Limited	20/09/2019

Appendix B: Consultations Update Status Report up to 4th November 2019

Ref No	Name of Consultation	Consulting Organisation	Consultation Lead	Received On	CLOSING DATE	Response Sent
399	Workforce Strategy for Health and Care	Social Care Wales & Health Education and Improvement Wales	Lisa Gostling	18.06.2019	18.09.2019	18.09.2019
400	WHSSC consultation CP174 paediatric epilepsy surgery commissioning policy	Welsh Health Specialised Services Committee	Keith Jones, Prem Kumar Pitchaikani, Paula Evans	01.06.2019	12.07.2019	02.07.2019
401	WHSSC Consultation CP49 War Veterans - Enhanced Prosthetic Provision and CP89, Prosthetic Provision	Welsh Health Specialised Services Committee	Karen Miles, Mandy Rayani, Sarah Jennings	21.06.2019	19.07.2019	19.07.2019
402	Health and Social Care (Quality and Engagement) (Wales) Bill	National Assembly for Wales	Mandy Rayani, Sarah Jennings, Louise O'Connor, Sian Passey	27.06.2019	02.08.2019	01.08.2019
403	WHSSC: Cochlear Implant for children and adults with severe to profound deafness, Commissioning Policy (CP35)	Welsh Health Specialised Services Committee	Joe Teape, Keith Jones, Claire Jones, Paula Evans	06.06.2019	04.07.2019	04.07.2019
404	Substance Misuse Delivery Plan 2019 – 2022	Welsh Government	Ros Jervis	05.07.2019	09.08.2019	02.08.2019
405	Safeguarding children from child sexual exploitation	Welsh Government	Mandy Rayani, Mandy Nichols-Davies, Janet Edmunds Lead Nurse LAC & CSE	16.07.2019	07.10.2019	24.09.2019
406	Welsh Government Draft Budget Proposals 2020-21	National Assembly for Wales	Huw Thomas	17.07.2019	25.09.2019	24.09.2019 Co-ordinated response submitted

Appendix B: Consultations Update Status Report up to 4th November 2019

Ref No	Name of Consultation	Consulting Organisation	Consultation Lead	Received On	CLOSING DATE	Response Sent
						via the Wales Director of Finance Group
407	Together for Mental health delivery plan 2019 to 2022	Welsh Government	Joe Teape, Liz Carroll, Thomas Alexander	19.07.2019	30.08.2019	16.08.2019
408	Implementation of the Regulation and Inspection of Social Care (Wales) Act 2016	Welsh Government	Lisa Gostling, Trish Mathias-Lloyd, Cheryl Raymond	25.07.2019	16.10.2019	16.10.2019
409	Children's rights in Wales	National Assembly for Wales	Mandy Rayani, Sian Passey, Lesley Hill	26.07.2019	20.09.2019	19.09.2019
410	Draft international strategy for Wales	Welsh Government	Ros Jervis	05.08.2019	23.10.2019	14.10.2019
411	Home Education – Statutory Guidance for Local Authorities and a Handbook for Home Educators	Welsh Government	Mandy Rayani, Mandy Nichols-Davies, Sian Passey	06.08.2019	21.10.2019	03.10.2019
412	WHSSC: Paediatric Nephrology Services (CP169)	Welsh Health Specialised Services Committee	Joe Teape, Keith Jones, Prem Kumar Pitchaikani, David Morrissey	29.08.19	24.09.2019	01.10.2019
413	Shaping the future - nursing & midwifery	Nursing & Midwifery Council (NMC)	Mandy Rayani, Sharon Daniel	10.09.2019	16.10.2019	16.10.2019
414	WHSSC: CP150, In-patient Child and Adolescent Mental Health Services (CAMHS)	Welsh Health Specialised Services Committee	Joe Teape, Liz Carroll, Warren Lloyd, Angela Lodwick	23.09.2019	18.10.2019	18.10.2019
415	Sepsis	National Assembly for Wales	Mandy Rayani, Mandy Davies, Sharon Daniel, Sian Hall	24.09.2019	08.11.2019	04.11.2019

Appendix B: Consultations Update Status Report up to 4th November 2019

Ref No	Name of Consultation	Consulting Organisation	Consultation Lead	Received On	CLOSING DATE	Response Sent
416	Proposed Service Specification for specialist oesophageal and gastric cancer services for Welsh residents	NHS Wales Health Collaborative, Wales Cancer Network	Mark Henwood Consultant Surgeon	25.09.2019	06.11.2019	30.09.2019
417	Strategic equality objectives 2020 to 2024	Welsh Government	Sarah Jennings, Anna Bird, Jackie Hooper, Rhian Evans	27.09.2019	19.11.2019	24.10.2019
418	National Health Service (Pharmaceutical Services) (Wales) Regulations 2020	Welsh Government	Jill Paterson, Jenny Pugh Jones, Stuart Rees, Sarah Isaac	01.10.2019	25.11.2019	
419	Proposals to ensure access to the full curriculum for all learners	Welsh Government	Ros Jervis, Rhys Sinnett, Barbara Morgan, Liz Western	03.10.2019	28.11.2019	
420	All Wales Guidance for Health Boards/Trusts and Social Care Providers in Respect of Medicines and Care Support Workers	All Wales Medicines Strategy Group	Mandy Rayani, Jill Paterson, Jenny Pugh-Jones, Mandy James	07.10.2019	23.10.2019	22.10.2019
421	Reducing Restrictive Practices Framework	Welsh Government	Mandy Rayani, Alison Shakeshaft, Mandy Nichols-Davies, Paula Evans, Lesley Hill, Barbara Morgan, Natalie Vanderlinden	16.10.2019	06.01.2020	
422	National Development Framework	Welsh Government	Sarah Jennings, Anna Bird	18.10.2019	15.11.2019	
423	HEFCW guidance on tackling violence against women, domestic abuse and sexual violence in higher education	Higher Education Funding Council for Wales	Mandy Rayani, Sian Passey, Mandy Nichols-Davies - lead	22.10.2019	22.11.2019	

Enw'r Pwyllgor: Name of Committee:	Audit & Risk Assurance Committee (ARAC)
Cadeirydd y Pwyllgor: Chair of Committee:	Mr Paul Newman, Independent Member
Cyfnod Adrodd: Reporting Period:	Meeting held on 22nd October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor:
Key Decisions and Matters Considered by the Committee:

In accordance with the guidance provided in the NHS Wales Audit Committee Handbook, the Board should look to their Audit Committee to review and report on the relevance and rigour of the governance processes in place and the assurances provided to the Board. Hywel Dda University Health Board's (HDdUHB's) Audit & Risk Assurance Committee's primary role is, as such, to ensure the system of assurance is valid and suitable for the Board's requirements and to support the Board by seeking and providing assurance that controls are in place and are working as designed, and to challenge poor sources of assurance.

This report summarises the work of the Audit & Risk Assurance Committee (ARAC) at its meeting held on 22nd October 2019, in monitoring, reviewing and reporting to the Board on the processes of governance, and facilitating and supporting the attainment of effective processes. At its meeting on 22nd October 2019, the Committee critically reviewed governance and assurance processes for a number of service/business areas, with the following highlighted:

- **Targeted Intervention** – the Committee was provided with an update from the Targeted Intervention meeting held with Welsh Government (WG) on 27th September 2019. WG remain concerned about specific areas of the UHB's performance, particularly in relation to finances and unscheduled care.

- **Standing Orders and Standing Financial Instructions** – the Committee considered the amendments to HDdUHB's Standing Orders since those approved by the Board in May 2019 and recommended the revised version of the Standing Orders and Standing Financial Instructions for approval by the Board.

- **Financial Assurance Report** – the Committee received the Financial Assurance report. Medical Negligence and Personal Injury claims had been discussed by the Finance Committee on 21st October 2019. It seems likely that the Welsh Risk Pool budget will be overspent this year and the risk share agreement will be invoked for the first time. This would involve a potential cost to HDdUHB of £1.4m, and is of concern for the future. The Committee approved the losses and debtors write-offs noted within the report.

- **Wales Audit Office Update Report** – the Committee received the Wales Audit Office (WAO) Update Report, providing an update on current and planned performance audit work. Members were informed that Charitable Funds audit work had been approved by the Charitable Funds Committee at its meeting on 20th September 2019. The accounts will receive final sign-off during the week commencing 28th October 2019. An update was provided on the work WAO are currently undertaking, including the Orthopaedics review and Structured Assessment.

- **WAO Structured Assessment 2018** – a report updating the Committee on progress with WAO recommendations was presented.

- **WAO Report: Implementing the Well-being of Future Generations Act - Hywel Dda Health Board** – the Committee received this WAO report, together with the associated Management Action Plan. Members heard that this WAO examination applies to all 44 bodies covered by the Act. Each review had focused on a specific step being taken to meet a wellbeing objective. For HDdUHB, the step selected had been in relation to Education Programmes for Patients (EPP) and the contribution these make to population health and wellbeing. It was noted that the step selected was for the organisation to choose; this was not determined by WAO.

- **Response to WAO Report: What's the hold up? Discharging Patients in Wales** – an update report was presented, with Members reminded of the background to this item, which had been discussed at the previous meeting. As stated at that meeting, it is not necessarily possible to provide assurance regarding the WAO report, as further work is in train. There are, however, strong information systems in place and good pockets of practice. The WG Delivery Unit had conducted a review last year, which had highlighted both good practice and areas for improvement. Previously there had been 6 discharge pathways; there are now 4 nationally agreed 'Discharge to Assess/Recover' (D2RA) pathways, which will form the basis of a new approach. The refreshed current plan and three-year plan will be presented to the Business Planning & Performance Assurance Committee (BPPAC). Assurance was provided that the UHB does recognise the impact of delays in discharge on patients and their families, and is committed to making improvements. It was observed that, whilst it is always possible for the UHB to consider how to improve its own processes, real change requires effective interaction with other bodies; and there was concern regarding the apparent lack of 'joined up thinking' and urgency in this regard. It was acknowledged that more effective escalation processes are required, and that there needs to be shared ownership, with clearly defined actions. This area presents an opportunity for shared benefits as well as shared responsibilities. It was reiterated that the UHB cannot work in isolation on this area; this requires a whole-system approach. As part of this, the Chair of HDdUHB would be attending the Regional Partnership Board to discuss this topic. It was agreed that the issue of discharging patients and the need for a whole-system/partnership approach should be highlighted to Board.

- **WAO Clinical Coding Follow-up** – the Committee received an update report, with it noted that steps are being taken to progress the recommendations. A number of actions are being put in place, including a prioritised work programme and whole hospital audits. Whilst recognising that there has been progress since the previous update, concern was expressed regarding the proposed timelines for case note tracking. This could be undertaken quickly, with relatively little training or investment required; the main requirement being a behavioural change. It was suggested that improvements are likely to be seen more quickly once the work plan is underway. Assurance was provided in respect of the importance of accurate information and its benefits to patients being emphasised. It was necessary, however, to put in place the relevant processes in order to determine 'what a good medical record looks like', before this message could be communicated to the workforce.

- **RCP Medical Records Keeping Standards (Reasonable Assurance)** – with regard to the recommendations around which assurance was sought, it was noted that the Medical Director had written to all medical staff reminding them of the RCP Record Keeping Standards and the Health Board policy, and that a new audit process and programme for heath records has been agreed which will result in a significant number of records being audited across all specialties. It was emphasised, however, that changes will not be delayed until this process is complete; improvements will be made in the interim. Concerns were expressed that the recommendations appear rather retrospective and reactive, as opposed to proactive, whilst acknowledging that the report presented is 'high level' and not intended to set out full details of all the improvements required. Concerns were also expressed in relation to the results of a 'snapshot' audit presented within the report, regarding the quality of medical records in view of the fact that these are legal documents. The Committee considered again the link between medical records and clinical coding, acknowledging the impact on the latter of imprecise signatures, dates and diagnoses in patient records, together with other implications including continuity of care, handover of care and mortality audits. Assurance was provided in respect of the process clinical coders follow. It was agreed that ARAC should continue to monitor both clinical coding and medical records, and that a further update would be provided in six months' time.

- **Consultant Job Planning** – the Committee received an update regarding progress, with concern expressed that certain of the wording around timelines and managerial training sessions does not provide adequate assurance/information. It was emphasised that the Medical Director's team is providing a significant number of e-job planning training sessions. The report reflects optimism in regards to certain aspects of Job Planning, whilst acknowledging continued concerns in regards to others. Whilst acknowledging these comments, it was suggested that Job Planning should be viewed as part of attracting and retaining staff, and means by which staff have a clear understanding of their role. It is key to delivering a quality service to patients along with good value for money. It was noted from information reported to Finance Committee that the percentage of job plans which are electronic is only 10%, and disappointment expressed that the introduction of the Allocate system had not been as 'transformational' as had been suggested. A further internal audit report will be discussed in December 2019 and an update on the WAO NHS Consultant Contract Follow-up Review is scheduled for April 2020.

- **WAO Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality** – an update report on this topic was presented, with the Committee's attention drawn to the one outstanding recommendation, which is linked to the need to undertake a 'whole system' demonstration of system recovery and failover as a result of a catastrophic fail or successful cyber-attack. Assurance was provided that the ICT team has worked to ensure that the organisation's infrastructure is as resilient as possible. Safeguards are also in place as part of the Major Incident Plan. ARAC accepted the view that the testing which the ICT team had undertaken would allow the recommendations to be closed.

- **Business Planning & Performance Assurance Committee Assurance (BPPAC) Report around the Discharge of their Terms of Reference** – the Committee received a

report detailing BPPAC activities during 2018/19. The Committee was assured that BPPAC is operating in accordance with its Terms of Reference and discharging its duties effectively on behalf of the Board.

- **Internal Audit (IA) Progress Report** – the Committee reviewed the Internal Audit Progress Report, noting developments since the previous meeting.

- **Internal Audit (IA)** – the Committee reviewed the following IA reports which had achieved substantial and reasonable assurance:
  - Welsh Language Standards Implementation (Reasonable Assurance)
  - Water Safety Follow-up (Substantial Assurance)

- **Water Safety – Additional Sampling (Limited Assurance)** – the findings of this IA report were discussed; noting that, whilst there were positive aspects identified, including improved governance structures and enhanced local procedures, there had been a small number of suspect/significant legionella water samples reported in the past 12 months at Withybush General Hospital (WGH). The Estates department needs to update schematic drawings to enable proactive management of this issue; work in this regard is ongoing and will take time to complete. It has been suggested that IA revisit this area before the end of the financial year. Approximately £120k has been spent on improving pipework on the UHB estate, and the department is committed to addressing the additional issues raised, with a number of mitigations already in place. There are known areas of risk at WGH, and a more targeted approach is required in this regard, with reports being made to the UHB Water Safety Management Group. It was explained that, for new projects/ builds/commissions, all the relevant pipework is labelled. For the older estate, however, it is not necessarily practical or safe to label/re-label the entire infrastructure, due to the risks and disruption involved in such an exercise. The Committee noted that the Estates department should not be relying on an IA report to identify this issue, it was emphasised that the issue of a lack of schematic drawings was known to Estates prior to the audit, and there were already plans to allocate resources to this. In view of this issue, and the likelihood of similar issues being in existence, it was suggested that the Executive Team and Board should be conducting a full review of the outstanding Estates/IT/Medical Equipment backlog.

- **Estates Directorate Governance Review (Limited Assurance)** – the Committee discussed the findings of this IA report; noting that a number of issues and high priority recommendations had been identified. It was acknowledged that there is work required in this area, focusing specifically on the issue of sickness management. The main issues identified within the report related to PADRs being meaningful and timely and how risks are recorded on the risk register.

- **Radiology Directorate (Reasonable Assurance) Update** – the Committee received an update on progress. The Task & Finish Group has been re-established, with a clear timeline for implementation defined and a risk assessment of the preferred option to be prepared. Whilst progress has been made, the process is not yet complete. It was agreed that a further update would be provided to the next meeting.

- **Scrutiny of Outstanding Improvement Plans: WAO Review of Estates 2016** – an update report was presented. The report included information on the capabilities of the

RAM 4000 system, with Members noting that an 'Invest to Save' bid has been submitted to WG for funding to upgrade the Estates Management System. The potential additional benefits of such a system were also outlined in the report. The second part of the report focused on workforce planning, including details of the gap analysis undertaken, and the external validation of this assessment being sought from NHS Wales Shared Services Partnership (NWSSP). Further work is required in terms of a risk assessment and succession planning, in view of the fact that the original WAO review was conducted in 2016, three years ago. It was emphasised that there is a need for tangible progress between now and the start of the next financial year, with a further update to be presented to the April 2020 meeting.

- **Scrutiny of Outstanding Improvement Plans: IA Health & Safety 2016** – an update report was received, noting that this was a follow-up to discussions at the previous meeting. The specific areas upon which ARAC had requested further assurance were: greater scrutiny around the timing of appointments; demonstration that the current team operates a risk-based approach. The report described how the Health & Safety (H&S) team take a risk-based approach to their work; including involvement with the Health & Safety and Emergency Planning Sub-Committee (H&SEPSC), the Datix incident reporting system and routine screening of H&S-themed high risks. It was noted that 8 HSE Improvement Notices had been issued to the UHB, and that this matter had been escalated to Board. Assurances were provided that, where immediate actions are required, these have been taken. The Estates department is developing a plan of works at pace to address the issues raised, although the cost implications involved are not yet confirmed. Progress will be reported via the H&SEPSC. In terms of short-term impact, the Committee was informed that the Chief Executive will be chairing fortnightly Control Group meetings to examine this area and ensure that it is being effectively managed. It was suggested that the original management response was overly optimistic, with the Committee noting that all responses should be Specific, Measurable, Achievable, Realistic, and Timely (SMART).

- **Audit Tracker** – the UHB Central Tracker, which tracks progress against audits and inspections undertaken within the UHB, was presented.

- **Counter Fraud Update** – an update was received, including the contents of the Overpayment Case Review.

- **Audit Committee Work Programme** – The Committee received for information the ARAC work programme for 2019/20.

Materion y Mae Angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd ar eu Cyfer: Matters Requiring Board Level Consideration or Approval:

- **HDdUHB's Standing Orders (SOs)and Standing Financial Instructions** – the Committee recommends the revised version to Board presented at Item 3.7.1 for approval, which includes revised Standing Orders for WHSSC (Welsh Health Specialised Services Committee) and EASC (Emergency Ambulance Services Committee);
- To highlight to Board concerns around the issue of **Discharging Patients** and the need for a whole-system/partnership approach;

- To note concerns regarding the findings of the **Internal Audit report into Water Safety** and the suggestion that the Executive Team and Board should be conducting a full review of the outstanding Estates/IT/Medical Equipment backlog.

Risgiau Allweddol a Materion Pryder:
Key Risks and Issues/Matters of Concern:

- **Medical Negligence and Personal Injury Claims** – the potential cost associated with the Welsh Risk Pool risk share agreement being invoked for the first time;
- **Clinical Coding and RCP Medical Records Keeping Standards** – concerns around the quality of medical records and impact on clinical coding;
  - It was agreed that ARAC should continue to monitor both matters, and that a further update would be provided in six months.
- **Estates Directorate Governance Review (Limited Assurance)** – concerns around the findings of this IA report;
- **Radiology Directorate (Reasonable Assurance) Update** – issues and risks around implementation of changes to shift systems for out of hours;
  - It was agreed that a further update would be provided to the next meeting.
- **Scrutiny of Outstanding Improvement Plans: WAO Review of Estates 2016** – continued concerns around implementation of recommendations from this review;
  - It was emphasised that there is a need for tangible progress between now and the start of the next financial year;
  - It was agreed that a further update would be presented to the April 2020 meeting.
- **Scrutiny of Outstanding Improvement Plans: IA Health & Safety 2016** – continued concerns around implementation of recommendations from this audit;
  - This will be reviewed by the control group which is being established by the CEO.
- **Audit Tracker** – concern was expressed regarding the number of reports exceeding their planned completion date, with Members suggesting that it is not unrealistic to expect delivery according to the agreed management response;
  - It was agreed that the letters previously sent on behalf of the ARAC Chair, regarding late or non-delivery of recommendations from external/internal audit and regulatory reports would be re-circulated.

Busnes Cynlluniedig y Pwyllgor ar Gyfer y Cyfnod Adrodd Nesaf:
Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol:
Future Reporting:

In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified above will be undertaken.

Dyddiad y Cyfarfod Nesaf:
Date of Next Meeting:

19th December 2019

Standing Orders

Reservation and Delegation of Powers

Hywel Dda University Local Health Board

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers. These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Standards of Behaviour Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the LHB.

Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/

Contents

Section A – Introduction

Statutory framework

i) The Hywel Dda University Local Health Board (the LHB) is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, "the Establishment Order".

ii) The principal place of business of the LHB is – Corporate Offices, Ystwyth Building, St David's Park, Carmarthen, SA31 3BB.

iii) All business shall be conducted in the name of Hywel Dda University LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension.

vi) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511).**

vii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

viii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8)** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.

x) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

xi) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014).**

xii) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xiii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xiv) Further duties and powers placed on health boards in relation to co-operation and partnership with local authorities and other partners in Wales are set out in the **Social Services and Well-being (Wales) Act 2014**. This Act establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015/1989),** made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services**.**

Guidance on the provisions of Part 9 can be found at https://gov.wales/docs/dhss/publications/151218part9en.pdf

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xvii) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS framework

xviii) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xix) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xx) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link:
http://www.wales.nhs.uk/governance-emanual/values-and-standards-of-behaviour-framew

xxi) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015,** have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xxii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxiv) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Hywel Dda University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

xxv) LHBs shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxiii below).

xxvi) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

xxvii) The SOs of the LHB (together with SFIs and the Standards of Behaviour Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule* 4.

xxviii) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit and Risk Assurance Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

xxix) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxx) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit and Risk Assurance Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxi) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxii) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Board Secretary

xxxiii) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within the LHB. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;

- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers;

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

xxxiv) Further details on the role of the Board Secretary within Hywel Dda University LHB, including details on how to contact them, are available via the following hyperlink to the LHB's website: http://www.wales.nhs.uk/sitesplus/862/page/91581

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 20 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members (appointed by the Board).

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights. There may also be Associate Members who do not have voting rights.

Officer Members [to be known as Executive Directors]

1.1.3 A total of 9 (including the Chief Executive), appointed by the Board, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.

Non Officer Members [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

Associate Members

1.1.5 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.

1.1.6 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.7 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

1.1.8 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i) Either or both persons may attend and take part in Board meetings;
ii) If both are present at a meeting they shall cast one vote if they agree;

iii) In the case of disagreement no vote shall be cast; and
iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the LHB Board and responsibilities of individual members

Role

1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.

1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.8 The Chair shall work in close harmony with the Chief Executive and,

supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.

1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i) Schedule of matters reserved to the Board;
ii) Scheme of delegation to committees and others; and
iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

i) By a Committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or
ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
iii) Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- joint-Committee
- sub-Committee
- joint sub-Committee

unless otherwise stated. The Board's Advisory Groups are referred to separately.

3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.2.3 The Board shall establish, as a minimum, the following joint-Committees:

- The Welsh Health Specialised Services Committee (WHSSC).
- The Emergency Ambulance Services Committee

Joint Committee Standing Orders, terms of reference and operating arrangements

3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
- Any budget, financial and accounting responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of

reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

3.4.6 Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

3.5.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

3.6 Confidentiality

3.6.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.7 Reporting activity to the Board

3.7.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("the Shared Services Regulations") require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations prescribe the membership of the Shared Services Committee in order to ensure that all LHBs and Trusts in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

5.0.3 The Board's commitment to openness and transparency in the conduct of

all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

5.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.2 Support to the Advisory Groups

5.2.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group

meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.3 Confidentiality

5.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:

- At Board meetings, through the SRG and HPF Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

5.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

5.6.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

5.6.3 The SRG's role is distinctive from that of Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

5.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.7.3 The Board shall determine the arrangements for any joint meetings

between the LHB Board and the SRG.

5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

5.9 Working with Community Health Councils

5.9.1 The SRG shall make arrangements to ensure designated CHC members receive the SRG's papers and are invited to attend SRG meetings.

5.9.2 The SRG shall work together with CHCs within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

5.10.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

5.10.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

5.11 Terms of reference and operating arrangements

5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

5.12.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.

5.12.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

5.12.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 The LHB Chair, on the advice of the Chief Executive and/or Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or
ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

5.13.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 7.5.7.

5.14 Relationship with the National Professional Advisory Group

5.14.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

Refer to Schedule 5.2 for detailed Terms of Reference and Operating Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

5.15.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

5.15.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.16 Relationship with the Board and others

5.16.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.16.2 The Board may determine that designated Board members or LHB staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of

population assessments and area plans.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 Community Health Councils (CHCs)

6.1.1 The **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288) (as amended) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289) place a range of duties on LHBs in relation to the engagement and involvement of CHCs in its operations.

6.1.2 In discharging these duties, the Board shall work constructively with the CHCs working jointly within the LHB's area by ensuring their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for changes in the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for

and formally consulting with those CHCs working jointly within the LHB's area on any proposals for substantial development of the services it is responsible for.

6.1.3 The Board shall ensure that each relevant CHC is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.4 The Board may determine that designated CHC members shall be invited to attend Board meetings.

6.1.5 The Board shall make arrangements for regular joint meetings between the CHC members and the Board, to be held not less than once every three calendar months and ensuring attendance of at least one third of the Board's members.

6.1.6 The Board's Chair shall put in place arrangements to meet with the relevant CHC Chair(s) on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;

- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 .

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g., through the SRG or CHCs.

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website. .

Annual General Meeting (AGM)

7.2.5 The LHB must hold an AGM in public no later than the 31 July each year. At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) at the LHBs principal sites and on the LHB's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others, such as the organisation's annual quality statement.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- At the LHB's principal sites; On the LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *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 in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).*

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as CHCs and the LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business

to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;

- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the CHC representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by

the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework**,** the Standards of Behaviour Policy, or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board, the Standards of Behaviour Policy, will

form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework, the Standards of Behaviour Policy, and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a LHB Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Standards of Behaviour Policy approved by the Board prohibits Board

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

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- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework, the Standards of Behaviour Policy**,** and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should

be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB ;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the LHB to be submitted to the Audit and Risk Assurance Committee at least annually. The Audit and Risk Assurance Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

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[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

9.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the LHB shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit and Risk Assurance Committee.

10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

10.0.4 Assurances in respect of the functions discharged by WHSSC and EASC shall be achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be

clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit and Risk Assurance Committee and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.2 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.3 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.4 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

10.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

11.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 A summary equality impact assessment has been carried out on these SOs prior to their formal adoption by the Board.

12.0.2 These SOs shall be reviewed annually by the Audit and Risk Assurance Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

i) A Committee, e.g., Quality and Safety Committee;

ii) A sub-Committee, e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;

iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs established to take forward matters relating to specialist services; and

iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the LHB's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit & Risk Assurance Committee

The Audit & Risk Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

The LHB's Scheme of Delegation was approved by the Board at its meeting on 29th November 2018. This detailed electronic scheme of delegation encompasses all delegations including Standing Orders, Standing Financial Instructions, financial delegations, legislative compliance, other delegations and responsibilities, both at delegated lead and operational responsibility level. It has been further expanded through Directorate delegations and is kept under regular review. It can be accessed via the following hyperlink to LHB's website:

http://www.wales.nhs.uk/sitesplus/862/page/49971

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

LHB framework

The LHB's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs*** *(see Schedule 2.1 below) – available via the following hyperlink to the LHB's website):*
  http://www.wales.nhs.uk/sitesplus/documents/862/Item%203.7.1%20Revised%20Standing%20Orders%2C%20Standing%20Financial%20Instructions%20and%20Commitee%20ToRs.pdf

- ***Values and Standards of Behaviour Framework*** – available via the following hyperlink:
  http://www.wales.nhs.uk/governance-emanual/values-and-standards-of-behaviour-framework

- **Standards of Behaviour Policy** – available via the following hyperlink to the LHB's website:
  http://www.wales.nhs.uk/sitesplus/documents/862/248-StandardsofBehaviourPolicyV4.pdf

- ***Risk and Assurance Framework****- available via the following hyperlink to the LHB's website:*
  http://www.wales.nhs.uk/sitesplus/documents/862/608-RiskManagementFramework.pdf

- ***Key policy documents*** *- available via the following hyperlink to the LHB's website:*
  http://www.wales.nhs.uk/sitesplus/862/page/59037

agreed by the Board. These documents must be read in conjunction with the SOs

and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by: contacting the Corporate Governance Team, Corporate Offices, Ystwyth Building, St David's Park, Carmarthen.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

STANDING FINANCIAL INSTRUCTIONS FOR HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Available via the following hyperlink to the LHB's website:
http://www.wales.nhs.uk/sitesplus/documents/862/Item%203.7.1%20Revised%20Standing%20Orders%2C%20Standing%20Financial%20Instructions%20and%20Committee%20ToRs.pdf

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

- Audit and Risk Assurance Committee
- Business Planning & Performance Assurance Committee
- Charitable Funds Committee
- Finance Committee
- Mental Health Legislation Assurance Committee
- Quality, Safety & Experience Assurance Committee
- Remuneration and Terms of Service Committee
- University Partnership Committee
- Primary Care Applications Committee

Terms of Reference for Board Committees available via the following hyperlink to the LHB's website:
http://www.wales.nhs.uk/sitesplus/862/page/99740

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Schedule 4.1 – Welsh Health Services Specialised Services Committee
Schedule 4.2 – Emergency Ambulance Services Committee

Available via the following hyperlinks:

Welsh Health Specialised Services Committee (WHSSC) – see Appendix 1

- WHSCC Standing Orders, Reservation and Delegation of Powers
- WHSCC Standing Financial Instructions

Emergency Ambulance Services Committee (EASC) – see Appendix 2

EASC Standing Orders

Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Schedule 5.1 – Stakeholder Reference Group
Schedule 5.2 – Health Professionals Forum
Schedule 5.3 – Local Partnership Forum

Terms of Reference for Board Advisory Groups available via the following hyperlink to the LHB's website:
http://www.wales.nhs.uk/sitesplus/862/page/99740

STANDING ORDERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Foreword

Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing Standing Orders Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Welsh Health Specialised Services Committee's (the WHSSC or the Joint Committee) proceedings and business[1]. These WHSSC Standing Orders (WHSSC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009[2] and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated 12 November 2019 made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated 12 November 2019 between the Joint Committee and Cwm Taf Morgannwg University LHB (the host LHB), form the basis upon which the Joint Committee governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1 Reference Part 3, Regulation 12 of WHSSC Regulations 2009 and Regulation 14(b) and 15(5) of the LHB Regulations 2009.
2 (2009/3097 (W.270)

All LHB Board members, Joint Committee members, LHB and Welsh Health Specialised Services Team (WHSST) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee. Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/

Contents

Section: A – Introduction

Statutory framework

i) The Welsh Health Specialised Services Committee (the Joint Committee) is a joint committee of each LHB in Wales, established under the **Welsh Health Specialised Services Committee (Wales) Directions 2009** (the WHSSC Directions). The functions and services of the Joint Committee are listed in Annex 1 of the WHSSC Directions and are subject to variations to those functions agreed from time to time by the Joint Committee**.** Annex 1 was amended by the **Welsh Health Specialised Services Committee (Wales) (Amendment) Directions 2014** following the establishment of the Emergency Ambulance Services Committee. The Joint Committee is hosted by the host LHB on behalf of each of the seven LHBs.

ii) The principal place of business of the WHSSC is Unit G1, The Willowford, Treforest Industrial Estate, Pontypridd CF37 5YL.

iii) All business shall be conducted in the name of the Welsh Health Specialised Services Committee on behalf of LHBs.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006**[3] which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006**[4] applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The WHSSC Directions provide that the seven LHBs in Wales will work jointly to exercise

3 c.42
4 c.41

functions relating to the planning and securing of specialised and tertiary services and will establish the joint committee for the purpose of jointly exercising those functions.

viii) Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009**[5] (the WHSSC Regulations) which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009**[6] (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) The Host LHB shall issue an indemnity to the Chair, on behalf of the LHBs

NHS framework

xi) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiii) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

5 (2009/3097 (W.270)
6 (2009/779 W.67)

xiv) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Ministers' Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of Committee/LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

xvii) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These WHSSC SOs and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation to others;
- The WHSSC SFIs;
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xviii) Annex 2 to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with the WHSSC SOs.

xix) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the WHSST and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these WHSSC SOs and SFIs. Details of the Joint Committee's key operating procedures are also included in

Annex 2 of these SOs.

Applying WHSSC Standing Orders

xx) The WHSSC SOs (together with the WHSSC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any joint sub-Committees established by the Joint Committee, including any Advisory Groups. The WHSSC SOs may be amended or adapted for the joint sub-Committees or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on joint sub-Committees and Advisory Groups may be found in Annexes 3 and 4 of these WHSSC SOs, respectively.

xxi) Full details of any non-compliance with these WHSSC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with WHSSC SOs is a disciplinary matter.**

Variation and amendment of WHSSC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxiii) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the WHSSC SOs, the Chair of the Joint Committee shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Committee Secretary.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes

precedence over these WHSSC SOs when interpreting any term or provision covered by legislation.

Relationship with LHB Standing Orders

xxv) The WHSSC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

xxvi) The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups;
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, WHSSC SOs and the framework set by the LHBs and Welsh Ministers.

xxvii) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committee's operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – WHSSC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions[7]

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the planning and securing of certain specialised and tertiary services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of specialised and tertiary services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;
- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;
- Agree annually those services that should be planned on a national basis and those that should be planned locally;
- Produce an Integrated Commissioning Plan, for agreement by the Committee in conjunction with the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the

7 The WHSSC (Wales) Directions 2009 and The WHSSC (Wales) Regulations 2009

contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

- Establish mechanisms for managing the in year risks associated with the agreed service portfolio and new pressures that may arise;

- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and

- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the Management Team undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee[8]

1.2.1 The membership of the Joint Committee shall be 15 voting members and three associate members, comprising the *Chair* (appointed by the Minister for Health and Social Services) and the *Vice-Chair* (appointed by the Joint Committee from existing non-officer members of the seven LHBs)[9], together with the following:

Non-Officer Members [known as Independent Members] [10]

1.2.2 A total of 2, appointed by the Joint Committee from existing non-officer members of the seven LHBs.

8 Ref. Welsh Health Specialised Services Committee (Wales) Directions 2009, 5(1) and Welsh Health Specialised Services Committee (Wales) Regulations 2009, Part 2
9 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009, Regulation 4(1) & 4(2)
10 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009, Regulation 4(3)

Chief Executives

1.2.3 A total of 7, drawn from each Local Health Board in Wales.

Officer Members [known as WHSST Directors]

1.2.4 A total of 4, appointed by the Joint Committee, consisting of a Director of Specialised and Tertiary Services[11]; a Medical Director of Specialised and Tertiary Services; a Finance Director of Specialised and Tertiary Services, and a Nurse Director of Specialised and Tertiary Services. These officer members may have other responsibilities as determined by the Joint Committee and set out in the scheme of delegation to officers. These officer members comprise the Management Team.

1.2.5 Where a post of WHSST Director is shared between more than one person because of their being appointed jointly to a post:

i. Either or both persons may attend and take part in Joint Committee meetings;
ii. If both are present at a meeting they shall cast one vote if they agree;
iii. In the case of disagreement no vote shall be cast; and
iv. The presence of both or one person will count as one person in relation to the quorum.

Associate Members

1.2.6 The following Associate Members will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust
- Chief Executive of the Welsh Ambulance Services NHS Trust
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.7 The Joint Committee Chair may invite other members of the WHSST or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

Use of the term 'Independent Members'

1.2.8 For the purposes of these WHSSC SOs, use of the term 'Independent Members' refers to the following voting members of the Joint Committee:

11 The Director of Specialised and Tertiary Services is also known as the Managing Director of Specialised and Tertiary Services Commissioning

- Chair
- Vice-Chair
- Non-Officer Members

unless otherwise stated.

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 Independent Members who are appointed to the Joint Committee must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.3 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.4 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with WHSSC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.5 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in relation to the delivery of the functions exercised by the Joint Committee on its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.7 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed[12].

1.3.8 The Vice-Chair is accountable to the Chair for their performance as Vice Chair.

Non-Officer Members

1.3.9 Non-Officer members are accountable to the Chair for their performance as Non-Officer members.

WHSST Director of Specialised and Tertiary Services

1.3.10 The WHSST Director of Specialised and Tertiary Services (Lead Director), as head of the Management Team reports to the Chair and is responsible for the overall performance of the WHSST. The Lead Director is accountable to the Joint Committee in relation to those functions delegated to them by the Joint Committee. The Lead Director is also accountable to the Chief Executive of the host LHB in respect of the administrative arrangements supporting the operation of the team.

WHSST Directors (excluding the WHSST Director of Specialised and Tertiary Services)

1.3.11 The Medical Director of Specialised and Tertiary Services, the Finance Director of Specialised and Tertiary Services, and the Nurse Director of Specialised and Tertiary Services are accountable to the Joint Committee and the Chief Executive of the host LHB through the Lead Director.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** shall be appointed by the Minister for Health and Social Services for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term[13].

1.4.2 The ***Vice-Chair*** and two other ***Independent Members*** shall be appointed by the Joint Committee from existing Independent Members of the seven

12 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 3, Regulation 13
13 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 7

Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than 4 years, in line with that individual's term of office on any LHB Board. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term[14].

1.4.3 The appointment process for the Vice Chair and the two other Independent Members shall be determined by the Joint Committee, subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;
- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and
- Potential conflicts of interest are kept to a minimum.

1.4.4 The ***WHSST Directors*** shall be appointed by the Joint Committee[15], and employed by the host LHB in accordance with the eligibility requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and the employment policies of the host LHB, as appropriate. The appointments process shall be in accordance with the workforce policies and procedures of the host LHB and any directions made by the Welsh Ministers.

1.4.5 WHSST Directors tenure of office as Joint Committee members will be determined by their contract of employment.

1.4.6 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they are applicable, and as specified in the relevant regulations. Any member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office[16].

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS[17]

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally

14 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 7
15 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 4(3)
16 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 6,7,8 and 11
17 Ref. Welsh Health Specialised Services Committee (Wales) Directions 2009 3(4)

accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of specialised services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the WHSST acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chair.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

2.0.5 The LHB Chairs *[through the lead Chair]* shall put in place arrangements to meet with the Joint Committee Chair on a regular basis to discuss the Joint Committee's activities and operation.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these WHSSC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i. Schedule of matters reserved to the Joint Committee;
ii. Scheme of delegation to joint sub-Committees and others; and
iii. Scheme of delegation to Officers.

all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Lead Director, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Independent Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

3.1.2 Chair's action may not be taken where either the Joint Committee Chair or the Lead Director has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or another WHSST Director acting on behalf of the Lead Director will take a decision on the urgent matter, as appropriate.

3.2 Delegation to joint sub-Committees and others

3.2.1 The Joint Committee shall agree the delegation of any of its functions to joint sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers.

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by joint sub-Committees which it has formally constituted or to others.

3.3 Delegation to Officers

3.3.1 The Joint Committee will delegate certain functions to the Lead Director. For these aspects, the Lead Director, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Lead Director will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Lead Director may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

3.3.3 Individual Directors are in turn responsible for delegation within their own teams in accordance with the framework established by the Lead Director

and agreed by the Joint Committee.

4. JOINT SUB-COMMITTEES

4.0.1 In accordance with WHSSC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum, it shall establish joint sub-Committees which cover the following aspects of Joint Committee business:

- Quality and Safety
- Audit

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own joint sub-Committees or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the joint sub-Committee structure established by the Joint Committee, including detailed terms of reference for each of these joint sub-Committees are set out in Annex 3 of these WHSSC SOs.

4.0.6 Each joint sub-Committee established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;

- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the joint sub-Committee, keeping any such aspects to the minimum necessary.

4.0.8 The membership of any such joint sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the joint sub-Committee's defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set in WHSSC Standing Order 4.0.9) or others.

4.0.9 WHSST Directors or officers should not normally be appointed as joint sub-Committee Chairs, nor should they be appointed to serve as members on any committee set up to review the exercise of functions delegated to officers. Designated WHSST Directors or officers shall, however, be in attendance at such joint sub-Committees, as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all joint sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint sub-Committee Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.2.2 Each joint sub-Committee shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in Annex 4 of the WHSSC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Expert Panel or Advisory Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Expert Panel or Advisory Group shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has

established.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Working with Community Health Councils

6.2.1 The Joint Committee shall make arrangements to ensure arrangements are in place to liaise with CHC members as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

6.3.2 The plan shall set out the arrangements in place to enable the Joint Committee to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

6.3.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of joint sub-Committees, Expert Panel and Advisory Groups.

6.3.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisation's website.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Lead Director, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from joint sub-Committees and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.5.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of Joint Committee business.

Notifying and equipping Joint Committee members

6.5.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10[18] calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.5.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.5.6 In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.5.7 Except for meetings called in accordance with WHSSC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On each LHB's website, together with the papers supporting the public part of the Agenda; as well as

18 See Schedule 3, 2(3) of the LHB (Constitution, Membership and Procedures) Regulations 2009

- Through other methods of communication as set out in the Joint Committee's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, each LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

6.6.1 The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

6.6.2 The Joint Committee shall conduct as much of its formal business in public as possible[19]. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting a WHSST officer or a patient. In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

> *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].*

6.6.3 In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

6.6.4 The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.6.5 In encouraging entry to formal Joint Committee Meetings from members of

19 Schedule 3, 8 of the LHB(Constitution, Membership and Procedures) Regulations 2009

the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.6.6 Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups

6.6.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.6.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice-Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

6.6.9 The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

6.6.10 At least 8 voting members, at least 4 of whom are LHB Chief Executives and 2 are Independent Members, must be present to allow any formal business to take place at a Joint Committee meeting.

6.6.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

6.6.12 If the Lead Director or another WHSST Director is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g., a person deputising for the Lead Director will usually be another WHSST Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

6.6.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their deputy disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member and seconded by another Joint Committee member (including the Joint Committee Chair).

6.6.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and

the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.16 The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

6.6.17 **Amendments –** Any Joint Committee member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.6.18 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.6.19 **Motions under discussion –** When a motion is under discussion, any Joint Committee member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;
- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.6.20 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.6.21 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

6.6.22 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

6.6.23 A Motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a joint sub-Committee/WHSSC Director to which a matter has been referred.

Voting

6.6.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Joint Committee.

6.6.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales. Such views may be presented to the Joint Committee through the Chairs of the LHB's Advisory Groups.

6.6.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.6.27 A nominated deputy of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of a WHSST member vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with Joint Committee

members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act, the Joint Committee's Communication Strategy and the host LHB's Welsh language requirements.

6.8 Confidentiality

6.8.1 All Joint Committee members (including Associate Members), together with members of any joint sub-Committee, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant joint sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, WHSST officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the WHSSC SOs.

7.1 Declaring and recording Joint Committee members' interests

7.1.1 **Declaration of interests –** It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Joint Committee member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. Joint Committee members must notify the Joint Committee of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Joint Committee members.

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Lead Director, through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This may include publication on the Joint Committee's website.

7.1.6 **Publication of declared interests in Annual Report –** Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides

specialised and tertiary services.

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary, before the start of the Joint Committee meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.

7.2.3 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting.

ii. The declaration is formally noted and recorded, and the Joint Committee member participates fully in the Joint Committee's discussion, but takes no part in the Joint Committee's decision;

iii. The declaration is formally noted and recorded, and the Joint Committee member takes no part in the Joint Committee discussion or decision;

iv. The declaration is formally noted and recorded, and the Joint Committee member is excluded for that part of the meeting when the matter is being discussed. A Joint Committee member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Joint Committee.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take

advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a Joint Committee member, or any person they are connected with[20] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 **The Local Health Boards (Constitution, Membership and Procedures) Wales Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The WHSSC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Lead Director, establishes and maintains a system for the declaration, recording and handling of WHSST officers' interests in accordance with the Values and Standards of Behaviour Framework.

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit Committee will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with offers of gifts,[21] hospitality and sponsorship

7.5.1 The Standards of Behaviour (including Gifts and Hospitality) Policy adopted by the Joint Committee prohibits Joint Committee members and WHSST

[20] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

[21] The term gift refers also to any reward or benefit.

officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or WHSST officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or WHSST officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Joint Committee members. WHSST Directors will adopt a similar mechanism in relation to WHSST officers working within their areas.

7.7.2 Every Joint Committee member and WHSST officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Lead Director, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regard to gifts and hospitality, individuals must apply the following principles, subject to the considerations in WHSSC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[22]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and WHSST Officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

[22] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its joint sub-Committees, Expert Panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each joint sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these WHSSC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the WHSST, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and

- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The WHSSC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in WHSSC SOs, including the appropriate impact assessment.

Annex 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Introduction

As set out in WHSSC Standing Order 3, the Welsh Health Specialised Services Committee (the Joint Committee) - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i. A sub-Committee of the Joint Committee, e.g., Audit Committee;

ii. A Group, Expert Panel or Advisory Group , e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii. Officers of the Joint Committee (who may, subject to the Joint Committee's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to sub-Committees or sub-Groups and others; and
- Scheme of delegation to officers.

all of which form part of the WHSSC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- *Everything is retained by the Joint Committee unless it is specifically delegated in accordance with the requirements set out in WHSSC SOs or WHSSC SFIs*

- *The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management*

- *Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility*

- *The Joint Committee must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development*

- *The Joint Committee must take appropriate action to assure itself that all matters delegated are effectively carried out*

- *The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes*

- *The Joint Committee may delegate authority to act, but retains overall responsibility and accountability*

- *When delegating powers, the Joint Committee will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.*

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Joint Committee

The Joint Committee will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Lead Director

The Lead Director will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Lead Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in WHSSC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Lead Director may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Lead Director of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Lead Director is absent their nominated Deputy may exercise those powers delegated to the Lead Director on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Lead Director or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[23]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with WHSSC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are listed below:
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards:

[23] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

			▪ WHSSC SOs ; ▪ WHSSC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
6	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework for performance management, risk and assurance
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Lead Director in accordance with WHSSC Standing Order requirements

9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with WHSSC SOs
10	FULL	OPERATING ARRANGEMENTS	Approve policies for dealing with complaints and incidents
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with WHSSC SFIs
12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Lead Director and Officers
13			N/A
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of the WHSST Directors and any other Joint Committee level appointments, e.g., the Committee Secretary
15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. from Audit Committee
16	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Joint Committee's top level organisation structure and Joint Committee policies
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-Committees, including any joint sub-Committees directly accountable to the Joint Committee

18	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the Joint Committee
19	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
20	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the Joint Committee
21	FULL	STRATEGY & PLANNING	Determine the Joint Committee's strategic aims, objectives and priorities
22	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Commissioning Plan
23	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Risk Management Strategy and plans
24	FULL	STRATEGY & PLANNING	Approve the Joint Committee's citizen engagement and involvement strategy, including communication
25	FULL	STRATEGY & PLANNING	Approve the Joint Committee's partnership and stakeholder engagement and involvement strategies

26	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient centred specialised and tertiary services for the population of Wales ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
27	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
28	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Lead Director set out in the WHSSC SFIs
29			N/A
30	FULL	PERFORMANCE & ASSURANCE	Receive reports from the WHSST Directors on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
31	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee's sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans

32	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
33			N/A
34			N/A
35			N/A
36	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government
37			N/A

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE-CHAIR AND INDEPENDENT MEMBERS			
	Chair		Chair of the Integrated Governance Committee
	Independent Member or Vice-Chair		Audit Lead
	Independent Member or Vice-Chair		Chair of the Quality and Patient Safety Committee

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[24]

WHSSC Standing Order 3 provides that the Joint Committee may delegate powers to sub-Committees and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

- Audit Committee (of the host organisation)
- Quality and Patient Safety Committee
- Individual Patient Funding Request (IPFR) Panel (WHSSC)
- Integrated Governance Committee
- Welsh Renal Clinical Network
- Management Group

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to sub-Committees.

[24] As defined in Standing Orders.

SCHEME OF DELEGATION TO WHSST DIRECTORS AND OFFICERS

The WHSSC SOs and WHSSC SFIs specify certain key responsibilities of the Lead Director, the Director of Finance and other officers. The Lead Director's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other WHSST Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the WHSSC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
Agreeing and signing Health Care Agreements and Contracts with service providers for health care services	Lead Director Director of Finance (Deputy)
Approval to commission Specialist healthcare services	Lead Director
Information Governance arrangements	Committee Secretary (in conjunction with the host LHB)
Management of Concerns	Director of Nursing & Quality Assurance
Health and Safety arrangements	Lead Director/ Committee Secretary (in conjunction with the host LHB)
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with government directions.	Chair/ Lead Director Director of Finance (Deputy)
Issuing tenders and post tender negotiations.	Lead Director Director of Finance (Deputy)
Legal advice	Committee Secretary

Action on litigation	Lead Director/ Committee Secretary
Operation of detailed financial matters, including bank accounts and banking procedures	Director of Finance (in conjunction with the host LHB Director of Finance)
Workforce	Committee Secretary
Public consultation	Lead Director
Manage central reserves and contingencies	Director of Finance
Management and control of stocks other than pharmacy stocks	Lead Director
Management and control of computer systems and facilities	Committee Secretary
Monitor and achievement of management cost targets	Lead Director
Recording of payments under the losses and compensation regulations	Director of Finance
Individual Patient Funding Requests	Director of Nursing & Quality Assurance
Approve and ensure the publication of non-statutory Annual Report	Lead Director

This scheme only relates to matters delegated by the Joint Committee to the Lead Director and other WHSST Directors, together with certain other specific matters referred to in WHSSC SFIs.

Each WHSST Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these WHSSC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***WHSSC SFIs***
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the WHSSC SOs and will have the same effect as if the details within them were incorporated within the WHSSC SOs themselves.

These documents may be accessed from the Committee Secretary by written request.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

[Joint Committee to insert details, including detailed Terms of Reference and Operating Arrangements for each sub-Committee]

Annex 4

ADVISORY GROUPS AND EXPERT PANELS TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

[Joint Committee to insert details, including detailed Terms of Reference and Operating Arrangements for each Advisory Group and Expert Panel]

Schedule 4.2

MODEL STANDING ORDERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing SOs Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Emergency Ambulance Services Committee's (the EASC or the Joint Committee) proceedings and business. These EASC Standing Orders (EASC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated [26 September 2017] made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated [26 September 2017] between the Joint Committee and Cwm Taf Morgannwg University Health Board (the host LHB), form the basis upon which the Joint Committee governance and accountability

framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members, Joint Committee members, LHB and the National Collaborative Commissioning Unit (NCCU) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee.

Further information on governance in the NHS in Wales may be accessed at www.wales.nhs.uk/governance-emanual/.

Contents

Section: A – Introduction

Statutory framework

i) The Emergency Ambulance Services Committee (the Joint Committee) is a joint committee of each LHB in Wales, established under the **Emergency Ambulance Services Committee (Wales) Regulations 2014** (the EASC Regulations). The functions and services of the Joint Committee are listed in the **Emergency Ambulance Services Committee (Wales) Directions 2014,** (EASC Directions) and are subject to variations to those functions agreed from time to time by the Joint Committee**.** The Directions were amended by the **Emergency Ambulance Services Committee (Wales) Amendment Directions 2016.** The Joint Committee is hosted by the Cwm Taf Morgannwg University Health Board on behalf of each of the seven LHBs.

ii) The principal place of business of the EASC is National Collaborative Commissioning Unit, 1 Charnwood Court, Heol Billingsley, Treforest Industrial Estate, CF15 7QZ.

iii) All business shall be conducted in the name of the Emergency Ambulance Services Committee on behalf of LHBs.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The EASC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance

and non-emergency patient transport services and for the purpose of jointly exercising those functions will establish the joint committee.

viii) Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the EASC Regulations, which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) The Cwm Taf Morgannwg University Health Board as the host LHB shall issue an indemnity to the Chair, on behalf of the LHBs.

NHS framework

xi) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiii) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xiv) The Welsh Ministers, reflecting their constitutional and legal obligations under the **Well-being of Future Generations (Wales) Act 2015 (2015 No.02)**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in

all it does.

xv) The **Well-being and Future Generations (Wales) Act** also places duties on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Minister's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

xvii) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These EASC Standing Orders (SOs) and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation (The former Cwm Taf University LHB Scheme of Delegation has been adopted for use by the Committee in November 2016) to others;
- The EASC SFIs (The former Cwm Taf Standing Financial Instructions have been adopted for use by the Committee in November 2016);
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xviii) **Annex 2** to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with these EASC SOs.

xix) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the National Collaborative Commissioning Unit (NCCU) staff and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these EASC SOs and SFIs. Details of the Joint Committee's key operating procedures are also included in **Annex 2** of these SOs.

Applying EASC Standing Orders

xx) The EASC SOs (together with the EASC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any Joint Committee Sub Groups established by the Joint Committee, including any Advisory Groups. The EASC SOs may be amended or adapted for the Joint Committee Sub Groups or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on Joint Committee Sub Groups and Advisory Groups may be found in Annexes 3 and 4 of these EASC SOs, respectively.

xxi) Full details of any non-compliance with these EASC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit and Risk Committee at Cwm Taf Morgannwg UHB to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with EASC SOs is a disciplinary matter.**

Variation and amendment of EASC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxiii) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the EASC SOs, the Chair of the Joint Committee shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Committee Secretary.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these EASC SOs when interpreting any term or provision covered by legislation.

Relationship with LHB Standing Orders

xxv) The EASC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

xxvi) The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members.
Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, Joint Committee Sub Groups and Advisory Groups;
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, EASC SOs and the framework set by the LHBs and Welsh Ministers.

xxvii) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committees operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – EASC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the commissioning of emergency ambulance and non-emergency patient transport services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales. Since 2016, this has also included the commissioning of the Emergency Medical Retrieval and Transfer Services (EMRTS).

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of emergency ambulance and non-emergency patient transport services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of emergency ambulance service, non-emergency patient transport services and emergency medical retrieval and transfer services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance, non-emergency patient transport services and emergency medical retrieval and transfer services;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of emergency ambulance, non-emergency patient transport services and emergency medical retrieval and transfer services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the National Collaborative Commissioning Unit (NCCU) staff) in

accordance with any specific directions set by the Welsh Ministers;

- Establish mechanisms for managing the commissioning risks;
- Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance, non-emergency patient transport services and emergency medical retrieval and transfer services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the National Collaborative Commissioning Unit (NCCU) staff undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee

1.2.1 The membership of the Joint Committee shall be 9 voting members and three associate members, comprising the *Chair* (appointed by the Welsh Ministers) and the *Vice-Chair* (appointed by the Joint Committee from existing chief officer (executive) or nominated representatives of the seven LHBs), together with the following:

Chief Officers or nominated representative

1.2.2 A total of 7, drawn from each Local Health Board in Wales. (Where a Chief Officer intends to nominate a representative the nomination must be an Officer Member (Executive Director) of the LHB, must be in writing addressed to the Chair of the Joint Committee and must specify if the nomination is for a specific length of time.

Officer Member

1.2.3 An officer member employed by Cwm Taf Morgannwg University Health Board (the host LHB) to undertake the functions of the Chief Ambulance Services Commissioner. In addition,

1.2.4 Where a post of Chief Ambulance Services Commissioner is shared between more than one person because of their being appointed jointly to a

post:

i. Either or both persons may attend and take part in Joint Committee meetings;
ii. If both are present at a meeting they shall cast one vote if they agree;
iii. In the case of disagreement no vote shall be cast; and
iv. The presence of both or one person will count as one person in relation to the quorum.

Associate Members

1.2.5 The following three Associate Members who will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust;
- Chief Executive of the Welsh Ambulance Services NHS Trust;
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.6 The Joint Committee Chair may invite other members of the National Collaborative Commissioning Unit (NCCU) staff or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.3 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with EASC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.4 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and

appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.5 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in relation to the delivery of the functions exercised by the Joint Committee on its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.6 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

1.3.7 The Vice-Chair is accountable to the Chair for their performance as Vice-Chair.

Officer Members

1.3.8 Officer members are accountable to the Chair for their performance.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.2 The ***Vice-Chair*** shall be appointed by the Joint Committee from amongst the Chief Executives or their nominated representatives of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than four years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.3 Reference to the tenure of office of the Vice-Chair are to this appointment and not to their tenure of office as a member of the Joint Committee.

1.4.4 The appointment process for the Vice-Chair shall be determined by the Joint Committee, subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;

- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and
- Potential conflicts of interest are kept to a minimum.

1.4.5 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they applicable, and as specified in the relevant regulations. Any member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of emergency ambulance or non-emergency patient transport services and emergency medical retrieval and transfer services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the National Collaborative Commissioning Unit (NCCU) staff acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chief Officer.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these EASC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i. Schedule of matters reserved to the Joint Committee;
ii. Scheme of delegation to Joint Committee Sub Groups and others; and

Scheme of delegation to Officers all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Chief Ambulance Services Commissioner, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Joint Committee Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

3.1.2 Chair's action may not be taken where either the Joint Committee Chair or the Chief Ambulance Services Commissioner has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair and/or Deputy Chief Ambulance Services Commissioner will take a decision on the urgent matter, as appropriate.

3.2 Delegation to Joint Committee sub Committees and others

3.2.1 The Joint Committee shall agree the delegation of any of their functions to Joint Committee sub-Committees or sub-Groups or others, setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers.

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by Joint Committee sub-Committees or sub-Groups which it has formally constituted or to others.

3.3 Delegation to Officers

3.3.1 The Joint Committee will delegate certain functions to the Chief Ambulance Services Commissioner (CASC). For these aspects, the CASC, when compiling the Scheme of Delegation, shall set out proposals for those

functions they will perform personally and shall nominate other officers to undertake the remaining functions. The CASC will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Chief Ambulance Services Commissioner may periodically propose amendments to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

3.3.3 Individual Chief Officers are in turn responsible for delegation within their own teams in accordance with the framework established by the Chief Ambulance Services Commissioner and agreed by the Joint Committee.

4. JOINT COMMITTEE SUB-COMMITTEES AND SUB-GROUPS

4.0.1 In accordance with EASC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint sub-Committees and sub-Groups of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a Joint Committee sub-Committee and sub-Groups structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum it shall establish joint –sub-Committee which cover the following aspects of Joint Committee business:

- Quality and Safety (of the Host body)
- Audit and Risk Committee (of the host body)

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own Joint Committee sub-Committee or sub-Groups or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the Joint Committee sub-Committee or sub-Groups structure established by the Joint Committee, including detailed terms of reference for each of these Joint Committee sub-Committees or sub-Groups are set

out in **Annex 3** of these EASC SOs.

4.0.6 Each Joint Committee sub-Committee or sub-Group established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Joint Committee Sub-Groups, keeping any such aspects to the minimum necessary.

4.0.8 The membership of any such Joint Committee sub-Committee or sub-Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the Joint Committee sub-Committees' or sub-Groups' defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set out in EASC SOs 4.0.9) or others.

4.0.9 Members of the National Collaborative Commissioning Unit (NCCU) staff should not normally be appointed as Joint sub-Committee Chair, nor should they be appointed to serve as members of any sub-Committee set up to review the exercise of functions delegated to officers. Designated National Collaborative Commissioning Unit (NCCU) staff officers shall, however, be in attendance at Joint sub-Committees/groups as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all Joint Committee sub-Committees and sub-Groups and other bodies or groups operating on its

behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint Committee sub-Committee and sub-Group Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.2.2 Each Joint Committee sub-Committee and sub-Group shall also submit an annual report to the Joint Committee through the Chair within - six weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in **Annex 4** of the EASC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Sub Group reports formally, regularly and on a timely basis to the Joint Committee on their

activities. Sub Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Sub Group shall also submit an annual report to the Joint Committee through the Chair within six weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Annual Plan of Committee Business

6.2.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall

appear on every Joint Committee agenda.

6.2.2 The plan shall set out the arrangements in place to enable the Joint Committee to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

6.2.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of Joint Committee sub-Committees or sub-Groups, Expert Panel and Advisory Groups.

6.2.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisations website.

6.3 Calling Meetings

6.3.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.4 Preparing for Meetings

Setting the agenda

6.4.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Ambulance Services Commissioner, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from Joint Committee Sub Group and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.4.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of Joint Committee business.

Notifying and equipping Joint Committee members

6.4.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.4.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.4.6 In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.4.7 Except for meetings called in accordance with EASC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- At each LHB and the Joint Committee's principal sites; On each LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Joint Committee's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, each LHB shall set out when and how the Agenda and the papers supporting the public part of

the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

6.5 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

6.5.1 The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

6.5.2 The Joint Committee shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting an National Collaborative Commissioning Unit (NCCU) staff member or a patient.

In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

> *'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].'*

6.5.3 In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

6.5.4 The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.5.5 In encouraging entry to formal Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.5.6 Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Joint Committee, its Joint Committee Sub-Groups, Expert Panel or Advisory Groups

6.5.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its Joint Committee sub-Committees or sub-Groups, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.5.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice-Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Chief Executives present will agree who will preside.

6.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

6.5.10 At least four voting members, whom are LHB Chief Executives, must be present to allow any formal business to take place at a Joint Committee meeting.

6.5.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a representative/deputy to attend on their behalf. The nominated representative/deputy should be an Officer Member (Executive Director) of the same organisation. Nominated representatives/deputies will

formally contribute to the quorum and will have delegated voting rights.

6.5.12 If the Chief Ambulance Services Commissioner or another Associate Member is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g. a person deputising for the Chief Ambulance Services Commissioner will usually be the Deputy Chief Ambulance Services Commissioner, they will not have any voting rights.

6.5.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their nominated deputy/representative disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.5.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member or their deputy/representative and seconded by another Joint Committee member or their deputy/representative (including the Joint Committee Chair).

6.5.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.5.16 The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

6.5.17 **Amendments –** Any Joint Committee member or their deputy/representative may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.5.18 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.5.19 **Motions under discussion** – When a motion is under discussion, any Joint Committee member or their deputy/representative may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;
- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.5.20 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.5.21 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

6.5.22 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

6.5.23 A motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a Joint Committee sub-Committee or sub-Group /CASC to which a matter has been referred.

Voting

6.5.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Joint Committee.

6.5.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales.

6.5.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.5.27 A nominated deputy/representative of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of the Chief Ambulance Services Commissioner vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.6 Record of Proceedings

6.6.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.6.2 Agreed minutes shall be circulated in accordance with Joint Committee members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Freedom of Information Act, the Joint Committee's Communication Strategy and the Cwm Taf Morgannwg University Health Board Welsh language requirements.

6.7 Confidentiality

6.7.1 All Joint Committee members (including Associate members), together with members of any Joint Committee sub-Committee or sub-Group, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant Joint Committee sub-Committee or sub-Group or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, National Collaborative Commissioning Unit (NCCU) staff officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the EASC SOs. The Values and Standards of Behaviour document is the same as the host body Cwm Taf Morgannwg University Health Board.

7.1 Declaring and recording Joint Committee members' interests

7.1.1 **Declaration of interests –** It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Joint Committee member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. Joint Committee members must notify the Joint Committee of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Joint Committee members.

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Joint Committee members are in any doubt about what may be considered as an

interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Chief Ambulance Services Commissioner, through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This will include publication on the EASC website.

7.1.6 **Publication of declared interests in Annual Report –** Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales.

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary before the start of the Joint Committee meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.

7.2.3 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting. This may be appropriate, for example where the Committee is considering particular aspect of healthcare and a Member's organisation may be affected by the commissioning intention determined by the Committee;

ii. The declaration is formally noted and recorded, and the Joint Committee member participates fully in the Joint Committee's discussion, but takes no part in the Joint Committee's decision;

iii. The declaration is formally noted and recorded, and the Joint Committee member takes no part in the Joint Committee discussion or decision;

iv. The declaration is formally noted and recorded, and the Joint Committee member is excluded for that part of the meeting when the matter is being discussed. A Joint Committee member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Joint Committee.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a Joint Committee

member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 The **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The EASC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Chief Ambulance Services Commissioner, establishes and maintains a system for the declaration, recording and handling of National Collaborative Commissioning Unit (NCCU) staff officers' interests in accordance with the Values and Standards of Behaviour Framework. This will be done in conjunction with the declarations of interest recorded by the Welsh Health Specialised Services Committee which is also hosted by Cwm Taf Morgannwg University Health Board.

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit and Risk Committee (of the host body) will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with offers of gifts,[2] hospitality and sponsorship

7.5.1 The Values and Standards of Behaviour Framework the Cwm Taf Morgannwg Standards of Behaviour Policy to be adopted by the Joint Committee prohibits Joint Committee members and National Collaborative

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

Commissioning Unit (NCCU) staff officers receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or National Collaborative Commissioning Unit (NCCU) staff officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or National Collaborative Commissioning Unit (NCCU) staff officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the

investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** Cwm Taf Morgannwg Standards of Behaviour Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts, hospitality and sponsorship made to Joint Committee members. The National Collaborative Commissioning Unit (NCCU) staff officers will adopt a similar mechanism in relation to Cwm Taf Morgannwg University Health Board staff working within their areas.

7.7.2 Every Joint Committee member and National Collaborative Commissioning Unit (NCCU) staff officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Chief Ambulance Services Commissioner, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regards to gifts and hospitality, individuals must apply the following principles, subject to the considerations in EASC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded,

e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and National Collaborative Commissioning Unit (NCCU) staff Officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit and Risk Committee (or equivalent) at least annually. The Audit and Risk Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit and Risk Committee (of the Host Body).

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Joint Committee Sub Group, expert panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each Joint Committee Sub Group and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within six weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee,

the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these EASC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the **National Collaborative Commissioning Unit (NCCU)** individuals supporting EASC at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;

- Ensuring an effective relationship between the Joint Committee and its host LHB; and
- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The EASC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in EASC SOs, including the appropriate impact assessment.

Annex 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Introduction

As set out in EASC Standing Order 3, the Emergency Ambulance Services Committee (the Joint Committee) - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i) A sub-Committee of the Joint Committee e.g., Audit and Risk Committee (of the Host Body);

ii) A Group, Expert Panel or Advisory Group, e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii) Officers of the Joint Committee (who may, subject to the Joint Committee's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to Joint Committee sub-Committee or sub Group and others; and
- Scheme of delegation to officers.

all of which form part of the EASC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- **Everything is retained by the Joint Committee unless it is specifically delegated in accordance with the requirements set out in EASC SOs or EASC SFIs**
- **The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management**
- **Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility**
- **The Joint Committee must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development**
- **The Joint Committee must take appropriate action to assure itself that all matters delegated are effectively carried out**
- **The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes**
- **The Joint Committee may delegate authority to act, but retains overall responsibility and accountability**
- **When delegating powers, the Joint Committee will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.**

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Joint Committee

The Joint Committee will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Ambulance Services Commissioner

The Chief Ambulance Services Commissioner will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Ambulance Services Commissioner will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in EASC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Chief Ambulance Services Commissioner may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit and Risk Committee (of the Host Body)

The Audit and Risk Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[The Chair of the Audit and Risk Committee]** of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Deputy or Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner or reallocate powers, e.g., to a Committee or another officer.

The Quality and Safety Committee

The Quality and Safety Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for managing quality and safety.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[Joint Committee to insert details]** of their

concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Deputy or Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[4]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with EASC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are: • Collaborative Commissioning Framework Agreement(s) • EAS Integrated Medium Term Plan
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: EASC SOs ; ▪ EASC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements.

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
5	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
6	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework for performance management, risk and assurance
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Ambulance Services Commissioner in accordance with EASC Standing Order requirements
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with EASC SOs
10	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Ambulance Services Commissioner and officers
11	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
12	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments, e.g., the Committee Secretary
13	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit and Risk Committee

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
14	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-groups, including any joint sub-groups directly accountable to the Joint Committee
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Joint Committee sub-groups, or Group set up by the Joint Committee
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
17	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all Joint Committee sub-groups, and groups established by the Joint Committee
18	FULL	STRATEGY & PLANNING	Determine the Joint Committee's strategic aims, objectives and priorities
19	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
20	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Risk Management Strategy and plans
21	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Commissioning Plan and Population Health Needs Assessment (from HBs and Trusts) ▪ The development and delivery of emergency ambulance, non-emergency patient Transport services and emergency medical retrieval and transfer services for the population of Wales ▪ Improving quality and patient safety outcomes

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
			▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
22	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
23	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Ambulance Services Commissioner set out in the EASC SFIs
24	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements
25	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's National Collaborative Commissioning Unit (NCCU) staff on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
26	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee sub-groups, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
27	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-groups (as appropriate)
28	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans through the arrangements of the Host Body

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
29	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the Joint Committee's external auditor and approve action required, including improvement plans through the arrangements of the Host Body
30	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the Joint Committee's performance against Healthcare Standards for Wales and approve action required, including improvement plans
31	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Assembly Government
32	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR AND VICE-CHAIR			
34	CHAIR		In accordance with statutory and Welsh Government requirements
35	VICE-CHAIR		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[5]

EASC Standing Order 3 provides that the Joint Committee may delegate powers to sub-groups and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Groups; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

Cwm Taf Morgannwg Audit and Risk Committee arrangements
Cwm Taf Morgannwg Quality and Safety Committee arrangements
Management Group
Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery and Commissioning Group
Non-Emergency Patient Transport Service (NEPTS) Delivery Assurance Group

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Group terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to Joint Committee Sub Groups.

[5] As defined in Standing Orders

SCHEME OF DELEGATION TO NATIONAL COLLABORATIVE COMMISSIONING UNIT (NCCU) STAFF AND OFFICERS

The EASC SOs and EASC SFIs specify certain key responsibilities of the Chief Ambulance Services Commissioner, the Director of Finance (WHSSC/EASC) and other officers. The Chief Ambulance Services Commissioner's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other National Collaborative Commissioning Unit (NCCU) staff level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, set out in detail, together with the schedule of additional delegations below and the associated financial delegations set out in the EASC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[Joint Committee to determine]	**[Joint Committee to determine]**

This scheme only relates to matters delegated by the Joint Committee to the Chief Ambulance Services Commissioner and other members of the National Collaborative Commissioning Unit (NCCU) staff together with certain other specific matters referred to in EASC SFIs. In November 2016, the Joint Committee agreed to use the host body's Standing Financial Instructions (former Cwm Taf) and Scheme of Delegation.

Each member of the National Collaborative Commissioning Unit (NCCU) staff is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated (aligned to the arrangements of the host body).

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these EASC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***EASC SFIs***
- ***Scheme of Delegation***
- ***Values and Standards of Behaviour Framework (Cwm Taf Morgannwg University Health Board Standards of Behaviour Policy)***
- ***Risk Register***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the EASC SOs and will have the same effect as if the details within them were incorporated within the EASC SOs themselves.

These documents may be accessed by:

EASC Website http://www.wales.nhs.uk/easc/the-committee

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at www.wales.nhs.uk/governance-emanual/.Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE SERVICES COMMITTEE Standing Orders

Sub Groups

Management Group The overall purpose of the Management Group is to make recommendations to EASC and to ensure that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance, non-emergency patient transport services and Emergency Medical Retrieval & Transfer Service for the purpose of jointly exercising those functions will establish the joint committee.	**Terms of Reference** EASC Management Group ToR approve Approved EASC Meeting September 2019
Emergency Medical Retrieval and Transfer Services (EMRTS) Delivery and Commissioning Group	Awaiting review
Non-Emergency Patient Transport Service (NEPTS) Delivery Assurance Group	Awaiting review

Annex 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Terms of Reference to be included when available

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Health and Care Strategy Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Philip Kloer, Medical Director & Director of Health and Care Strategy
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mrs Libby Ryan-Davies, Strategic Programme Director

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

At its March 2019 meeting, the Health Board approved the Portfolio of Programmes - Scoping, Governance and Delivery document, and in doing so approved the initiation of a portfolio of programmes to deliver the Health Board's Health and Care Strategy, *A Healthier Mid and West Wales: Our Future generations living well*, namely Transforming our Communities, Transforming our Hospitals and Transforming Mental Health and Learning Disabilities. This paper provides an update on:

- Delivery of the Health and Care Strategy, through the portfolio of programmes, further to the update provided at the Public Board meeting on 25th July 2019;
- Developments in Carmarthenshire in relation to the delivery of *A Healthier Mid and West Wales* including delivery through the Transformation Fund;
- An update on progress with regard to the Portfolio of Programmes including the in-year re-prioritisation undertaken during 2019/20 to deliver the Annual Plan.

Cefndir / Background

The Health and Care Strategy *A Healthier Mid and West Wales: Our future generations living well* was approved by the Health Board at its Public Board meeting in November 2018. It sets the strategic direction for delivering care that is safe, sustainable, accessible and kind and describes:

- Our 20-year vision for the population health outcomes for current and future generations; and
- Our 10-year health and care strategy.

Since Board approval of the Health and Care Strategy in November 2018, and subsequent approval of the portfolio approach to delivery in March 2019, significant work had been undertaken to plan for the delivery phase. This progress was shared with the Board in July 2019. This progress update included establishment of the Portfolio of Programmes and subsequent programme activity; an update on achievement of/progress towards the portfolio establishment milestones; updates from key Portfolio and Programme Group meetings, including the Health and Care Strategy Delivery Group and Strategic Enabling Group; project updates; Risk Register; governance and resourcing.

Upon establishment, it was acknowledged that the portfolio of programmes will develop as the programmes emerge and mature, and as programme groups establish milestones, risks and benefits. Accordingly, it is necessary to provide updates at regular intervals on progress with regard to the portfolio.

This paper provides a more general update in relation to achievements towards delivery of *A Healthier Mid and West Wales* since approval of the strategy in November 2018, including a focus on Carmarthenshire in terms of key areas of delivery. A further update on progress with regard to the Portfolio of Programmes, since July 2019, is also included.

Asesiad / Assessment

1. General Update – Progress towards delivery of *A Healthier Mid and West Wales*

Since approval of *A Healthier Mid and West Wales*, the Health Board has been making progress at pace towards the delivery of the future models of health and care as set out in the Health and Care Strategy, and in particular early delivery of an enhanced primary and community care model as agreed by the Board. Key examples are included below:

***A Healthier Mid and West Wales* - A service that keeps people well, prevents ill-health or worsening of ill-health, and provides help early on**

- Increase in the number of Community Pharmacies who are able to deliver a Triage and Treat service (25 Community Pharmacies and 111 staff trained as at October 2019); plans are in place to further upscale this and to roll out the service in 2020 and beyond.
- Development of the Community Pharmacy Walk In Centres; further work is in train to scale up both the number and range of services that Community Pharmacy Walk In Centres will be able to deliver, to complement both in hours and out of hours service provision.
- Work is ongoing to develop a series of videos demonstrating the work that Community Pharmacies offer, which will be inclusive of the Triage and Treat service and Community Pharmacy Walk In Centres. Information Boards are available in all Community Pharmacies and Secondary Care Pharmacies across Hywel Dda promoting alternative access to services. A number of the Primary Care Clusters have also invested in information Pods/Boards for the GP practices as a mechanism of providing the most up to date information on service availability.
- Clusters have been working with varying models of Social Prescribing to assist with de-

medicalising a number of the issues that patients present with at GP Practices. This is something that the clusters continue to see as a priority in enabling patients to consider alternative ways of taking an active role in their own health and wellbeing.

- A pilot to support direct referral from Community Pharmacies in Llanelli to chest x-rays as part of a lung cancer early identification pathway has received ethical approval and has had a small number of referrals made. The project group will be reviewing the project, with a view to extending the roll out to other clusters where there is a high incidence of late identification of lung cancer.
- As part of the 2019 Pacesetters scheme a pilot of Sore Throat Test and Treat was supported as a joint innovation between a GP Practice and a Community Pharmacy. Training has now commenced for the roll out of this scheme which will be made available in 2020 onwards.
- Work is ongoing with Welsh Ambulance Services NHS Trust (WAST) to secure Advanced Paramedic Practitioners to work in managed practices as part of a rotational programme to assist with demand for home visits.
- Active engagement in the development of the Primary Care Academy at Swansea University which places Year 3 Medical Students in a GP Practice in Pembrokeshire for 11 weeks to provide them with the enhanced experience of working in General Practice.
- In 2019-2021 the Health Board has committed to funding places for three Academic Fellows to work in Practices where there are recruitment and retention, as well as potential sustainability, issues. It is anticipated that this programme will continue to develop and grow in numbers as the last two Academic Fellows who completed the programme have gone on to take partnerships in Hywel Dda GP Practices.
- As part of the Winter Funding Initiative, three bids have been submitted to Welsh Government for consideration to support enhanced care to patients in Care Homes through the use of technology to enable Skype consultations; proactive care for patients in Care Homes in the evenings and weekends (both in Ceredigion), and a proposal for extended weekend opening for Community Pharmacies Hywel Dda wide.
- A further five Independent Prescriber Community Pharmacy training places have been identified as part of the nationally funded programme.
- Pembrokeshire Primary Mental Health Practitioner - Since July 2019 a Primary Care Mental Health practitioner has been working from two GP surgeries in Pembrokeshire. This project has been modelled on a successful pilot in Cardiff and Vale UHB that has shown that having a Mental Health Practitioner based within GP surgeries leads to earlier and easier access for service users and a reduction in referrals to primary and secondary mental health services. Data is currently being collected to review the impact of the project, however early feedback has been positive from service users, GPs and Community Mental Health Teams.
- Occupational therapists are in the South Pembrokeshire Cluster, Ty Elli and Burry Port GP practices, providing a proactive and preventative community approach especially for frail patients to promote self-management of their health condition and maintain their independence and supporting a primary care vocational clinic research project in Pembrokeshire. This supports the population, including our workforce, to remain in or return to work.
- First contact point physiotherapy practitioners in all counties in primary care providing early assessment and intervention for people with musculoskeletal conditions. These advanced

practitioners provide specialist assessment, referral for investigations, deliver injection therapy, prescribe and refer to others. This supports GP sustainability, releases capacity and is a proactive approach.

- Implementation of multi-disciplinary working has commenced across Pembrokeshire and has been embedded in 11 out of 13 practices, with plans to implement fully across the system. The establishment of regular community and primary Multi-Disciplinary Team (MDT) meetings within GP practices enables the early identification and treatment/ support of vulnerable people in the community and those people who will benefit from an integrated approach to care.
- Development of a joint preventative strategy in Carmarthenshire called PEIPIL (Prevention Early Intervention and Promoting Independent Living).
- Development of the care aims approach within paediatric therapy services, which supports patients and families in their ability to stay well, self-manage and increases their ability to control their own lives. It ensures that intervention delivered is proportionate to their needs.

***A Healthier Mid and West Wales* - Providing more support so people can manage their health and well-being in their own homes and communities.**

- Opening of Aberaeron Integrated Care Centre in October 2019.
- Cardigan Integrated Care Centre on schedule to open in December 2019.
- Welsh Community Care Information System (WCCIS) anticipated to be operational in Ceredigion from December 2019. This will provide a single point of reference for health and social care professionals working in community settings.
- Ceredigion County team has commenced work with Aberystwyth University to explore opportunities for technological developments to support health care delivery and population health.
- Four “shared care” older people’s beds anticipated to open in Ceredigion in January 2020.
- Submission to Welsh Government of the Cross Hands Outline Business Case in October 2019.
- Development of the Gorwelion 24 Hour Community Mental Health Centre into a 24/7 drop-in service from Gorwelion (current Aberystwyth Community Mental Health Team base) including a designated place of safety for those people that may come in via the police for a mental health assessment. The Community Mental Health Team, Crisis Team and Local Primary Mental Health Support Service and Peer Mentors are working together to provide the 24/7 rota needed for the project. Additionally, a significant capital investment from the Health Board has been committed to ensure the building is fit for purpose. Gorwelion is currently operating on a 7 day basis and will be expected to phase up to a 24/7 service from January 2020.
- Since December 2018 the Health Board has been working with Hafal, Llanelli Mind, the Local Authority, WAST and Dyfed Powys Police to develop a joint run out of hours mental health service (6pm-2am, Thursday-Sunday) in Llanelli town centre, called the Llanelli Twilight Sanctuary. This ambitious project, the first service of its kind in Wales, opened on 12th September 2019. The Twilight Sanctuary provides a place of sanctuary for individuals at risk of deteriorating mental health, who may require support and advice

through the provision of a range of supportive interventions in a welcoming and homely environment. This is a managed drop in service and service users are encouraged to ring directly in order to book an appointment.

- Successful amalgamation of Goodwick Surgery with neighbouring Fishguard Surgery in March 2019, and full renovation of the integrated health centre to create additional clinical space and improved access to a number of healthcare professionals.
- Development of Virtual Pulmonary rehabilitation as part of care closer to home. A pilot project was established for people with chronic respiratory disease to receive specialist intervention closer to their home and support them to manage their chronic health condition. This uses technology and a hub and spoke methodology and has received awards for innovation. The project is now being rolled out across the Health Board in 2020, and being progressed in a new approach to the multi-morbidity rehabilitation model going forward.
- A significant reduction in bed days in Carmarthenshire during 2018/19, saving 17,500 bed days across Glangwili and Prince Philip Hospitals which can be linked to the significant Integrated Care Fund investment into the Transfer of Care Advice and Liaison Service (TOCALS).
- Promotion of the Making Every Contact Count (MECC) methodology within Hywel Dda, and a proposal to train the Health Board's entire therapies workforce to Make Every Contact Count. MECC is a proven approach to encouraging more conversations about health and health behaviours by staff during their routine contacts with patients. Having a brief non-judgemental conversation, when the appropriate opportunity comes up, can support people to take responsibility for their own health and wellbeing.
- A Learning Disabilities Intensive Support Team has been created, including staff from Ty Bryn and Tudor House, with the aim of people being supported at home to help avoid inpatient admissions. This will be a 12 month 'proof of concept' pilot with built in evaluation as part of the Bevan Commission Exemplar Programme. The team of nurses and support workers will provide support for people that require an increased level of input for a short and focused amount of time.
- Support worker development to upskill staff and introduce new roles to enable a consistent approach to preventing deconditioning, rehabilitation and enablement and release time of registered professionals. This includes accredited training e.g. diploma and apprenticeship.
- A number of initiatives across therapies to support people to manage their own health and well-being:
    - Embedding the cancer rehab approach across the Health Board;
    - Therapist delivered dementia well-being service;
    - Supporting people with chronic conditions such as osteoarthritis of knee and low back pain. Collaborative rehabilitative and self-management approach with local authority (NERS);
    - Podiatry professionals working collaboratively with the expert patient programme (EPP) to support people to maintain healthy feet and to self-manage their chronic condition. This project has won an NHS Wales award;
    - Foodwise programme - working with expert patient programme, a dietetic intervention to help people to manage their weight;
    - Chronic condition management- Diabetes management- Type 2 diabetes first steps

group education programme providing early intervention to help people manage their condition. This has been tested and is now being rolled out across the Health Board
  - Weight management emotional eating groups promoting self-management established across the Health Board
  - Improving patient experience and access - the dietetics service is working with medicines management providing an alternative method of supporting people to self-manage their coeliac disease

***A Healthier Mid and West Wales* - Through Localities we will develop solutions on what matters to local people, connecting and building on the strengths of communities so people have a sense of belonging and stay well.**

- Establishment of a multi-agency group in Milford Haven which includes statutory and non-statutory partners who are integral stakeholders within integrated community networks, for example, the local fire station crews, neighbourhood Police Community Support officers, leisure centre teams, library staff, neighbourhood youth workers, third sector teams and other community anchors who epitomise the core of community centred approaches. Building on the success of this group the ambition is to develop the model across all integrated community network areas in Pembrokeshire.
- The Investors in Carers quality assurance scheme has also been rolled out to many health and social care settings as a means of helping carers to be identified and to be signposted to gain help and support to continue caring.
- The Dream Team, a stakeholder group of people with learning disabilities that fully engage with the Learning Disabilities Programme Group (LDPG), won an NHS Award for Empowering People to co-produce their care at the NHS Awards in September 2019. The Dream Team have developed a Charter for people with learning disabilities to explain what matters to them, and have achieved considerable success in securing widespread sign up to the Charter .
- Successful award of over £12 million in Transformation Funds and progress in relation to delivery of funded projects:

  Programme 1- Proactive Technology Enabled Care
  - Regional Service Level Agreement in place with Delta Wellbeing for delivery of wellbeing assessment and proactive calls
  - Regional strategic and operational group well established
  - Strategic partnership agreed with Tunstall
  - Finalised assessment, support and review tool hosted on data platform
  - All infrastructure upgrades completed
  - Commissioned community based pathways in place (Carmarthenshire and Pembrokeshire)
  - Recruitment in train for all counties – filled posts in Carmarthenshire

  Programme 3 – Fast-tracked, consistent integration – Crisis Response Service
  - Detailed structures for delivery of crisis response function developed across the three county areas and alignment with programme 1 arrangements to ensure effective clinical response where necessary, with recruitment to the teams commencing
  - Appointment of project managers at locality level to coordinate integration and

improvement initiatives
- Established governance arrangements at county level
- Completed and modelled business cases
- Financial sustainability modelling completed (Carmarthenshire)
- Recruitment to key clinical roles in train
- Additional patient capacity secured with incremental roll out of delivery models
- Staff training secured and in progress
- Engagement and consultation events in progress

Programme 7 – Connections for All
- Specification developed for review of community connector arrangements, and recruitment commenced to key posts to take forward development of a consistent and sustainable model
- Volunteering Officers being appointed by County Voluntary Councils
- West Wales is Kind investment fund launched 1st October 2019
- Digital Skills Platform being explored
- Community Connector Plus posts being filled (regional post via HDdUHB)
- Specification for West Wales is Kind campaign under development

***A Healthier Mid and West Wales* - Our hospitals will play an important role providing quality specialist support when needed.**

- Development of the "Bronglais General Hospital: Delivering Excellent Rural Acute Care" strategy which aims to ensure sustainability of the acute services provided from Bronglais District General Hospital to the population of Ceredigion and mid-Wales. The BGH strategy is being presented to Board [see agenda item 4.2].
- Investment in Withybush General Hospital to provide the best care possible for patients now which includes a £3 million refurbishment of Wards 9 and 10; improvements to the Coronary Care Unit and Ward 3 (surgery); and opening of an Ambulatory Care Unit. This also includes recruitment to three physician associate roles, advanced nurse practitioners, and advanced paramedics in out-of-hours.
- Front door therapy services have been established at all 4 acute hospitals. The therapists facilitate rapid assessment to ensure that patients are not being inappropriately admitted and introduce therapeutic intervention into the care plans for those that need to progress through to inpatient care. The service are now progressing this multidisciplinary model including developments such as clinical criteria for discharge.
- The fire and ambulance services development of co-responders, to provide the earliest possible response to life threatening medical emergencies, in St David's, Crymych and Angle.
- Commencement of a collaborative care model at Enlli ward, Bronglais General Hospital, for Older Adult Mental Health Services.

In order to progress the capital planning process to support delivery of the Health and Care Strategy, it was agreed with Welsh Government that a plan for the capital programme would be required. This has been produced and shared with Welsh Government colleagues and sets out the key deliverables and the broad timescales for the:

- Business Case process;
- Land acquisition process, and
- Infrastructure developments included in the capital programme.

The capital programme plan also sets out the external specialist expertise as well as an in-house team which will be required to manage the programme. A draft 'plan on a page' which sets out at high level the main components of the capital programme which the UHB will need to manage in support of delivery of the Health and Care Strategy is provided at Appendix 1.

2. Carmarthenshire Update

The approach in Carmarthenshire is to build on strong integrated structures delivering seamless care and support at locality level, working across primary and community health and social care with an embedded MDT approach. Services are co-designed at a locality level, which is evidenced by the recent approach that has taken place in the Amman Gwendraeth locality in relation to local sites and development of health and wellbeing centres, using an assets based approach.

The Outline Business Case (OBC) for the Cross Hands Health and Wellbeing Centre has been approved by the Health Board via the Executive Team and Chair's Action on 31st October 2019, for submission to Welsh Government during week commencing 4th November 2019. Instruction to progress to developing the Full Business Case has been provided to the design team, to commence further detailed design work with outline planning permission awaited.

Carmarthenshire's social model for health acknowledges that the population's health is largely shaped by factors outside of health and care services and aims to address a place based model of health and wellbeing. Carmarthenshire will continue to recognise this through integrated locality plans supported by a coherent locality leadership group which designs services and provision based not only on the localities identified needs but also its assets and strengths. A large scale asset mapping exercise is currently underway in Amman Gwendraeth as part of the co-design process and will be replicated across the county.

The priorities for Carmarthenshire's county based and locality plans over the next three years are to co-design services based on four tiers of support outlined both in the three year plan and delivery plan entitled ***A Healthier Carmarthenshire***. These documents operationalise ambitions and design assumptions set out in the strategy.

The four tiers are:

- Tier 1. Locality Resilience: *'Help you develop strong communities'*
- Tier 2. Integrated Proactive Care and Support; *Help to Help Yourself*
- Tier 3. Integrated Intermediate Care; *Help when you Need It*
- Tier 4. Integrated Progressive and Complex Care and Support; *Ongoing Help when you Need It*

A Healthier Carmarthenshire focuses directly on the next 18 months in order to maximise the impact achieved through additional funding sources such as the Integrated Care Fund and Transformation fund. This plan identifies a significant piece of work that will be delivered across the whole county at each tier of delivery and clearly sets out how the shift from acute to community services will be achieved.

Progress since November 2018 on these tiers include:

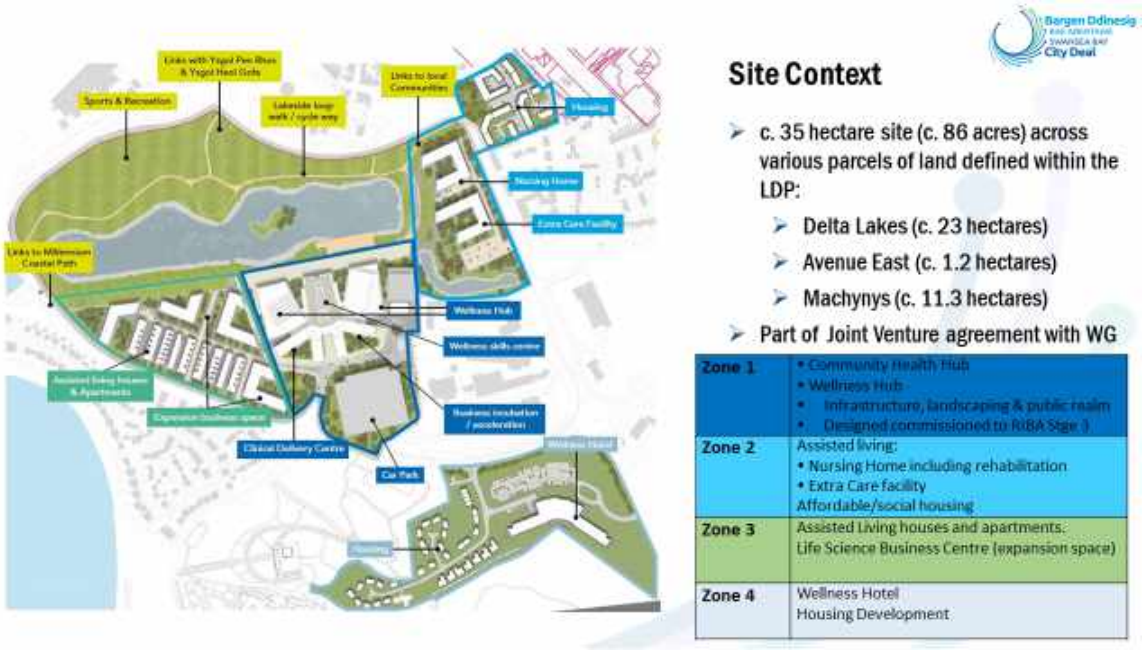
Tier	Progress (since November 2018)
Helping strong communities	• A cross sectional steering group set up through the Public Services Board (PSB) which aims to deliver a place based system of wellbeing. • Co-design workshops held where an action plan to deliver a model of community resilience was devised by front line workers. • ***Carmarthenshire is Kind*** initiative devised and developed with a co-design event and to date delivered to nearly 200 community members. ***Carmarthenshire is Kind*** is currently being integrated into education. • Wide scale implementation of Dementia Friendly Communities with two communities in the 3T's localities working towards Dementia Friendly status.
Help to help yourself	• A major success at locality level which addresses wider determinants is the employing of Social Prescribers for every practice in Carmarthenshire through joint arrangements between primary care/social care and/or the third sector. • Increase in third sector and community groups listed on Dewis. • Increase in community groups set up since November 2018 with direct support from social prescribers or community connectors. • Workforce within Delta Wellbeing has been increased to deliver the 'CONNECT' Technology Enabled Care (TEC) prevention programme and discussions are progressing with Welsh Ambulance NHS Services Trust and the Mid and West Fire and Rescue Service to develop rapid response pathways for citizens who require urgent response following TEC trigger to situations including falls. • Existing care pathways within the Localities and their Community Resource Teams are being realigned to support the TEC prevention programme and our Single Point of Contact (SPoC). The latter is being strengthened with additional multi disciplinary professionals to ensure effective, efficient and safe decision making.
Help when you need it	• Improved model of therapy-led reablement showing improved outcomes and higher percentage of individuals leaving with no long term support required. • A flexible model of community based support has increased its capacity and spread through the CUSP programme (Home from

	Hospital / Home not Hospital) – where the third sector collaborate to improve individual outcomes. • Programme 3 of the Transformation Fund which is related to the development of a crisis response intermediate care pathway (as according to National Audit for Intermediate Care and NICE Guidance) is also well under way. This development aligns to both TEC prevention and the SPoC improvements outlined above. We have successfully recruited additional registered nurses and health care support workers to the crisis response pathway which will enhance our existing Acute Response Team to provide an alternative to admission for our GPs and support earlier discharge from hospital (within 72 hours). A demand and capacity modelling exercise undertaken to support development of the crisis response pathway demonstrated that it should deliver a 25% reduction in bed days and reduce our conveyance rate to hospital which is currently at 73% and hence aligns with 'A Healthier Mid and West Wales' design assumptions.
Ongoing specialist help	• Rolled out the Fulfilled Lives model of care and support for those living with cognitive impairment or dementia across the whole county after successful evaluation in Llanelli locality. • Development of reablement ward in Glangwili Hospital providing focussed therapy support for patients needing rehabilitation prior to discharge and reducing the requirement for care packages on discharge. • Development of separate minor injury unit from the main A&E department in Glangwili Hospital. • Implementation of frailty support workers on Cadog, CDU and Teifi ward in Glangwili Hospital to ensure patients mobilise and prevent deconditioning. • Implementation of Advanced Nurse Practitioner's in A&E, CDU and cardiology in Glangwili Hospital. • Surgical Assessment Unit in Glangwili Hospital from December 2018 to triage surgical referrals and seeing patients direct on the unit, thereby avoiding GP referrals being seen in A&E. • Cadog frailty unit commenced in Glangwili Hospital to ensure frail older adults receive geriatric assessment and enhanced therapy support. • Availability of 7 day Trauma Nurse in Glangwili Hospital. • 7 day physiotherapy working at Prince Phillip Hospital • Frailty clinic dally in Prince Philip Hospital to provide an alternative to admission for frail patients

Llanelli Wellness Village Update

The overall project deliverables and benefits remain unchanged as the full scope of the Village project will be maintained, and is overseen by a Project Board chaired by Carmarthenshire County Council (CCC) Chief Executive, and comprising membership from key stakeholders.

The Village comprises a number of individual parcels of land, these have been divided into zones, and the zoning strategy is set out below:



The Community Health Hub is the only area of City Deal funding and therefore the only area covered within the City Deal Full Business Case, and comprises an Education and Training centre, research, business development and clinical delivery, designs for which continue to evolve with stakeholder engagement.

A work stream has also been established to scope the assisted living elements of the Village. This will comprise a nursing home, residential rehabilitation and extra care housing.

3. Progress with Portfolio of Programmes

a. Executive Team Priorities for 2019/20 – Annual Plan

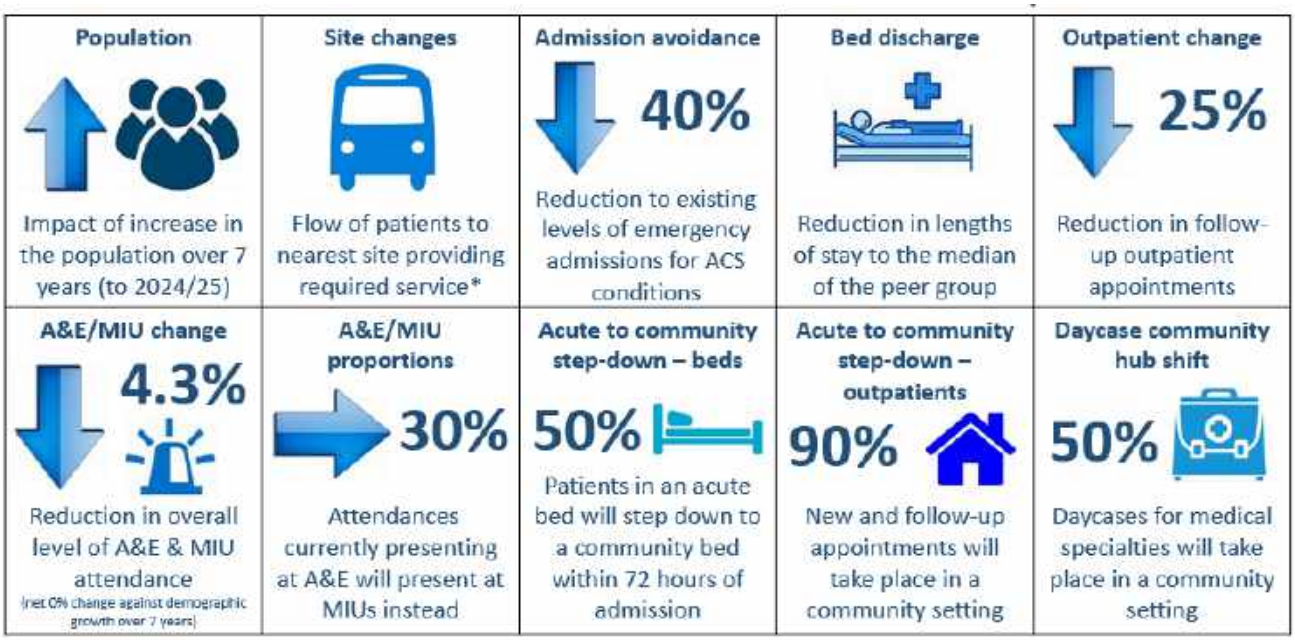
In order to accelerate the delivery of key projects identified both within the 2019/20 Annual Plan and Portfolio Programmes; and to achieve in-year performance and financial targets, a re-prioritisation exercise was completed in September 2019, by the Executive Team.

This resulted in the identification of a number of prioritised projects, to be delivered at pace during 2019/20. In order to successfully deliver the projects, it was agreed that resource would be directed through the establishment of project teams for each project, consisting of clinical input; project management and project support (through both the Programme Management Office and Transformation Programme Office); service improvement expertise; analytics; and communications where required. It is noteworthy that the resources are allocated across multiple projects, rather than being dedicated to a single project, therefore each individual identified will be supporting more than one of the

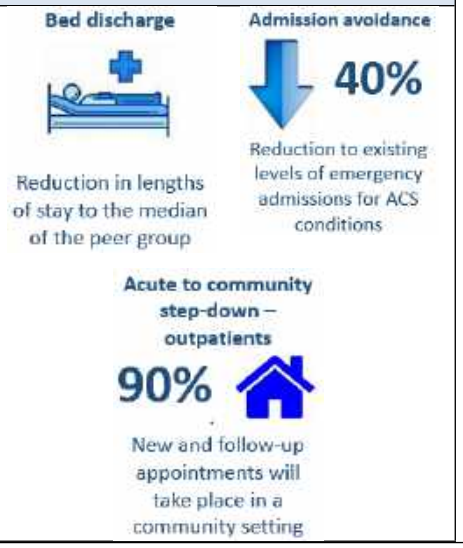
projects.

As a proportion of the projects align with the scopes of the three strategic programmes within the Portfolio of Programmes, it was agreed that the prioritised projects would continue to report through this structure and governance. For all of the prioritised projects, the reporting arrangements are detailed below.

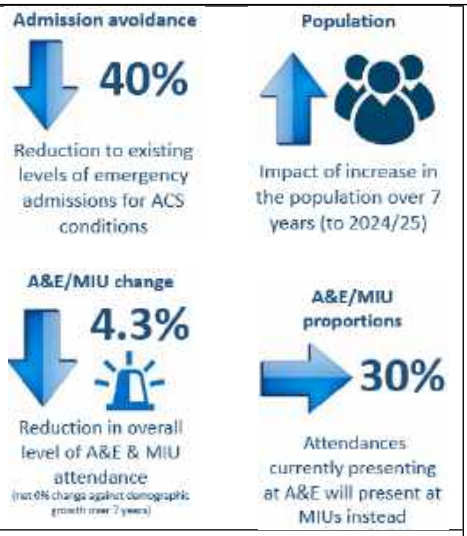
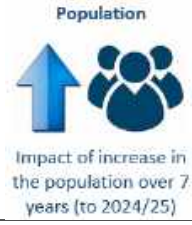
Assurance is provided to Board on the alignment of the prioritised projects to the delivery of *A Healthier Mid and West Wales,* through their contribution towards the achievement of the design assumptions underpinning the strategy, which are included below:



The prioritised projects are listed in the table below, along with the project team skills and resource allocated to support the operational teams, reporting arrangements, and the design assumptions to which they contribute:

Project	Reporting	Design Assumption(s)
Patient Flow – Length of Stay	Transforming our Hospitals Programme Group	

Patient Flow – Critical Care	Transforming our Hospitals Programme Group	
Outpatients	Transforming our Hospitals Programme Group	
Stroke Pathway	Transforming our Hospitals Programme Group	
Programme Business Case	Transforming our Hospitals Programme Group	
Patient Flow – Out of Hours	Transforming our Communities Programme Group	

Patient Flow – Primary Care	Transforming our Communities Programme Group	
Chronic Conditions /Community	Transforming our Communities Programme Group	
Mental Health and Learning Disabilities	Transforming Mental Health and Learning Disabilities Programme Group	
Dementia Action Plan	Executive Team	
Portfolio Milestones/Actions	Health and Care Strategy Delivery Group	
Workforce	Workforce Project Group / Executive Team	
Theatres	Executive Team	
Demand Optimisation – Pathology & Radiology	Executive Team	

Commissioning & Contracting	Executive Team	
Efficiency Opportunities	Executive Team	
Medicines Management	Executive Team	
Turnaround Corporate Support	Executive Team	

b. Slippage on Delivery of Portfolio Milestones

Recruitment into the Transformation Programme Office over recent months has impacted on capacity to progress key elements of portfolio level work. This, alongside the re-allocation of resource to support prioritised projects for 2019/20 as detailed above, has resulted in slippage with a number of portfolio milestones, previously for completion by July 2019. This was discussed at the Health and Care Strategy Delivery Group meeting on 16th September 2019 [see update report at agenda item 6.1.1 for detail) and it was agreed to revise the projected completion dates for the affected milestones to 31st March 2020, to be progressed with limited capacity at portfolio level during the next six months alongside the prioritised projects for 2019/20.

The affected milestones are detailed below:

Milestones	Projected Completion Date	Revised Completion Date
Development of detailed plans for all programmes.	**31-07-2019**	**31-03-2020**
Identification of programme milestones.	**31-07-2019**	**31-03-2020**
Development of a detailed portfolio timeline (Gantt chart) based on detailed programme milestones.	**31-08-2019**	**31-03-2020**
Development of a benefits realisation management methodology.	**30-06-2019**	**31-03-2020**
Development of a robust process for the management of risks.	**31-07-2019**	**31-03-2020**
Establishment of a variety of evaluation methods.	**31-07-2019**	**31-03-2020**
Development of detailed communications and engagement plan based on the final programme plans.	**31-07-2019**	**31-03-2020**

Argymhelliad / Recommendation

The Board is asked to receive and discuss updates on:

- Delivery of the Health and Care Strategy, through the portfolio of programmes, further to the update provided at the Public Board meeting on 25th July 2019;
- Developments in Carmarthenshire in relation to the delivery of *A Healthier Mid and West Wales,* including usage of Transformation Fund;
- In-year re-prioritisation of projects undertaken during 2019/20 to deliver the Annual Plan.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	NA – no open risks on Datix Risk Register. A Portfolio Risk Register is under development, to be informed by HCSDG. Identified risks which threaten achievement of the Health Board's strategic objectives will be considered for escalation to Board Assurance Framework and Corporate Risk Register.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Transforming Clinical Services: • Engagement Review findings (ORS Report) • Phase 1: 'Discover' Output Report - The Case for Change (Phase 1 Output Report) • Consultation closing Report The Parliamentary Review of Health and Social Care in Wales – A Revolution from Within: Transforming Health and Care in Wales The King's Fund - Developing accountable care systems Lessons from Canterbury, New Zealand (2017) The King's Fund - Transforming our health care system: Ten priorities for commissioners (2016) The King's Fund - Reimagining community services: making the most of our assets (2018) The King's Fund - New care models Emerging innovations in governance and Organisational form (2015) http://www.wales.nhs.uk/sitesplus/862/page/95249
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	HDdUHB Executive Team HDdUHB Board Seminar HDdUHB Community Health Council

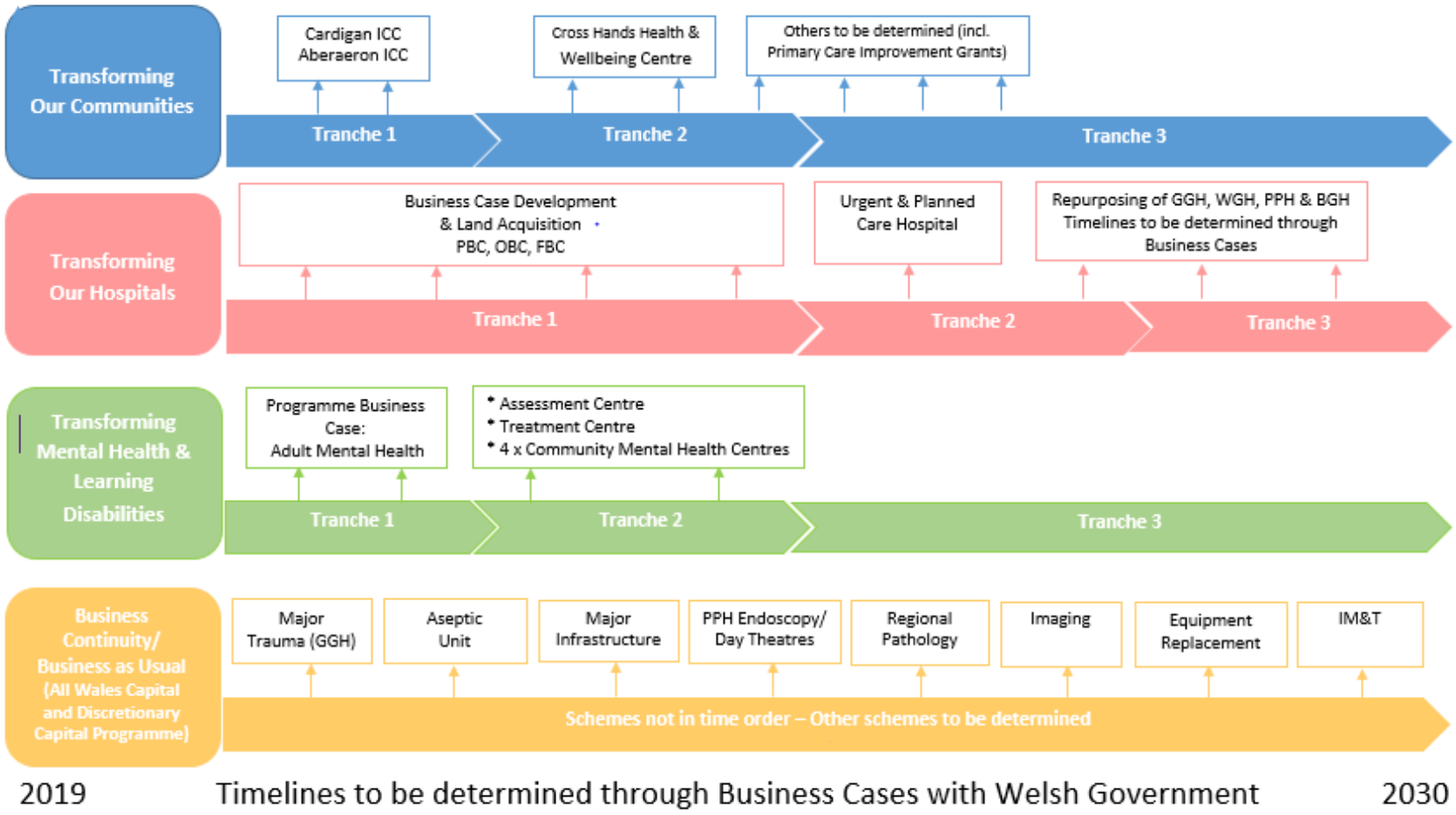
Parties / Committees consulted prior to University Health Board:	Integrated Executive Group of the Regional Partnership Board

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Discussions are progressing with Welsh Government on the resourcing of the core team. Further impact assessment will be undertaken during the delivery of the health and care strategy to identify any specific financial/service impacts and mitigations. Integrated Impact Assessment approved by Board 29th November 2018
Ansawdd / Gofal Claf: Quality / Patient Care:	No adverse quality and/ or patient care outcomes/ impacts are expected. Further impact assessment will be undertaken during the delivery of the health and care strategy to identify any specific quality/patient care impacts and mitigations. Integrated Impact Assessment approved by Board 29th November 2018
Gweithlu: Workforce:	No adverse or future staffing impacts are expected. Communications and continuous engagement with staff will seek to reduce any potentially adverse workforce impacts. Further impact assessment will be undertaken during the delivery of the health and care strategy to identify any specific workforce impacts and mitigations. Integrated Impact Assessment approved by Board 29th November 2018
Risg: Risk:	A comprehensive risk management approach for the delivery of the strategy is in development with the TPO and the Head of Assurance and Risk. Further impact assessment will be undertaken during the delivery of the health and care strategy to identify any specific risks and mitigations. Integrated Impact Assessment approved by Board 29th November 2018
Cyfreithiol: Legal:	There are potential legal impacts or potential legal challenge to any design that would alter the way services are operated. Further impact assessment will be undertaken during the delivery of the health and care strategy to identify any specific legal impacts and mitigations. Integrated Impact Assessment approved by Board 29th November 2018
Enw Da: Reputational:	There is significant political and media interest in service changes as a part of the delivery of the health and care strategy. Further impact assessment will be undertaken during the delivery of the health and care strategy to identify any specific reputational impacts and mitigations. Integrated Impact Assessment approved by Board 29th November 2018

Gyfrinachedd: **Privacy:**	No impact on individual's privacy rights, confidentiality or an information security risk anticipated. Further impact assessment will be undertaken during the delivery of the health and care strategy to identify any specific privacy impacts and mitigations. Integrated Impact Assessment approved by Board 29th November 2018
Cydraddoldeb: **Equality:**	The Equality Impact Assessment (EqIA) for Phase 2 of the TCS programme identified that certain people with one or more protected characteristics, and other potentially vulnerable groups, may be disadvantaged by service changes. It also identified how these risks may be mitigated and where there may be positive impacts. Further impact assessment - and specifically equality impact assessment - will be undertaken during the delivery of the health and care strategy to identify any specific equality impacts and mitigations. Integrated Impact Assessment approved by Board 29th November 2018.

Appendix 1

Capital Programme Plan: Draft Plan on a Page



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	A Healthier Mid and West Wales: Our Future Generations Living Well Bronglais General Hospital: Delivering Excellent Rural Acute Care
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Phil Kloer, Medical Director & Director of Clinical Strategy
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joe Teape, Director of Operations & Deputy Chief Executive

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Hywel Dda University Health Board's (HDdUHB) strategic vision, "*A Healthier Mid And West Wales: Our Future Generations Living Well*" was agreed in November 2018 and confirmed the strategic importance of Bronglais District General Hospital (BGH) as a provider of urgent and planned health care services to the population of mid Wales and as a hub from which care closer to home can be delivered. The delivery phase of the strategy required the production of a clinical strategy for the future services at BGH, in line with the core principles Safe, Sustainable, Accessible and Kind, setting out:

- A vision for BGH as a rural provider of acute health services
- How BGH will provide high quality care to its patients
- How services will network so that they are provided as close to home as possible across the whole of mid Wales (the populations of Ceredigion, Montgomeryshire, South Merionethshire and parts of Brecknockshire and Radnorshire)
- The impact of service, professional and technological development and innovation on the delivery of acute care for patients
- How long term sustainability of services will be delivered

The development of the clinical strategy for BGH has been clinically led as part of Hywel Dda's strategic development programme and addresses the challenges of providing high quality care to remote urban and rural populations, and supported by the Transformation Programme Office. The Board approved check and challenge process has been applied to test against key domains and support the decision making process.

The clinical strategy document "Bronglais General Hospital: Delivering Excellent Rural Acute Care" is attached in full at Annex 1.

Cefndir / Background

The confirmation of the strategic importance of BGH in HDdUHB's Health & Care Strategy meets the recommendations of the Longley Review (2014), Welsh Government aspirations and the required focus that has been identified from the Mid Wales Joint Committee for Health and Care's work programme through extensive patient and public involvement.

The resulting strategy for BGH sets out how 24/7 acute and elective care can been delivered to the population of mid-Wales, who would otherwise be unable to access services in a reasonable timescale.

This strategy is specific to BGH and secondary care acute and planned care provision, and aligns with the Community and Primary Care plans as part of the whole system of health care for mid Wales. The strategy document, therefore, addresses the requirement as part of the delivery of the Health & Care Strategy, for BGH to:

> "…build its reputation as an excellent rural provider of acute and planned-care. It will continue to provide urgent, emergency and planned care services, with more specialist cases transferred to our new urgent and planned care hospital as part of our wider hospitals network (as well as other regional sites for more critical care)" *A Healthier Mid and West Wales 2018*

The BGH clinical strategy must be read therefore as a key driver for the Ceredigion's whole system plan "CAREdigion" which sets out how the development of primary and community services will move care closer to patients and maximise opportunity for repatriation of services to BGH as part of a hospital network and with our partners.

The BGH Strategy Group facilitated comprehensive clinical involvement and engagement across all services to ensure that those services not under the direct leadership of the Ceredigion/BGH team were involved in the development of the strategy.

However, as the first of the "hospital" strategies developed to define the future vision for hospital services, and being one of only two hospitals that will provide 24/7 emergency care within the Health Board as set out in the Health & Care Strategy, it provides significant learning to apply to the development of the other hospital strategies and plans.

Asesiad / Assessment

Health and care services in Ceredigion are progressing early delivery in key areas of the Health and Care strategy with the provision of two Integrated Care Centres by the end of 2019 which puts in practice the care and support required to support the needs of the local populations alongside improved access to services in BGH as part of a whole system of care.

The BGH clinical strategy has been developed by clinicians utilising the latest evidence and thinking around rural healthcare, and with reference to the relevant guidelines, policies and strategies in its development. The strategy has been reviewed and scrutinised at key points during its development:

- Executive Team meetings on 11 February 2019 and 10 June 2019
- Health Board Public meeting on 25 July 2019
- Transforming our Hospitals programme group meetings on 12 June 2019, 13 August 2019 and 11 October 2019
- Mid Wales Joint Committee for Health and Care meeting on 21 May and 1 July 2019
- Mid Wales Joint Committee Planning / Delivery Executive Group 11 June 2019
- Mid Wales Joint Committee Public meeting 1 July 2019

At the meeting of the Transforming our Hospitals programme group on 13 August 2019 it was agreed that the Board approved check and challenge process would be applied to the strategy to provide assurance to and assist the decision making of the Health and Care Strategy Delivery Group.

The population served by BGH has a complexity that other hospitals are not exposed to in terms of the geography, commissioning arrangements and clinical pathways across rural mid Wales, hence ready-made models of service do not provide a single solution, but form an opportunity for a unique model and approach to provision.

As the first hospital strategy to be developed in order to deliver the HDdUHB *A Healthier Mid and West Wales* Health & Care Strategy, the check and challenge process undertaken for the BGH strategy confirmed a number of key areas where a Health Board wide approach is required across the portfolio of transformation programmes, to ensure consistency, namely:

- Evaluation and outcome measures at both strategic and implementation level
- Service commissioning relationships, including need to adopt tertiary level pathways that reflect "close to home" for residents in non-HDdUHB areas
- Using Teulu Jones "avatar" family to explore, test and describe the experience of people across a wide geographical area
- Recognition of the "bedless" community model of delivery in Ceredigion may impact upon investment assumptions in the overall Health Board strategic model and the opportunities this presents for the wider health and care system
- The importance of defining the community service model and plan in detail within a locality to frame the opportunities for acute service change and activity shift in order to deliver the design assumptions underpinning the Health & Care strategy

Oversight of the development and implementation of the plan will need to be coordinated and, because of the unique geographical challenges that BGH responds to, this will be led by the Mid-Wales Joint Committee for Health and Care's Clinical Advisory Group and overseen by the Transforming our Hospitals programme to ensure alignment across the 3 strategic programmes (Transforming our Hospitals, Transforming our Communities and Transforming Mental Health & Learning Disabilities). This will ensure:

- Defined clinical leadership
- A coordinated approach across all work-streams to ensure appropriate governance arrangements, and the availability of support from key enabling functions (workforce, finance, informatics, estates).
- Continuous engagement and communication with the population who access services at BGH
- Consistent and continuous staff engagement and partnership working with staff side trade union representatives during the implementation phase.

Implementation of the strategy will be progressed through development of detailed service-level plans. These plans will set out:

- Financial assessment including opportunities to improve "value" and maximise alignment between various funding streams with a plan to ensure that on-going revenue commitments are sustainable and deliverable
- Equality impact and integrated impact assessments
- Workforce planning (recruitment, retention and organisational change / development)
- Service level change required to deliver the BGH strategy

It is important to recognise that the strategy sets out a vision for future services at BGH, but that this now needs to be translated into detailed implementation plans, subject to Board approval, as part of the whole system plan for health and care in Ceredigion and surrounding areas.

As this is a Strategy, Business Cases will be completed for significant individual investments as part of the detailed implementation plan. These cases would of course be subject to normal Health Board scrutiny arrangements. In addition, costs will be kept under review as the wider Strategy, and supporting activity and cost modelling, evolves across the Health Board.

Implementation of the community model of health and care, as set out in the HDdUHB Health & Care Strategy, is progressing at pace in Ceredigion with the development of two Integrated Care Centres to deliver enhanced care and services outside of an acute hospital setting. The implementation of the Welsh Government mandated information system (WCCIS) in Ceredigion, also a first for the Health Board, will support shared information to assist with the delivery of integrated care.

The future clinical model for BGH is of significant strategic importance for the Health Board as part of a whole heath and care system in order to deliver the benefits of a bedless community model with reduced hospital admissions, quicker discharges and a focus on helping people to recover and stay well in their own homes and communities for as long as possible, helping to prevent deconditioning and disorientation that often accompanies emergency hospital admissions. The delivery of this community model is essential to maximising the community capacity that will enable the clinical strategy for BGH to be achieved.

The strategic activity modelling currently being updated will be key to identifying opportunities across Ceredigion for further shifts in activity from secondary to community care, to create capacity to explore additional commissioned work from cross-border commissioners, including work currently commissioned from English providers.

BGH plays a significant role in a number of regional collaborations and wider service networks including a long standing contractual and clinical relationship with health services in Swansea Bay UHB, as the regional tertiary provider, and further opportunities will be progressed through the Regional Planning Board and ARCH as the implementation plan is developed. Additionally, relationships and commissioning arrangements with the Welsh Ambulance Services Trust (WAST) will need detailed consideration as part of the development of detailed implementation plans.

Argymhelliad / Recommendation

The Board is requested to:

- Approve the Strategy *Bronglais General Hospital: Delivering Excellent Rural Acute Care*
- Approve the development of Clinically Led Service Delivery Plans to inform the implementation of the strategy.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: *Datix Risk Register Reference and Score:*	Reference 1 to 10
Safon(au) Gofal ac Iechyd: *Health and Care Standard(s):* Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: *UHB Strategic Objectives:* Hyperlink to HDdUHB Strategic Objectives	8. To improve early detection and care of frail people accessing our services in cluding those with dementia specifically aimed at maintaining wellbeing and independence. 9. To improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.

	10. To deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: *UHB Well-being Objectives:* Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: *Evidence Base:*	Each scheme is underpinned by specific evidence bases.
Rhestr Termau: *Glossary of Terms:*	Descriptions contained within body of report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: *Parties / Committees consulted prior to University Health Board:*	HDdUHB Executive Team Meeting: 11/2/2019 Mid Wales Joint Committee for Health and Care (MWJC) Clinical Advisory Group: 21/5/2019 HDdUHB Executive Team Meeting: 10/6/2019 MWJC Planning/Delivery Executive Group: 11/6/2019 HDdUHB Transforming Our Hospitals Group: 12/6/2019 MWJC Public Meeting: 1/7/2019 HDdUHB Public Board Meeting: 25/7/2019 HDdUHB Transforming Our Hospitals Group: 13/8/2019 HDdUHB Transforming Our Hospitals Group: 11/10/2019

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Initial high-level costing has been completed within the usual caveats that apply to costing strategic documents. The need to develop community health care services to support the shift from acute to community is referenced and a fuller account of this is set out in Ceredigion's plan for community delivered care, "CAREdigion". The high level costing identifies this at approximately £1.2m. Alongside this, costs are also identified that will be required regardless of the strategy being implemented or not to ensure current services are delivered safely to the strategic intent; these are costed to approximately £1.2m. This leaves the strategic developments which are costed to approximately £600,000. This is investment to ensure the safe and sustainable delivery of 24/7 emergency care from BGH, while also allowing the expansion of services it delivers which, in turn, provides an opportunity to attract cross-border activity and the income stream that follows. Further expansion will be supported by commissioned activity as BGH delivers its commitment to its population.
Ansawdd / Gofal Claf: Quality / Patient Care:	No adverse quality/patient care impacts are expected. Service delivery plans will need to set out how they will deliver accessible services that are provided to and exceed quality and waiting-times standards.

Gweithlu: **Workforce:**	Initial high level workforce assumptions have been described within the strategy where these are known. Some assumptions are adoption of known developments and, as such, are not "new" developments. The need to deliver a shift from acute into community will necessitate development of new and more agile roles. Staff side representation and the involvement of the Workforce Directorate has been achieved at all stages of the development of this strategy and will continue in the development of service delivery plans, implementation and evaluation phases. Specialist workforce input will be required to achieve successful implementation of the strategy and ensure appropriate governance and organisational development/change requirements are met.
Risg: **Risk:**	No risk identified on Datix. Strategy implementation risk register in place'
Cyfreithiol: **Legal:**	The strategy is written with acknowledgement of the Health Board's duties under the following legislation: • Welsh Language Act 1993 • National Health Service (Wales) Act 2006 • Equality Act 2010 • Welsh Language (Wales) Measure 2011 • Social Services and Well-being (Wales) Act 2014 • Local Government (Wales) Act 2015 • Well-being of Future Generations (Wales) Act 2015 • Nurse Staffing Levels (Wales) Act 2016 • Environment (Wales) Act 2016 There are no anticipated legal impacts or challenge associate with the strategy itself. The development of service delivery plans that will comprise the implementation programme will be tested against relevant legislation to ensure compliance.
Enw Da: **Reputational:**	The strategy aims to achieve the Health Board's vision for delivery of services in mid-Wales and in so doing, reflects the complexity of care from a patient perspective. The delivery of a sustainable 24/7 acute district general hospital to provide care to a population who would otherwise be unable to access timely care is of both regional and national strategic importance.
Gyfrinachedd: **Privacy:**	There are no specific implications for the privacy of patients, staff or members of the public associated with this strategy.
Cydraddoldeb: **Equality:**	A statement regarding the Equality Impact Assessment (EqIA) for this strategy is attached at Annex 2. An EqIA will be a requirement for each service delivery plan that will be developed to deliver this strategy.

Annex 1

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

A HEALTHIER MID AND WEST WALES:
OUR FUTURE GENERATIONS LIVING WELL

Bronglais General Hospital:

‘Delivering Excellent Rural Acute Care’

Executive Summary

The delivery of high quality, sustainable and accessible care to the people of mid Wales is a priority for Hywel Dda University Health Board.

Bronglais District General Hospital (BGH) in Aberystwyth is a strategically important provider of accessible high quality emergency and elective health care services to a largely remote, rural population who would otherwise experience significant disruption to their lives and to who we would otherwise be challenged to achieve the best possible outcomes.

BGH's unique position in Wales means that a significant part of its role is providing care to residents from other Health Boards. In addition, BGH's adjacency with the University and National Library creates, in effect a "Penglais Campus of Learning, Information and Health" which presents significant opportunities to develop partnerships that will promote the delivery of healthcare to remote rural populations and promote Aberystwyth and BGH as an employment location of choice for health care professionals.

Because BGH serves both a remote urban population and residents of three health boards (Hywel Dda, Betsi Cadwaladr and Powys) from a geographically large rural area, pathways need to be able to access the most appropriate specialist care that ensures patients who need to be transferred, are transferred to the most local centre to their home. For some this will be Cardiff and Swansea, for others possible destinations include Bangor, Wrexham, Stoke, Shrewsbury, Manchester and Liverpool.

Partnerships with a wide range of specialist units will promote learning networks and offer opportunities to access training and development both by rotation out of and by bringing trainers into BGH. The opportunity to use the high quality clinical environments at BGH as a training hub will offer benefit to the whole of Hywel Dda University Health Board.

The concept of "rural" can be applied to every service, specialty and sub-specialty providing services from BGH and will promote recognition of the complexity of providing accessible care across the wide geographical catchment area.

Rural also defines a way of working that recognises the need for services to work across traditional "health and social", "primary and secondary", "physical and mental" and professional boundaries in a way that promotes the realisation

of the benefits a network of NHS facilities provides to deliver "care" as close as is possible to people's homes.

Sustainability of service provision is no less important because a service is "essential" and we recognise the importance of doing more at BGH so that it achieves a cost effective and efficient scale of provision.

We will:

- Maximise the utilisation of BGH's modern facilities
- Maximise the benefit of BGH's high quality services
- Develop the range of services provided
- Extend BGH's catchment area

So that:

- BGH becomes the provider of choice for access to specialist health care services both within the main hospital and at networked "Bronglais@" services across the mid Wales area.

The "Bronglais Commitment" will be to provide high quality services, on-time and as locally as possible.

Within the hospital, provision of acute emergency and urgent care services is a 24/7 collaboration of all "essential" services. BGH provides these services and will continue so to do. A patient's emergency care pathway starts in the community and is supported by primary care, 111 and 999 services. In order to ensure long term sustainability, however, we need to recognise that services will have to change what is provided and how this is done. The progress of technological advancement will increasingly challenge services to be provided in a different way, some of which will increase the opportunity to do more locally, while others will redirect certain clinical presentations to specialist centres to ensure the optimal outcome.

BGH will also need to do more to support the attainment of the Health Board's strategic goals, repatriating care for people across the whole of Ceredigion to support delivery across the whole Hywel Dda University Health Board, whilst also recognising the need to do more for patients for whom BGH becomes the closest provider as the Health Board's Health and Care strategy is implemented.

Improvements are required in both emergency and urgent care and planned care. Because of the economies of scale required at BGH, co-location is necessary, but the workflows need to be separated to ensure elective care is protected.

Primary care services will be an essential component of the emergency "front door". Appropriate streaming into a Community Urgent Integrated Care Centre located on the hospital site will direct patients whose clinical presentation can be managed within primary care, but require rapid access to hospital based diagnostics or specialist advice will not be admitted to a hospital bed and will be able to return home following consultation. The relationship between the hospital based and community based services will be fluid so that the appropriate skill set can be directed to meet patient needs no matter which care setting they are currently in.

The front door service will be able to access a wide range of specialist medical and surgical support with all essential life-saving interventions available onsite other than those for which there are specific treatment pathways specified on a regional/all-Wales basis (where a patient would usually be taken from the scene).

Because of its remoteness, BGH receives patients who have suffered trauma or are obstetric and paediatric emergencies and the models of service required for each are set out in this Strategy.

Supporting the provision of the emergency services will be access to 24/7 hot (time critical) diagnostics and pharmacy with daily access to other key services, therapies, social services and diagnostics that will promote diagnosis, treatment and discharge, but which are not a first line diagnostic for emergency patients (e.g. MRI).

Access to therapy and on-site pharmacy services daily will also support patient recovery and discharge and is a key investment in order to achieve optimal length of stay.

In order to ensure patients waiting for elective/planned treatment receive their procedure on time, we will re-provide the day surgery unit as a 23:59 unit. This will support day-case as the norm by protecting the recovery capacity required and allowing day cases to be operated on as part of an extended theatre list.

Protection of in-patient capacity will be dependent upon the implementation of Ceredigion's vision for community delivered services ("Caredigion") so that there is sufficient capacity in the community to ensure patients are discharged to an appropriate setting when they are ready to be discharged rather than waiting for the package of care they need or space in an appropriate setting to become available. Once this is achieved, elective capacity will be ring-fenced and BGH will be able to deliver on its commitment to provide its high quality services on time and, at this point, be able to offer its services to a wider catchment population.

The importance of networking with our neighbouring services and those within Hywel Dda cannot be understated. This is essential to ensure skills are maintained and developed and that patient pathways promote timely access to high quality care. Cardiac services are a model of how a service can be delivered, developed and grown in a rural setting and are described to give an example of what effective collaboration can achieve.

Significant opportunities are presented by the adjacency of BGH to Aberystwyth University and the National Library of Wales which forms a campus of Health, Care and Learning. The development of a School of Nursing and Health Science together with provision of General Practitioner and Biomedical Science courses and modules will enable clinicians to achieve academic ambitions and academics and clinicians to work together on research and development across a broad spectrum of interests. The opportunity to develop as a University Hospital is something that BGH should explore as part of a package of incentives to promote recruitment and retention that would also support initiatives to strengthen local economy and industry.

Moving services closer to people's homes will allow resources to be re-profiled across the health community. For BGH and mid Wales, delivering sustainability will be achieved by:

1) *An emphasis on population health, health promotion and prevention to enable people to live well for as long as possible*
2) *Services moving from acute settings into community settings across mid Wales*
3) *Acute services being re-profiled across Hywel Dda so that more is provided at BGH thus reducing the need for patients and families to travel further for treatment*

BGH will deliver value at a local level by:

- Providing more within our existing resource allocation
- Delivering better outcomes for patients
- Ensuring additional investment supports the above

When considering patient outcomes, we will need to consider:

- Clinical outcomes; these should be as good as or better than is available anywhere else
- Patient centred outcomes; patients as individuals have their own specific view of what "good" is to them. This will include many factors, but is principally a balance of how long they will wait against how accessible the service is both for them and their family

BGH will play an important role in the provision of some population health activities, such as screening and surveillance, but other activities such as healthy diet and lifestyle will be focussed across the services working in community settings and extend into other areas such as education. The attainment of population health goals will result in reduced presentation of certain conditions in acute settings and promote people remaining at home, but an ageing population brings with it its own challenges for the whole care system and is not in itself without its costs.

Services that have traditionally been provided at BGH will move into community settings across mid Wales to improve access for patients and allow BGH to focus on the delivery of more complex acute care and support the planned service changes in the south.

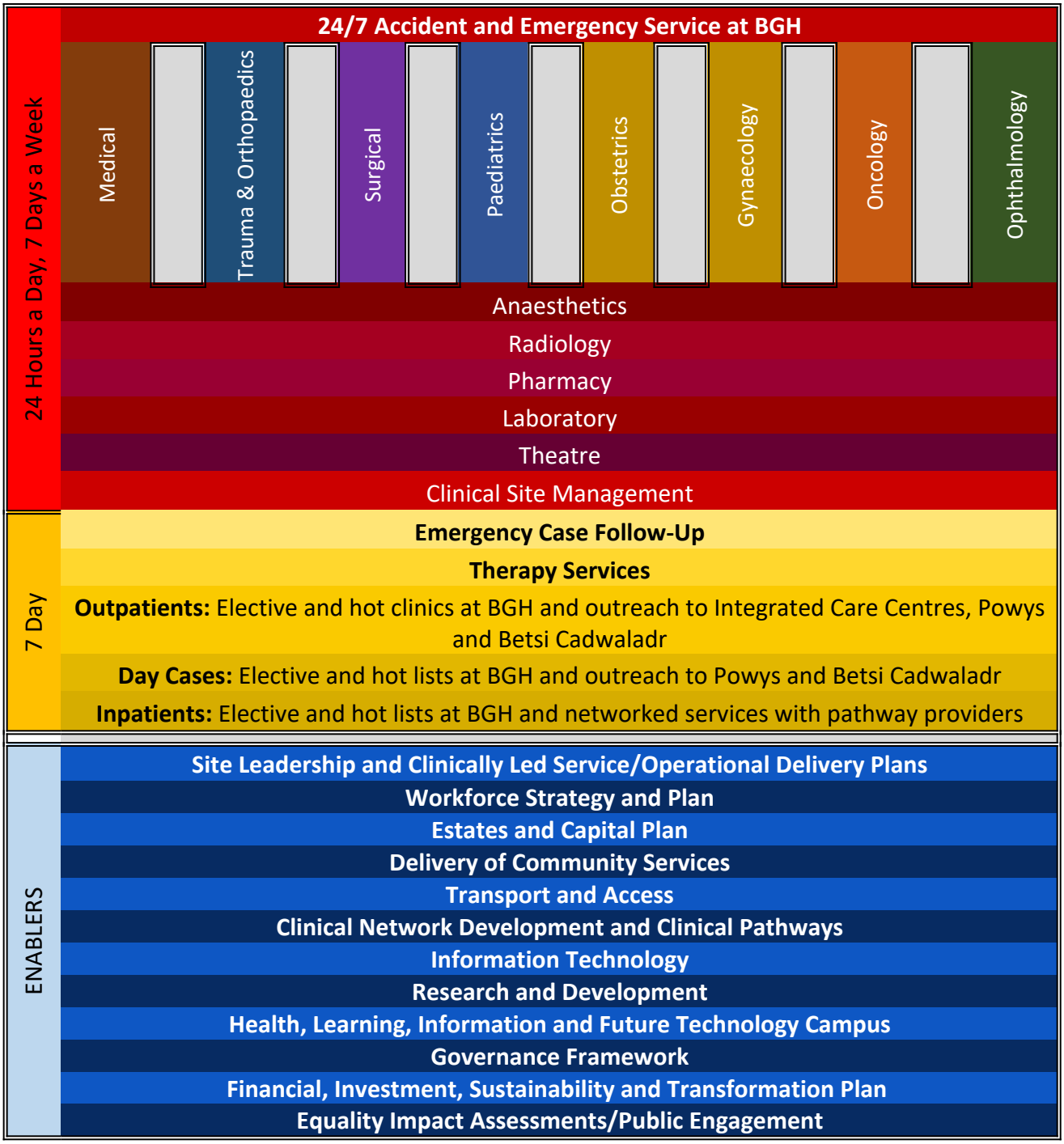
An initial high level review of the financial implications of this strategy shows a resource requirement of approximately £3m. This is split evenly between:

- Improvements and developments that would need to be implemented whether or not this strategy existed, e.g. therapy provision
- Strategic developments set out in the Health Board's strategy
- Strategic developments to deliver excellent acute health care in mid Wales

The Health Board's overall strategic model shows that a shift to a community based services would enable inpatient hospital beds to be re-profiled. For BGH this would not necessarily result in a reduction of beds, but allow the hospital to increase throughput to support both the repatriation of services from the south

of Hywel Dda to meet the service changes in that area and also to offer a broader range of services to the population of mid Wales on an in, day and outpatient basis in partnership with other providers thereby balancing the income and expenditure for the hospital.

This document combines a number of different perspectives which are threaded throughout its sections. Detailed planning encompassing both the operational services and the supporting "enabling" functions to realise our vision will be developed following approval of this document by Hywel Dda University Health Board:



A Healthier Mid and West Wales:

Our Future Generations Living Well

The Role of Bronglais General Hospital in Delivering the Highest Quality Services & Care For The People and Families Of Mid Wales

Safe *Sustainable* *Accessible* *Kind*

November 2019

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

Why are we here?

Uniquely placed in Wales, Bronglais General Hospital (BGH) is an Acute District General Hospital serving a diverse and rural population living across mid Wales.

BGH's location is relatively isolated with travel times to the next nearest hospitals being:

- 90 minutes to the south (Glangwili)
- 120 minutes to the east (Shrewsbury)
- 120 minutes north-east (Wrexham)
- 200 minutes to the north (Bangor)

Consequentially, BGH has been identified as strategically important by Welsh Government and Hywel Dda University Health Board for the delivery of health care to a population for whom there is no readily accessible alternative to acute care.

Because of its unique situation, BGH does not always fit into nationally established service protocols and pathways which may be completely appropriate for services in an urban environment. In response, BGH has developed a reputation for being agile and adaptable with services evolving over time to meet presenting needs across the whole spectrum of care, but this requires careful mitigation to ensure safe and sustainable outcomes.

Health service organisation is described by levels, 1 being the least complex and 3 the most. The services BGH must provide to meet the immediate presenting needs of its population straddle levels 1 and 2, but some emergency presentations at BGH are more serious and complex and encroach on level 3, e.g. strangulated hiatus hernia or perforated oesophagus where the hospital must be able to meet the immediate needs of these patients and stabilise them prior to decisions being made about their onward management. In these circumstances, the intervention BGH provides aims to stabilise the patient in order to maximise their outcome potential following transfer to an appropriate specialist centre.

For elective care, it is essential to recognise that the requirements of a rural, agricultural community are not consistent with that of a more urban population. Rural populations already travel relatively long distances to access their health service and further travel for patients, carers and relatives can significantly

disrupt lives and business. It is essential, therefore, that innovative approaches are used to meet these access requirements and ensure patients only have to travel away from their home area for the most complex procedures that cannot be sustainably provided at BGH.

The health care workforce, therefore, need to be able to respond to as wide a range of conditions as would present more frequently in more urban centres whilst recognising that increased specialisation means that health care professionals cannot work in isolation. A culture based around the needs of the patient and continuous improvement will support the attainment of our plans.

This will be achieved by a combination of:

- Developing the concept of Rural Facilities, Units and Centres across the spectrum of services
- Utilising enabling technologies in a way that challenges the perceived limits regarding their application in health care delivery
- Establishing agile rural health improvement networks in every specialty from primary to tertiary care that adapt to the different patients' pathways and ensure clinicians link with specialist centres
- Enabling a full range of emergency and elective surgical and medical services to be provided at BGH

The care service will adopt anticipatory approaches that utilise current and emergent technological solutions, so that timely intervention is achieved both for patients with known health conditions and, at a population health level, screen for certain conditions which are best, or can only be safely managed by planned intervention that is not available locally.

With the minor cases being managed appropriately in community settings, a greater proportion of emergency presentations at BGH will be major/higher acuity cases and the delivery of resulting treatment and care will be supported by the increased range of elective services being provided locally.

Although BGH has many unique characteristics, it cannot provide its services in isolation. The historic agility that BGH and Ceredigion Community services have demonstrated has resulted in the development of innovative approaches with our Hywel Dda colleagues and wider partners in the Welsh Ambulance Services NHS Trust, Local Authority services and Powys and Betsi Cadwaladr Health

Boards to meet the challenge of rural isolation and this provides a firm foundation upon which to build services that deliver care as close to home as possible.

This document sets out the ambition for BGH. In so doing, we recognise that BGH does not function in isolation. Recognising the relative complexity of services commissioned by three health boards and provided by many more providers across Wales and England, we will continue to develop, with our partners, the collaborative pathways, networks, service models and support services that need to be enhanced and implemented in order to achieve the objectives set out in Hywel Dda Health Board's Health and Care Strategy, "*A Healthier Mid and West Wales: Our future generations living well*" and the objectives of the Mid Wales Joint Committee for Health and Care.

Bronglais General Hospital will build its reputation as an excellent rural provider of acute and planned-care. It will therefore continue to provide urgent, emergency and planned care services, with more specialist cases transferred to our new urgent and planned care hospital as part of our wider hospitals network (as well as other regional sites for more critical care).

A Healthier Mid and West Wales 2018

Cyflawni i Gymraeg *(Committed to Welsh)*

Daeth y Safonau Gymraeg i'r rym yn mis Mehefin 2018 ac mae nhw'n ei gwneud yn ofynnol i sefydliadau statudol gydymffurfio a'r rhain erbyn 31 Mai 2019. Mae'r safonau yn sicrhau:

- eglurder i sefydliadau mewn perthynas â'r iaith Gymraeg

The Welsh Language Standards came into force in June 2018 and require statutory organisations to comply with them by 31 May 2019. The standards ensure:

- clarity to organisations in relation to the Welsh language

- eglurder i siaradwyr Cymraeg ar ba wasanaethau y gallant ddisgwyl eu derbyn yn Gymraeg
- mwy o gysondeb mewn gwasanaethau Cymraeg a gwella ansawdd i ddefnyddwyr

Yr egwyddor allweddol yw na ddylid trin yr iaith Gymraeg yn llai ffafriol na'r Saesneg.

Mae yna lawer iawn o amrywiad yn nifer y siaradwyr Cymraeg ar draws dalgylch Bronglais gyda chyfrannau uwch yn y gorllewin a llai yn y dwyrain, ond mae nifer y siaradwyr Cymraeg yn tyfu o flwyddyn i flwyddyn ac wrth i ein gwasanaethau tyfu mae angen i ni sicrhau bod eu hanghenion yn cael eu diwallu.

Ar gyfer rhai cyflyrau fel strôc a dementia, rydym yn cydnabod yn llawn, mai iaith gyntaf rhywun yn aml yw'r iaith y maent yn rhagosod i a byddwn yn sicrhau bod cleifion yn derbyn y cymorth sydd angen arnynt yn yr iaith honno.

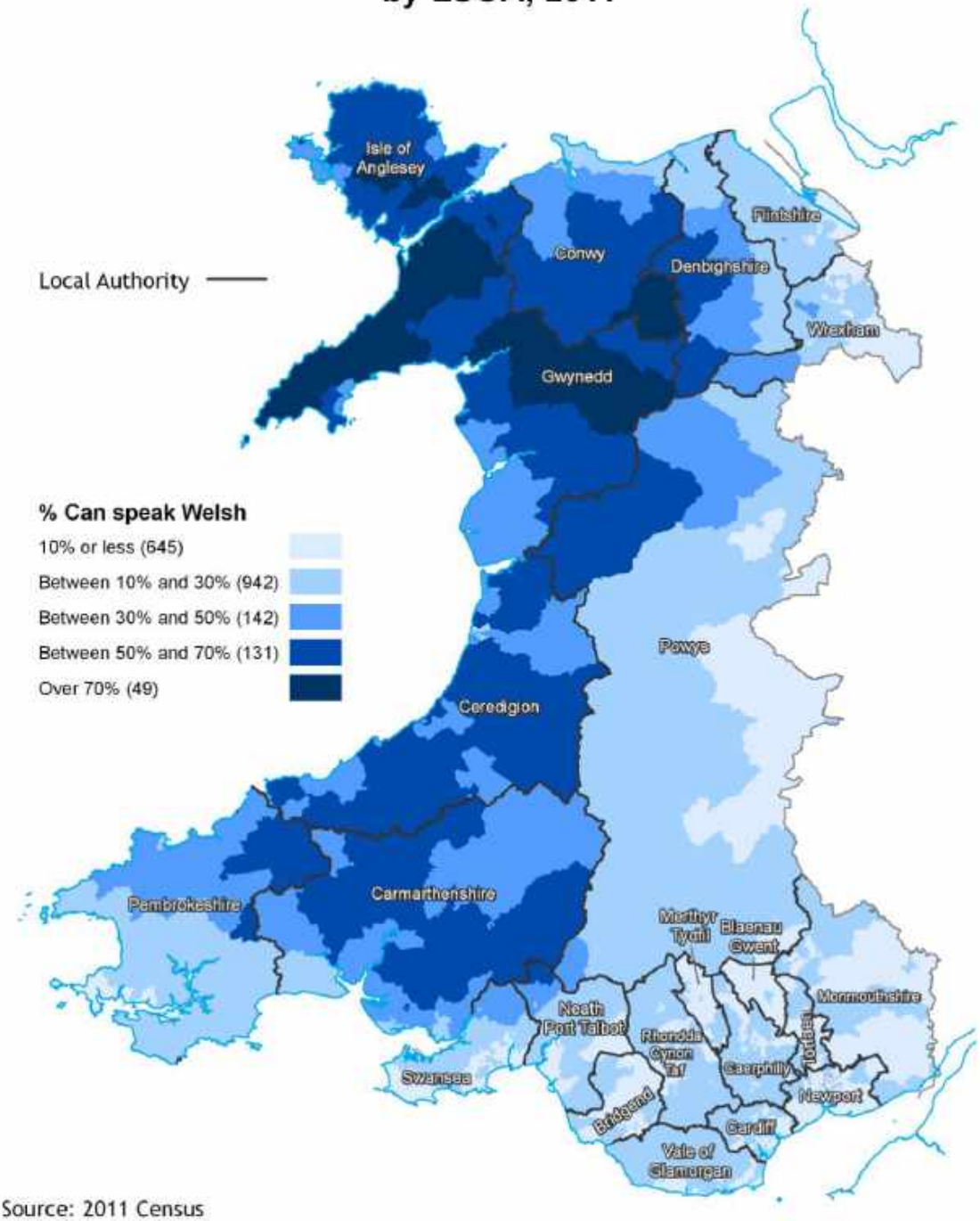
- clarity to Welsh speakers on what services they can expect to receive in Welsh
- greater consistency in Welsh language services and improve quality to users

The key principle is that the Welsh language should not be treated less favourably than the English language.

There is a great deal of variation in the numbers of Welsh speakers across the Bronglais' catchment area with greater proportions in the west and fewer in the east, but the number of Welsh speakers is growing year on year and we need to ensure that as our services grow, that their needs are met.

We fully acknowledge that for some conditions such as stroke and dementia, a person's first language is often the language to which they default and we will ensure that patients receive the support they require in that language.

Proportion of people (aged 3 and over) able to speak Welsh, by LSOA, 2011



Source: 2011 Census

193.12-13

Geography & Technology

Llywodraeth Cymru
Welsh Government

Mae Ysbyty Cyffredinol Bronglais yn recriwtio staff o gymunedau lleol ac yn cynnig gwasanaethau yn Gymraeg. Fodd bynnag, ar gyfer rhai gwasanaethau, ni allwn recriwtio siaradwyr Cymraeg a lle mae hyn yw'r achos, byddwn, lle bynnag y bo modd, yn cynnig aelod o staff sydd yn siarad Cymraeg gyda profiad addas i gyfieithu a helpu i hwyluso sgwrs / ymgynghoriad ystyrlon.

Byddwn yn gweithio i sicrhau bod y gwasanaethau yr ydym yn eu darparu a'u comisiynu yn bodloni'r gofynion a nodir yn Safonau'r Gymraeg a, lle nodir nad ydym yn bodloni safon, byddwn yn cymryd camau i unioni hyn.

Bronglais General Hospital recruits staff from local communities and offers services in Welsh. However, for some services we are unable to recruit Welsh speakers and where this is the case we will, wherever possible, offer a Welsh speaking member of staff with suitable experience to translate and help facilitate a meaningful conversation/consultation.

We will work to ensure services we provide and commission meet the requirements set out in the Welsh Language Standards and, where it is identified that we do not meet a standard, we will take action to remedy this.

Equality, Communication and Engagement

Findings from the Hywel Dda University Health Board's public survey conducted to inform its Equality Objectives for 2020-24, to meet the obligations of the Equality Act 2010, indicated that disabled people, older people, transgender people and people from black and minority ethnic backgrounds identify as having worse experience of health services in comparison to the population as a whole across the Hywel Dda UHB area. Common themes in relation to health services that emerged from the survey in relation to the experience of protected groups were access, communication, engagement and involvement, staff training (in relation to meeting the needs relating to individuals' protected characteristics) and barriers to accessing employment.

Anyone, irrespective of any protected characteristics, could be impacted by the development of service plans to achieve this strategy and there is potential for certain protected groups to be disproportionately represented amongst service users for any particular service.

The Mid Wales Joint Committee for Health and Care has run a continuous public engagement process and those responses have informed the strategic direction for BGH. Feedback to date has indicated that the public in general are keen to see services provided as close to home as possible and it is anticipated that the proposals to provide services close to home, be that in community settings or by service development at BGH, will be welcomed by and be of benefit to service users, particularly those who may currently face barriers in accessing services at a distance.

The commitment to continuous engagement will be carried on through development of a Communication and Engagement Plan to guide the implementation of the strategy as it moves to more service and condition specific planning. The clinically led project groups will be required to ensure that appropriate engagement with the public, patients and staff has informed the design of their service in a way that allows the final design to address and mitigate for identifiable impediments to access and to promote equitable, person–centred service delivery.

Services delivery plans will be expected to ensure engagement with the populations from across Hywel Dda University Health Board, Betsi Cadwaladr University Health Board and Powys Teaching Health Board areas and ensure targeted notifications to protected groups and organisations who represent protected groups who may be identified as being disproportionately affected, and/or who face particular barriers when accessing services.

Staff, who due to their protected characteristics, might be affected by changes arising from service delivery plans, will need to be identified through the organisational change process and addressed on an individual basis.

The Mid Wales Clinical Advisory Group will provide oversight of the service delivery work streams, including scrutiny of Equality Impact Assessments. This will ensure that pathways and service development proposals are “check and challenged” with regards to their actions to remove and any barriers/negative impacts on staff or service users, as identified through the equality impact assessment process. A robust scrutiny process will also afford an opportunity to consider any potential positive equality impacts and how these may be enhanced. Each service lead will be responsible for completing equality impact assessments and related action plans, as appropriate in relation to proposals for their particular services.

Teulu Jones Family; the Mid Wales Perspective

In order to understand the impact of plans upon people living in Hywel Dda, the Teulu Jones Family were created:

What does it mean to…?	
Mari	Mari is 78 years old and lives at home with Alun, her husband of 50 years. A retired teacher and a former President of the local Women's Institute which she still attends. She loves cooking, especially baking cakes. In recent months, Mari has developed mild dementia and has become increasingly frail. She is becoming more confused and has often been found wandering.
Alun	Alun is 80 years old, is husband to Mari and is a retired electrician. Alun enjoys his daily walk to the local shop to get the newspaper. He is a non-insulin dependent diabetic and takes medication to control it. He has a history of ischaemic heart disease and had a heart attack when he was 70. His sight is starting to fail due to a cataract.
Gareth	Gareth is 38 years old and the younger brother of Sioned. He is the finance director of an engineering company, and is married with two sons. Gareth is a keen cyclist and has been a social smoker. He tries to visit his older parents as much as he can, and stays in contact with Sioned.
Ayesha	Ayesha is 39 years old and the wife of Gareth, with whom she shares a love of cycling. She is a primary school teacher and is expecting her third child, a sister for the two sons she has with Gareth.
Sioned	Sioned is 47 years old, is mum to Lianne and grandmother to Ben. She works part-time as a healthcare support worker at her local hospital and is enrolled on an access to nursing course at her local college. Sioned is carer to both her ageing parents and her young grandson, and has been suffering with stress, anxiety and low mood.
Rhys	Rhys is 52 years old. He lives with his wife Sioned, daughter Lianne and grand-son Ben. Rhys is a long distance lorry driver and is away from home a couple of nights a week. He has smoked and is overweight, due to a combination of poor diet and limited physical activity.
Lianne	Lianne is 19 years old and lives with her parents. She has a three-year-old son, Ben, and is pregnant with her second child. Lianne hopes to become a childcare assistant. She is enrolled on a part-time course at her local college but is currently unable to attend due to pregnancy related sickness.
Ben	Ben is three years old. He was born prematurely and has lived with respiratory problems from birth. He has a mild developmental delay and has recently been diagnosed with a rare genetic condition. He lives with his mum and grandparents.

Teulu Jones will be used in this document to illustrate how the development of BGH will impact upon our patients and both our resident and visiting populations. Gareth and his wife Ayesha live with their children in the village of Talybont in north Ceredigion. The other members of the Jones family enjoy visiting, and they often take holidays together in the caravan parks along the Ceredigion coastline.

Strategic Context

This document outlines our vision and strategy for the future of Bronglais District General Hospital (BGH), Aberystwyth. It does not provide detailed plans for how this will be achieved, rather setting the direction of travel and our aspirations for the future to make a real difference to the health and wellbeing of the people of mid Wales.

The development of our vision for BGH has been informed by a number of key recent developments, namely:

- The work of the HDdUHB Transforming Clinical Services programme
- HDdUHB Health and Care Strategy
- HDdUHB Transforming Mental Health Strategy
- The Board approval of the HDdUHB Health and Wellbeing Framework
- The vision and aims of the Mid Wales Joint Committee for Health and Social Care

BGH provides services to people from across a wide area of Wales which adds complexity to the planning, delivery and commissioning of services. The services provided are, therefore, influenced by the strategic and Integrated Medium Term Plans (IMTP) of a number of other key organisations/ collaborations, including:

- Powys Teaching Health Board
- Betsi Cadwaladr University Health Board
- Swansea Bay and Hywel Dda University Health Boards "ARCH"
- South Wales Trauma Network
- Welsh Ambulance Services NHS Trust
- Shrewsbury and Telford NHS Trust "Future Fit"

Detailed planning and actions to realise our vision will be developed following approval of this document by the Hywel Dda University Health Board. This will include:

- Operational/Service Delivery Plans
- Clinical Network Development and Governance Plan
- Workforce Development, Recruitment and Retention Plan
- Estates Plan
- Financial, Investment, Sustainability and Transformation Plan.
- Future Technology Plan
- Communication and Engagement Plan

The Hywel Dda Strategic Context

Hywel Dda University Health Board's agreed Health and Care Strategy sets out the future of BGH as a District General Hospital within a wider hospital network across HDdUHB. Building upon previous successes at BGH, the strategy provides an opportunity to address the challenges in the delivery of health and care services that characterise the communities and geography of mid Wales, for example:

Population ageing and a rise in chronic conditions

The need to **travel** often long distances to access health and care services and a reliance for many on infrequent public transport

Recruiting and deploying skilled health and care staff

Delivering safe, sustainable, accessible and kind health and care services across a large and mainly rural geography, including considerations of equity

Providing digital solutions and ways of working to underpin health and care, including access to digital information, tools and services to help people maintain and improve their health and wellbeing

BGH is a key service provider for residents in Ceredigion, mid-Powys and South Gwynedd. Hywel Dda's strategic direction will extend the catchment area to the south of Ceredigion and the strategic direction of the Future Fit programme (the strategic plans for Shrewsbury and Telford NHS Trust) is likely to see an increase in demand for elective care from Powys residents which will be delivered by outreach into and partnership with Powys' other providers. It is, therefore, important to set out the plans for service enhancements and change that will ensure there is the capacity to meet this demand in collaboration with neighbouring health boards and providers.

Affordability and Sustainability

The assumptions set out in the Health Board's strategy are that more will be done closer to people's homes and that will allow resources to be re-profiled across the health community.

In the context of BGH and mid Wales, this has three main strands:

1) ***Emphasis on population health, health promotion and prevention to enable people to live well for as long as possible***
2) ***Services moving from acute settings into community settings across mid Wales***
3) ***Acute services being re-profiled across Hywel Dda so that more is provided at BGH thus reducing the need for patients and families to travel further for treatment***

Just because something is affordable, does not necessarily mean that it is sustainable or vice-versa. Sustainability also takes a longer term and broader view of a service than affordability and requires us to examine how our services deliver value.

It has long been recognised that expenditure on health care supports the delivery of both well-being and prosperity. At a population health level, immunisation against preventable illness and improvements in child health are relatively low cost interventions that provide significant value for the whole life of a person.

At a macro-economic level, interventions to prevent and treat illnesses improves workforce productivity and health and safety improvements reduce the chance of people becoming ill because of their occupation. A healthy population delivers a healthy workforce and, as a result, promotes the overall economic wellbeing of a country which in turn supports investment in health improvement activities and in the provision of a broader range of health care services.

To be sustainable, health services must allocate its finite resource in a way that maximises population health and responds to the overall healthcare needs of its population. In essence the key challenge for the NHS is to deliver a service that promotes macro-economic benefit, but that also responds to needs on the

smallest of scales, that of the individual and it is in this context that the concept of delivering value at a local level is brought into focus.

In this strategy, we will deliver value by:

- Providing more within our existing resource allocation
- Delivering better outcomes for patients
- Ensuring additional investment supports the above

When considering patient outcomes, we will need to consider:

- Clinical outcomes; these should be as good as or better than is available anywhere else
- Patient centred outcomes; patients as individuals have their own specific view of what "good" is to them. This will include many factors, but is principally a balance of how long they will wait against how accessible the service is both for them and their family

A centralised care service may be financially efficient and produce clinically optimum outcomes immediately post treatment, but if it comes at a cost of greater travel and more difficulty in maintaining independence through deconditioning before, during and after treatment, this may not provide an optimum outcome for the patient and their family.

In order to achieve the Health Board's commitment to deliver care closer to home, we need to promote people remaining in their own homes and localities so that they can, as far as possible, maintain their normality and routine. As our population ages, the need to preserve independence and support informal care arrangements will become paramount; failing to do so will significantly challenge the sustainability of health and social care in the longer term.

BGH will play an important role in the provision of some population health activities, such as screening and surveillance, but other activities such as healthy diet and lifestyle will be focussed across the services working in community settings and extend into other areas such as education. The attainment of population health goals will result in reduced presentation of certain conditions in acute settings, but an ageing population brings with it its own challenges for the whole care system and is not in itself without its costs.

The movement of services that have traditionally been provided in acute settings into the community is a key development that will both improve access for patients and allow BGH to focus on the delivery of more complex acute care. Key opportunities are for consultants at Bronglais to provide outreach services to facilities in Ceredigion, Powys and Gwynedd with the aim of treating patients in those settings unless their clinical need requires more specialist input. Alongside this, all clinical pathways will need to be reviewed so that they are appropriate both clinically and geographically while ensuring they achieve the benefits of prudent healthcare and support a whole service shift from illness to wellbeing.

In order to achieve the Hywel Dda University Health Board's strategic objectives, re-profiling of services across its catchment will be required so that the new configuration of acute and community provision can deliver as planned. This will mean that BGH will need to do more work for patients within Hywel Dda. Some of this being provided from community facilities and some will be provided at BGH. This is, in essence, both an expansion of BGH's catchment area and of the services it provides and will be achieved by delivering efficiency improvements to allow increased throughput which will support future investment for extended service delivery.

There are opportunities, costs and compromises to strategic developments across the whole Health Board, but it has been agreed that there needs to be investment in community services to deliver the Health Board's objectives.

An initial high level review of the financial implications of this strategy shows a resource requirement of approximately £3m over the next 5 to 10 years. This is split evenly between:

- Improvements and developments that would need to be implemented whether or not this strategy existed, e.g. therapy provision
- Strategic developments set out in the Health Board's strategy
- Strategic developments to deliver excellent acute health care in mid Wales

The Health Board's overall strategic model shows that a shift to a community based services would enable inpatient hospital beds to be re-profiled. For BGH this would not necessarily result in a reduction of beds, but allow the hospital to increase throughput to support both the repatriation of services from the south of Hywel Dda to meet the service changes in that area and also to offer a broader range of services to the population of mid Wales on and in, day and outpatient basis in partnership with other providers which will improve long term sustainability across the whole of the mid Wales health and care system.

Setting the Scene

Bronglais District General Hospital is a strategically important hospital that provides accessible care for the remote, rural population of mid Wales.

Access to services is one of the most significant factors affecting rural populations that can impact on a patient's clinical outcome and also their perception of the service they receive, their family life, education, employment and income.

The most critical element of the service provided is "Urgent Care":

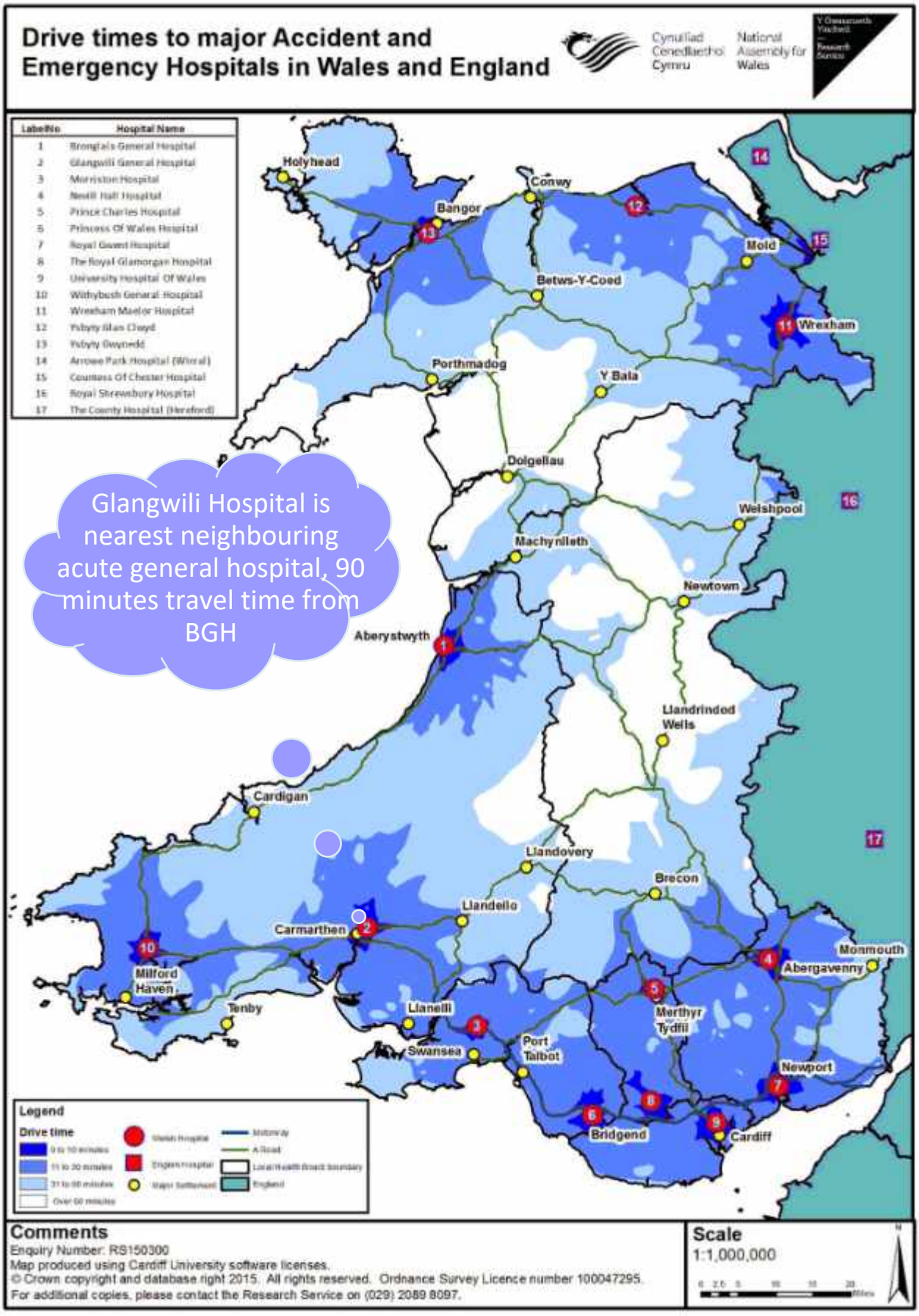
Urgent Care must be accessible within reasonable period of time. The "golden hour" has been used as one measure of this, but as healthcare evolves, some condition specific critical time limits will be agreed. Transport and transfer protocols will be put in place that allow patients to access care from specialist centres that are further away, but who may require initial assessment and stabilisation either at scene or in a local District General Hospital to achieve the best possible outcome.

Urgent care can be provided by primary and community services, but treatment and stabilisation of life threatening conditions requires the support of a range of diagnostic services and multi-disciplinary teams that is only available in an acute hospital setting.

However, the population also requires access to planned (elective) care which, although less urgent, can present significant challenges to them:

Planned Care, although not time critical in terms of intervention, is traditionally provided during the "normal working week", 9-5 on Mondays to Fridays. Accessing planned care that is not local to the patient can impact family life, education, income and employment all of which can impact upon the patient's perception of their outcome.

BGH is also the most remote hospital in Wales with travel times to the nearest neighbouring hospital of at least 90 minutes.



From the perspective of urgent care, this means that the hospital receives a large range of conditions, from relatively minor (could possibly be seen in another setting if service was available/available in time) to highly complex major presentations. With a significant elderly demographic, there are often added factors of multiple co-morbidities and a break-down of established care networks, for example when a family member becomes ill.

BGH must, therefore, be able to provide a comprehensive range of emergency interventions across a wide range of clinical specialisms, including:

Medicine	**Surgery**	**Trauma & Orthopaedics**	**Obstetrics & Gynaecology**	**Paediatrics**
Anaesthetics				

The 24 hours a day, 7 days a week (24/7) on site, consultant provided Anaesthetic service at BGH is an operationally important service that provides all other clinical services with essential specialist input to ensure the diverse range of conditions and presentations at BGH can be safely and sustainably managed.

In addition, a wide range of allied services supports the delivery of emergency services and need to be provided in, or readily accessible through, the emergency and Urgent Care stream:

• Theatres	• Diagnostics
• Therapies	• Pharmacy
• Transport	• Social Care
• Third Sector	• Housing
• Communication & Information	• Administration & Management

Ideally, these would be available 7 days a week if not 24/7:

There are 168 hours in a week.

Monday to Friday, 9 to 5 = 40 hours.

The service operates for 128 hours outside of the "normal working week

This is when Urgent Care must be provided

This is when Planned Care is provided

Both the population's rurality and the wide range and complexity of urgent conditions with which they present, sets the stage for the organisation of the whole of BGH's operation plan, that is that the service must respond at any time, day or night, to patients who self-present or are brought here by the ambulance service.

It is essential, therefore, that there are sustainable rotas of senior clinicians supported by appropriately resourced teams to provide high quality "generalist" response in an emergency.

For some medical emergencies, there are specific pathways for certain conditions with what are described as "red flag" symptoms (e.g. **F***ace* **A***rms* **S***peech* **T***ime* for stroke). However, much of what people present with as an emergency is less than clear and a generalist approach to their assessment, diagnosis and treatment is required.

Similarly, for some surgical and trauma emergencies, there are specific pathways that will direct patients to specialist services that are out of area. These are, however, less well established and, again, the cause of presenting symptoms is not always clear which also necessitates an initial wide ranging diagnostic approach. The South Wales Major Trauma Network is developing pathways for major trauma for implementation by 2020 and these are reflected in the section on rural trauma later in this document.

Although the "normal working week" is only one-quarter of the week, the provision of planned care is essential to ensure that staff are able to have exposure and are skilled in a wide range of clinical conditions and presentations whilst carrying on caring for patients who have presented as an emergency during the other three-quarters of the week.

It will not, however, be possible to provide every service from BGH and some will need to be supported by clinicians in other hospitals via agreed clinical pathways which will be enabled by technological opportunities such as tele-health.

Throughout this document, we explore service provision to set out what needs to be provided 24/7 days a week and what needs to be provided on a daily basis.

What is Rural Care?

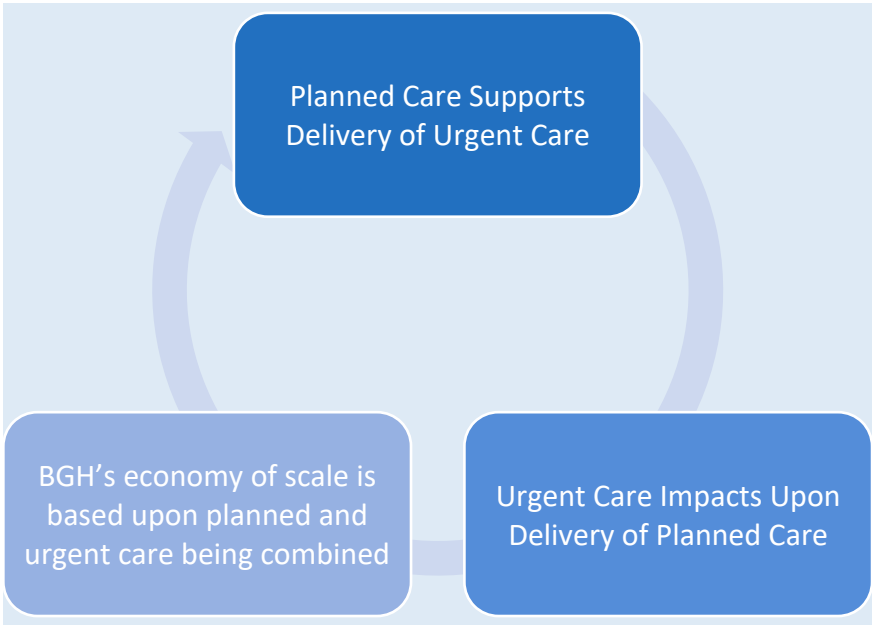
Rural is not a definition of location, but of character. Rural areas co-exist adjacent to large urban areas and those that do can have access to a comprehensive range of services and public utilities that do not exist, per se, in those rural areas.

When people talk about the challenges of being "rural", they are really talking about the challenge of being "remote" from services typically available in more urban areas.

It is the relative remoteness of the population of mid Wales with its two urban centres of Aberystwyth (c.20-25,000) and Newtown (c.10-15,000) that requires us to define a service that will properly respond to the routine, urgent, ongoing and long term needs of a population that are not significantly different to those presented by populations in more urban areas, but do need different service models to deliver.

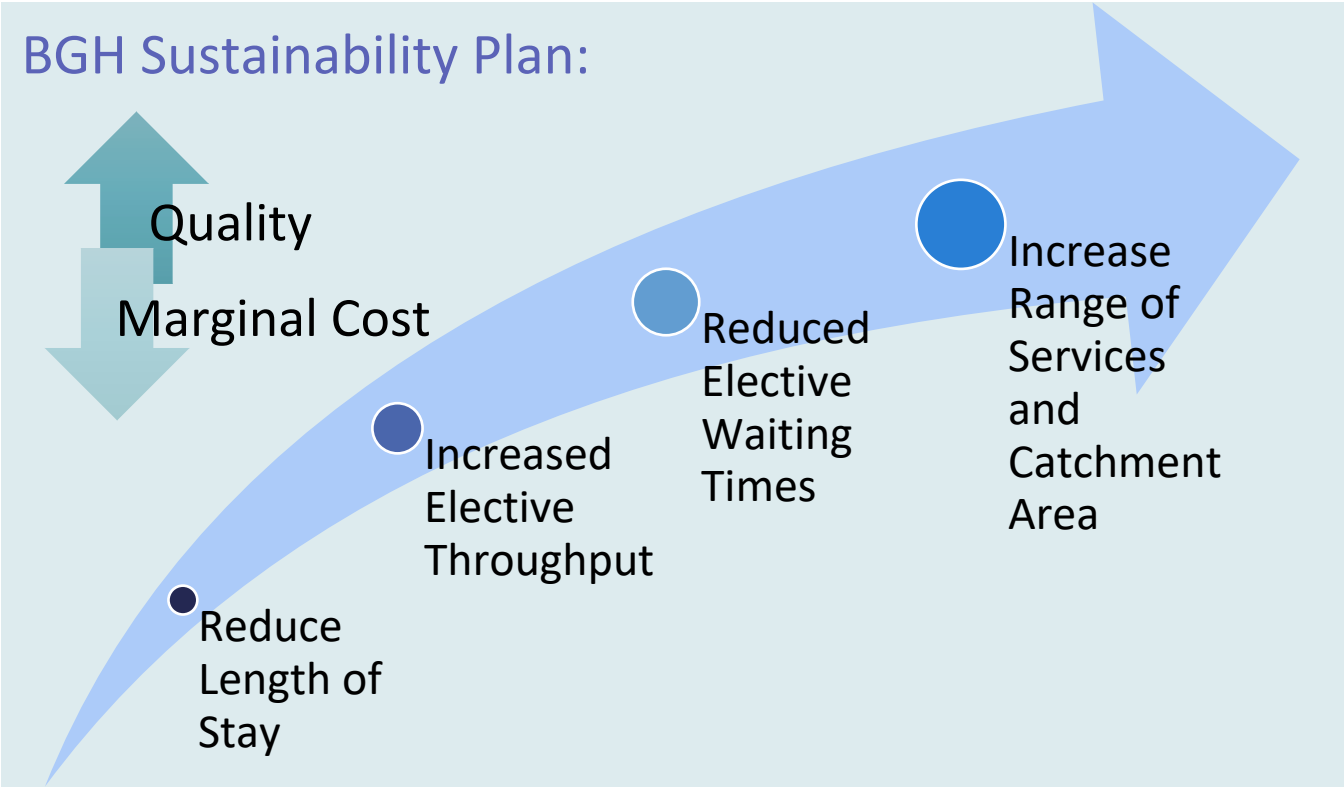
The Care Conundrum

We have described above how a site such as BGH relies upon the co-location and co-operation between planned and unplanned care. However, there is a fundamental conundrum that needs to be understood and properly addressed if services are going to be reliably provided.



This is not to say that all the solutions lie within

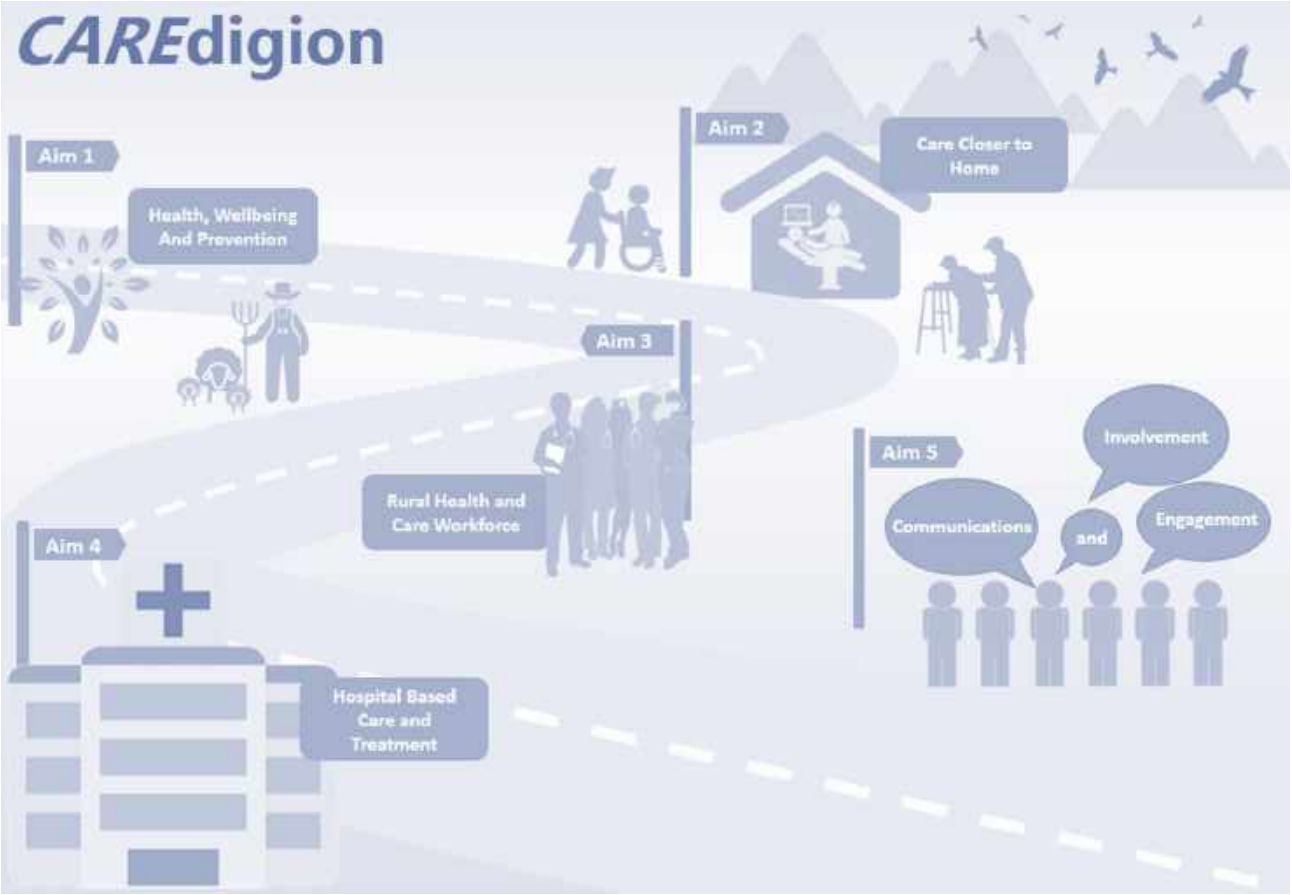
the hospital itself. The importance of ensuring that the whole care system works to support people receiving the care they need, when it is needed in the most appropriate care settings is key to resolving the conundrum and that will ensure the long term success and future sustainability of BGH.



Home First – Alignment with Community Services

In response to the challenges presented by an ageing population with increasing comorbidities who are growing old in a community where traditional models of care based around the family can no longer be relied upon, services in Ceredigion have developed the concept of "CAREdigion". This approach to care will be seamless, working across traditional organisational and professional boundaries so that the population of Ceredigion receive a truly joined-up service across the entire spectrum of care including services provided at BGH.

There will be no significant boundaries between health, social or third sector services and roles within those service areas will be less defined within a narrow band of activity, but reflect the holistic needs of the patient which are more generalised. By blurring the boundaries of care and testing the potential of shared professional responsibility, services will be able to evolve across the whole care system to meet individual needs and respond pro-actively to these as they change.



BGH is a key service partner in "Caredigion", but has traditionally been a place of safety for people in crisis whether this is caused by a deterioration in health or not. By ensuring care is provided along a "home first" principle, "Caredigion" will promote a reduction in avoidable attendance at BGH and prompt discharge home, or to an appropriate alternative setting, when the patient is medically fit and will not benefit further from the care an acute hospital provides.

Partnership Working

Successful delivery of safe, sustainable, accessible and kind services relies on the whole system working together. To do this, partnerships will need to be built and maintained across all partners in mid Wales.

Partnership with the three mid Wales local authorities will be key to ensuring patients accessing emergency and inpatient services at Bronglais receive the appropriate assessment and care planning required so that when admission is not needed, they can return home that same day and, following admission, are discharged when they attain their optimal fitness.

Ceredigion's Health and Social Services have a track record of partnership working and this provides a firm foundation to deliver a seamless, personalised

service to patients that anticipates and responds to change in a person's condition, provides rapid assessment and support when a person presents in crisis and ensures support is provided to let people live fulfilling lives in their communities.

We believe that patients across mid-Wales would be served well by an integrated service so that "trusted assessors" can assess, advise and plan to meet an individual's needs which fully reflects their personal circumstances and what matters to them. We will work with all our partners to establish these arrangements across the multidisciplinary team.

Working Across Regional Boundaries

Although the successful delivery of "Caredigion" is essential to the success of BGH, there is a need to reflect BGH's significant catchment area across mid Wales, including Powys and Betsi Cadwaladr Health Boards.

This adds both complexity and opportunity with six different statutory organisations involved in the planning and delivery of health and social care, combined with a number of specialist pathways commissioned for residents in neighbouring health boards often with different specialist and tertiary partners that do not apply to Hywel Dda University Health Board residents.

The Mid Wales Joint Committee for Health and Care is responsible for ensuring close co-operation and, where possible, integration of functions to establish whole-area multi-disciplinary teams will provide opportunities for innovation to improve care for all patients who regard BGH as their local hospital regardless of where they live.

Promotion of high quality, accessible services will be achieved by the development of a "Bronglais@" service to identify the service provider and associate this with a "Bronglais Commitment" to high quality service provision, on-time and as locally as possible.

Population Health

In order to achieve long-term sustainability, a long-term view of health is required and actions to address inequalities across the determinants of health need to be delivered in order to have benefits for future generations. Long term health conditions caused by lifestyle choices are preventable and health

care professionals working in the acute sector will support health improvement activities starting with expectant mothers, through the early stages of a child's development, involvement in secondary education and engagement with students in further education.

From a rural perspective, services need to reflect the farming seasons which, in a rural sheep and cattle farming area, give windows for engagement during mid-winter, the summer agricultural show season and early autumn. Weekly farmers' markets also provide an opportunity to support farmers during busier seasons. Partnerships with the farmers' unions could help gain access to and target promotion campaigns in ways that will capture the various generations of the agricultural community.

The services in Ceredigion and across mid Wales are committed to public involvement in the planning and delivery of services and we will use Hywel Dda's Framework for Continuous Engagement and those of our partners to ensure this is achieved for all our patients as service plans are developed in response to this strategy. Service leads will be required to assess opportunities for prevention and early intervention to reduce morbidity and occurrence within the population and set these out in the respective plan. We are especially keen to involve groups who have traditionally not been heard, for example people from younger age groups, and will ensure our engagement and involvement activities are inclusive so the views, opinions and aspirations of the whole population inform our future services.

Core Principles

People in remote rural areas:

- Will be provided with access to the full range of services that anyone else in Wales would be able to access
- Will have access to services that are of at least the same quality as those available to others
- Will not have to travel long distances to access services that can safely be provided in their locality
- Will receive timely, appropriate response to their presenting condition

It is not that people should receive a different service to that provided to populations in urban areas, but the way in which the service will be provided and people access those services will be different.

Assumptions

We have made a number of assumptions as we have developed our vision for services:

1. People are born, grow up, live, work, grow old and die in rural areas just as people do in more urban areas. Rurality, however, provides a framework upon which community resilience can flourish and can be harnessed to support population health, although it can never be taken as a resource that can replace essential life-saving services
2. The community elements of the "CAREdigion" model are resourced and functional as set out in Ceredigion's Integrated Medium Term Plan
3. BGH is part of a network of services that reach to the North Coast of Wales, to Stoke, to Birmingham, to Hereford to Cardiff and the South Coast of Wales. Patients will come from and need to return to their homes and services patients receive will be provided in partnership with a significant number of health care providers across the catchment area
4. Mid Wales has significant seasonal population fluctuation due to the academic sector and the tourist industry. These populations present with a range of conditions that need to be met, some of which are relatively unusual in the context of the resident mid Wales population
5. Home first is a statement of intention for all we do. What it will be possible to do at home will evolve, supported by technological development, and this will change the balance of what is provided in various settings and, in itself, releasing acute capacity to do more procedures at BGH
6. Where services cannot be provided at home, we deliver these at BGH or an appropriate community facility close to the patient wherever possible and ensure that the quality and outcomes are at least as good as those in other commissioned providers
7. Patients should be able to access the best possible available care. Patients will, however, have different definitions of what good means to them. The service must respect that for some, local access may be more important than quick access to a service and for some conditions, outcomes can decrease the further a patient travels from their home

What will the service look like?

This plan sets out the services to be delivered from BGH starting at the "front door" for emergency access. This reflects the importance of urgent healthcare provision as an absolute requirement of BGH for the people of mid Wales and then sets out plans for services that will meet this need and which directly and indirectly support its provision.

How will we know it is working?

Healthcare and health services are measured and performance managed through a range of mechanisms. Performance measures, such as the A&E 4-hour target, the waiting time 26-week target and ambulance response and turnaround times give some indication as to how well a system is performing overall. Other measures, such as the number of falls, infection control rates and drug administration errors give us an indication of how well a system is providing.

All have a role to play in understanding what works, but a broader view must also be taken in order to understand how the whole system performs.

To help, Hywel Dda University Health Board describes outcomes from different perspectives against which we will assess the impact of our services and the changes we make:

- Quality and Safety
- Value Based Health Care
- Access (physical, virtual, communication)
- Population Health
- Performance and Delivery

Patients and families are at the heart of delivering a service that is "safe, sustainable, accessible, kind". "What does 'good' mean to you" is an essential question we should ask every patient so that the balance of outcomes and experience meets their specific requirements. There are three patient centred approaches to providing accessible, consistent and relevant information to both clinicians and service users that:

- Identifies what is working well and areas for improvement
- Informs care planning and service delivery

These are:

- ***Patient Reported Outcome Measures (PROMs):*** allow a person's perception of their own health to be captured to understand symptoms, concern and needs which can then be monitored over time
- ***Patient Reported Experience Measured (PREMs):*** capture a person's perception of their experience of the services they are receiving. This will allow matters that often frustrate patients to be understood, such as waiting times, ease of access, communication in language of choice and support provided to manage their condition
- ***"Friends and Family Test":*** which asks whether a patient would recommend a service to their family or friends

We will develop a system of recording and using PROMs. PREMs and Friends and Family tests to support the continuous improvement of services provided to our patients. We will also utilise other surveys, when available, such as the Macmillan Cancer Experience Survey, to inform how we can improve our services.

In addition, we must ensure that the most valuable resource, our staff, are able to report on their experience of providing services and working for the Health Board. A national NHS staff survey is carried out every few years and provides a high level overview of how well an organisation is perceived by its staff. This survey does not, however, provide real time feedback and we will develop a system of Staff Reported Outcome Measures (StROMs) and Staff Reported Experience Measures (StREMs) to ensure that our service improvements truly cover both what patients need and how we support our staff to meet that need.

Although being a small hospital, BGH has a track record of delivering excellent services and has achieved recognition as such:

- British Lymphedema Society Award winning Nurse Specialist
- First Integrated Blood Science Laboratory in Wales
- Surgical Induction Teaching Programme "Above Outlier"
- Best fractured Neck of Femur Survival in UK
- The Best Heart Failure Outcomes in Wales
- Only Consultant Delivered Anaesthetic Service in Wales

- First Joint Advisory Group unconditionally accredited Endoscopy Unit in Wales
- Excellent results in the National Emergency Laparotomy Audit
- Nationally Recognised Osteoporosis Service
- Fastest Radiological Reporting Turn Around in Wales
- Fastest Radiology Procedure Turn Around in Wales (exc. MRI)
- Integrated Multi-Disciplinary Alcohol, Liver and BBV Service
- "**F***ace* **A***rms* **S***peech* **T***ime*" positive (Stroke) Ambulance Direct to Computed Tomography (CT)
- One of the Best Performing Stroke Services in Wales

We will utilise national audits and other external mechanisms to help us understand how well we are doing and what we need to do to improve the services we provide.

The development of services at BGH is of significant strategic importance for the delivery of the Health Board's overall Strategy for Health and Care in Mid and West Wales. As such, the success of the BGH strategy cannot be viewed in isolation and needs to be part of a whole-system evaluation of the wide ranging and complex programme for change across the entire health and care system. Improving outcomes, as set out above, will be a key objective of the service delivery plans and service leads will need to identify measurable indicators within their plans that can demonstrate, or at least be a proxy for, improvement.

Delivering Excellent Rural

Emergency and Urgent Care Services

Rural Emergency and Urgent Care Services

The services provided in response to emergency or urgent care needs are some of the most visible services provided by the NHS and are provided 24 hours a day, 365 days a year.

These respond to:

- Acute medical emergencies
- Acute surgical emergencies
- Acute trauma and orthopaedic emergencies
- Paediatric medical and surgical emergencies
- Obstetric and gynaecological emergencies

The Front Door

The Accident and Emergency (Emergency and Urgent Care) service has traditionally been seen as the front door for emergency health care. For many cases, this is entirely appropriate and admission to inpatient services locally or transfer to higher levels of service further away occurs after assessment, diagnosis and treatment initiation.

There is, however, a need to consider how services are coordinated before a patient arrives at the Front Door so that patients whose presenting condition is best managed in primary care or could, following diagnosis and initial care, be managed effectively at home or in another appropriate community setting are maintained in that setting.

At the same time, it is important to recognise that the benefits of co-location of services in both decision making and efficiency and the need for the interface between services to be fluid to allow a seamless provision of care to patients.

It is anticipated that developments in the provision of emergency helicopter services will mean that the patients who should be transferred from scene to a higher level of service will increasingly so be. However, the significant quantity of relatively high priority conditions that patients self-present within the department means the service must be able to step up to provide higher levels of care when required that will support the stabilisation and, if necessary, commencement of treatment for individuals with conditions that cannot wait.

In order to reduce the risk associated with some rare and life threatening conditions, an anticipatory approach will be taken, for example, by screening for risk factors and early indications of disease so that advice and support can be given to minimise the risk of occurrence together with timely early intervention when disease progression suggests that this would be optimal in preventing it becoming an emergency.

Because of the level of self-presentation, BGH will have to respond to any major condition. Ambulance protocols will, however, direct patients with some conditions that are within certain timeframes to regional centres for treatment in line with best practice protocols and, therefore, BGH would not, usually, receive those patients.

In order to better meet demand, we will work with the Welsh Ambulance Services NHS Trust to develop the role of paramedics in delivering pre-hospital assessment so that care can be appropriately given or directed in the community with rapid access to multi-disciplinary/multi-agency support when

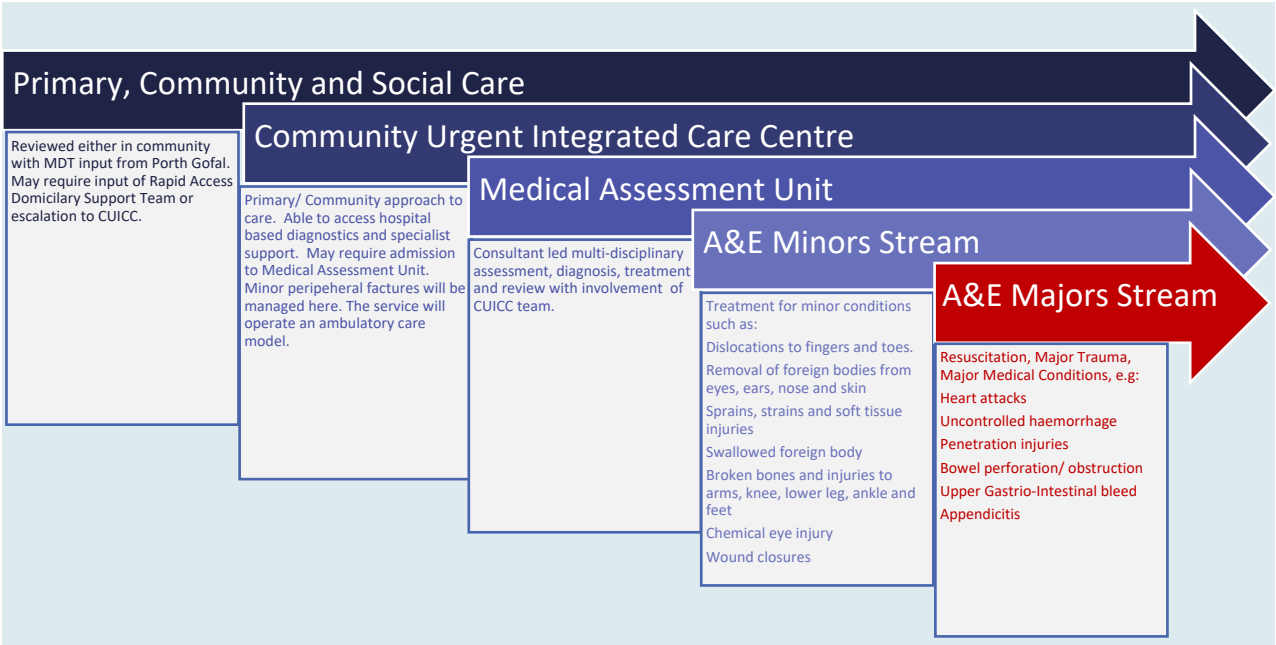
the needs of a patient are not best served by being taken from their home to an acute hospital setting.

Non-blue light GP referrals for hospital care will be referred through the BGH Community Urgent Integrated Care Centre (CUICC) for initial assessment, work-up and treatment. Patients who can be assessed, treated and discharged within the CUICC will be discharged back home or to an appropriate unit if non-health related factors prevent this from being achieved.

Patients requiring further care will be admitted to the hospital's Acute Medical Admission Unit for ongoing care with referral to the appropriate medical team.

Self-presenting patients will be streamed according to their condition.

- Those with minor illness that could be treated within primary care will be streamed to the CUICC for assessment, work-up and treatment.
- Those with minor injuries and illnesses that would not be within the scope of the CUICC will be streamed to the Minor Injury Unit.
- Those presenting with major injury or illness will be streamed accordingly.



Following initial assessment, patients may be transferred to the care of the service that will most appropriately meet their needs (so a patient assessed in the CUICC will be transferred into the A&E Majors stream if appropriate).

Paediatric emergencies will flow through the designated paediatric unit in the minors unit, with cases needing full Accident and Emergency Department care being streamed into resuscitation for urgent intervention.

The Health Board's strategic plan for mental health services will develop local community based mental health services to meet the need of patients who present with mental health conditions. However, from time to time, some patients will present at BGH with a primary or secondary mental health condition and they will be cared for in a dedicated room with 24/7 input from the mental health services being provided from the local community mental health team.

Staffing the Front Door

As can be seen above, a greater involvement of primary care at the front door as part of a multi-disciplinary team (MDT), person-centred approach is a key requirement for system sustainability moving forward.

A "General Practitioner" approach will apply specialist knowledge of "whole person" health to ensure only those for whom there are no other appropriate options are admitted to an emergency department bed and collegiate support between GPs and specialist consultants will ensure that patients receive the most appropriate intervention. Patients who require other support can be triaged appropriately to a range of supporting services with input from, for example, therapies, social care and domiciliary care services with promotion of return to their usual place of residence. Although significant progress is being made on specialist consultant recruitment "inside" the hospital, recruitment to GP posts is currently challenging and the workforce model for the front door needs to reflect this.

In addition, it should be noted that the needs at the front door require a whole-system "CAREdigion" approach and that the staffing requirements, are multi-disciplinary, multi-professional, multi-agency and multi-sectoral.

The staff at the front door also need to be versatile so that appropriate care can be delivered when it is required, rather than requiring referral and subsequent wait.

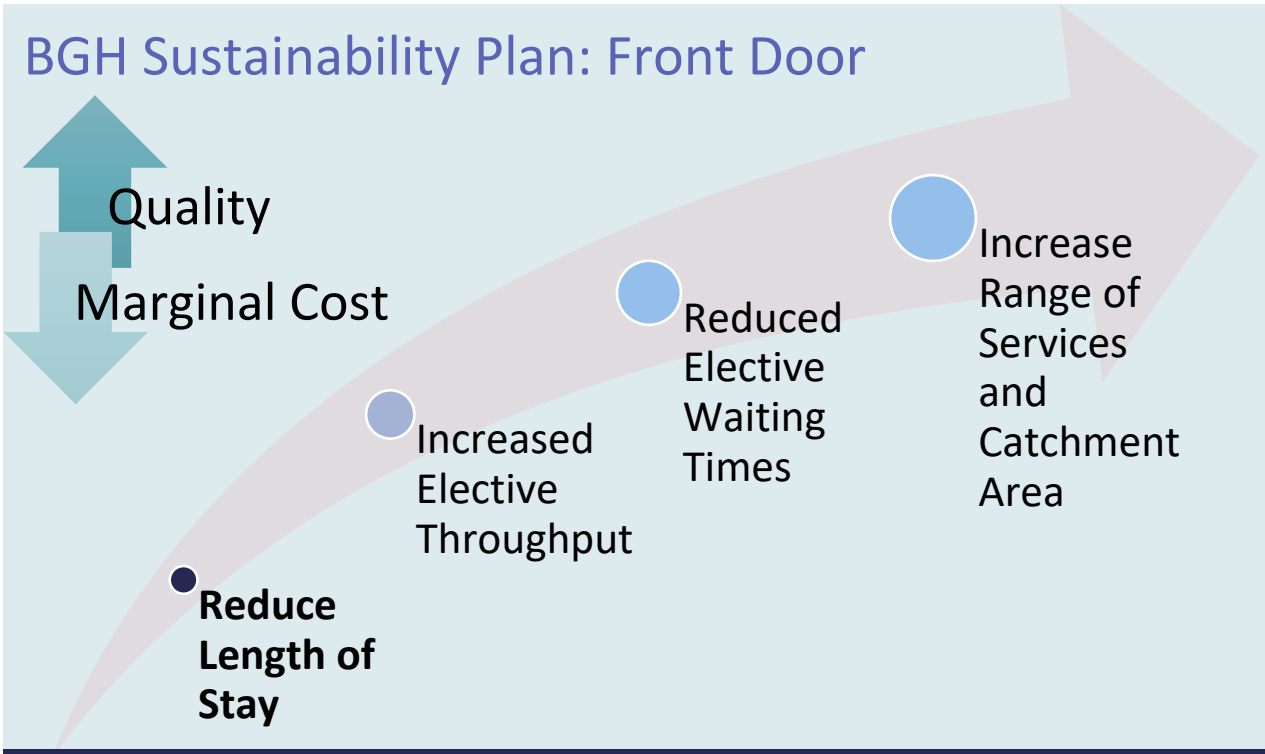
BGH has been part of the Physicians Associates Training Programme since 2016

The utilisation of new and advanced roles, such as physicians' associates, advanced nurse practitioners, consultant nurses and therapists supported by a team of versatile practice assistants (who can apply a wide range of support skills to a broad range of needs) will provide a core of staff to deliver a new front door model so that the specialist emergency department nurses and support staff can focus on the direct care of the most acutely ill patients.

Front Door Model Core Assumptions

Requirement	In Place?	Notes
Clinically led model; integrated with Primary Care.	In part	
Supported by new role applications:		
Consultant Nurse Intensivist	No	
Physicians Associates	Yes	
Senior specialty support provided in AMAU	Yes	
Acute take medical rota	Yes	
Acute take surgical rota	Yes	
Acute take Gynaecology and Obstetrics	Yes	
Acute take Paediatrics	Yes	
All ED nurses complete Paediatric Advanced Life Support Training	Yes	
Paediatric stream to be supported by Registered Sick Children's Nurse on every shift.	In part	See Paediatric Section
MDT working before and across front door services including therapies, paramedics and pharmacy.	In part	Emergency pharmacy and paramedics are 24/7, but whole system, joined up approach needs to be developed to provide consistent input across the whole week.
Mental Health room and 24/7 liaison with Community Mental Health Team	Yes	Response times to be improved alongside the development of the community model for Mental Health Services.
Pathways for referral to Hot Clinics	Surgery	Other pathways to be developed

BGH Sustainability Plan: Front Door



- Pre-hospital admission avoidance (CUICC)
- Rapid Frailty Assessment
- Whole person MDT approach
- Consultant Nurse Intensivist
- Rapid Response Domiciliary Care Service
- Rapid assessment and treatment
- Daily MRI and ultrasound
- 24/7 full body CT
- Mental Health Liaison
- Reablement/Rehabilitation

Delivering Excellent Rural

Acute Medical Services

Rural Acute Medical Centre

A significant proportion of BGH's emergency demand falls under the General Medical specialty. Although there is also a "planned" general medical stream, where patients are referred for an outpatient appointment, these patients present with a range of acute and chronic conditions that, if left unchecked, could deteriorate leading to a crisis requiring either an A&E attendance or inpatient admission.

General medical services, therefore, are key partners in the anticipatory approach that GPs and community services will provide in order to maintain people at home.

Patients in the community with known health conditions need to be managed by their GP and Primary Health Care Team, accessing specialist support when required. When patients are in crisis, the best outcome may not be achieved by hospital admission and it is essential that services are provided for the rapid assessment of people in their home setting and modification of their care package in response to the presenting circumstances.

When patients are admitted to the Acute Medical Assessment Unit, they will be managed under the care of an appropriate specialist based upon their diagnosis or presenting symptoms.

The general medical service at BGH provides a wide range of sub-specialisms:

- Stroke
- Cardiology
- Respiratory
- Haematology
- Oncology
- Falls
- Endocrinology and Diabetes
- Gastroenterology
- Care of the Elderly
- Palliative Care (via community team)
- Neurology (via telehealth)
- Fracture Liaison

An overall generalist approach in medicine requires all medical staff to have a broad knowledge to ensure patients receive the appropriate care outside of the "normal" working week. Dual accreditation of medical consultants allows them to provide specialist and generalist care.

The diagnosis of general medical conditions requires access to a significant range of diagnostic tests and imaging. Although there are a standard core, there is significant variation between specialties.

Computed Tomography scans (CT) are available 24/7 and the provision of daily ultrasound (US) and Magnetic Resonance Imaging (MRI) would significantly enhance the response provided at emergency admission and, if extended to some "wellness" tests, would promote timely discharge throughout the week.

Elderly Care Model

Keeping older people at home is essential to prevent deconditioning that reduces independence and worsens outcomes. This is especially apparent in patients over the ages of 80.

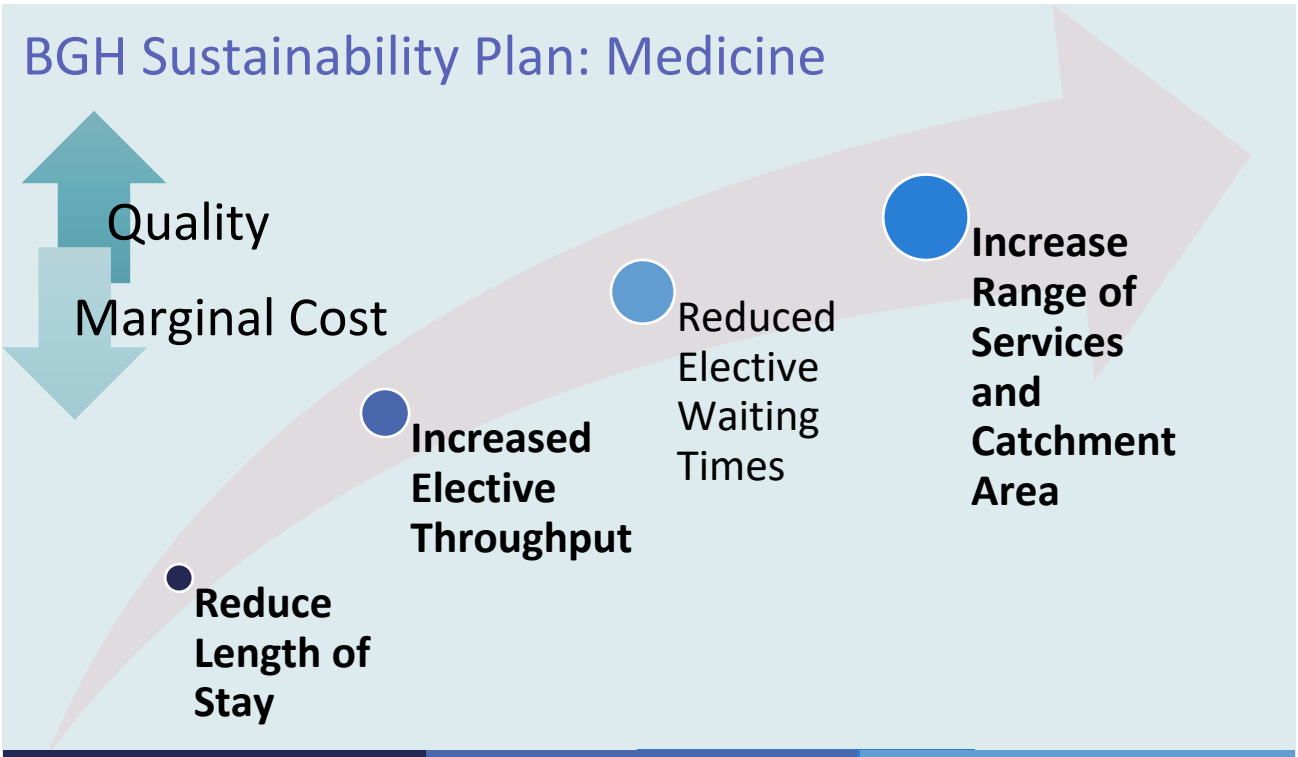
When community admission prevention has exhausted available options, or where patients unknown to the service deteriorate and are conveyed by ambulance to A&E as an emergency, there will be:

- Anticipatory community based approach to manage changes in people's conditions in the community
- Front Door Frailty Team: Delivered in the Community Urgent ICC. Provides rapid holistic assessment by community team to calculate a frailty score and support the provision of emergency home support that allows the patient to return home
- Elderly Care Short Stay Model (Length of Stay 72 hours or less): Dedicated elderly care beds with high levels of therapy input
- Collaborative Care Dementia Service: In line with National Institute for Clinical Excellence guidelines, an integrated acute and mental health shared care older persons unit
- Registered Mental Health Nurse Outreach: Providing support to patients with a dementia co-morbidity

We were visiting Gareth in Talybont. Mari fell as she was coming into the house from the garden. She was in a lot of pain and couldn't get up. The falls response team arrived quickly. The paramedic and occupational therapist suspected Mari had fractured her hip so they called an ambulance, which also arrived quickly. The x-rays taken at the A&E in Bronglais confirmed that Mari had fractured her hip and it would need to be replaced. A nice doctor explained that they will operate within 36 hours. I explained that Mari has early dementia and might get confused, so they made arrangements for her to be admitted to her own room and for the Specialist Dementia Nurse to visit and assess her and ensure that the service she received did not add to her confusion. They informed me of a butterfly scheme so I could let them know what was important to Mari. I was worried about her, but the Consultant Ortho-Geriatrician was able to reassure me and I was told I could visit her whenever I wanted. There was a reclining chair that I could sleep on and I had some meals with her to keep things as normal as possible.

Medical Model Core Assumptions

Requirement	In Place?	Notes
No single handed specialties.	In Part	2 specialities funded for 1 consultant only. Recruitment is underway to fill vacant post.
Specialist Nurses key part of team	In Part	There are opportunities to develop additional roles to meet patient's needs and fill gaps in certain services, e.g. gastroenterology and movement disorder.
Falls service (Safe and Steady)	In part	Development of single point of access and MDT approach pulling together existing services responding to and working to prevent falls.
Fracture liaison service	Yes	
24/7 Full Body CT	Yes	
Daily Ultrasound	No	Currently provided 5 days a week.
Mental Health Liaison	Yes	
Dementia Friendly Working	Yes	



- Elderly care model
- Daily diagnostics
- Reablement/ Rehabilitation

- Recruit to last respiratory vacancy

- Sleep disorders
- Develop outreach clinics in Ceredigion, Powys and Gwynedd

Delivering Excellent Rural

Acute Surgical Services

Rural Acute Surgical Unit

Patients presenting at BGH's Accident and Emergency department and those who are brought in by ambulance or referred by GPs requiring emergency surgery will have a wide range of clinical conditions, some of which require rapid surgical intervention.

Some patients presenting with apparent medical conditions may convert to surgical intervention after initial assessment and diagnosis.

The case mix includes patients of all ages and an appropriate response to cover both adult, paediatric and obstetric emergencies needs to be in place.

There are currently no protocols in place for ambulance services to divert surgical patients to other centres as there are with patients who present with certain cardiac or trauma conditions.

The Rural Acute Surgical Unit, will:

- Provide rapid surgical assessment by a senior surgeon
- Access rapid diagnostic imaging and pathology
- Access specialist/multi-disciplinary input where required (this would include discussion regarding appropriate transfer to specialist services if this would provide the best outcome for the patient)
- Agree a diagnosis and recommended definitive treatment plan for discussion and agreement with the patient and family
- Proceed with plan

Some clinical presentations require immediate treatment that should be initiated after the initial assessment (by any senior clinician). These are conditions that must be operated on immediately (either to stabilise prior to transfer or to treat) and include, for example, treatment of ruptured appendix, strangulated hernia, ruptured spleen and other such conditions.

Multi-Disciplinary Team

Multi-disciplinary working across and within medical, surgical, radiological and anaesthetic specialties is essential to the delivery of the front door service. In addition, established partnerships with specialist services provided at tertiary centres, e.g. vascular and neurosurgery, support the management of patients presenting with conditions that are not, usually, easily or successfully managed outside of a tertiary centre. There are, however, a number of multi-disciplinary approaches that, whilst as essential, are not as visible, but need to be recognised, including:

- General Surgery and Obstetrics & Gynaecology
- Gynaecology and Urology
- General Surgery and Paediatrics
- General Surgery and Trauma and Orthopaedics
- Trauma and Orthopaedics and Geriatric Medicine
- General Surgery and Geriatric Medicine
- General Surgery and Palliative/Oncological Medicine
- General Surgery and Radiology (interventional)

The provision of obstetrics and gynaecology, paediatrics and trauma services are set out later in this document.

Emergency and Elective Surgery

Emergency unplanned surgery presents immediate challenges that planned surgery does not. However, the tests, diagnostic considerations and procedures performed are much the same. It is clear, therefore, that surgeons performing emergency surgery must be providing an elective service and that, given the access considerations for the population of mid Wales, this is best provided as locally as possible by BGH.

Hot surgical clinics have been introduced so that a consultant surgeon will assess a patient in the emergency department and identify individuals who can be safely discharged home following pre-assessment with a booked date for the required procedure on the next available day surgery list. This avoids admitting patients who can safely be cared for at home. We will extend the coverage of our hot clinics so that patients presenting in community settings can be appropriately assessed and booked in this way.

High Quality Outcomes and Facilities

Following a multi-million pound investment, BGH now has four of the most modern operating theatres in Wales. It also has a fifth “pod” theatre that is remote from the two main theatre suites, but is ideally suited to providing high volume or low complexity treatments, such as cataract, dental and some ear, nose and throat (ENT) procedures.

These world-class environments support the whole team in their commitment to excellence in the delivery of surgical services to their patients. The services

provided at BGH have demonstrated excellent outcomes in national audits including those for emergency laparotomy and fractured neck of femur.

Elective Surgical Provision

In addition to the need to provide elective care locally, it would not be possible to recruit and retain doctors to an emergency-case only job plan. The provision of a broad range of elective procedures, including cancer and benign surgery, will be provided at BGH to ensure the whole surgical team have exposure to the widest possible range of conditions and maintain and develop their skills in treating these, including:

- Colorectal benign and malignant
- Benign Upper GI and hepatobiliary surgery
- Diagnosis and initial management of upper gastro-intestinal cancer
- Diagnostic and therapeutic endoscopy (including endoscopic retrograde cholangiopancreatography and stenting)
- Urological benign and cancer surgery including kidney
- Breast benign conditions and cancer
- Abdominal wall surgery (hernias)
- Ear Nose and Throat
- Gynaecological

Ophthalmology services are of particular relevance to an ageing population but also provide essential diagnostic and treatment for patients in younger age groups. Outpatient and diagnostic services are provided from the North Road Clinic with surgical procedures being performed at BGH. The ageing population across mid Wales results in an increasing demand for procedures for cataracts and age related macular degeneration alongside the management of glaucoma, diabetes related conditions and other general ophthalmic conditions. There is a significant opportunity to deliver ophthalmology services closer to peoples' homes and we will work with our neighbouring Health Boards to establish local diagnostic and treatment services in their community facilities.

Clinical Pathways

Links with specialist centres that reflect BGH's catchment area will be established so that patients for whom a BGH/Shrewsbury/Telford pathway

provides them with the best outcome, can access the appropriate services seamlessly across that pathway. Similarly, patients for whom BGH/Glan Clwyd/Christie provides them with the best outcome will have access to those services.

Opportunities to utilise new facilities being developed in both Powys and Gwynedd will promote outreach, networking, staff rotation and skills development with specialist and training centres. BGH will become a training hub for surgeons within Hywel Dda to access advanced laparoscopic training provided by Shrewsbury and Telford NHS Trust, significantly enhancing Hywel Dda's overall skills and capacity to the benefit of all Hywel Dda patients.

Delivering Emergency Care – Protecting Elective Capacity

Elective care capacity is best protected when its physical environment is separated from that required for emergency care. At BGH, however, the economies of scale required to deliver financial sustainability do not support physical separation of those facilities and separation of the elective and emergency work-streams will be enforced to ensure that the emergency work is done in a timely way that does not compromise elective cases.

The opening of the new inpatient and emergency theatre suite paves the way for the day surgery unit to move to a 23:59 service model (which promotes patient recovery following day case surgery, but protects the capacity for elective cases).

We were on a short holiday in Aberaeron when Ben became unwell with severe stomach pains. I took him to the local GP surgery for emergency treatment. The GP suspected appendicitis and called an ambulance, which arrived almost immediately. We didn't have to wait in Bronglais A&E. 30 minutes later, Ben had the operation to remove his appendix, and the surgery only took 20 minutes. We stayed for 2 days until Ben was well enough to be discharged. The doctors and nurses were fantastic and looked after us really well. They arranged a reclining chair for me next to Ben's bed for me to stay overnight, which was fantastic for both of us.

Improvements can also be made with regard to preparing patients for surgery and we will establish “prehabilitation” for patients for whom better outcomes can be obtained following health improvement activities, such as smoking cessation.

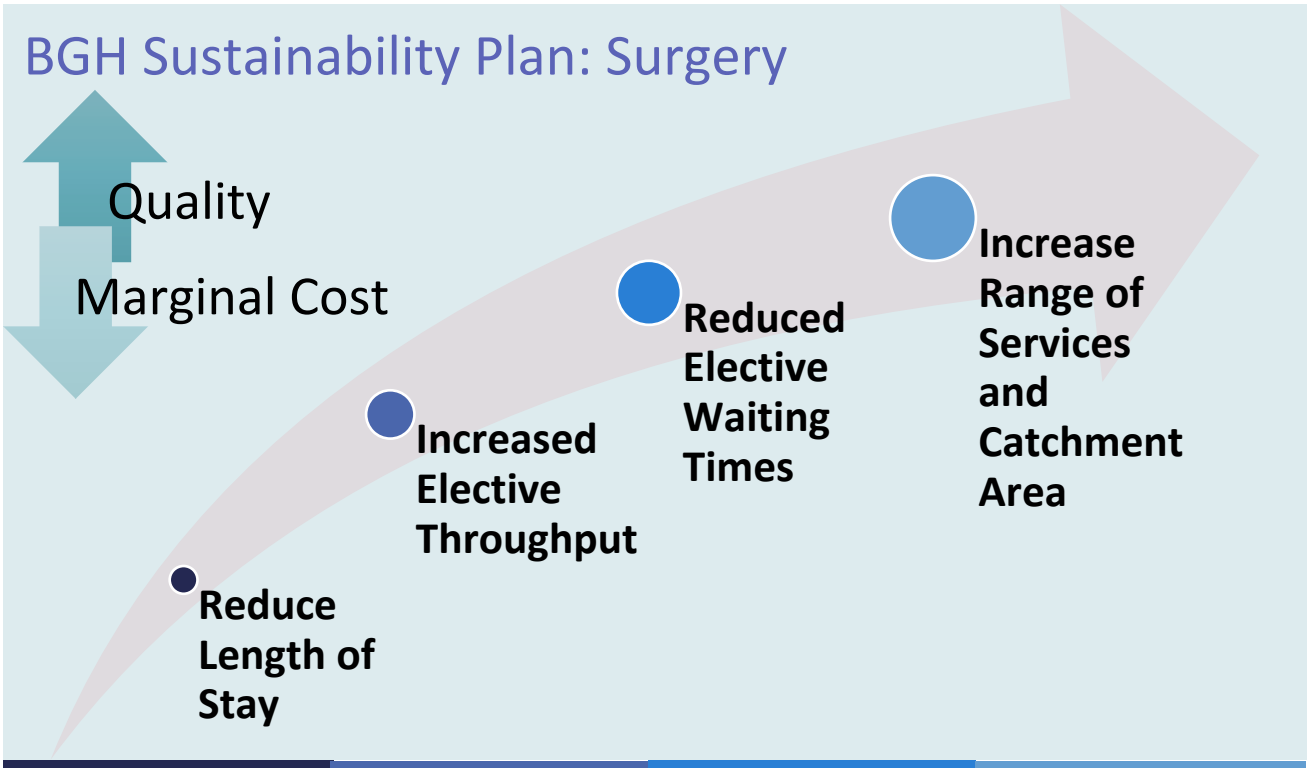
In addition to improving wellbeing prior to admission, it is important to ensure that patients receive appropriate support before and after surgery to reduce the time a patient needs to stay in a hospital bed. The provision of physiotherapy and occupational-therapy support seven-days a week is essential to ensure therapy plans are consistently delivered.

More detail on providing “Excellent Rural Planned Care” is provided later in this document.

Surgical Model Core Assumptions

Requirement	In Place	Notes
Move to 6 surgeon rota (to meet Royal College of Surgeons recommended on-call cover)	No	Currently 1:4 as agreed with Royal College of Surgeons. Increased numbers will be supported as workload grows due to repatriation and catchment area extension.
Theatre on-call/emergency surgery/trauma teams to meet guidelines and any emergencies that cannot wait.	In part	Plan to establish appropriate staffing mix and levels to be developed.
24/7 Obstetrics and Gynaecology support for emergency surgery	Yes	
Upper GI Bleed Rota	Yes	Ensure sufficiently trained members of on-call team to cover service.
Rotation of Staff	No	To be introduced as part of Health Board wide programme of staff rotation with options to rotate with other providers relevant to BGH patients.
23:59 “Day Case” Unit	No	To be implemented after the new inpatient theatre suite has bedded in.
Daily therapy support for elective surgical cases	No	7 day support to be developed utilising opportunities of new role development.
Outreach Clinics to Ceredigion, Powys and Gwynedd	In part	In Mid Wales Clinical Advisory Group’s work plan
Vascular Surgery	No	Patients currently travel for appointments. Opportunity to work with partners across Mid Wales to improve access.
Clinical Pathway Development	In Part	Some pathways exist, but full and comprehensive review required to ensure they provide the best possible outcome for the patient and reflect the commissioned services of Powys and Betsi Cadwaladr Health Boards.

BGH Sustainability Plan: Surgery



Reduce Length of Stay	Increased Elective Throughput	Reduced Elective Waiting Times	Increase Range of Services and Catchment Area
• Maximising day case potential • Admission on day of surgery • Optimising pre-assessment screening • ERAS • Patient optimisation • Discharge planning from Day 1 • Criteria led discharge • Daily MRI and ultrasound • Frailty ANP • Rehabilitation • Reablement	• Maximise theatre efficiency • 12 hour elective day • Separate emergency theatre facilities (NCEPOD) • Separate elective and emergency ward base • Develop surgical short stay model • Daily therapy support	• Maximise theatre efficiency • Separate elective and emergency ward base • Local management of elective services • Versatile Operating Department Practitioner roles to take on minor procedures • Promote minor surgery in community	• Outreach to Machynlleth • Outreach to Tywyn • Outreach to Newtown • Increase service provided within specialties • Extend service portfolio (networking north, east west and south)

Delivering Excellent Rural

Acute Trauma Services

Rural Trauma Facility

Major trauma care is a whole-service, networked approach to managing seriously injured adults and children. By providing a multi-disciplinary specialist approach, the Major Trauma Network improves patient outcomes by saving life, reduce disability and improve recovery to functional life.

BGH's remote rural position in Wales results in a level of self-presentation and "nearest hospital" blue light arrivals where travel time to a Major Trauma Centre or Major Trauma Unit is outside timeframes required to attain the best outcome for patients.

When a patient presents with simple trauma, e.g. a fractured leg, that can readily be stabilised with "plaster" then the trauma service comprises a relatively straightforward team of orthopaedic doctor, radiologist, nursing, plaster technician and physiotherapy. However, seemingly simple trauma can, upon imaging, present more complex challenges, such as penetration or risk of penetration of skin, blood vessels, thoracic and abdominal organs. More complex trauma, therefore, requires an enhanced skill-mix to agree and enact an appropriate management plan.

Major trauma services aim is to preserve life, prevent secondary injuries, assess, diagnose and agree a treatment plan for the presenting conditions. Evidence supports a view that these patients are best treated at a specialist Major Trauma Centre as part of a Major Trauma Network. The development of the Emergency Medical Retrieval and Transfer Service (EMRTS) and air ambulance services will facilitate these transfers either directly from the scene or post stabilisation at BGH.

Because of the remoteness of the mid Wales area, the vital initial response and stabilisation of patients within the critical period of time from the trauma will have to be done at BGH for patients who:

- Are too unstable to go directly to a Major Trauma Centre
- EMRTS are unable to attend or where patients
- Self-present

For patients who do present at BGH, decisions regarding their care will be made by a multi-disciplinary team including rapid access to highly specialised support from the Major Trauma Centre to ensure the best outcome possible for the patient.

In some cases, initial treatment of some elements of the trauma will be required prior to transfer to a Major Trauma Centre for repair of more complex conditions (e.g. to manage uncontrolled blood loss or other immediately life threatening condition).

Technology presents opportunities to support decision making and remote treatment, for example cameras can be mounted in theatres to let remote surgeons advise on procedures where patients are too ill to be transferred and this will be explored to support providing patients with the best possible outcome given their presenting circumstances.

High Quality Services

BGH actively participates in the Trauma Audit and Research Network (TARN) and demonstrates good outcomes for Major Trauma patients being managed at or via its services. There are agreed stabilisation and transfer pathways to the Major Trauma Centres that have been developed in collaboration with WAST. Although not classified as Major Trauma in older people, BGH delivers excellent outcomes for patients presenting with hip fractures and meets more of the quality criteria than any other hospital in Wales in the National Hip Fracture Audit.

Fractured Neck of Femur: BGH has demonstrated consistently high compliance with the national hip fracture audit's requirements and has developed practice that challenges some assumptions about what good looks like in this area. Pre-operative optimisation at BGH has shown that for some patients, although time to theatre is longer, overall recovery time and length of stay is shorter, with survival and outcomes improved.

Clinical Pathways

Hywel Dda's Trauma Unit will be based in the new hospital development (temporarily at Glangwili). Tertiary level services will be available across south Wales at the Cardiff Major Trauma Centre. Powys residents receive major trauma care at Cardiff or Stoke and North Wales patients receive their care at Stoke. The Major Trauma Network also includes the tertiary level services for cardiovascular and plastic surgeries provided by Swansea Bay Health Board.

Any trauma currently presenting at BGH that involves an existing joint replacement, is transferred to Glangwili Hospital. This ensures that patients who might require revision surgery are at a facility that is equipped to provide it. A major trauma triage tool will be used to assess the manner of the initial intervention (ambulance/air ambulance/EMRTS) and direct patients to the most appropriate service relative to their presenting need.

Networks with specialist centres provide opportunities for skills maintenance and development together with continued professional development. BGH hosts an annual meeting where the clinical team from Oswestry and BGH meet to discuss case management and networking.

Spinal Trauma

Following imaging and diagnostic tests at BGH, information is sent to the on-call Major Trauma Team at the University Hospital of Wales in Cardiff (UHW). The information is relayed to UHW's spinal team for advice on management locally or transfer. This allows patients to be managed as close to home as will achieve the best outcome for them, but steps need to be taken to guarantee the provision of timely advice or instruction for transfer. For some patients, Cardiff will redirect the pathway to Oswestry which is facilitated by the teams at BGH.

Paediatric Trauma

Common trauma conditions will be treated at BGH.

Core complex and less common paediatric trauma, such as fractured hip, bone and joint infection or slipped upper femoral epiphysis, are transferred to specialist centres in Cardiff or Oswestry following discussion with clinicians specialising in this level of care.

Delivering a Rural Trauma Facility

What is set out above describes the services currently provided from BGH and there is no proposal to change this. While there may be some changes to the protocols for transfers from scene, the presenting cases do require this level of service to be available 24/7 at BGH.

By recognising BGH's unique position as a "*Rural Trauma Facility*" within the national trauma network, BGH will be able to appropriately respond to any level of trauma offering resuscitation, stabilisation, treatment and transfer as appropriate to presenting cases. This recognition will also promote repatriation of patients back from the Major Trauma Centres to their local hospital for ongoing care and rehabilitation.

To better support the current service provided and seek to develop the service to meet the increased demand that will be placed upon BGH, a number of services need to be provided:

- Access to urgent full body CT within 1 hour 24/7
- Access to MRI within the "day", (24/7 for spinal cord compression)
- Consultant review will be required daily with two ward rounds required for the most acutely ill patients
- Trauma Specialist Nurse
- Daily trauma theatre list including all support services (e.g. imaging intensifier)
- Daily therapy input
- Pathways for transfer to the Major Trauma Centres at Cardiff and Stoke and, where appropriate, to the specialist orthopaedic hospital in Oswestry
- Protocols for transfers between the Hywel Dda Major Trauma Unit and the Rural Trauma Facility for Hywel Dda patients

Rehabilitation

Rehabilitation post trauma should start on day 1, even if this is only planning. The timescale for active mobilisation will depend upon specific condition, but in general, evidence suggests that the sooner someone becomes mobile, the better their outcome.

It is important to have access to daily physiotherapy, occupational therapy and, where appropriate other therapy support such as clinical psychology, which may be provided by qualified or appropriately trained support staff, to ensure that mobilisation and rehabilitation is a continual process that will reduce the time spent in hospital and improve the patient's outcome.

Input from Consultant Orthogeriatricians improves outcomes by supporting the care of older people following trauma as part of a multidisciplinary team and is provided at Bronglais.

For more complex trauma, e.g. spinal, a higher level of support is required. In order to achieve the optimal outcome for these patients, this needs to start as soon as possible. We will ensure that networks are in place so that specialist advice from the centre, that if required would receive the patient, is provided to promote the delivery of seamless care.

Rehabilitation post specialised care delivered by tertiary centres is not just required for trauma, but for a number of other conditions and consideration will be given to the development of a mid Wales rehabilitation unit in a central location. By combining the rehabilitation pathways into a single unit, we will be able to deliver high quality, sustainable care as locally as possible to the patients of mid Wales.

Care for the Family

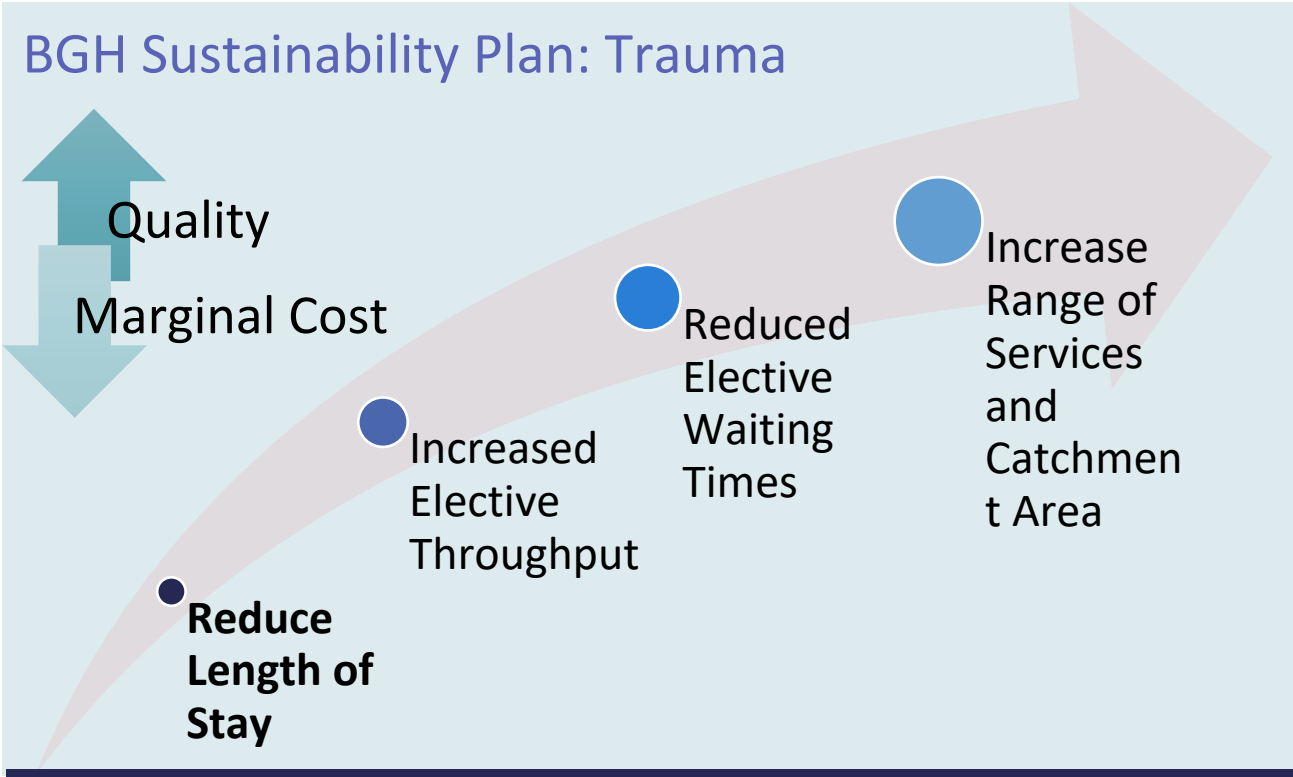
For patients where the prognosis is clear that potentially curative treatment will not be appropriate, the trauma service enables the provision of best supportive care to ensure pain management, comfort, family support and rituals to provide the best possible death.

Because of the rurality of the area and the distances to the trauma units and centres, the needs of the family in being able to have last moments with their loved one will be promoted and maintenance of patients locally or access to rapid transport to and return from Major Trauma Centres is essential in the provision of a holistic model of care that recognises the both the promotion of the best outcomes for the patient and the best experience possible for the family.

Trauma Model Core Assumptions

Requirement	In Place?	Notes
5 Consultant Orthopaedic Surgeons	No	Currently 3 of the 4 funded posts are filled. Increased numbers will be supported as workload grows due to repatriation and catchment area extension.
24/7 Full body CT in 1 hour	In Part	Service available; review as to root cause of non-compliance to be undertaken
Daily MRI (24/7 MRI Spine)	No	Not first line diagnosis except for spinal cord compression. Following installation of the new MRI, this service could be considered initially on the basis of a call-in service if clinically essential.
Specialist Trauma Nurse	Yes	We have an elderly trauma advanced nurse practitioner in place managing complex fractures
Trauma Theatre List	Planned	Will be introduced as part of new theatre roll-out.
24/7 radiology support for trauma theatre	Yes	Currently provided by on-call radiographer.
Daily Poly-therapy input	No	Essential for rehabilitation initiation, progression and discharge.
Clinical Pathway Development	In Part	Protocol for transfer to Major Trauma Centre in Cardiff are in place. Protocols for transfer of patients from Powys and Gwynedd to the Stoke Major Trauma Centre are in place but will be reviewed. Pathways between Hywel Dda Major Trauma Unit and the BGH Rural Trauma Facility to be agreed.
Telemedicine Links	No	Theatre cameras and tele-links to specialist centres to be installed/created as appropriate.
Staff Rotation	No	Rotation of staff to the major trauma centres in South Wales and Stoke to establish key relationships, develop skills and support clinical pathways.

BGH Sustainability Plan: Trauma



- Discharge Planning from Day 1
- Patient optimisation
- Daily therapy input
- Daily “care and repair”
- Trauma Theatre List
- MDT
- Cross border liaison for complex discharges
- Elderly trauma advanced nurse practitioner
- Daily MRI and Ultrasound
- Major trauma pathways supported by transport arrangements

Delivering Excellent Rural

Acute Obstetric Services

Rural Obstetric Unit

Consultant led obstetric services are an essential part of a 24/7 unselected acute emergency service. The need to respond to maternity emergencies necessitates 24/7 cover which in BGH's case is supported by the 24/7 on-site consultant anaesthetic service. Obstetric services are closely linked with gynaecological and paediatric services in the hospital and with community mid-wives and paramedics pre-hospital, all of which must work together to provide safe services for mothers and babies.

Because of the remoteness of the population served, BGH provides essential access to families who would otherwise experience significant disruption to their lives in order to access services at other units.

Maternity services at BGH are provided by teams of staff including midwives, obstetricians, paediatricians, anaesthetists, and other support staff. The pattern of care provided to women will depend on each woman's individual needs. Our maternity services have been developed to meet the needs of local women and their families.

Midwifery services are provided across acute and community services and ensure that mothers (and families) to be, are provided with the support they need during their pregnancy and consultant supervision is provided to those who require additional support. Antenatal care is provided in a variety of settings such as at home, community or hospital settings.

Community Midwives also provide care for women having home births, and are available to give advice to women throughout their pregnancy.

Ceredigion has the lowest fertility rate in Wales at around 47 births per 1000 women of child bearing age each year. With services at Glangwili being more conveniently located for families in the southernmost part of the county, this means that, together with relatively low numbers of births from the remote areas of Powys and South Gwynedd, the total number of births at BGH is low at around 400 births per annum, although this has been higher in the past.

In order to balance quality and access with the low number of births, the BGH service is provided from co-located consultant and midwifery led units which includes a stabilisation and step-up short term enhanced care environment (providing a more specialist care for those babies who require transfer to a higher level of care in another centre) so that the service can respond to a wide range of complications that present unexpectedly at BGH (e.g. unexpected breach/premature labour); the consultant team networks with specialist centres to ensure appropriate management of mother and baby in these cases.

When required, a dedicated emergency surgery/maternity theatre is provided three floors above the maternity unit allowing access to surgery well within the required timescales for emergency caesarean sections.

The Gwenllian maternity unit provides a high quality environment for mothers, families and staff. Health Inspectorate Wales' unannounced inspection of BGH's maternity services (January 2017) found that:

> "Overall, Gwenllian ward provided safe and effective care, which met with the Health and Care Standards. Patients were satisfied with the care they received and spoke highly regarding the professional, courteous and supportive attitudes of the staff."

Stabilisation, Enhanced Care and Risk Management

The low number of births in BGH mean it is not viable to provide a permanent Special Care Baby Unit at BGH and criteria are applied for delivery:

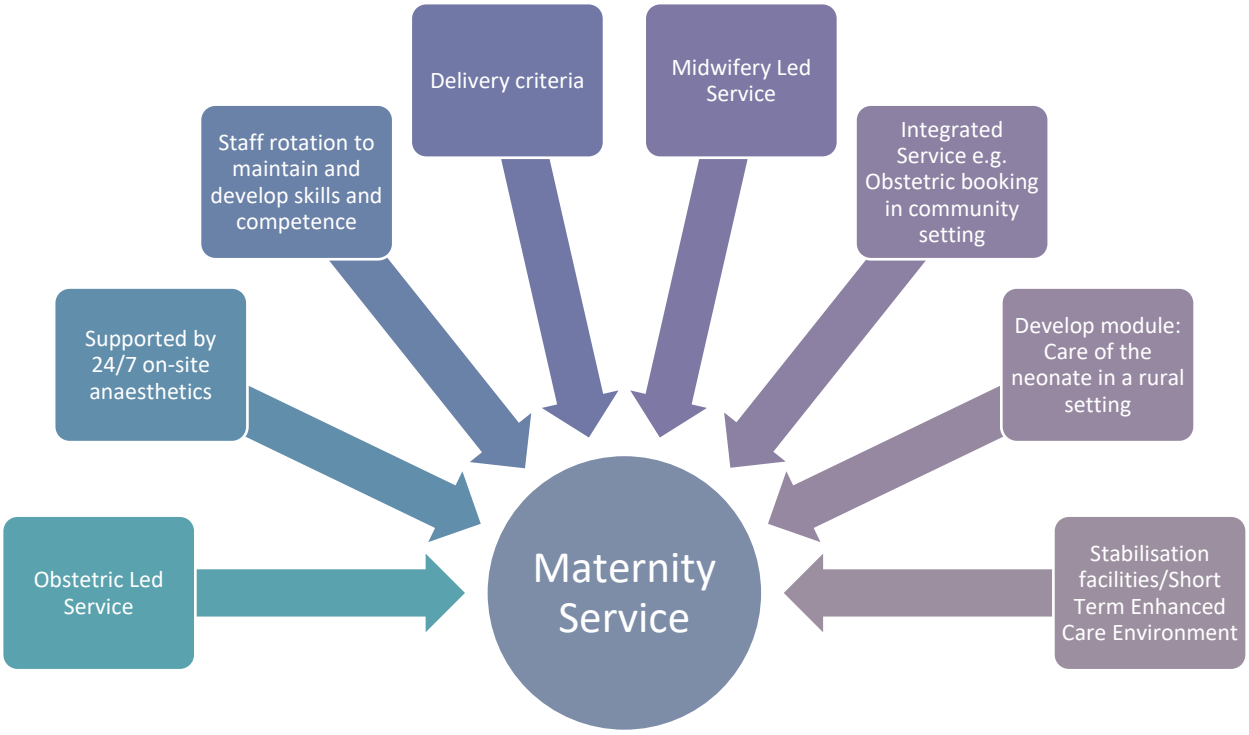
- Deliveries at 37+ weeks
- No twins or higher multiples deliveries
- No high-risk factors (baby)
- No insulin-dependent diabetic mothers

These criteria will continue to be applied in our future model.

We will implement a development of our existing ultrasound scanning service to improve screening for risks of later complications. The provision of a 5-minute scan at 20 weeks would:

- Identify babies at higher risk of later growth related complications
- Enable better planning by the service and families with timely referral for pregnancies that require higher level support
- Reduce the burden on the sonography department by screening out the low-risk pregnancies

The provision of 24-hour on-site consultant provided anaesthetic services at BGH is a key enabler of safe paediatric and maternity services. BGH will also have an established 24/7 on-call rota model for maternity, 24/7 theatre access for caesarean section deliveries, and stabilisation facilities for rescue and transfer of neonates which can step up when needed to provide enhanced care when remote assistance is not available.



Staff Rotation

The low number of births at BGH will require us to ensure a programme of rotation is in place to enable midwives and obstetricians to maintain their skills and competence. We will ensure these staff maintain and develop their skills and knowledge, e.g. one 'hot' week every three months in a specialist unit.

Integrated Service

We believe that some of the services that are traditionally provided in a hospital can in future be provided in a community setting. For example, obstetric booking will take place in the Integrated Care Centres being developed in the community, rather than at BGH.

The health of a new born child starts with the health of their mother and maternity services have a key role in ensuring children get the best start possible by supporting mums to be, in attaining optimal health and wellbeing during their pregnancy.

Midwives are part of the local community and are able to appropriately focus support that is relevant to the needs of the mothers they are supporting. This may be by one to one support or by group sessions. Offering holistic assessment will support the take up of healthy activities and behaviour changes that will benefit not only the health of the baby, but can have significant benefit on the health of the mother and the wider family and the opportunity to discuss parenting and child development should be taken when appropriate to help the attainment of a healthy, happy childhood.

To better meet the needs of mothers from Powys and Gwynedd, we will explore the establishment of virtual clinics that will reduce the need to travel to BGH with local provision of ultrasound scanning the day before the appointment to enable a meaningful consultation to take place.

Care of the Neonate in a Rural Setting

Recognising the particular challenges of providing maternity services in an isolated setting we will work with Aberystwyth University to develop a training module for paediatricians, midwives, paediatric nurses and therapists in Care of the Neonate in a Rural Setting.

Obstetric Triage Unit

The current obstetric service at BGH is geared towards “delivery” and the current pathways do not sufficiently promote obstetric outreach to support the management of non-obstetric emergency presentations to ensure best outcomes for the baby and the mother.

We will establish a 24/7 Obstetric Triage Unit to ensure that all patients who are pregnant and who attend the emergency department with a non-pregnancy related condition are assessed appropriately by a multidisciplinary team, including:

- Consultant Obstetrician
- Advanced Midwifery Practitioners
- Integrated referral pathways to other specialties
- Access to high quality diagnostic ultrasound
- Pathways to specialist centres

This service would also support the management of concerns relating to mothers under community midwives so that escalation to obstetrician support is done in where there is an identified need. It could function as a “Porth Mam” providing a single point of contact for support, advice and intervention relating to maternity matters.

System improvements will also be made to ensure that health care professionals caring for mothers who are deemed, by their consultant, to be of higher risk can be alerted to the need to alert a member of the obstetric team for assessment.

Modernising the Maternity Record

Mothers to be are given the "All Wales Hand Held Maternity Record" that they are asked to keep with them at all times. While this provides easy access to information for health care providers when needed, it is bulky to carry and could allow access to personal information should it be mislaid or misplaced.

A move to a digital health hand held record that updates from a secure information cloud would allow this information to be carried securely and be accessible to healthcare providers when required, with their updates being available to all who need to access that information in the delivery of care.

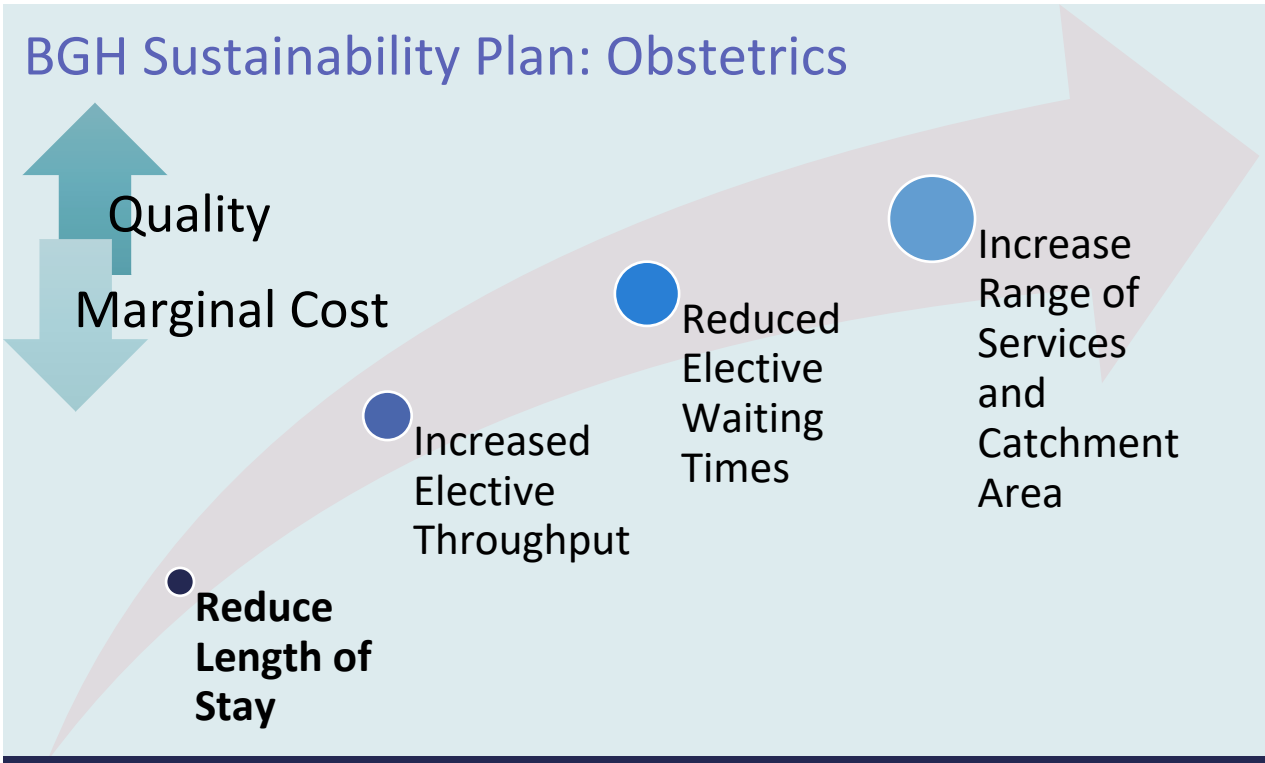
Streamlining and computerising assessment processes would improve efficiency and enable sharing of information with key members of the wider health care team. Partnership working with services in and commissioned by our neighbouring health boards would be promoted by the provision of computer based integrated health records so that the latest information is readily available when needed, wherever a patient presents. This development is currently being pursued on an all Wales basis and we will ensure that the scope of such developments include the provision of information to NHS organisations both inside and outside Wales.

Ayesha had a very healthy pregnancy and kept active throughout. We had discussed her labour plan with the midwife and chose to have the baby in the midwife led unit, rather than the labour ward, as we wanted a calming environment for the birth of our third baby. Ayesha stayed at home for as much of the labour as she could, but after a few hours we travelled the short distance to the midwife led unit. The midwife explained the risks and benefits of different forms of pain relief and encouraged Ayesha's use of the breathing exercises she had learned during pregnancy. The labour was relatively straightforward and our third child - our first daughter, Bethan - was born safe and well with no intervention needed. Our experience of the midwife led unit was entirely positive; we felt listened to and well cared for at all times.

Obstetric Model Core Assumptions

Requirement	In Place	Notes
1:4 Consultant Rota	Yes	
24/7 Anaesthetic support	Yes	
24/7 Colorectal and surgical support	Yes	
24/7 Obstetric Theatres	Yes	
Stabilisation Unit (and Short Term Enhanced Care Environment)	Yes	
Community and hospital based midwifery	Yes	
Obstetric Ultrasound	Yes	
24/7 retrieval service within target time	No	CHANTS provided 12 hours a day; nationally provided.
Pathways with specialist units for Powys and Gwynedd	Yes	
Obstetric Triage Unit	No	Current arrangements to be reviewed to ensure effectiveness

BGH Sustainability Plan: Obstetrics



- Review and develop services to promote next day discharge after caesarean-section.
- Promote community deliveries
- 24/7 Retrieval Service within Target Time
- Obstetric Triage Unit

Delivering Excellent Rural

Acute Paediatric Services

Rural Paediatric Unit

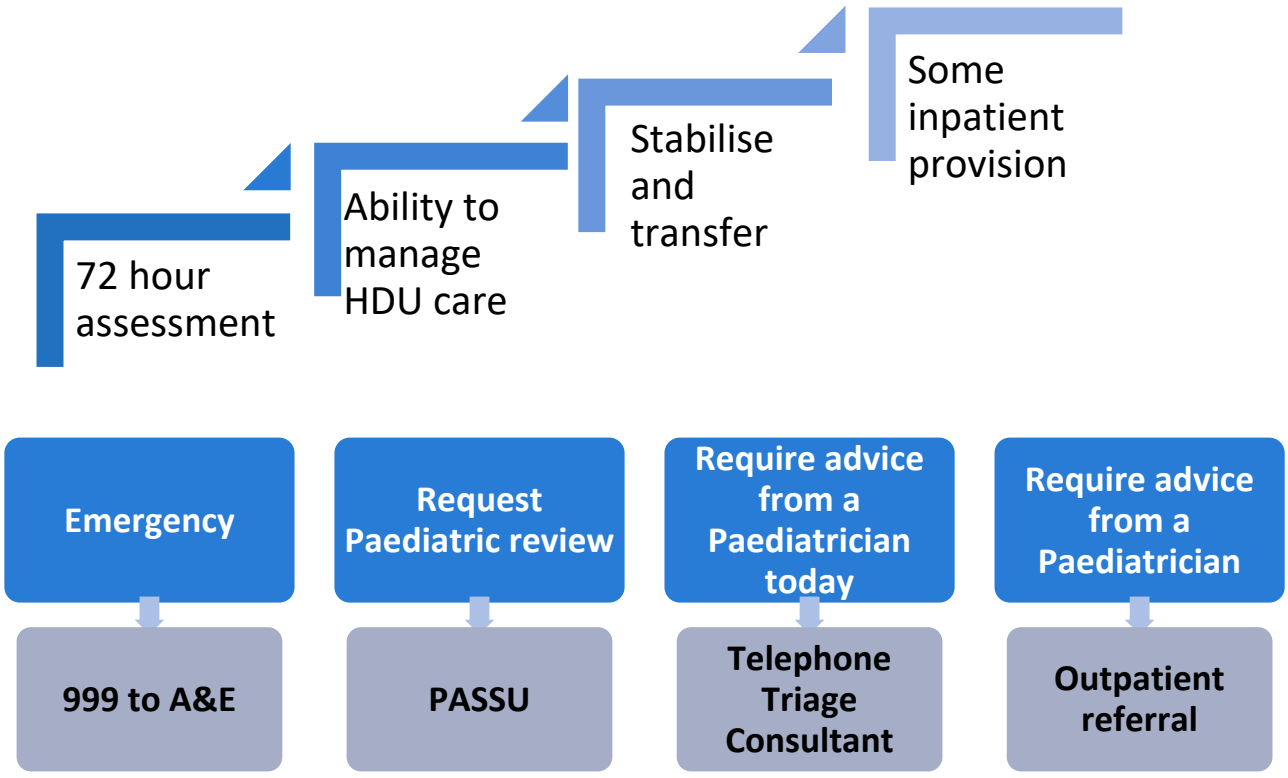
A 24/7 consultant-led, paediatric service is essential to support an unselected emergency care service.

General paediatric units are moving to a Paediatric Ambulatory Care Unit model which aims to provide support and treatment that does not require inpatient admission. In the context of BGH's dispersed catchment population, this model would not work and our plan is to develop it to provide a Paediatric Assessment and Short Stay Unit (PASSU).

The PASSU will provide:

- 72 hour assessment facility
- High Dependency Unit (HDU) care
- Inpatient provision for children requiring specialist input for more than 72 hours
- Community nurse referrals

Where a child has been assessed in a community setting by a competent health professional (e.g. GP, Community Nurse), there are four pathways available to them:



Emergency Services

The consultant-led paediatric service, working with the consultant provided anaesthetic service, will provide care and treatment for the majority of children presenting and referred to BGH. In addition emergency surgery will be provided in partnership with the surgical team at BGH where children presenting with life, limb or organ limiting conditions.

While this will ensure that all children and babies presenting receive high quality specialist support, not all will be able to be treated at BGH. Some will be diagnosed with non-urgent conditions that can be referred to the appropriate specialist centre, others will have a more complex diagnosis that will require rapid transfer to a specialist centre and this will be done in accordance with clear agreed clinical pathways reflecting the child's area of residence so that they are transferred to the most appropriate and local specialist centre in a smooth and timely way. There are three main transport services relevant to patients who attend BGH:

- Wales & West Acute Transport for Children service (WATCh) linked to Cardiff and Bristol Paediatric Intensive Care Unit
- North West and North Wales Transport Service (NWTS) linked to Paediatric Intensive Care Units in North Wales, Manchester and Liverpool
- Emergency Medical Retrieval and Transfer Service (EMRTS) providing pre-hospital critical care at the scene of an accident prior to transfer to the most appropriate unit for ongoing treatment

Where retrieval is not immediately possible, there are options to transport specialist teams to BGH to take over management of care until such time as the patient can be transferred. It is essential that transport services acknowledge the remote and rural nature of both BGH's location and the population served. When required, pathways for transfers out of BGH should be to the specialist centre closest to, or at least closer to the patient's home, to enable onward care and support by and of the family.

Pathways and Surgery

The paediatric team at BGH support a wide range of services in both inpatient and outpatient settings where children come into contact with "general"

specialist services, such as orthopaedics, ophthalmology, ENT and general surgery. The service also reaches into accident and emergency when children present and is also a point of referral and support for primary care services. Importantly, the service supports BGH's obstetric services, providing essential input during deliveries and input to the Special Care Baby Unit (SCBU) for stabilisation of unexpected sick new-born babies pending transfer to more specialist care as required.

Emergency surgery for children is performed at BGH where it is required to save life, limb or organ. There are protocols in place for the transfer of children to other units as required.

Pathways are in place with Cardiff and Liverpool for highly specialist support and with Glangwili for less complex elective surgery and Oswestry for orthopaedics.

Elective surgery for children is, in general, kept to a minimum and when required should be provided by surgeons who are operating on sufficient numbers of children to ensure they are suitably experienced. The most common procedures and pathways are:

- Inguinal Hernia repair at Glangwili
- Umbilical (belly-button) hernia repair at Glangwili
- Correction of undescended testis at Glangwili
- Circumcision at Prince Philip Hospital

Referral pathways for children from Powys and Gwynedd are to the respective hospitals in North Wales and Telford.

We will seek to work in partnership with colleagues within Hywel Dda and with specialist centres so that routine elective paediatric surgery is returned, where appropriate, to BGH. The surgical facilities at BGH do not have a designated paediatric unit, so surgery will need to be managed in such a way that it was separated from adult care. Surgeons performing procedures would need to be part of a rotation that would allow them to perform sufficient operations to maintain their skills and competence. We will also provide additional training for anaesthetists and ensure that a Registered Specialist Children's Nurse is present in theatres.

Paediatric Staffing

The service is a consultant-led service supported by middle grade doctors, an Advanced Paediatric Nurse Practitioner (APNP), Registered Sick Children Nurses (RSCN), children's trained nurses and health care support workers. Hospital play specialists provide support Monday to Friday. The paediatric unit delivers education and training opportunities including overseas post-graduate trainees from Sri Lanka and Medical Students from Cardiff. The provision of training opportunities is essential in order to meet the challenge of recruitment and retention to the team and ensure the provision of a 24/7 service.

BGH's unique situation offers an opportunity to provide trainees with a rural perspective which provides a highly diverse and unpredictable case mix that will support the development of their case management and collaboration skill-set to meet the demands and resources available.

The adjacency of BGH to Aberystwyth University and the drive to develop clinical education in mid Wales will help deliver the academic and practical support structures that doctors working towards specialisation required.

The appointment of an Advanced Paediatric Nurse Practitioner to BGH has allowed us to explore alternative workforce solutions to providing the services. This includes the assessment, examination and management of acute presentations including decision to refer on, admit or discharge supported by access to a full range of diagnostic tests.

Advanced Paediatric Nurse Practitioner

APNPs support the acute medical team and enhance access to paediatric care.

They use independent clinical judgement to assess, investigate, diagnose, plan, implement and evaluate the clinical management and care of children. They are able quickly exclude serious illness and identify those children who are sick from those who are well, but presenting as a concern.

APNPs work across the acute paediatric, ambulatory and out-patient care settings and provide nurse-led clinics to assess both new patients as well as follow-up reviews reducing the number of children attending the ward for services that can be provided in a more appropriate setting.

Prudent healthcare is an essential component of health care for children; too much or too little intervention can have long lasting effects on wellbeing. APNPs are ideally placed as part of a wider multi-disciplinary team to provide a

skilled holistic clinical assessment and recommendation and we will develop our service so that APNPs are available 24/7.

By developing additional APNP posts within the department, it would be possible to remodel the service to provide a 24/7 nurse led service with access to call-in consultant support. This would support the delivery of accident and emergency liaison whilst delivering safe, accessible and patient focused care in a local setting. The consultant team will focus on the specialist care needs presenting in the department and across the community.

Care of the Paediatrics in a Rural Setting

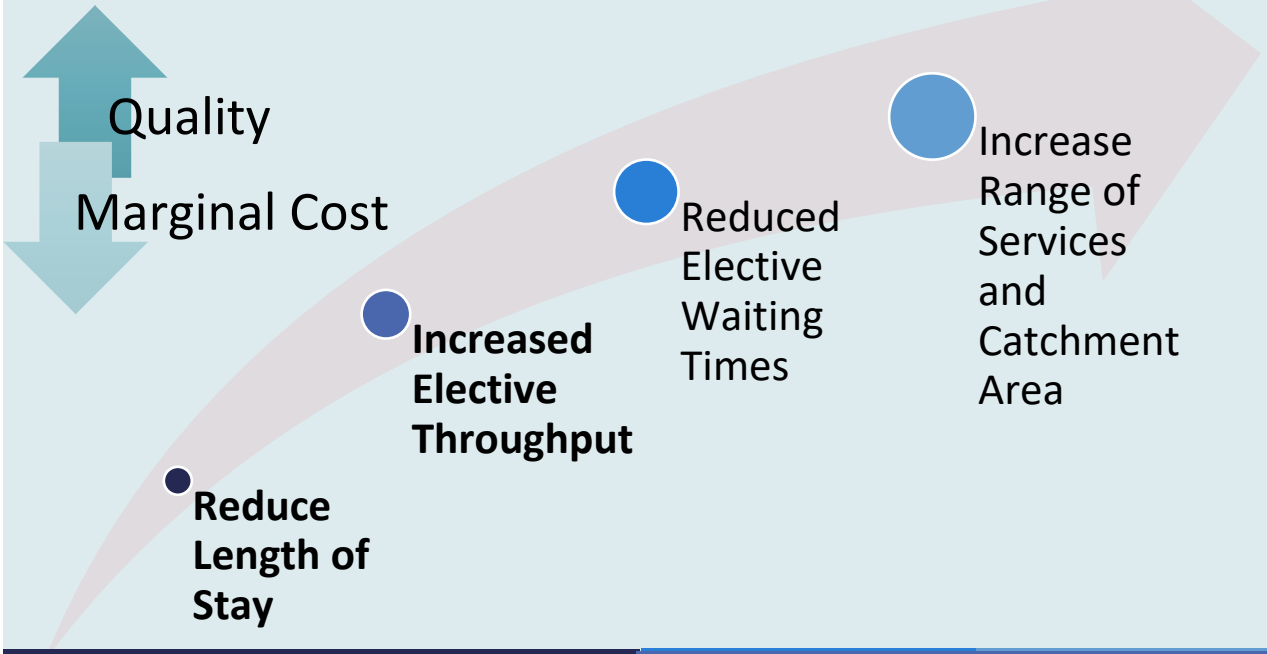
We will work with Aberystwyth University to develop accessible modules for supporting clinical staff and teams to maintain and enhance their skills in providing care for paediatric patients in isolated, rural locations.

Baby Bethan was six months old when she developed a barking cough and shortness of breath. I rang the GP out of hours' service. The GP said it sounded like a case of croup and that most cases are relatively mild and can be managed at home, but because of the baby's breathing difficulties I should take her to A&E for assessment. We were seen quickly and the doctor diagnosed croup. We were admitted to the paediatric unit where an Advanced Paediatric Nurse Practitioner reviewed Bethan and after a short period of time with an oxygen mask the baby started to recover quite rapidly. We were discharged with medication and we were reassured we could access advice if Bethan had got any worse, but she was fully recovered within a few days.

Paediatric Model Core Assumptions

Requirement	In Place	Notes
Consultant rota (4 consultants)	Yes	
Middle Grade rota	Yes	Recruitment and retention of staff to be enhanced
Advanced Paediatric Nurse Practitioner	Yes	1 ANP in post. To provide 24/7 rota as alternative service model, 5 more will be required. This would also support emergency paediatric take.
Area single point of access for paediatric advice	In part	Angharad ward informally provides this service, but consideration should be given to developing formal protocols.
Return of elective paediatric surgery	No	To be considered by service in partnership with commissioners and other providers.

BGH Sustainability Plan: Paediatrics



- APNP Rota
- Single point of access

- Paediatric surgery

Delivering Excellent Rural

Critical and Intensive Care Services

Rural Intensive Care Service

BGH's Intensive Care Service is the only unit in Wales that is consultant delivered. This unique service has evolved to ensure that there is senior presence to respond to the highly unpredictable presentations BGH receives due to its remoteness.

The anaesthetists provide a clinical foundation for the whole hospital and their 24/7 presence allows essential services to be provided that may otherwise be challenging so to do.

All the Anaesthetists are trained in paediatric life support and work in pairs to provide step up special care baby support when required prior to transfer to a specialist unit. All Anaesthetists are trauma trained and are equipped and skilled to lead on trauma care out of hours until the specialists arrive (within 30 minutes).

The Intensive Care Service is provided in multiple locations across BGH, but is based in the Intensive Care Unit in the surgical block.

Anaesthetic Services

The Anaesthetists provide:

- Anaesthesia for all elective surgery and emergency surgery required
- Pre-assessment clinics (nurse and doctor led)
- Ventilation, invasive monitoring and care of very sick patients in the Intensive Care Unit (ICU)
- Medically induced coma to aid treatment
- Stabilise sick children prior to retrieval; short term care of sick children not needing or offered transfer to a specialist centre. Supporting transfer of very sick children if not transferred to a specialist unit.
- Stabilisation and transfer very sick patients if not retrieved. In the majority of cases, consultant anaesthetists accompany the patient during transfer. The transfer distances are usually longer than in other areas.
- Haemofiltration

Highly specialised critical care services, such as neurology and burns, are provided in tertiary centres and will not be provided at BGH.

Intensive Care Unit

BGH's Intensive Care Unit comprises 3 beds and 1 isolation room. A fifth bed-space is available if additional capacity is required.

Staffing levels allow the unit to care for 3 of the most seriously ill patients (level 3/ITU) at any one time or, up to 4 level 2, high dependency patients (HDU).

Organisation of Intensive Care Services

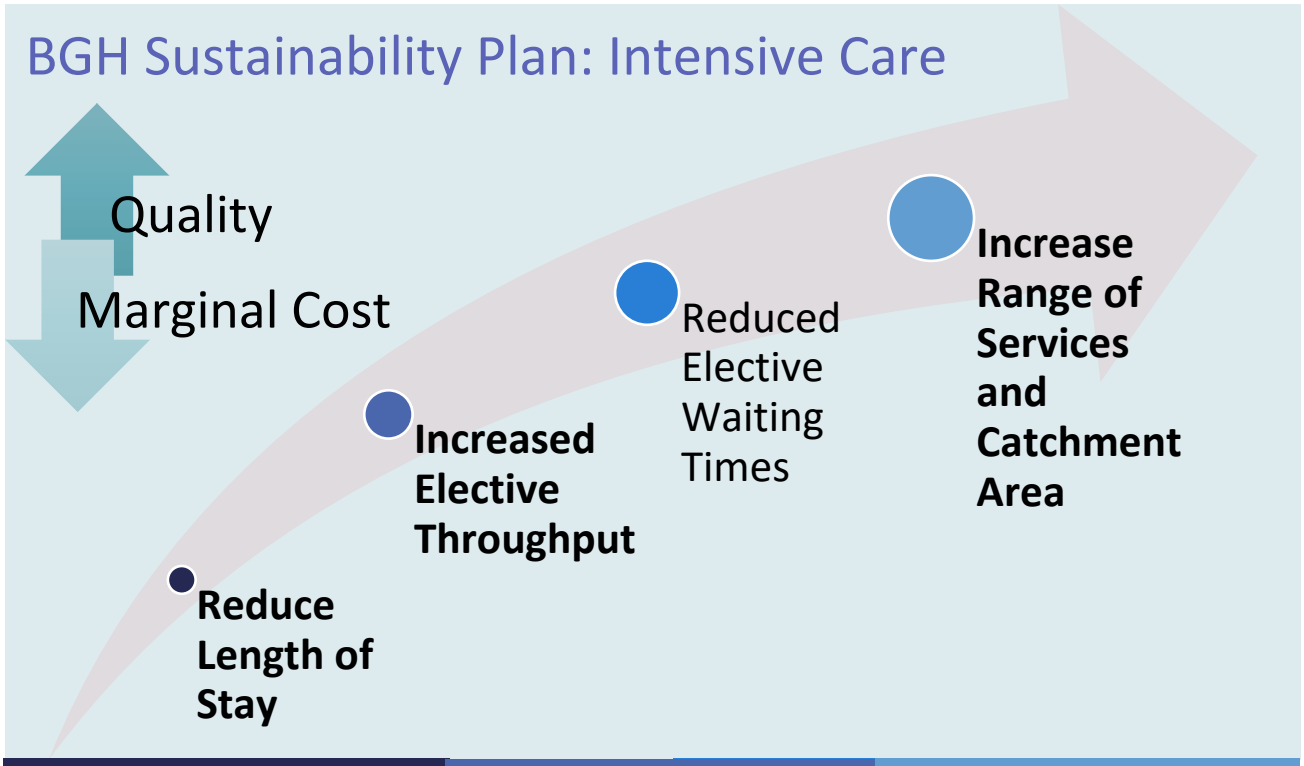
The services currently provided generally meet the presenting needs of BGH's patients. There are some areas where improvements could be made:

- Repatriation of level 1 patients to wards; management of some patients would require availability of suitably trained staff on the wards to manage specific medication regimens.
- Outreach service to the wards to support acutely ill patients in a ward environment and provide advice to their medical and nursing team.
- Utilisation of fifth bed space to improve access to intensive care beds and guarantee space for complex elective care cases that require higher levels of post-operative care than is provided on an inpatient ward
- Development of multi-disciplinary pain management service to deliver both acute pain in the hospital setting and work with community based colleagues to manage chronic pain in community settings

The provision of 24-hour on-site consultant provided anaesthetic services at BGH will continue in order to ensure the delivery of support to all other services.

Intensive Care Model Core Assumptions

Requirement	In Place	Notes
Outreach Service to Wards	In Part	Plan for development of nurse led ward outreach service to be produced
Level 1 repatriation to Wards	In Part	Protocol to be developed alongside outreach service and review ward capacity to accept.
Formalisation of 5th Bed Space	No	Plan to be developed alongside the planned care repatriation and expansion.
Chronic Pain Management	No	Service specification to be developed across primary, community and secondary care with focus on community based delivery supported by multi-disciplinary team.



• Outreach service to wards • Level 1 repatriation to wards	• Formalise 5th bed space	• Pain management

Delivering Excellent Rural

Acute Cardiac Services

Rural Cardiac Unit

BGH has a track record of delivering high quality cardiac services in partnership with specialist centres and by the utilisation of technology to improve patient experience and outcomes. The provision of highly specialised surgical services relating to cardiology and the thorax will remain the preserve of the specialist centres and while patients with specific type of heart attacks (ST elevation myocardial infarction (STEMI)) will be identified in the community, or Accident and Emergency, and immediately transferred to the Morriston Heart Attack Centre, all other adults living locally presenting with cardiac conditions will need:

- Investigation
- Stabilisation
- Treatment

This is provided by a multi-disciplinary approach to care at BGH, where the consultant-led service supported by specialist cardiac nurses will have access to:

- On-site cardiac-monitored beds
- A designated state of the art cardio/respiratory diagnostic suite including:
  - Transthoracic echocardiography
  - Transesophageal echocardiography
  - Stress echocardiography
  - Exercise stress testing
  - CT Coronary angiography
  - Pacemaker implantation

By utilising the above services, the large majority of patients will be able to have their definitive care locally. Patients requiring more specialist services, such as inpatient coronary angiography, angioplasty and stenting (Percutaneous Coronary Intervention) or cardiac surgery will be transferred to Morriston, Swansea on a "treat and return" basis.

Improving Access

There are significant opportunities to utilise technology to improve patient access both in terms of timeliness and distance travelled with added quality improvements, with CT angiography being a good example:

CT angiography increases the overall capacity of cardiac diagnostic services in the South West Wales Cardiac Network, reduces unnecessary invasive procedures and reduces the distances travelled by mid Wales' patients.

CT angiography also has the potential to provide rapid diagnosis for patients presenting at A&E with chest pain:

Rhian is 58 years old and the neighbour of Gareth and Ayesha. She smoked until she was age 40 and has high blood pressure and long standing knee problems. Rhian has experienced chest pains on a number of occasions in the past month and is uncertain about what it means. Her son is getting married this summer, and this has heightened Rhian's anxieties about her heart health.

"*I have been experiencing chest pains recently. One evening, they were very strong so Ayesha took me to A&E in Bronglais. The doctor ruled out serious cardiac problems and recommended I see a GP for consideration of possible angina. I had similar symptoms but more pain on the weekend so went back to A&E. The A&E team recommended a cardiology review, which I had the next day. The specialist didn't think the pain was cardiac in origin. She was very reassuring and spoke with me about my history of smoking and my ongoing anxiety, and how these might be causing my symptoms. I wasn't able to have an exercise test because of the arthritis in my knees. I had a CT angiography that same day in Bronglais, as there has been a cancellation. The results were clear – I do not have problems with my heart, which is a huge relief. I was discharged from the Medical Assessment Unit the same day and do not need a follow-up. But I have seen the GP about my anxiety and have started an online cognitive behavioural therapy course to help deal with my anxiety.*"

Remote Monitoring

Work is underway to look at the application of remote monitoring for patients with pacemakers and cardiac monitors that will allow early detection of significant events to promote timely intervention and improved patient outcome. This will also reduce the inconvenience and geographical challenges to accessing follow-up clinics and expert advice. Such a development is key to the ability for patients to be managed on an "anticipatory" basis which reduces their need for emergency intervention and resulting hospital admission.

Developing Diagnostics

The installation of the new Magnetic Resonance Imaging suite at BGH opens up the opportunity for some provision of Cardiac MRI to allow an increased range of diagnostic imaging techniques to be available to aid diagnosis and disease management.

Pathway Development

The established cardiac network links BGH to the specialist services provided by Swansea Bay University Health Board. However, as with all services provided at BGH, the patients who present have commissioned pathways to other centres that may, geographically, be more convenient for them, for example Shrewsbury and Glan Clwyd hospitals for patients from Powys and North Wales respectively. These broader networks will need to be incorporated into service plans so that patients who may be known to any centre or service can be seamlessly and safely supported wherever they present in an emergency.

On-going follow-up and support will be provided by the local Cardiology Clinic Service for all patients who require it post intervention. This service will also be where all local adult patients referred by primary care with symptoms of cardiovascular disease receive their initial assessment and diagnosis, using predominantly the diagnostic services stated above, but with access to invasive coronary angiography at Morriston Hospital, Swansea, and, in future, in the dedicated Hywel Dda Cardiac Catheterisation laboratory, located in the south. Demand for interventional angiography will increase over time and future capacity profiling should examine the potential for delivery of a mid Wales service.

While some patients with specialist needs due to, for example, Adult Congenital Heart Disease will need routine follow-up at Specialist Centres in south Wales, patients with complex needs and implanted Cardiac Devices (such as Defibrillators) will be able to receive shared care with some follow-up visits provided locally to limit the burden of travel with telemedicine being utilised where appropriate.

The Cardiology Team

Although the service will be led by BGH based Consultants, success is dependent upon a wide range of professionals, without whom a comprehensive service could not be provided:

- Hospital and Community Specialist nurses
- Advance Nurse Practitioners
- Cardiac Physiologists
- Exercise rehabilitation specialists
- Psychologists
- Community palliative care team

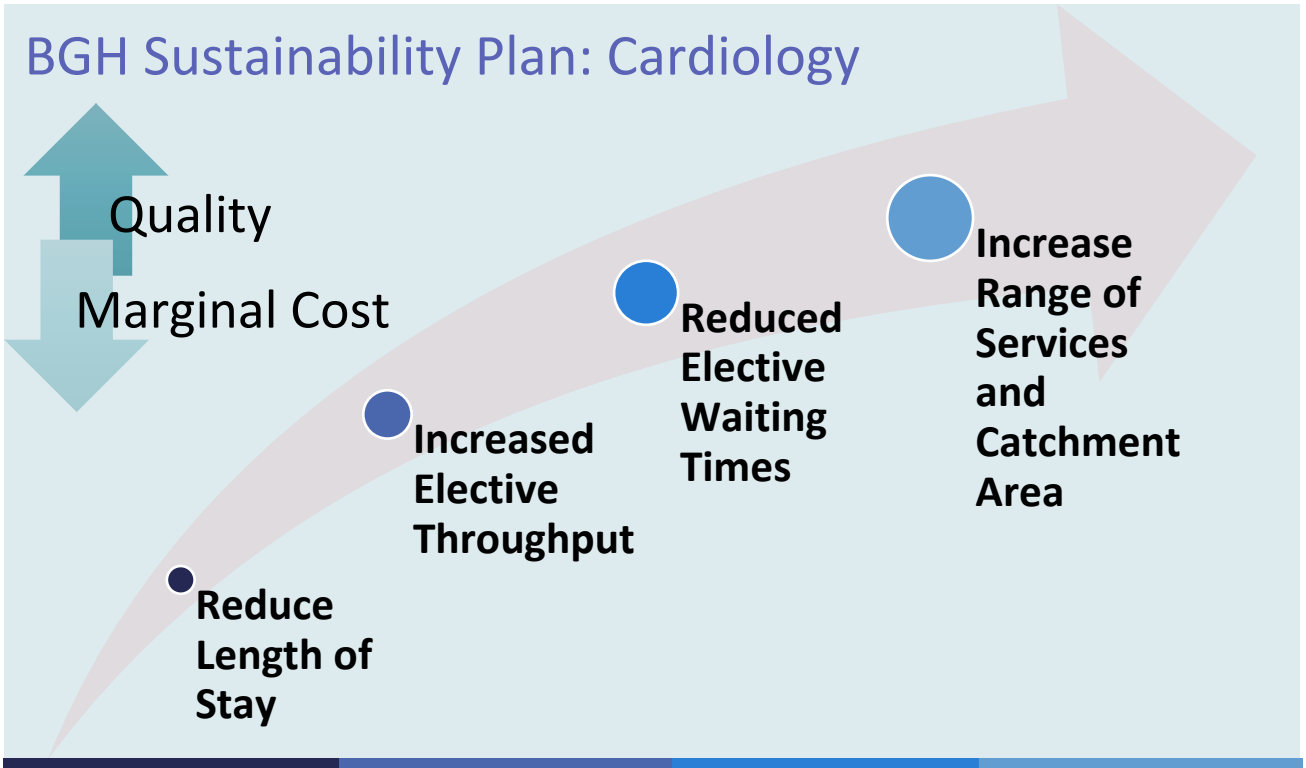
Cardiac rehabilitation services are an essential part of the cardiology service working with patients to promote healthy lifestyles to reduce risk of recurrence. It is important to ensure that the team providing the service are appropriately resourced and provide a multi-disciplinary support to their patients.

GPs and primary care teams provide a key role in both the initial identification and ongoing care and support of patients. As the relationship across “care” evolves and matures, the ability to deliver truly holistic care and support for patients will become a key cultural driver for the service. This will ensure that the “care” system works to ensure that services are personalised, as far as possible, to the individual circumstance in a way that supports and promotes independence.

Cardiology Model Core Assumptions

Requirement	In Place	Notes
3 Consultant Cardiologists	Yes	
Dedicated cardio/respiratory diagnostic facility	No	Current provision too small with no designated patient waiting area. Plan for development currently in draft.
Heart Failure Nurse	Yes	Recruiting to a second post. Nurse also in Powys and Gwynedd.
Advanced Nurse Practitioner	Yes	
Outreach Clinics	In part	To be developed in line with Mid Wales Clinical Advisory Group's work plan
Cardiac Rehabilitation	In part	Support from Occupational Therapy, Physiotherapy and Dietetics to be developed to promote MDT approach.
Clinical Pathway Development	In Part	Pathways exist for certain conditions, but do not reflect pathways and opportunities provided by services commissioned by Powys and Betsi Cadwaladr Health Boards for their patients.
Remote Telemetry	Pilot	Remote telemetry for patients is being piloted. Development subject to evaluation, but is anticipated to deliver significant benefits for outcomes.
Cardiac MRI	No	Options to be explored once MRI unit installed.

BGH Sustainability Plan: Cardiology



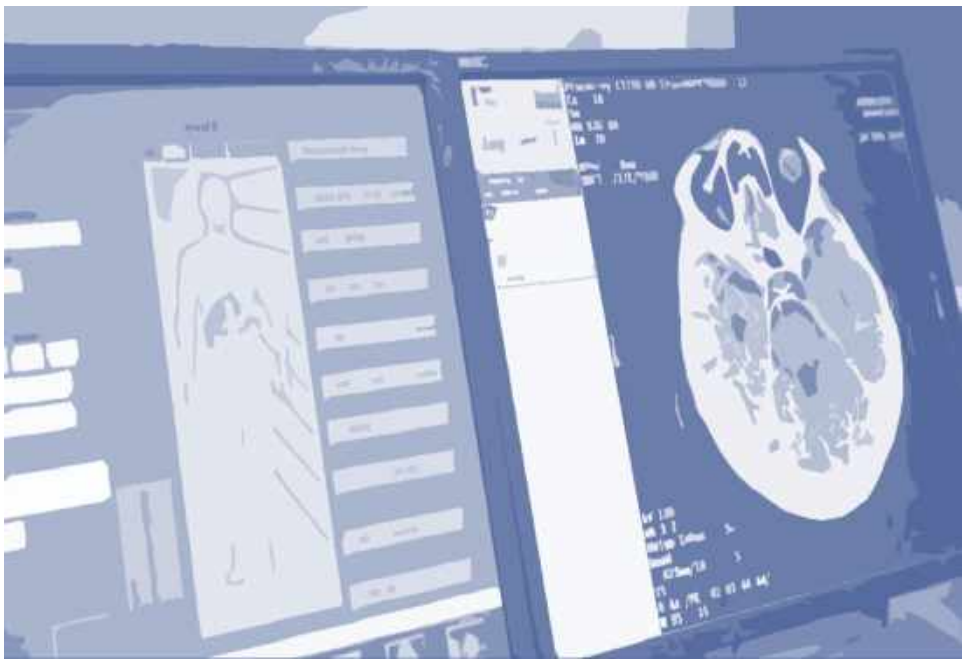
• Develop remote monitoring service • CT Angiography	• Develop remote monitoring service • CT Angiography	• Extend CT Angiography • Develop remote monitoring service	• Cardiac MRI • Outreach to Machynlleth and Newtown (Shrewsbury) • Outreach to Tywyn (North Wales)

Delivering Excellent Rural

Radiology Services

Rural Radiology Services

Radiology services play a key role in the delivery of both urgent and planned care. The service provides both imaging using ionising radiation (e.g. “x-rays” and Computed Tomography (CT) and non-ionising radiation (e.g. ultrasound and Magnetic Resonance Imaging (MRI)).



While all staff using radiological imaging equipment must be appropriately trained, there are strict rules and regulations regarding the use of ionising radiation and only highly trained staff, known as Radiographers or assistant practitioners (under the supervision of Radiographers), may use this equipment. Some non-ionising imaging equipment, such as ultrasound, can be used by a wider range staff who have the appropriate training.

Once an image is taken, it needs to be “reported”. Traditionally, reporting has been provided by Radiologists (doctors who specialise in radiology) and in more recent times, Radiographers have been trained to report on certain types of images to help speed up the time it takes to obtain a result.

Doctors in other specialties are also able to access and assess images to inform initial diagnosis and case management whilst awaiting a formal report so that more minor conditions, such as some fractures, can be treated before a radiologist report has been received. The specialised reporting skills of a Radiologist or Reporting Radiographer may identify additional important information of relevance to the treatment plan and it is a legal requirement that all imaging is fully reported in this way.

Fast track reporting pathways exist for certain key conditions (e.g. for a CT in a suspected stroke patient) so that confirmation can be received within the critical response period. To ensure a 24/7 reporting service, some images are reported by Radiologists in Australia utilising the digital images which can be transferred via protected networks.

Although MRI is not a first line diagnostic for urgent care except in the case of spinal cord compression and spinal infection, provision at BGH needs to be increased to at least 2 sessions per day, 7 days a week (it is currently provided Monday to Friday). This will improve access to urgent MRI and reduce the number of patients who have to travel for this service. The level of demand at night would not support the delivery of a 24/7 service at BGH.

Ultrasound provides a relatively inexpensive imaging tool for both acute and non-acute presentation which can also be provided in community settings without having to build specialist facilities to accommodate it. Ultrasound is currently available 6 days a week at BGH and we will enhance this to deliver daily coverage in addition to re-introducing community based services both within Hywel Dda and in our neighbours' community facilities.

More specialised imaging, which utilise radioactive isotopes, such as Positron Emission Tomography (PET) scanning, to identify body parts and pathology, are not provided at BGH.

Radiology Equipment

The equipment used in radiology is very expensive and due to its reliance on modern IT technology requires frequent updating and replacement. Staff receive specialist training in order to maximise its utilisation and we will offer our services to an increased catchment population by providing outreach and support to community services both within Hywel Dda and in our neighbouring health boards.

A summary of the radiology equipment at BGH and in the health care buildings that comprise the Ceredigion and Mid Wales area, is shown below.

Mid Wales Radiology Service	
Service locations	BGH. General radiography*, CT*, MRI, ultrasonography, dual energy X-ray absorptiometry (DEXA), Mammography and Fluoroscopy. All available 5 days a week (ultrasound 6 days) with * available 24/7 Cardigan Hospital General radiography available 5 days a week 9-5 Machynlleth Hospital General radiography available 1 days a week Newtown Hospital General radiography available 5 days a week 9-5. US 2 days a month Welshpool Hospital General radiography available 5 days a week 9-5. US 2 days a week. Dolgellau Hospital General radiography available 5 half-days a week Tywyn Hospital General radiography available 1 day a week
Image reporting	Undertaken by Radiologists, sonographers and reporting radiographer based in BGH, and Betsi Cadwaladr University Health Board.
Staffing	There are several vacancies, radiologists, radiographers, sonographers and support staff. Recruitment has proven difficult.

Funding to replace the existing MRI unit at BGH was approved by Welsh Government in 2017. Because of the limited footprint of the site in its current format, siting the new scanner required innovative thinking to bring a currently unused area into service. Works commenced in 2018 and the unit is scheduled to open by December 2019. The new scanner will be much faster than the one it replaces and this will significantly increase the number of patients who will be scanned at BGH and also the range of conditions that can be scanned and for which patients have to currently travel for their scan.

The CT scanner at BGH is currently nearing the end of its serviceable life and needs to be replaced by 2020. A general x-ray room is already provided within the A&E department and we will consider the replacement CT's location in order to improve access for patients from the emergency department without impacting upon that for patient in the Intensive Care Unit.

The MRI development will enabled the provision of increased ultrasound provision and reporting facilities which will allow reporting radiographers to increase the service's reporting capacity which will both improve scan to report times and allow some reporting that is currently "sent away" to be performed within the NHS (NHS Wales currently spends approximately £6m per annum on out-sourced reporting).

We will review core opening hours and staff skill mix within both BGH and the community hospitals with the aim of providing a responsive and local service.

Radiology Network

The services provided at BGH provide a hub for services across the mid Wales area. For some services, such as MRI and CT, BGH will be a sole provider of services for patients. For other services provided in community locations BGH can act as a hub for staff, training and reporting.

Additionally, mobile scanners can be used to provide outreach into areas that do not have access to services, although this may not be the most cost effective way in which to deliver a service if there are not enough patients needing a particular type of scan in an area so such services will need to be scaled accordingly.

Additional reporting room provision at BGH will allow the Reporting Radiographers based there to provide hot reporting on images taken at community sites, thereby speeding up the time to diagnosis and potentially reducing the need for a patient to travel for urgent diagnostics.

We will work with both Powys and Betsi Cadwaladr Health Boards to explore models to best provide outreach services to community settings, balancing patient demand with efficient use of staff and equipment. We will also explore the potential of mobile services to deliver care as close to home as possible.

There is a need to ensure the current radiological provision in community settings is maximised. Not all community based services are open 5 days a week and patients may have to wait or travel for a scan. A mid Wales radiology appointments service will be introduced to co-ordinate waits across mid Wales and offer patients an appointment that meets their individual requirements of access and timeliness. Reporting radiographers would provide outreach clinics so that scan and report are completed at the same time.

The development of advanced roles such as Reporting Radiographers is key to delivering both increased service capacity and providing career development for Radiographers that will improve recruitment and retention. The opportunity to develop clinic based approach to the delivery of services across the large geographical area covered will also be attractive to potential staff.

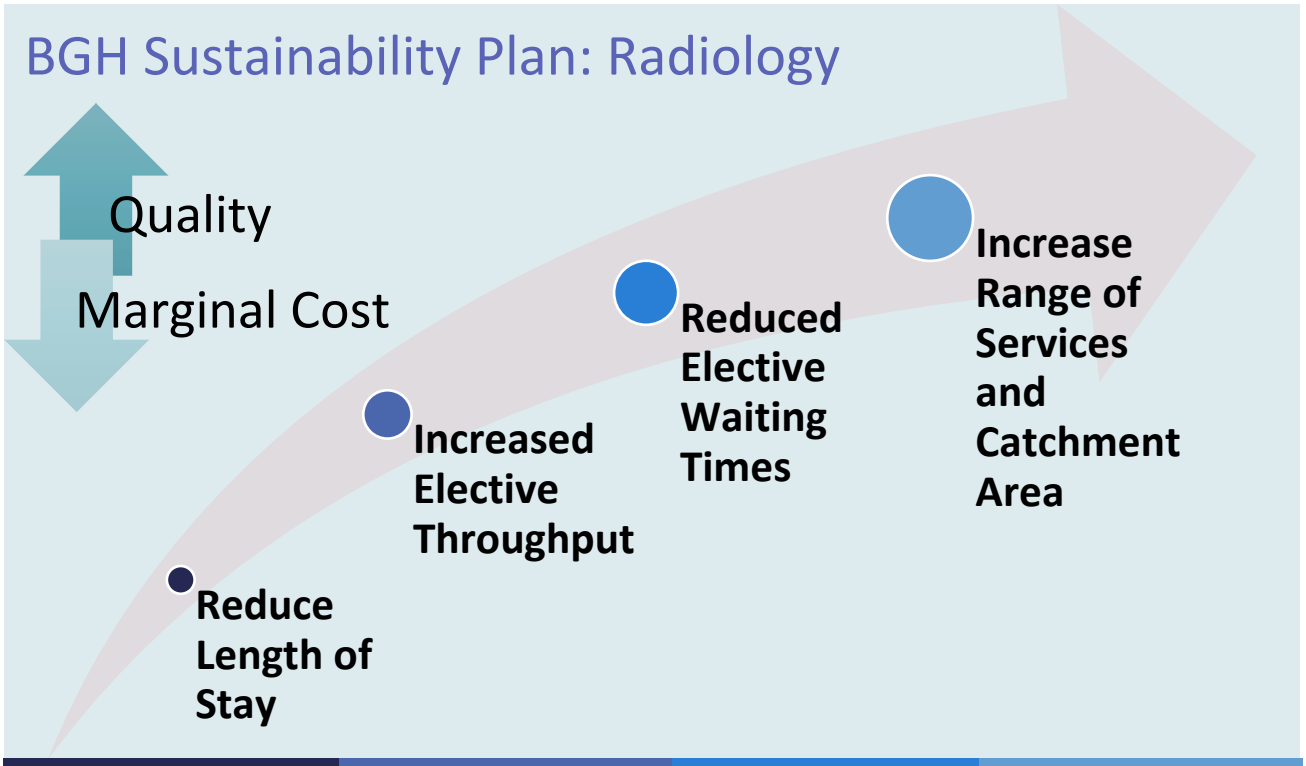
Improving access to services will also require additional Sonographers (who perform ultrasound), the development of trainees and additional support staff, Assistant Practitioners (specially trained support workers able to undertake x-ray procedures) and clerical staff.

Because of the many different pathways for patients at BGH, it is important to ensure secure links with NHS providers throughout the UK to ensure relevant images can be shared in order to promote the best possible patient care.

Radiology Service Core Assumptions

Requirement	In Place?	Notes
3 Consultant Radiologists	Yes	
4 Reporting Radiographers	Yes; 2 general, 1 CT, 1 MRI	Plan for development and expansion of role including supporting community delivered radiology to be produced.
6 Sonographers	In Part	6 posts providing 4.2wte. Increasing application for ultrasound will require investment in staffing.
2 Assistant Practitioners	Yes	The potential for assistant practitioners to support radiographer provided care will require the further roll out of these posts.
CT Colonography.	Yes	
CT angiography	Yes	First unit in Health Board to delivery service.
27/7 CT	Yes	Full body CT available
Out of hours urgent specialist cover	Yes	Provided by third-party company
Daily MRI	No	Service will be required to support trauma care.
Daily US	No	Currently 5 day service.
Weekday DEXA	Yes	

BGH Sustainability Plan: Radiology



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Delivering Excellent Rural

Laboratory Services

Rural Laboratory Services

BGH's facilities have received significant capital investment over the past 15 years. This investment has included the provision of state of the art laboratory facilities.

There are four main laboratory services:

- Haematology (analysis of blood)
- Biochemistry (analysis of chemical processes in the body)
- Microbiology (analysis of microorganisms in the body)
- Histopathology (analysis of tissues and cells)

Haematology and Biochemistry tests are those most commonly used for rapid diagnosis with many tests being ready within 30 minutes of samples arriving in the laboratories. Haematology includes blood bank provision and both Biochemistry and Haematology provide more specialist tests in their own laboratory spaces.

Microbiology provides a range of facilities up to Category 3 (for use with pathogens such as Tuberculosis). Samples of more dangerous pathogens, such as Ebola, require Category 4 facilities of which there are fewer than 10 in the UK and are currently managed as part of the European Network of Biosafety-Level-4 Laboratories. Some microbiological tests can also be provided relatively rapidly, but because much microbiology require the growth of bacteria, tests, including antimicrobial susceptibility, can take a few days to provide results. The implementation of genetic testing and other automation, however, has speeded up this process where technology and finance allow.

The Microbiology service, provided by Public Health Wales, is accredited to ISO 15189 for the majority of its tests. The Haematology and Biochemistry (collectively "Blood Sciences") laboratories, have recently moved to the ISO 15189 scheme and are working to implement this within their respective areas.

Histopathology can also provide rapid diagnostic information through use of certain processing techniques, but in general requires tissue processing and fixing prior to slides being made up for review by a Pathologist. All Histopathology work is currently undertaken at laboratories in GGH.

The BGH laboratories are Consultant led with a multi-disciplinary team of healthcare scientists and nurses providing:

- Routine analytical services for diagnosis (acute and non-acute)
- More specialised analytical services for the wider Health Board
- Blood bank services and Blood Transfusion training
- Specialist nurse services (Haematology and Coagulation)
- Phlebotomy services
- Educational services
- Point of Care Testing (POCT) – professional and governance

Haematology and Biochemistry are highly automated and all major analysers have been updated within the past 2-3 years. This also includes a pre-analytical sorting and sample portioning (*aliquoting*) instrument.

Automation is, however, increasing and the laboratory 20 years in the future may well look very different to the laboratory today. We must ensure that the BGH laboratory service responds to the opportunity technological advancement presents to provide quicker and better access to our services.

Microbiology services are introducing automated urine analysers to replace manual microscopy. This will provide a fully quality controlled process with improved reproducibility, reducing staff hands on time.

The BGH laboratory services, as a hub for care in mid Wales, will need to respond to demands to do more in community settings and innovative approaches to meeting this need will need to be employed.

The need to provide rapid turnaround times and the ability to deliver service improvements in-house necessitate the continuation of the current laboratory configuration. Transportation to other laboratories is not suitable for all specimens and is not available 24/7. Some specimens need to be processed within strict time limits which prevents their centralisation. It is important, therefore, that the BGH laboratories, in meeting the requirements of the UK Accreditation Services, ensure their overall benefit is maximised so that their essential presence is sustainable.

Advancements in equipment have allowed many tests to be delivered at the "Point of Care". This may be within the hospital or in remote community settings. It is anticipated that the application of point of care testing will expand in time. The provision of point of care testing requires robust checks of the devices being used to ensure they are accurate and this needs to be managed

within a quality assured framework. This will require new staffing models and ways of ensuring that the appropriate training, support and governance is assured, whether within hospital or community setting.

Samples taken in community settings that are not able to be analysed using point of care devices will need to be transported to the BGH labs for processing and analysis. This is currently achieved by a once-a-day collection by the "hospital van", but this is not a rapid delivery service that will help GPs and community health care staff respond to needs as they present in the community. Homing pigeons were used in the late 1970s/early 1980s to provide rapid and affordable transport between Devonport and Plymouth hospitals in England and the potential for drones to be used to achieve similar benefit is currently being explored by the University of Aberystwyth. The establishment of a "droneport" adjacent to the laboratories would allow autonomous drones to be sent from GP surgeries, community hospitals and by community staff from remote locations so that urgent samples are delivered quickly to the laboratory and can be processed with results available before the end of surgery or a nurse's round so that appropriate actions can be taken more quickly than they might otherwise have been; at the same time the development of point of care testing may reduce the numbers of tests that need to be sent to central laboratories for testing.

The services provided to our neighbouring health boards also form a key component of laboratories' work. Opportunities to develop services in these areas to better meet the needs of mid Wales' patients will help to deliver a sustainable service that maximises efficient and effective use of resources across the whole health community.

Analytical services

It is essential that pathology services continue to modernise and ensure that they continue to provide timely results to aid clinicians in both diagnosis and monitoring of individual patients.

We will continue to adapt our working practices in line with clinical need. Sample analysis will still benefit from the cost efficiencies of automated laboratory analysis, but the equipment used is very expensive and may only be operated by appropriately trained staff. We will ensure that we make best use of this by offering our services to an increased catchment population and by

providing outreach support to community services both within Hywel Dda and in our neighbouring health boards.

We anticipate a growth in the use of point of care testing as technology advances in this area and the new working practices take patient diagnosis and care into the community and closer to patients' homes. We will review how the emerging technology will impact upon future workforce requirements and will invest accordingly to ensure we have an appropriate skill mix to support the service. There will be an opportunity to develop a new community point of care testing worker role acting as liaison with the hub laboratory and offering practical training and trouble-shooting advice to users within the community.

Hours of Operation

Laboratory services provide a full range of services during the "working week" with a restricted number of tests and the blood bank service available "out of hours" from on-call staff.

We will review the service's core opening hours and staff skill mix with the aim of providing a responsive and local service.

Role Development

The development of advanced roles such as Physician Associates with specialist interests in, for example, lipids, cardiovascular and metabolism, is being explored in some health boards. This would assist in delivering both increased service capacity and providing career development for healthcare scientists that will, in turn, improve recruitment and retention. The opportunity to develop clinic based approach to the delivery of services across the large geographical area covered will also be attractive to potential staff.

Education

Laboratory services provide essential education to its users by formal lecture, tutorials or practical training. As newer specialist roles are created for health professional who, perhaps, have never received formal pathology training, it will become increasingly important for senior pathology staff to be involved in educative roles, whether regarding appropriate test selection, result interpretation or practical skills such as phlebotomy, blood transfusion safety, point of care testing training or quality control competencies.

Research has shown that where people train influences where they work. The availability of training and development necessary for maintaining professional registration and advancing ones skills is also important to staff in the health care profession and if this is not reasonably easy to access, the ease within which health care professions can transfer between differing NHS organisations means that staff may decide to move to where they feel that their career ambitions will be more easily met.

Building upon our past training programmes for medical students and phlebotomists, we will continue to provide, and expand, our education function as clinical need arises. The provision of GP and nurse training at Aberystwyth University will necessitate the provision of training to equip them with the essential knowledge and skills to enable them to better fulfil their roles and professional development.

Aberystwyth University have expressed an interest in the provision of a Biomedical Sciences Degree which, if accredited by the Institute of Biomedical Sciences, would offer significant benefit in attracting staff to the area and offer potential lecturing opportunity for BGH clinicians or relevant health professional staff. We will work with the University to ensure the benefits of our proximity can achieve maximum potential for both institutions.

We will also continue to provide continuing professional development for our own staff and focus on cross-training of newer staff to increase the robustness of our staffing and provide interest for recruitment and retention. We will increasingly develop the role of bands 3, 4 and 5 staff within the laboratory areas.

Service improvement/Audit

Laboratory services must develop in line with changing models of clinical care, ensure safe and efficient use and that the services provided meet the necessary quality requirements.

We will continue to audit and improve our services – working in line with prudent healthcare principles to ensure best use of resources, minimise wastage and understanding of variance.

Service development

As services evolve, both because of technological innovation and users expectations, we will need to regularly review our mix of services to ensure they support the provision of the best outcome for patient. This will include opening hours, range of tests provided and the skill mix both within BGH and in the community to providing a responsive and local service.

Recent improvements in services include:

- Earlier phlebotomy to enable earlier discharge
- Point of Care Testing blood gas machine for A&E and maternity
- Genetic testing in Microbiology to reduce turnaround times for flu and other diagnoses

Developments in laboratory services involve the development or utilisation of new tests, using old tests in new ways or adopting new technologies such as genetic testing and metabolomics (the study of the chemistry of the metabolism).

With colleagues across the Health Board, we will also build on our experience of developing new tests or bringing tests in house where possible and enabling their use for the benefit of all the Health Board's patients.

The Microbiology service at BGH is the first laboratory in Wales to introduce molecular enteric testing facilities which is a single test for multiple infections that can be more quickly performed, thereby reducing the need for unnecessary infection control precautions, improving decision making regarding treatment and, therefore, improving the overall patient experience. The laboratory also provides genetic testing for the flu virus which allows the results to be available in hours rather than days. The provision of these services allows a quicker and more appropriate response from Public Health teams in the event of a potential outbreak and, consequently, more appropriate and timely patient management. These tests are expensive and, in order to support their use, there should be demonstration of benefit in terms of reduced length of stay, reduced time of barrier nursing and other similar measures that, in effect, can be classed as a saving to the service overall.

Because all three laboratories are co-located, significant economies of scale can be obtained through common processes (e.g. reception and waste

management). In addition, the modern facilities at BGH enable us to work in ways which may not be possible for other sites and will allow BGH to adopt new analytical technologies that are common across the pathology disciplines and we envisage further cross disciplinary working over the timescale of this plan. Services also link with other laboratories within the Health Board and across the region so that non-urgent tests can be provided in the most cost effective way whilst also promoting quality. Regional working also promotes contingency planning which reduces risk of service failure.

Research and Development

Unique within the Health Board, BGH is directly adjacent to the National Library of Wales and the University of Aberystwyth.

A shared campus brings many opportunities for the development of partnerships and research that cover health services, the determinants of health, interventions to improve health and the information and communications used to support and deliver care.

The development of health and care has increased and this will continue in the future. R&D is an essential part of any developing service and one that pathology will continue to embrace.

We will build on our track record of research involvement, providing support both to clinicians and others requiring pathology testing for their studies, but also for professional development of our staff and services for all our patients.

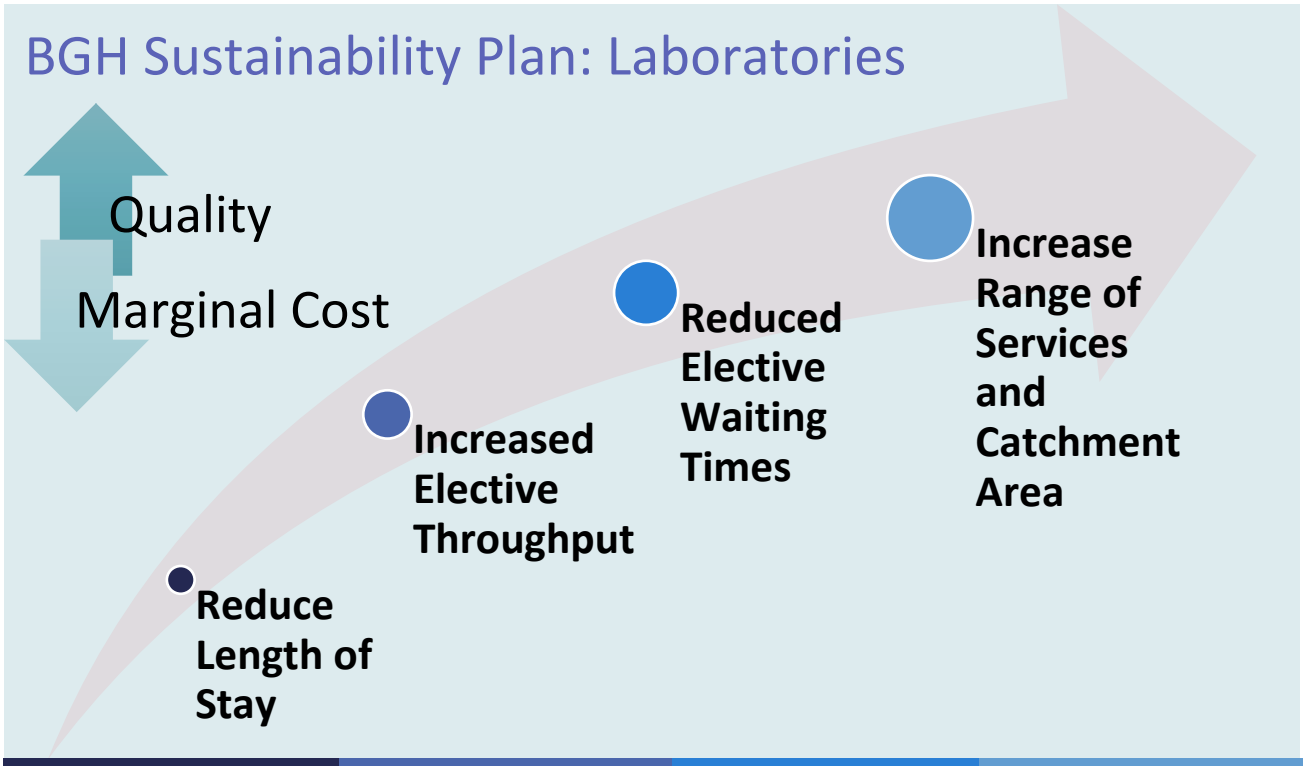
Over the last two years, the BGH laboratories have supported studies jointly with the University of Aberystwyth and is a partner in the University's Well-being and Health Assessment Research Unit's project with the University of Grenoble which brings within it both reputational benefit and income to the department.

We will continue to build and strengthen working relationships with our academic colleagues to develop further joint projects and find better ways of true partnership working. This will require shared governance arrangements, but must be progressed in pursuit of closer working practices to benefit both and the health of our residents.

Laboratory Service Core Assumptions

Requirement	In Place	Notes
1 Consultant Clinical Biochemist	Yes	Also Cons Haem/Micro
Microbiology service to be provided by Public Health Wales. Minimum staffing levels 5 BMS plus support staff to ensure out of hours cover.		
Blood Bank	Yes	
Hot Haematology Tests	Yes	
Hot Biochemistry tests	Yes	
Cold Haematology/Biochemistry tests	Yes	For service economy and viability
Specialist nurses Haematology Coagulation	 Yes Yes	Succession planning for posts required
Blood Transfusion Practitioner	P/T	Scoping required for Full Time service
Point of Care Testing lead Band 7 to oversee increasing requirements Roving Point of Care Testing support worker	New New	This is an urgent need that will be resourced by increased automation in core labs.

BGH Sustainability Plan: Laboratories



• Develop remote monitoring service • CT Angiography	• Develop remote monitoring service • CT Angiography	• Extend CT Angiography • Develop remote monitoring service	• Cardiac MRI • Outreach to Machynlleth and Newtown (Shrewsbury) • Outreach to Tywyn (North Wales)

Delivering Excellent Rural

Hospital Pharmacy

Rural Hospital Pharmacy

Most public contact with pharmacy services is with community pharmacists who are readily accessible, not only to sell "over the counter" medications or dispense prescriptions, but who can also provide a range of other services and support, including health screening and consultation for minor ailments.

Within a hospital setting, the highly specialised training and continued professional development pharmacists undertake, is applied to a wide range of functions that, although not always visible, provide essential support across all services provided.

Pharmacists can provide:

- Clinical review of patients' medications to identify any drug related issues that maybe latent or contributing to the presenting condition and recommend changes to optimise therapeutic outcomes
- Medicine reconciliation in a timely manner
- Advice, support and training to clinical colleagues
- Review and advise on formulary and national guidelines to ensure compliance and identification of opportunities for efficient utilisation of resources
- Governance structures for the introduction, storage and administration of medication
- Chronic condition clinics
- Support to prevent drug-resistance (anti-microbial guidelines)
- Support for research, development and clinical trials
- Diagnosis and treatments of minor illnesses and ailments
- Health Screening and counselling

Pharmacy services at BGH are available 24/7 either by on-site support or an on-call rota with medicines made available at the point of need

Lord Carter's report "Shaping Pharmacy for the Future" (2015) set out a blue print for the model pharmacy provision, including:

- Increased front-line patient facing activities to improve medicine optimisation

- Increased use of Information Technology to improve governance , patient outcomes and safety

Pharmacy services can directly support the attainment of many health care targets and are well placed to support the broader strategic objectives set out within this document.

Modernising "Front Door" Pharmacy

By increasing the pharmacy team, the emergency department will benefit from daily provision. The team would deliver "acute interventions", including:

- Review and reconcile medication of all patients attending the emergency department within 24 hours
- Be part of a holistic frailty service to identify patients where a medication review would reduce likelihood of re-attendance
- Provide daily support to the Community Integrated Urgent Care Service

This will be supported by

- ED team of 2 pharmacists, 2 technicians 1 assistant technical officer
- Community Integrated Care Centre input from 1 pharmacist,
- Implementation of Medicines Transcribing and e-Discharge system (MTeD) in the Clinical Decisions Unit
- Development of e-links with community pharmacy to support unified patient record

Modernising Ward Based Pharmacy

Pharmacists provide ongoing review of patients who have been admitted to a hospital bed.

MTeD had been established on most inpatient wards, but additional resources are needed to maximise the benefits of a full roll-out. Automated stock holding facilities on all wards will provide safety and financial governance to the site. Further training of pharmacy support staff to will allow for enhanced roles such as Pharmacy Technicians performing "medication rounds" to support nurses in meeting the increasing care needs of their patients.

A satellite pharmacy has been established in the surgical block. One pharmacist, a medicines management technician and an assistant technical officer provide a service between 9:00 and 15:30 to support timely patient discharge. A similar arrangement will be implemented on the medical side once a suitable space has been identified.

Pharmacy should be supporting consultant ward rounds. To do so would require additional pharmacy time and is challenging because BGH does not provide specialty based wards. A move to ward based working for consultants would allow pharmacy to provide better support and more actively be involved in the broader MDT activities.

Investment will allow members of the pharmacy team to take ownership of the medicine prescribing process at discharge to support the clinical teams. This will allow a more timely discharge for patients and improve patient flow through the site.

Supporting Chemotherapy Services

There is a national move towards chemotherapy medication being produced by regional licensed “production” sites which will support the delivery of chemotherapy treatments in local units. The implications of this for local services and access is being reviewed, but it is expected that this will enable pharmacists to have increased clinical engagement with patients to enhance care delivery.

Pharmacy Led Care

We will increase the number of pharmacist Independent Prescribers (IP) who would use their expertise to run their own clinics to support the increasing demands of chronic conditions. This will allow medical teams to focus on more complex cases.

Pharmacist are also well placed to ensure seamless integration with the primary care teams.

Training and Workforce Development

The pharmacy at BGH provide placements for pharmacy students from Bath and Cardiff Universities and the development of a School of Pharmacy at Swansea University will build upon this.

In addition the department provides:

- Clinical Pharmacy Diploma training
- Pre-registration pharmacy training
- Vocational placements for undergraduate and 6th form students
- Pre-registration technician training
- Assistant Technical Officer training

As the potential for pharmaceutical roles to be applied to wider benefit is realised, there will be a need to explore how pharmacy technician and assistant technical officer roles can be developed to enhance care delivery and provide support to enable the training and development required to achieve this.

The opportunity presented by working with Aberystwyth University to facilitate training and development will be explored.

Modernising Prescribing

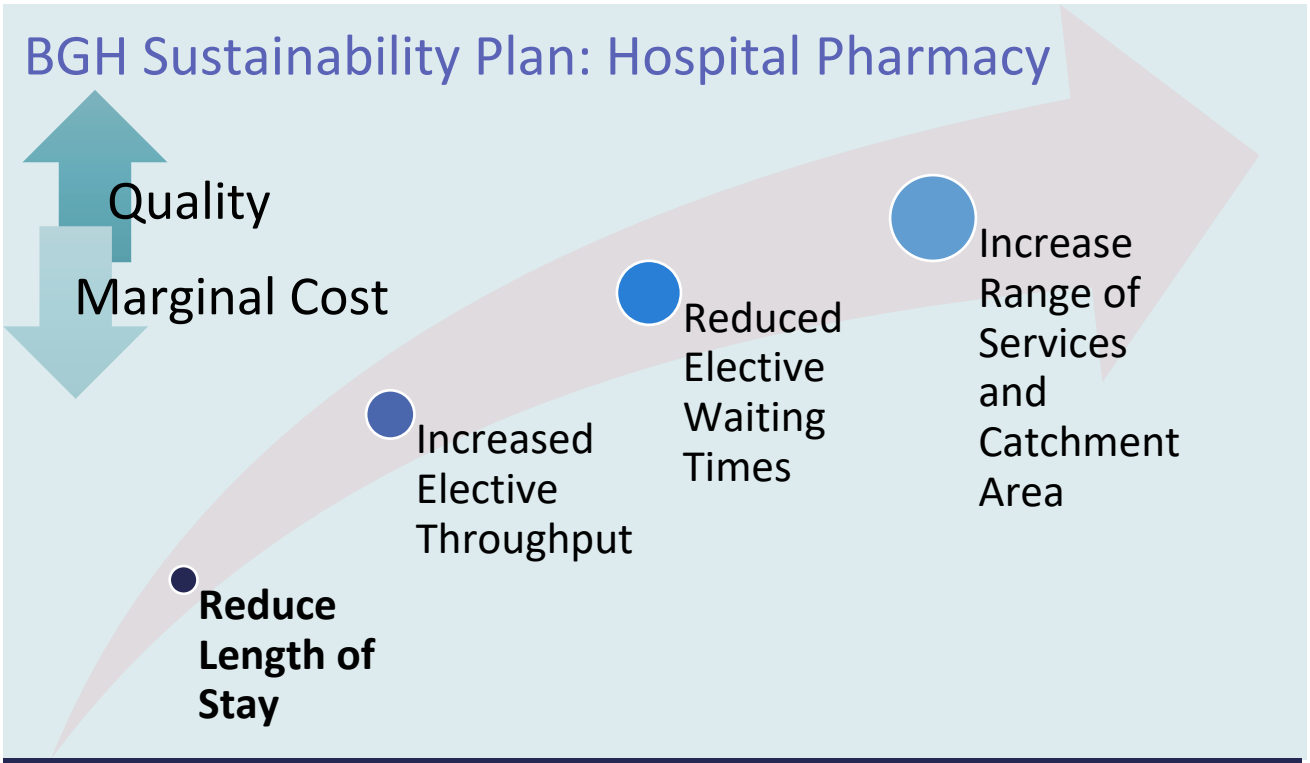
Writing of prescriptions has moved from handwritten to computer printed "scripts"; the latter improving readability and dispensing accuracy. The next step is to move to full electronic prescribing as part of a centrally held electronic patient record which will:

- Improve patient safety by reducing medication errors and potential adverse drug events
- Support the delivery of virtual clinics in the community setting and the resultant medication requirements
- Improved compliance with agreed formulary and guidance to ensure medicine optimisation and financial governance
- Streamline medication prescribing , administration and supply at discharge

We will explore the potential to be a beacon in the implementation of e-prescribing so that the benefits for patients in remote rural communities can be realised.

Hospital Pharmacy Core Assumptions

Requirement	In Place?	Notes
24/7 pharmacy service	Yes	On-site 5.5 days per week with on-call out of hours.
Pharmacy delivered medicine reconciliation within 24 hours of ED attendance	No	Extend on-site pharmacy to 7 days presence (i.e. 0.5 days on a Sunday).
Participation in frailty service to identify when medication review would reduce likelihood of re-attendance	Yes	0.5 wte currently involved; to be reviewed as frailty service development.
Provide daily support to the Community Integrated Urgent Care Service	No	To be developed alongside plans for service. Estimated 1wte member of staff.
Fully integrated Emergency Department pharmacy service	No	Team of 2 pharmacists, 2 technicians 1 assistant technical officer would maximise the potential for pharmacy-led care at front door.
Medicines Transcribing and e-Discharge system (MTeD) in the Clinical Decisions Unit	No	Included in staffing plan for fully integrated ED pharmacy service above.
Pharmacy Independent Prescribing	No	Programme in place to replace IPs when they leave and participate in Health Board programme to train more IPs and develop roles to allow involvement in clinical settings.
Pharmacy Robot	Yes	The unit is now 10 years old and will need to be replaced.
Aseptic pharmacy service	Yes	
Ward-based-working for clinical teams	In part	Surgical patients are, generally managed, in specific wards and ward level dispensing is achieved for these patients. Space required to establish on medical wards.
Developing support roles through training and education to release qualified staff.	Yes	In house training of Assistant Technical Officers is in place.
e-prescribing	No	Part of all-Wales programme. Discuss opportunity to deliver a pathfinder project at BGH.



- Pharmacy delivered medicine reconciliation within 24 hours of ED attendance
- Participation in holistic frailty service to identify patients where a medication review would reduce likelihood of re-attendance
- Support Community Integrated Urgent Care Service
- MTeD in Clinical Decisions Unit
- Pharmacy Independent Prescribing
- Ward based working for pharmacy.
- e-Prescribing

Delivering Excellent Rural

Therapy Services

Rural Therapy Services

Therapy services are provided across the entire care system by "allied health professionals". Although they are a relatively small proportion of our total expenditure, they are involved in almost every service we provide and therapy services will play a significant role in the delivery of our strategic aims.

Therapists holistically assess and evaluate patient needs to plan and deliver interventions that enable people to recover from and self-manage conditions so that they can live fulfilled lives to their maximum.

There are many different registered therapy and health science disciplines supporting patients across a wide range of conditions and across all age groups. This strategy does not underestimate the impact of all of these on the health and wellbeing of patients. There are, however, five therapies that are more commonly seen supporting patients in acute health care settings and upon which we focus:

- Dietetics: Nutritional and dietary advice, education and support
- Occupational Therapy: Skills and abilities to enable activities
- Physiotherapy: Restoration of movement and function
- Podiatry and Orthotics: Treating feet and ankles to promote mobility
- Speech and Language Therapy: Assessment, management, education and support for dysphagia (swallowing difficulties) and communication difficulties

Different conditions require a different mix of therapist input and, within each therapy, application of different techniques. An individual's age, social circumstances and nature of their condition also influence the therapy input they require.

- Early detection and management of Dysphagia will prevent some patients ending up as nil-by-mouth and reduce the risks of aspiration pneumonia and its associated complications, which can result in longer hospital length of stay and clinical outcomes

An integrated approach to therapy services is required to ensure:

1) That there is sufficient resource in the community to:
    - Support population health improvement through supporting wellness, interventions to optimise people's physical and functional ability
    - Empowering people to manage their own conditions (e.g. pulmonary rehabilitation)
    - Provide anticipatory support to maintain people in their homes
    - Support prehabilitation for patients who are waiting treatment
    - Support rehabilitation for patients after treatment
    - Provide palliative care for patients in the community living with life limiting conditions
2) That there is sufficient resource in the acute setting to:
    - Provide rapid and holistic assessment planning for emergency patients
    - Provide specialist input to the management of certain conditions (e.g. stroke, major trauma, progressive neurological diseases, inflammatory bowel disease, pain)
    - Support rehabilitation and reablement as part of an integrated recovery pathway
    - Allow participation in ward rounds, board rounds and MDT meetings
    - Deliver education and training to enable other staff groups to effectively support patients with lower level therapeutic needs
    - Support the development of hospital ward environments and models that improve patient outcomes

Working across acute and community settings, therapists also support broader population health by, for example:

- Maintenance of movement, function and self-care in a person's own environment promotes exercise and independence.
- Nutritional interventions can be targeted to support the 30% of people admitted to hospital who are at risk of malnutrition which effects both hospital length of stay and clinical outcomes.

The availability of timely and consistent therapy input is a factor in determining how long a patient takes to recover following elective or emergency treatment. By developing other clinical staff to perform less specialist therapy functions we will promote attainment of both improved patient experience, patient outcomes and service performance, for example:

- Delivery of stroke swallow screening training to registered nurses, empowering nursing staff to assess and make clinical decisions regarding stroke patients' nutrition and hydration needs, within 4 hours of admission

Longer lengths of stay impact upon the overall wellbeing of patients and this is especially apparent in older people who can rapidly become less able to remain independent following an inpatient stay in hospital. Longer lengths of stay also compromise delivery of both urgent care performance (i.e. the 4 hour A&E waits) and the ability to treat elective patients on time.

Frailty

An ageing population presents an increasing demand on our health services as people become increasingly frail. Evidence shows that when older people with acute health problems are admitted to hospital, better outcomes are achieved by returning them home as soon as possible to reduce confusion and promote the continuation of their usual routine. Patients can return home on a discharge to recover or discharge to assess pathway to provide the support and care required in the home.

A multi-disciplinary team led ambulatory care approach will be able to support patients who are suitable for same day return and this will be provided by the Community Urgent Integrated Care Centre. Some patients will, however, be unable to return home on the same day and will be provided with treatment and intensive therapy support with a view to returning them home within 72 hours of admission.

Multidisciplinary team working that ensures appropriate skills are available where and when required is key to success. By providing targeted intervention to meet both the patient's acute needs and any adjustments required in their home to support their return, we will delivery effective patient focused care.

Rehabilitation

As discussed previously, therapy services play a significant role in patient recovery after major trauma. The proposals for Hywel Dda's trauma service are currently being consulted upon and the final service structure is as yet unknown. However, as set out earlier in this document, BGH will receive and need to treat some trauma and will also be the most local hospital for patients returning home after treatment in a trauma centre or trauma unit.

Therapy input will, therefore, be required both within BGH and in community settings in which patients will receive support post discharge from the acute services. Networks with other trauma rehabilitation services will need to be established so that patients can seamlessly move closer to their home whilst receiving the care appropriate to their needs.

Major Trauma is not, however, the only service where specialist tertiary level care will be centralised to one or two sites and a consistent step down rehabilitation service will need to be developed to support people recovering from, for example, neurological conditions, complex orthopaedic surgery, stroke and cardiothoracic surgery in addition to support for patients who receive their treatment for these conditions locally.

The rehabilitation "prescription" provided to patients will be specific to their presenting condition, but will be provided by a wide range of therapists including the five listed previously, but there will also be support from a wider range of therapy services to address specific presentations, but most notably Clinical Psychology and Psychological Therapy input needs to be strengthened to support patients with mental, emotional and behavioural consequences of their conditions.

A mid Wales approach is required, which could be a therapist-led service, and we will work with our partners to develop proposals for a community delivered rehabilitation service to meet the needs of the populations of Powys, Gwynedd and Ceredigion.

Developing Therapy Services

It is essential that therapy services are developed to work seamlessly across acute and community, resourced to enable them to be responsive to patient need. It is also important to recognise that community therapy services for

patients in Powys and Gwynedd are provided by their respective Health Boards and that there will need to be consistency in approaches for patients who are admitted to BGH in order to promote timely discharge.

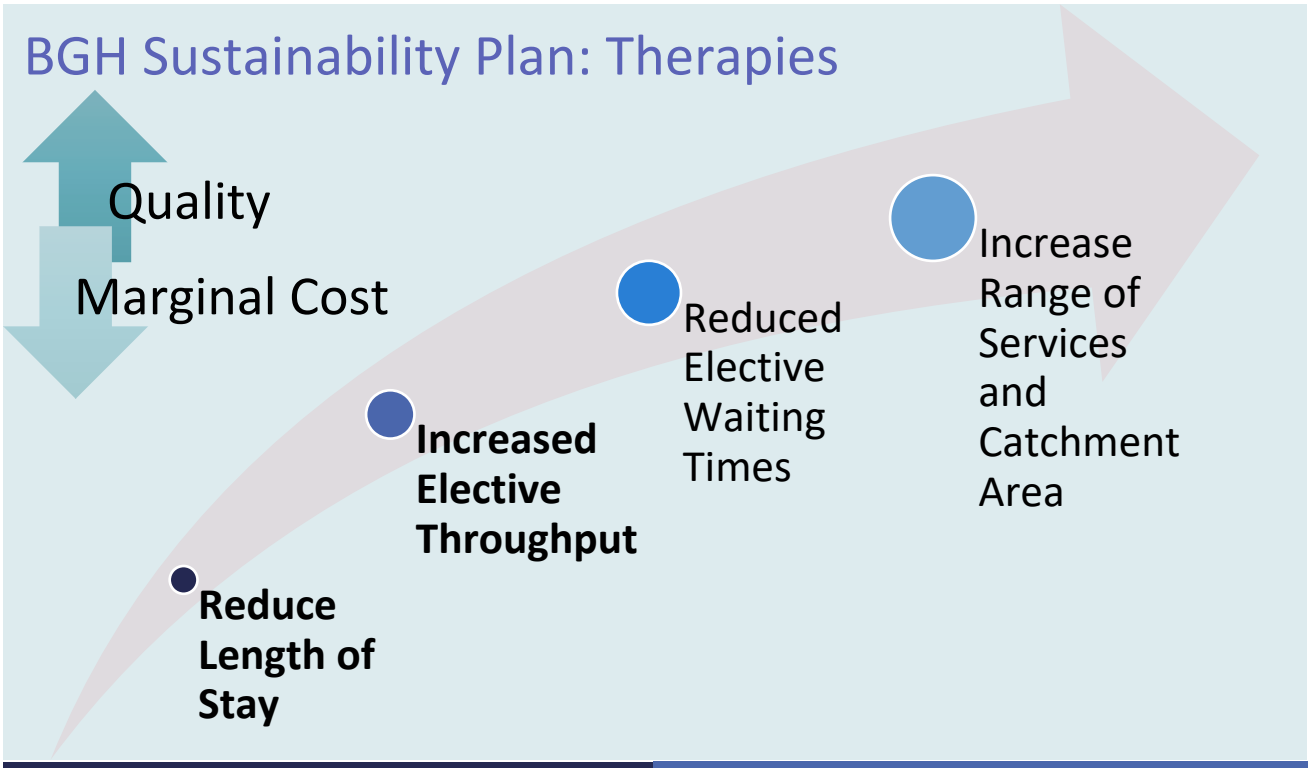
By strengthening therapy presence at BGH, we will be able to deliver services in a timely way that promotes patient outcome, time to recovery and a reduction in length of stay. There is a need to move towards a 7 day service across the five therapy services, although some will be in more demand than others, so that there is no break in the therapy patients receive.

Because of the range of support provided by therapy services, there is a need to move towards a versatile model of provision to ensure that appropriate care can be delivered across the whole care system. The development of linked roles across, say, physiotherapy and occupational therapy, will enable a timely response to be delivered without delay.

Therapy Services Core Assumptions

Requirement	In Place	Notes
Therapy workforce plan	No	Service delivery plans will set out the essential support therapy services will provide to their specific client group. These will need to challenge conventional assumptions about roles to ensure opportunities for the development of enhanced roles such as advanced practitioners, therapy support workers and therapy assistant practitioners.
Therapy Education and Training programme	In part	Competency development at every grade needs to be standardised and accredited. Local provision in mid-Wales to be promoted by partnership working with Aberystwyth University.
Mid-Wales Rehabilitation Plan	No	
Research Programme	No	To be developed in partnership with Aberystwyth University which will support recruitment, retention and service growth.
Recruitment and resourcing plan	No	To be developed in line with service delivery plan outputs.

BGH Sustainability Plan: Therapies



- Therapist at Front Door
- Frailty MDT
- Rehabilitation

- Prehabilitation
- Developing therapy support workers and therapy assistant practitioners

Delivering Excellent Rural

Elective Care Services

Rural Elective Care Services

As described earlier in this document, BGH has a requirement to deliver planned (elective) care in support of the delivery of its essential emergency function.

A typical elective care pathway is:

- Referral
- Waiting List
- Outpatient Appointment
- Diagnostics
- Follow-Up Appointment
- Decision
- Discharge / Treat and Follow-up/ Waiting List for Procedure
- Preoperative assessment
- Procedure
- Recovery
- Discharge
- Follow-up

The national targets for elective care waiting times is that no patient should wait more than 26 weeks from the date of referral to their treatment with significantly shorter waiting times for cancer patients.

It is important that elective care is protected from the pressures of emergency care so that patients are treated as soon as possible.

Ensuring Capacity

BGH has five operating theatres.

- 1 Emergency Surgery/Trauma/Maternity Theatre
- 1 Inpatient Theatre
- 2 Day-case Theatres
- 1 Head and Neck Theatre (for ophthalmology, ENT and dental)

Not all treatments need to be done in a theatre and some can be done in clinic rooms and some need to be done in other specialist environments such as:

- Endoscopy (for gastrointestinal and respiratory treatments)
- X-ray (for interventional radiology)

Nationally, there is a drive for making as many procedures as possible managed on a day-case basis. "Day Case as the Norm" has been helped by technological advancements in surgical techniques, such as minimally invasive surgery, that reduce the need to be admitted to hospital to recover.

For some procedures inpatient admission is required, either because the surgery is such that post-operative pain and recovery will need to be managed or because the home circumstances of the person would not allow them to be discharged safely the same day.

Emergency department "Hot Clinic" cases will be booked onto a day case list, when appropriate, to avoid unnecessary admission

BGH will aim to deliver the majority of its elective care under one of the following pathways:

1. Procedure room
2. Day surgery
3. 23-hour stay
4. 72-hour stay

In order to achieve this a number of developments are required which are set out below.

Decision to Treat Pre-Operative Assessment

When a patient and doctor have agreed that a procedure is required, an initial health screening relevant to that procedure will be done so that action can be initiated immediately to resolve any "red flag" conditions (high blood pressure, poorly controlled diabetes, high body mass index (BMI) too high, medication cessation etc.)

For patients where there is reason to suspect that there may be some underlying health problems, there will be rapid referral to a full pre-operative assessment as soon as possible.

All routine patients will receive a full pre-operative assessment by 4 weeks prior to their planned date of procedure. If all is well, their admission date will be confirmed. Urgent cases will be prioritised as required by their relevant pathways.

Patients who have issues identified at the pre-operative assessment may require reassessment after another two weeks or postponement of their procedure until the matter has been resolved.

Pre-Operative Assessment Location

Pre-operative assessments have traditionally been provided at BGH. Some patients can have their pre-operative checks by phone, others need to attend a clinic because they need some biometric measurements, such as ECG, blood tests etc.

Pre-operative tests do not require highly specialised equipment and are able to be done in a variety of locations provided that the patient's history is available to inform the discussion and there is access to an ECG machine. Patients who need enhanced diagnostics following their assessment will need to attend BGH, or any other convenient location where available, to have these done.

Our aim is for the majority of pre-assessment to take place in community settings and we are involved in an all Wales initiative to develop community-based pre-assessment and will take advantage of opportunities to deliver this as they arise.

We will utilise improvements in our IT system to help streamline pre-assessment and support remote pre-operative assessment.

"Prehabilitation" – Getting Fit For Surgery

The best recovery after elective surgery starts before the surgery has happened and pre-operative assessments will identify lifestyle factors that can be changed to optimise a patient's health to give the patient the quickest possible return to normality after their surgery. The provision of prehabilitation would include physical training supported by exercise prescription, nutritional optimisation, reduction of smoking and alcohol consumption.

Macmillan Cancer Support currently supports a transformation scheme to inform the design and implementation of rehabilitation opportunities for people with cancer across Hywel Dda. Alongside this, work to develop

prehabilitation for patients with lung cancer by incorporating it into the tele-health pulmonary rehabilitation service (VIPAR) is underway.

In addition, occupational therapy services are developing a model of care that will include falls, stroke, cardiac, respiratory, cancer and diabetes patients to optimise their wellbeing to promote positive outcomes.

Admission on day of surgery

There are very few clinical reasons that require a patient to be admitted to hospital before the day of surgery. On rare occasions, the remoteness and distances travelled by some patients to BGH does mean that some complex patients are admitted for a procedure that starts early the next day. Clearly this is not good use of a hospital bed and we will find alternative ways to meet these patients' needs in the future, for example by providing local accommodation where appropriate.

Enhanced Recovery After Surgery

"Enhanced Recovery After Surgery" is an initiative that currently requires some patients to be admitted to an inpatient bed prior to their surgery so that their condition can be optimised ahead of the procedure. We will explore how this can be delivered in community settings or in patients' own homes to reduce the need for patients to be admitted prior to the day of surgery and how ERAS can be provided across the whole mid-Wales area.

Separation of Elective and Emergency Care

The separation of elective and emergency care is key to ensuring that elective beds are protected for elective patients. For the foreseeable future, BGH will not be able to achieve geographical or site separation and we would need to ensure that if this was proposed, the economy of scales that co-location achieved were not compromised.

In order to protect elective beds, robust management procedures must be put in place. The current levels of cancellations demonstrate that more needs to be done and the opportunities to do so are:

1) ***23:59 Unit in Day Surgery:*** The opening of the new inpatient theatre suite will allow us to manage the Day Surgery Unit on a 23:59 basis so that patients who have had a day case procedure, but need a bit

longer to recover can do so in the unit rather than having to be admitted to an inpatient bed. This will mean that day case surgery should never be cancelled.

2) ***Community Integrated Urgent Care Centre:*** Admission avoidance and reduction activities will provide a range of alternatives to reduce the need to admit patients in emergencies and thereby reduce the risk that beds required for elective procedures will need to be used.
3) ***Alternative Emergency Pathways:*** Enhancements in community services will allow some patients who, having presented as an emergency, but who are having conservative treatment (for example after a non-complex fractured humerus) can be appropriately cared for in non-acute hospital settings.
4) ***Surgical Assessment Unit/Hot Clinic:*** A surgical assessment unit model will stream surgical patients presenting at the front door which will promote rapid assessment and treatment planning including booking onto a rapid access day case list.
5) ***Surgical Short Stay:*** A short stay surgical unit will allow appropriate clinical management and care for patients who need slightly longer recovery than can be provided in the 23:59 unit.

Efficient Operating Theatres

The way in which our operating theatres are organised and work impacts upon the number of cases we can treat.

“Theatre Utilisation” is a measure of how effectively we are utilising our operating theatres. Even in the most efficient theatre, it is not possible to achieve 100% utilisation due to essential functions such as cleaning and maintenance.

BGH aims to meet or exceed best practice in theatre management procedures and we recognise the need to make good use of our assets and plan to optimise theatre utilisation over 7 days to maximise efficiency. Our aim is a target utilisation of at least 83% in our elective theatres.

To achieve this we will:

- Ensure theatre capacity and allocation is locally managed so that it reflects the overall teams' skills and capacity
- Run our elective theatres for 2 extended 5½ hour sessions which we believe to be the most efficient configuration
- Run dedicated trauma lists
- Provide daily emergency theatre sessions for emergency cases
- Separation of elective and emergency procedures
- Run a specialty-based theatre model e.g. specific kit stays in a dedicated theatre

Repatriation of activity

As BGH recruits more substantive consultants into post and starts to be able to provide an assurance that planned activity will happen when it is scheduled, we will be able to bring more work into the hospital.

We aim to provide everything at BGH that does not need tertiary level hospital support. Presently, this includes a full range of elective:

- Colorectal surgery
- Upper gastro intestinal surgery
- Orthopaedic surgery
- Gynaecological surgery
- Breast surgery
- Ophthalmic surgery
- Urological surgery

In time, this will be extended to include:

- Ear Nose and Throat surgery
- Orthodontics

Some services will be provided by visiting consultants with patients being operated on at BGH and cared for after their surgery by the highly skilled team based here.

Other surgery may need to be provided at specialist centres, but patients will be repatriated back to BGH as soon as possible for recovery and rehabilitation so

that they are only away from their home area for the shortest time that is required.

Clinical and activity coding provides essential information in support of service planning, delivery and quality improvement. It is acknowledged that there is variation in coding within the Health Board, between Welsh Health Boards and the countries that comprise the United Kingdom of Great Britain and Northern Ireland. It is accepted that improvements in the data collected within Hywel Dda would give greater granularity and allow better definition and quantification of services provided in support of future models of service provision and we will work with our commissioning partners and the Health Board's information team to achieve this.

Outreach Services

Outreach services are provided into Powys and Betsi Cadwaladr Health Boards. These are mainly outpatient clinics with patients travelling to BGH for treatments.

We will expand our outreach services to meet patient need and look to provide more procedures in local settings. There are opportunities to provide some procedures currently performed at BGH in community hospitals across all three Health Boards and this opens up opportunities to build strong links with other providers to improve patient access and flow.

By providing more treatments on an outreach basis, BGH will be able to meet its commitments in terms of waiting times and quality to patients in Powys and Gwynedd while freeing up capacity at BGH to treat the more complex cases.

Outpatient Services

Outpatient services are currently the beginning of most elective care pathways. These are currently mostly provided from BGH with some outreach to community hospitals. There are opportunities to change how outpatient services are provided including:

- Increased range of outpatient clinics provided in community settings
- Video and telephone consultation (especially for follow-ups)
- Allied Health Professional led clinics
- GP direct referral to diagnostic tests
- Screening

By reducing outpatient waiting times to a maximum of 4 weeks, there will also opportunities to provide direct booking into a suitable slot at the point of referral by the GP. Improvements in waiting times can be achieved by a number of means including a reduction in the number of follow-up appointments and reducing “did not attend” rates and best practice in outpatient provision will be delivered by the whole service.

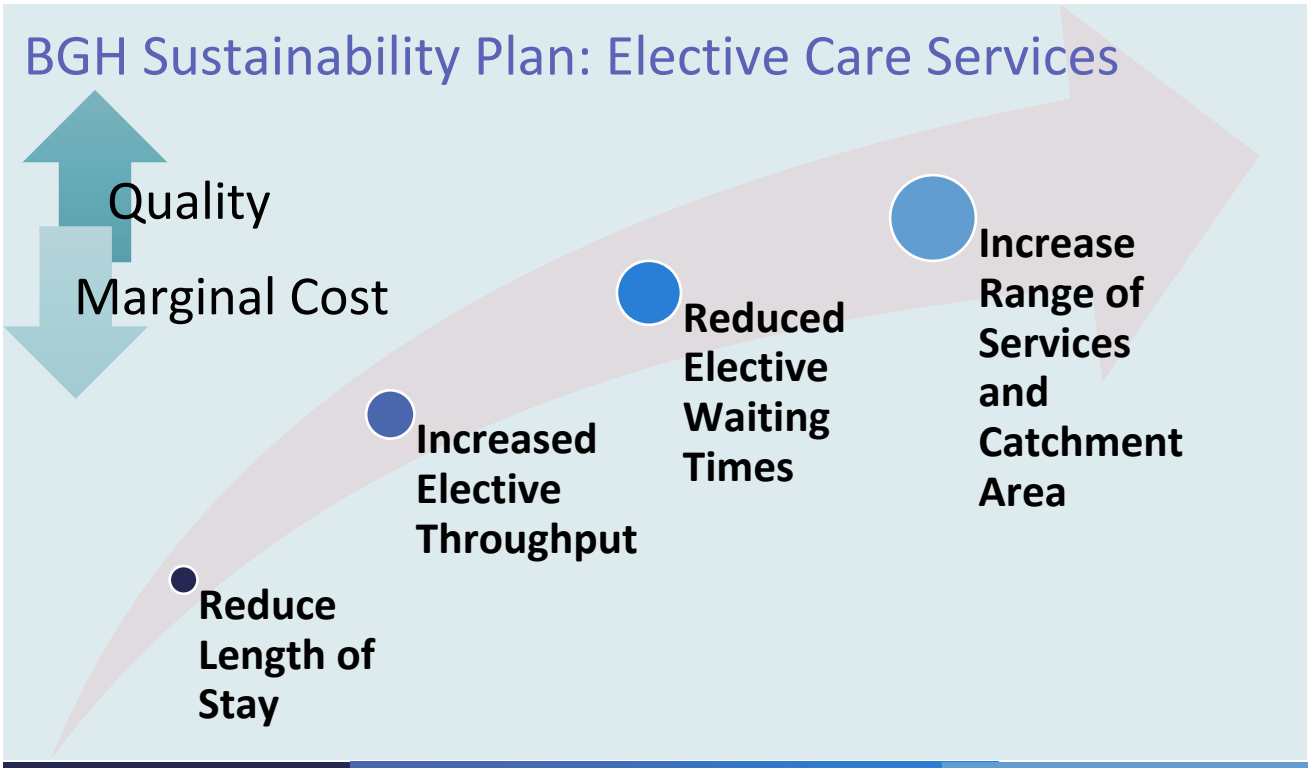
To achieve greater agility, local booking arrangements will need to be in place so that geographical sensitivity can be applied to ensure mid-Wales patients are offered the most appropriate local setting for their appointment.

The opportunity to do more and work differently and the ease with which this can be implemented will vary from specialty to specialty. Pathways will be reviewed and opportunities to do things differently so that the patient is at the centre of the service being provided. Opportunities to utilise technology and new workforce models will be reflected in service specific plans.

Elective Care Services Core Assumptions

Requirement	In Place?	Notes
Day Case as the "norm"	Yes	
Surgical Assessment Unit/Hot Clinics	No	Plans to introduce being discussed.
Pre-op at DTT	No	Protocol to be developed.
Community Pre-Op	No	
Prehabilitation	In Part	Informal at moment.
Same day admission	Yes	Review outliers to understand any variation.
23:59 Day Case Unit	No	Review estate and options as part of capacity plan.
Surgical Short Stay	No	
Site led theatre management	No	
Extended theatre sessions	No	Requires job plan review
Dedicated trauma lists	No	In plan.
Daily emergency theatre list	Yes	
Separation of Elective and Emergency surgery	In part	Theatre lists separate, but facilities are shared.
Specialty based theatres	No	Requires capacity review.
Expanded range of services (ENT and Orthodontics)	No	
Coding improvements	No	
Powys/Gwynedd/Ceredigion Outreach Clinics	In part	Opportunities to utilise ICCs and Tywyn, Machynlleth, Dolgellau, Llanidloes and Newtown hospitals.
Outpatient Tele-clinics	No	
AHP Outpatient Clinics	No	
GP Direct to Test	In part	Requires capacity review.
4 week maximum outpatient wait	No	Will enable direct booking by GPs.
Mid-Wales regional outpatient booking service	No	Currently centralised in Llanelli.
Clinical pathways for mid-Wales	In development	Included in work of Mid Wales Clinical Advisory Group

BGH Sustainability Plan: Elective Care Services



• Day Case as "norm" • Surgical Assessment Unit/Hot Clinics • Prehabilitation • GP direct to test	• 4-week OPD waiting times and move to direct booking by GPs • Pre-Op at DTT • Same day admission • 23:59 Unit • Surgical Short Stay • Extended theatre sessions • Trauma Lists • Emergency Theatre List	• Community Pre-Op • Local theatre logistical planning • Specialty based theatres • ENT • Orthodontics • Coding Improvements • Outreach clinics • Tele-Clinics • AHP-Clinics • Mid-Wales booking service • Mid-Wales Clinical Pathways

Delivering Excellent Rural

Technology Enabled Care

Future Technology Campus

Unique within the Health Board, BGH is directly adjacent to the National Library of Wales and the University of Aberystwyth.

A shared campus brings many opportunities for the development of partnerships and research that cover health services, the determinants of health, interventions to improve health and the information and communications used to support and deliver care.

The development of health and care has increased and this will continue in the future. Innovation in response to new challenges is being supported by both the exponential increase in the ability of humans to build ever more powerful computers, miniaturisation and the development of nanotechnology.

This rapid advancement creates a need for organisations to look further ahead and adopt a view of the possible, rather than being constrained by the current limits of technology and industry. A future vision for health care is likely to have increased ability to understand biometrics via non-invasive devices so that the requirement to "take bloods" will, largely be a thing of the past. When a blood test is required, robotic development will mean that this can be done at any time in a wide variety of locations. The concept of homes being designed with a "health chair" that takes the most common readings such as blood pressure, oxygen saturation, and, if necessary, "takes blood" which is then transported by drone with any other required samples to the nearest lab for processing may sound far-fetched, but many of the technologies to do this already exist.

Non-invasive blood tests already exist for blood counts, lipids and glucose; this is the start of an exciting development in biomedical science that will help people manage their lifestyles in a health conscious way that will allow signals of early changes that warrant further investigation to be identified so that appropriate and timely action can be taken.

The "Internet of Things" has provided smart fridges that could be utilised to help a patient with diabetes manage their insulin levels and ensure that they are always

stocked up with supplies. Drone delivery systems are being piloted for a number of applications across the world.

You wake in the morning and you stand in front of the bathroom sink. The mirror turns on and shows your weight and BMI and how this has changed over the past few weeks. The body condition monitor has auto analysed your biometrics and your key indicators are normal, except that you are a bit more dehydrated than you would normally expect and a message informs you that you should drink more fluids today; a reminder is sent to your smart device and, since you selected the option, to your work calendar to remind you when you get in. You're good to go.

Such opportunity does come with certain cautions. It is not healthy to be obsessed by being healthy to the point where a person becomes socially dysfunctional or cannot derive any pleasure from life. Life is about living and technology must support people in understanding how they can be healthy for as long as possible so that they can have the maximum potential for happiness; there is a proven link between being happy and being healthy. Whether a person chooses to avail themselves of the opportunities technology presents or take action should one biometric change is that person's individual choice. We must also never forget that as humans, we are social animals and that no matter how far technology evolves, the need to have contact and be able to empathise with others, especially during major life events, is unlikely to be found in artificial intelligence systems or androids. Simply holding someone's hand provides both emotional comfort and has been shown to help dissipate pain.

Building upon the development of rural doctor training and the world-class Institute of Biology, Environmental and Rural Sciences, the development of a school of nursing and health sciences will add to the potential for partnership across all faculties and departments. Partnerships between the hospital and departments such as Psychology and Biology are relatively obvious. There is also significant potential to develop partnerships with other departments, such as Geography, Computer Science and Mathematics so that their knowledge and skill sets can be applied to health and care models and solutions to help understand population health and how our actions impact upon outcomes.

Research and Development

The Health Board's Research and Development department seeks to gain participation in as many studies and trials as possible across the whole Health Board. These studies allow patients to access new and novel treatments for their condition while helping to inform the direction of care in the future. The Research and Development department at BGH supports participation in studies and trials within the hospital.

Recognising the shared campus, the department is building stronger links with Aberystwyth University and is establishing a triumvirate of research champions, one from the university, one from the medical library and one from the clinical research team. The champions will be points of contact for new research and seek to promote the engagement of nurses and other non-medical health professionals in research, supporting and encouraging people to conduct their own research and promoting participation in multi-centre studies.

Healthcare studies involve hospital based face to face patient research and, therefore, requires a hospital presence. Outpatient studies can be delivered in other settings and WARU already deliver a number of these on the University Campus. The current facilities in BGH are not purpose built and we will explore options to develop such alongside improvements to the post-graduate facilities in partnership with the Universities of Aberystwyth, Swansea and Cardiff.

The opportunity to develop a University Hospital model is something that BGH should explore as part of a package of incentives to promote recruitment and retention while also supporting initiatives to strengthen local economy and industry.

Application of Current Technology

The Telemedicine Strategy for Mid Wales sets out four key areas for development:

- Development of specialist consultant in-reach services to BGH from patient to clinician and clinician to clinician.
- Development of clinician outreach into rural communities.
- Supporting Primary and Secondary care joint working.

- Establishing Mid Wales as an exemplar for the deployment of telemedicine.

Services will utilise a number of technologies to promote care:

- Telecare: The use of technology to provide continuous, automatic and remote monitoring of real time emergencies, impact of lifestyle changes in order to manage the risks associated with frailty and independent living.
- Telemedicine: The practice of medical care and consultations using interactive audio-visual and data communications.
- Telehealth: The use of technology to provide remote monitoring of people living with a chronic condition and to support self-management and delivery of care (e.g. monitors).
- Tele-coaching: Telephone or remote audio-visual advice from a coach to build people's knowledge, skills and confidence to change behaviours.
- E-health: Information and communication tools and services that can improve prevention, diagnosis, treatment, monitoring and management of ill health.
- Self-care apps: Internet-based software applications that raise awareness and help people self-manage their health and wellbeing via smartphones, tablets or websites.
- General Wellness Devices or 'Wearables': These devices are worn on the person to help promote, track and/or encourage the lifestyle choices and healthy activity for general wellness.

BGH, as part of the "Future Technology Campus" will be the hub for the mid Wales telemedicine strategy, offering both formal outreach as well as virtual clinic options for patients via telemedicine. This is already provided in Care of the Elderly, falls, and movement disorder clinics, Respiratory, Cardiology and General Surgery.

We will work with our neighbouring health boards to understand the patient needs that can be fulfilled through expansion of this portfolio to promote access to the population we serve.

Implementing Excellent Rural

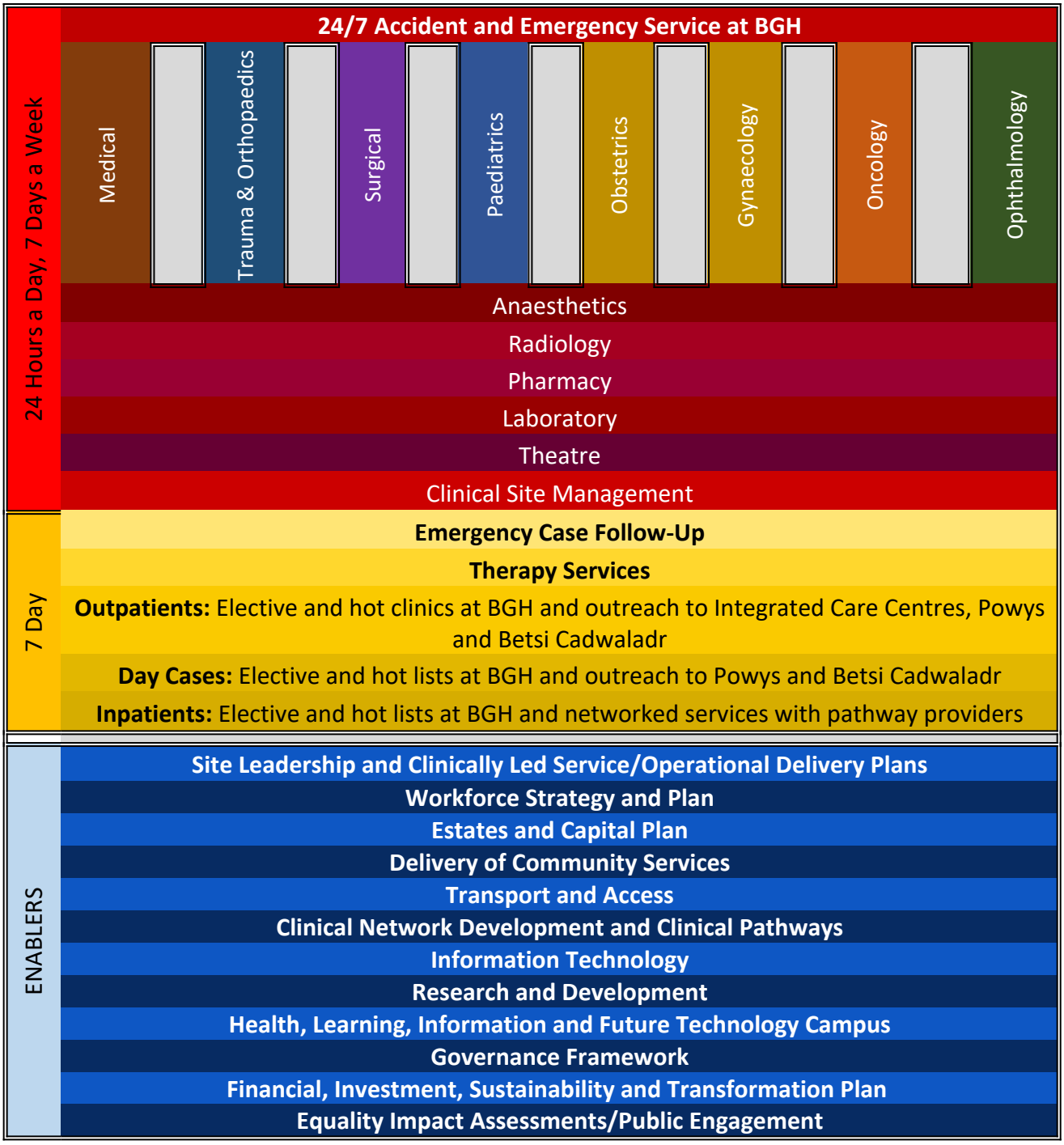
Acute Services

Implementing Our Strategy

This strategy is, by design, focussed on acute health care and the services provided by BGH.

Setting out our ambition is the first stage of our journey and much more work is required if we are to achieve what we have presented.

To deliver, we will require development across of a number of areas that are set out below.



Site Leadership and Operational Delivery

The delivery of the highest possible levels of services within a remote, rural environment requires a leadership style that can gain support both for a strategic vision and the work required for its implementation.

Visible and credible leadership is required to drive a culture of delivery towards one that knows what it needs to do. Accessible leadership for all services will be provided locally to deliver the operational delivery plans that emerge from this strategy.

Leaders will support and develop the people delivering the services and encourage creativity and innovation in order to meet the services' objectives. Management, direction and involvement need to be finely balanced and avoid feelings of a punitive culture from evolving within the organisation.

Within an effective quality management framework, the fact that, from time to time, mistakes will be made can be embraced as an opportunity to learn, develop and evolve.

In order to deliver a rural service that understands and reflects the values and culture of the population served we will establish a local management team with accountability for all services provided within BGH. Some services will, necessarily, be provided by services outside of the hospital, but the local management team will be accountable for ensuring the effectiveness of these arrangements and that they meet the current and future needs of the service.

Workforce Planning

This plan has set a vision across key service areas within BGH. In so doing, it identifies high level and, to some extent, overly simplistic gaps in services. There are a number of other strategic goals that need to be reflected, such as the minimum ward staffing levels, in an overall plan for delivery. Ultimately, the attainment of service improvement will need to be resourced either by savings made in other parts of the service, efficiency improvements or additional investment. Technological improvements offer an opportunity to re-profile our workforce as, amongst other developments, automation increases which will allow us to increase the direct patient care element across a wide range of staff groups.

Detailed service plans will need to be developed to meet BGH's vision and these will inform the development of a workforce investment plan.

Alongside this, the development of high quality locally available training will be implemented in partnership with Aberystwyth University so that we develop a wide range of health care professionals locally which will support our recruitment and retention requirements. In addition, we will develop contracts of employment that reflect the services accessed by patients from mid-Wales so that clinicians can be appointed by, and work across the respective provider organisations to promote seamless care for the patient across their care pathway wherever that care is provided.

Developing Roles

Workforce is threaded throughout this strategy and, as the NHS' single most valuable resource, our present and future staff will be key to its successful implementation.

The Health Board has adopted extended and advanced roles to support service development and to meet the needs of the population where traditional roles are hard to recruit or require modernisation and in June 2019 introduced an apprenticeship programme to offer people who are studying an opportunity to gain practical experience to support their learning.

Specialists, enhanced roles, extended scope practitioners and advanced and assistant practitioners have a huge role in supporting the Health Board to modernise workforce models. It is key that staff maximise the use of their knowledge and skills and that we use every opportunity to support staff through career pathways to 'grow our own' staff for the future. This will be the strategic programme to drive future developments across all staff groups.

This will be key to the attainment of this strategy and the Health Board's Excellence, Assurance and Governance in a Learning Environment framework (EAGLE) will allow us to develop extended, expand and adopt new roles in the absence of statutory regulation.

Centre of Excellence for Rural Health Care

BGH is ideally situated to establish itself as a centre of a network that develops and delivers excellent rural care. The scale of BGH promotes effective cross-

specialty and multi-professional team working to deliver comprehensive and holistic services.

Opportunities to work creatively with the wider network of services across the whole of BGH's catchment area will be utilised to develop an agile network of care services that promotes adaptation and innovation to meet patient needs and service outcome expectations.

Strong research links will be created with the University of Aberystwyth and other research centres to facilitate development, introduction and evaluation of new ways of delivering care whilst also allowing clinical staff to become involved in teaching and other academic pursuits.

School of Medicine, Nursing and Health Science

The University Partnership Board is an important collaboration between Hywel Dda University Health Board, the University of Aberystwyth, Swansea University and University of Wales Trinity Saint David promoting the health, wellbeing and education to the population of Hywel Dda. Partners work together to deliver improvements across the region by brining health and education closer together. This provides a solid foundation upon which we can build academic and clinical collaboration to address the issues of rural care in Wales.

Research has shown that where people do their undergraduate and postgraduate training influences where they work. The availability of training and development necessary for maintaining professional registration and advancing one's skills is also important to staff in the health care profession and if this is not reasonably easy to access, the ease within which health care professions can transfer between differing NHS organisations means that staff may decide to move to where they feel that their career ambitions will be more easily met.

BGH is uniquely located within the Health Board in that it is adjacent to the University of Aberystwyth campus. This provides an opportunity to define a Penglais Health, Care and Learning campus that incorporates the hospital, university, Coleg Ceredigion and the National Library. We will also utilise other forms of learning and professional development, such as that provided by the Open University, to provide accessible learning to those for whom traditional models of education provision are not suited.

Both Cardiff and Swansea Universities are providing rural general practitioner training in partnership with Aberystwyth University and plans are in development to provide a nursing course from Aberystwyth.

The World Class “Institute of Biology, Environmental and Rural Sciences” at Aberystwyth already provides opportunities for joint working and research and this will be developed into a School of Medicine, Nursing and Health Science in a phased approach starting with the delivery of nursing degrees.

Along with the training and development of healthcare professionals the University offers excellent opportunities for joint research across a wide range of academic and health care disciplines. We will bring academics and clinicians together to pursue mutually beneficial research opportunities and anticipate that such activities will be attractive to potential future members of staff.

Rural Acute Care Facilities

BGH’s facilities have received significant capital investment over the past 15 years and patients are able to access care in some of the highest quality and most modern environments available in Wales.

BGH’s key challenge is the relative small footprint it occupies with little opportunity to extend this further.

The shift of some services that are provided at BGH into more appropriate community based settings will release some space to allow reconfiguration and improvements which will allow some of the development needs identified in this document to be realised.

The installation of a new MRI scanner is underway and due to complete in December 2019. In addition, a programme of site development is currently underway to provide an integrated care ward for older people, a new chemotherapy day unit, a cardiorespiratory diagnostic suite and an ambulatory/medical day unit to improve those environments and enhance capacity. The time-frame for completion is approximately 24 months, with individual elements becoming operational throughout this period.

Future demand on acute hospitals will be fundamentally changed by the move to “home first” and this will allow increased ring-fenced beds for specific clinical conditions and for the protection of elective care pathways.

The future strategic direction of BGH is to do more and there may come a time when the bed base is no longer sufficient for the cases requiring admission. Maximising theatre productivity and a move to day-case will to some extent balance each other out and a 10 year forward view could require additional beds or other facilities as demand increases and technology evolves.

With lateral expansion space limited, other options need to be explored including:

- Integration of Post-Graduate and accommodation areas with Aberystwyth University and re-development of area release for appropriate facilities, such as a Health Research Centre.
- Building on top of the "Front of House" (which houses the Emergency care and Day-Case units) to generate additional floor space for service development.

The current capital plan for BGH will be reviewed in light of the vision set out in this strategy to ensure the opportunities to maximise the value provided by the site's available footprint are delivered.

Delivery of Community Services

A core assumption in this plan is that the community services improvements as set out in the Integrated Medium Term Plan and the Health Board's Strategy will be delivered. The "bedless" model in Ceredigion needs to be fully functioning in order to ensure timely discharge either home or to other appropriate environments. In addition the move towards an anticipatory care service in the community which works towards appropriately managing changes in peoples' needs must be delivered in order to reduce the emergency demand placed upon the acute services.

Transport and Access

Feedback from the Transforming Clinical Services public engagement exercise indicated that transport and access to services are major concerns for service users, particularly when they have to travel further to access services.

The need to ensure patients can access services is, therefore, paramount. A transport and access plan will be developed that will meet the needs for:

- Emergency Patient Transport

- Non-Emergency Patient Transport
- Discharge within and outside of Wales
- Public Transport
- Car Parking
- Green Transport and Alternatives

The Welsh Ambulance Services NHS Trust (WAST) is responsible for delivering unscheduled care services (999 and NHS Direct) and planned patient transport services to the people of Wales and is the principle employer of paramedics who provide first line response and care during patient transport.

Changes to the way in which services are delivered can have significant impact on the demand for transport services and the roles required of paramedics.

We will work with WAST to ensure that our service plans are aligned so that we maximise the benefit that can be gained from a collaborative approach for the people of mid Wales.

The majority of patients make their own way to BGH and we will work with public transport companies and Local Authorities to promote access that is both convenient and environmentally responsible.

In a rural area, however, it is inevitable that some patients will need to use a car to access the hospital and we will work to provide sufficient protected parking spaces on the BGH site including sufficient protected spaces for “blue badge” holders.

Clinical Networks and Clinical Pathways

As described throughout this document, BGH has links with a number of health care providers on a regular basis that are not common at the Health Board’s other acute sites.

In order to ensure patients receive the best outcomes possible, the development of pathways with commissioned service providers for patients from Gwynedd and Powys will be developed to promote patients being as close to their home as possible when specialist care is required.

Development of clinical pathways will embrace wider population health aims and ambitions so that opportunities to promote health and wellbeing are exploited to their fullest.

Information Technology

The future opportunities provided by advancements in information technology provides many opportunities to do things in different and more efficient ways and will support the delivery of the BGH vision.

Services will ensure technological improvements are identified within their development plans and these will contribute to an overall Information Technology Plan to support our vision.

Bronglais' services will ensure technological improvements are identified within their development plans and these will contribute to an overall Information Technology Plan to support our vision.

Financial, Investment, Sustainability & Transformation Plan

Bronglais has, over the years, faced particular financial challenges being unique within Wales in the provision of small scale rural acute care to a remote and sparsely populated catchment area with a marked seasonality.

In purely financial terms the comparative efficiency of service delivery, when set against other acute hospitals in Wales is at the lower end of the range. Nevertheless, it has been recognised by policy makers, for many years now, that Bronglais is a strategic healthcare asset serving a large area of mid Wales. In the "Healthier Mid and West Wales" Health and Care Strategy, Hywel Dda University Health Board agreed to preserve and enhance the service provision in Bronglais and the allocation by Welsh Government of £27m "Zero Based Review" monies reflected in part the scale, rurality and remoteness challenges faced in delivery services to the Health Board's population.

It is important that the Financial, Investment, Sustainability and Transformation Plan, that underpins the delivery plan, is able to clearly articulate the cost drivers, outcomes and therefore the value that the transformed services will deliver. This needs to quantify the "rurality premium" (the additional costs associated with the provision care in a remote, rural environment) that was recognised in the "Zero Based Review" allocation whilst at the same time ensuring that current and enhanced services are delivered in the most efficient way possible consistent with the population health ambition expressed in the strategy.

Recognising and testing BGH's contribution to the residual underlying deficit, after the "Zero Based Review" funding, is a key deliverable, notwithstanding the fact that this strategy outlines the need for targeted investment and that Hywel Dda University Health Board expects the greatest efficiency in acute care will be delivered in the south of Hywel Dda.

In order to achieve high value service delivery locally, this strategy identifies the need to integrate services with partners across mid Wales, to establish transformative and sustainable workforce models and to target increased workload from our wider catchment area. These patient activity opportunities are influenced in part by strategic change in neighbouring areas and the changes to acute care in the south of Hywel Dda that are increasing distance to current acute care providers at the borders of our existing catchment area. Service delivery plans will be required to identify this potential and, alongside the need to assure equality commitments are met, will ensure a broad definition of value is taken that reflects the various patient, population and service focussed variables and factors.

The key to sustainability in Bronglais has always been leveraging the opportunity presented by having onsite access to a range of consultant led specialty rotas for emergency and urgent care. These facilitate planned care capacity that is both high quality and can deliver at or within target waiting times. It is essential, therefore, that the integrated financial assessment recognises the interdependencies between services whilst ultimately proving that they are embedding optimal service efficiency within agreed parameters of access and quality.

Clinical and Staff Engagement

BGH Vision and Strategy Group Engagement Phase 1, 11/6/18 - 19/2/19

Name	Job Role/Title	Group
Peter Skitt	Director Ceredigion County/Mid Wales Joint Committee	Core Group
Maggie Collingborn	Consultant Anaesthetist, BGH	Core Group
Allison Brooks	Programme Manager	Core Group
Bec Hill	Principal Project Manager	Core Group
Meinir Jones	Clinical Director Transformation	Core Group
Matthew Willis	Head of Service Development and Integration	Core Group
Dawn Jones	Acute Site Lead Nurse	Core Group
Dr Annette Snell	Consultant Physician; Joint Hospital Director	Core Group
Dr Sion James	GP/Cluster Lead North Ceredigion	Core Group
Hazel Davies	Hospital General Manager, BGH	Core Group
Lou Cullum	Service Delivery Manager, BGH	Core Group
Tracy Walmsley	Senior Workforce Development Manager	Core Group
Gina Callanan	Senior Workforce Manager, Ceredigion	Core Group
Ann Taylor Griffiths	Clinical Site Manager (Staffside Representative), BGH	Core Group
Katie Darby	Clinical Lead Occupational Therapist	Core Group
Kerrie Phipps	Occupational Therapy Service Lead	Core Group
Mandy Davies	Asst Director of Nursing	Core Group
Angie Oliver	Asst Director of Workforce & Organisational Development	Core Group
Stephen Forster	Strategic Change Finance Director	Core Group
Mr Said Awad	Joint Hospital Director BGH	Core Group
Dr Shiblee Hafeez	Joint Hospital Director BGH	Core Group
Emma Pritchard	Transformation Facilitator BGH	Improvement
Mr Mark Henwood	Clinical Director Scheduled Care	Scheduled Care
Steph Hire	General Manager Scheduled Care	Scheduled Care
Selina Marshall	Service Delivery Manager	Scheduled Care
Mr Taha Lazim	Consultant Surgeon, BGH	Scheduled Care
Mr Mohamed Omar	Consultant Orthopaedic Surgeon, BGH	Scheduled Care
Susan Griffith	Operational lead: Acute & Community Physiotherapy	Scheduled Care
Karen Barker	Head of Nursing, Scheduled Care	Scheduled Care
Gordon Wragg	Service Delivery Manager, Scheduled Care	Scheduled Care
Diane Knight	Service Delivery Manager, Scheduled Care	Scheduled Care
Rita Stuart	Service Delivery Manager, Scheduled Care	Scheduled Care
Lydia Davies	Service Delivery Manager, Scheduled Care	Scheduled Care
Lisa Lewis	Service Delivery Manager, Scheduled Care	Scheduled Care
Dr Khan	Consultant Radiologist, BGH; Radiology Lead, HDuHB	Diagnostics
Mark Sherratt	Lead Radiographer BGH	Diagnostics
Amanda Evans	Head of Radiology	Diagnostics
Andrea Stiens	Head of Pathology	Diagnostics
Dr Karen Poyser	Consultant Clinical Scientist, BGH	Diagnostics
Dylan Jones	Blood Sciences Manager	Diagnostics
Dr Jeremy Williams	Clinical Director Unscheduled Care	Unscheduled Care

Name	Job Role/Title	Group
Chris Edwards	Accident and Emergency Sister, BGH	Unscheduled Care
Dr Martyn Sawyer	Accident and Emergency Consultant, BGH	Unscheduled Care
Laura Price	Women's Health Physiotherapist	Women & Children
Janet Millward	Senior Nurse Paediatrics	Women & Children
Dr Francis Kumar	Consultant Paediatrician	Women & Children
Dr Kausik Khan	Consultant Paediatrician	Women & Children
Paula Evans	Directorate Nurse, Paediatrics	Women & Children
Margaret Devonald-Morris	Service Delivery Manager, Women and Children	Women & Children
Julie Jenkins	Head of Midwifery	Women & Children
Angharad Eynan	Paediatric Physiotherapy	Women & Children
David Morrissey	Service Delivery Manager, Paediatrics	Women & Children
Diane Towell	Health Care Support Worker Angharad Ward, Unison Rep	Women & Children
Dr Prem Pitchaikani	Paediatric Lead Consultant	Women & Children
Louise Hughes	Senior Sister, Angharad Ward, BGH	Women & Children

BGH Vision and Strategy Group Phase 2, 19/2/19 - 16/5/19		
Name	**Job Role/Title**	**Date**
Core Group Members	Members attended meetings/received updates	
Dr Alwyn Jones	Specialty Doctor Accident & Emergency Department, BGH	27/03/2019
Sr Chris Cook	Accident and Emergency Department, BGH	27/03/2019
Dr Donogh McKeogh,	Consultant Cardiologist, BGH	28/03/2019
Dr Graham Boswell	Consultant Geriatrician, Emergency Department, BGH	28/03/2019
Mr Taha Lazim	Consultant Surgeon, BGH	29/03/2019
Mr Samy Mohamed	Consultant Surgeon, BGH	29/03/2019
Mr Zeyad Sallami	Consultant Surgeon, BGH	29/03/2019
Mr Mohamed Omar	Consultant Trauma and Orthopaedic Surgeon, BGH	09/04/2019
Mr Said Awad	Consultant Obstetrician & Gynaecologist/Hospital Director	02/04/2019
Jenny Pugh-Jones	Health Board Head of Medicines Management	04/04/2019
Mark Sherratt	Lead Radiographer BGH	23/04/2019
Dr Karen Poyser	Consultant Clinical Biochemist, BGH	23/04/2019
Dr John Williams	Consultant Paediatrician, BGH	01/05/2019
Dr Martin Sawyer	Accident & Emergency Department Consultant, BGH	07/05/2019
Chris Edwards	Accident & Emergency Department Senior Sister, BGH	07/05/2019
Carys Williams	Accident & Emergency Department Sister, BGH	07/05/2019
Rita Stuart	Service Delivery Manager, Scheduled Care, BGH	07/05/2019
Mr Alan Treharne	Consultant Obstetrician & Gynaecologist, BGH	08/09/2019
Donna Robson	Pharmacy Site Manager, BGH	09/05/2019
Geraint Morgan	Pharmacist (former County Lead Pharmacist), BGH	09/05/2019
Elin Guest	Advanced Paediatric Nurse Practitioner, BGH	09/05/2019
Dr Mike Simmons	Consultant Microbiologist, Public Health Wales	10/05/2019
Caroline Longman	Microbiology Manager, Public Health Wales (BGH)	10/05/2019
Sarah Jones	Lead Research Nurse, BGH	13/05/2019
Further discussion regarding specific service detail:		
Louise Quincy	Clinical Lead Nurse, EUCC and Site, BGH	24/5/2019
Mark Sherratt	Lead Radiographer, Ceredigion	28/5/2019

BGH Vision and Strategy Group Draft Consultation; responses received from		
Name	**Job Role/Title**	**Date**
Stuart Gill	Clinical Lead Major Trauma Service	21/5/2019
Kerrie Phipps	Lead Occupational Therapist, Ceredigion	24/5/2019
Susan Griffiths	Senior Physiotherapy manager	
Karen Thomas	Joint Head of Dietetics	
Eleri Sargent	Dysphagia Clinical Lead	
Dr Prem Pichanikani	Consultant Paediatrician	26/5/2019

Draft Discussed at:	
Name	**Date**
Hywel Dda University Health Board Executive Team Meeting	11/2/2019
Mid Wales Joint Committee for Health and Care Clinical Advisory Group	21/5/2019
Hywel Dda University Health Board Executive Team Meeting	10/6/2019
Mid Wales Joint Committee for Health and Care Planning & Delivery Executive Group	11/6/2019
Hywel Dda University Health Board Transforming Our Hospitals Group	12/6/2019
Meeting of the Mid Wales Joint Committee for Health and Care	1/7/2019
Hywel Dda University Health Board	25/7/2019
Hywel Dda University Health Board Transforming Our Hospitals Group	13/8/2019
Transforming Clinical Services “Check and Challenge”	23/9/2019

Bronglais General Hospital: Delivering Excellent Rural Acute Care
Equality Impact Assessment Statement
Anyone, irrespective of any protected characteristics has the potential to be impacted by the proposals for Bronglais General Hospital "Delivering Excellent Rural Acute Care". Certain protected groups may be disproportionately represented amongst service users for any particular services. A communication and engagement plan will be drawn up where required to take account of the need to offer the opportunity for the populations from mid Wales accessing services at Bronglais to contribute to providing feedback on proposals where appropriate. These will include populations from across Hywel Dda University Health Board, Betsi Cadwaladr University Health Board and Powys Teaching Health Board areas. Potential engagement will include targeted notifications to protected groups and organisations who represent protected groups who may be identified as being disproportionately affected and/or who face particular barriers when accessing services. Issues arising for staff impacted by the proposals in relation to their protected characteristics will need to be identified through the organisational change process and addressed on an individual basis. At this stage, with the drive to provide services closer to home in many instances and facilitation of service provision using digital technology, reducing the need to travel, some potential positive impacts have been identified across all protected groups. However, arrangements will need to be put in place for individuals who are not able to use digital technology where this may be a requirement for accessing services or managing their health. However, the project group and associated work-streams will need to be continually mindful of the barriers that some protected groups face when accessing services and how these may be overcome in the new service delivery models. Feedback from our public engagement to date in relation to Transforming Clinical Services and the various associated projects have indicated that transport and access to services are major concerns for service users, particularly when they have to travel further to access services. Finding from the HB's recent public survey conducted to inform the Health Board's revised Equality Objectives for 2020 – 2024 indicated that disabled people, older people, transgender people and people from black and minority ethnic backgrounds identify as having worse experience of health services in comparison to the population as a whole across the Hywel Dda UHB area.

Common themes in relation to health services that emerged from the survey in relation to the experience of protected groups were access, communication, engagement and involvement, staff training (in relation to meeting the needs of individuals in relation to their protected characteristics) and barriers to accessing employment.

Each service will be responsible for undertaking equality impact assessments as appropriate in relation to proposals for their services.

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Winter Preparedness 2019/20
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Director of Operations/Deputy Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Alison Bishop, Unscheduled Care Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Board with details of winter preparations for the upcoming period of seasonal high demand expected to impact the local unscheduled care system. The winter plan itself, included as an attachment, provides details of the planning and associated actions to be deployed, whilst this report offers a general synopsis and overview of the intentions of the key components of the unscheduled care system.

The planning process has been driven from the perspective of maintaining safety, quality and continuity of care for Hywel Dda University Health Board's (HDdUHB's) patients through the most consistently challenging period in the NHS calendar.

Given that HDdUHB, with its Local Authority partners and Welsh Ambulance Services NHS Trust (WAST) have co-produced the plan, the plan was endorsed at the Integrated Executive Group Meeting which includes Directors of Social Services from all three Local Authorities, and those schemes agreed to be progressed via regional funding have been endorsed by the Regional Partnership Board.

Cefndir / Background

Winter Planning Process

The UHB commenced its preparations for winter in July 2019, following the Welsh Government Winter Planning Event on 25th June 2019 and in preparation for the first Winter Resilience Summit meeting between Welsh Government and HDdUHB held on 13th August 2019.

Targeted Financial Support from Welsh Government

In September 2019, Welsh Government (WG) confirmed the winter funding package to support delivery of health and social care services. In contrast to last year, this year the funding has been allocated to both Health Boards and Regional Partnership Boards (RPBs), with RPBs being identified as a key vehicle to support the integrated planning and delivery; as such, £17m of the funding package has been allocated across Wales. The West Wales RPB received a total allocation of £2.062m. Plans for the RPB element are required to demonstrate collaborative approaches to ease pressure on the system. These must be informed by

integrated, regional planning across health and social care services to support delivery of the Quadruple Aim. They must align with Health Board plans, reflect official guidance issued by Welsh Government and address the following seven themes:

- Optimising cross-organisational and sector working to support resilience
- Urgent primary care/out of hours resilience
- Preventing unnecessary conveyance and admission to hospital
- Discharge to assess/recover (D2AR)
- Community step down capacity
- An enhanced focus on the respiratory pathway
- An enhanced focus on the frailty pathway

Health Boards across Wales received a total funding package of £10m, of which the HDdUHB allocation is £1.213m. HDdUHB has also allocated £1m recurrently, to support new/additional initiatives across the acute sites. The total HDdUHB funding support for winter in our direct control is therefore ***£2.213m,*** of which £1m has been allocated recurrently and £1.213m on a non-recurrent basis.

In addition, there is the opportunity to bid for specific primary care schemes over and above the funding outlined above and WG continue to fund British Red Cross and Care and Repair initiatives at our acute hospitals.

Governance

The governance arrangements supporting the winter resilience plan set out how the effectiveness of plans will be monitored and reviewed throughout the winter period.

The draft plan and any additional costs have been discussed at the following meetings and the plan amended as a result:

- Finance Committee – 21st October 2019
- Executive Team – 6th November 2019
- Integrated Executive Group– for approval 11th November 2019
- Regional Partnership Board – final approval 14th November 2019
- Hywel Dda University Health Board – final approval - 28th November 2019

The result of this approach is a more streamlined plan, with weekly monitoring of the benefits and spend being undertaken during weekly winter conference calls with all partners.

Asesiad / Assessment

The process of planning for winter uses the same methodology as last year with an analysis of bed demand and capacity outturn positions for winter 2018/19. This approach focuses on the acute and community actions and initiatives best placed to close this gap. The bed gap consists of surge beds plus medical patients on surgical wards (outliers) plus patients lodging overnight in Emergency Departments (EDs) or Minor Injury Units (MIUs). This overall gap equates to 158 beds which need to be accommodated if we are to safely navigate through winter 2019/20.

Bed Capacity

Taking the 158 medical bed deficit opening position, and adjusting for known changes since last year, as well as allowing for tolerable whilst largely unavoidable capacity impacts arising from emergency department lodgings and general outlying; both without significant

detriment to clinical safety or patient experience, produces an overall bed deficit of 155 medical beds which needs to be addressed with winter actions to give assurance that the UHB has a plan to safely navigate through winter 2019/20.

Applying the impact of acute and community actions planned for 2019/20, including the opening of surge beds, this accounts for expected equivalent bed gains of 146 which would mitigate this gap and result in a final bed deficit of **9** medical beds. It is proposed that this residual gap of -9 beds, which is the same bed gap that the UHB faced going into last winter, is within a reasonable level of tolerance.

UHB Funded Actions

The initiatives within the winter plan are focused on actions that had a proven benefit in previous years or new/additional initiatives supporting patient flow across the acute sites.

The key actions are:-

- Extending the Geriatric review of care home patients to other care homes in Carmarthenshire
- Implementation of an ED streaming system at Withybush General Hospital
- Rotation of ED & Community Advanced Nurse Practitioners to work at the 'front door' to manage patients with long term conditions
- Extension of the British Red Cross 'Home from Hospital' service at Glangwili and Withybush General Hospitals
- Extension of the 'Care & Repair' service at Glangwili and implementation of a new service at Withybush General Hospital
- Extension of the Flu Point of Care testing
- Additional support to provide 7 day working e.g. additional therapy, medical, phlebotomy and support staff, additional discharge vehicles
- Additional daily 'hot clinics', both in and out of hours
- Increased opening hours for Minor Injury Units
- Additional surge capacity at peak periods

The costs of these actions is summarised below:-

University Health Board Winter Allocation	**Recurrent full year**	**Winter**
UHB recurrent allocation	£ 1,000,000	£ 1,000,000
WG allocation		£ 1,213,000
Total	**£ 1,000,000**	**£ 2,213,000**

Funded Actions		
Corporate	£ 301,644	£ 299,604
Bronglais	£ -	£ 422,225
Glangwili	£ 209,898	£ 698,527
Prince Philip	£ 100,185	£ 648,345
Withybush	£ 408,332	£ 460,866
Total	**£ 1,020,059**	**£ 2,529,567**
Variance	-£20,059	-£316,567

It should be noted that, of the £2,529,567 of local schemes, circa £0.9m relates to planned bed closures that will be delayed until April 2020. This will need to be carefully monitored over the winter period as, if these beds cannot be closed in 2020/21, this will be a recurring pressure.

Whilst the local schemes are currently showing a potential over-allocation of £316,567, the service areas are working with finance business partners to forecast their predicted spend over the winter period. In addition, due to delays in commencing the schemes and the ability to obtain locum/agency staff, there will already be slippage in October 2019. This will be monitored during the weekly conference calls that have already commenced.

Recurrent Investments
In addition to the above, our current planning has allocated £1m recurrently, to support new/additional initiatives across the acute sites. These are all subject to approval (and business cases where required). Whilst these are included above for the winter period, they have a recurrent cost and are summarised below:

- Additional therapy support at Glangwili, Prince Philip and Withybush Hospitals
- Additional pharmacy support at the 'front door' at all 4 sites
- Continuation and expansion of the Home Support Team at Withybush General Hospital to facilitate discharge
- New co-ordinator for the treat and repatriate Acute Coronary Syndrome (ACS) service that was piloted last winter

<u>RPB Allocation £2.062m</u>
In addition to the locally funded actions outlined above, the Integrated Executive Group agreed to a split of the regional allocation across counties on a population basis, resulting in the following local allocations:

- Carmarthenshire (48%) £989,760
- Ceredigion (20%) £412,400
- Pembrokeshire (32%) £659,840

The initiatives within the integrated winter plan are focused on actions that have had a proven benefit in previous years or new/additional initiatives supporting patient flow across community and social care services which will impact positively on patient flow at the acute sites.

The key actions are:

- Advanced care planning & Stay Well planning support to care homes
- Local commissioning for implementation of the 4 Discharge to Recover and Assess Pathways, including bridging service & Community Care Beds
- Establish a Chronic Obstructive Pulmonary Disease (COPD) pathway to improve self-management
- Dedicated Acute Response Team resource to support GP Out of Hours (OOH) services for palliative care patients, avoiding unnecessary conveyances to hospital
- Purchase of additional community equipment and leasing of vehicle to ensure delivery
- Extending evening and weekend opening hours of Porth Gofal (single point of contact) in Ceredigion
- Provision of planned weekend day centre support in Ceredigion
- Community mental health service crisis response service in Carmarthenshire
- Extending third sector support to palliative care patients
- Appoint housing officers to attend daily Board Rounds in acute and community hospitals

- Additional therapist hours to support enhanced Transfer of Care Advice & Liaison Service (TOCALS) cover across Carmarthenshire
- New admin flow coordinator to improve flow through the community hospital beds in Pembrokeshire

The costs of these actions is summarised below:

Regional Funding					
	Carms	**Ceredigion**	**Pembs**	**Corporate**	**Total**
WG allocation	£989,760	£412,400	£659,840	£0	£2,062,000
Funded Actions	£1,317,000	£423,335	£660,700	£45,000	£2,446,035
Variance	-£327,240	-£10,935	-£860	-£45,000	-£384,035

The regional plan is currently over committed by £384,035. This will be monitored on a regular basis; there is a high level of confidence that the deficit will be met through slippage.

Argymhelliad / Recommendation

The Board is asked to:

- Note the extent of preparations and planning undertaken ahead of winter 2019/20 and the position from which the unscheduled care service will enter winter;
- Note the content of the winter resilience plan;
- Take assurance from the measures the service has designed into its plan to tackle the pressures expected to impact through the period; and
- Approve the winter plan and allocation of funding and associated costs, as set out in this report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 629
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation 5.1 Timely Access 6. Individual care
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Welsh Government Winter Planning directives
Rhestr Termau: Glossary of Terms:	Within the document
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Finance Committee Executive Team Integrated Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There will be significant financial costs associated with winter planning, these are currently being evaluated and a decision on tactical investment will need to be considered by the Executive Team
Ansawdd / Gofal Claf: Quality / Patient Care:	Robust winter plans will ensure patient care continues to be provided throughout the winter period.
Gweithlu: Workforce:	Use of agency resources to mitigate internal human resource capacity limitations details are contained within the winter plans.
Risg: Risk:	The winter period presents heightened risk to the UHB with increased demand across the unscheduled care system. The risk issues associated with the unscheduled care system and across winter are recorded on existing risk registers. Due to bed reconfigurations and overspends on the acute sites some of the escalation capacity opened during 2018/19 will not be available for this year and this remains a significant risk at this point.
Cyfreithiol: Legal:	N/A
Enw Da: Reputational:	There could be significant reputational risks for the UHB and partners in the event of major incident.
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	Bespoke winter plans are in place for the three counties which reflect the needs of the population within each of these counties.

INTEGRATED WINTER RESILIENCE PLAN

2019/20

INTEGRATED WINTER RESILIENCE PLAN 2019/20

Contents

1. Introduction

This plan has been produced collaboratively with our Local Authority, Primary Care, Public Health and Welsh Ambulance Services NHS Trust (WAST) partners with the aim of articulating our winter preparations for 2019/20 in order that our local citizens' health care expectations and associated outcomes can be optimised during the forthcoming period of expected highest demand. This plan for winter 2019/20 focuses on the period 1st October 2019 through to 31st March 2020.

The University Health Board's (UHB) winter plan will focus on the additionality factor that was applied in previous years and rationalises the initiatives within a manageable cohort of themes centred on two aspects, namely reducing demand to a minimum and managing resultant demand effectively.

2. Partnership and Governance Arrangements

In line with guidance provided by Welsh Government and the UHB's Unscheduled Care Programme Meeting, the winter plan has been designed and prepared collaboratively with Local Authority, Mental Health, Primary Care, Public Health, WAST, and GP Out of Hours (OOH).

This plan will be approved in partnership with Local Authority partners through the Integrated Executive Group, and also requires approval from the Chair of the Regional Partnership Board and Hywel Dda University Health Board.

Governance Arrangements			
Responsible executive officer for winter resilience planning	Local Health Board Executive	Local Authority Executives	Welsh Ambulance Services NHS Trust Executive
	Joe Teape Deputy Chief Executive Officer Andrew Carruthers Director of Operations (w.e.f 2nd December 2019)	<u>Pembrokeshire</u> Jonathan Griffiths Director of Social Services & Leisure <u>Carmarthenshire</u> Jake Morgan Director of Community Services <u>Ceredigion</u> Carys James Director for Care & Protection & Lifestyle	Lee Brooks Director of Operations
Winter resilience planning:	• Welsh Government Winter Planning Event 25th June 2019 • Welsh Government Winter Summit Meeting 13th August 2019 • Winter Resilience Steering Group monthly meetings commencing 10th July 2019 • Finance Committee – 21st October 2019 • Executive Team – 6th November 2019 & 13th November 2019 • Integrated Executive Group– for approval 11th November 2019 • Regional Partnership Board – final approval 14th November 2019 • Hywel Dda University Health Board – final approval - 28th November 2019		

3. The Population and Health Perspective

The focus of the last 3 year's winter resilience plans has been to deliver additional actions in support of 'business as usual' activities during the winter period, as evidence shows that this was when demand on the unscheduled care services was at its greatest.

The local perspective is one of increasing demand and insufficient capacity across primary, secondary, social and residential care. Added to this, winter brings its own additional challenges including those arising from weather influences. In recent years, these pressures have tended to push out beyond the period generally acknowledged as winter and our elective care ambitions add further to the overall challenge. That said, the priority for winter is to maintain a safe and quality centred unscheduled care service for our patients whilst remaining within our financial means.

These challenges are described in the following specific paragraphs:

3.1. GP Out of Hours Services

The Out of Hours Service is responsible for providing access to Urgent Primary Care clinicians between 18:30 and 08:00 hours daily and 24 hours at weekends. The service, traditionally staffed by experienced General Practitioners, currently operates from 5 bases located across the Health Board. These are:

1. Bronglais General Hospital
2. Llandysul GP surgery
3. Withybush General Hospital
4. Glangwili General Hospital
5. Prince Philip Hospital

The Out of Hours (OOH) service continues to experience variable staffing positions, which result in frequent reductions in front line service provision. In order to provide a robust service during the winter, it is likely that changes will need to continue be made on an ongoing basis to centre opening times due to shortage of capacity to fill all shifts. An operational plan is in place to manage this on an ongoing basis. Specifically the Prince Philip Hospital's Minor Injury Unit will continue to support treatment centre activity for Llanelli patients and where needed GPs will be re-located between centres in order to provide maximum resilience and peer support. All staff, supported by the Advanced Paramedic Practitioner (APP), would also be expected to support with wider Health Board demand where it occurs, acknowledging the need to embrace cross-county collaboration by the eradication of county boundaries.

Additional measures are being put in place to support the service:

Measure	Benefit
Advice GP	Support the wider HB operation by increasing GP advice capacity
Introduction of Shift Lead GP	To assist with patient flow and allocation/ direction of available resources
Dedicated nurse response car	To support the OOH position and the existing ART caseload by providing dedicate response for OOH referrals- Catheters, verification of death and availability for palliative care calls are essential roles- with cross-border cooperation
Increase in APP rota	Increase APP by 24 hours over weekend hours
Home working GPs	To supplement the advice GP rota by operating from home at times of acute service pressure / escalation etc.

3.2. Bed Capacity

The process of planning for winter 2018/19 commenced with an analysis of bed demand and capacity outturn positions for winter 2017/18. This was a new approach to identifying the bed gap and allowed the acute and community to focus actions on those initiatives best placed to close this gap.

This methodology has been utilised again with the bed gap has been derived empirically from the actual January to March 2019 position. The gap consists of surge beds plus medical patients on surgical wards plus patients lodging overnight in Accident and Emergency Departments or MIUs. The overall gap equates to 158 beds.

Taking this 158 medical bed deficit opening position, some allowance has been made for what is considered tolerable but largely unavoidable capacity impacts arising from emergency department lodgings and general outlying; both without significant detriment to clinical safety or patient experience. (49 beds have been assumed in the plan to be utilised again this winter).

The analysis then assumes that medical bed closures (mainly reductions in surge beds and outliers) already achieved through improvement actions can be maintained over the winter period. (18 beds have been assumed in the plan to be utilised again this winter)

Applying this logic, the table below illustrates the opening position and the in-year adjustments that impact either positively or negatively:

2019/20 Winter Gap (Bed Equivalent)	Bronglais Hospital	Glangwili Hospital	Prince Philip Hospital	Withybush Hospital	Health Board
Last Year's Gap	-32	-48	-14	-64	-158
Current Tolerance for ED lodgers	7	10	0	8	25
Current Tolerance for outliers (i.e. no impact on electives)	8	5	1	10	24
Flow Improvements in 2019	1	0	3	14	18
Lost Capacity in 2019	0	-5	0	-16	-21
Further bed closures included in savings plans	-14	-8	-21	0	-43
Total Winter Gap	**-30**	**-46**	**-31**	**-48**	**-155**

The adjustments produce a bed deficit of 155 medical beds and applying the impacts of tactical improvements from the actions within this winter plan reduces the deficit to 9.

2018/9 Winter Planning Actions	Bronglais Hospital	Glangwili Hospital	Prince Philip Hospital	Withybush Hospital	Health Board
Total Winter Gap	**-18**	**-26**	**-14**	**-15**	**-73**
Corporate Schemes	3	5	3	3	14
Community Flow Improvements	6	5	3	11	25
Acute Flow Improvements	3	9	5	18	35
Acute Bed Capacity	18	27	22	5	72
Total Winter Plan	**30**	**46**	**33**	**37**	**146**
Residual Gap	**0**	**0**	**2**	**-11**	**-9**

It is proposed that the residual gap of 9 beds is within a reasonable enough level of tolerance that it can be absorbed through the benefit of schemes that have not been assigned a bed capacity improvement, coupled with further efficiency improvement work particularly in Withybush Hospital which shows a predicted 11 bed shortfall. This is an approach adopted in previous years.

4. 2019 /20 Tactical Actions (Appendix A)

The tactical actions aimed at reducing the equivalent bed gap are listed in the winter plan on a page included at Appendix A.

4.1. Targeted Financial Support from Welsh Government

In September 2019 Welsh Government (WG) confirmed the winter funding package to support delivery of health and social care services. In contrast to last year, this year the funding has been allocated to Health Boards and Regional Partnership Boards (RPBs), with RPBs being identified as a key vehicle to support the integrated planning and delivery, as such £17m of the funding package has been allocated across Wales. The West Wales RPB received a total of £2.062m. Plans for the RPB element are required to demonstrate collaborative approaches to ease pressure on the system. These must be informed by integrated, regional planning across health and social care services to support delivery of the Quadruple Aim. They must align with Health Board plans, reflect official guidance issued by Welsh Government and address the following seven themes:

- Optimising cross-organisational and sector working to support resilience
- Urgent primary care/ out of hours resilience
- Preventing unnecessary conveyance and admission to hospital
- Discharge to assess/ recover (D2AR)
  Community step down capacity
- An enhanced focus on the respiratory pathway
- An enhanced focus on the frailty pathway

4.2. Recurrent Initiatives

As part of the budget setting process, HDdUHB has allocated £1m recurrent funding to support new or additional initiatives during the winter period and to ensure that these key actions can continue on a sustainable basis.

Previously, any actions have been funded on a non-recurrent basis through the additional winter monies provided by Welsh Government and scaled up over the winter period of October to March and then scaled down again in April. However, the pressures on the unscheduled care system that these actions seek to address, are now present throughout the year and, as such, the initiatives need to form part of our core services.

The recurrent funds of £1m have been allocated to a small number of schemes that will deliver the biggest impact across the acute sites to help alleviate the continued additional pressure on the unscheduled care system. These schemes are:

- Pharmacy at the Front Door

From January to March 2019 WG provided a small amount of additional funding to undertake a number of pilots to provide pharmacy cover in Emergency Departments (ED). There were a number of benefits demonstrated by these pilots including improved patient flow and preventing harm. Currently within HDdUHB there is limited cover for ED, whilst some ad hoc cover is provided during extreme pressures this funding would provide cover across all 4 sites on a permanent basis, extended weekend opening hours and support the wider roll out of Medicines Transcribing and Electronic Discharge (MTeD)

- Additional Therapy Support

Over the last 2 winters, the acute sites have sought to address the gap in therapy services by utilising locums and/or HDdUHB staff on an ad hoc basis to provide additional support to the EDs to avoid admissions or to the acute wards to facilitate discharge at weekends. Securing this support in this way has been problematic and costly where locums have been able to be secured. This recurrent funding will allow substantive recruitment of additional occupational therapists and physiotherapists across Glangwili, Prince Philip and Withybush Hospitals. These therapist posts will be pivotal in improving care and the reducing the length of stay.

- Home Support Team

This home support service, currently in place across Orthopaedics and General Surgery at Withybush Hospital , bridges the gap between acute and community and reducing the average length of stay, particularly for those having suffered a fractured hip. The proposed scheme is to extend this service across the general medical and stroke wards. The service would operate 7 days a week, providing direct care and support for up to 2 weeks following discharge. This will assist patients to return home in a more timely way which will, in turn, improve flow through the hospital reducing waits for inpatient beds as well as supporting earlier assessment and commencement of treatment. Patient & staff feedback of the existing home support service has been extremely encouraging with several examples of positive patient feedback having been received.

- Acute Coronary Syndrome (ACS) Treat & Repatriate Coordinator

As part of the winter plan in 2018/19, 6 beds were reconfigured at Prince Philip Hospital to provide a treat and repatriate service for ACS cardiac patients from Bronglais and Withybush Hospitals awaiting treatment at Morriston Hospital. The aim of this service is to avoid unnecessary delays whilst awaiting transfer and to facilitate improved patient flow on the acute sites. This service has continued to be provided and to ensure continued delivery of efficient service, a Band 8a ACS Treat & Repatriate ANP/Coordinator is being sought along with some additional medical cover. The ANP element of this role will support the on-going clinical management of patients using this service, whilst the coordinator element will provide leadership and liaison in terms of necessary processes and communication between sites within the Health Board and with Morriston Cardiac Centre. Combined, both elements of the role will build on the successes of the service to date and further reduce length of stay.

- Glangwili Front Door Support

In order to facilitate patient flow and avoid unnecessary admission or increased length of stay an additional band 3 frailty Support Worker and an additional band 2 Porter are being sought for the Clinical Decisions Unit/Emergency Department at Glangwili Hospital. These posts will be in addition to the current team and allow the services to be delivered over extended hours during weekday evenings and weekends.

4.3. Mental Health Initiatives

As part of the Implementation of Transforming Mental Health, the Community Mental Health Teams and Crisis Resolution Teams will be merged in order to resource Community Mental Health Centres. The aim of which would be to develop a service available 24/7 and reduce the reliance on A & E departments, as there will be alternative provision. This has started in Ceredigion with a view over the next two to three years to role this out in other areas

A twilight drop in service has been developed in Llanelli and operates from Thursday to Sunday, the impact of this service will be measured and the success of this pilot may lead to further roll out across the health board.

In Pembrokeshire a Mental Health practitioner will be working with 2 GP surgeries to provide advice and support, it is anticipated that this post will reduce reliance on secondary care as well as A&E presentations

The development of a Single Point of Access will also provide an opportunity to sign post people to services more appropriate to meet their needs, rather than attending an A&E department.

4.4. Staff Health & Wellbeing Initiatives

The communications plan, see Appendix C, details actions focused on supporting staff well-being;

- Focused communications around staff flu vaccination;
- New staff well-being poster campaign see being distributed to all acute and community hospital sites
- Video explainers from staff case studies where colleague compassion has helped them. This all complements what we have already started with ‘This is me’ videos celebrating the diversity of staff and forthcoming staff values videos
- Celebrating staff and create a shared community – i.e. our Christmas and Boxing Day selfies

5. Escalation

5.1. Acute Site Escalation Plans

Comprehensive escalation plans are in place across each of the acute, community and mental health systems and in addition, situation reports (SITREP) for all parts of the system including primary care will be available daily throughout the winter period.

5.2. Ambulance Off Load Policy

In line with the NHS Wales Ambulance Availability Protocol, the Health Board developed an Ambulance Off Load Policy to ensure delivery of safe, effective and dignified care to patients when they arrive by emergency ambulance transport at hospital, to achieve optimal outcomes for patients and also to ensure that ambulance crews are released to respond to other patients in the local community.

In times of escalation, actions will have to be undertaken by Emergency Department (ED) and ward staff that are not part of their normal practice. Patients who are waiting in ambulances are those most at risk, as they require medical investigation and treatment. Therefore, delays at this point can significantly affect the quality and outcome of care. This policy seeks to provide clear procedures in order to minimise the known risks associated with the practice of off-loading ambulances at time of increased capacity. The policy also reinforces the need to maintain good communication with patients and their family/carers throughout the process and ensure safe staffing levels.

6. Performance

The effectiveness of this plan will be monitored through a number of system wide indicators, both in terms of in year trends and comparison with last year:

- Impact on unscheduled care performance standards – 4-hour, 12-hour, 1-hour, ambulance response times
- Cancellations of operations due to bed shortages
- Excess numbers of medical outliers
- Delayed Transfers of Care, medically fit numbers and days lost

The Unscheduled Care Programme have agreed a suite of system wide measures to enable the whole system’s unscheduled care performance to be monitored and evaluated.

7. BREXIT (Appendix B)

A review of the impact Brexit may have on the additional winter actions has been undertaken and any consequences fed back to the Brexit task and finish group for consideration and any mitigating actions to be taken, is included at Appendix B.

8. Winter Wise Communication Plan 2019/20 (Appendix C)

The purpose of the Communications Plan is:

- To gain high exposure amongst the general public for key winter health information, focusing on keeping yourself well (flu), choosing the best health service to meet your needs (particularly around community pharmacies), and looking after your vulnerable family and neighbours.
- To build public confidence and improve take up of the flu vaccination.
- To reduce unnecessary attendances at emergency units by diverting appropriate patients elsewhere in the health service.
- To educate and inform the public, via innovative new communications techniques and platforms, about our operational and escalation procedures during times of peak pressure, and to use this awareness to signpost to alternatives (as above).
- To boost staff morale for those working in challenging, busy winter conditions and to give public confidence by issuing positive, proactive stories.

In addition, the UHB will play a part in a national drive to educate and communicate to the public regarding certain issues – this is likely to take the form of national media briefings by spokespeople from across all Health Boards on a rotational basis.

9. 18 Day Operational Plan (Appendix D)

The detailed 18-day operational plan, which includes management arrangements for the bank holidays and weekends amounting to nine days that fall within the period 23rd December 2019 to 12th January 2020, is included at Appendix D.

10. Influenza Vaccination Plan (Appendix E)

The influenza vaccination plan on a page, which has been developed and led by the Director of Public Health, is included at Appendix E.

APPENDICES

Appendix A – Winter Planning Tactical Actions

Reducing Demand

WAST
Development of a non-injured fallers service in partnership with Fire Service & St Johns Ambulance
Manchester triage of patients on the ambulance stack
Analysis of the Carmarthenshire conveyance rate

Primary Care
Extended opening hours;

OOH
Integrated nursing approach with ART teams

Community
Continue bridging initiatives in Carmarthenshire & Pembrokeshire
Crisis response teams offering alternative pathways and virtual ward
Establish a COPD pathway to improve self-management
Provision of planned weekend day centre

Secondary Care
Further development of geriatrician review of care home patients project
Additional evening 'Hot Clinics' at Glangwili Hospital
Improved use of Ambulatory Care Units
Clinical Redirection from ED at Withybush Hospital–with primary care, OOHs, community & WAST
Pilot project with ANP for long term conditions working across front door & community

Public Health
Improved vaccination for flu – focused proactive call & recall service across all 7 primary care clusters
Focused campaign for 'super spreaders' 2/3 year olds & partnership working with community midwives to improve vaccination rates

Mental Health
Developing 24/7 CMHT/CRHTT
Llanelli drop in centre – twilight service Thursday to Sunday

Managing Demand

WAST
HALO for Glangwili & Withybush Hospitals
Management of WAST stack by HALO/APPs

Community
Commission additional step down / care home beds
New leadership model for community beds in Pembrokeshire

Secondary Care
Pharmacy at the 'front door' & extended weekend opening
Introduction of Pitstop model into ED at Withybush
Additional A&E staff to cover peaks in demand
Proposed MIU opening times 24/7 at Glangwili
Extension British Red Cross 'Home from Hospital'
Exploration of Hospital @ night model in Glangwili
Daily frailty / hot clinics to support frailty assessment teams at the front door
Scheduling of GP patients to AEC - avoiding batching
Dedicated co-ordinator for ACS patients and 'treat & repatriate service'

Mental Health
Escalation protocol for admitted patients
Liaison teams working in partnership with front door

Public Health
Focus on long stay patients & outpatients to improve flu vaccination rates
Provide in house flu testing at all acute sites

Enhancing Operational Grip

Development of on-line SITREP reporting and on call arrangements
Robust on-call management - doubling up on call/senior support/management lead for the day
Establish Control centre with named manager of the day - WAST manager to attend during periods of high escalation
Director of Operations acting as Executive on-call & chairing daily conference calls during Jan 2020

Reducing Length of Stay

Community
Implement D2AR pathways & commission D2AR care home placements
Purchase additional community equipment & To lease additional vehicle and appoint driver to ensure that equipment is delivered
Dedicated social worker for Bronglais Hospital & cross border discharges
Appointment of 3rd sector co-ordinators to support complex discharge planning in Carmarthenshire
Additional weekend working for 'front door' turnaround team in Withybush Hospital
Additional flow co-ordinators for community hospital beds in Pembrokeshire
Integrated working with housing department in Carmarthenshire to reduce delays in discharge
Implement Care & Repair in Withybush Hospital

Secondary Care
Extend 'home support team' to work across general medical & stroke beds in Withybush Hospital
Additional weekend capacity to support 7 days working; medical, therapy, pharmacy & support staff, discharge vehicle
Additional echocardiography clinics / support
Additional frailty support worker on CDU in Glangwili
Extended discharge lounge opening times
'Perfect week' – 4 & 2 weeks prior to and 2 weeks post-Christmas
Intensive review of stranded patients
Extension of 'care & repair' service to Pembrokeshire

Improving Patient Experience

Safer staffing extra nursing hours in ACU/ED
Delivery of respite & palliative care services in the community by 3rd sector
Proactive messaging for respiratory patients
Porth Gofal - extending opening hours to evenings and weekends
Utilise existing services to also transport drugs and prescriptions where known gaps in provision

Appendix B – Brexit Considerations

Winter Initiative		Initiator	Brexit Impact (Y/N)	Impact Details	SRO
4	Bridging initiatives Carmarthenshire & Pembrokeshire	Community	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit and retain unless the mileage rates are adjusted.	Rhian Dawson Elaine Lorton
5	Crisis response teams offering alternative pathways & virtual	Community	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit and retain unless the mileage rates are adjusted.	Rhian Dawson
12	Developing 24/7 CMHT/CRHTT	MH&LD	Y	Possible increased number of referrals e.g. Farming community	Liz Carroll
15	Community step down/care home beds	Community	Y	Instability in the care home sector may reduce capacity – not all BREXIT related	Peter Skitt
16	Additional community nursing & ART resource in Ceredigion	Community	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit and retain unless the mileage rates are adjusted. Some staff utilise pool cars therefore risk to individual is reduced but the cost is transferred to the HB.	County Directors
20	Additional A&E staff to cover peaks in demand	Acute	Y	Potential cost impact for staff if petrol prices increase Lack of availability of agency staff.	
28	In house flu testing	Public Health	Y		Public Health
35	Implement D2AR pathways & commission D2AR care home placements	Community	Y	Instability in the care home sector may reduce capacity – not all BREXIT related	County Directors
36	Community equipment	Community	Y	Critical lines and non stock has been reviewed – limited short to medium term impact – potential for long term impact depending on suppliers	County Directors
38	Dedicated social worker at Bronglais	Community	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit and retain	Peter Skitt
39	Third sector co-ordinators – discharge planning	Community	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit and retain	County Directors
43	Additional home support team to work across acute beds in Withybush Hospital	Acute	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit and retain	Janice Cole-Williams
44	Additional weekend capacity to support discharges – medical, therapy, facilities staff	Acute	Y	Potential cost impact for staff if petrol prices increase Lack of availability of agency staff.	General Managers
52	Phased implementation of Nurse Staffing Act	Acute	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit	General Managers
53	Dedicated co-ordinator for ACS patients and ' treat & repatriate' service	Acute	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit	Brett Denning
54	Delivery of respite and palliative care in community by 3rd sector	Community	Y	Potential cost impact for staff if petrol prices increase – this may make it more difficult to recruit and retain unless the mileage rates are adjusted.	County Directors

Appendix C – Winter Wise Communications Plan

<table>
<tr><th colspan="3">Winter Wise Communications Plan</th></tr>
<tr><th>Reducing Demand</th><th>Managing Demand</th><th>Enhancing Operational Grip</th></tr>
<tr>
<td>Choose Well – signposting to on-line Directory of Services

Working closely with Flu Communications Lead and Public Health Wales Team colleagues to ensure a robust and consistent approach to reducing winter pressures through promotion of the seasonal flu vaccination campaign for healthcare staff and eligible population groups

Social media themed campaigns;
Frailty & Falls. Highlighting the importance of looking after vulnerable relatives and neighbours and ensuring they don’t have to come to A&E
Minor Injuries Units. Tenby, Cardigan, Llandovery – what they can do for people living in respective communities
Respiratory conditions. The importance of not letting a cough or could get worse and develop into an infection / acute admission
Winter wise themed articles to be distributed on social media (Twitter, Facebook) through October-February

Utilising Teulu Jones animation – encouraging use of Pharmacy Walk-in Centre & explaining Triage and Treat</td>
<td>Winter Wise branding on all Health Board owned digital screens and Primary Care commissioned services

Flu articles to be distributed on social media, at least one article targeted at each eligible group (pregnant women, chronic conditions, carers, frontline NHS staff)

Targeted social media campaign: Hospital flow and clinical prioritisation of patients to manage expectations

Proactive pre-Christmas message via social media; if you’re feeling unwell or have a non-urgent but longer term medical complaint, book in to see your GP now – don’t leave it too late

Improving Patient Experience

Updating links to useful existing web pages - NHS Direct Wales, Choose Well, Seasonal Flu pages, Hospital contact details, Primary care opening hours, weather warnings) and any emerging news (ward closures, visiting restrictions, postponed operations etc.)

Publish videos showcasing staff at work during times of peak pressure and appealing to the public to choose well.</td>
<td>Significant Met Office hazard warnings to be published to staff through Intranet and global email as appropriate, and if site specific, on our Internet and social media. Reactive Comms desk signed up to receive alerts

Winter wise themed articles to be distributed internally (staff newsletter, global email), externally (media releases, owned newsletters)

Supportive and encouraging global emails for staff pre-winter period and encourage sharing of messages

Distribution of staff wellbeing checklists at acute sites and via county teams including Interview with Simon Clothier, community staff nurse on staff wellbeing

Selfies/photos of winter heroes who work 24/7 to keep us well – promoted internally and externally through usual channels

Staff Christmas Day/New Year’s Day selfies & staff delivering Christmas Day and New Year’s Day babies</td>
</tr>
</table>

Appendix D – 18 Day Operational Plan

23rd to 29th December	30th December to 5th January	6th to 12th January
Additional community nursing & acute response team (ART) resources	Additional community nursing & acute response team (ART) resources	Additional community nursing & acute response team (ART) resources
Extended MIU opening hours	Extended MIU opening hours	
Additional GP & A&E Consultant cover on shop floor on bank holidays	Additional GP & A&E Consultant cover on shop floor on bank holidays	
Spot purchase additional step down beds	Spot purchase additional step down beds	Spot purchase additional step down beds
Additional support to improve discharge profile weekend and bank holidays	Additional support to improve discharge profile weekend and bank holidays	Additional support to improve discharge profile weekend and bank holidays
Pharmacy at the 'front door' & extended weekend opening	Pharmacy at the 'front door' & extended weekend opening	Pharmacy at the 'front door' & extended weekend opening
Dedicated co-ordinator for ACS patients at Prince Philip to ensure improve transfer times	Dedicated co-ordinator for ACS patients at Prince Philip to ensure improve transfer times	Dedicated co-ordinator for ACS patients at Prince Philip to ensure improve transfer times
Intensive review of stranded patients, improving discharge profile		Intensive review of stranded patients, improving discharge profile
Perfect week - focused actions related to improving social care discharge profile (GGH & WGH)		Perfect week - focused actions related to improving social care discharge profile (GGH & WGH)
Extension British Red Cross 'Home from Hospital'	Extension British Red Cross 'Home from Hospital'	Extension British Red Cross 'Home from Hospital'
	Release Senior Manager capacity - cancellation of all non-essential meetings (until 18th January), focusing support to acute sites	Release Senior Manager capacity - cancellation of all non-essential meetings (until 18th January), focusing support to acute sites
Robust staffing rotas - nursing & medical staff (annual leave management)	Robust staffing rotas - nursing & medical staff (annual leave management)	Robust staffing rotas - nursing & medical staff (annual leave management)
Management of WAST stack by HALO/APPs	Management of WAST stack by HALO/APPs	Management of WAST stack by HALO/APPs
Enhanced on-call rota - doubling up of on call managers at peak demand, ensuring strong operational experience	Enhanced on-call rota - doubling up of on call managers at peak demand, ensuring strong operational experience	Enhanced on-call rota - doubling up of on call managers at peak demand, ensuring strong operational experience
	Director of Operations - Executive on-call for first 2 weeks of January & chairing daily conference calls, providing consistent support to site teams	Director of Operations - Executive on-call for first 2 weeks of January & chairing daily conference calls, providing consistent support to site teams

Appendix E - Influenza Vaccination Plan

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda University Health Board
Influenza Vaccination Improvement Plan
2019/20

Click on the arrow to move to the contents page

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	NHS Delivery Unit (DU) Audit on Primary Mental Health Services for Children and Adolescent Mental Health Services (SCAMHS)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Deputy Chief Executive/Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joe Teape, Deputy Chief Executive/Director of Operations

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide Hywel Dda University Health Board (HDUHB) with an assurance that an action plan has been developed, following the NHS Delivery Unit (DU) Audit undertaken on the Primary Mental Health Service (PCAMHS) for children and young people provided within Hywel Dda UHB.

On 20 June 2019, the Minister for Health and Social Services provided an update to the Assembly's Children Young People and Education Committee on progress against the Mind over Matter report. During the discussion on improvements to the CAMHS primary care services, the Committee Chair requested both the national Delivery Unit Report and the individual LHB reports be shared with the Committee.

In response, the Minister has agreed that all Health Boards would ensure their Delivery Unit report and related action plan would be considered during a Board meeting and place both elements in the public domain. This was communicated by letter from Joanna Jordan, Director of Mental Health, National Health Service – Governance and Corporate Services. The update to the Board will also include details of how the additional funding would respond to the Delivery Unit findings.

The Delivery Unit report, subsequent action plan and letter can be viewed via the following links:

HDdUHB Delivery Unit Review report
Hywel Dda UHB under 18 LPMHSS Delivery Unit Action Plan
Welsh Government Letter to Health Boards

Progress of the action plan is monitored via the Mental Health and Learning Disabilities Quality, Safety, Experience Sub-Committee and is on track for delivery.

Cefndir / Background

Meeting the emotional and mental health needs of children and young people enables them to develop resilience, to grow and develop to their full potential.

These needs are frequently met within the family, by education and youth services. However, where children and young people experience more profound emotional or mental health problems they may require more specialist Child and Adolescent Mental Health Services (CAMHS). Early intervention from these services increases the potential for recovery, limiting the impact of these problems on the young person's development.

Previous reports and reviews of SCAMHS in Wales have looked at a variety of aspects of this service provision including accessibility, issues raised and identified by both service users and their families, and those of the wider stakeholders including GPs and the services themselves.

The Mental Health (Wales) Measure 2010 was introduced as a Wales specific piece of legislation in order to improve the delivery of mental health services to people of all ages in Wales. This included the development of Local Primary Mental Health Support Services (LPMHSS) including services to people under the age of 18 years.

The NHS Delivery Unit (DU) was commissioned by Welsh Government to undertake an assurance review using an appreciative inquiry approach that sought to provide a constructive feedback to impact positively on service provision.

The review consisted of two separate, but related, strands to be undertaken in each health board:

- A DU review of primary care Child and Adolescent Mental Health Services (CAMHS) services and wider NHS primary care provision.
- A CAMHS Network collaborative review of wider Primary Care CAMHS stakeholders to measure current stakeholder engagement with Primary Care CAMHS in Wales

This was undertaken from September 2018 to April 2019. The CAMHS Network approached the wider stakeholder analysis in 3 distinct phases:

- **Phase 1** was the design and roll out of an on line smart survey. This was designed by the CAMHS Network team and sent to health boards who were responsible for disseminating widely to their Primary Care CAMHS stakeholders.
- **Phase 2** consisted of a site visit to each health board area for the convening of a Stakeholder Engagement Discussion Meeting. Each health board was responsible for arranging location and inviting Primary Care CAMHS stakeholders to the meeting.
- **Phase 3** focused on gaining wider service user feedback including that of young people, their families, siblings and carers at each health board. This took the form of one to one meetings on an individual service user basis. However, if service users preferred, a telephone call was offered to them at a time that suited them best. This telephone call was offered with consideration of school and college hours of young people and the working commitments of parents and adult carers.

Review Methodology

- Audit of case notes
- Feedback from Patients, Families and Stakeholders
- Semi-structured interview with Managers
- Desk top review of policies & data

Asesiad / Assessment

The review of Primary Care CAMHS (known as under 18's LPMHSS) in Hywel Dda University Health Board took place between 12th and 22nd November 2018. Verbal feedback was provided to the Health Board Directorate Managers on 29th November 2018.

Key Findings

1. Under 18 LPMHSS in Hywel Dda University Health Board (HDUHB) operates as a discrete team, within a unified CAMHS management system.

2. The CAMHS service operates a Single Point of Contact (SPOC) which receives all referrals and serves to gather additional information as required, reviewing referrals in a dynamic manner. The operation of the SPOC and its managerial arrangements were considered an example of good practice, delivering timely and effective signposting, information and advice to referrers and assisting the management of demand on the whole CAMH service.

3. Staff within under 18s LPMHSS presented as dedicated and committed, with regular peer support from colleagues.

4. Under 18s LPMHSS are structured around the boundaries of the 3 local authorities within the HDUHB "footprint". However, the staff in each area undertake assessments and interventions across the HB footprint to assist the management of demand.

5. Practitioners have access to an IT system which allows the recording of fully integrated case records. However, the lack of mobile IT equipment, prevents staff from maintaining contemporaneous records whilst working in dispersed locations. The multiple IT systems prevents managers from using data in a timely manner to understand demand and capacity and the use of manual submissions leads to inaccuracies in data reporting and validation.

6. Demand on the service follows clear and predictable patterns and has not increased over the last 3 years. Assessment activity reflects seasonal variation and working patterns and represents a reduction in the number of assessments undertaken between July 2015 and June 2018. Referrals have remained broadly static during this period.

7. Whilst workforce has increased since the implementation of the Measure, the service remains very small and lacks the critical mass to meet demand and to adequately provide all five of the LPMHSS functions. These include:

   1) and (2) Undertaking assessments and interventions
   (3) The Measure requires that LPMHSS staff signpost children and young people to other services
   (4) Liaise with agencies to provide support in meeting need
   (5) Provide information and advice, which should be directed not only to children and their families but also to schools, General Practice, and other statutory and non-statutory child and family services meeting the needs of children and young people experiencing emotional and mental health problems. The provision of advice and information can assist other agencies to increase their confidence and competence in meeting the needs of children and their families

Performance and waiting list data suggest that children are being assessed and treated within 28 days of referral; where the service needs to be strengthened is in other aspects of the five functions – the recent additional resources from Welsh Government will assist with this as well as the pilot Schools In Reach project that is currently in place – it is hoped that this will be strengthened further.

The assessment process is comprehensive, covering a range of categories and case records demonstrated a rationale for outcomes reported. Staff reported that the time taken to record assessments was not always proportionate to presenting need.

The number of interventions being commenced each year has increased, with the majority of children being seen within 28 days. The main therapeutic modality identified in the case note audit is Cognitive Behavioural Therapy.

The support and advice function is highly valued by under 18s LPMHSS staff. However, teams report an inability to provide this consultative work to the extent that they would wish, due to competing and prioritised pressures to meet WG assessment and intervention targets. Staff believe that consultation, information and advice is a vital part of prevention and early intervention work, and in reducing demand for CAMH services.

The schools in-reach pilot is in its early stages and may serve to recreate the previous input from under 18s LPMHSS into schools, preventing the need for formal CAMHS referrals.

The perception of GPs is that CAMHS services are underdeveloped and underfunded and as a result they are not currently able to provide a timely response. Referrals are perceived to be frequently rejected leading some GPs to not refer cases they otherwise would. GPs would value improved feedback from under 18s LPMHSS and SCAMHS on the outcome of assessment and intervention.

Funding

Additional Welsh Government allocation of funds for 2019/2020 are being utilised by the Directorate to support the findings of the report in those areas where additional resources were required. Bids have been submitted to and approved by Welsh Government, the full year effect of the additional funding is £321,007. The service is now in the process of securing additional resources and equipment to ensure progress against the action plan. The following outcomes are expected to be achieved:

Workforce

- All patients presenting to Primary Care will be assessed by a Primary Mental Health Worker
- Primary Mental Health clinicians will undertake assessment and treatment within the patient's local area.
- PMHW will support primary care practitioners in education and child services through liaison, consultation, supervision and advice.

Clinical

- Children and young people able to access specialist physical and psychological intervention in a timely manner and as clinically indicated.
- Children and young people and their families have access to specialist services
- Direct support in Primary Care settings in assessing and treating young people.
- Consultation and support for all primary care staff.

Risk reduction

- Specialist timely assessment to determine level of risk.
- Timely access to evidence based treatment reducing the risk of physical and psychological deterioration, morbidity and mortality.
- Children and family and professionals better able to manage physical and psychological risks associated with presentations

Recovery Focus

- Specialist primary care clinical interventions will improve adherence to treatment.
- Early intervention will improve prognosis.
- Early recovery as the focus.

Cost Effectiveness

- Effective assessment and treatment leading to increased compliance with care plan, reducing length of time in services.
- Early intervention and prevention improving recovery and reduced , psychological and social effects

The findings of the report and the associated actions as recommended within the report have been accepted by the service with an action plan which is on track for delivery. This is monitored through the Mental Health and Learning Disability Quality, Safety, Experience Sub-Committee.

Argymhelliad / Recommendation

The Board is asked to note that the action plan is in place, supported by a tracker system to ensure that all actions are monitored for delivery within the required timescales.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	5.2 Provide assurance to the Board that risks relating to quality, safety, statutory duty/inspection (and workforce/OD/staffing/competence and safeguarding via Sub Committees) are being effectively managed across the whole of the University Health Board's activities, including for hosted services, and through partnerships and Joint Committees.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce Support people to live active, happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk registers on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners

Rhestr Termau: Glossary of Terms:	Risk Appetite - *the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009) Risk Tolerance - *the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives* (ISO Guide 73, 2009)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	MH&LDQSESC MH&LD Business, Performance and Planning Group QSEAC

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are financial impacts associated with the current risks, mainly in relation to variable pay – medical and nursing as well as an over-stretched commissioning budget.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from the report however impacts of each risk are outlined in the risk description.
Gweithlu: Workforce:	There is an impact for the work force as many of the risks are associated with recruitment challenges. The workforce will need to be redesigned on the basis of safe and sustainable staffing.
Risg: Risk:	The Directorate works continually to mitigate risks as the service needs evolve.
Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: Reputational:	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: Privacy:	No direct impacts.
Cydraddoldeb: Equality:	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No A full EqIA was undertaken on the Transforming Mental Health Programme of work.

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Major Trauma Network Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Steve Moore Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Miles Director of Planning, Performance, Informatics & Commissioning

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to update Hywel Dda University Health Board on the current status of the Programme Business Case being progressed by the Major Trauma Network [MTN] implementation programme.

Cefndir / Background

This report focuses on MTN programme activity undertaken since September 2019 (Hywel Dda University Health Board received a comprehensive report at its September 26th Public Board meeting) and outlines the status of the overall Programme Business Case [PBC], with steps required from now to ascertain approval to take the PBC forward to Network launch.

Board Members will recall that there are significant clinical drivers for change and there is clear evidence that this new service will deliver significantly improved outcomes for patients suffering major trauma. To this end, the MTN operational model will comprise:

Major Trauma Centre [MTC] – based at the University Hospital of Wales, Cardiff; optimised consultant level trauma care for all types of severely injured patients.

Trauma Units [TU] – optimised for definitive care of injured patients, and, provide a managed transition to rehabilitation and community care. TUs will have a role for receiving patients back from the MTC who require ongoing care in hospital, via an automatic repatriation policy. Glangwili Hospital will be the TU for Hywel Dda, in the years leading up to the building of our new Urgent & Planned Care Hospital.

Trauma Unit with Specialist Services – in addition to the above specification for TUs, Morriston Hospital will provide specialist services support to the MTC and provide specialist surgery for patients who do not have multiple injuries, given the presence of burns, plastic, spinal and cardiothoracic surgery at Morriston.

Local Emergency Hospitals/Rural Trauma Facilities [LEH/RTF] – these will be hospitals within the Network, which do not routinely receive major trauma patients, however, they must have processes in place to ensure that should this occur, there is appropriate initial management and transfer to the MTC or nearest TU. Bronglais and Withybush Hospitals will be RTFs within the Hywel Dda region.

Rural Trauma Facility – A bespoke term for Wales/Hywel Dda that has been adopted in recognition of the fact that, within Hywel Dda there are hospitals that would usually be seen as a standard LEH (not normally receiving patients with Major Trauma), but because of geographical location will inevitably on occasion need to provide services – predominantly resuscitation/stabilisation – of patients with major trauma.

Rehabilitation – hyper-acute rehabilitation will be initiated early at the MTC with local rehabilitation occurring in hospitals and the community within each Health Board. Specialist rehabilitation will continue to be managed at Rookwood Hospital, Cardiff and Neath Port Talbot Hospital.

To support the Network, there will be a pre-hospital triage tool to convey patients directly to the MTC or TUs. This tool will be operated by Welsh Ambulance Services NHS Trust (WAST), the Emergency Medical Retrieval and Transfer Service (EMRTS), Search and Rescue Services and voluntary agencies.

Asesiad / Assessment

The report to the Hywel Dda Public Board on September 26th 2019 focused on and agreed:

- The outcome of the public engagement process.
- Acknowledged the report from the CHC and its recommendations.
- The recruitment of key enabler roles that are required to launch the MTN on April 1st 2020, with associated local costs of £70k in 2019/20. The full year effect to support these roles totals £415k in 2020/21, with following years requiring investment of £515k per year as the Trauma Unit become fully strengthened.
- There is also a requirement to contribute to the general operational costs of the overall MTN, via WHSSC contributions, which will be c. £262k for 2019/20 and are likely to be circa £2.48m per annum from then on, subject to the approval of the programme business case.

Since the report of September 26th 2019, the MTN Board has concentrated on finalising the PBC. The last MTN Board on October 21st 2019 reviewed the content of the PBC in detail, with the following amendments, comments and tasks agreed:

- There is a key risk in that Cardiff & Vale UHB still needs to secure funding to set up the poly-trauma ward at the MTC. However, so as not to hold up the April 2020 implementation, work has already started to move wards to accommodate the poly-trauma elements of the MTC in anticipation of funding endorsement.
- The MTN Board has established a Workforce Sub Group to propose mitigation to combat the recruitment impact of the large number of new roles that will be required (example of 81 new posts to MTC required for Go Live on April 1st 2020). The aim is to focus on expanded roles (e.g. AHPs undertaking geriatric assessments), opportunities to have rotational posts, Network wide posts and portfolio careers, including Emergency Medicine consultant posts. This will require longer term strategic planning and will need senior workforce/OD executive engagement from each Health Board.
- The All Wales Repatriation policy is being revised to take account of the MTN Repatriation protocols. It is expected that this new policy will be issued in November 2019. The HDUHB project team has held a workshop with clinicians and managers to determine how patients will be managed once they are ready to return to Hywel Dda from the MTC, including accepting specialty, expected length of stay, onward transfer arrangements etc. Further work, including the holding of a virtual ward round exercise with Rehab Medicine consultant input, is planned.
- The Operational Delivery Network [ODN] authority and governance arrangements are to be worked through in November 2019. It was agreed at the MTN Board on October 21st 2019 that this section in the PBC needs more work and it has been made clear by WHSSC that the ODN will not have financial authority i.e. no ability to impose financial penalties.

- A Network Communications Strategy will be developed. The Director of NHS Wales Health Collaborative will take the lead on this, and is heading up an engagement meeting with all Community Health Councils in November 2019.

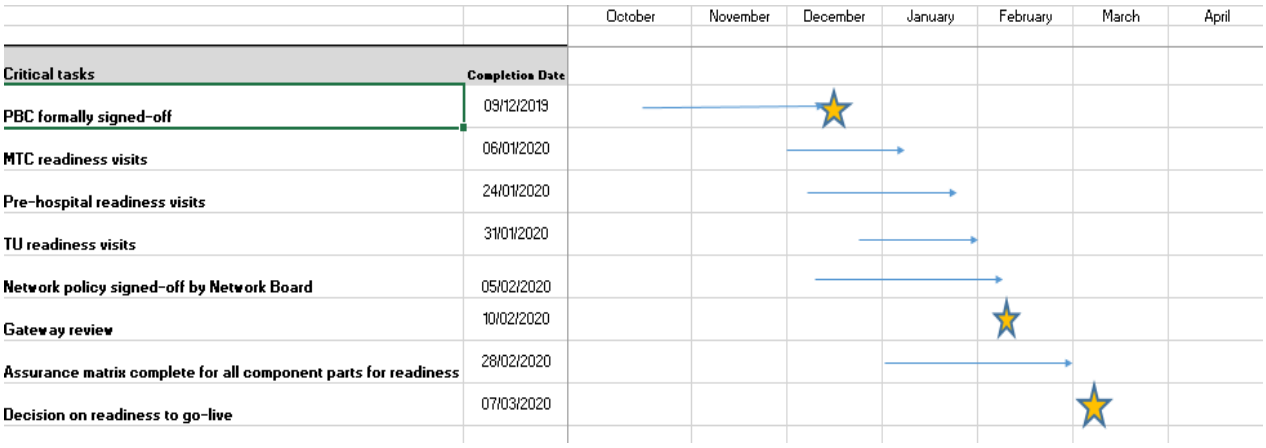
The MTN programme team held a briefing session for Health Boards on October 23rd 2019 – Chairs, Independent Members and Executives from involved Health Boards attended. The plan, following the session, is to have a presentation that each Health Board will then be expected to share with their Boards in November 2019, once the PBC is signed off by WHSSC. Health Boards will also need to determine how to factor the PBC costs into their IMTPs.

At the briefing session, the MTN Clinical Lead reiterated the clinical drivers for change and the clear evidence that this new service will deliver significantly improved outcomes for patients suffering major trauma.

During the briefing session, debate around the ongoing costs of the MTN recommended there should be further clarity on the costs/resources expected to deliver phase two i.e. year one of MTN operation. Health Boards felt it would be difficult to assure colleagues of the programme effectiveness and affordability without this clarity. It was noted that this clarity would be provided by the MTN Implementation Board as the programme evolves.

It was emphasised by clinical colleagues at the briefing session that investment in rehabilitation services over the timeline of the MTN implementation - although focused within the Programme on supporting major trauma patients - should also advance wider rehabilitation systems e.g. Stroke services. It was noted that the MTC will have the key role in managing patient expectations in relation to the Rehabilitation Prescription and rehabilitation packages of care/treatment. A focus on a longer term, phased approach to investment in rehabilitation services will be fundamental to the success of the Network.

At the session, WHSSC advised there will be further review of the MTC/Swansea Bay Specialist Services arrangements (i.e. orthoplastics, spinal surgery) and that the ODN governance framework and WHSSC contractual arrangements will be developed as a matter of urgency. Finally, the plans to launch the MTN on April 1st 2020 are still focusing on that date; an excerpt from the MTN plan is noted below, highlighting the key tasks relevant to HDUHB:



A third Gateway Review of the PBC took place week commencing October 28th 2019. The two previous reviews had issued a PBC status at Amber/Red (successful programme delivery in doubt). The status of the PBC following the third Review is now Amber/Green, indicating that successful PBC delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery. The third Review gives a clear message that the ODN's governance & operational authority needs to be strengthened and that

the MTN Programme establishes a “readiness assessment process” with Health Boards. This process will commence in December 2019. WHSSC will continue to develop contracting arrangements to deliver an appropriate contracting and funds flow model that will replace the current trauma income flows into Cardiff & Vale UHB. WHSSC will also work with the Collaborative to revise the MTN programme board arrangements to move to the implementation phase of the project. The ODN will, through a new Major Trauma Delivery Assurance Group, be accountable to the WHSSC Joint Committee, escalating directly to Joint Committee through the WHSSC structure.

Following discussion at WHSSC Joint Committee on 12th November 2019, final revisions have been made to the programme business case for the South Wales Major Trauma Network. The final version of the PBC is appended to this SBAR.

Argymhelliad / Recommendation

The Board is requested to note the latest position in planning for the launch of the Major Trauma Network for South and West Wales, South Powys.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce Support people to live active, happy and healthy lives

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	MTN briefings, PBC revisions
Rhestr Termau: Glossary of Terms:	Contained within body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Public and staff engagement Community Health Councils

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial impact is considered within the PBC
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Early intervention within a MTN system aims to improve survival rates by up to 20%.
Gweithlu: **Workforce:**	Extra staff are planned to support the launch of the MTN. Audit of MTN effectiveness will take during year 1 of Network operation to determine future resource requirements.
Risg: **Risk:**	Major risk at this stage of the project is the sign-off by WHSSC and Welsh Government to allow the PBC to be taken forward.
Cyfreithiol: **Legal:**	Not applicable
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Full EQIA has been undertaken.

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

Date: 18/11/19	**Version:** 1.0 (Final)

Purpose:

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

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

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

Boards are asked to:

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

b. role of the health board, as a provider of respective component of service model.

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

1 Introduction

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

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

2 Background

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

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

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

3 Network Structure

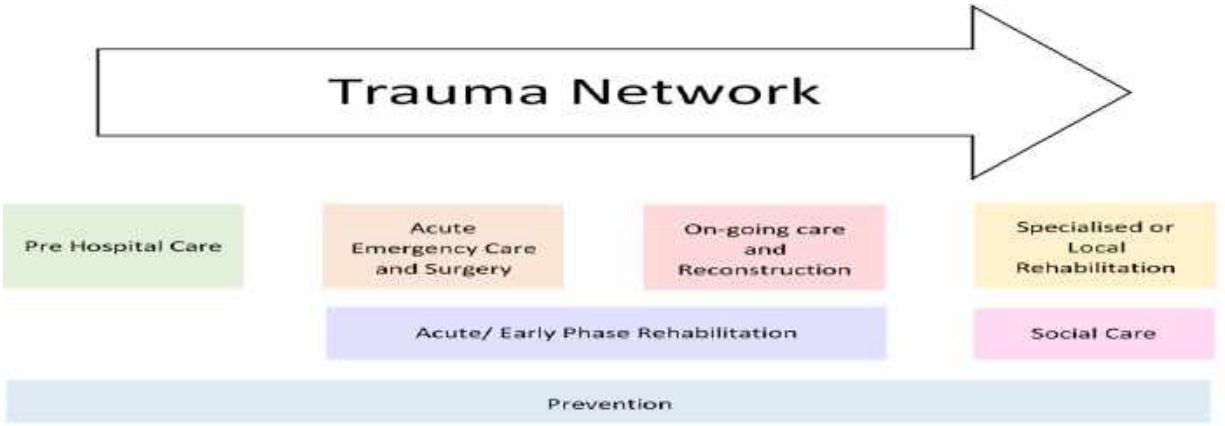
The structure of the South Wales Trauma Network will be comprised of the following elements:

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

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

  The TUs will provide care for injured patients and have systems in place to rapidly move the most severely injured patients to hospitals that can manage their injuries, in most cases the MTC. They will also receive patients back who require ongoing care in hospital.
- **Rural trauma facilities** at Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest, which will maintain the ability to assess and treat major trauma patients, given their unique geographical locations.
- A **Local Emergency Hospital** at Royal Glamorgan Hospital, Llantrisant. This hospital will not routinely receive acute trauma patients but, should this occur, it will ensure appropriate initial management and transfer to the MTC or nearest TU.

4 Clinical and Operational Model



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

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

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

  - Hyper acute rehabilitation service – to provide early rehabilitation plans for trauma patients with intensive rehabilitation needs.
  - Specialist services – new local plastic surgery availability on site to deliver improved outcomes (through collaboration with Swansea Bay University Health Board).
  - MTC directorate – senior leadership to drive improvements in rehabilitation, clinical practice, and audit and outcomes.

- **Trauma Units** (Chapter 8) – 26 indicators, many are already being met or could be met through the provision of network policies and internal re-organisation of resources. The initial focus for additional resources is on key enabling posts to improve clinical governance, data collection and patient flow. Further resources will be required to meet standards in Years 2 and 3. The TU at Morriston Hospital will have a role in providing specialist services support to the network. The PBC includes costs for locating up to four plastic surgeons at the MTC.
- **Operational Delivery Network** (chapter 5) – investment required to manage the network and coordinate operational delivery.

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

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

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

Rehabilitation services are vital to the care of patients following major trauma. Major trauma practitioners and rehabilitation coordinators will be new roles in the health boards and will be vital in ensuring seamless care and key points of contact for patients returning from specialist care to a TU or the community. A consultant in rehabilitation medicine will operate in

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

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

5 Network Workforce

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

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

6 Revenue and Capital Costs

The totality of the revenue and capital costs included in the PBC is set out in the tables below. This has been informed by significant scrutiny of the network requirements through the programme arrangements and, also, independently through clinical peer review and Gateway Reviews. Learning lessons from the establishment of major trauma networks in other parts of the UK has been of particular importance. This has informed the scale of the MTC requirements and also the enabling requirements for the pre-hospital services, trauma units and the rehabilitation pathway. This will ensure the maximum benefit for the most seriously injured patients, the majority of whom will go to the MTC. There are some elements of the MTC

case that are phased and, also, the resource requirements for the TUs reflect a more phased approach.

Summary of revenue costs

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

Summary of health board and trust funding shares

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

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

7 Value, Cost Effectiveness and Benchmark Cost Comparison

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

There is international evidence that investment in major trauma is cost effective. The NHS Confederation (2010) reported the work of Nicholl (Sheffield University Health Economics) which indicated that, based on a

10% improvement in mortality, a health economy could invest £5m per annum per million population and achieve a quality gain cost effective at within the £20,000 per QALY standard. A comprehensive study from the United States (Mackenzie 2010) compared the outcomes in Level 1 trauma centres with non-trauma centres and quantified the cost effectiveness at $36,961 per QALY. When adjustments are made to translate into much lower UK health system costs, investment in major trauma compares well against common investment priorities such as hip and knee surgery.

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

8 Programme Assurance

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

9 Next steps

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

The Trauma Network Programme Board will be refocused on implementation, with a leaner membership once the PBC is approved. There will be some parallel running of the programme team and the new ODN, and full handover to the ODN prior to go-live. Arrangements are planned to hold critical readiness reviews for the MTC and TUs, which will focus on

recruitment and, within the MTC, on capital works. Also, the automatic acceptance policy for repatriation will need to be in place. This will inform decisions on the date from which the network will become operational, which will be signed off by WHSSC, as the lead commissioner.

10 Recommendations

Boards are asked to:

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

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

Programme Business Case

18 November 2019

For reporting to Health Boards

Acknowledgements

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

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South Wales Trauma Network

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

Our mission statement:
'Saving Lives,Improving Outcomes, Making a Difference'

Pre-hospital care

Treat me quickly and effectively

Acute emergency care and surgery

Recognise and treat my injuries quickly and **effectively**

Take me to the right hospital the first time

Explain to my family and me **what is happening at each step**

Manage my pain **appropriately**

Ongoing care and reconstruction

Give me and my family easy to **understand information to make sense of what happened to me**, my injuries and make choices about my care

Provide welfare support and advice to my family

Rehabilitation and social care

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

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

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

GIG CYMRU NHS WALES
Rhwydwaith Thrawma De Cymru
South Wales Trauma Network

1 Executive Summary

1.1 Introduction

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

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

1.2 Vision

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

1.3 Background

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

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

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

1.4 Strategic Case

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

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

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

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

1.5 Case for Change

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

Health gain – improving patient survival and outcomes

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

Equity – people of highest health need prioritised

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

Clinical skills and sustainability – reducing service and workforce vulnerabilities

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

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

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

1.6 Clinical and Operational Model

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

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

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

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

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

1.7 Operational Delivery Network

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

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

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

1.8 Pre-hospital Care and Transfers

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

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

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

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

1.9 Major Trauma Centre

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

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

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

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

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

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

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

1.10 Health Board Configuration

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

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

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

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

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

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

Within the network structure, there are two rural trauma facilities in West Wales which will need to maintain the ability to assess and manage major trauma patients. These facilities will be supported by:

- Trauma desk and network pre-hospital triage tool to guide decision-making
- Confirmation of 24/7 EMRTS availability, providing pre-hospital critical care and hyper-acute transfers
- Remote telemedicine to guide management of trauma teams in rural trauma facilities ahead of arrival of EMRTS
- An operational policy between the TU and rural trauma facilities, forming part of the network operational policy

The trauma unit at Morriston Hospital will also have a role in providing specialist services support to the network (e.g. orthoplastics, spinal surgery, level 1 rehabilitation). In addition the trauma unit in ABUHB provide a spinal service for some trauma patients.

1.11 Financial Case

The totality of the revenue and capital costs is set out below. The case for the MTC is front-loaded having learnt lessons from the implementation of networks in the rest of UK, which has reinforced the need to achieve quality indicators and service standards at an early stage. This will ensure the maximum benefit for the most seriously injured patients, the majority of whom will go to the MTC. However, there are some elements of the MTC case that are phased. The resource requirements for the TUs reflect a much more phased approach and subsequent business cases may be required (where appropriate) to meet service specification and quality indicators that cannot be met on Day 1.

Summary of Revenue Costs

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

The costs have been derived through an iterative process of reviewing the gap between commissioning expectations and provider costs.

The summary revenue contribution for each health board is outlined below:

Summary of funding of Trauma Network by Health Board					
Reflects local Trauma Unit / Rehabilitation costs plus share of Major Trauma Centre, Specialist Services and WAST Pre-hospital care					
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Aneurin Bevan	£353	£3,549	£3,571	£3,573	£3,574
Cwm Taf Morgannwg	£308	£2,743	£2,758	£2,759	£2,760
Cardiff and Vale	£247	£2,808	£2,826	£2,828	£2,829
Hywel Dda	£262	£2,462	£2,477	£2,479	£2,479
Powys	£27	£225	£226	£226	£226
Swansea Bay	£281	£2,678	£2,695	£2,696	£2,697
WAST (2019/20 funded by Welsh Government, year 1 onwards by Health Boards)	£58	£0	£0	£0	£0
Total NHS System Revenue	**£1,536**	**£14,465**	**£14,553**	**£14,562**	**£14,564**

There are several factors which will impact on revenue costs and apportionment, including:

- Monitoring changes in RTA income during 2020/21 by health board
- Assessing the impact of the planned earlier repatriation of patients from the MTC to TU 'landing pads'
- Assessing and managing slippage
- Testing the assumption that capital charges will be funded by Welsh Government
- Further review of staffing plans for the MTC
- Monitoring operational efficiencies.

Capital costs will be met through the Welsh Government strategic capital route. Estate development and equipment has been identified by both Cardiff and Vale UHB and Hywel Dda UHB:

Programme Capital Requirements					
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
MTC Cardiff & Vale (MTC Construction and Equipment)	£5,426				
Hywel Dda Trauma Unit (West Wales General)			£1,252		
Capital Total	**£5,426**	**£0**	**£1,252**	**£0**	**£0**

Future revenue and capital business cases will be prepared by the relevant organisations and a timetable is provided in chapter 9.

1.12 Economic Case

There is consistent national and international evidence indicating that the establishment of trauma networks is cost effective.

Within a mature trauma system, investment in the MTC in itself is cost-effective, with evidence of a five to 15 fold return on investment for each patient successfully returned to work. In terms of cost per life year saved, regionalised MTC care costs are cost-effective when compared with the provision of other medical interventions. A recent study from NHS England indicated that English trauma network have been cost effective, given that they are significantly under the NICE QALY threshold for cost effectiveness of £20,000. Based on the expected number of 'candidate' major trauma patients (2,112) across the entire South Wales Trauma Network, the investment is significantly below the NICE QALY threshold of £20,000 (£6,896 per additional QALY gained), comparable with the 2013 study from NHS England on cost effectiveness of trauma networks and with other interventions (e.g. hip and knee replacements).

In addition, approximately an extra 14 lives will be saved per year based on experience of enhanced survival in NHS England. For the given investment, this would equate to a cost of lives saved of approximately £17m per year. Thus, the service would pay for itself in terms of economic benefit.

Linked to cost effectiveness, value will come from realising benefits as outlined in a comprehensive benefits realisation plan. Whilst it is imperative that the network focuses on the key investment objectives of improving survival and functional outcomes, one of the areas that will be measured are the wider system benefits.

1.13 Commercial Case

The commercial case outlines the proposed procurement and capital requirements in respect of the preferred way forward. It should be noted that responsibility for the production, delivery and management of capital cases identified as part of this PBC will sit with the providing organisation but will need to be supported by the ODN and wider network.

1.14 Management Case

The management case sets out the actions required to ensure the successful delivery of the trauma network against the agreed investment objectives and timeline. To achieve this, it sets out the programme management arrangements and implementation plan. It gives details of the commissioning arrangements and considers how these will affect the organisational and clinical governance arrangements once the network is operational.

Since approval of the recommendations of the independent panel review by health boards in 2018, the programme and the development of this case has been overseen by the trauma network board, which is accountable to WHSSC Joint Committee.

The scope of the commissioning framework is summarised as;

- The ODN will oversee the delivery of trauma services to the population of South Wales, West Wales and South Powys.

- The ODN, Major Trauma Centre at University Hospital Wales and orthoplastic services at Morriston Hospital will be commissioned by WHSSC.
- The Emergency Ambulance Services Committee will commission WAST and the EMRTS.
- Health boards will be responsible for local commissioning.
- Existing trauma commissioning arrangements for Betsi Cadwaladr UHB will be retained.

As the network moves from its planning phase to implementation and operational delivery, hosting of the network will shift from the NHS Wales Health Collaborative to Swansea Bay UHB. A robust and methodological programme arrangement will continue to be applied, but the roles and representation across the programme will be amended as the focus moves from planning for implementation to mobilisation.

The operational governance structure will ensure clear lines of accountability and responsibility across the pathway in order to achieve the best possible outcomes and experience for patients. This will align with the network's mission statement of 'saving lives, improving outcomes, making a difference.'

Evaluation is an essential requirement and the ODN management team will manage the process in partnership with the lead commissioner (WHSSC) and will include participation in national peer review.

1.15 Summary and Recommendation

The network board has overseen the development of the structure of the network, comprised of the following elements:

- An Operational Delivery Network (ODN) hosted by Swansea Bay University Health Board
- Pre-hospital developments including WAST and 24/7 EMRTS
- An adult's and children's MTC at UHW, Cardiff
- An adult and paediatric TU with specialist services at Morriston Hospital, Swansea
- Six adult and paediatric TUs at the following locations:
    - UHW, Cardiff
    - Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Aneurin Bevan University Health Board)
    - Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend
    - Glangwilli General Hospital, Carmarthen
- Rural trauma facilities at Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest
- A Local Emergency Hospital at Royal Glamorgan Hospital, Llantrisant

The network board has also developed a phased clinical and operational model, based on the NHS England quality indicators and service specification for major trauma services. All providers and relevant commissioning bodies have agreed this model and requisite resource requirements, following several tiers of internal and external reviews.

The case describes the delivery of absolute requirements for Day 1, but also the schedule of business cases that will follow as part of the phased introduction of the network. In doing so, the case also sets out a timeline for implementation of the network (and composite parts) on 1st April 2020, with the ODN management team being put into place in January 2020. Whilst this presents an ambitious timeline, the programme is committed to achieving this.

In order to manage implementation, the case describes a revised implementation structure, commissioning and organisational governance arrangements and workforce principles to maximise positive benefits of recruitment for the wider healthcare system. Finally, a focus is placed on giving the ODN operational authority, particularly in relation to the repatriation of patients from the MTC and maintaining patient flow across the network.

The network board recommends that health boards, commissioners and Welsh Government approve and endorse this Programme Business Case, the agreed structure and the requisite phased resource requirements for the establishment of the South Wales Trauma Network, serving the population of South Wales, West Wales and South Powys, so that it can proceed with implementation.

The programme team would like to thank all contributors for their time and advice in developing this complex and challenging Programme Business Case.

2 Strategic Case

2.1 Introduction

The purpose of this section is to explain how the scope of the proposed programme and investment aligns with national drivers, interdependent policies and the strategic vision for Wales. It also sets out how the programme supports and complements the existing business strategies of NHS Wales, local health boards (health boards), Welsh Ambulance Service NHS Trust (WAST), the Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru, Welsh Government and NHS Wales as a whole. In doing so, it sets out the case for change, in terms of the existing and future operational needs of these organisations, pertaining to major trauma care.

In particular, this section of the Programme Business Case (PBC) demonstrates the strong links between policies, strategies and the drivers of joint working and how these can be used to deliver better trauma services, more efficiently for the people of South Wales, West Wales and South Powys.

The programme is also committed to delivering value for our patients, to provide the best patient outcomes through optimally directing our resources.

2.2 Strategic Context

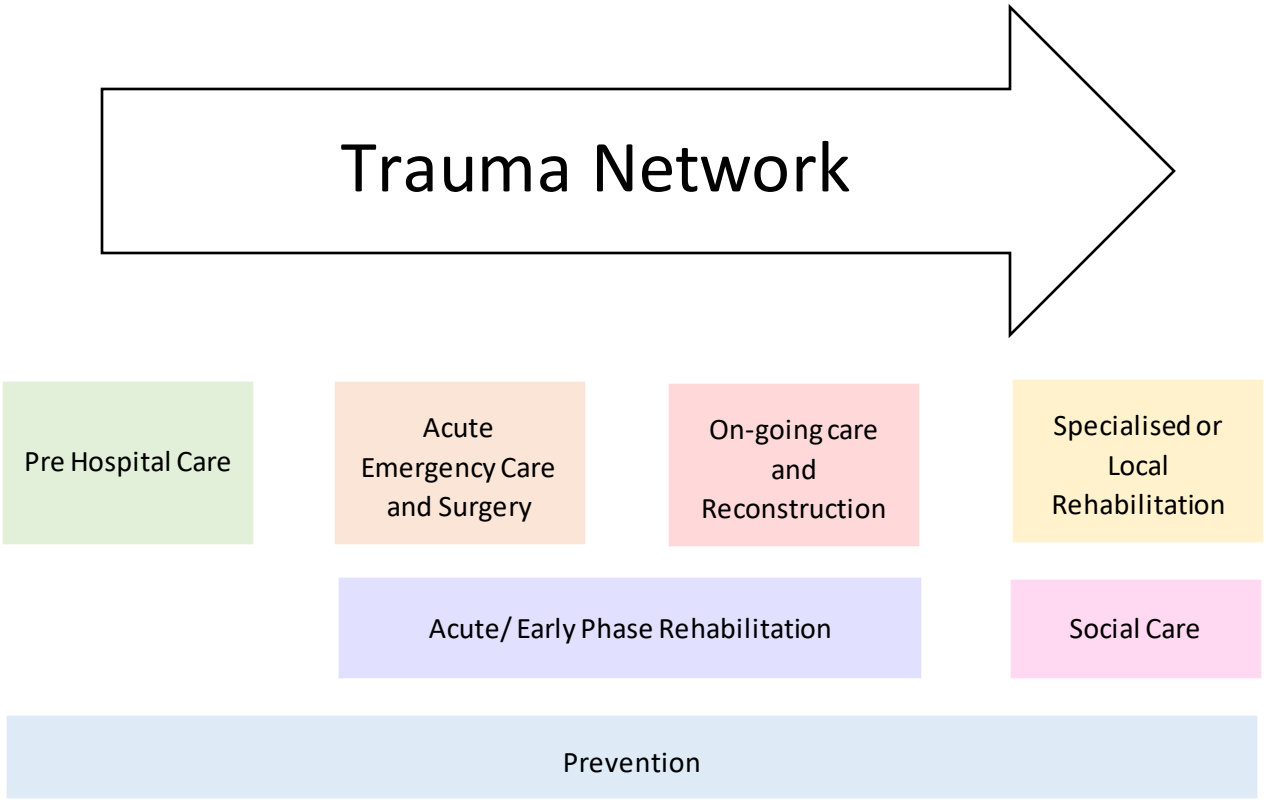
This section outlines the strategic context for the proposed change as follows:

- National drivers for change
- Key interdependent policies
- The local context – population and existing activity profiles
- An overview of the baseline position with respect to the trauma pathway

The vision for the establishment of a trauma network for the population of South Wales, West Wales and South Powys is to enhance patient outcomes and experience, across the entire patient pathway from the point of wounding to recovery and includes injury prevention. The network represents a partnership between participating organisations, each responsible for working collaboratively to achieve this common goal and purpose. The trauma network will improve patient outcomes by saving life and preventing avoidable disability, returning patients to their families, work and education.

A trauma network consists of a Major Trauma Centre (MTC), with a number of Trauma Units (TUs) and Local Emergency Hospitals (LEHs), and rehabilitation services. The trauma network ensures rapid transfer of patients who are most severely injured from the scene of an incident or other hospitals to the MTC, in order to benefit from timely and efficient specialist care. Care continues closer to home or in the community once specialist care is completed. Care closer to home is generally facilitated through rehabilitation. Indeed, the key to keeping the trauma pathway open is for specialist and local rehabilitation to be optimally organised and resourced, linking into continuing healthcare packages for patients who need them. Benefit for patients is realised across the network, not just in the MTC.

The trauma pathway consists of a number of component parts in the patient's journey, with the relationship between, and integrity of, component parts being critical to the successful delivery of the network. Each part has equal merit. This is summarised in the diagram overleaf.



2.3 National Drivers for Change

This section sets out the links between the proposed investment and key national drivers for change.

2.3.1 A Healthier Wales

A Healthier Wales (2018) sets out a long-term vision of a "whole system approach to health and social care". Underpinning this is the 'quadruple aim' of improving population health and wellbeing; better quality and more accessible health and social care service; higher value health and social care and a motivated and sustainable health and social care workforce. Thus, both Prudent Healthcare and Value-Based Healthcare principles underpin the plan. The development of the trauma network sits firmly within this strategic space, as it will deliver care in the right way and at the right time:

- A whole system approach with seamless coordination between health and social care – as reflected in the above trauma pathway
- An equitable system, which achieves the best health outcomes for all – equity of access to specialist care is an important investment objective for the trauma network
- Delivery of services as close to home as possible – this aligns with the requirements for a congruent health and social care model, so that once specialist care is complete, rehabilitation can be delivered within the community setting as soon as possible
- Using technology to support high quality, sustainable services – this is explored further in Chapter 5 on improving data collection on outcomes and experience

2.3.2 Strategic Drivers

The development of the trauma network aligns itself with a number of other strategic drivers specific to Wales:

- **NHS Wales Service Change Plans** – NHS Wales is undergoing a series of changes focusing on the reshaping of acute clinical services, with a view to changing the delivery of some services. This includes centralisation of specialist care (e.g. for patients who sustain cardiac arrests and regain a pulse), with the rationale of delivering improved clinical outcomes and ensure services remain sustainable in the face of challenges in the medical workforce. Each health

board will have its own clinical priorities. Specific examples include Hywel Dda University Health Board plans for Transforming Clinical Services and the development of The Grange University Hospital for specialist and clinical critical care services in Aneurin Bevan University Health Board (ABUHB).

- **National Programme for Unscheduled Care** – The aim of this programme is to redesign unscheduled care processes across the total patient journey and to alleviate pressure within the system including the National Collaborative Commissioning Unit's current programme of work in these areas (e.g. the Emergency Department Quality and Delivery Framework).

2.3.3 Trauma Specific National Drivers

There are a number of trauma specific national drivers relevant to the development of the trauma network, which will increasingly have an impact on the delivery of health services across Wales. The points below summarise these drivers:

- **National Reports** – the National Audit Office (2010) report on major trauma care in England and the *National Confidential Enquiry into Patient Outcome and Death* (2007) were key reports highlighting deficiencies in trauma care in the UK and resultant negative impact on survival and outcomes for patients suffering major trauma. These reports identified that services achieve better care and outcomes when formal trauma networks are in place.
- **Trauma Networks in the UK and Ireland** – based on the above, NHS England established regional trauma networks. In 2010, London introduced its pan-regional major trauma system, consisting of four trauma networks, each with an MTC. Following this, regional trauma networks were established in the rest of England, now consisting of 11 adult MTCs, 5 children's MTCs and 11 combined adult and children's MTCs. Delivery of these networks occurred simultaneously in April 2012 and have taken five years to develop and mature. In 2018, the Scottish Trauma Network was established, with four regional trauma networks and MTCs in Aberdeen and Dundee, as part of a phased five-year development. The Scottish Government is making an incremental new investment of £27 million per year into major trauma services. Furthermore, both Northern Ireland and the Republic of Ireland are making good progress with their respective developments.
- **Trauma Network in North Wales** – since 2012, North Wales has formed part of the North West Midlands and North Wales Trauma Network, with patients from TUs in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital going to the MTC at Royal Stoke University Hospital.
- **Service Specification and Clinical Standards** – a hallmark report, NHS Clinical Advisory Groups (CAG) Report (2010) *Regional Networks for Major Trauma*, underpinned the development of the above networks, which provides detailed recommendations for the delivery of trauma services across the patient pathway. This report formed the basis of the NHS England service specification and quality standards. The North Wales service already aligns with the position set out in this report. Furthermore, there are number of evidence-based clinical guidelines that support the service specification (e.g. National Institute of Clinical Excellence *Trauma Guidelines* – 2018, British Society of Rehabilitation Medicine *Core Standards for Specialist Trauma Rehabilitation* – 2014).

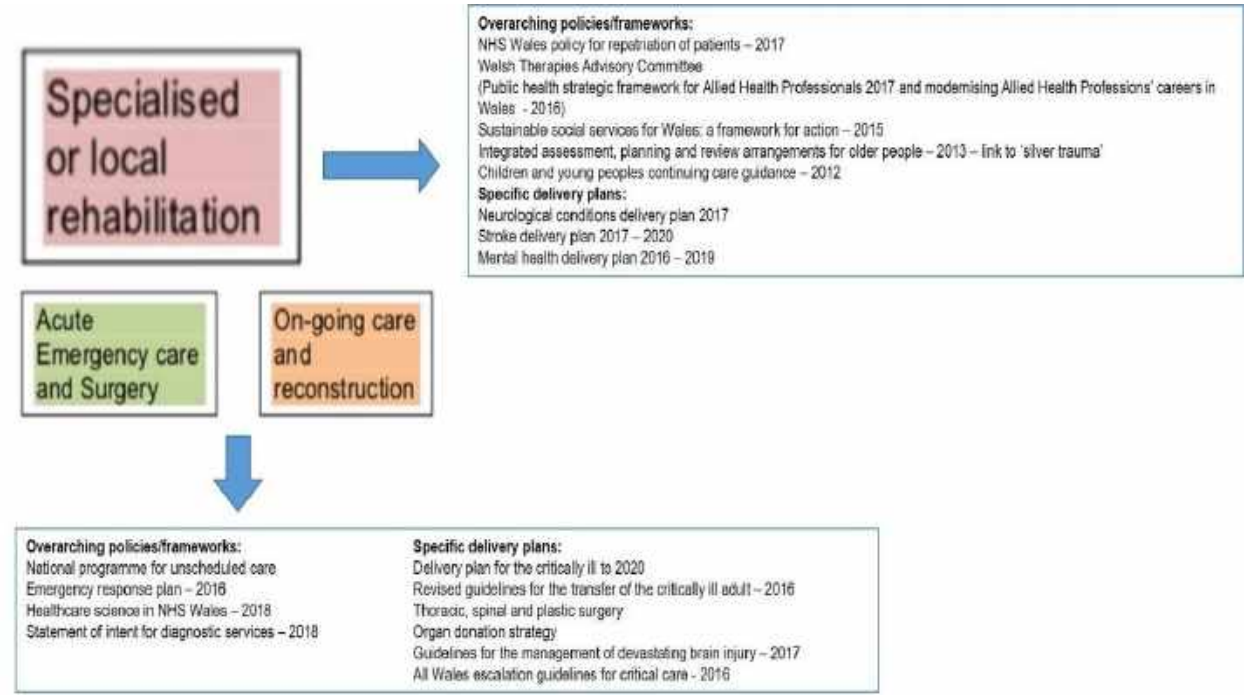
In March 2018, based on the above and the work undertaken since 2012 to develop a trauma network (see subsequent chapters for details), all six health boards covered by the proposed trauma network fully endorsed the recommendations of an independent expert panel review, which indicated that:

- A major trauma network for South and West Wales and South Powys with a clinical governance infrastructure should be quickly developed
- The adults and children's MTCs should be on the same site

- The MTC should be at University Hospital of Wales, Cardiff
- Morriston Hospital should become a large TU and should have a lead role for the major trauma network
- A clear and realistic timetable for putting the trauma network in place should be set

2.4 Key Interdependent Policies

There are a number of clinical and non-clinical polices developed and endorsed by Welsh Government that align with the development of the trauma network as shown below:



2.4.1 Critical Care

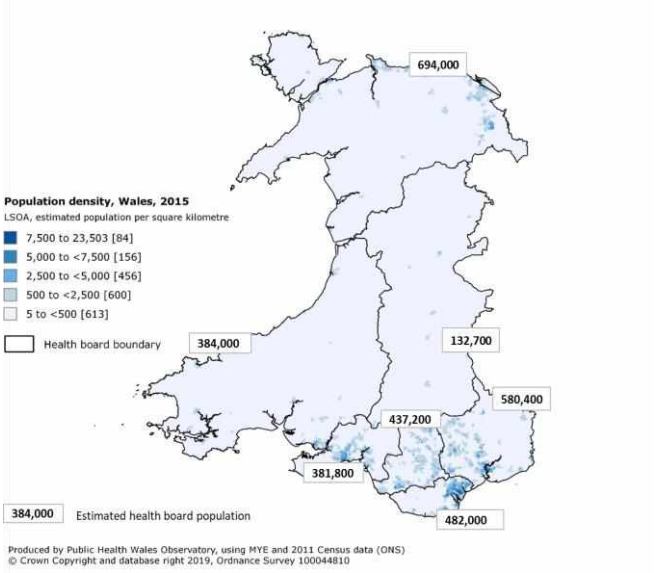
The Welsh Government *Critical Care Task and Finish Group Report*, published in July 2019, set out a national directed programme, which looks strategically at the issues and challenges for critical care services across Wales. The approach builds on the work already being taken forward with the implementation of the delivery plan for the critically ill. The report is honest about the challenges facing critical care, and provides a strategic view on the steps necessary to ensure services for people who are critically ill are fit for the future.

The report makes a number of recommendations that will benefit the establishment of the trauma network. These include the establishment of a non-emergency transfer service for critically ill adults, the development of a long-term ventilation unit, some additional critical care capacity within regional services as well as supporting the development of local services such as post-anaesthetic care units (PACU) and critical care outreach. This work will not replace the need for investment in critical care services, which are necessary for major trauma patients within the MTC.

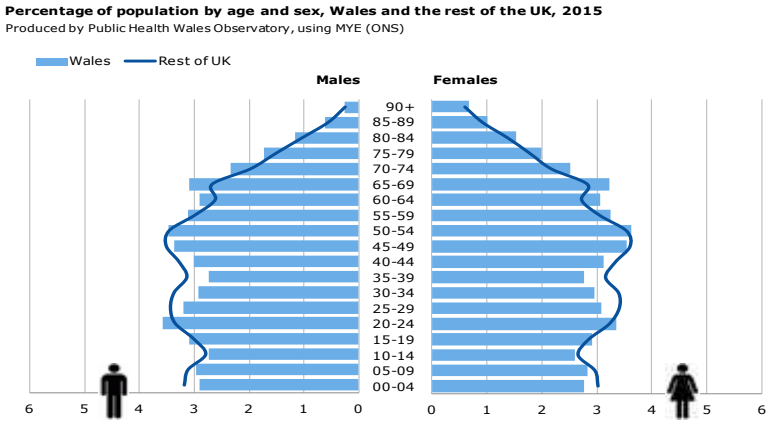
2.5 Population and Existing Activity Profiles

2.5.1 Population Profile

In 2015, the total population of Wales was approximately three million people, excluding transient populations. The population of South Wales, West Wales and South Powys was 2.4 million people. The map below shows population density and breakdown per health board (Note a boundary change took effect from April 2019):



The above graphic illustrates that the population of South Wales is concentrated in the densely populated urban areas of Cardiff, Newport and Swansea, with a spread across more sparsely populated rural areas. It is likely that major trauma would follow this distribution, being concentrated in more urban areas of higher population density.



The above figure demonstrates that Wales has a similar population structure to the rest of the UK, but with slightly more older people and fewer younger working age adults aged 25-50 years. Furthermore, the age structure of the population varies across South and West Wales, with Pembrokeshire, Monmouthshire and Swansea (in that order) demonstrating a higher proportion of older people compared to Cardiff. Moreover, in the last 10 years, the population of Wales has become older with a 54% increase predicted in the over 65s by 2036. This provides evidence for considering the design of the trauma network, taking into account the changing population.

Paediatric major trauma is most common in children under the age of one year, with this peak in incidence often being accounted for by non-accidental injury. Across all paediatric age groups, road

traffic collisions are the commonest mechanism of injury and head injuries are the predominant injury type. Severely injured children present mostly in daytime hours with a peak in the evenings and at weekends. Paediatric major trauma after midnight is rare. It should be recognised that a significant number of children with major trauma arrive at emergency departments by car and therefore may continue to attend their nearest hospital.

2.5.2 Existing Activity Profiles

Fewer than 0.1% (1/1000) patients who arrive at an emergency department will have major trauma. Based on the population of South Wales, West Wales and South Powys this equates to approximately 2,400 cases per year. In 2016, approximately 750,000 people attended an emergency department and the Welsh Ambulance Service attends approximately 800 emergency calls across Wales per day. Thus, major trauma represents a small proportion of the unscheduled care workload.

Furthermore, the incidence of paediatric major trauma is even lower. However, the face of major trauma is changing. Whilst the overall incidence of major trauma has not increased in the UK, the incidence of major trauma in older people greatly exceeds earlier predictions in NHS England. Rather than being something that afflicts young men, the majority suffering major trauma are now older than 65 years of age. This is likely to hold true for Wales, given the population profile described above.

The table below illustrates the expected number of cases per year modelled on the Trauma Audit Research Network (TARN) data reported for 2016-2017, using hospitals with good TARN data collection. The data is broken down according to Injury Severity Score (ISS) – see glossary of terms:

Site	Moderate Trauma ISS 9-15	Major Trauma ISS>15	'Candidate' Major Trauma Total
Morriston Hospital	227	147	374
Princess of Wales Hospital	91	59	150
Aneurin Bevan UHB	255	166	421
University Hospital Wales	181	335	516
Prince Charles Hospital	97	63	160
Royal Glamorgan Hospital	84	55	139
Bronglais General Hospital	41	27	68
Glangwili General Hospital	111	72	183
Withybush General Hospital	65	42	107
Total	**1,146**	**966**	**2,112**

Finally, a TARN report for the region from 2017-2018, demonstrated that falls from greater than two metres were the commonest mechanism of injury (56%), followed by road traffic collisions, falls from

less than two metres and penetrating trauma (e.g. shootings and stabbings). Falls from less than two metres demonstrate no seasonal variation whilst the peak time for road traffic collisions/falls from height appears to be between 3pm-6pm, with the lowest period of activity between 12am-6am.

2.6 Overview of the Current Position – The Trauma Pathway

Currently there is no adult and paediatric trauma network serving the population of South Wales, West Wales and South Powys. Whilst there are examples of good clinical and operational governance within participating organisations, there is no oversight of strategic planning, operational delivery, local advice, maintaining quality and standards of care and partnership development. NHS organisations in South Wales, West Wales and South Powys have undertaken the following to assess the value gap and level of confidence in the existing trauma pathway.

2.6.2 Pre-hospital Care and Secondary Transfers

Welsh Ambulance Service NHS Trust (WAST)

The main provider of pre-hospital care and secondary transfers for major trauma patients is WAST, which is commissioned by the Emergency Ambulance Services Committee (EASC). However WAST is supported by a number of organisations including the Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru, health boards, the Critical Care Network, paediatric retrieval services and third sector organisations.

As part of WAST's quality strategy (2016-2019) there have been a number of advances with respect to trauma management, including improvements in guidelines, equipment, and administration of Tranexamic acid. In 2015, WAST introduced a new clinical response model to identify those patients who require an immediate life-saving response, to receive the highest priority response in the fastest time possible, which was evaluated as part of the Amber Review in 2018.

Presently, a number of patients are taken by WAST directly to specialist units. This includes patients suffering from an ST elevation myocardial infarction (heart attack) and cerebrovascular accident (stroke). However, in the absence of pre-hospital enhanced care, ambulance crews take many patients suffering major trauma to the nearest emergency department (ED), rather than directly to specialist definitive care. Whilst a pre-alert process exists for informing EDs about critically injured patients, this is not consistently undertaken and delivered across the regions. There is also variation in the handover of these patients on arrival at the ED.

Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru

In April 2015, EMRTS went live from its South and Mid Wales bases. EMRTS represents a collaboration between NHS Wales and the Wales Air Ambulance Charity Trust (WAACT). The service is hosted by Swansea Bay University Health Board and commissioned by the Emergency Ambulance Services Committee (EASC). It is a consultant led, consultant delivered, road and air based service providing the following:

- Pre-hospital critical care for all age groups (advanced airway management and anaesthesia, surgical interventions and advanced haemorrhage control including blood products).
- Time critical adult and paediatric inter-hospital transfers.
- Coordination of above and provision of advice to WAST through a National Air Support Desk staffed by an EMRTS Critical Care Practitioner (CCP) and allocator, with remote support by a 'Top Cover' consultant.

The above has allowed enhanced decision-making for major trauma patients to bypass their local hospital and be taken directly to specialist centres at University Hospital of Wales, Cardiff and Morriston Hospital, Swansea. The service has robust operational and clinical governance in place and

a number of best practice Standard Operating Procedures related to major trauma. Major trauma represents approximately half of the service's workload.

In 2017, the service expanded to include North Wales. In addition, the WAACT provided a charity funded service from Cardiff Heliport for Paediatric/Neonatal retrieval teams and long distance repatriations.

The EMRTS is currently only a 12 hour service (8am-8pm). Outside of these hours, voluntary organisations (including. BASICS schemes in South and Mid Wales) provide a doctor at the scene on an ad hoc basis to provide a variable level of care for major trauma patients outside standard ambulance service practice.

The service is undergoing a phased temporal and geographical expansion as part of the ongoing programme of service development. The first phase of this expansion will be the introduction of a South Wales overnight service with effect from April 2020. (See chapter 6)

Third Sector and Commercial Organisations

For the provision of extrication and initial management of trauma patients in austere environments, there are six Mountain Rescue services and several Royal National Lifeboat Institute Coastguard services. In addition WAST provides a tier of volunteer Community First Responder, who will frequently be first on scene at an incident.

Since 2015, Bristow has run commercial helicopter operations from Caernarfon airport and RAF St Athan in Cardiff, providing Search and Rescue services. The service is principally for rescue and recovery, but will frequently take patients to nearest accessible Emergency Department. Requests from health boards for support with transfers, regardless of urgency, are not guaranteed to be undertaken and are chargeable. In recent years, the service has developed a close working relationship with WAST and EMRTS.

Adult and Paediatric Critical Care Transfers

In the absence of the EMRTS, health boards are required to undertake adult critical care transfers for patients that require definitive care in specialist centres, using WAST to access an ambulance. These transfers are overseen by the Wales Critical Care and Trauma Network (principally it is a trauma network due to the already-established Trauma service for North Wales), who provide oversight of clinical and operational governance. Health boards also perform time-critical paediatric transfers in the absence of the EMRTS. In addition, the Wales and West Acute Transport for Children Service (WATCh), based in Bristol undertake paediatric critical care transfers that do not require immediate onward transfer.

2.6.3 Acute Emergency Care and Surgery

Overview of Provision

There are six health boards covering the region of South Wales, West Wales and South Powys. Across the region, 10 emergency departments currently receive major trauma patients. Variation exists in the seniority of trauma team leaders and the threshold for activation of trauma teams. The composition of trauma teams also differs, but all hospitals have access to anaesthetists, intensive care physicians, general surgeons and trauma and orthopaedic surgeons. The rapid availability of blood products is achieved through activation of hospital massive transfusion protocols. There is also access to CT scanning, emergency theatres and intensive care, but variable access to MRI scanning.

Historically, University Hospital of Wales (UHW) and Morriston Hospital have been the main centres for receiving major trauma patients in the regions.

University Hospital of Wales (UHW), Cardiff

UHW (Cardiff and Vale University Health Board – C&VUHB) has established a major trauma directorate, which since 2016 has been overseeing the development of a cohesive plan for a high quality trauma

service for patients. Activities have included establishing major trauma service models, clinical governance, training, patient experience, pathways and protocols. So far, this has been overseen by a clinical lead and deputy lead, trauma manager and two major trauma practitioners.

Patients arrive by road or by air (at a co-located 24 hour lit helipad) and receive treatment in the emergency unit. The unit has the following features: a seven bedded resuscitation room including a dedicated paediatric bay equipped with advanced airway equipment; ultrasound; rapid blood transfusers; and a co-located CT scanner allowing selected patients to be transferred direct to the scanner by the EMRTS. There is a tier of consultants in emergency medicine and paediatric emergency medicine, supported by a multidisciplinary team.

Radiology is supported by 24-hour access to interventional radiology following the centralisation of vascular surgery in South East Wales and 24 hour access to MRI scanning. UHW also has two 24 hour emergency theatres and a trauma and orthopaedic theatre. Several surgeons currently have a specific interest in trauma surgery.

In addition to the services outlined above, UHW provides the following specialties pertaining to emergency trauma surgery:

- Neurosciences – 10 neurosurgeons provide the single adult and paediatric neurosurgery unit for the region, including two neurosurgical theatres.
- Cardiothoracic surgery – the service is delivered by five cardiac and three thoracic surgeons. The service includes repair of blunt and penetrating injuries, aortic injuries (including endovascular repair) and rib fixations. There are three dedicated cardi othoracic theatres.
- Welsh Centre for Spinal Trauma and Surgery – provided by seven spinal surgeons with access to emergency and trauma and orthopaedic theatres.
- Vascular/endovascular Surgery.
- Oral and maxillofacial surgery, urology, ENT surgery and obstetrics.

In addition to the above the trauma and orthopaedic unit provides specialist care for patients with pelvic and acetabular trauma and complex extremity trauma. However, there is no dedicated plastic surgery service.

UHW is host to the Noah's Ark Children's Hospital for Wales, which includes a paediatric intensive care unit, neonatal intensive care unit, general paediatric medicine, specialist paediatric medicine, paediatric surgery, paediatric trauma and orthopaedics, children's theatres and children's x-ray department.

Morriston Hospital, Swansea

Morriston Hospital (Swansea Bay University Health Board - SBUHB) has an emergency department with a five-bedded resuscitation room, with patients arriving by road and by air at a 24 hour lit helipad. In addition to the services outlined above, Morriston Hospital provides the following specialties pertaining to trauma surgery:

- Welsh Centre for Burns and Plastic Surgery – the centre provides tertiary care for plastic surgery for South Wales, West Wales and South Powys. Adult burns care is provided for both South Wales and South West England. The service consists of dedicated burns and plastics theatres and an intensive care unit, led by specialist multidisciplinary teams. This forms part of the regional Burns Network for adults, with transfer of paediatric major burns to the Bristol Children's Hospitals.
- Cardiothoracic surgery – five cardiac surgeons and two thoracic surgeons. Following a recent independent review of thoracic surgery in 2017 and a public consultation process, Health Boards have recommended a single thoracic centre at Morriston Hospital.

- Trauma and orthopaedics – one consultant with an interest in orthoplastic surgery, pelvic surgery, complex extremity surgery and rib fixations.
- Spinal surgery – three spinal surgeons provides urgent but not emergency spinal surgery for trauma.
- Oral and maxillofacial surgery, urology and ENT surgery.

All Other Health Boards

The following hospitals currently provide acute emergency and predominantly non-specialised surgery for major trauma patients:

- Aneurin Bevan University Health Board (ABUHB) – The Royal Gwent Hospital, Newport (with some urgent pelvic and spinal surgery) and Nevill Hall Hospital, Abergavenny. This is pending the opening of The Grange University Hospital in Cwmbran (Spring 2021) which will result in a single acute hospital site within the health board.
- Cwm Taf Morgannwg University Health Board (CTMUHB) – Prince Charles Hospital, Merthyr Tydfil, Princess of Wales Hospital, Bridgend (following Health Board boundary changes in April 2019) and Royal Glamorgan Hospital, Llantrisant.
- Hywel Dda University Health Board (HDUHB) – Glangwili General Hospital, Carmarthen, Withybush General Hospital, Haverfordwest and Bronglais General Hospital, Aberystwyth.

Of note, Powys Teaching Health Board (PTHB) does not have an acute hospital. In the absence of the EMRTS, WAST conveys major trauma patients in South Powys to Bronglais General Hospital, Prince Charles Hospital, Nevill Hall Hospital and Hereford County Hospital (which is a TU).

All health boards include a number of minor injury units to which major trauma patients may infrequently self-present, but are rapidly transferred to the one of the above hospitals.

All health boards have the ability to transfer radiology images using the PACS (Picture Archiving and Communications Systems).

Major Incidents

WAST is a 'Category 1 responder' under the auspices of the Civil Contingencies Act 2004, with responsibilities at a major incident or mass casualty event for co-ordinating health resources, casualty triage, treatment, and casualty removal from scene. Augmenting this responsibility is a tiered response from the EMRTS and hospital based MERIT teams. All health boards have emergency planners and hospital major incident plans in place. Strategically, there is a national framework in place for mass casualty events including capacity planning in the event of a major incident.

2.6.4 On-going Care and Reconstruction

Intensive Care Medicine

All of the hospitals proposed for MTC, TU or LEH status have intensive care units providing Level 2 (high dependency) and Level 3 (intensive care) ongoing care for major trauma patients.

UHW has a 33-bedded adult intensive care unit supporting a number of regional trauma tertiary services including neurocritical care, spinal injuries, oral and maxillofacial surgery, vascular, and thoracic Surgery. It has the presence of consultants delivering a 24 hour resident service. It has recurrent funding to staff 28 Level 3 beds. In addition, UHW has a dedicated cardiac intensive care unit and paediatric intensive care unit.

Morriston Hospital has a 22-bedded adult intensive care unit, a cardiac intensive care unit and an adult burns intensive care unit.

Surgery and Ward Care

Presently, UHW provides regional neurosciences services including an 18 bedded high care ward with a further 35 general neurosurgical beds. Facilities also exist for the management of craniofacial trauma spinal trauma and hand surgery.

In the present system, patients who require definitive surgery for orthoplastic trauma are transferred to Morriston Hospital, which has facilities for managing complex orthoplastic surgery, peripheral nerve injuries, and hand injuries. Specialist burns management is also provided.

None of the receiving health boards has dedicated trauma services that directly admit major trauma patients. Currently, patients are admitted under the speciality that covers the predominant injury or the one requiring operative intervention. Whilst all health boards have orthogeriatric input into the care of patients with neck of femur fractures, there is variable input into the care of older major trauma patients.

Repatriation ('Care Closer to Home')

An NHS Wales policy, endorsed by all health boards, outlines the process for repatriating individual patients for 'care closer to home' once specialist care is complete. This consists of an operational process, escalation procedures and the requirements to complete a repatriation database including delayed transfer of care.

WAST undertakes transfers of patients from specialist care to their local hospital including use of the Non-Emergency Patient Transfer Service (NEPTS).

2.6.5 Rehabilitation

The Welsh Health Specialist Services Committee (WHSSC) commissions adult and paediatric rehabilitation for spinal injury, brain injury and paediatric rehabilitation and health boards provide services for older people and for musculoskeletal rehabilitation. WHSSC commissioned services provide equitable access across the geographical region covered by the planned trauma network. The services provided by the health boards are varied and there is no current agreed service model.

WHSSC commissions 26 spinal injury beds and 22 acquired brain injury beds based at Rookwood Hospital in Cardiff. Both teams provide a weekly in-reach service to review acute referrals and provide advice to the University Hospital of Wales. Both teams review approximately three times the number of individuals than they admit to their beds. There is provision at Llandough Hospital for managing individuals with spinal injury requiring ventilation, but this is not a formally commissioned service.

There are 12 acquired brain injury beds at Neath Port Talbot hospital. These beds would be defined as a Level 1 unit by the English definition of rehabilitation services: serving a population of over a million people and led by a consultant in rehabilitation medicine. There are no English definition Level 2 units commissioned by WHSSC or the health boards. Community services are patchy, with no agreed model and centre on brain injury provision. The region currently has consultants in adult rehabilitation medicine, supported by neurology consultants and a senior speciality doctor. There is one rehabilitation medicine trainee in Wales based at Rookwood Hospital, rotational neurology trainees and three junior posts at Rookwood Hospital.

There are community neurological rehabilitation teams in all of the health boards but there are no common referral criteria or service models. There is a community brain injury service in C&VUHB, CTUHB and SBUHB, but again with different service models and referral criteria.

The paediatric rehabilitation commissioned at the Children's Hospital for Wales provides inpatient rehabilitation. This Phase 1 provision has avoided the need for external specialist placements (e.g. Tadworth) but the resources do not allow formal outreach services provision to the other health boards. There is no Certificate of Completion of Training (CCT) in paediatric rehabilitation and a paediatric neurologist with an interest in this area leads the team.

With respect to psychology and neuropsychology for adult and paediatric patients that experience major trauma, there is a variable and complex provision across the region, which is complex. In C&VUHB, patients with spinal injuries have access to inpatient psychological support at Rookwood Hospital or during their care in Intensive Care, but not on the spinal ward or in the community. This also applies to patients who go to SBUHB, there is a community traumatic brain injury service with a one whole time equivalent (WTE) clinical psychologist and the same in HDUHB. There are no acute or in-reach neuropsychological assessments or treatment in the health board.

A number of third sector organisations work alongside the healthcare sector (e.g. Headway).

Trauma Prevention Programmes

In Wales, prevention programmes are led through Public Health Wales. In 2011, a report by Public Health Wales was published on the burden of injury in Wales and outlined a series of recommendations. The main interventions that have occurred are in relation to preventing falls in older patients.

2.6.6 Clinical and Operational Governance

Training and Education

There have been a number of improvements in the awareness of trauma management by WAST, predominantly through local educational initiatives and EMRTS engagement events. In relation to acute emergency care, each health board has developed its own approach to trauma training. In 2012, Morriston Hospital established the Trauma Resuscitation Education and Training Sessions (TREATS) for a multidisciplinary audience. TREATS has now been adopted by Hywel Dda University Health Board. UHW runs an equivalent course (titled the Cardiff Trauma Course). A number of locally run courses exist for trauma team leader training and emergency trauma anaesthesia. In addition to this, all health boards are providers for and/or have access to the Advanced Trauma Life Support Course (ATLS), Advanced Paediatric Trauma Life Support (APLS) or the European Paediatric Life Support Course (EPALS). There are no providers of the European Trauma Course (ETC) in the region. Some senior nurses across the network have attended the Trauma Nursing Core Course (TNCC). In addition, there is senior nursing representation on the National Major Trauma Nurses Group, which informs standards and competencies for nurses across trauma networks. Finally, training in Damage Control Surgery is outsourced to the Definitive Surgical Trauma Skills (DSTS) Course.

In 2018, Health Education and Improvement Wales (HEIW) was established as a new special health authority in Wales, bringing together the Wales Deanery, NHS Wales' Workforce Education and Development Services (WEDS) and the Wales Centre for Pharmacy Professional Education (WCPPE). There is a material link with supporting the development of trauma training and education across the network.

Trauma Audit and Research Network (TARN) and Research

TARN is the national clinical audit for traumatic injury across England, Wales, Ireland and a number of hospitals across Europe. It holds the second largest global trauma registry and has become a key national provider for the delivery of evidence of quality of trauma care for both clinical and commissioning purposes, providing and supporting the functionality for hospitals to collect individual patient data. TARN delivers information in the form of national clinical reports and dashboards to support hospitals in their governance of trauma care. Its data has been the driver for commissioning of trauma services in England and is hosted by Manchester University.

Five health boards across the region contribute to TARN, but case ascertainment and accreditation within health boards varies considerably. One health board contributes to TARN Patient Reported Outcome Measures (PROMS) and Patient Related Experience Measures (PREMS). Two health boards have dedicated TARN coordinators (hosted by clinical audit departments) to identify cases and submit

entries to TARN. All participating health boards have non-dedicated support for data collection (e.g. clinicians).

There are a number of opportunities for research in the area of trauma management across the region and examples from both UHW and Morriston Hospital (incl. the Welsh Centre for Emergency Medicine Research). Furthermore, Swansea University has a long history of supporting trauma research at an international level through the Secure Anonymised Information Linkage (SAIL) database.

Clinical Informatics

Currently, clinical informatics support for the various stages of the patient pathway is provided by health board informatics departments, WAST and the NHS Wales Informatics Service (NWIS). Whilst much progress has been made at a national level to create a single integrated patient record accessible through the Welsh Clinical Portal (WCP), there exists a number of opportunities to further enhance the linkage and transfer of information between care providers. WAST and EMRTS maintain pre-hospital records, and these are available in both paper and electronic form. Health boards maintain a combination of paper based and electronic records. Local informatics departments support the work of those who collect TARN data locally by producing reports of potential major trauma patients facilitating access to results of investigations and tracking of patient notes. The current process is labour intensive, but could be improved through the linkage and improved use of routinely collected data.

WAST and the EMRTS already work together to improve the data quality feeding of national audits (e.g. National Cardiac Arrest Registry), and are both working to improve accessibility to patient data to improve healthcare delivery across the range of patients seen (e.g. ongoing national WCP trials). As already mentioned, one health board already collects PROMS for TARN, in addition to existing PROMS data collection by EMRTS as part of its ongoing service evaluation.

A number of systems currently support patients who suffer from major trauma at various stages in their patient journey. These include: MIS C3 Ambulance control system; WAST Anoto e-Pen system; EMRTS Clinical database; Emergency department systems; Welsh Care Records Service (WCRS); Welsh Clinical Portal (WCP) Welsh Patient Referral Service (WPRS); Welsh Results Reports Service (WRRS); Welsh Patient Administration System (WPAS); Welsh GP Record; and TARN data collection system.

3 Case for Change

3.1 Introduction

This chapter sets out a comprehensive case for establishing a trauma network for the population of South Wales, West Wales and South Powys. It should be recognised that major trauma patients are already being managed across our healthcare system including in specialist centres; therefore, the development of a trauma network represents a significant service change, but not a new service development. Thus, the programme has been developed based on strengthening existing clinical services through re-organisation, introducing new pathways and enhancing clinical and operational governance. Furthermore, requirements for additional resources have been considered within the context of enhancing existing service specifications to meet national standards for major trauma.

Building on the current position described in chapter two, details are provided on the difficulties and service gaps associated with existing organisations against the trauma pathway, compared to what is occurring in regions with established trauma networks.

Furthermore, key benefits are identified using an evidence-based approach and lessons learnt from both national and international experience. An emphasis is placed on the added value of developing a trauma network to wider NHS clinical services. In doing so, this chapter makes a strong case for benefits being realised, against the key investment objectives outlined below, to ensure NHS Wales leads the way in the provision of excellent trauma care through establishing the network.

Finally, this chapter describes the value to individual organisations and how the network development aligns with their strategic plans.

3.2 Investment Objectives

The overarching investment objective of a trauma network for the population of South Wales, West Wales and South Powys can be summarised by the network's mission statement:

'Saving Lives, Improving Outcomes, Making a Difference'

Furthermore, key investment objectives defined by Welsh Government are referenced throughout this business case with added value that could be delivered. These include:

- **Health gain**: improving patient experience and outcomes.
- **Equity**: where people of highest health needs are targeted first.
- **Clinical and skills sustainability**: reducing service and workforce vulnerabilities and demonstrating solutions that are flexible and robust to a range of future scenarios.
- **Value for money**: demonstrating the least costly way of generating the anticipated benefits.
- **Affordability**: given the revenue assumptions, there should be an explicit reference to reducing revenue costs. This will be discussed in section chapter 10 – the economic case.

During the development of the programme, the network board recognised the importance of all of the above investment objectives, however, health gain for the population was deemed most important and aligns with the mission statement of the network.

A fundamental rationale is to improve patient outcomes through organising services into a trauma network and enhancing services through a phased investment and working towards meeting national standards. The table below summarises these benefits against key investment objectives which are expanded on in this chapter, chapter 12 and evidenced by a recent literature review focused on the value of major trauma networks (see Appendix 1):

Investment objective	Benefits
Health gain	Improving survival Improving functional outcomes Improving timely clinical care and patient experience Improving data collection Enhancing response at major incidents or mass casualty events Enhancing injury prevention
Equity	Enhancing access to specialist care Enhancing patient flow System wide improvements in care Equity of care for trauma in older people Veterans trauma network
Clinical and skills sustainability	Enhancing multiprofessional training and education Enhancing recruitment and retention of workforce Developing of new roles and ways of working
Value for money	Economic benefits Savings across the system Value to other patient groups and networks

3.3 Summary of Service Opportunities

Following on from the key investment objectives, the intention of the programme is to establish a model of care, using a phased approach, aligned with quality indicators and service specification. These are summarised below and developed further in chapters five - eight:

- There is an opportunity for new investment in major trauma services in South Wales, West Wales and South Powys to clearly improve the outcomes in major trauma.
- In doing so, there is an opportunity to develop an adult and paediatric trauma network covering the region of South Wales, West Wales and South Powys.
- There will be a designated adult and/or paediatric MTC to serve the region of South Wales, West Wales and South Powys.
- There is an opportunity to implement and develop designated regional TUs to serve the region of South Wales, West Wales and South Powys.
- Consistent clinical standards and specifications will be put into place for the management of seriously injured patients across the region. Furthermore, there will be a network management structure overseeing how care is being coordinated or provided.

- WAST will be able to develop and utilise a pre-hospital trauma triage tool to identify patients requiring specialist centres. The opportunity to develop a trauma desk facility will enable coordination and remote clinical incident support.
- The EMRTS will become a 24 hour service in April 2020 as part of its phased development. There will be dedicated access to pre-hospital critical care or transfer capability for major trauma patients.
- There will be a single point of access and an automatic acceptance policy into specialist centres in the region. Referrals have previously been often made to multiple teams in the receiving centres for those patients requiring hyper-acute transfers. The development of the network will directly avoid delays in access to treatment.
- Pathways for patients requiring urgent transfer for injuries that require operative intervention in specialist centres will be developed.
- The network will ensure there is an end to variation in seniority of trauma team leaders and the composition of hospital trauma teams across the region, responsible for reception and resuscitation.
- Specialist centres will be able to guarantee the presence of a consultant trauma team leader 24 hour a day. Furthermore, there can be consistency in initial and ongoing clinical assessment and treatment, imaging and documentation. In particular, systems can be established to recognise and manage trauma in older people.
- There is an opportunity to eliminate the variation in the anaesthetic and surgical approach to managing trauma patients with significant haemorrhage.
- There is an opportunity for specialist centres to have major trauma service or ward under which patients are admitted and managed. This will be addressed with the network approach to major trauma. Currently, patients are often admitted under several specialties.
- There is an opportunity to improve access to hyper-acute rehabilitation and develop an early rehabilitation plan for trauma patients.
- Patients will have better and more rapid access to specialist neuro and spinal rehabilitation than they currently do. There will be automatic repatriation of trauma patients from specialist centres to their local hospital or coordination across health boards.
- Hospital and community rehabilitation services will be configured to support recovery, rehabilitation and re-enablement of trauma patients.
- There is the opportunity to develop consistent and robust clinical and operational governance processes (including training and education) in place and improve sharing of learning from clinical issues is variable.
- There will be full participation from the health boards in TARN. TARN data entry relies on retrospective review of case notes following clinical coding which has and investment in this function will provide alleviation of stretched clinical audit staff.
- There will be 'live' identification of patients at all points of the pathway. Data can then be routinely shared between health boards even when the patient crosses these multiple boundaries
- There will be a more uniform approach to incident reporting systems and an opportunity to remedy the issue of data being manually shared when an incident crosses over multiple organisations.

- There will be development of a mechanism to conduct multi-disciplinary trauma quality improvement in either the specialist centres or other hospitals and a regional quality improvement structure to address issue that cross between providers.
- There will be development of a mechanism to ensure that innovation in trauma care is fostered in the region and to ensure that innovations adopted by one provider is compatible with systems of care in other providers who may treat the same patient.

3.4 Health Gain

3.4.1 Improving Survival

The following case illustrates the current situation in South Wales, West Wales and South Powys (no patient identifiable information to maintain confidentiality):

> A young male was assaulted late at night in a rural part of Wales. He sustained a significant head injury and was unconscious at the scene. A paramedic ambulance was deployed and the patient was taken to the local acute hospital. On arrival in the emergency department, his windpipe was obstructed and his oxygen levels were very low. A junior emergency department doctor and anaesthetist managed him and after some delay, the patient was transferred to the CT scanner.
>
> A CT scan demonstrated an extensive bleed with pressure on the brain and a significant chest injury. After delays in a referral being accepted, the hospital transfer team transferred the patient to the nearest neurosurgical facility eight hours after the injury. Unfortunately, he deteriorated *en route* and, despite emergency neurosurgery, had a poor outcome.

There is a significant body of evidence that demonstrates that patients who suffer major trauma and are treated within a trauma network generally have better outcomes and a greater chance of survival. Evidence shows that severely injured patients are 15%-20% more likely to survive their injuries if they are admitted to an MTC (Celso *et al*, 2006). MTCs have 24 hour access to consultant trauma team leaders, available on arrival of the patient in the emergency department with rapid coordination of initial assessment, resuscitation and imaging. All key surgical specialties are available, performing multidisciplinary management of patients and provision is made for these patients to receive early operative management and ongoing surgery. Patients are also cared for under the umbrella of the major trauma service, with multidisciplinary input. It is difficult to isolate which part of the MTC system contributes most to improvements in survival.

Improvements in survival have been substantiated by a large national longitudinal study of 110,863 patients using the TARN dataset, which demonstrated that in the first five years after the launch of the English trauma networks, there has been a significant (19%) improvement in survival for patients alive on arrival at hospital, with 1,656 more survivors than would be expected based on historical performance (Moran *et a*l, 2018). This is ahead of the target of 450-600 additional survivors that NHS England predicted. Scaling these results to the relevant population, an estimated 70 additional trauma patients over five years would survive in South Wales, West Wales and South Powys if the trauma network were implemented.

This benefit was conferred across trauma networks and not just in the MTCs, as a significant proportion of major trauma patients continue to be appropriately managed locally. Furthermore, the trend towards improving survival is consistent with international studies (e.g. McDermott *et al*, 2007 and Gabbe *et al*, 2011).

Locally, the picture has been similar for North Wales with patients being treated at the MTC in Royal Stoke University Hospital; approximately 900 patients were transferred to the MTC since 2013, with 18 more survivors from major trauma than expected.

Therefore, evidence indicates that patients in South Wales, West Wales and South Powys are set to benefit from improvements in survival from major trauma through the establishment of a network. It can be concluded that more patients are currently dying compared to other regions in the UK that have trauma networks in place, including North Wales.

As illustrated in the one-year evaluation of the EMRTS (2016), there is an intrinsic relationship between pre-hospital critical care and acute hospital care in improving health gain for trauma patients, strengthened further in the presence of a trauma network. The EMRTS has made significant progress in demonstrating the benefit of early critical care interventions at the scene of the incident, transfer of more trauma patients to definitive specialist care and setting patients on the correct trajectory (e.g. taking patients direct to CT imaging at UHW). Furthermore, international evidence indicates improvements in survival of major trauma patients taken to MTCs by physician-led Helicopter Emergency Medical Services compared to paramedic-led transfer (Engel *et al*, 2010). However, the full benefit of the EMRTS will only be realised within the context of an integrated trauma system.

3.4.2 Improving Functional Outcomes

The following cases illustrate the current situation in South Wales, West Wales and South Powys (no patient identifiable information to maintain confidentiality):

> A young boy was a pedestrian in a road traffic collision and sustained a severe traumatic brain injury. He had a protracted stay in hospital, followed by specialist neuro-rehabilitation. His mother described his acute care and specialist rehabilitation as excellent, but on discharge home there was a lack of appropriate discharge planning and awareness of her son's acquired brain injury. There was a lack of consideration given to adaptations at home, integration back into education and long-term rehabilitation. Furthermore, there was a lack of support for the mother as his main carer.
>
> Whilst the boy's mother managed to cope due to good family support, she fears others may not cope if placed in a similar situation.

> A 20 year old female had a fall from a significant height and sustained a severe traumatic brain injury and multiple fractures. She was admitted for emergency neurosurgery and spent several weeks in the specialist centre before being discharged. She was promised ongoing rehabilitation but nothing materialised. The patient was left with no hearing in the left ear, left sided weakness and severe hip pain. It took 26 calls over 6 weeks to arrange follow-up for these problems. The patient felt that she had been forgotten about once she left the specialist centre and believes that this had an impact on her ability to return to work sooner and on her psychological wellbeing.

Functional outcomes define results of patient care focused on physical ability. The two main ways to determine a patient's physical ability is either to ask about abilities (Patient Related Outcome Measures - PROMS) or to observe physical ability (Performance Measures). A good functional outcome is often best defined by a level of physical ability that matters to the patient. For example, TARN PROMS measures change in ability to work and other activities six months after injury, reporting extreme problems and a visual analogue score on how they rate their health at six months. Currently, only one hospital contributes to TARN PROMS, making it challenging to objectively understand the current levels of functional outcome and the impact any interventions might have.

As illustrated by the above patient stories, rehabilitation is key to improving functional outcome. The British Society of Rehabilitation Medicine (2013) defines rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological

function, participation in society and quality of living. This has to be inclusive of hyper-acute, specialist, TU and community based rehabilitation of trauma patients.

Since 2010-12, there have been significant advances in acute care of trauma patients in NHS England. Despite the NHS Clinical Advisory Groups (CAG) Report (2010) clearly indicating the importance of the rehabilitation pathway, there was a lack of new investment in rehabilitation in NHS England and this is one of the main lessons that has been learnt through the establishment of regional trauma networks. To date, no national functional outcome data have been published, which is likely to reflect the significant variation in rehabilitation capability across the English networks. Consequently, in 2014, the British Society of Rehabilitation Medicine published core standards for trauma rehabilitation, indicating a substantial body of trial-based evidence to support the effectiveness of trauma rehabilitation, in particular for patients with traumatic brain injuries. These guidelines form the basis for the development of clinical and operational service modelling for all trauma networks.

In contrast, a site visit to Scotland in October 2018, revealed that the Scottish Trauma Network has identified trauma rehabilitation as a key enabler for improving functional outcome and patient flow. Their mission statement is 'saving lives, bringing life back.' In doing so, the network will be providing resources for an additional 30 rehabilitation allied healthcare professionals (AHPs) and 17.6 trauma coordinators between 2018-2022. NHS Scotland are learning the lessons from NHS England in focusing on improving rehabilitation capacity from the outset.

Internationally, there is a body of evidence demonstrating improvements in functional outcome in trauma systems that have incorporated rehabilitation across the pathway from the outset. Gabbe *et al* (2012) reported that following the formation of the Victorian State Trauma Service in Australia, risk-adjusted functional outcomes improved significantly. That is, not only were more patients surviving, they were doing so with less disability. Furthermore, a 10-year study from this trauma system demonstrated that years of life lost decreased by 43% and lost disability-adjusted life years fell overall by 28% over the period. This indicates that enhanced survival associated with trauma networks does not necessarily result in an overall increase in non-fatal injury burden (Gabbe *et al*, 2015). A systematic review of multidisciplinary rehabilitation in major trauma patients revealed the importance of early recognition and initiation of rehabilitation in this group, which was associated with improved functional outcomes (Khan *et al*, 2012).

Furthermore, service providers for rehabilitation echoed the views of patients with respect to current trauma rehabilitation in South Wales, West Wales and South Powys at a rehabilitation workshop in December 2018. Providers raised concerns about the lack of rehabilitation services within health boards, especially for rural areas. There was a recognition that health boards are not sufficiently resourced or experienced to accept complex trauma patients back from specialist centres. Providers felt that they currently lacked the expertise in managing these patients and in meeting their rehabilitation requirements. This is compounded by the inability to access outreach rehabilitation support from the specialist centres. Finally, providers indicated that 'without investment in the back door there was not value in investing in the front door.' They saw the benefit of improvements in rehabilitation as not only giving patients the best possible experience and chance of a good functional recovery, but as a vehicle for improving patient flow across the system.

3.4.3 Improving Timely Clinical Care and Patient Experience

The following case illustrates the current situation in South Wales, West Wales and South Powys (no patient identifiable information to maintain confidentiality):

> A 72 year old male presented overnight to an emergency department having fallen down three to four steps at home. He was seen by a junior doctor several hours later and received an x-ray of his neck, chest and pelvis. The next morning, he was seen by a consultant, who organised CT scans, which demonstrated multiple injuries. With some difficulty, the patient was admitted under the trauma and orthopaedic team. Over the course of next few weeks, the patient moved wards at least four times, developed delirium secondary to a urine infection and was eventually placed in a residential home. There was no multidisciplinary review of the case. Furthermore, the health board did not contribute to TARN, making it challenging to understand the extent of the problem.

The above case illustrates a common problem with trauma care in South Wales, West Wales and South Powys. In the presence of a trauma network, the patient may still not have been taken direct to the MTC, but would have received a pre-alert to the local TU and been received by the hospital trauma team. There would have been early recognition of significant injuries with whole body CT on arrival and a detailed secondary survey undertaken for detection of smaller injuries. The initial review would include an assessment of cognition and frailty. Clear network operational procedure would have guided the admitting speciality. Early orthogeriatric review and referral to a care-of-the-elderly physician may have reduced the number of moves to different wards, whilst improving patient recovery. Furthermore, in the event of an adverse event, this case would be subject to TU multidisciplinary case review and escalated to the network clinical governance structure, to ensure lessons learnt were shared transparently and widely.

From patient experience and rehabilitation workshops, one of the key reasons given for a poor experience by trauma patients and their families or carers was the lack of good quality communication and coordination across the pathway. All patients interviewed cited this issue as important to them. Patients talked about delays in treatment and how these were not adequately explained to them. Information was not shared in simple language that could be easily understood. There was a lack of consistent information conveyed between healthcare providers (particularly between specialist centres and local hospitals and community healthcare). Variation in clinical informatics systems has been given as a reason for this. Furthermore, the expectations of patients and their families or carers were not well managed, with a lack of support provided by specialist centres once patients were discharged. Finally, practical support for families and carers was often overlooked (e.g. accommodation for those travelling some distance, signposting financial/legal advice and welfare services). Monitoring of patient experiences is limited with only one health board contributing to TARN PREMS. Thus, the workshops have provided a useful insight into current issues to ensure patient experience is considered in the design of the network.

3.4.4 Improving Data Collection

There are significant improvements in health gain that can be achieved by improving data collection. It is recognised that there is a lack of consistent TARN data collection across the region, despite contribution to TARN being a mandatory audit for health boards in the annual national clinical audit and outcome review annual plan as illustrated by the TARN network report, 2018 overleaf.

Case Ascertainment & Accreditation

If case ascertainment is low then the analysis in the rest of the report may not be reflective of true practice.

	01 April 2017 to 31 March 2018				01 April 2016 to 31 March 2017			
Trust / Hospital	N	E	C (%)	A (%)	N	E	C (%)	A (%)
ABM University Health Board	600	663 - 787	76.2 - 90.5	95.6	643	663 - 787	81.7 - 97	95.2
Morriston Hospital	595	474 - 559	100+	96	594	474 - 559	100+	95.2
Princess of Wales Hospital	5	189 - 228	2.2 - 2.6	89	49	189 - 228	21.5 - 25.9	95.9
Aneurin Bevan Local Health Board					1	530 - 634	0.2 - 0.2	54.8
Cardiff and Vale University Health Board	627	709 - 843	74.4 - 88.4	95.7	687	709 - 843	81.5 - 96.9	94.9
University Hospital Llandough	12	51 - 68	17.6 - 23.5	95	23	51 - 68	33.8 - 45.1	92.6
University Hospital of Wales	615	658 - 775	79.4 - 93.5	96	664	658 - 775	85.7 - 100+	95.0
Cwm Taf Health Board	373	373 - 452	82.5 - 100+	85.5	444	373 - 452	98.2 - 100+	87.0
Prince Charles Hospital	156	200 - 242	64.5 - 78	72	254	200 - 242	100+	81.5
Royal Glamorgan Hospital	217	173 - 210	100+	95	190	173 - 210	90.5 - 100+	94.3
Hywel Dda Health Board	186	444 - 546	34.1 - 41.9	95.8	195	444 - 546	35.7 - 43.9	91.0
Bronglais General Hospital	149	82 - 105	100+	98	144	82 - 105	100+	97.9
Glangwili General Hospital	8	230 - 277	2.9 - 3.5	78	50	230 - 277	18.1 - 21.7	71.2
Withybush General Hospital	29	132 - 164	17.7 - 22	89	1	132 - 164	0.6 - 0.8	85.7

N The number of approved submissions for the period
E The expected number of submissions for the period (from HES / HIPE / PEDW)
C The case ascertainment % for the period
A The accreditation % for the period

This indicates that case ascertainment (i.e. completion of the dataset) was 54.8-65.7% (average 60%). This is below the target of 80%, making subsequent data analysis difficult to interpret. Nonetheless, data accreditation (i.e. quality of entry) at 93.5% was acceptable, but still below the target of 95%. In England, most networks now have case ascertainment and data accreditation exceeding the target threshold, owing to the deployment of TARN coordinators across the network and enhanced 'live' case identification, which South Wales, West Wales and South Powys currently lacks. Furthermore, the total number of cases submitted to TARN increased from 23,211 in 2011/12 to 44,059 in 2016/17.

The absence of TARN data available to health boards has resulted in a number of problems. Firstly, it has led to an inability to objectively determine the current level of clinical care and gaps. Secondly, it has affected both the deliverability and impact of any quality improvement interventions. Thirdly, it has made it difficult to identify outlier cases for further evaluation and longitudinal review. Fourthly, as a network has not yet been established, TARN does not produce dashboards for each hospital to provide comparison with English hospitals or North Wales. Finally, it has made predicting future changes in patient flow particularly challenging.

It is recognised that the network will need to have informatics systems established to ensure both TARN data and data that fall outside the remit of TARN is collected and available for quality improvement, commissioning and research, which will allow the development of an effective data-driven system to improve patient outcomes.

A work programme will be established to implement a central trauma-specific electronic patient administration system. The system will aim to identify patients at the earliest opportunity, ideally pre-hospital, or in the emergency department, and start to track the patient's journey through the pathway. It will integrate with local and national systems in use across NHS Wales (including the Value Based Healthcare Programme and National Data Resource Plans) providing the relevant near real-time information to all involved in the management of the pathway. This includes clinicians, managers, clinical audit, and administrative staff. It will also link with systems used to communicate with patients to facilitate TARN PROMS/ PREMS. A cohort of the patients who are TARN eligible will then be fed into the TARN database. This approach will allow Wales to hold its own trauma registry for operational management, with potential for service evaluation, additional audits and research. With a scope wider than the TARN criteria, it will provide unique opportunities to improve service delivery and facilitate injury prevention activities. The system will also support clinical governance processes through tracking of case reviews.

3.4.5 Enhanced Response at Major Incidents or Mass Casualty Events

The Health Prepared Wales conference in 2017 demonstrated the benefit of having trauma networks during the recent terror attacks in London and Manchester, where patients were effectively managed across several MTCs and TUs. System knowledge and coordination allowed pre-hospital teams to appropriately triage patients and subsequently minimise the number of patients needing transfer later to MTCs. For the London terror attacks, the London Trauma System effectively turned a mass casualty event into several smaller incidents that fell well within the capacity and capability of the receiving hospitals.

Whilst there have been significant improvements due to the creation of a national framework for mass casualty events including capacity planning, there is scope to go further. The establishment and integration of a regional trauma network into the national framework will be a key enabler for the successful management of a major incident or mass casualty event. South Wales and, in particular, Cardiff host many large, high-profile sport and music events every year. The region remains a potential target for terrorist activity now and in the future. The lack of a trauma network presents a significant strategic risk to the region and its population. Furthermore, there is currently a lack of alignment with England, leading to an inability for NHS Wales to provide an effective mutual aid response to NHS England as part of the national response to a major incident.

3.4.6 Enhancing Injury Prevention

In Wales, most injury prevention strategies are coordinated through Public Health Wales. Road traffic collision prevention is coordinated by multiple agencies including local authorities and the police service. In the future, the trauma network could make a significant contribution to injury prevention programmes through data sharing, research and educational initiatives (e.g. motorcycle safety, wearing cycle helmets). Opportunities also exist to access funding to prevent serious knife and gun crime. Furthermore there is a material link between the establishment of the trauma network and the national falls prevention programme being undertaken by Public Health Wales.

3.5 Equity

The benefits that the trauma network can deliver in improving equity can be explored through a number of lenses.

3.5.1 Enhanced Access to Specialist Care

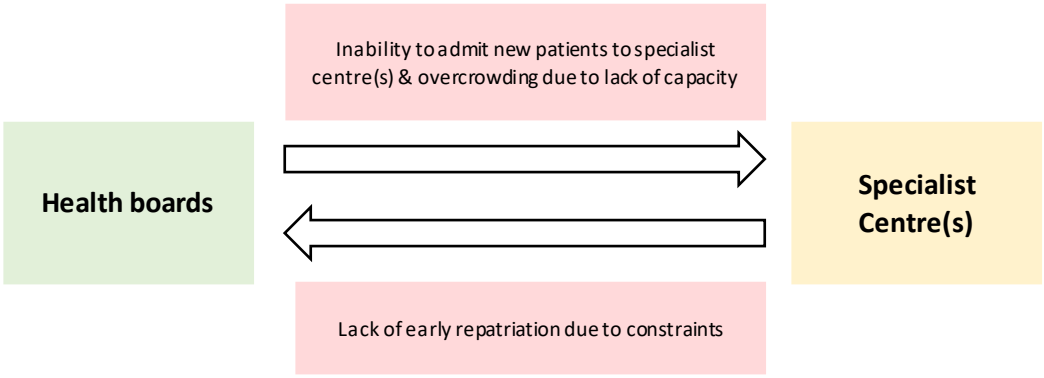
Equity of access to specialist trauma care remains an issue for patients who are injured outside the normal catchment area of specialist centres and, in particular, for rural areas (e.g. in Mid and West Wales). The presence of the EMRTS since 2015 has helped improve equity and timeliness of access to definitive specialist trauma care. The one year evaluation demonstrated 58% of patients being transferred directly to specialist care. EMRTS is currently only a daytime service but plans have been agreed to expand to 24/7 from the South Wales base from April 2020. Overnight and when the service is busy, major trauma patients continue to be taken to their local hospital. This is compounded by a lack of a pre-hospital triage tool and WAST trauma desk facility to coordinate the transfer of patients to specialist centres. Sinclair *et al* (2018), who introduced a clinician-staffed trauma desk as part of the Scottish Trauma Network, have highlighted the benefit of this approach. They demonstrated a significant increase in the sensitivity for identifying major trauma from 11.3% to 25.9%.

In the absence of a regional MTC and the lack of an automatic acceptance policy to support both direct admissions and secondary transfers, a significant proportion of trauma patients who could benefit from specialist care currently do not. This is illustrated by the fact that the assumed current position for moderate and major trauma going direct or being transferred to UHW is low and pre-dates 2011 from NHS England (see Appendix 2).

Evidence from NHS England (see Appendix 2) indicates an increase in the proportion of moderate and major trauma cases taken direct to the MTCs from 2011 to 2013, after which a steady state was reached. For major trauma, there was a decrease in transfers from TUs to MTCs, owing to enhanced pre-hospital triage. Overall, this resulted in a significant increase in the proportion of patients having an MTC as an initial (53% to 72%) or final (73% to 82%) care destination. Thus, in the presence of a trauma network, more trauma patients from South Wales, West Wales and South Powys are set to benefit from specialist care, reducing inequity of access. Currently, geographical inequity exists across Wales, with trauma patients in North Wales benefitting from accessing MTC care at the Royal United Hospital, Stoke.

3.5.2 Enhanced Patient Flow

To reduce inequity, a number of requirements are important in the design of the network. Firstly, 24 hour availability of the EMRTS, with pre-hospital triage and a remote facility to support decision-making by paramedics. Secondly, the MTC will need to maintain an automatic acceptance policy, but this will be determined by the ability of the MTC to maintain sufficient capacity and this depends upon the timely repatriation of patients for 'care with treatment closer to home.' Currently, there are significant delays in the transfer of care for patients who have completed specialist care, where ongoing care could be managed locally whilst waiting for discharge home or specialist rehabilitation. Data on the magnitude of the problem is sparse, as the NHS Wales Repatriation database is frequently not completed; however, local data indicates a 6-8 week delay in the transfer of patients with head and spinal injuries from UHW to health boards. As part of the network development, a patient flow workshop was undertaken in February 2019 to explore the reasons for delays. This is summarised in the process map illustrated below:



Constraints included a lack of an automatic repatriation policy and coordination, a lack of local rehabilitation services for trauma patients and an inability to manage complex patients (e.g. tracheostomy care, bowel and bladder care, behavioural disorders). System wide issues were also

raised including a lack of bed capacity due to poor access to packages of social care and pressures on unscheduled care. Finally, the current fragmented commissioning of services pertaining to major trauma was considered to be a key problem. These issues are not isolated to NHS Wales. In NHS England, some regional trauma networks have developed escalation procedures for patients in MTCs to be transferred back to their local Emergency Department; however, this forced measure has rarely been enacted.

3.5.3 System-Wide Improvements in Care

Leading on from the above, a key lesson from the English trauma networks relates to a lack of new investment in TUs compared to MTCs. Given that, in 2017, 61% of moderate trauma and 36% of major trauma remained in English TUs, this lack of investment was an oversight. To address this, NHS England are in the process of developing a best-practice tariff for TUs, similar to that developed for MTCs. For patients who remain in TUs and LEHs in South Wales, West Wales and South Powys, there should be equity of access to improved standards of care and this will require some additional investment. Without this additional investment in TUs, LEHs and community-based rehabilitation, all patients who are treated in the region are set to be disadvantaged in achieving the best functional outcomes possible. Furthermore, patient flow will not be maintained without getting the 'landing pad' (see section 8.4.2) at the TUs optimised for patients discharged from the MTC. This will have a direct impact on the ability of the MTC to accept new patients from across the network.

3.5.4 Equity of Care for Trauma in Older People

Equity must also be considered in the context of the patient's age, given population profiles (chapter 2). A further lesson learnt from the establishment of English trauma networks, was a lack of planning in relation to the 'changing face of trauma' (Kehoe *et al*, 2015). In 2017, TARN produced a report based on data from England and Wales, indicating that the majority of major trauma occurs in patients older than 65 years. The commonest cause of death was traumatic brain injury and falls from standing height were the commonest mechanism of injury. Existing pre-hospital tools were not good at identifying older major trauma patients. Consequently, there was a lack of activation of hospital trauma teams and seniority of initial assessment. There was a higher mortality in this group. Nonetheless, those that did survive major trauma did not have a higher incidence of disability compared to younger people. Thus, it is imperative that network design takes into consideration the specific requirements of older patients to ensure equity for this population group.

3.5.5 Veterans Trauma Network

Finally, the establishment of the trauma network lends itself to supporting the Veterans Trauma Network (VTN). The VTN exists to ensure that the needs of veterans with complex physical injuries are met. It is specifically focused on those who sustained complex physical injuries because of military service. The VTN has been successfully established in NHS England, based upon a collaboration with the MTCs. It provides a single point of referral for all stakeholders who are concerned about the medical care of a veteran with complex physical injuries, including patients, clinicians (from both physical and mental health services in primary or secondary care) and third sector agencies. Equity of access to ongoing surgical care and rehabilitation for those injured through military conflict would be an important benefit.

3.6 Clinical and Skills Sustainability

3.6.1 Enhanced Multi-Professional Training and Education

Presently, there is no regionally agreed training and education programme. Existing arrangements for the delivery of training and education pertaining to trauma can be divided into nationally/internationally recognised resuscitation courses or locally developed solutions. Resuscitation courses are expensive and thus often only accessible to doctors. Currency is often

challenging, with one 'candidate' TU reporting that only half of its Emergency Medicine consultants were current. Whilst locally developed solutions are cost effective and accessible to a wider audience, they vary in content, quality assurance and delivery. Discussion with trainees indicates variations in practice between hospitals, leading to inconsistencies in key educational messages and consequently patient care. To date, there has been no formal evaluation of these latter courses. Furthermore, all trauma courses focus on pre-hospital care and initial emergency care of trauma patients. There is less emphasis on the rest of the trauma pathway including surgical skills, critical care, ongoing care (especially for local hospitals receiving patients back from specialist care) and rehabilitation. The establishment of a trauma network also enhances training in the psychological aspects of physical trauma including supporting victims, their families and providers.

In England, each regional trauma network has taken a different approach to training and education, but there has been no determination of which strategy is most effective. Several programmes have aligned with national nursing competencies as defined by the National Major Trauma Nursing Group, to give nurses career progression opportunities. Furthermore, Scotland are in the early stages of developing a network wide training and education programme, but with no answer on the best approach.

There is an exciting opportunity to develop a network wide educational programme using a combination of established courses and those developed through the network. The programme will need to be multi-professional, aligned with national competencies and bridge the entire patient pathway. There is an opportunity work in collaboration with Health Education and Improvement Wales as a new, innovative health authority, in order to ensure that the programme is firmly linked with the network governance structure and is subject to formal evaluation. This will lead to an enhanced knowledge and skill base across the network.

Finally, learning from a site visit to the Scottish Trauma Network, the establishment of an annual event, bringing together healthcare professionals from across the network was seen as a key step in sharing best practice, stakeholder engagement and driving interest in the development. Currently there are no conferences specific to major trauma held in Wales, but as the network develops there is an opportunity to explore this further as part of its establishment.

3.6.2 Enhance Recruitment and Retention of Workforce

Currently health boards across South Wales, West Wales and South Powys struggle to recruit to key disciplines pertaining to major trauma such as Emergency Medicine, Intensive Care Medicine, Rehabilitation Medicine and surgical specialties. For many senior trainees interested in major trauma, the absence of a trauma network clearly factors in their decision-making and choice of consultant posts. Whilst there is a paucity of evidence to quantify the impact of a trauma network on recruitment, it is likely that its development will positively contribute to both recruitment and retention of medical personnel. It is likely that the MTC will benefit most from this; the challenge will be to ensure this applies across the network, to include TUs and LEHs. This could be overcome by ensuring that all new posts in the MTC are made as joint appointments with other health boards, where appropriate, ensuring a network approach to the workforce strategy. This will also help mitigate against depletion of workforce from health boards outside the MTC.

Appropriate resourcing of the entire network will be required to prevent the development of an MTC focused approach, as was demonstrated in England. Improved consistency of clinical governance and standards across the network will benefit trainees who rotate across the health boards. The enhancement of recruitment and retention can also be extended to include allied health care professionals (e.g. nurses, paramedics, theatre staff, therapists), reinforced by the development of new roles working across the network including major trauma practitioners and rehabilitation coordinators.

The establishment of the EMRTS, which placed clinical and skills sustainability as an important investment objective, demonstrated enhanced recruitment and retention. Since its establishment, the service has recruited four consultants in Emergency Medicine to Wales and contributed to enhanced retention. This is a trend that is likely to be mirrored in-hospital once the trauma network is established, through the creation of attractive and varied job plans.

3.6.3 Development of New Roles and Ways of Working

The establishment of the network presents an opportunity for the development of new roles and ways of working. There will be an opportunity for allied health care professionals to engage in new roles included in an extended scope of practice (incl. tertiary assessments, frailty/cognitive assessments) traditionally undertaken by the medical profession. For therapists there is an opportunity to expand their remit of practice to include a broader range of presentations. Nursing staff in health boards are likely to benefit from training offered by rehabilitation specialists in line with developing the right conditions for patients returning for 'care with treatment closer to home.' This includes tracheostomy care, bowel and bladder care and behavioural management.

The development of the network as a platform for training and education will promote new areas of training, previously not considered in Wales. For example, the adoption of the curriculum for training in trauma surgery, fellowships in trauma surgery and the creation of trauma surgery as a speciality in Wales.

3.7 Value for Money

3.7.1 Economic Benefits

With enhanced investment across the trauma pathway (including rehabilitation), there is evidence of improvements in functional outcome and, therefore, reducing ongoing healthcare requirements and improving ability to return to work. Gabbe *et al* (2015) demonstrated that after 10 years of introducing the Victorian State Trauma Service, there was a cost saving per case of $633,446 in 2010-2011, compared with 2001-2002, owing to increased disability free years.

Taylor *et al* (2012) demonstrated that Helicopter Emergency Medical Services working within the context of a mature trauma system resulted in a reduction in hospital mortality leading to a cost per life saved of $1,566,379, $533,781 and $519,787 in all patients, patients with serious injury and patients with traumatic brain injury respectively. The cost savings are not just related to additional patients who survive, but to all patients who survive. With improvements in rehabilitation, enhancements in functional recovery will be seen across a wide group of patients.

Furthermore, there are a number of studies demonstrating cost effectiveness of rehabilitation interventions. Wood *et al* (1999) demonstrated an estimated lifetime saving in the cost of care of over £1 million per patient receiving neuro-rehabilitation with good functional outcome. The same trend has been demonstrated in other studies related to the provision of neurorehabilitation.

With 14 additional lives saved across the network per year, this is likely to equate to a cost of life saved of approximately £17 million, with the economic benefits from improving functional outcomes to be quantified as part of the benefits realisation plan.

Furthermore, national and international trauma networks have demonstrated costs effectiveness in terms of Quality Adjusted Life Years (QALYs). This is explored further in the economic case.

3.7.2 Savings across the System

There are savings across the system through the introduction of the network. Firstly, five years' experience from England indicates that through the introduction of enhanced pre-hospital triage and enhanced pre-hospital care the proportion of moderate and major trauma transferred directly to

MTCs has increased. Thus, overtime the number of acute secondary transfers has fallen, by taking the 'right patient to the right place in the right time.' The effects on hospital personnel required to undertake these transfers should not be underestimated, particularly out of hours. Furthermore, there is an impact on WAST due to increased secondary transfers. Thus, there is a direct cost-saving to hospitals and WAST in not having to undertake these transfers but these benefits will take time to be realised.

It is possible that this benefit will be largely due to pre-hospital enhanced care and decision-making provided by the EMRTS and support provided to WAST by a trauma desk facility. However, by delivering patients direct to definitive care, there will be less duplication of trauma team activation, assessment and investigations (including imaging and pathology). Furthermore, patients are likely to require fewer operations if managed with definitive surgical care from the outset. For example, a local study demonstrated that 80% of patients requiring operative intervention for open fractures required two procedures or fewer in the first 12 months after injury if managed by specialists compared to 28% in whom surgery was less well coordinated.

Whilst there are likely to be more emergency department attendances, increased operative requirements and requirements for critical care/ward-based care at the MTC (Yip *et al,* 2016), by contrast TUs and LEHs will see and admit less moderate and major trauma. Although major trauma represents a small proportion of overall unscheduled care workload, patients are often complex with a median length of stay in hospital of nine days. Thus, centralisation of trauma care is likely to allow TUs and LEHs to focus more on routine unscheduled care and create space for elective operative workload to support referral-to-treatment times.

Savings can also be demonstrated through collaboratively commissioning patient pathways, with new approaches leading to maximum utilisation of allocated resources and effective monitoring.

Finally, whilst there was no significant reduction in the length of stay of trauma patients since the introduction of the English trauma network, the median length of stay for critical care fell from 4 to 3 days (Moran *et al*, 2018).

3.7.3 Value to other Patient Groups and Networks

The development of an appropriate rehabilitation model across the network with additional resourcing is likely to benefit a wider group of patients with non-traumatic problems, as the knowledge and skill base of allied healthcare professionals will extend beyond trauma. This includes strokes and complex neurological problems. Enhancement of orthogeriatric trauma will lead to improvements in the care of patients with fractured neck of femurs, an area where there is a variability of input from orthogeriatricians across health boards.

Once the network is established for South Wales, West Wales and South Powys, developing a national position will bring benefits to North Wales. Initially, the availability of national trauma desk will allow enhanced support and coordination of trauma cases directed to the TUs or MTC in Stoke-on-Trent. Later, there will be enhancement of clinical and operational governance, and the opportunity to support the development of a trauma rehabilitation model, with learning from the experiences in South Wales.

If successful, there will be significant learning from the operational capability of the network for other networks (e.g. the approach taken to clinical governance and repatriation for patients for 'care with treatment closer to home'). Whilst patient groups will be different, the system challenges will be the same. Thus, there will be an opportunity to learn from new and innovative practice. This benefit also extends to how we commission clinical services and specialist clinical services in the future, through commissioning differently.

3.8 Local Health Board and WAST/EMRTS Specific Benefits

In this section, organisational specific benefits are described, with an emphasis on how additional resources may provide wider benefits and align with the organisations strategic plans.

3.8.1 Cardiff and Vale University Health Board (C&VUHB)

The mission for the health board is 'Caring for People, Keeping People Well.' The vision is 'a person's chance of leading a healthy life is the same wherever they live and whoever they are.' These statements align with the aims for the trauma network.

The development of an adult and paediatric MTC at UHW presents an exciting time for C&VUHB. There are clear links between the establishment of the MTC and C&VUHB Strategic Goals in its 'Shaping our Future Wellbeing Strategy 2015-2025.' The Strategy sets out objectives that link directly with the delivery of a MTC:

- Reduce health inequalities
- Have an emergency care system that provides the right care, in the right place, first time.
- Be a great place to work and learn.
- Work better together with partners to deliver care and support across care sectors, making best use of our people and technology.
- Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives.

The establishment of the MTC will address a number of service gaps specific to UHW that need to be addressed which will be explored further in Chapter 7:

- There is currently no MTC for adult or paediatric patients in the South Wales, West Wales and South Powys region.
- There is no single point of access into C&VUHB as a specialist centre for major trauma cases. There is limited repatriation or transfer of patients to their local hospital following specialist treatment.
- Consultant led trauma team leaders are not 24/7 in the Emergency Unit.
- There is limited capacity for treating the current number of seriously injured patients who are brought to C&VUHB. This is evident in areas such as the Emergency Unit and theatres.
- There is no dedicated ward or area where multiply injured patients are managed and cared for as a cohort.
- There is a lack of consistent coordinated care and clear communication with seriously injured patients and their families/carers.
- There is no multidisciplinary approach to governance, quality improvement, research and audit at present.
- Seriously injured patients are not currently provided with any rehabilitation plan/prescription.
- The critical care unit at UHW is recognised as being under strain.

In addition to those benefits detailed in this chapter, the expected quality benefits for attending the MTC are set out below:

- Patients will receive a service that delivers the highest possible care for patients 24 hours a day, seven days a week.

- Reduction in preventable deaths, in particular enhancing the rate of unexpected survivors.
- Improved functional outcome, from early rehabilitation interventions.
- Improved patient and carer experience through increased coordination of care and communication around expected pathway and ongoing care plan.

3.8.2 Swansea Bay University Health Board (SBUHB)

SBUHB recognises the pivotal role it plays in the delivery of major trauma services to patients and their families in South West Wales, as well as providing wider-scale specialist services in relation to burns and plastics. The establishment of the trauma network lends an opportunity for the community to see the same improvement in standards of care for trauma patients as delivered elsewhere in the UK and globally. To achieve the national quality indicators for major trauma requires an increase in staff and service capacity to deliver an effective pathway from before the 'front door', through to the patient returning for rehabilitation and back into the community. Through a multi-disciplinary approach, embracing clinicians, therapists and managers, SBUHB has benchmarked against best practice to identify where the investment will add most value.

Admittedly, there are constraints on space at Morriston Hospital, which will be addressed through opportunities for collaboration with HDUHB via the ARCH programme, optimising the use of existing workforce and infrastructure assets across South West Wales and addressing potential areas for improvement in patient pathways and shared learning. Swansea Bay has acknowledged the need to redistribute some of the work currently undertaken at Morriston Hospital, which will require investment, over and above that linked to the delivery of the network. For example, when neurosurgery moved from Swansea to Cardiff, the remaining spinal services at Morriston Hospital were funded on an elective basis and so additional resources will be needed to deliver this service to support the emergency aspects of the network. With the implementation of the network and subsequent capacity constraints at Cardiff, there may be a further impact on patient pathways relating to urgent, not emergency, spinal surgery. Investment in spinal services will support delivery of care for some spinal trauma patients as well as an opportunity to improve the management of non-traumatic conditions such as cauda equina syndrome and malignant spinal cord compression.

The focus on the importance of creating the 'landing pad' at Morriston Hospital (to enable early repatriation from the MTC to a more local treatment and care facility) has identified extra capacity within the inpatient setting, with a concomitant uplift in the number of therapy and nursing staff. The coordination of care for major trauma patients – ensuring seamless transition from acute care into recovery and rehabilitation – is seen as key to the efficient delivery of the network, given the range of services that will require synchronisation to deliver best outcomes. Isolated open lower limb fractures and transfers of patients needing orthoplastics intervention, will require wider trauma coordinator input than the average TU. The network will need to ensure that there is a robust plastics surgery presence on both the Morriston Hospital and UHW sites to deliver a proactive surgical service. Thus, there is an opportunity to build a foundation for better collaboration between the two sites, which is part of a wider strategy on tertiary service partnerships. The network will provide the best opportunity to deliver gold standard care to improve survival and outcomes for major trauma patients and fits with the longer-term vision for Morrison Hospital being the site to support this goal.

3.8.3 Aneurin Bevan University Health Board (ABUHB)

ABUHB welcomes the development of a unified Trauma network across South Wales, West Wales and South Powys that will ensure that patients receive prompt specialist trauma care when needed.

When the trauma network is established, it is less likely that patients will require a secondary ambulance transfer to a specialist centre and the resources previously devoted to managing these patients within the health board will be able to be directed towards other ABUHB patients. When significantly injured patients do present to emergency departments in ABUHB, there will be a simple and clear pathway to facilitate transfer to the MTC.

The health board currently accepts major trauma patients into its two emergency departments at The Royal Gwent Hospital and Nevill Hall Hospital sites, from where patients often require a secondary ambulance transfer to UHW in order to receive specialist treatment not available at ABUHB. These transfers lead to delays in patients receiving definitive care and depletion of resources at the referring hospitals as well as reducing WAST resources available for the local community.

The health board actively engaged in the consultation process in relation to major trauma and more latterly, the TU designation process outlined in chapter four.

The expected benefits of the major trauma network for the ABUHB population, the health boards and partner services are as outlined in the benefits outlined in this chapter.

3.8.4 Cwm Taf Morgannwg University Health Board (CTMUHB)

CTMUHB sets patients and the delivery of quality services at the heart of everything that they do. The health board is focused on exploring opportunities to further develop their population healthcare system into one that is more preventative and person-centric. The proposals developed by the health board are to take forward the implementation of its TUs as part of the network, within the context of the health board's Integrated Medium Term Part (IMTP) to ensure that:

- There is provision of high quality care as locally as possible where it is safe and sustainable.
- Services provided are accessible and sustainable into the future.
- Service delivery will be innovative, reflect the principles of prudent healthcare and promote better value for users.
- District general hospitals will work together.
- Emergency services will be provided across district general hospitals with a focus on early comprehensive assessment driving care in the right setting.
- There is development of local and regional hospital service planning and delivery where appropriate.
- The health board continues to improve scheduled and unscheduled patient care, patient flow and urgent care processes.

The main benefits of enhancement of rehabilitation services will add considerable value and will have a positive impact on wider health care delivery within the health board, in particular as part of the ongoing redesign of trauma and orthopaedic services. Provision of care of the elderly and orthogeriatric physicians will add value to both major trauma patients as well as those with fractured neck of femurs. Finally, improvements in TARN data collection leading to better opportunities for quality improvement.

3.8.5 Hywel Dda University Health Board (HDUHB)

HDUHB faces a significant challenge in delivering equitable health care to a geographically spread population with large remote and rural catchment areas. Key to improving timely access and equity for people living further away from the MTC are:

- Provision of a 24/7 EMRTS response.
- Provision of a triage trauma tool.
- High quality advice for paramedics and hospital clinicians through the trauma desk.
- Streamlined early acceptance for transfer to specialist care.

Maintaining clinical governance standards across a large geographical area is also challenging. Co-ordination, information gathering and sharing is key. Although there is an exemplar in Bronglais Hospital, Aberystwyth, TARN completeness is generally poor, with heavy reliance on clinician time to enter data. The appointment of TARN coordinators and major trauma practitioners will be vital to improving information to allow proper understanding of performance and identify areas for improvement. Additionally, the provision of training and value for money via a network-training programme will improve the ability to keep distributed workforce skilled.

There is a significant gap in rehabilitation provision for patients. Regular local access to a rehabilitation consultant, the development of inpatient rehabilitation beds, the presence of a rehabilitation co-ordinator and some skilled assistant practitioner resource will enable quality local teams, such as the established community neuro-rehabilitation team, to work more effectively and in a more co-ordinated way both in hospital and the community. There will also be potential benefits for complex rehabilitation needs beyond trauma. In line with the health boards strategy of increasing care closer to home where possible, the addition of a rehabilitation coordinator role will improve the ability to deliver quality community based care and greater access to specialist rehabilitation clinics within the health board. Previously, patients may have had to travel out of area.

3.8.6 Powys Teaching Health Board (PTHB)

The reality of rurality within Powys generates considerable challenges for managing trauma (and indeed just about any other hospital-based care pathway) in that, with no secondary care facility in Powys, all hospital admissions occur out of county. This generates issues that impact in many areas: equity, effectiveness, convenience, accessibility and continuity for both patients and their family and wider support networks. The drive to develop a trauma network for South Wales, West Wales and South Powys is a very welcome development for the people of South and Mid Powys and will address some of the issues, although time and distance from the TUs will remain an enduring issue in terms of equity and outcome.

It is acknowledged that Powys' principle contribution to maintaining patient flows through the network pathways will be by providing rehabilitation services. Expansion of the therapy service will also allow Powys the opportunity to develop new services that will help to deliver against the broader agenda of the Healthier Wales strategy by providing more complex services closer to home.

3.8.7 Welsh Ambulance Service NHS Trust (WAST)

WAST is a critical enabler in the success of the trauma network for South Wales, West Wales and South Powys. For the vast majority of patients who suffer major trauma their first contact with NHS Wales will be with the ambulance service as care is initially provided to them at scene and then during their journey to either a MTC or TU.

The service will also play a critical role either in taking these same patients home or for local or specialist rehabilitation.

The role that the ambulance service is being asked to play within the new network aligns seamlessly with the organisation's recently agreed long-term strategy for ambulance services in Wales - Delivering Excellence. A strategy, which articulates a desire by 2030 to:

- Ensure quality is at the heart of everything we do.
- Providing the right care, in the right place wherever and whenever it is needed.
- Enable our people to be the best they can be.

WAST's and EASC's 2019/20 IMTPs both articulate a commitment to develop an all Wales transfer and discharge service. Such a service, which will not only be critical to the success of the network but will also help support improvements in wider system flow in time. It will also act indirectly as a 'spring board' to the wider strategic development so that it can, in time, support the transfer and discharge needs of other strategic service changes, most notably the opening of the new Grange University Hospital in ABUHB, which will flow circa twelve months after the trauma network becomes operational.

3.8.8 EMRTS

As a national service, EMRTS already has experience of working within the North West Midlands and North Wales Trauma Network. Therefore, the service has a familiarity with the operational and clinical governance arrangements provided by a trauma network and its role as a provider within that structure. The service has seen the value of these both in terms of receiving feedback on all major trauma patients taken to the MTC in Stoke and participation in network clinical activities.

The development of the trauma network in South Wales, West Wales and South Powys is seen as a key driver for the expansion of EMRTS to provide a 24/7 response. The expansion of the service will benefit wide groups of patients with both critical illness and injury, and will support health boards make decisions about reconfiguration of their acute services.

The establishment of the network will also bring maximal benefit from the interventions undertaken and triage decisions made by the service, as other components of the trauma pathway will start to align. Ultimately, this will allow EMRTS to realise many of the benefits outlined during its inception, particularly improvements in functional outcome, which will come from optimisation of the entire pathway and not just pre-hospital elements.

4 Clinical and Operational Model

4.1 Introduction

This chapter sets out the detailed work undertaken to develop the clinical and operational model for the trauma network for South Wales, West Wales and South Powys over the last seven years. It describes the historical context, with the establishment of the major trauma project and clinical reference groups, leading to a non-financial options appraisal for the location of the MTC, an independent panel review and the subsequent public consultation on the decision to establish a trauma network and the chosen site for the MTC. Subsequently, a description is provided of the designation process for TUs and LEHs. This section also presents a summary of the work undertaken to understand the predicted change in activity across the region.

A summary is also provided of recent peer reviews of business case submissions by all providers, in order to deliver the robust clinical and operational model presented here.

Subsequent chapters summarise baseline assessments for the MTC, TUs and pre-hospital providers against the agreed quality indicators and service specification including where these are already being met, could be met through internal re-organisation, or where additional resources will be required. This section also provides details of the phasing of the quality indicators and service specification over a five-year period in developing the clinical and operational model. The approach is aligned with recommendation derived following clinical peer review.

Finally, based on the above and on the predicted change in activity, additional resource requirements are quantified and justified in line with the phased introduction of the model for the following:

- Operational Delivery Network - ODN (including clinical informatics as well as training and education requirements) – Chapter 5.
- Pre-hospital provider (WAST and EMRTS) - for EMRTS this is provided for reference only, as resourcing for EMRTS expansion has been subject to a prior separate business case process – Chapter 6.
- Adult and paediatric MTC – Chapter 7.
- Morriston hospital – TU with specialist services – Chapter 8.
- Health boards (including TUs and LEHs) – Chapter 8.

The provision of rehabilitation and repatriation for 'care with treatment closer to home' will be incorporated into the above where appropriate. The results will inform the schedules presented in the financial case (Chapter 9) and make the case for the establishment of a trauma network for South Wales, West Wales and South Powys, with the benefits that this will bring as described in Chapters 3 & 12.

4.2 Chronology of Developing the Model

The following table outlines the stages of developing the clinical and operational model for the trauma network. Subsequent sections describe each of these stages in more depth.

Date	Key Decision Milestones
October 2012	Workshop held to discuss development of trauma network
May 2015	Service model agreed by Major Trauma Project Group & Clinical Reference Group
June 2015	Options appraisal for MTC location (UHW and Morriston Hospital taken forward)
March 2017	Recommendations from independent panel review published on MTC location
November 2017 – February 2018	Full public consultation on recommendation of independent panel review
March 2018	Recommendations of independent panel review endorsed by all six health board chief executives
November 2018	Designation of TUs endorsed by health board chief executives
September 2019	Designation of TU in HDUHB

4.3 Initial Service Modelling

4.3.1 Defining Quality Indicators and Service Specification

In 2012, the South Wales Programme (SWP) was established to develop clinically safe and sustainable service models in consultant-led maternity and neonatal care, in-patient children's services and emergency medicine for the population of South Wales and South Powys. The SWP covered Cardiff and Vale University Health Board, the former Abertawe Bro Morgannwg University Health Board, the former Cwm Taf University Health Board, ABUHB and PTHB. The programme did not specifically consider major trauma but as part of the work reviewing emergency medicine services, clinicians identified the need to develop a trauma network as a priority, following the establishment of the English trauma networks between 2010-12.

Following the conclusion of the SWP, NHS Wales Chief Executive Officers (CEs) asked the South Wales Health Collaborative (superseded by the NHS Wales Health Collaborative) to develop a service model for the trauma network. A project board was established, supported by a clinical reference group (CRG). Both groups comprised representatives from each of the health boards in the region, WAST, EMRTS and WHSSC. The scope was widened to include Hywel Dda University Health Board, which had not been involved previously in the SWP.

In England, quality indicators and a service specification were developed from the national service specification for major trauma (NHS England D15/S/a 2013) and the NHS clinical advisory group report

of major trauma workforce (CFWI, March 2011). These support the NHS England quality surveillance programme for major trauma services, enabling quality improvements, both in terms of clinical and patient outcomes. The indicators cover adult and paediatric major trauma services across the whole trauma pathway from point of wounding to recovery. They include sections for the Operational Delivery Network (ODN), pre-hospital care via ambulance services, adult and paediatric MTCs and TUs. There are no quality indicators or service specification for LEHs. The quality indicators are provided in Appendix 3. Presently the English clinical reference group oversees the review and development of the quality indicators with a cohort of national experts led by Professor Chris Moran (national director, major trauma, NHS England).

The CRG decided that the development of the service model would align with the quality indicators for NHS England for the following reasons:

- Quality indicators and service specification led to the effective establishment and delivery of major trauma services in England.
- Subsequently, these formed the basis of the national evidence-based clinical guidelines for major trauma (e.g. National Institute of Clinical Excellence *Trauma Guidelines* – 2018, British Society of Rehabilitation Medicine *Core Standards for Specialist Trauma Rehabilitation* – 2014).
- North Wales had already adopted these quality indicators and service specification as part of the North Wales and North West Midlands Trauma Network. Establishing a different set of standards would create inequity with North Wales.
- Data from TARN was being used to support the review of the quality indicators and health boards already had a mandate to contribute to TARN, thus allowing comparison with other networks. Establishing a different set of standards would necessitate creating a separate audit process and registry.
- Allow participation in the English peer review process.

The major trauma project board endorsed this decision in 2015 and the standards formed part of the supporting documentation for the consultation in 2017/18. In March 2019, CEs via WHSSC Joint Committee re-confirmed their support for adopting the NHS England quality indicators and service specification, but indicated their preference for a phased approach to their introduction, in keeping with the English Trauma Networks. It was noted that the development of the trauma network based on these quality indicators would not affect existing arrangements in place in North Wales.

4.3.2 Purpose of the Service Model

In considering the development of the service model, a number of principles were defined by the CRG to underpin subsequent processes, which align with the key investment objectives for establishing the network. These principles are outlined as follows:

To improve quality and safety of care for patients (health gain) by:

- Providing a comprehensive system of specialist care for people who have suffered serious injury (major trauma) through the delivery of a trauma network for all age groups.
- Improving the functionality, health and psychological well-being in those patients who survive their traumatic injuries, increasing their quality of life.
- Ensuring that services meet agreed national clinical and workforce standards.
- Always meeting fundamental standards of care.

- Valuing patient experience as much as clinical effectiveness.
- Ensuring responsibility for each patients care is clear and communicated.
- Providing effective and timely access to care, including appointments, tests, treatments and moves out of hospital.
- Ensuring robust arrangements for transferring care are in place ('care with treatment closer to home').
- Tailoring services to meet the needs of individual patients, including vulnerable patients and older people.
- Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment.
- Ensuring the quality of the system is monitored and subject to a process of continuous quality improvement.
- Reducing avoidable deaths in the population of patients who would previously have died of their injuries.

To improve access for patients (equity) by:

- Delivering a system based on a pathway of care from the pre-hospital phase through acute care, ongoing care and rehabilitation and a return to socio-economic functioning.
- Ensuring effective triage and assessment of emergencies to enable conveyance by the most appropriate means to the most appropriate destination according to agreed criteria.
- Improving information and support to patients and families to encourage them to be active participants in their care.

To improve the sustainability of services to patients (clinical and skills sustainability) by:

- Providing robust staffing arrangements that comply with employment legislation (e.g. working time directive) and meet the requirements for clinical training and supervision where appropriate.
- Developing clinical roles to provide future workforce flexibility, enhancing recruitment and retention.
- Ensuring the population has access to major trauma services within a reasonable timeframe.
- Planning capacity to meet demand and providing appropriate resources across the network.
- Ensuring the network is kept under continuous review and responds to changes in relevant strategies, standards and policies.

The above principles have been taken forward in the planning phases of trauma network.

4.3.2 Outline of Scope and Structure of the Trauma Network

The scope of the trauma network is to provide seamless care to major trauma patients, characterised by an Injury Severity Score (ISS >15) and most patients with moderately severe trauma (ISS>8), from the point of injury to recovery. This includes all age groups.

An inclusive trauma system (ITS) is responsible for all aspects of trauma care across the pathway, from the point of wounding to recovery, and injury prevention. Each ITS comprises one or more trauma network and features a population-based approach to assessment of need and treatment, a role for every hospital and provider of care and provision of rapid transfer to the MTC. It includes a quality

assurance structure that penetrates across the region at each stage of care, underpinning providers' clinical governance processes and identifying inadequate performance in order to support its correction. It also informs commissioning about quality of care being delivered.

A trauma network is the name given to the collaboration between all providers commissioned to deliver trauma care services in a geographical area. The trauma network for South Wales, West Wales and South Powys will have the following structure:

- **Pre-hospital providers** – pre-hospital triage tool to convey patients directly to the MTC or TUs. These include WAST, EMRTS, Search and Rescue Services and voluntary agencies.
- **MTC** – a multispecialty hospital, on a single site, optimised for the provision of trauma care for all types of injuries through the provision of consultant level care. It will have access to all major trauma specialist services relevant to major trauma. It will provide a managed transition to rehabilitation and the community. It will take responsibility for the care of all patients with major trauma in the region covered by the network via an automatic acceptance policy. In addition to an active, effective quality improvement programme, it will collaborate and support other hospitals in the network. The adult and paediatric MTC for the region will be at UHW.
- **TUs** – there will be a number of TUs in the trauma network that provide care for injured patients and will be optimised for definitive care of injured patients. They will provide a managed transition to rehabilitation and the community. They will run an active, effective quality improvement programme. In addition, they will have systems in place to rapidly move the most severely injured patients to hospitals that can manage their injuries, in most cases, the MTC. TUs will have a role for receiving patients back who require ongoing care in hospital and have a suitable 'landing pad' via an automatic repatriation policy. See chapter 8 for TU designation.
- **TU with specialist services** – in addition to the above specification for TUs, Morriston Hospital will provide specialist services support to the MTC and provide specialist surgery for patients who do not have multiple injuries, given the presence of burns, plastic, spinal and cardiothoracic surgery.
- **LEHs** – these will be hospitals within the network, which do not routinely receive acute trauma patients, however, they must have processes in place to ensure that should this occur, there is appropriate initial management and transfer to the MTC or nearest TU. See chapter 8 for operational model for Hywel Dda University Health Board.
- **Rehabilitation** – hyper-acute rehabilitation will be initiated early at the MTC with local rehabilitation occurring in hospitals (TUs/LEHs) and the community within each health board. Specialist rehabilitation will continue to be managed at Rookwood Hospital, Cardiff and Neath Port Talbot Hospital.

Overseeing the above will be an Operational Delivery Network (ODN), hosted by SBUHB, which will comprise the management function of the network, in order to undertake strategic planning, operational delivery, tactical and local advice to commissioners, improve quality and standards of care and partnership development.

4.3.3 Summary of Service Model

The major trauma project board approved the work of the CRG in May 2015. Details of this are provided in Appendix 4. Pathways for care were derived from the Regional Networks for Major Trauma, NHS Clinical Advisory Groups (CAG) Report (2010), which formed the basis of the development of quality indicators and service specification in NHS England. The pathways included

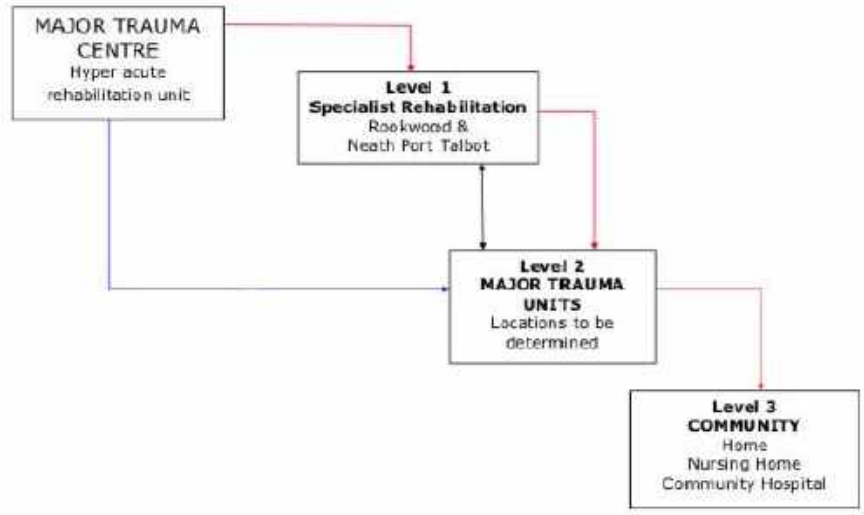
quality indicators and service specification for pre-hospital care, referral and the MTC (i.e. emergency care and surgery, diagnostics and radiology, ongoing care and reconstruction). It also included early and hyper-acute rehabilitation, specialised and local rehabilitation, network delivery, discharge planning and continuing care. In addition, there were sections on patient transfer, communication, audit, data management, governance and quality improvement.

The work undertaken by the CRG was refreshed in October 2018, when baseline assessments for all participating organisations were undertaken against the NHS England quality indicators and service specification. A detailed map of the service model is provided in Appendix 4. Thus, the service model developed by the CRG has been referenced here in order to note the historical context and as a demonstration of the breadth of work that has been undertaken incrementally since 2015.

4.3.4 Summary of Rehabilitation Service Model

The CRG was also tasked to develop the rehabilitation model. Throughout the work to develop the model, clinicians consistently highlighted rehabilitation as a key part of the patient pathway commencing at admission, continuing through the inpatient phase to discharge from the MTC or TU out into the community. It is believed that this is a true enabler to achieving the best outcomes for the patient and improving patient flow across the system. Details of this are provided in Appendix 5. The aim of the rehabilitation model is to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable trauma rehabilitation services at all points along their care pathway, in line with best practice. Paediatric rehabilitation is discussed within the context of the final operational model, as this did not form part of the historical work undertaken.

The structure of the rehabilitation model is based on the British Society of Rehabilitation Medicine Core Standards for Specialist Trauma Rehabilitation – 2014 and is illustrated below:



Hyper Acute Rehabilitation

Rehabilitation will start as soon as is appropriate after admission, ideally in the critical care setting and in line with NICE guideline CG83: rehabilitation after critical illness in adults (2014). The hyper-acute service will enable early rehabilitation input to patients who have intensive rehabilitation needs. Patients with poly-trauma, head injuries, spinal injuries or multiple fractures will be co-located within a designated ward/unit area within the MTC site allowing enhanced co-ordination from the multi-disciplinary team involved in their care.

Level 1 – Specialist Rehabilitation

A small number of very complex trauma patients will require the skills and facilities of a Level 1 specialist rehabilitation facility. These patients will typically present with complex disabilities and a range of medical, physical, sensory, cognitive and behavioural problems. The patients will require input from a wide range of rehabilitation disciplines, including trained nurses, physiotherapy, occupational therapy, dietetics, speech and language therapists, psychology and artificial limb and appliance services (ALAS).

Specialist rehabilitation input will be initiated early during the patient's journey. This may commence when the patient is in ITU and will continue beyond this phase of treatment. Rehabilitation input will commence with the initiation of a rehabilitation plan within 72 hours, which will define the rehabilitation needs of patients and identify how these needs will be addressed. A rehabilitation consultant, through a specialist rehabilitation plan, will provide access to specialist rehabilitation.

When the patient is ready to move from a hyper acute rehabilitation facility, they may be transferred to a Level 1 facility according to their needs. In some cases, patients will be transferred to their nearest TU or back into the community whilst waiting for specialist rehabilitation, thus maintaining patient flow across the system.

Level 2 – Acute Ongoing Rehabilitation in TUs

For the majority of patients whose needs will be less complex and at a lower level, acute and ongoing rehabilitation will be provided in a TU near their area of residence. They may be directly admitted to the TU or as a 'landing pad' via the MTC. The patients will require input from a wide range of rehabilitation disciplines, including trained nurses, physiotherapy, occupational therapy, dietetics, psychology and ALAS. Rehabilitation input will commence with the initiation of a rehabilitation plan within 72 hours and will be overseen by a consultant in rehabilitation medicine, helping to manage risk and expedite discharge. The TU rehabilitation team will have the capacity and skill set to advise the community teams and local rehabilitation hospitals and provide outreach to local hospitals or units for patients with ongoing rehabilitation needs.

Level 3 – Ongoing Rehabilitation in the Community

As patients improve and no longer require care within an acute setting, they will be transferred into a community setting to continue their rehabilitation. The local model of care, which will be different across the network area depending on rural or urban localities, will contain vocational/social participation and third sector support as necessary. Many patients will return home from the MTC and have community based rehabilitation needs. A consultant in rehabilitation medicine will maintain an overview and patients will be reviewed and managed within the community. There will be links with GPs, the wider primary care team and third sector organisations. Specialist community teams such as those working in acquired brain injury and spinal Injury will support primary care teams with a seamless approach between community and specialised care.

TU rehabilitation coordinators will have important role in ensuring patients returning to the community have appropriate involvement in planning in their care journey, including the interface with social care.

4.4 Non-financial Options Appraisal for MTC Location 2015

In June 2015, a workshop led by clinicians considered the options available to support the development of a trauma network for South Wales, West Wales and South Powys and specifically the

location of the MTC. A detailed report of the work is provided in Appendix 6. The workshop comprised representatives from health boards throughout the region, WAST and EMRTS. Patient representatives were invited through the third sector support groups and the community health councils (CHC) in an observer capacity. The workshop incorporated a non-financial option appraisal process and concentrated on the clinical benefits of the different options. In doing so, delegates were asked to consider the infrastructure requirements for the number of MTCs in a sustainable system and siting of major trauma services, based on the clinical service model and proposed activity developed by the CRG. Furthermore, consideration was given to co-located and interdependent services required at the MTC and scoring of each option against a series of benefits criteria.

A 'long list' of options was considered as illustrated below:

Investment objective	Description
Option 1 – Do nothing	This option described the current situation and clinical pathway delivery and was used as the baseline comparator. Currently there is no trauma network serving South Wales, West Wales and South Powys and no hospitals have been designated MTC or TU.
Option 2 – Single site, UHW	This option proposed the development of a single-site MTC at the UHW, Cardiff. This would mean the designation of UHW as the MTC serving South Wales, West Wales and South Powys with other consultant-led emergency departments acting as TUs within the trauma network structure, some providing specialist services.
Option 3 - Single site, Morriston Hospital	This option proposed the development of a single-site MTC at the Morriston Hospital, Swansea. This would have meant the designation of Morriston Hospital as the MTC serving South Wales, West Wales and South Powys with other consultant-led emergency departments acting as TUs within the trauma network structure, some providing specialist services.
Option 4 – Dual site	This option proposed the development of an MTC delivered across two sites: UHW and Morriston Hospital. This would have meant that the full requirements for a MTC would not be provided on each site. One of these sites would be the designated lead for the trauma network. Some specialist services would need to be provided from Morriston to UHW (e.g. burns and plastics) and from UHW to Morriston (e.g. neurosurgery) through emergency outreach clinical teams. The remaining consultant-led emergency departments would act as TUs within the trauma network structure.
Option 5 – Outsourced service (no MTC in South Wales)	This option proposed that a MTC was not established within South Wales but that this service would be commissioned from a provider partner outside Wales. This would have meant the designation of a MTC in England serving South Wales, West Wales and South Powys with the consultant-led emergency departments in South and West Wales acting as TUs within the trauma network structure, some of which may provide specialist services.

The following benefit criteria were used to score each option at the workshop. These criteria were aligned with those used for other national programmes and were given a weighting, agreed by the CRG and project board:

- **Quality and safety** – 35%
- **Equity** – 10%
- **Strategic fit** – 10%
- **Sustainability/future proof** – 25%
- **Access** – 15%

Details of the methodology and outcomes are provided in Appendix 7, which included sensitivity analysis of the outcomes.

The outcome of the analysis was that the option to do nothing and continue with the South Wales area remaining as the only region not being supported by a trauma network was quickly eliminated. It was also agreed that to support a population of approximately 2.4 million the network would need to be supported by a MTC located within the region. This was in keeping with similar sized populations being supported by networks in England. Thus, the outsourcing option was ruled out.

The potential for a dual site solution was seriously considered but subsequently eliminated because the critical mass for sustainability could not be delivered through such an arrangement and experience of some English trauma networks, which had operated a dual site solution and encountered significant operational problems.

UHW and Morriston Hospital were the only two hospitals in the region identified as having the potential to meet the necessary quality indicators and service specification for a MTC. This was due to the specialist nature of the trauma service itself and the need for co-location with other specialist services.

Thus, the preferred option from the non-financial options appraisal was to develop a trauma network for South Wales, West Wales and South Powys that contained a number of TUs supported by a single site MTC.

These options were taken forward through an independent panel review and public consultation.

Following the options appraisal, an Equality Impact Assessment was completed to support engagement with key stakeholders.

4.5 Independent Panel Review

Building on the work of the project board and the outcome of the clinical workshop, the NHS Wales Health Collaborative Executive Group (chief executives) agreed with the recommendation to establish a trauma network with the MTC located in either UHW or Morriston Hospital.

To facilitate the decision on the preferred location of the site for the major trauma centre, NHS Wales CEs meeting as the Collaborative Executive Group proceeded to recommend that an independent, expert clinical panel be commissioned to review the available evidence and provide advice. The proposed process for the independent panel was endorsed through individual public board meetings. CHC chief officers were also briefed as part of this process.

Professor Chris Moran chaired the independent panel, with support from a group of eight experts selected to be part of the panel based on their national and international reputations as experts in trauma care and the development of trauma systems.

The panel was provided with all the relevant information required to enable them to consider the position for the region. This included a high-level financial appraisal of the indicative capital and revenue requirements for either option and WAST resources (see Appendix 8). This appraisal did not include an assessment of capital and revenue requirements for TUs or the ODN. Furthermore, isochrone maps were developed indicating the proportion of the population within 60 minutes of the MTC for both UHW and Morriston Hospital (see Appendices 9 & 10). Clear terms of reference were provided to inform the assessment.

In February 2017, a session was convened with the panel where representatives from across the region and other key stakeholders were invited to attend. This included: clinical representatives from all participating health boards; Public Health Wales; Welsh Government; CHCs; EMRTS; WAST; WHSSC and EASC. Colleagues from UHW and Morriston Hospital gave presentations.

When considering the location of any new service, the Independent Panel determined that there were three main factors that need to be taken into consideration:

- **Clinical interdependencies (services that must be located together)** - the independent panel advised that one of the most important factors in the effective management of major trauma is the immediate availability of key specialist services. Most of those specialist services were already provided in both UHW and Morriston Hospital. However, specialist neurosurgery was only provided in UHW and burns and plastics services only in Morriston Hospital. Given that approximately 60% of major trauma cases require support for head injuries, the panel advised that same-site provision of specialist neurosurgical services (adult and paediatric) should be a key requirement for the location of the MTC. The panel also recognised the importance of the burns and plastics service as part of the trauma network and identified that whilst co-location was not a critical factor, it was imperative that the burns and plastics centre worked very closely with the MTC to make sure patients receive the care they need.
- **Critical mass** – it was recognised that neurosurgery and burns and plastics services were so specialist they could only be provided from one hospital site for the population of South Wales, West Wales and South Powys. The same held true for the establishment of a single MTC for the region.
- **Travel times** - the panel considered the geography of Wales and made it clear that an inclusive trauma system is expected to improve mortality in all geographical regions of South Wales, West Wales and South Powys regardless of the transport time to the MTC. They recognised that irrespective of the location of the MTC, at either Morriston Hospital or UHW, some parts of the population in Hywel Dda and Powys will be a considerable distance from the MTC. This was not an unusual situation and most trauma networks in England supported services that were a considerable distance from the MTC. The panel did not believe that either Morriston Hospital or UHW as a MTC would have any significant advantage over the other in terms of geography. Working as part of a network, most ambulance services in England operated a bypass system of up to one hour. This meant that patients identified as having suffered major trauma by ambulance personnel would be taken directly to the major trauma centre if it were within one-hour travelling time. This time could be extended after advice was taken. Patients with more immediate needs would be transported to a TU and stabilised prior to transfer. Only a small proportion of trauma patients required immediate surgery and this was likely to be achieved more rapidly in the MTC, mitigating any increase in transport times. The wider network model (including trauma units, automatic acceptance at the MTC, enhanced triage

decision making and 24 hours availability of EMRTS) had a key role to play in managing patients who may be further away from the MTC.

Considering all three factors, in March 2017, the independent panel produced a report (see Appendix 11) of their findings making the following unanimous recommendations for consideration by the constituent health boards:

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

It is significant that in making recommendations of the development of the wider network, the independent panel recommended that Morriston Hospital should be a large TU. As a large TU, Morriston Hospital is likely to be able to manage some conditions that other trauma units will not, due to the specialist services it already provides. This means that following clinical assessment a more complex patient may not need to be transferred to the MTC (within agreed protocols) and will continue to be managed within Morriston Hospital. This may be different for other TUs in the region, which do not have such specialist services. The term 'large TU' is defined as a TU with specialist services in the remainder of this document for consistency of nomenclature with NHS England.

The panel also specified that Morriston Hospital should take the leadership role in the major trauma network, hence the decision for SBUHB to host the ODN. This follows the model in England where the leadership for the network is often, but not always, provided from a hospital other than the hospital where the MTC is located. A lead hospital is necessary to ensure the trauma network works in a coordinated way and makes sure the patient and the complete patient pathway is the focus rather than the MTC itself.

4.6 Public Consultation Process and Recommendations

The recommendations from the independent panel were reviewed through the Collaborative governance arrangements (Collaborative Executive Group and Leadership Forum) and the benefits for the population of South Wales, West Wales and South Powys associated with developing a trauma network fully considered. Health boards also considered and agreed in principle to the recommendations and for a period of consultation. Whilst the development of the trauma network represented a service change and not a service development, health boards recognised that a period of public engagement and consultation was required to ensure a clear understanding of the role of network and its component parts.

In accordance with this, the NHS Wales Health Collaborative team developed consultation documentation with individual health boards engaging with their local CHC to facilitate the local consultation exercise to seek views on the development of the trauma network and the implementation of the recommendations of the independent panel (see Appendix 12). In doing so, a clear scope was defined for the consultation process and three questions that would be asked of stakeholders:

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

A detailed stakeholder mapping exercise was undertaken with key groups identified as NHS Wales staff, CHCs, the public, national bodies/organisations, third sector, local authorities and elected members, people with protected characteristics and specialist groups. The consultation started in November 2017 and was completed by February 2018. All documentation including historical work was made available via the Public Health Wales website; consultation documentation was developed and shared with all participating organisations and public engagement sessions were held in each health board (see Appendix 12).

Responses were analysed by the NHS Wales Health Collaborative and themes identified. This information was shared with CHCs to enable production of a formal response. A report was produced which included the findings of the consultation (see Appendix 13). This was considered by health boards in their public board meetings in March 2018.

In relation to the consultation, each CHC provided feedback to their health board in relation to the consultation and whether individual CHCs were in a position to support the recommendations of the independent panel. In general, CHCs were unable to agree or disagree with the recommendations contained in the report. Common themes in the concerns raised by CHCs were:

- A lack of public engagement prior to formal consultation.
- A lack of detailed information about the overall design of the network, including the location of TUs.
- Insufficient financial information and a lack of an assessment of the impact on other services of investing in the network.
- A lack of space and capacity at UHW.
- Arrangements for patient transfer outside the operational hours of the EMRTS.

Despite this and based on the evidence of the positive benefits of a trauma network, in March 2018 all six health boards across South Wales, West Wales and South Powys approved the recommendation to establish the trauma network in line with the independent panel report.

Subsequently, a 'lessons learnt' exercise was held in September 2018, with involvement of CHCs. The network clinical lead and director of the NHS Wales Health Collaborative took the opportunity to meet with CHC Chief Officers on a number of occasions and produced update reports, providing mitigations to the above concerns. At the time of writing, CHCs from two health boards have agreed to the recommendations of independent panel review, with ongoing positive engagement by the health boards with respect to seeking agreement from remaining CHCs. It is anticipated that this dialogue will continue once the network is operational. Furthermore, all of the issues outlined above have been discussed in the context of this Programme Business Case.

4.7 Designation of Trauma Units

Having completed the process for designation of the adult and paediatric MTC at UHW, Morriston Hospital as a TU with specialist services and the ODN function being hosted by the SBUHB, a process was established to designate Tus. This process coincided with the establishment of the trauma network board (June 2018) and confirmation that WHSSC would be the principle commissioner for the network.

4.7.2 Designation Process

To support health boards to make choices in relation to TU designation, the network board confirmed a process in August 2018, as follows:

- The network board requested that health boards complete a baseline assessment against NHS England quality indicators and service specification for hospitals proposed as 'candidate TU's.' Information was provided as to which indicators needed to be met for day one and which could follow once operational.
- The network clinical lead wrote to directors of planning of each health board requesting meetings to discuss baseline assessments.
- Meetings were held September to October 2018 with all health boards. These meetings were chaired by the network clinical lead, some of which supported by the director of the NHS Wales Health Collaborative. Health board representation included directors of planning or a nominee and clinical and managerial network leads. In addition, the network interim rehabilitation lead provided health boards a useful insight into TU service specification from a rehabilitation perspective.
- The purpose of these meetings was to discuss the baseline assessments against a series of questions:
    - Where gaps exist, how could these be quantified? In the first instance, how could the gap be closed through internal re-organisation? This was used as a starting point for all discussions in relation to quality indicators.
    - Where there is a need for additional resources above what can be achieved through internal reorganisation, what are the implications of this?
    - With additional resources, will it be possible to meet the quality indicators?

These baseline assessments form the basis of the resource requirements set out in Chapters 8 & 9.

- The above questions were used to inform final submissions for all 'candidate TUs,' based on those that could most closely meet the quality indicators. In addition, health boards were asked to indicate whether the 'candidate' TU would be adult and paediatric or adult only, justification for their choice and to consider how patients would be served in regions without a nearby TU.
- Following endorsement by the network board in October 2018, a paper was taken through the WHSSC management structure and to WHSSC Joint Committee to make a recommendation in November 2018, followed by approval of TU designation by each health board in January 2019. In most part, choices were in keeping with the result of the SWP, in terms of future location of emergency departments.
- The network board recognised the need for informing and engaging CHCs with respect to TU designation, recognising that health boards would be principally responsible for this through normal processes, supported by trauma network board members. All health boards confirmed the location of their TUs with their CHCs.

- It was recognised that the designation of TUs would be reviewed after the first year of being operational and national annual trauma peer review.

4.7.3 Trauma Unit Locations

The following hospitals were approved as adult and paediatric TUs, following a recommendation by WHSSC Joint Committee and endorsed by health boards:

- UHW, Cardiff – TU function for its own population.
- Morriston Hospital, Swansea – TU with specialist services
- Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the health board)
- Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend.
- Glangwili General Hospital, Carmarthen (section 4.7.4).

In relation to LEHs, the following hospital will be a LEH within the network structure:

- Royal Glamorgan Hospital, Llantrisant.

As described below, Bronglais General Hospital, Aberystwyth and Withybush General Hospital, Haverfordwest will be rural trauma facilities for the purposes of major trauma.

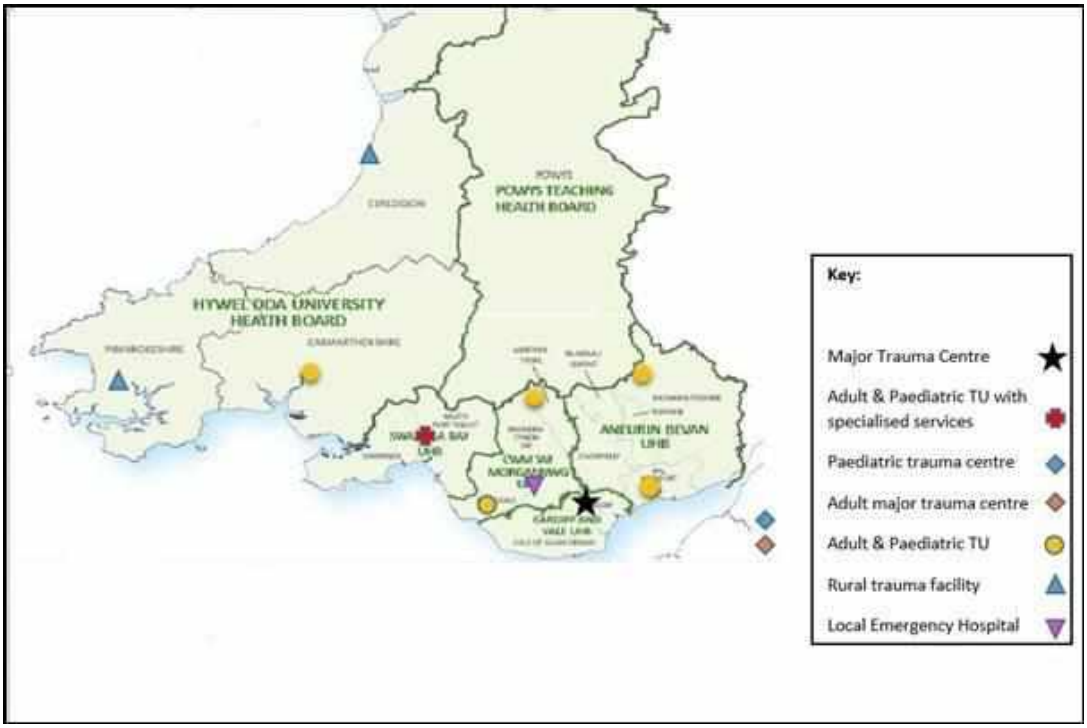
4.7.4 Proposed Structure in Hywel Dda University Health Board

Following full public consultation in 2018 as part of its *Transforming Clinical Services Strategy*, the health board confirmed its intentions to develop a new urgent and planned care hospital within the region, which in the future will function as the TU and main emergency department for the health board. In addition, Bronglais General Hospital will be a rural provider of urgent and planned care, including the presence of acute services. Glangwili General Hospital and Withybush General Hospital will become GP led Minor Injury Units alongside community beds and outpatient facilities.

Following a period of public engagement in June and July 2019, the health board has designated Glangwili General Hospital as the TU in the years preceding the development of the new hospital. This, along with the role of the remaining hospitals is being worked through as part of a public engagement process.

With respect to Bronglais General Hospital and Withybush General Hospital, a baseline assessment demonstrated that both hospitals fell significantly short of the quality indicators compared to other TUs, and it was unlikely the 'gap' could be closed easily, even in the presence of additional resources. However, given the rural nature of the catchment areas of both hospitals and concerns in relation to the term LEH it has been proposed that for the purposes of the trauma network, both hospital will be termed rural trauma facilities in recognition of this strategic importance. Whilst as for LEHs there are no specific quality indicators for a rural trauma facility, the Health Board is committed to ensuring these hospitals maintain the ability to assess and treat major trauma patients, given their relatively unique geographical location. In addition, they will need to maintain the ability to rapidly transfer patients to the MTC at UHW, TU with specialist services at Morriston Hospital or the TU in Glangwili General Hospital.

4.7.5 Proposed Map of Trauma Network



4.8 Predicted Change in Patient Flow

Early predictions on the change of flow of moderate and major trauma patients was captured as part of the consultation process in 2017, with an estimated 1,500 moderate and major trauma cases across the region. Historically, basic modelling was also undertaken as part of the EMRTS Strategic Outline Programme using a population-based approach in 2014.

Subsequently, the network board identified the need to undertake a more in-depth analysis of current and predicted activity to inform the planning of the network. A number of strategies have been adopted to achieve this. It was recognised that it would be challenging to solely use baseline data from TARN given the significant variation in completeness and quality across the region. Consequently, the network board enlisted the support of Gareth John, NWIS, and Andrew Nelson, C&VUHB. A detailed presentation of the methodology used, key assumptions and results are presented in Appendix 2.

Essentially, patient episode data for Wales (PEDW) was obtained from NWIS for 2017 to calculate current activity. ICD-10 codes were translated into TARN codes, in order to present a breakdown by ISS. Furthermore, hospital spells were used rather than number of cases, as a more accurate metric for making planning assumptions. A complex modelling algorithm was developed in order to inform the data presented for current activity and this was developed on 5 years of C&VUHB data.

Further analysis was undertaken to predict the change in flow, in line with the assumed current position for South, Mid and West Wales and using the proportions for the English trauma networks (derived from TARN) for 2011, 2012 and 2013, represented as year 1, 2 and 3 respectively below:

ISS	'Patient pathway'	Assumed current position	Year 1	Year 2	Year 3 & steady state
9-15	% direct to MTC	22	25	28	31
9-15	% transfer TU to MTC	0	7	7	8
9-15	% TU only	78	68	65	61
>15	% direct to MTC	32	35	39	42
>15	% transfer TU to MTC	6	25	25	22
>15	% TU only	62	40	36	36

The above table demonstrates that the current position in the region pre-dates that of the year 1 of the establishment of the English trauma networks. Furthermore, the proportion of moderate and major trauma subjected to direct and secondary transfer to the MTC increased and then reached a steady state in year 3. However, the total number of cases reported to TARN continues to rise.

The table below illustrates the predicted change in first spell presentations to the MTC for moderate and major trauma. One hospital spell covers the activity whilst a patient remains within that hospital for a continuous length of time:

ISS 9-15 – moderate	Assumed current position	Year 1	Year 2	Year 3
Direct to MTC	154	206	231	256
Transfer TU to MTC	11	58	58	66
% TU only	660	561	536	503
Total	825	825	825	825
ISS >15 – major	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	284	306	341	368
Transfer TU to MTC	49	219	219	193
% TU only	542	350	315	314
Total	875	875	875	875

ISS >9 – candidate	Assumed current position	Year 1	Year 2	Year 3
Direct to MTC	438	512	572	624
Transfer TU to MTC	60	277	277	259
% TU only	1202	911	851	817
Total	**1,700**	**1,700**	**1,700**	**1,700**
Combined Direct to MTC & Transfer TU to MTC	**498**	**789**	**849**	**883**

Subsequent analyses were undertaken to determine the change in flow for all other receiving hospitals in the region and bed capacity requirements. This included a subgroup analysis for paediatric trauma, bed requirements for patients returning to a 'landing pad' following care at the MTC and further work undertaken within HDUHB. From these, a number of observations can be made:

- The total moderate and major trauma workload of 1,700 spells per year correlates well with earlier predictions.
- In year 1, it is predicted that moderate and major trauma spells will increase by 290 per year once UHW becomes an MTC. By year 3, predicted number of spells will reach a steady state. The main reason for the increase relates to the increase in the proportion of transfers to the MTC of major trauma from TUs. The programme team at UHW have used this data to inform subspecialty specific analyses, ward bed/critical care bed capacity planning and theatre capacity planning.
- It is predicted that all other hospitals in the region will see a fall in admitted moderate and major trauma, owing to increased flows to the MTC. Overall TUs will retain 68% of moderate trauma and 40% of major trauma in year 1. Thus, overall acute bed capacity requirements will fall in these hospitals.
- Approximately 20-34% of patients will return from the MTC and require access to a 'landing pad' in their health board. This largely represents new flow of patients. Requirements will vary from ongoing medical care, hospital care whilst awaiting social care packages, level 2 rehabilitation and a small proportion awaiting specialist rehabilitation. Current practice is that these patients rarely experience timely transfer back their local hospital. For all regions, it is predicted that bed requirements for the 'landing pad' will not exceed the overall fall in acute bed requirements. Thus, the totality of beds required in each hospital (except UHW) will not increase.
- The exception to this is for Glangwili General Hospital, which has been designated a TU. Further local analyses predict a maximum of 1-2 extra patients per week attending the TU acutely from regions served by Bronglais General Hospital and Withybush General Hospital. Furthermore, Morriston Hospital is predicted to see some additional patients acutely due specialist services provided (e.g. orthoplastics).
- The data have indicated the need for additional ambulance journeys (both for direct and secondary transfers to the MTC) and repatriation. This has informed planning assumptions for WAST (see chapter 6).

- Finally, small increases in moderate and major paediatric trauma will be observed at the MTC.

The work undertaken was reviewed and scrutinised by all health boards and was approved by the network board as a single data source for all health boards/WAST when undertaking service planning and informing additional resource requirements outlined in subsequent chapters.

4.9 Summary of Review of Clinical and Operational Service Model

Following the business case submissions from each organisation to inform this programme business case, the following levels of review were undertaken:

- Verbal and written feedback from the NHS Wales Health Collaborative programme team (ind. the network clinical lead). Face-to-face meetings with network board representatives from all organisations with programme team.
- Internal health board scrutiny and review of all submissions.
- A presentation and review of all submissions at the trauma network board in June 2019.
- A professional clinical review of the MTC case, C&VUHB and orthoplastic case, SBUHB by Professor Chris Moran, National Clinical Director, Major Trauma, NHS England on the 2nd July 2019.
- Review of the MTC and orthoplastic business cases by the WHSSC management team.
- Review of the WAST business case by the EASC Management team.
- OGC Gateway review 0 of the entire case 8-10 July 2019.

One of the recommendations of the Gateway review 0 was to undertake a critical scrutiny of all business case submissions in order to close out the gap between the programme team specification of minimum Day 1 requirements and submissions. This include further development of the planning assumptions for each phase to progressively meet quality indicators and service specification.

In response to this, the NHS Wales Health Collaborative organised a one day professional peer review event, bringing together experts from across the UK to undertake a review of the entire system including proposals from WAST, C&VUHB (MTC), SBUHB (specialised services), TUs and the ODN. This also included reviews of the rehabilitation model. A subsequent review of therapy requirements and the spinal trauma case were remotely undertaken and the outcome shared with organisations.

The review was informed by a series of questions generated by an Executive Strategic Group formed following the Gateway 0 review. Following a successful and positively supported event, which took place on 13 August 2019, the Executive Strategic Group generated, a series of recommendations based the discussions that had taken place and these were shared with the network board to consider on 19th August 2019. The network board supported in principle recommendations pertaining to the MTC and specialised services, but fully supported recommendations pertaining to WAST, TUs and the ODN. Appendix 14 provides a summary of recommendations made.

Following this, C&VUHB and SBUHB were asked to consider the recommendations in the context of their revised submissions. With the support of an OGC Gateway Assurance of Action Plan review (undertaken on the 9 September 2019), further work was undertaken between these organisations and WHSSC to agree an appropriate position described in subsequent chapters.

5 Operational Delivery Network

5.1 Introduction

The creation of a trauma Operational Delivery Network (ODN) is central to the development of a trauma network for South Wales, West Wales and South Powys. A Trauma ODN involves cross-organisation and multi-professional working through a whole system approach, ensuring the delivery of safe and effective services across the patient pathway. Under an ODN, patient pathways pertaining to trauma are coordinated between providers over a wide geographical area to ensure equity of access to specialist resources and expertise. Its aims align with the key investment objectives outlined in Chapter 2 and 3 in order to improve patient outcomes, patient experience and quality standards from the point of wounding to recovery.

This chapter provides a description of the purpose of the ODN, its phased implementation against service specification and quality indicators and the resource requirements for the ODN management team. Furthermore, it describes the parallel arrangements for the Veterans Trauma Network (VTN). The commissioning and governance arrangements for the ODN are described in the management case (Chapter 12).

Finally, details are provided of the clinical informatics and training and education requirements for ODN using a phased approach.

5.2 What is a Trauma Operational Delivery Network (ODN)?

A Trauma ODN involves cross-organisation and clinical multi-professional working, through a whole system collaborative approach, ensuring delivery of safe and effective services across the patient pathway. Under an ODN, patient pathways pertaining to trauma are coordinated between providers over a wide geographical area to ensure equity of access to specialist resources and expertise. Thus, its aims are to improve patient outcomes, patients experience and quality standards from the point of wounding to recovery.

In September 2018, WHSSC Joint Committee agreed that an ODN will be established to oversee the delivery of trauma services to the population of South Wales, West Wales and South Powys and that a health board should host the ODN; SBUHB was agreed as the host organisation for the ODN.

It was also agreed that the ODN and MTC at UHW will be commissioned by WHSSC. EASC will commission WAST and the EMRTS. Health boards will be responsible for local commissioning of TUs. In addition, existing major trauma commissioning arrangements for BCUHB will be retained.

5.3 Purpose of the Operational Delivery Network

The term 'ODN' was developed in NHS England in 2012, to reflect the shift in the function of some clinical networks to focus on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise. Thus, trauma networks developed as ODNs with a focus on operational delivery. As defined by the service specification below, the network board and WHSSC agreed to the formation of an operational delivery network. In NHS England, provider organisations host Trauma ODNs in order to ensure optimal delivery of the service specification. In keeping with this and aligning with recommendations of the independent panel, a provider, SBUHB, will host the trauma ODN for South Wales, West Wales and South Powys.

The ODN will represent a collaboration between all providers commissioned to deliver trauma care services (both specialised and non-specialised), focused initially on the population of South Wales, West Wales and South Powys. Providers will include the pre-hospital services (WAST and the EMRTS), MTCs, TUs, LEHs and rehabilitation services. The ODN will also have appropriate links to social care and the third sector.

The key responsibilities of the ODN can be summarised as follows (adapted from the Intercollegiate Group for Trauma Standards, 2009):

- A focus on improving functional outcome and patient experience from the outset.
- Ensuring injured patients are delivered to the MTC for definitive care quickly and safely.
- Maintaining patient flow across the region, ensuring timely 'care with treatment closer to home' once specialist care completed.
- Clinical responsibility for a seriously injured patient anywhere in region and ensuring clinicians maintain a responsibility extending outside their traditional health board boundaries.
- Adopting a culture of integrated multi-disciplinary working across health boards through specialist and professional groups.
- Acute and ongoing rehabilitation services to improve outcomes and restore patients back to productive roles in society.
- Adopting a population based approach; in particular developing pathways for trauma in older people (see section 5.4.4).
- A continuous process of system evaluation, governance and performance improvement.
- Develop multi professional training and education across the patient pathway.
- Supports active injury prevention programmes to reduce the burden of injury for the network population.
- Active development of an audit and research programme and support of research into trauma and its effects, to improve outcomes.
- Integration with multi-agency mass casualty planning in the region.

These are expanded further in the next section on service specification and quality indicators.

5.4 Phased Implementation

The baseline position is that currently there is no trauma ODN serving the population of South Wales, West Wales and South Powys. Only some aspects of network wide service specification or quality indicators exist.

Two sources have been used to develop the model for the phased implementation of the trauma ODN. Firstly, the NHS England commissioning service specification D15a, Trauma ODN 2012/13. Secondly, the NHS England network quality indicator document, 2013. The rationale for adopting these is presented in chapter 4. The proposed model is further divided into those elements that are essential, desirable and aspirational. Phasing of essential elements has been undertaken including specification and quality indicators that need to be in place before the ODN is operational (i.e. before day 1) and those that will develop in year 1, 2 and 3.

5.4.1 Service Specification

All specifications will need to be in place before the ODN becomes operational (i.e. before Day 1) unless indicated below. Each element will be ongoing from the point of implementation, unless otherwise stated.

Essential

These aspects are considered essential and are critical to the successful delivery of the ODN and its key investment objectives.

Strategic planning

- Provide professional and clinical leadership across the network.
- Undertake comparative benchmarking and audit across the network through TARN – supporting the enhancement of data collection.
- Effective linkage into commissioning groups – in this case, WHSSC and EASC.
- Hosting a risk register and undertaking risk management across the network.
- Produce quarterly and annual reports – Year 1.
- Develop an annual working plan for the network to deliver against the quality and delivery framework – Year 1.
- Contribute to evaluation of the network – Year 2.
- Develop a longer-term plan going out 5-10 years to ensure new capabilities can be brought into core operations in quickly and efficiently as possible – Year 2.

Operational delivery

- Develop coordinated patient clinical pathways between services over a wide area to ensure access to specialist major trauma care.
- Develop a comprehensive system of delivery through A) a pre-hospital triage tool and criteria for immediate inter-hospital transfer and transfer within 48 hours of referral; B) Automatic acceptance and repatriation policies; and C) rehabilitation pathways.
- Ensure improved access and equity of access to trauma services – Year 1.
- Responsible for monitoring of day-to-day capacity across the network, agreeing and working to an escalation plan (with agreed thresholds for escalation triggers) both within and across network to monitor and manage surges in demand – Year 1.
- Support capacity planning and activity monitoring for collaborative matching or demand and supply (e.g. through implementing a trauma tracking system) – Year 1.
- Ensure appropriate repatriation for ongoing 'care with treatment closer to home' – Year 1.
- Ensure the quality of the network is monitored and subject to a process of continuous quality improvement through clinical audit – Year 1.

Tactical (local) advice and support to commissioners

- Provide local information, data and intelligence to support performance monitoring of the network (i.e. TARN clinical reports, process measures, key performance and quality indicators, case-mix standardised outcomes, workforce data) – Year 1.

- Support national annual trauma peer review and assurance of the MTC, TUs/LEHs and pre-hospital services with commissioners – Year 1.
- To provide ongoing programme management of a phased implementation across the network – Year 1.
- Support local implementation of products produced by the national trauma clinical reference group (NHS England) as appropriate – Year 1.

Improved quality and standards of care

- Develop and implement network protocols for trauma patients.
- Deliver a clinical governance framework with the MTC, TUs, LEHs, pre-hospital services and rehabilitation services including a process for incident reporting with follow up action plans and network morbidity and mortality review. This includes collaborative serious incident investigation.
- Deliver a network-wide training and education programme encompassing the whole patient pathway prioritising key areas (see section 5.6)
- Implement a clinical informatics system for the network – Year 1 (see section 5.5)
- Ensuring on-going service improvements and best practice models are embedded and contribute to improved quality performance (i.e. dashboard measures) – Year 1 and ongoing.
- Monitoring of MTC and TU dashboard measures and provide advice on improvements to clinical services and commissioners – Year 1.
- Use clinical process and clinical outcome measures to compare and benchmark providers – Year 1
- Deliver an annual quality improvement and audit programme – Year 1.

Partnership development

- Engagement with third sector organisations.
- Linkage with other relevant networks (e.g. North Wales and North West Midlands Trauma Network).
- Embed communication strategy and key communication deliverables – Year 1.
- Monitoring and performance management of active engagement by members in the network to improve performance against agreed outputs – Year 1.
- Participation in relevant national policy or guideline development – Year 2

Desirable and Aspirational

Some aspects are considered desirable or aspirational. Whilst not critical to the successful implementation of the ODN, they represent future areas of development:

- A research programme focused on all parts of the trauma pathway, as a vehicle for driving improvements in patient outcome and experience. Enhanced profile of the region through sharing knowledge nationally and internationally (e.g. publications and presentations).
- An injury prevention programme in association with Public Health Wales (e.g. knife crime prevention, motorcycle safety, wearing cycle helmets).
- Sharing successful components of the ODN development with other networks, bringing benefits of the programme to other areas of healthcare.

- Utilising local knowledge and experience to support the development of trauma networks in less developed parts of the world.

The programme will consider these opportunities at future points in its development.

5.4.2 Quality Indicators

Essential quality indicators for the ODN are presented in the table below. For each quality indicator, a code is assigned, in order to cross-reference (Appendix 3). All quality indicators will need to be in place before the ODN becomes operational (i.e. before Day 1) unless indicated below. Six out of 13 quality indicators are already being met.

Quality Indicator	Currently met/unmet
T16-1C-101 - Network configuration The network structure should be identified in the network operational policy including pre-hospital services, hospitals and rehabilitation services.	✓
T16-1C-102 - Network governance structure A clinical governance structure that includes a network manager, clinical lead and a number of leadership roles, identified in the network operational policy.	✓
T16-1C-103 – Patient transfers Review of patient transfers from year 1 to include the following: • The number and proportion of patients transferred directly to MTC, including cases of significant under and over pre-hospital triage. • The number and proportion of patients that have an acute secondary transfer (within 12 hour) from a TU to MTC. • The proportion of urgent transfers that occur within two calendar days. • The number of patients with ISS ≥15 managed definitively within a TU. • The number of patients where repatriation from MTC exceeds 48hrs from when referred.	X
T16-1C-104 - Network Transfer Protocol from TUs/LEHs to MTC There should be a network protocol for the safe and rapid transfer of patients to specialist care with the following components: • A pre-hospital triage tool with specific criteria for triage of patients, based on mechanism, injury pattern and clinical condition to ensure direct transfer to the MTC or nearest TU. • A protocol for the transfer of adult patients specifying that transfers should be carried out by teams trained in the transfer of patients. This standard is already being met by the Designed for Life, Welsh Guidelines for the Transfer of Critically Ill Patients, 2016. • A protocol for the transfer of paediatric patients. This standard is already being met by the Wales and West Acute Transport for Children Service (WATCh) based in Bristol.	X ✓ ✓
T16-1C-105 - Teleradiology services There should be teleradiology facilities between the MTC and all TUs/LEHs in the network allowing immediate image transfer 24/7. This standard is already being met.	✓

Quality Indicator	Currently met/unmet
T16-1C-106 - Network wide TARN review The MTC, TUs and LEHs should participate in the TARN audit, with at least 1 year of back dated baseline data before network operational. Data should meet the following standards:	Partially met
Case ascertainment – patients submitted to TARN compared to expected based on Patient Episode Data for Wales (PEDW) dataset –target of 80% across the network by end of year 1.	X
Case accreditation - this is the proportion of key fields used in this report that are filled in for each patient submitted to TARN –target of 95% across the network by end of year 1.	X
The standards set are to ensure subsequent TARN metrics can be meaningfully interpreted.	
TARN audit should be discussed at the network audit meeting at least annually and distributed to all constituent members of the network.	X
A working plan has been produced to enhance TARN data collection including appointment of TARN coordinator(s) in health boards where gaps exist.	X
Develop strategies for undertaking TARN PROMS and PREMS in year 1.	
T16-1C-107 – Trauma management guidelines There should be network agreed clinical guidelines for the management of: • Standardised patient care. • Emergency anaesthesia and emergency surgical airway. • Resuscitative thoracotomy. • Abdominal injuries. • Severe traumatic brain injury. • Open fractures. • Compartment syndrome and vascular injuries. • Penetrating cardiac injuries • Spinal cord injury. • Severe pelvic fractures including urethral injury. • Chest drain insertion. • Pain relief for chest trauma with rib fractures. • CT imaging and imaging for children. • Interventional radiology. • Non-accidental injury in the child.	X
T16-1C-108 - Management of severe head injuries All patients with a severe head injury should be managed according to NICE guidance (Head injury: assessment and early management, 2014)	X
T16-1C-109 – Management of spinal injuries There should be a network protocol for the following: • Assessment and imaging of the spine. • Resuscitation and acute management of spinal cord injury linked with a Spinal Cord Injury Centre (SCIC) at the MTC. • Emergency transfer of spinal patients.	X

Quality Indicator	Currently met/unmet
T16-1C-110 - Emergency planning The network should have an emergency plan for dealing with a mass casualty event that is reviewed and updated annually. The integration of the All Wales Mass Casualty Plans into the network operational policy.	✓
T16-1C-111 – Network rehabilitation director There should be a network lead for rehabilitation with experience in trauma rehabilitation. The director should have an agreed list of responsibilities and time specified for the role. This has been achieved through appointment of the network rehabilitation lead	✓
T16-1C-112 - Directory of rehabilitation services, referral guidelines and education programme To form part of the network operational policy in year 1.	X
T16-1C-113 – Patient transfer policies There should be following network policies in place: • Automatic acceptance policy to the MTC for patients who are transferred from scene or arrive in a TU/LEH and need urgent transfer to the MTC. • Automatic repatriation policy ('care with treatment closer to home'). Further detail is provided in chapter 8 which covers the 'landing pad' configuration.	X

5.4.3 Collaborative Working with North Wales

In contrast to North Wales, there currently is no trauma network serving the population of South Wales, West Wales and South Powys. Therefore, there is an immediate requirement for an ODN to be established here. As the Network in South Wales is established, every opportunity will be taken to work closely with colleagues in North Wales to share good practice, benchmark and work towards equity of quality of care for the whole population of Wales. The South Wales Network will work with colleagues in the North West Midlands and North Wales Trauma Network to forge strong links and establish regular opportunities to share learning and processes.

5.4.4 Specific Patient Groups

Trauma in Older People

Given that older people represent the largest group sustaining major trauma (see chapter 2), it is important that the ODN is proactive rather than reactive. In doing so, it will take a population based approach, tailored to the ageing population of South Wales, West Wales and South Powys. Many of the principles of assessment and care are similar to those of existing fractured neck of femur pathways. Furthermore, the NHS England CRG for major trauma has recently introduced standards for the management of trauma in older people.

The development of robust systems will ensure that older people that are appropriate for specialist care will have equity of access to the MTC, whilst the majority could be managed to a higher standard and a better experience in TUs/LEHs, based on comorbidity and frailty. The table below summarises the essential additions to the ODN service specification and quality indicators above, mirroring that of the NHS England and has been approved by the network board:

Quality Indicator	Currently met/unmet
The network will develop a 'silver' trauma triage tool as an addendum to the 'standard' pre-hospital triage tool supported by trauma desk to enhance identification, leading to early senior involvement in Emergency Departments – in place before year 1.	X
Network guidelines on trauma in older people including assessment, specific sections in trauma patient record for documentation of assessment (e.g. cognition/frailty/nutritional status) and care bundle – in place before year 1.	X
Review by a ST3/equivalent or above in orthogeriatric medicine, geriatric medicine or care of elderly medicine as soon as possible and definitely within 72hrs of admission – in place years 3 - 5.	X
Early brief educational/training interventions for WAST/ED (triage nurses/trauma teams/team leaders) as part of initial programme – in place before year 1.	X

Desirable aspects include establishment of a 'silver' trauma working group within the network specifically looking at additional rehabilitation requirements, enhancing outcome assessment and a bespoke educational programme.

Veterans Trauma Network

The Veterans Trauma Network (VTN) provides a single point of referral for all stakeholders who are concerned about the medical care of a veteran with complex physical injuries, including patients, clinicians (from both physical and mental health services in primary or secondary care), third sector agencies and others. Patients eligible for management by the VTN are ex-service personnel who sustained complex physical trauma due to their service. The VTM is principally concerned with ongoing rather than acute care. Patients will be referred to the VTN when there is concern that the complex nature of their injuries means that the normal pathways in primary, secondary and tertiary care are unable to deliver the appropriate treatment.

To establish the VTN in Wales, the following will be required:

- Creation of a single point of referral for all eligible NHS Wales patients.
- Appointment of VTN clinical lead and deputy.
- Nomination of a Veterans Trauma Centre (VTC). As the MTC for most of NHS Wales, C&VUHB is the natural choice to be the VTC.
- Hosting arrangements for the VTN will be C&VUHB until the trauma ODN is established, at which point it will be hosted within the ODN management structure and SBUHB.
- Infrastructure to allow secure communication between VTN Wales and the VTN in England.
- Referral pathways for the management of identified clinical issues.
- Appropriate linkages between VTN Wales and leads for veteran's affairs in all health boards.
- Suitable governance and reporting structures to be provided by the ODN.
- Communication and stakeholder engagement strategy.

As such, it is anticipated that VTN Wales will deal with less than one patient per month once fully established. Costs of running the VTN/VTC are minimal. There will be some costs to health boards and WHSSC in terms of treatments that will be delivered once issues have been identified. However, these

will all be standard treatment costs for these conditions (or subject to individual patient funding requests if not). The cost to the ODN will be minimal. The lead and deputy will offer their clinical time from their 'military protected time'. Support functions will be absorbed within the ODN management infrastructure. Further details are included in.

5.5 Clinical Informatics Model

Informatics support is essential to improving patient outcomes through both direct support for patient care and indirectly through improving efficiency of the administration of the patient pathway. Making use of existing systems, and harnessing ongoing developments and the future plans of NHS Wales, the informatics programme seeks to reduce the burden of data entry on clinicians and administrative staff, and ensure timely, accurate information is available to patients, clinicians, and management structures, as well as commissioners.

The work stream will seek to work with health boards, trusts, and NWIS to assess the current situation, including mapping information flows relating to major trauma patients, and look at the short, intermediate and long term expectations of the network and how informatics can support this. It will also reach out to the wider UK and internationally to look at best practice and the lessons learned.

In the context of Wales informatics, significant progress has been made recently with the roll out and expansion of national systems allowing cross boundary access to patients records. This provides a unique opportunity to build on existing technologies, and use routinely collected data to track trauma patients in the network.

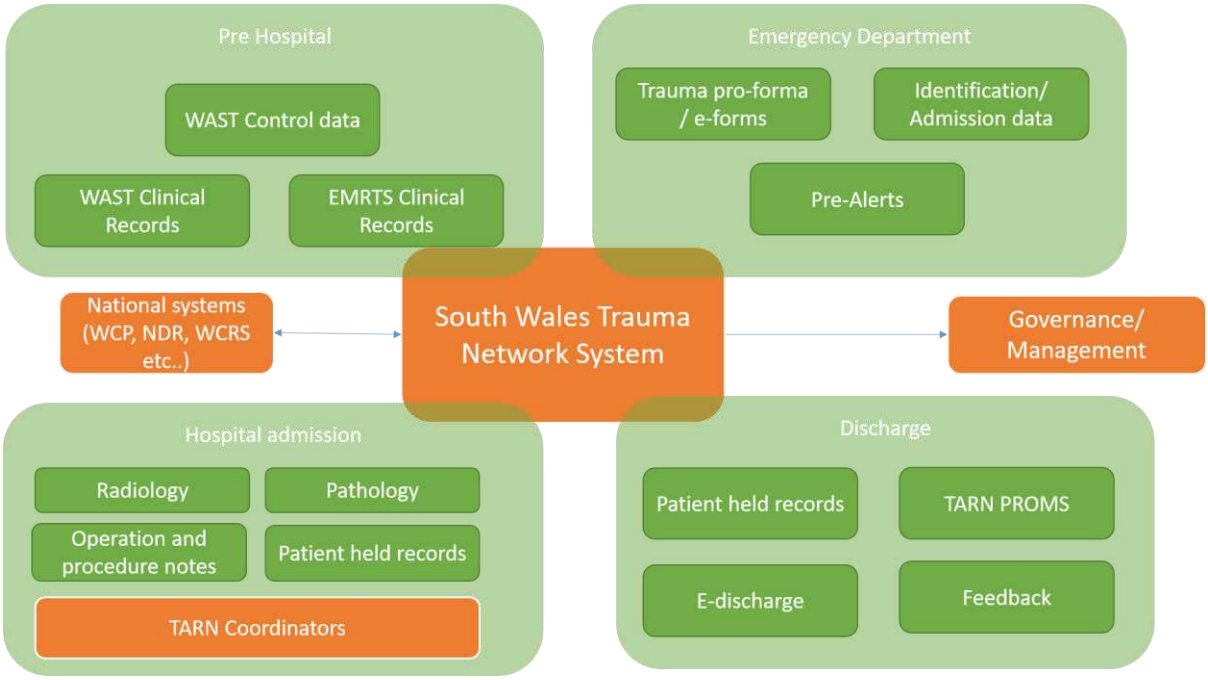
The following areas will be facilitated through the work programme:

- Implementation of a trauma clinical system
- Implementation of a central incident reporting short form, and integration with systems
- Provision of call recording to support governance process
- Development of a network wide information repository / "app"
- Integration of patient held records to support quality discharge
- Supporting training, education, quality improvement and research activities as required.

5.5.1 An Overarching Trauma Informatics System

C&VUHB are developing a bespoke clinical system to improve data collection and aid the tracking of patients across the network pathways. The informatics work programme will seek to implement this across the network, and provide a single point of access for those in involved in the care of trauma patients.

A high level overview of the anticipated landscape of the systems is included in the figure overleaf:



It is recognised the work plan is ambitious given the short time frames to 'go-live', and ongoing existing work streams in an already stretched informatics landscape. In addition, although important, major trauma makes up a very small proportion of the overall workload in NHS Wales, and will be competing with other established projects which impact far greater number of patients (e.g. introduction of new emergency department systems, implementation of electronic records in WAST).

Thus, a phased approach will need to be taken, and phased over five years. An illustration of the essential and desirable deliverables are included below, subject to change once formally handed over to the ODN.

Year	Essential	Desirable
19/20 (in place for day 1)	• Data sharing agreements in place • Pre-hospital patient reports from WAST & EMRTS to be available to TARN coordinators & Network office no more than 4 weeks following incident • WAST/EMRTS to be flagging potential major trauma cases on control systems • Up to date pre-hospital operational data available for interrogation and business intelligence dashboards • Network information "app" live • Trauma tool "app" live • All TU's to upload trauma pro-forma to document management systems that interface with national repository • CAV to be using the network trauma information system pro-actively	• Patient held records (for rehabilitation prescription) functioning • Capture of additional trauma cases in systems that are not TARN eligible, but of interest for injury prevention and service planning e.g. death at scene in HB's that have capacity (i.e. are already up to date with retrospective data collection)

	• Network incident reporting system short form live and process in place for handling cross boundary/ organisational incidents • Call recording available for non-emergency case discussions/ referrals • All TARN coordinators to have access to national instance of Welsh Clinical Portal • Network data analyst in post (training/ development with stakeholders)	
20/21	• Integration with national systems complete (to include operation notes, emergency department systems, all radiology, pathology results) • Transition to electronic clinical data capture in emergency department (replacement of trauma paper pro-forma) CAV • Patient held records (for rehabilitation prescription) functioning for MTC patients	• Transition of other TU's to electronic data capture • Export of year 1 • & year -1 data to SAIL
21/22	• Patient held records (for rehabilitation prescription) functioning for MTC patients + 2 TU's	
22/23	• Patient held records (for rehabilitation prescription) functioning for MTC patients + 4 TU's	• Patient held records (for rehabilitation prescription) functioning for 6 TU's
23/24	TARN integration 1 TARN to have direct access to the network trauma information system data including all relevant linked data to complete a TARN submission. 2 Network to have direct link to TARN data to augment data already available within NHS held datasets e.g. addition of Ps, ISS etc… in operational dashboards. 3 PROMS data to be linked back into welsh systems, and in turn into National data repository 4 Export of dataset to SAIL with 3 complete years of network operation, and to include PROMS, and TARN metrics.	• Patient held records (for rehabilitation prescription) functioning for all 8 TU's

5.5.2 Estimated Resource Requirements

An estimate of resource requirements are provided here to aid planning, and is subject to change as the work progresses with formal project management. It should be noted that work is not in established work plans, and crosses multiple stakeholders with complex integration work required in some areas. Each stakeholder may also incur additional resource requirements to complete the work, not detailed here.

Resource

Estimated resource to implement the 3 year plan are illustrated, and it is anticipated they would start 6 months prior to network go-live.

Resource	WTE	Level	Duration
Clinical Informatics support	0.1	8b	2 years

Further details around the informatics requirements for the network can be found in Appendix 15.

5.6 Training and Education Model

The development of the training and education programme for the network is being undertaken in partnership with HEIW. This will provide an excellent opportunity for the network and HEIW to implement an innovative approach to the programme both being new organisations within the landscape of NHS Wales. The principles of developing the training and education models are as follows:

- A focus on multidisciplinary training across health care providers
- The opportunity to support the development of new roles within NHS Wales (e.g. the extended role of allied health care professionals)
- Prioritise training and education in areas of highest risk and acuity
- A blended approach to the delivery of the programme using a combination of ODN led and provider led deliverables
- A strong emphasis on the evaluation of the training and education programme to inform subsequent refinements as the programme evolves

Training has been organised using the main structural elements of a trauma network organisation:

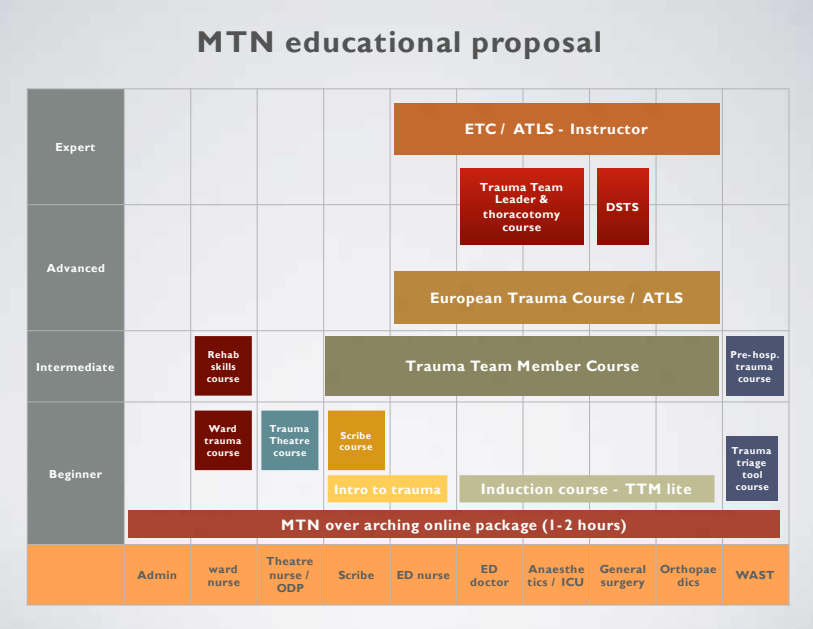
- Prehospital
- Hospital reception
- Definitive care
- Rehabilitation

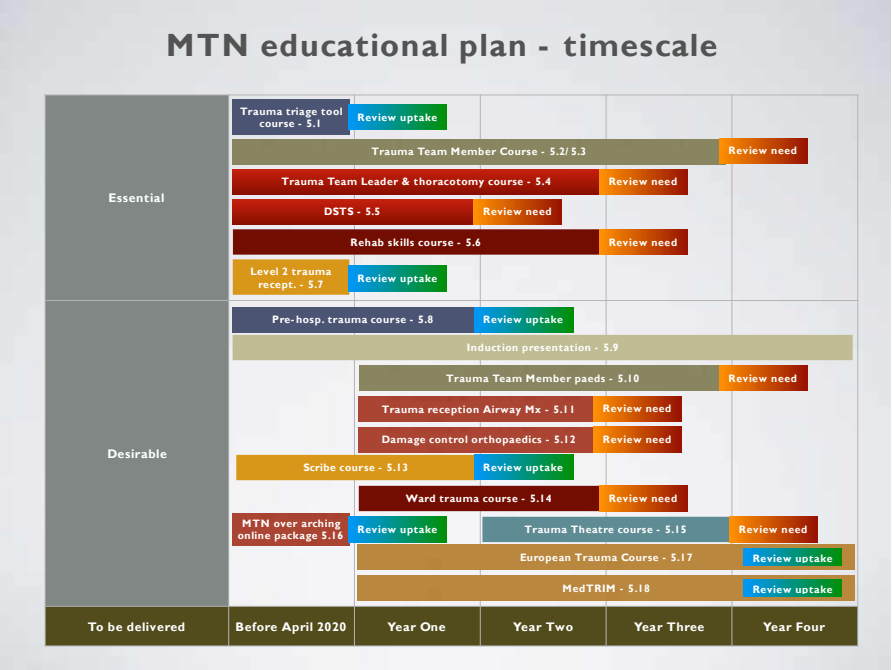
5.6.1 Learning Package Summary

Facet		Modality	Description	Governed by	Priority
5.1	**Trauma triage tool**	On-line learning	Online training package created by onclick	WAST	Essential before April 2020
5.2	**Trauma team member course on-line learning environment**	On-line learning	On line learning material to support a one day course for nurses and doctors working in trauma reception	Network	Essential before April 2020
5.3	**Trauma team member face to face course**	Classroom and scenario based learning	One day course format similar to intermediate trauma life support course	Network	Essential before April 2020
5.4	**Trauma team leader course**	Classroom and hands on learning	One day course to cover human factors and resuscitative thoracotomy	Network	Essential before April 2020
5.5	**Definitive Surgical Trauma Skills**	Classroom and dissection room course	Two day course to cover elements of damage control surgery for trauma surgeons	Network	Essential before April 2020
5.6	**Landing pad course**	Classroom based course supported by the on-line learning environment	Course for nurses working in trauma units and local emergency hospitals to aid landing pad arrangements	Network	Essential to start before April 2020
5.7	**Level 2 training for nurses working in trauma reception**	TNCC and/or APLS	National Trauma Standards recognised courses to fulfil level 2 competencies	To be managed by health boards	Essential to have 24/7 staffing before April 2020 in MTC and TU's
5.8	**Trauma skills course for prehospital staff**	Classroom and scenario based learning	One day course delivered by WAST. Train the trainers by EMRTS and quality assurance by network	WAST	To start before April 2020 in certain vulnerable areas. To be completed in year one of the network.

Facet		Modality	Description	Governed by	Priority
5.9	**Lecture given to doctors at induction**	Presentation given to doctors at their induction	To be created by the working group. Delivered to doctors working in trauma reception	Network	Desirable to deliver before April 2020
5.10	**Trauma team member course for paediatric staff**	Classroom and scenario based learning	A one day paediatric themed trauma intermediate life support course	Network	Desirable to deliver before April 2020. Essential component for year one
5.11	**Trauma course for trauma team Airway management**	Classroom and scenario based learning	A one day or half day session to support staff intubating patients in the trauma reception environment	Network created. Delivered within HB's	Desirable component for year one
5.12	**Trauma course for orthopaedic surgeons working in trauma teams**	Classroom and scenario based learning	A one day or half way session to support staff practicing damage control orthopaedics	Network created. Delivered within HB's	Desirable component for year one
5.13	**A trauma scribe course**	Classroom based learning	A one day or half day session to train HCP's to work as scribes for a trauma team	Delivered by Public Health Wales	Desirable before April 2020 and year one
5.14	**A course for ward staff looking after trauma patients**	Classroom and scenario based learning	A one day course to support nurses working on the major trauma ward	Delivered by MTC nurse educator with support from the Major trauma nurse practitioners	Desirable for year one and two
5.15	**A course for theatre staff looking after trauma patients**	Classroom and scenario based learning	A one day course to support theatre staff	Delivered by the MTC with support from the Network	Desirable for year one, two and three
5.16	**Overarching package for managers**	Online learning	An online course to support management staff	created by the network	Desirable before April 2020
5.17	**European Trauma Course**	A national gold standard course	A gold standard course	Delivered by the national group and local faculty creation	Desirable for year one onwards

Facet		Modality	Description	Governed by	Priority
5.18	**MedTRIM course**	Classroom based course	A course to promote resilience of staff working in the network	Delivered by HEIW. With support from the network.	Desirable for year one onwards
5.19	**TARN coordinator training**	Classroom based course	A course to teach TARN data collection	Delivered by TARN	Essential before April 2020 with ongoing commitment
5.20	**Trauma Practitioner training**	Classroom and scenario based learning	A course to train TU trauma practitioners	Delivered by major trauma practitioners with support from the Network	Desirable before April 2020 with ongoing commitment
5.21	**Therapists / rehabilitation co-ordinator training**	Classroom based course	A course to train therapists and rehabilitation co-ordinators	Delivered by the network	To be undertaken before March 2020





The resource requirements for in year, year one and year two will be described in the financial case see chapter 9.

5.7 Resource Requirements

In order to deliver the service specification and quality indicators outlined above, there will requirements to establish a trauma ODN management team. This represents a new component within the structure of the network and will be required to be in place in-year (i.e. 2019/20) in order to ensure the following:

- Implementation of a clinical and operational framework across the trauma pathway and work closely with all participating organisations to ensure a state of readiness for delivery of the network within the agreed timelines (see chapter INSERT).
- Suitable governance and reporting structures in place.
- Test clinical and non-clinical policies as indicated above.
- Baseline TARN data collection optimised.
- Quality assurance of key components of the training and education programme.
- Early clinical informatics structures in place to allow appropriate data collection.
- Oversee stakeholder communication and engagement.

The ODN management team will be hosted by SBUHB. Further details in relation to organisational governance are provided in management case (chapter 12). The following table summarises and provides justification for additional resource requirements, which have been developed to align with comparable networks in the UK. It highlights new posts as key enablers for the network and existing posts, where there is currently non-recurrent funding and ongoing resource requirements. In view of the requirements for in year funding of these posts, in line with the timeline for implementation of the network, a proposal has been concurrently submitted for early release of funding through the WHSSC Integrated Commissioning Plan (ICP) prioritisation process.

Role	Purpose	WTE*	Band
Network clinical director (to develop as a national role subject to agreement for ODN taking on a national function)	The network clinical lead is already in place – ongoing resources required to fund this post at point of handover to the ODN. The resource requirement is from August 2020. The purpose of this role can be split up to the following: **Strategic planning:** Provide strategic vision and direction to the entire network from a clinical perspective. Provide professional and clinical leadership across the network. Service senior clinical representative (4 Nations and Welsh Government level). Support the phased implementation of the network from a clinical perspective (including the development of an all Wales approach). **Operational delivery:** Oversee the co-ordination of patient clinical pathways between services over a wide area to ensure access to specialist major trauma care. Ensure the quality of the network is monitored and subject to a process of continuous quality improvement. **Tactical (local) advice and support to commissioners:** Provide leadership in national review and assurance of the MTC, TUs and pre-hospital services with commissioners. Support local implementation of products produced by the National Trauma Clinical Reference Group (NHS England) as appropriate. Advise commissioners on all clinical issues pertaining to major trauma services. **Improved quality and standards of care:** Oversee the clinical governance framework with the MTC, TUs, LEHs, pre-hospital services and rehabilitation services. Ensure on-going service improvements and best practice models are embedded and contribute to improved quality performance. **Partnership development:** Clinical team development and oversee the activity of network clinical lead positions and health board clinical leads. Partnership working in national clinical policy development.	0.3	Consultant

Role	Purpose	WTE*	Band
Network Manager (to develop as a national role subject to agreement)	There is a requirement to have a dedicated full time operational network manager in place – this post is new and ongoing resources required to fund this post in year to facilitate lead into the ODN. This resource is required in year. The purpose of this role can be split up to the following: **Strategic planning:** Lead on the annual working plan for the network to deliver against the quality and delivery framework Undertake comparative benchmarking and audit across the network through the Trauma Audit and Research Network (TARN). Support the phased implementation of the network from an operational perspective (including the development of an all Wales approach). **Operational delivery:** Managerial responsibility for the ODN and senior support for network clinical director. Senior responsible officer for monitoring of day to day capacity across the network, agreeing and working to an escalation plan (with agreed thresholds for escalation triggers) for both within and across network to monitor and manage surges in demand. Support capacity planning and activity monitoring for collaborative matching of demand and supply (e.g. through implementing a trauma tracking system). Work with very senior health board management to maintain necessary flow and support to nationally co-ordinated delivery. Development and monitoring of network operational policies. **Tactical (local) advice and support to commissioners:** Provide local information, data and intelligence to support performance monitoring of the network Oversee ongoing programme management of a phased implementation across the network. Senior Manager representative for the Network at relevant national commissioning functions **Improved quality and standards of care:** Lead for quality and safety. Monitoring of MTC and TU dashboards and provide advice on improvements to clinical services and commissioners**.** Use clinical process and clinical outcome measures to compare and benchmark providers **Partnership development:**	1.0	8C

	Monitoring and performance management of active engagement by members in the network to improve performance against agreed outputs.		
Sessional clinical leadership	These posts are funded non-recurrently until end of March 2020. Ongoing funding required as these roles are critical to clinical governance of the network Clinical lead functions for: Governance – policy development, assess and review all clinical governance issues, provide recommendations to the wider network. Training and education – oversee and evaluate the phased model for multidisciplinary training and education programme across the pathway. Paediatric trauma - policy development, assess and review all clinical governance issues, provide recommendations to the wider network. Quality improvement, innovation and research – improve TARN data collection as a platform for developing a QI and research programme Rehabilitation – oversee and advise on the delivery of rehabilitation services across the pathway including hyper-acute, specialist, local and community based rehabilitation.	0.1 x 5	Consultant
Network administrative support	This post is new and ongoing resources required to fund this post to facilitate lead into the ODN. This resource is required in year. The purpose of this role can be split up to the following: Administrative support, general admin duties (supporting training events, audit, communications activity etc.).	1.0	4
Programme manager	This post is funded non-recurrently until end of March 2020. Ongoing funding required. The purpose of this role can be split up to the following: Business and operational support to network clinical director and operational network roles. Senior manager responsible for line management of admin and TARN co-ordinators. Lead for network communications and engagement, with key deliverables. Lead for financial and budgetary management. Performance management lead. Responsible for all programme and project management relating to major trauma service development in Wales, as part of their phased implementation.	1.0	8B

Role	Purpose	WTE*	Band
Senior Data analyst and service improvement manager	This post is new and ongoing resources required to fund this post to facilitate lead into the ODN. This resource is required in year. Reporting and analysis of all data sets pertaining to trauma across the network (incl. TARN, operational data) for QI, research and commissioning purposes. Production of data sets and necessary development. Enabling of national and local level reporting and self-reporting. Production of routine and targeted data audits. Supporting health boards in the development of and reporting on TARN data.	1.0	7

*WTE – whole time equivalent

5.8 Key Challenges

From the above the following themes have emerged:

- The maintenance of optimal patient flow between the MTC and TUs is critical to ensuring the network can deliver its benefits realisation plan.
- Complex commissioning arrangements with multiple commissioning bodies involved, leading to a lack of accountability across the pathway. There is a risk that no one commissioner has oversight or commissioning influence over the entire patient pathway.
- The inability of the trauma ODN board to hold organisations to account since it will not have a direct commissioning remit and will be acting in a professional capacity in relation to developing responses to clinical and operational governance issues. An inability to be effective at maintaining 'operational delivery', given the complexity of commissioning arrangements and multiple providers.
- The design must recognise that NHS Wales's policy is to follow a route of planning and partnership working instead of incentivisation and an internal market.

5.9 Issues Arising for Resolution

- Management of and responsibility for escalation
- Management of and responsibility for interventions
- Management of and responsibility for workforce development
- Provision of coordination, advice and professional steer for workforce related matters
- Management and responsibility for service improvement

5.10 Options to the give the ODN Meaningful Operational Authority

In the interim options to give the ODN, operational authority include:

- The ODN (and therefore the 'host' organisation) – has some financial responsibility for contracting and managing aspects of performance or delivery of the pathway in order to maintain authority.

- The ODN Board could, with the correct membership and 'Terms of Reference', discharge an effective commissioning and performance management support function – would require EASC and WHSSC to be appropriately represented and engaged.

Arrangements for the delivery and management of the ODN are described in the management case (see chapter 12).

6 Pre-Hospital Care and Transfers

6.1 Introduction

This chapter sets out the case for improvements in the delivery of pre-hospital care and inter-hospital transfers of major patients, as part of establishing the trauma network. It summarises the service specification and quality indicators in relation to the current position of services.

Building on this, the chapter describes in detail the resource implications for WAST in terms of increased ambulance journeys resulting from direct and secondary transfers to the MTC. The chapter also considers the requirements for ensuring timely repatriation for 'care with treatment closer to home' within this context. The preferred option for online and phased face-to-face training of ambulance service personnel is discussed, expanding on section 6.3.5. Finally, this chapter describes the development of a dedicated trauma desk facility as a key coordinating function within the network structure.

The details provided here in relation to the WAST case have been considered within the context of the professional peer review that took place on the 13th August 2019.

For completeness and information, this chapter also sets out the requirements for 24/7 availability of EMRTS in South Wales aligned with the timeline of the network becoming operational. At the time of writing, EMRTS 24/7 development in South Wales had been approved and recruitment of posts had commenced. Whilst the resource requirements for this are not provided in this case, the delivery of the service is a pivotal development and has the support of the network.

6.2 Service Specification and Quality Indicators

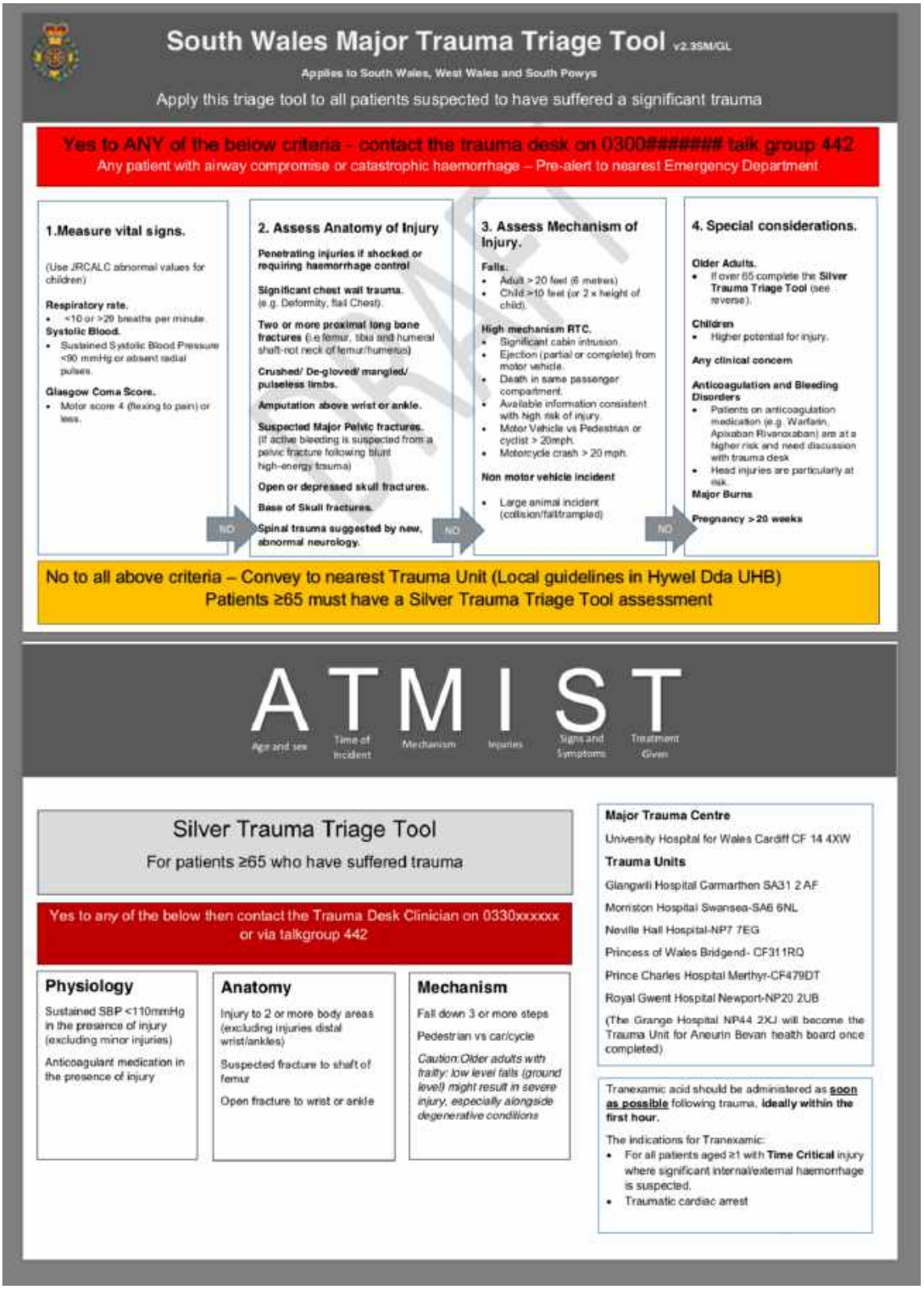
6.2.1 Pre-Hospital Care

Pre-hospital Trauma Triage Tool

The introduction of a network pre-hospital triage tool at the scene of incidents will bring about a significant change in triage decision-making by all pre-hospital providers. The purpose of a pre-hospital triage tool is to make informed decisions in relation to disposition, based on the mechanism of injury, injury pattern and clinical condition of the patient. In many cases, this will support providers to bypass the local emergency department and take the patient directly to the MTC at UHW, TU with specialist services at Morriston Hospital, or the nearest TU. Whilst EMRTS currently bypasses local emergency departments and take patients directly to specialist care, there is no mechanism for other providers such as WAST to undertake this consistently. This concept is not new to WAST in other clinical instances given that ambulance crews routinely convey heart attack and stroke patients over significant distances direct to specialist care.

Currently there is no standardised national pre-hospital triage tool available, although work has started to develop one. Current pre-hospital triage tools are all similar in terms of their triage accuracy; however, a key difference is whether a time-to-MTC rule is applied. Using this rule, if a patient is triage tool-positive (i.e. is a 'candidate' major trauma patient) and is within 60 minutes by road from the MTC, the patient is taken there directly. Outside 60 minutes, the patient goes to the nearest TU. The exception to both these rules is if the patient has signs of airway compromise and/or catastrophic haemorrhage. In these cases, the crew will take them to the nearest emergency department. With the development of a national trauma desk facility (see below), there is opportunity to support providers make individualised decisions about the disposition of patients that are less based on the time to MTC rule. For example if a patient is triage positive and 70 minutes from the MTC, logically they should go

direct to the MTC. The copy of the proposed network triage tool is provided below, for which decision-making is supported by the presence of a trauma desk facility:



WAST have developed an adult and paediatric triage tool, which has been approved and will be owned by the ODN. Furthermore, and in keeping with the ODNs aims of adopting a population-based

approach to its design, this includes a triage tool specifically for trauma in older people, otherwise termed a 'silver triage tool.' It is widely recognised that generic pre-hospital trauma triage tools are poor at identifying trauma in older people. By incorporating factors like low mechanisms of injury, differences in vital signs and presence of anticoagulation, a 'silver triage tool' increases identification of major trauma in older people. This has the effect of improving pre-alerting to receiving hospitals and activation of trauma teams, without over triage to the MTC.

All pre-hospital providers will adopt the pre-hospital trauma triage tool across the region (including Search and Rescue Services). As the tool will change patient flow, the tool will come into use at the time the ODN becomes operational and the MTC/TUs are in a state of readiness. In the meantime, familiarisation training for all WAST personnel will commence as described below.

Quality Indicators

In addition to the above specification, there are a number of essential quality indicators presented in the table below. Each quality indicator has an assigned code in order to cross-reference (Appendix 3). All quality indicators will need to be in place before the ODN becomes operational (i.e. before day 1) unless indicated below. Presently these quality indicators are only being partially met.

Quality Indicator and how met	Currently met/unmet
T16-2A-101 – Pre-hospital care clinical governance The pre-hospital providers should be part of the clinical governance structure for the network and send a representative to the network governance meetings. This will be met through the introduction of the ODN as described in the management case (see Chapter 12)	X
T16-2A-102 – 24/7 senior advice for the ambulance control room There should be an advanced paramedic or a critical care paramedic present in the ambulance control room 24 hours a day. This senior clinician should have 24/7 telephone access to pre-hospital consultant advice. This standard is partially met through the availability of the EMRTS air support desk (ASD) and remote 'Top Cover' consultant support, albeit 12 hours/day. The 'Top Cover' consultant support is limited overnight. As indicated in the WAST case below, plans will be put in place to develop a national trauma desk facility, co-located with the existing ASD. The desk will serve the following roles: • Notified by providers of all triage positive and triage equivocal cases to support decision making on assessment, management and disposition. • Interface between providers and receiving hospital for passing pre-alert information. • Retrieval coordination role for all moderate and major trauma transfers. • Major incident/mass casualty coordination. The ASD Critical Care Practitioner (CCP) and remote EMRTS 'Top Cover' consultant will support the desk. Benefit will come from a national approach, serving both regional trauma networks. The ASD will subsume the trauma desk function overnight as part of the expansion of the EMRTS operational hours	Partially met

Quality Indicator and how met	Currently met/unmet
T16-2A-103 – Dedicated enhanced care teams available 24/7 Enhanced care teams should be available in the pre-hospital phase 24/7 to provide care to the major trauma patient. This standard is already being provided 12 hours/day (8am-8pm) by the EMRTS and ad hoc overnight by voluntary doctors. It has been agreed that the service will be expanded to 24/7 in line with the network becoming operational. The configuration will remain consultant led and delivered, with CCPs responding by air or road from South Wales. Provision will be made for overnight ASD cover to support tasking.	X
T16-2A-104 – Clinical management protocols There should be protocols in place for the pre-hospital management of major trauma patients which includes: • Airway management. • Chest trauma. • Pain management for adults and children including advanced. analgesia options (i.e. ketamine) • Management of major haemorrhage including: the administration of tranexamic acid, application of haemostatic dressings, application of tourniquets and application of pelvic binders All providers already manage patients who have sustained major trauma in line with national standards (Joint Royal Colleges Ambulance Liaison Committee) and therefore meet all of the above already. However given increased distances over which patients will be conveyed, WAST will be undertaking some refresher training on the above. It should be noted that WAST paramedics do not routinely provide advanced analgesia with ketamine, although this is being identified as an area of development. Currently, EMRTS and voluntary doctors provide this.	✓
T16-2A-105 - Hospital Pre-Alert and Handover There should be a network wide agreed pre-alert system with effective communication between pre-hospital and in-hospital teams. This should include documented criteria for trauma team activation and patient handover. Although the above exists, delivery is not consistent across the region. The pre-alert communication system will be built into the pre-hospital triage tool function and trauma desk capability. Standard trauma team activation criteria will be developed by the ODN.	Partially met

6.2.2 Inter-Hospital Transfers

There will be no change to existing arrangements for inter-hospital transfers. EMRTS or the hospital to transfer team will continue undertake critical care transfers by air or road. These transfers will continue to be monitored and quality assured by EMRTS and the Critical Care Network, respectively. Through the availability of resources from the Critical Care Implementation Group, opportunities exist to develop a non-urgent critical care transfer service as described in Chapter 2. WAST will continue to manage non-critical care transfers and repatriations. Increased ambulance journeys have been reflected in the WAST case below.

The availability of 24/7 EMRTS and trauma desk facility for coordination and delivery of trauma transfers will enhance the quality of these transfers and reduce the pressure on hospital transfer teams.

6.3 Welsh Ambulance Service

6.3.1 Context

The internal and wider context for WAST as a critical enabler for the success of the network is described in Chapter 3. However, the ambulance service will be unable to play this leading role within the network unless appropriately resourced. Whilst the anticipated numbers of patients being cared for within this new model are not expected to change from historic numbers, the new clinical model for major trauma will result in the ambulance service making many more 'new' journeys; journeys which may often involve significant distance. Existing resources may be taken out of their local area for much longer periods.

These longer journeys will also result, in some cases, patients needing to be cared for by ambulance crews for much longer. This will be a significantly different way of working for WAST staff and they will need support to ensure they can care for their patients to an optimal level. Failure to ensure both these aspects are fully acknowledged and commissioned will ultimately result in the erosion of wider operational performance and patients not being conveyed to the right location first time.

WAST makes ongoing commitments within its integrated medium term plans (IMTPs) to be a full and active partner in supporting the successful delivery of a major trauma network for South Wales, West Wales and South Powys. However, as a commissioned service through EASC current and future plans will stop short of being able to offer assurance on the service being fully funded from an ambulance perspective until all of the elements of the new service have been agreed and funded by the commissioners.

6.3.2 Description of the Clinical and Operational Model for WAST

WAST's clinical and operational model that will support the major trauma network will be complementary to the organisations nationally agreed clinical model as shown below:

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Step Two – Answer my call

All calls that the Ambulance receives via 999 are classified as follows:

RED – BLUE LIGHTS	**Immediately life-threatening calls**	Multiple dispatch Blue light emergency response
AMBER – BLUE LIGHTS	**Life-threatening / Serious calls**	Blue light emergency response
GREEN 2 and 3– NORMAL ROAD SPEED	**All other calls**	Face to face response Clinical telephone assessment

The vast majority of major trauma cases will be classified as a red response – immediately life threatening.

Step Three – Come to see me

Effective pre-hospital decision-making will take place within this step and decisions will be taken about the most appropriate response to send to each case - WAST, EMRTS or both.

This decision process would be facilitated by a trauma desk facility located within the Ambulance Services Clinical Contact Centre and co-located with the EMRTS ASD.

It is the assumption of this business case that EMRTS will be a 24/7 service by the time the trauma network goes live.

Step Four – Give me treatment

WAST has developed a pre-hospital triage tool in conjunction with the network, which will be used to support pre-hospital decision making at this step with regard to direct transfer from scene to the MTC in appropriate cases. Good discussions have taken place with all stakeholders and refinements have been made to the tool following the professional peer review.

This tool will be supplemented with live clinical decision support of a major trauma desk (see section 6.3.6) for more borderline cases.

Step Five – Take me to hospital

Decision taken in step 4 guided by the effective use of the two major trauma triage tools will then determine if in this stage patients are conveyed to the nearest TU or directly to the MTC.

6.3.3 Phased Implementation

In an approach that is complementary to an underlying principle of the wider trauma network board, WAST is taking a 'phased approach' in regards to support of the network. WAST are committed to ensuring that the network is safe and effective on delivery and that from this point forward the service will be on a trajectory of continued improvement and maturity.

In this respect, a phased approach is outlined below:

	Activities	Why?	Additional Resource Required
Essential in place For Day 1	• Trauma Triage Tools	Supports patients being apparently triaged and conveyed to most appropriate location	See section 6.2.1
	• Online training for staff in relevant geographical areas	Further supports paramedic triage of patients and convey of patient to most appropriate location	See section 6.3.5
	• Trauma Support Desk / Expansion of EMRTS Desk to fulfil this function	Final line of support in triage of patient by offering clinical leadership to on scene paramedics. Ensures	See section 6.3.6

	(including recruitment of relevant posts)	most appropriate on scene car is provided and plays a system co-ordination role	
	• Agreement on commissioned activity levels for year 1	Ensures WAST is deploying the most appropriate amount of resources on any given day and that the go live of the network does not destabilise wider WAST operational performance and its ability to attend other non-major trauma cases in the community.	See chapter 12
Essential in Year 1	• Commencement and completion of 'face to face' staff training • Governance structure in place both network wide and internal to WAST (where relevant) to support decision-making. • Transfer and discharge service		See section 6.3.5
Essential in Year 2-3	• Ongoing data collection • Dedicated EMRTS vehicle		
Essential in Year 4-5	• Ongoing data collection		
Desirable & aspirational goals	• It is desirable for some face to face training to begin prior to go live		

The following specific governance arrangements have been agreed for training and are reflected in the management case:

Pre-hospital triage tool –the network will 'own' this tool as indicated above:

- Responsibility – WAST will be responsible for developing the tool.
- Accountability – Network board will approve the tool. Monitoring of the tool through the ODN Board on behalf of WHSSC/EASC, however this will require data from WAST on compliance/health board issues.
- Consulted – WAST clinical governance/EMRTS/network governance subcommittee.
- Informed – Providers (online & face-to-face training).

Online & face-to-face training:

- Responsibility – WAST will be responsible for developing both of these elements.
- Accountability – EASC.

- Consulted – WAST learning and development and network training and education lead
- Quality Assure – EMRTS (as preferred provider).
- Informed – Providers.

6.3.4 Additional Resource Requirements for Increased Ambulance Journeys

WAST have identified that the development of a trauma network will have a significant impact on its resources. In beginning to quantify and understand these implications, a number of existing policies, Welsh Health Circulars and agreed stances of EASC have been considered. These include:

- WHC (2017) 008 NHS Wales Policy for Repatriation of Patients.
- Designed for Life Welsh Guidelines For The Transfer Of The Critically Ill Adult.
- Developing a Once for Wales approach to quantifying the impact of Health Board strategic service changes (26 June 2018).

In noting the documented implications on the Ambulance Service in these papers, it is important to note that it has been necessary to use a number of assumptions over and above those used in the production of the dataset approved by the network board, which is the basis of the whole networks planning.

Individual assumptions used for particular areas are clearly documented in the relevant section of this paper. An executive decision of the organisation was taken that where assumptions need to be used that 'worst case scenario' assumptions should be used.

In light of this, it is highly recommended that after year one of the service when accurate 'actual' activity has been collected that further commissioning discussions are held regarding pre-hospital conveyance, secondary conveyance, repatriations and follow up rehabilitation activity.

Emergency Conveyance Times (job cycle times)

The implication here derives from the fact that traditional suspected major trauma cases would have been conveyed from scene to the nearest appropriate hospital. The new model will see the patient either conveyed to the nearest TU or direct to the MTC at UHW, Cardiff.

The following assumptions are made:

- NHS Wales is collectively unable to determine exactly where suspected major trauma incidents take place. To mitigate this an assumption has been made that they all happen at the hospital site to which they would have been conveyed under the existing model. This is clearly not reality.
- Because existing incident locations are not known, existing conveyance distances/times have not been able to be deducted to understand the 'new' element of activity.
- HDUHB have engaged with the public on the status of Bronglais General Hospital and Withybush General Hospital within the new model. It has been confirmed that both sites will become rural trauma facilities for the purposes of major trauma. On the basis of this, the WAST submission assumes that the forecast of activity for these hospitals will initially be conveyed to Glangwili General Hospital only.
- It has been agreed between WAST, EMRTS and Office of the Chief Ambulance Service Commissioner that there should be no attempt to split the total activity requiring conveyance between WAST and EMRTS and that instead it is clinically appropriate to model on the basis that WAST will have a role to play in all initial 999 major trauma calls.

Secondary Transfers (transfer from TU to MTC)

The implication for the ambulance services derives from the fact that in some cases it will be appropriate for the patient to be conveyed to the MTC via a TU, for example for stabilisation.

Within the traditional model it would have been unlikely for the patient to have ever been moved from the destination of their first conveyance thus this re presents new activity for WAST.

Repatriations (back to TU and/or patients local district general hospital (DGH), to specialist rehabilitation, home or home of a carer)

Whilst repatriations will have been a feature of current service provision there are 'new' implications for WAST in that there will now be a greater number of people in UHW that will need repatriation for 'care with treatment closer to home.'

The following assumptions are made:

- Some data exists to project the proportion of patients who will die as a result of their injuries whilst in UHW and those who will require repatriation or transfer to specialist rehabilitation sites (and thus these numbers are built into modelling).
- No data exists to indicate that when a patient is ready to be discharged home/nursing home/ home of carer etc. how they return to these places. It has therefore been assumed that WAST will undertake all of these transfers.
- In addition to the above, existing places of residence and other key data information that determine where patients might need to be conveyed to does not exist. Therefore, modelling is always based on returning to the patient's local DGH. This will not reflect reality.
- A lack of data means it is not possible to understand existing repatriation distances/times and to deduct it in order to understand the 'new' element of repatriation activity.
- Repatriations will be undertaken by the WAST Urgent Care Service and Non-Emergency Patient Transfer Service crews in line with existing NHS Wales policy.

6.3.5 Staff Training and Education

Background and Proposed Approach

The system of major trauma network proposed for South Wales, West Wales and South Powys will require the transport of patients with identified injuries to the MTC. A trauma triage tool (and where appropriate 'silver' triage tool) would be used to identify patients who fall into the major trauma category and these patients would be taken directly to a MTC for optimal care.

This may require WAST Emergency Medical Service staff to manage patients with serious traumatic injuries for longer periods of time. This will require training in the management of trauma patients using the current trauma equipment supplied by WAST. It will also be necessary for staff to undertake training in using the pathway and familiarisation with the trauma network.

Whilst many of the organisations Emergency Medical Service colleagues get 52 hours continuous professional development time, others receive less (it is hoped that this allocation will be standardised across all staff in this group once an internal roster review exercise has been complete). In addition there is a long standing agreement with the organisations trade union partners that only 15 hours of total CPD time is 'directed' by the organisation

The organisation recognises that the annual CPD programme for WAST colleagues would usually be the best option for delivery of such training, however, the directed 15 hours' time for the next year

has been ring-fenced for the Band 6 education process (which has been planned since 2017) and other standard mandatory training which staff are required to undertake.

Mandating staff to also use their CPD hours for the required major trauma training would require detailed conversations with our trade union partners to extend the number of CPD hours which the organisation currently ring-fences. Early discussions with trade union partners have begun but at this moment in time, negotiations are ongoing. This business case is therefore predicated on the assumption that CPD hours cannot be utilised as this represents the worst-case scenario financially for commissioners to plan against.

WAST is the only provider of emergency transport in Wales, operating in a complex environment in terms of geography and topography. Whilst the establishment of the trauma network presents many benefits and opportunities, it should be recognised that it compounds existing service delivery challenges. WAST must ensure that practitioners are fully equipped in terms of decision making and clinical intervention skills to fully support this initiative.

WAST currently operates from 105 sites across Wales meaning that education and training of colleagues is not a straightforward task. It is important that we recognise and utilise the expertise of EMRTS colleagues in relation to trauma in order to ensure quality of learning. Support is therefore required from EMRTS colleagues in relation to delivering "train the trainer" sessions for our staff and quality assurance of our delivery.

Potential delivery options have been reviewed in collaboration with the network clinical lead and network training and education lead and the preferred option is set out below:

- All colleagues complete the eLearning module (1 hour) before the network goes live. This learning will be provided in workbook format for those colleagues who require it.
- EMRTS have agreed to carry out 'Train the Trainer' training and quality assurance for WAST as part of their business as usual. Following this colleagues will then receive a 1-day (7.5 hours), face-to-face trauma network training session delivered by the recruited trained WAST tutors. These roles will need to be filled on a secondment basis, as the existing small education and training delivery team in WAST is fully committed to a challenging workforce/training plan. Additionally, there will be a need to recruit a trauma network lead tutor to oversee delivery, recording and reporting.

The team would comprise:

- 1 x lead tutor (responsible for overseeing project delivery and reporting and delivery of training) – 12 month secondment at band 7.
- 3 x tutors (responsible for delivery of training) – 3 x 7 month secondments (delivery of South Wales training) and 3 x 5 month secondments (delivery of Mid and North Wales training) all at band 7.

WAST recognises that whilst the face-to-face training is a one-off cost it will still represent a significant investment from the wider system which commissions Ambulance Services in Wales. Detailed conversations have taken place not only internally but also with the network board, commissioners and through the external peer review exercise as to the most appropriate way to roll out this training.

Discussions allowed three options to be considered:

- Do nothing – have no face-to-face training.

- Conduct face-to-face training of all staff during 2020/21 with a prioritisation of staff in the most geographically important areas of Wales during quarter 1.
- Phase training over three years with a prioritisation of staff in the most geographically important areas of Wales during 2020/21.

Option one was immediately discounted because of the significant impact of quality of service provision and the wider implications this would have for the success of the network.

A SWOT analysis of options two and three were subsequently undertaken. This has resulted in option 2 being the preferred option.

Benefits of this approach:

- Timely delivery
- High quality training
- Appropriately skilled workforce
- Existing training plan is not adversely affected – ensure business continuity
- Enhanced trauma management skill set for colleagues across Wales
- Fully supports the Trauma Network initiative.

Online Training

The preferred supplier is Onclick, as WAST is already using this company for other eLearning. Onclick is building a good portfolio of eLearning packages and remains competitive in this field. The eLearning will include design and development of interactive major trauma triage tool, for installation on the WAST Learnzone. It will include instructional design and copywriting of content, custom graphic design and eLearning build. There will also be a bank of multiple choice questions, case study-based assessment to be built within a learning platform, with certification on successful completion. Further signposting and resources to be embedded within WAST Learnzone. A scheduled report to be set up for WAST and South Wales Trauma Network. The duration of eLearning will be 1 hour. Back fill costs will be required for this.

Face-to-Face Training

The total number of staff requiring training is 1434 including:

- Paramedics (band 6): 949.
- Advanced Paramedic Practitioners (band 7): 19.
- Advanced Emergency Medical Technician / Emergency Medical Technician (band 5): 92.
- Emergency Medical Technician 1 / Emergency Medical Technician 2 (band 4): 374.

Costs are provided in the financial case for one lead tutor (band 7), three tutors (band 7) and backfill costs for staff. Equipment costs are also presented here for the training sessions.

Risks, Issues and Dependencies

This training requires the full support of WAST operational teams and resource departments to ensure staff attendance to maximise educator-to-student ratio. Support is required from EMRTS in terms of "train the trainer" delivery and quality assurance. Support from area managers (WAST) is required in relation to accessing suitable teaching spaces at existing WAST sites. Success is dependent on availability of funding and allocation in a timely manner. The model requires full support of WAST

operations directorate to release four colleagues to facilitate this training (lead tutor and tutor roles) on a secondment basis. Full support from the clinical and medical directorate is required, in terms of provision of advice, guidance and support from health board clinical leads/consultant paramedics. Support from and collaboration with trade union partners is also required, as well as engagement from staff.

6.3.6 Trauma Desk Facility

In order for step two of our clinical model to operate as effectively as possible in the context of major trauma, new arrangements within WASTs Clinical Contact Centres are required and an effective major trauma desk is an absolute requirement from day one of a live network.

A field visit was made in 2019 to the West Midlands Ambulance Service Trauma Desk, who have been supporting their major trauma networks for five years. That visit has enabled us to see how best a major trauma desk is configured for the Welsh context.

Options considered included:

1. The status quo. No changes to existing practices and should paramedics on scene have queries regarding a patients suitability for conveyance to the MTC then dialogue directly with on-call MTC consultants takes place.

2. There is suitable expansion of the EMRT Air Support Desk (ASD) in order for this service to co-ordinate the pre-hospital element of the network.

3a. The creation of a separate 'WAST' major trauma desk which works conterminously with the existing EMRTS ASD, is staffed by a band 7 clinician and operates 24/7.

3b. As above but with reduced operational hours. 14/7 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS ASD out of hours.

4a. The creation of a separate 'WAST' major trauma desk, which works conterminously with the existing EMRTS ASD, staffed by an additional allocator band 5 role and operates. 24/7.

Here the clinical decision-making would rest with the EMRTS Critical Care Practitioner on the desk with the band 5 freeing up the CCP to make the clinical decisions, rather than undertaking non-clinical communication duties.

4b. As above but with reduced operational hours. 14/7 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS desk out of hours.

Option 3b has been identified as the preferred option.

The creation of a separate 'WAST' major trauma desk which works conterminously with the existing EMRTS ASD, is staffed by a band 7 senior paramedic and operates 14/7 (hours of the day being 0800-2200) and the function 'falling back' to the EMRTS ASD out of hours.

EMRTS have confirmed that they are supportive of this preferred approach and it is recognised that the working relationship with the ASD staff is vital to the success of the desk.

To support the operation of the WAST Trauma Desk it is essential that the clinicians maintain their clinical skills within a face-to-face role. Therefore, to facilitate this rotation between the Trauma Desk and operational setting, it is vital to create capacity in the clinician's roster hours to enable patient

contact and the maintenance and development of clinical skills. Therefore, whilst draft versions of this business case have shown a necessity for 3.48 WTE this has been scaled up to 4 WTE to allow the aforementioned rotation.

6.3.7 Transfer and Discharge Model

With many more journeys relating to Major Trauma taking place across South Wales, West Wales and South Powys the establishment of a function to effectively and efficiently co-ordinate these journeys will be critical.

An expanded additional call handler/dispatcher resource will provide the required capacity to ensure the safe delivery of journey co-ordination. However, the need for an effective and efficient co-ordination of journeys function is not limited to the changes planned for major trauma. It will play an equally critical role in the success of other strategic developments across NHS Wales such as the opening of the Grange University Hospital in Aneurin Bevan University Health Board.

In recognising this both the WAST and EASC IMTPs make the commitment to develop a proposal for All Wales Transfer and Discharge service within 2019/20. The creation of the trauma network has been identified as being the ideal 'spring-board' for the potential creation of this test service that can be trialled and evaluated prior to wider rollout across Wales. A wider piece of work is being taken forward by WAST, EASC and Health Boards to determine what the preferred model could look like. However, for the purposes of this business case an assessment has been made as to what funding maybe required supporting transfer and discharging service for major trauma. The figure represented in the business case for this part of the service represents the additionality in activity that is forecast to be created by the network.

6.4 Emergency Medical Retrieval and Transfer Service (EMRTS)

This section provides an outline of a review undertaken to allow the phased 24/7 development of the EMRTS. t is referenced here for completeness and for information only, as the first phase of expansion has already been approved and the service model and timeline is congruent with the network development. There is a key dependency on service expansion and the network development as illustrated by the above quality indicators. This case does include the financial case for the service expansion as this has been considered separately by EASC.

The purpose of this review was to explore the options for the proposed expansion of the EMRTS in response to the Welsh Government Gateway Review in May 2017 and correspondence from the Chief Executive Officers, NHS Wales in June 2018.

This review provided comprehensive information on the establishment of the EMRTS in April 2015, an organisation overview and details of the current service model. Following discussion with stakeholders, it was agreed that the scope of the project would include:

- Extension of EMRTS operating hours.
- The ASD to operate in line with EMRTS operating hours.
- Options that address the main peak of unmet demand.

The key investment objectives, agreed with stakeholders, align with those of the network and describe what the project was seeking to achieve and provide a basis for post-project evaluation.

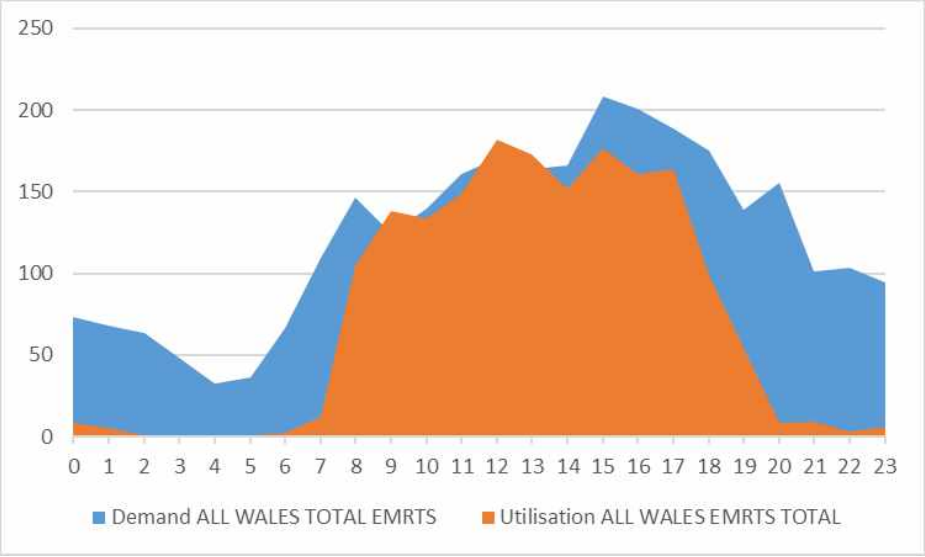
A three-year evaluation report builds on this work and will be published in 2019. This will provide a detailed analysis of the benefits delivered by EMRTS against the benefits set out in the relevant Strategic Outline Programme and Business Justification Cases and set out an approach for the robust management of benefits going forward. The three-year report will provide a more robust assessment, analysing three-years of data and supported by established data linkages.

Key strategic drivers for the expansion of the EMRTS are described along with details of how the project both aligns with and enables them. Key drivers are to address:

- Unmet critical care need in the target population in uncovered and existing operating hours.
- The critical care and time critical transfer needs created by key service changes such as the development and requirements of the major trauma network and other national and regional planning initiatives.

The unmet need data provided indicated that, with the current 12-hour service model, EMRTS is reaching 70% of the predicted demand for pre-hospital critical care, and 63% of demand for time-critical transfers for the whole 24-hour period. This is not just exclusive of major trauma, but also includes medical emergencies.

The analysis utilised data from multiple sources and suggests unmet need of 1,796 cases (meeting EMRTS service specification and appropriate for EMRTS intervention per annum across 24 hours. 991 cases were during the 2000hrs - 0800hrs period (when EMRTS is not currently operational) and 805 cases relate to current EMRTS operating hours of 0800hrs – 2000hrs. These latter cases related to the main peak of demand from early afternoon when there are insufficient EMRTS assets to cover demand. The overall level of unmet need was greater than anticipated. The graphic below shows the total demand compared to EMRTS activity over a 24-hour period (April 2017 – March 2018):



TYPE	0800-2000hrs	2000-0800hrs	Total
Time Critical Transfers	n/a	82	82
Trauma	668	497	1,165
Medical	137	412	549
Total	**805**	**991**	**1,796**

Further analysis was carried out, broken down by health board.

In addition, key principles and implications of air and road response for night operations were developed. It was clear that, due to the additional risks and restrictions, air response would be utilised less at night and the reliance on road response would be even greater. For this reason, it was confirmed that, whilst details relating to both air and road responses and the respective population coverages were provided, the options appraisal process utilised road response figures due to this increased role at night.

From the analysis the following conclusions were reached:

- The main peak of unmet demand was between 1500hrs and 0000hrs, and was most significant in the South East Wales area. A twilight rapid response vehicle shift was therefore explored as a key part of the option appraisal.
- The bases at Caernarfon and Welshpool airports have relatively poor population coverage and that any option that only included a base at Welshpool airport or Caernarfon airport or an option that only provided a combination of them would not provide equity in terms of effective population or geographical coverage.
- No single base could provide the required national population coverage and that at least two bases would be required overnight to provide the required population and geographical coverage within agreed response times thereby ensuring equity.
- The preferred option would include a base in North Wales and a base in South Wales. This would ensure an equitable and effective air and road responses and maximise health gain.
- Road responses wold continue to forward-locate to central locations close to key road links in order to maximise population coverage and peaks in activity in order to ensure greater equity and health gain.

It should also be noted that the ASD would need to be extended to provide this important support and coordination function across all operational hours.

An options appraisal defined the scope of the project, main benefits, risks, constraints, dependencies and assumptions, and was agreed with stakeholders. Members of the trauma network board gave input to this process. A long list of options was reduced to a short list of options using key indicators. A shortlist of five options was carried forward to the economic appraisal to evaluate in further detail. The 'Do Minimum' and 'Do Maximum' options were also included for reference.

A number of factors relating to the agreed investment objectives were used to determine the preferred option including capital, revenue and transitional costs, cost per case, unmet demand and population coverages for each option.

The preferred option was then presented as follows:

- 2000hrs – 0800hrs: Consultant and CCP at a South Wales base with a rapid response vehicle (RRV).
- Double pilot crew and aircraft available at the South Wales base to support either.
- 2000hrs – 0800hrs: Consultant and CCP at Caernarfon airport with a RRV.
- RRV including a Consultant and CCP operating 1400hrs - 0200hrs along the M4 corridor to meet the main peak of unmet demand.

The preferred option includes three operational rotas and indicative implementation timelines were developed as set out below:

Project Phase	Year 1	Year 2	Year 3
Introduction of first 24/7 base in South Wales and 24/7 ASD coverage	Phase 1		
Introduction of second operational rota		Phase 2	
Introduction of third operational rota			Phase 3

The year 1 implementation has commenced and has an indicative timeline of April 2020 to be operational.

7 Major Trauma Centre

This chapter provides an overview of the extensive work undertaken by Cardiff and Vale University Health Board (C&VUHB) and the network board in developing a comprehensive and robust business case for the adult and paediatric Major Trauma Centre (MTC) at University Hospital of Wales, Cardiff (UHW). The position described here follows a number of internal and external reviews, including feedback received from a recent professional peer review. The principles are supported by commissioners. The approach to the reviews is described in Chapter 4.

The complete MTC business case is presented in Appendix 16. Where references are made to sections in the MTC business case, these are stated below.

7.1 Overview

The MTC business case seeks to demonstrate the need for investment in services for seriously injured adults and children for the population of South Wales, West Wales and South Powys. Investment will be crucial across full pathways of care for those patients treated at C&VUHB in order to establish an MTC for the South Wales Trauma Network and realise the improvements in outcomes and quality of care for this diverse and complex group of patients. The establishment of the MTC is pivotal to the development of the trauma network.

The MTC business case sets out a compelling case for change and identifies areas where investment will be required in order to deliver timely and improved quality of care. The investment required aligns to meeting national adult and children's MTC quality indicators/service specification and/or a predicted activity uplift.

The case has been separated between adult and paediatric MTCs to highlight the requirements for both. Where possible, proposed models combine investment across both adult and paediatric patients in order to minimise the cost impact.

The MTC business case provides an overview of each core specialty in the patient pathway identifying current models of care and a proposed model based on meeting the relevant MTC quality indicators over years one and two, as well as meeting the predicted activity uplift. This is in keeping with a phased approach to the establishment of the network, but, in line with MTCs in NHS England, requires some considerable frontloading, in order to demonstrate maximal benefit.

The case for increased provision should be considered in relation to delivery of the MTC quality indicators/service specification and the totality of major trauma activity. Where there are requirements to increase service provision relating to activity only, this has been clearly identified in the specific sections of the MTC business case. Furthermore, both capital and revenue costs are outlined in each section of the MTC business case and a schedule detailing workforce and associated costs provided as an Appendix to the business case submission (see Appendix 16).

Finally, C&VUHB demonstrate a positive approach and contribution to collaborating with the wider network across the patient pathway as evidenced below.

7.2 National Major Trauma Quality Indicators

The development of the trauma network aligns itself with a number of national drivers as summarised in Chapter 2.

More specifically, there are clear links between the establishment of an MTC and C&VUHB Strategic Goals in its 'Shaping our Future Wellbeing Strategy 2015-2025.' The Strategy sets out objectives that link directly with the delivery of an MTC:

- Reduce Health inequalities.
- Have an emergency care system that provides the right care, in the right place, first time .
- Be a great place to work and learn.
- Work better together with partners to deliver care and support across care sectors, making best use of our people and technology.
- Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives.

7.3 Case for Change

The overarching investment objective of a trauma network can be summarised by the network's mission statement **'Saving Lives, Improving Outcomes, Making a Difference'.**

Furthermore, key investment objectives defined by Welsh Government are referenced throughout this business case with added value that could be delivered. These include:

- **Health gain**: improving patient experience and outcomes.
- **Equity**: where people of highest health needs are targeted first.
- **Clinical and skills sustainability**: reducing service and workforce vulnerabilities and demonstrating solutions that are flexible and robust to a range of future scenarios.
- **Value for money**: demonstrating the least costly way of generating the anticipated benefits.

These investment objectives align with C&V UHB strategic vision to deliver the MTC for the South Wales Trauma Network.

7.3.1 Investment in MTC Services in Wales

The investment in services proposed in the MTC business case for patients from across the Network from day 1 would deliver:

- A designated adult and paediatric MTC to serve the region of South Wales, West Wales and South Powys, providing patients with direct access to specialist teams and state-of-the-art equipment to ensure that they receive immediate treatment, 24 hours a day, seven days a week.
- A single point of access into UHW as a specialist centre for major trauma cases.
- A Consultant led service for the reception and resuscitation of patients 24/7 allowing for immediate senior decision making and consultant led care from the outset.
- Multispecialty trauma teams including dedicated paediatric trauma teams and mobilisation of supporting departments and services such as transfusion, radiology and surgery.
- Enhanced capacity in the emergency unit to allow for access to effective and timely lifesaving interventions.
- Enhanced capacity in theatres to ensure timely access for a variety of complex injuries.

- Improved capacity in the critical care unit at UHW.
- A dedicated ward where multiply injured patients are managed and cared for as a cohort.
- A designated consultant available to contact seven days a week who has responsibility and authority for the hospital trauma service and leads the multidisciplinary team care.
- Availability of hyper-acute rehabilitation for seriously injured patients.
- Provision of a rehabilitation plan/prescription for all seriously injured patients.
- Consistent and coordinated care with a named member of staff and clear communication with seriously injured patients and their families/carers and ongoing care provider.
- Improved information and communication of discharge and enhanced repatriation and transfer of patients to their local hospital following specialist treatment to avoid unnecessary delays for patients awaiting care with treatment closer to home.
- An MTC Directorate to oversee and drive the governance agenda.
- Enhanced audit data submission into the national audit (TARN) to be met within 25 days from discharge.
- A multidisciplinary approach to governance, quality improvement, research and audit.
- A Network wide approach to training and education including rotational posts for the network through the MTC.

In addition to those benefits detailed in the case for change section of the network programme business case, the expected quality benefits extended to those attending the MTC are as set out below:

- Patients will receive a service that delivers the highest possible quality of care for patients 24 hours a day, seven days a week
- Reduction of 20% in preventable deaths as measured by the National Trauma Audit Research Network (TARN).
- Improved functional outcomes
- Improved patient and carer experience through increased coordination of care and communication around expected pathway and ongoing care plan.

7.4 Workforce Summary

The full national major trauma quality indicators are provided in Appendix 3.

7.4.1 MTC Indicators

An analysis has been undertaken reviewing current C&VUHB services against the agreed national quality indicators for MTCs. There are 52 adult indicators and 46 Children's indicators in total. The analysis has shown that a number of indicators are currently achieved by C&VUHB as a regional specialist centre. Those not met are listed below and form the basis of the required investment.

There are 20 key indicators that are not currently met:

1. T16-2B-101/201 – 24/7 Consultant Trauma Team Leader
2. T16-2B -103/203 - Emergency Trauma Nurse

3. T16-2B-107 – CT reporting
4. T16-2B -113 - 24/7 Access to Consultant Specialists
5. T16-2B-115/213 Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries
6. T16-2B-118/216 - 24/7 Specialist Acute Pain Service
7. T16-2C-102 Major Trauma Service (Consultant)
8. T16-2C-103 /202 Major Trauma Coordinator Service
9. T16-2C-104/203 Major Trauma MDT Meeting
10. T16-2C-105 Dedicated Major Trauma Ward or Clinical Area
11. T16-2C-110 /209 Management of Musculoskeletal Trauma
12. T16-2C-113 /212 Management of Maxillofacial Trauma
13. T16-2C -118/215 Specialist Dietetic Support
14. T16-2C-121/218 - Patient Experience – Trauma Audit Research Network (TARN) PROMS and PREMS
15. T16-2D-101/201 Clinical Lead for Acute Trauma Rehabilitation
16. T16-2D-103 /203 Rehabilitation Coordinator
17. T16-2D-105/205 Keyworker
18. T16-2D-106 /206 Rehabilitation Assessment and Prescriptions
19. T16-2D-102/202 Specialist Rehabilitation Team
20. T16-2D-109 Clinical Psychologist for Trauma Rehabilitation

The ability to meet the above will place CAV UHB in a strong position to deliver the benefits as outlined in chapter 4 of this programme business case.

Similar to MTCs in England, there are a number of indicators of the 20 above that will not be met on day 1. They are as follows:

1. T16-2B-201 – Paediatric 24/7 Consultant Trauma Team Leader
2. T16-2B -203 – Paediatric Emergency Trauma Nurse
3. T16-2B-107 – CT reporting, this will be monitored during year 1
4. T16-2B-118/216 - 24/7 Specialist Acute Pain Service

This case clearly indicates relevant MTC quality indicators throughout the pathway service specification and how plans will ensure these are met over the first 2/3 years of MTC launch.

7.4.2 Trauma Unit indicators

A review of TU standards demonstrates that C&V UHB already meets 86% of the national TU standards. Those that are not met are as follows:

1. T16-2C-301 Major Trauma Lead Clinician
2. T16-2C-303 Major Trauma Coordinator Service

3. T16-2D-301 Rehabilitation Coordinator
4. T16-2D-303 Rehabilitation Prescriptions

A plan has been developed to meet the above indicators as a part of the local UHB IMTP process for 2019. The additional resource requirements for this are outlined in Chapter 8.

Note: Resources for plastic surgery are not included in the MTC business case.

7.5 Predicted Activity Uplift

Appendix 1 details the current and expected trauma activity that has been used as a basis for service planning. This was taken from an agreed set of data assumptions commissioned by the trauma network and signed off at the network board in February 2019. This modelling utilised NWIS and TARN data as well as observed changes in English network flows to provide a predicted model for use in planning.

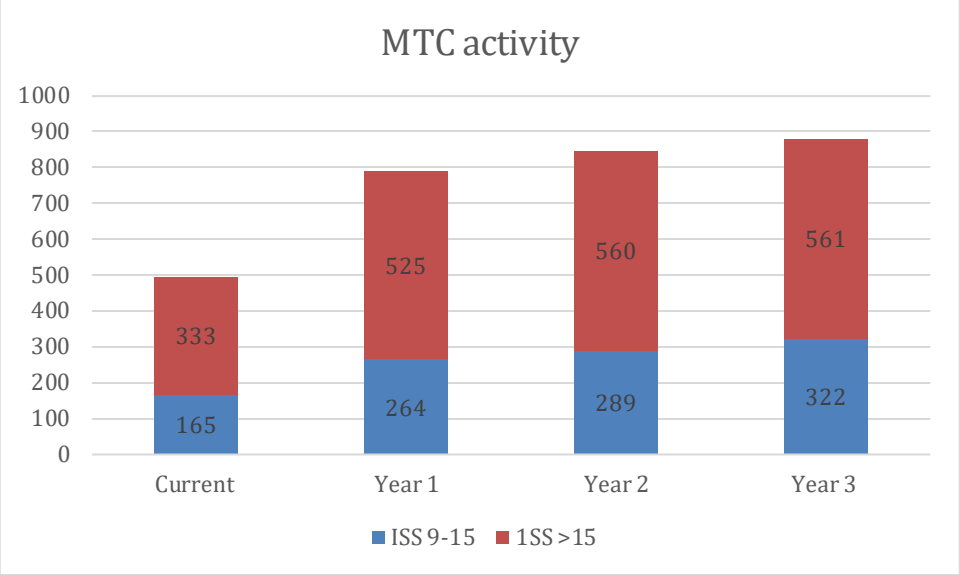
In relation to CAV UHB, current activity is modelled at 385 Major Trauma patients and 164 moderate trauma. The first year predicts an overall uplift of 294 candidate major trauma patients. This can be broken down into 193 Major Trauma patients with an additional 101 patients classified as 'overtriage' in the first year after go live. Overall, this equates to a 50% uplift in Major Trauma patients with a 35% 'overtriage' rate.

'Overtriage' is a term used to describe patients who arrive directly at the MTC from scene, who otherwise could have been treated locally. It is recognised that an element of 'overtriage' is acceptable to avoid missing major trauma cases that could benefit from the MTC; however, the exact rate for the network cannot be predicted at this stage. The effectiveness of the trauma desk should enhance triage decisions and will be evaluated in year one.

Further specialty level activity modelling has been challenging to obtain due to the complex nature of the clinical injuries and pathways for this patient group and lack of TARN data submitted across all of the Health Boards.

7.5.1 Activity Assumptions and Profile

CAV UHB currently receives and treats around 40% of all major trauma (Injury Severity Score (ISS) >15) patients within the network region. This equates to approximately 300 cases, with a further 200 cases treated who are moderately injured (ISS 9-15). Network modelling suggests that in its first year as an MTC, C&VUHB will treat 54% more patients, an additional 294 candidate trauma patients. These candidate major trauma patients can be broken down into two categories, Major Trauma (ISS>15) and moderate trauma (ISS 9-15) which is often described as 'false positive' or 'overtriage'. Year 2 and 3 data modelling suggests a smaller incremental increase in activity:



Predicted activity increase to the MTC Years 1 – 3

Network data analysis shows changes in network flow in the first three years, with the number of patients bypassing directly to the MTC rather than transferring increasing as the network develops:

ISS 9-15 – moderate	Assumed current position	Year 1	Year 2	Year 3
Direct to MTC	154	206	231	256
Transfer TU to MTC	11	58	58	86
% TU only	660	561	536	503
Total	825	825	825	825
ISS >15 – major	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	284	306	341	368
Transfer TU to MTC	49	219	219	193
% TU only	542	350	315	314
Total	875	875	875	875
ISS >9 – candidate	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	438	512	572	624
Transfer TU to MTC	60	277	277	259
% TU only	1202	911	851	817
Total	1,700	1,700	1,700	1,700
Combined Direct to MTC & Transfer TU to MTC	498	789	849	883

Predicted change in activity flows for network, predicted data activity for the trauma network

Due to the complex nature of the clinical pathways and the lack of TARN data submitted across all of the health boards it is difficult to predict the predominant specialty of patients with multiple trauma, including impact on specialties in terms of workload in theatres. Discussions (supported by Professor Moran) with other MTCs in England and benchmarking against Nottingham and Bristol MTCs show that this increase is variable but that a large percentage of the increased workload impacts on Trauma and Orthopaedics. This is reflected in the case and will be reflected in the theatres utilisation plan.

Paediatric MTC Activity

The predicted uplift in paediatric Major Trauma cases is shown a as 'sub set' of the above data and is shown below:

	Assumed current position	Year 1	Year 2	Year 3
ISS 9-15	22	27	30	33
ISS >15	53	55	56	60

Predicted data activity for the Wales Trauma Network 2019

There are significant problems with the paediatric data captured in TARN in relation to:

- Capturing all paediatric trauma cases.
- The injury severity score (ISS) is an adult tool that fails to accurately reflect the pattern of paediatric injuries.

We can therefore assume that activity may be more than predicted, as reflected by experiences within the Bristol Royal Hospital for Children, and shared at the professional peer review panel. During the first year, an analysis of TARN data will be undertaken by both the network and MTC to assess both under and overtriage of patients for transfer to the MTC. This will provide an indication of whether activity modelling in the planning phase was accurate, and allow further planning for year two.

Additional Factors Impacting on MTC Activity

It is important to highlight that there has been an increase in major trauma activity in UHW since the establishment of the EMRTS. The one-year evaluation demonstrates that this has helped improve equity and timeliness of access to definitive specialist trauma care for patients brought to UHW. During this time, 58% of patients were transferred directly to specialist care. Nonetheless, this change in flow has impacted on C&VUHB services.

An estimated additional 64 patients with major and moderate trauma were predicted to flow to UHW per annum. Since the launch of this new service there has been no investment in critical services such as Emergency Unit, Theatres and ward capacity in relation to the care of seriously injured patients, this is expected to increase by a further 100 patients upon the extension of the service next financial year.

7.5.2 Capacity Requirement Assumptions – ward beds, theatre sessions and critical care beds

Following the overarching network data modelling, further local data analysis was undertaken to identify capacity requirements for year one. This was based both on total numbers but used a number of local data sources including Ward Watcher, TheatreMan and a number of specialty specific clinical databases (e.g. Neurosurgery, Maxillofacial Surgery) plus some specific clinical reviews of health board TARN data.

Due to the variable nature of unscheduled care activity, modelling has necessarily taken account of not only average attendances but peaks in flow (particularly for the emergency unit and theatres) and also current delays for major trauma patients accessing theatres.

Ward Beds

The table below shows the modelled current and predicted bed occupancy relating to major trauma patients. The number of beds by percentile, shows the number of beds needed for major trauma patients for that percentage of days of the year. For example, it is modelled that, for current activity levels, 30 dedicated beds would be enough for major trauma patients 50% of the time and that 38 beds would be enough 95% of the time.

Modelled current and predicted bed occupancy (LOS ≥3days)

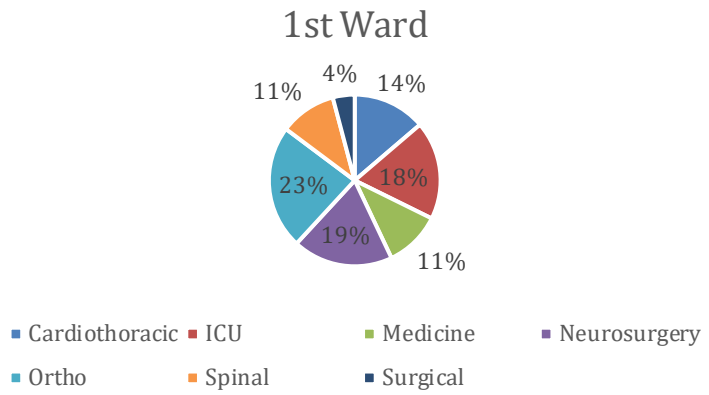
	Beds Occupied - Current			Year 1			Year 2			Year 3		
	5%ile	50%ile	95%ile*	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile
University Hospital Of Wales	23	30	38	42	47	53	45	50	56	46	52	58

Predicted data activity for the Wales Trauma Network 2019 – excludes critical care beds.

Comparing the beds required for Year 1 suggests an increase of between 15 (5th centile) and 19 beds (95th centile) in Year 1 with a further 3 beds in Year 2. Note that this has been based upon current LOS for all ISS >9 patients at UHW. Published evidence shows that a reduction in length of stay (LOS) was not seen in the English MTCs post MTC launch and introduction of an automatic acceptance and repatriation system. Overall median length of stay in acute care was unchanged from initially 10 (IQR 5–21) to finally 9 (5 to 19) days (Moran *et al*, 2018). Therefore, a reduction has not been factored into bed calculations at UHW based on MTC status.

One should not consider length of stay in isolation, the impact of repatriation within and outside the network will play an important role in determining the efficacy of the polytrauma unit. There is an All Wales Repatriation Policy currently in place and the issues around operationalising the policy are well recognised. Whilst it is recognised that work is ongoing at network level to improve repatriations, this falls outside of the sole remit of C&VUHB and cannot be relied upon to have any definite impact upon length of stay until it is realised and understood. It is important to note, therefore, that the 14 beds modelled on an 18 day length of stay are the minimum requirement to admit seriously injured patients to an appropriate location in a safe and timely manner.

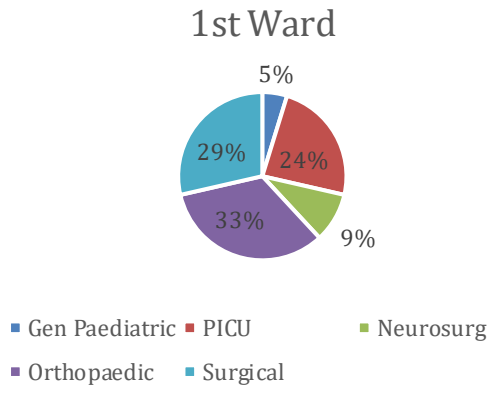
The largest uplift in patients is expected to occur in the first year particularly as EMRTS has been approved to extend to 24/7 cover in line with the MTN go live. It is anticipated that the uplift in beds and critical care capacity will be needed for day one. An analysis of the 2018 UHW dataset from TARN provided a baseline for where seriously injured patients are currently being treated in UHW:



2018 adult UHW TARN data, first ward

Around 20% of the current major trauma patients treated at UHW have significant multiple injuries and require polytrauma unit care, this equals six beds. As highlighted, it is a challenge to accurately predict activity by specialty. It would not be sensible to apply the percentage uplift to all specialties, for example, as UHW currently receives the large majority of major trauma patients requiring neurosurgical intervention. After discussion with MTCs in England, it is assumed that UHW will predominantly see an increase in patients with multisystem injuries requiring multispecialty input as well as an increase in those patients with severe isolated orthopaedic injuries. Therefore, from a total expected uplift (based on 50th percentile) of 17 beds a pragmatic approach has been taken for year 1 to start with 14 beds and that these be placed together to collocate care on the adult polytrauma unit.

Paediatric TARN data shows a large proportion of orthopaedic and surgical patients with a much smaller percentage of patients care for under neurosurgical wards. Due to the smaller number of patients predicted in year 1, it is not expected this percentage split will change dramatically, but this will be audited:



2018 Paediatric UHW TARN data, first ward

Theatre Sessions and Critical Care Beds

It was recognised within the network data paper that further analysis would be required in relation to impact on critical care and theatres. This was undertaken following a health board review of Ward Watcher.

The table below shows the modelled requirements for current major trauma activity at UHW and compares it to the modelled requirements in year one and year two.

		Current	Year 1	Increase	Year 2	Increase
		Predicted Median	Predicted Median	Increase on 2017-18 (Median)	Predicted Median	Increase on 2017-18 (Median)
Theatre time (weekly)	Cases (patients)	7.8	12.6	4.4	13.0	5.2
	Hours operating	26.7	43.7	14.4	43.8	17.2
CriticalCare	Total Beds	3.0	5.8	2.8	6	3

Local UHB data review April 2019

The modelling suggests that on average an additional 14.4 hours of theatre sessions (median) will be required based on average operating for theatre cases. A review of the range between 5th percentile and maximum from current shows a range of between 6.39 and 9.24 sessions. A total of 9 sessions has been planned to account for increased activity and to protect existing theatres during peak times of activity.

There will be further work required to review where the sessions will be timetabled and against which specialty.

Critical care modelling has estimated an uplift by 3 beds. The sections on theatres and critical care, which follow, explain what has been planned for in these areas.

7.6 Workforce Summary

Based on both meeting the quality indicators/service specification and the uplift in predicted activity, an additional 191 staff will be required to establish CAV UHB as an MTC in April 2020, with the largest groups being Nursing, Healthcare Support Workers and Medical Staff. This has reduced substantially from the first submission of the MTC business case, following internal and external reviews. Whilst MTC status should attract and help to retain staff, it is recognised that this is a significant challenge to the delivery of the MTC by April 2020. There is a recruitment strategy being developed led by the head of workforce and detailed planning work underway at a specialty level. A full time recruitment support post has been recruited to, supported by the head of workforce and OD to drive the recruitment strategy and ensure Clinical Boards are supported fully throughout the recruitment process.

An overview of this is presented in the MTC case in Appendix 16.

Staff Group	WTE
Medical Staff	29.5
HCSW	37.65
Registered Nurses	85
AHPs, Scientists & Techs etc.	27.5
Admin and Clerical	11
Total	**191**

In addition, CAV UHB recognises the potential impact upon recruitment and retention of staff in other health boards and thus is committed to collaboration as part of a network to ensure that skills and development of staff can be maximised within the network. There is a network workforce group

supporting development of recruitment principles/plans and this will include a number of cross health board joint appointments and rotational posts to ensure that skills and training can be maximised across the network (see Chapter 13).

7.7 Benefits and Risks

The networks benefits realisation plan provides a robust foundation to evaluate the effectiveness of the MTC and will be considered in the context of data collection and analysis in year one.

There are a number of risks in relation to both the delivery of the network and MTC. These include significant risks related to workforce and capacity detailed in the MTC business case (Appendix 16) and in the network risk register.

In considering this case, the risks to go live should be carefully considered against the benefits that have been highlighted.

7.8 Planning and Assurance Process

Planning Process for Specialties

This case has been developed with strong involvement from all core specialities. Service planning templates have been completed by each of the specialties at C&V UHB along with face to face meetings with the MTC project team. This has supported the Directorates to review their current service and supported planning against:

- The expected increase in activity following Network 'go live.'
- The relevant national MTC quality indicators/service specification.

The planning templates completed covered both adult and paediatric indicators. However, a separate template was completed by the paediatric team and signed off by Women and Children's Clinical Board for indicators specific to paediatric major trauma.

Internal Assurance and Approval

In order to provide assurance to the Network Board, WHSSC and Welsh Government that the MTC components of this programme business case have been internally scrutinised, the following were agreed and have taken place:

- Clinical Board sign off

  Completed templates have been signed off by the relevant Clinical Board. By signing, the Board provided assurance that due diligence has been undertaken in completion of the template, and that the revenue implications of the pathways are understood and relate solely to the national MTC quality indicators for the totality of major trauma patients and/or uplift in major trauma activity.

- C&V UHB Executive Assurance panel

  A panel was convened to ensure overarching assurance of Clinical Board elements of the business case before the full case is submitted to an internal major trauma business case approval group.

- MTC Business Case Approval

  Final internal sign off of the business case at combined Major Trauma Project Board/ Business Case Approval Group meeting.

- Further Business case revisions based on external feedback

  A number of external reviews of the case have now taken place and all feedback has been considered by Clinical Boards and submitted for discussion at an Executive UHB panel. The changes following feedback are highlighted in green in the financial tables of the case.

- Executive Scrutiny Panels

  There have now been three panels convened who have reviewed each round of revisions to the case and provide any further challenge and scrutiny as well as discussions around assurance and risks to revisions and reductions to areas of the MTC case.

7.9 Financial Summary

Revenue Costs

A detailed financial schedule is provided in the MTC business case, with a summary provided in financial case (Chapter nine).

The health board believes that the costs identified represent the minimum current investment that is required to allow the health board to deliver the additional modelled volumes and standards expected of an MTC.

It is expected that the costs within the case will present a loss when reviewed against income comparisons from NHS England. This is comparable to other MTC designations. Two similar combined adult and paediatric MTCs in Oxford and Southampton both confirmed they launched with a gap between costs required to go live as an MTC and the expected income through activity and Best Practice Tariff.

This is also evidenced in standalone paediatric MTCs where incidence of major trauma are small and therefore income related to this, not sufficient to support the delivery of MTC standards.

Efficiencies

The modelling within this document is based on current efficiencies and working practices. Further opportunities to deliver improvements in productivity and efficiency within the major trauma patient pathway through new ways of working and streamlined patient pathways have been reviewed and it is agreed that there has been significant work undertaken by the health board to date and any further efficiencies may not be realised immediately.

Anecdotally, there is recognition that other MTCs in England have delivered improvements in efficiency, such as theatre times and, in some specific patient groups, length of stay. It should be noted that these improvements have been realised five years post implementation of networks and as systems develop and improve.

A review of length of stay efficiencies was undertaken as part of a review of the proposed Polytrauma Unit. Published evidence shows that a reduction in LOS was not seen in the English MTCs post MTC launch and introduction of an automatic acceptance and repatriation system (C Moran, 2018). Therefore, starting with a bed base that is lower than the modelled 50th percentile is a risk for MTC capacity upon go live and agreements for increase in bed capacity in year will be required.

The design and delivery of service improvements will form a fundamental part of the on-going clinical governance of the MTC. Service improvements will be informed by and defined at a network level. Post implementation service efficiency and productivity will also be reviewed via benchmarking with other Centres.

Capital Costs

In line with a phased implementation approach there are developments within the current timelines that are an absolute requirement for operational readiness and those that can be safely enabled once the MTC is operational; the former are listed below:

- Sufficient adult resuscitation capacity
- Additional theatre capacity
- Poly Trauma Ward capacity
- Uplift in Critical Care capacity

Accepting that not all the capital and estates timelines are aligned to an April 2020 'go live', an assessment of alternative solutions to each of the absolute requirements for operational readiness has been discussed at the MTC Project Board, UHB Management Executive and Network Board.

It has been agreed that the solutions proposed for all workstreams are acceptable in principle, as an interim solution for year one starting April 2020. With this in mind there will be a requirement for a release of funds 'in year' in order to begin the capital works. Along with these, equipment costs have been identified, and together these are detailed in the finance case and in the Appendix 16.

Year 2

In order to ensure sufficient operating capacity, a capital business case is being developed, alongside a programme of work for vascular services, to deliver a new theatre from April 2021. This will deliver a dedicated operating space to ensure that Major Trauma cases can be treated safely in a timely manner as the activity increases, and to meet all national guidelines and standards. The timescales for the case is as follows:

- February 2020 – OBC
- September 2020 – FBC
- Construction completion – June 2021

There will be further requirement to expand the polytrauma ward to meet standards including IP&C. A separate business case will be submitted to Welsh Government in year 1.

The estimated future capital requirement for the MTC theatres at the time of publication is in the region of £20-25m. Note that this is an integrated capital scheme which includes the vascular hybrid theatres.

7.10 The Major Trauma Centre Role within the wider Network and Opportunities for Collaboration

As a part of its role within the network, it is crucial that the MTC effectively collaborates with all other organisations within the trauma network system in order to ensure benefits for patient's right across the pathway.

Experience in England has demonstrated that Trauma Units (TUs) have, over time, become deskilled in major trauma. This is a situation that the South Wales Trauma Network is keen to avoid and the role of the MTC will important in supporting and developing the network as it matures. The MTC's key role and responsibilities are set out in the 2013 Major Trauma Service Specification (D15/S/a) and in relation to support and collaboration within the wider network include:

Clinical Advice & Leadership Roles

The MTC will provide clinical advice to other providers within the network. This will include; in pre-hospital stage and whilst patients are awaiting transfer to the MTC for definitive treatment or following acute care when the patient is discharged to on-going specialised or local rehabilitation services.

There are a number of roles within this business case that will be key enablers to ensure that effective advice and support is available 7 days a week. These include, Trauma Team Leaders, Advanced Nurse Practitioners and Rehabilitation Consultant, Consultant AHP and Coordinators. The MTC recognises the value of sharing experience across the Network and is committed to the provision of posts which allow for rotation through both TUs and the MTC. There are clear opportunities within the Rehabilitation posts for providing outreach and support to TUs.

Training, Audit & Quality Improvement

The MTC will commit to being actively engaged and contributing to the Trauma Network, particularly in operational requirements, training, governance and audit. The MTC has a role to ensure that all organisations within the network are actively engaged and supported as a part of and effective trauma Quality Improvement programme.

There are a number of opportunities for the MTC to act as a hub for training provision within the network, working with the Network lead for training. This will be vital to minimise impact of deskilling in local Trauma Units over time.

This includes the development of leadership and faculty for key 'in house' training programmes including Trauma Team Leader and Trauma Team member, nursing and scribe training as well as ward skills and rehabilitation. There is also an opportunity to develop outreach programmes to deliver training locally and host annual events similar to those delivered by other MTCs within England and Scotland.

Trauma Team Leaders working as a part of a network model, will also be key to the continued development of trauma team skills within trauma units. These shifts within the MTC will provide clinicians working in TUs with regular exposure to trauma cases (see below).

Rotational Posts & Joint Appointments

Joint appointments in key areas will be considered in order to ensure the development of the MTC does not destabilise other Health Boards services and this is aligned with the principles of workforce recruitment into to the MTC. This will bring benefits to the wider network, which C&VUHB is committed to as part of its critical role in the network.

There is also an opportunity for rotational posts within the Polytrauma Unit. This would include staff employed both within C&V UHB and within Trauma Units to ensure expertise can be spread to the network. The Polytrauma Unit will be key in providing delivery of training and up skilling staff in the definitive care of seriously injured patients.

The ability for Major Trauma Practitioners and Rehabilitation coordinators from around the region to spend time in the MTC will ensure that good links can be made between teams that will support the effective flow of patients within the Network

Audit and Quality Improvement
The additional TARN coordinator roles within the business case will support the timely and quality entry of a large percentage of network data into the National Audit. In turn, this will be key for developing an audit programme for the centre, which develops in collaboration with the network and organisations within it. There is also a role for TARN coordinators at the MTC to support colleagues within the network in relation to training and development.

Rehabilitation
The MTC will provide early/hyper acute rehabilitation as well as a managed transition to rehabilitation and the community. Key roles within this case such as the rehabilitation consultant, Consultant AHP, lead therapist and nurse for Major Trauma as well as psychologists will integrate into the network to support wider programmes of quality improvement, training and education.

Collaboration with other Specialist Services
There are a number of interdependent services and specialties required to work in partnership to deliver seamless and high quality care. In particular, the services delivered for Major Trauma patients with orthoplastic requirements will need close joint working between C&VUHB and SBUHB to ensure the care delivered is to an excellent standard regardless of where the patient is treated. It is proposed that one of the Major Trauma Practitioners will be recruited with an interest in Orthoplastics to ensure a strong link with the Regional Centre for Burns and Plastics in Morriston and enabling collaborative rotational working, training and education between the two centres.

Patient Flow and Access to Services
The MTC is committed to ensuring that patient flow is maximised to ensure that the quality benefits set out in section 6 of the case can be realised. This includes commitment to an automatic acceptance policy ensuring 24/7 access to specialist services. It is essential this is aligned with an automatic repatriation/transfer of care policy.

The MTC also supports a network approach and its role in the delivery of care closer to home following completion of the MTC phase of treatment. This includes clear and timely information to both health boards, patients and their families as well as a clear point of communication including escalation so that patient flow can be maintained, pull back to the originating HB is promoted and patient experience is maintained.

The MTC will take part and lead in governance around this which includes collecting accurate and timely data so that this can be utilised to inform governance and recognises the importance of the ODN having operational authority in the escalation processes and that commissioning will support this in a timely way.

8 Local Health Board Configuration

8.1 Introduction

In 2018, health boards undertook a process of confirming Trauma Units (TUs) and Local Emergency Hospitals (LEHs) as part of defining the network structure.

The following hospitals were approved as adult and paediatric TUs, following a recommendation by WHSSC Joint Committee and approval by health boards:

- Cardiff and Vale University Health Board: University Hospital Wales (UHW), Cardiff – TU for its own population.
- Swansea Bay University Health Board: Morriston Hospital, Swansea – TU with specialist services
- Aneurin Bevan University Health Board: Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the health board)
- Cwm Taf Morgannwg University Health Board: Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend.
- Hywel Dda University Health Board: Glangwili General Hospital, Carmarthen (subsequently confirmed following a period of public engagement)

In relation to LEHs, the following hospital will be a LEH within the network structure:

- Royal Glamorgan Hospital, Llantrisant.

As described below, within Hywel Dda University Health Board, Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest, will be rural trauma facilities for the purposes of major trauma.

This chapter sets out the requirements for health boards by providing an outline of baseline assessments against the agreed quality indicators and service specification, in order to illustrate those that are already being met, those that could be met through internal re-organisation and those that require additional resources. A description is also provided of the configuration of local and community based rehabilitation and requirements for the 'landing pad' for patients returning from the MTC for 'care with treatment closer to home.' This follows on from developing a more phased approach to implementation of quality indicators and service specification over five years following the recent Gateway review.

Furthermore, a summary is provided of each health board business case against this phased model, outlining additional resource requirements.

Although Powys Teaching Health Board does not have a TU itself, the health board's model and resource requirements are also described here.

Finally, an outline is given of the clinical and operational models for specialist services supporting the MTC (i.e. orthoplastic surgery, spinal trauma surgery, thoracic trauma surgery and pelvic trauma surgery).

8.2 Overview of the Model

The composition of health boards in the context of the trauma network will include TUs, LEHs, rural trauma facilities (in Hywel Dda University Health Board only) and community-based rehabilitation. The latter will require close working with social care.

All 'candidate TUs' are already managing moderate and major trauma patients. In the trauma network, TUs will continue to provide initial assessment, imaging and treatment of trauma patients. TUs will be optimised to provide definitive care and admit major trauma patients. However, they will also enhance existing systems to rapidly move the most severely injured to specialist centres that can manage injuries. In doing so, TUs will develop an effective quality improvement programme. By day one, all TUs will have undertaken the requisite level of medical and nursing training and education (supported by the network programme) and embedded network policies within their systems. Organisational governance structures will be established, consisting of an operational manager (from an existing directorate), clinical lead, major trauma practitioners, rehabilitation coordinators and TARN coordinators. There will be a named executive lead. The team will work closely with the equivalent team in the MTC and the trauma ODN management team. These roles are considered key enabling roles in-year.

Major trauma practitioners and rehabilitation coordinators will be new roles in the health boards and will be vital in ensuring seamless care of major trauma patients and key points of contact for patients returning from specialist care to the TU or community. In particular, rehabilitation coordinators will provide a link to community resources, allowing early notification of individuals who require support, facilitating discharge and managing patient and family expectations. They will be seen as the 'flight controllers' of the system. This will be augmented by the availability of a consultant in rehabilitation medicine operating in each health board on a weekly basis, playing key roles in coordinating the team, managing complex patients and facilitating discharge.

In years two and three, there will an enhancement of core therapy roles as well as some specialist roles (e.g. neuropsychology), providing both in-reach and outreach services within the health board. Opportunities will exist for these specialist therapy roles to work across neighbouring health boards.

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

This model will not just benefit major trauma patients returning to TUs and the community, but also those admitted locally and other patients groups with complex rehabilitation requirements. It will lead to the establishment of TUs as level two rehabilitation facilities and an enhancement of a level three community based rehabilitation response. By ensuring health boards are appropriately prepared and supported, they will be in a position to provide an optimised 'landing pad' for patients returning from specialist centres (e.g. the MTC). This timely repatriation of patients from specialist care has been termed 'care with treatment closer to home' or CWTCH by the network.

Within the network there will be one LEH as indicated above. This hospital will not routinely receive acute trauma patients; however, they will retain processes to ensure that, should this occur, there is appropriate initial management and transfer to the MTC or nearest TU. Given the proximity to the MTC and TU, this will be a rare occurrence. In Hywel Dda University Health Board, Bronglais General Hospital and Withybush General Hospital will be termed rural trauma facilities. Whilst, as for LEHs, there are no specific quality indicators for a rural trauma facility, the health board is committed to ensuring these hospitals maintain the ability to assess and treat major trauma patients, given their

relatively unique geographical location and distance from the MTC and nearest TU. Furthermore, the health board's organisational structure will need to ensure appropriate oversight of clinical and operational governance activities in these hospitals. The TU team described above, together with an enhancement in therapists and consultants in Rehabilitation Medicine will have a key role in supporting these rural trauma facilities.

Finally, a key risk of establishing the network, as evidenced in NHS England, is deskilling hospitals outside the MTC in acute and ongoing care of major trauma patients. The risk of this will be mitigated in several ways including a commitment of the network to deliver quality improvement equitably across the region and evidence of collaboration of the MTC with the wider network.

8.3 Quality Indicators

As part of the TU designation process, each health board undertook a baseline assessment against essential quality indicators. Quality indicators for TUs and a summary of the baseline assessments are presented in the table below. For each quality indicator, a code is assigned, in order to cross-reference to Appendix 3. The table also indicates where quality indicators could be met through internal re-organisation or network support (indicated in italics) and where additional resource requirements are needed. Furthermore, an indication of phasing of quality standards is provided (i.e. in place for Day 1, year 1 – 3) as agreed by the network board.

Essential Quality Indicator	Currently met/unmet/partially met
T16-2B-301 – Trauma team leader – in place for Day 1	
There should be a trauma team leader of ST3 or above or equivalent non-consultant career grade doctor (NCCG), with an agreed list of responsibilities available within 5mins, 24/7 – in TUs where this cannot not be entirely achieved through Emergency Medicine, a trauma team leader could be sought from Intensive Care or a surgical specialty.	**Partially met and could be fully met through internal re-organisation**
There should also be a consultant available in 30 minutes.	**Met**
The trauma team leader should have been trained in advanced trauma life support (ATLS) or equivalent – this could be achieved through existing in house training and network training and education programme.	**Partially met and could be fully met as described**
There should be a clinician trained in advanced paediatric life support (APLS) available for children's major trauma – this could be achieved by ensuring paediatric registrar or consultant on call on paediatric trauma team.	**Partially met and could be fully met through internal re-organisation**

Essential Quality Indicator	Currently met/unmet/partially met
T16-2B-302 – Emergency trauma nurse/allied healthcare professional (AHP) – variable timeline In place for Day 1 - All nursing/AHP staff caring for a trauma patients should have attained the competency and educational standard of level 1. In units that accept paediatric major trauma, this should include the paediatric trauma competencies (as described in the National Major Trauma Nursing Group guidance) – overlapping with Royal College of Nursing competencies and supported by network training and education programme. End of Year 1 plan and deliver Year 2 – 3 - There should be a nurse/AHP available for major trauma 24/7 who has successfully attained or is working towards the adult competency and educational standard of level 2 as described in the National Major Trauma Nursing Group guidance – phased approach and supported by network training and education programme. In units that accept children: there should be a paediatric registered nurse/AHP available for paediatric major trauma 24/7 who has successfully attained or is working towards the paediatric competency and educational standard of level 2 as described in the National Major Trauma Nursing Group guidance - phased approach and supported by network training and education programme. (It is acknowledged that recruitment of paediatric nursing staff can be difficult. If the emergency department does not have a paediatric nurse with Level 2 equivalent trauma training available 24 hours a day, then it is suggested that a senior paediatric ward nurse bleep holder could attend all paediatric trauma calls. Note that APLS has been recognised as Level 2 compliant, as well as the Advanced Trauma Nursing Course (ATNC), the Trauma Nursing Core Course (TNCC), the European Trauma Course (ETC).)	**Partially met and could be fully met as described** **Unmet and could be fully met as described** **Unmet and could be fully met as described**
T16-2B-303 – Trauma team activation protocol – in place for Day 1 There should be a trauma team activation protocol – all health boards agreed to follow network trauma team activation protocol aligned with major trauma and 'silver' trauma triage tools. The trauma team should include medical staff with recognised training in paediatrics and paediatric trained nurses with experience in trauma – this could be achieved by ensuring paediatric registrar or consultant on call on paediatric trauma team and by nursing competencies outlined above.	**Met but will be required to adopt network protocol** **Partially met and could be fully met through internal re-organisation**
T16-2B-304 - Network Transfer Protocol from TUs/LEHs to MTC – in place for Day 1 The TUs/LEHs should agree the network protocol for the transfer of patients from trauma unit to MTC – all health boards agreed to follow this protocol.	**Will be fully met with network protocol**

Essential Quality Indicator	Currently met/unmet/partially met
T16-2B-305 - 24/7 CT Scanner Facilities – in place for Day 1 There should be CT scanning available within 60 minutes of the trauma team activation. Whilst 24/7 access to MRI is not a pre-requisite for TUs, it will be desirable that all health boards move towards having this provision by year 2 to support the spinal clinical service model.	**Met** **Unmet**
T16-2B-306 – CT reporting – in place for Day 1 There should be a protocol for trauma CT reporting that specifies there should be a provisional report within 60 minutes.	**Met**
T16-2B-307 – Teleradiology facilities – in place for Day 1 The TU should have an image exchange portal that enables immediate image transfer to the MTC 24/7.	**Met**
T16-2B-308 – 24/7 access to surgical staff – in place for Day 1 The following staff should be available within 30 minutes 24/7: • A general surgeon ST3 or above, or equivalent NCCG. • A trauma and orthopaedic surgeon ST3 or above or equivalent NCCG. • An anaesthetist ST3 or above or equivalent NCCG.	**Met**
T16-2B-309 - Dedicated orthopaedic trauma operating theatre – in place for Day 1 There should be dedicated trauma operating theatre lists with appropriate staffing available 7 days a week. The lists must be separate from any other emergency operating. In TUs that run 5 days a week, a 7 days a week service could be achieved by prioritising trauma cases on the emergency theatre list as is practiced in some English TUs.	**Partially met and could be fully met through internal re-organisation**
T16-2B-310 - 24/7 access to emergency theatre and surgery – in place for Day 1 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.	**Met**
T16-2B-311 - Trauma management guidelines – in place for Day 1 The TU should agree the network clinical guidelines specified in T16-1C-107 The TU should include relevant local details. These are listed in Chapter 5 and health boards agreed to implement guidelines	**Unmet and will be fully met as described**

Essential Quality Indicator	Currently met/unmet/partially met
T16-2B-312 - Transfusion protocol – in place for Day 1 There should be a protocol for the management of massive transfusion in patients with significant haemorrhage.	**Met**
T16-2B-313 - Administration of tranexamic acid – in place for Day 1 Patients with significant haemorrhage should be administered tranexamic acid within 3 hours of injury and receive a second dose according to CRASH-2 protocol - network protocol to be followed. Evidence now points to administer within 1hr, thus, this has become a pre-hospital care standard. WAST carry tranexamic acid and have a protocol for administration.	**Met**
T16-2C-301 – Major trauma lead clinician – in place for Day 1 There should be a lead clinician for major trauma, who should be a consultant with managerial responsibility for the service and a minimum of 1-programmed activity specified in their job plan - network board provided sample job description and personal specification. Achieved across health boards through programme resource.	**Partially met and ongoing resource requirements from April 2020**
T16-2C-302 – Organisational governance structure – in place for Day 1 The TU should have a trauma group that meets at least quarterly - all health boards have established health board trauma project groups with a template terms of reference provided by the network board. This will form a TU committee once operational. The TU should have a lead executive and named operational manager (from a suitable directorate overseeing the service and TU team	**Met** **Could be met through nominations by each HB**
T16-2C-303 - Trauma coordinator service – in place for Day 1 There should be a trauma coordinator service available Monday to Friday for the co-ordination of patients; this will be provided by major trauma practitioners (suggested 1.5 whole time equivalent (whole time equivalent)/TU) The coordinator service should be provided by nurse or allied health professionals. Network board provided sample job description and personal specification. New key enabling roles in the health boards and will have the following responsibilities: • Developing a structure/strategy for identifying all patients treated within health boards (including those transferred to and from an MTC). • Coordinate care for this patient group, identify and highlight gaps in care. • Act as the key point of contact for patients and their families and be an advocate for patients (incl. issues such as safeguarding).	**Not met and requires additional resources**

• Deliver information for patients appropriately incl. ensuring that the patients are provided (if appropriate) with a rehabilitation prescription and that this is updated prior to discharge and on return from the MTC. • Work with major trauma practitioners in the MTC to support patients transferring back from the MTC to ensure timely, safe and smooth transfer of care. • Promote and highlight this patient group across the health board with relevant specialities and staff groups and alongside clinical and managerial leads act as a champion for this patient group developing improved pathways and care. • A core member of the TU committee. • Take an active role in governance for this patient group, highlighting possible cases for review and taking part in morbidity and mortality meetings. Support the TARN coordinator(s) with life case identification for TARN and TARN PROMS/PREMS. • Support relevant training and education (formal and informal) across staff groups linking with national and network initiatives.	
T16-2C-304 – Management of spinal injuries – in place for Day 1 The TU should agree the network protocol for protecting and assessing 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.	**Will be fully met with network protocol** **See section 8.12.2**
T16-2C-305 - Management of multiple rib fractures – in place for Day 1 There should be network agreed local management guidelines for the management of multiple rib fractures including: • Pain management including early access to epidural. • Access to surgical advice.	**Will be fully met with network protocol and thoracic trauma clinical service model**
T16-2C-306 – Management of musculoskeletal trauma – in place for Day 1 There should be guidelines for: • Isolated long bone fractures. • Early management of isolated pelvic acetabular fractures. • Peri-articular fractures. • Open fractures. • The guidelines should include: • Accessing specialist advice from the MTC. • Imaging and image transfer. • Indications for managing on site or transfer to the MTC.	**Will be fully met with network protocols and orthoplastic/pelvic trauma clinical service model**
T16-2C-307 - Designated specialist burns care – in place for Day 1 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. This is already in place in conjunction with the regional burns centre at Morriston Hospital	**Met**

Essential Quality Indicator	Currently met/unmet/partially met
T16-2C-308 - Trauma unit agreement to the network repatriation policy – in place for Day 1 The TU should agree the network repatriation policy There should be a protocol in place for identifying a specialty team to accept the patient. The protocol should include the escalation process in the event of there not being access to a specialty team.	**Will be fully met with network protocol**
T16-2C-311 - The trauma audit and research network (TARN) – variable timeline In place for Day 1- The TUs and LEHs should participate in the TARN audit, with at least 1 year of back-dated baseline data before network operational. Data should meet the following standards: Case ascertainment – patients submitted to TARN compared to expected based on Patient Episode Data for Wales (PEDW) dataset –target of 80% across the network by end of year 1. Case accreditation - this is the proportion of key fields used in this report that are filled in for each patient submitted to TARN –target of 95% across the network by end of year 1. The standards are to ensure subsequent TARN metrics can be meaningfully interpreted. TARN audit should be discussed at the network audit meeting at least annually and distributed to all constituent members of the network. A working plan has been produced to enhance TARN data collection including appointment of TARN coordinator(s) in health boards where gaps exist. In year 1 - Develop strategies for undertaking TARN PROMS and PREMS. New TARN coordinators required. Network board provided health boards a sample job description and personal specification. As a guide, 1 day per week of a TARN coordinators time is required per 100 expected cases per annum. Network board provided approximate whole time equivalents.	**Partially met and could be fully met with additional resources**
T16-2C-310 - Discharge summary – in place for Day 1 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. Electronic discharge record already in place, enhanced through clinical informatics development and patient held record.	**Partially met and could be fully met through clinical informatics development**

Essential Quality Indicator	Currently met/unmet/partially met
T16-2D-301 - Rehabilitation coordinator – in place for Day 1 There should be a rehabilitation coordinator who is responsible for coordination and communication regarding the patient's current and future rehabilitation including oversight of the rehabilitation prescription. Service provided Monday to Friday. This rehabilitation coordinator should be a nurse or allied health professional (suggested 1.5 whole time equivalent/TU), maybe split role between therapists, with some clinical commitment. Network board providing sample job description and personal specification. New key enabling roles in the health boards and will have the following responsibilities: • Responsibility for the rehabilitation planning process for TU patients and review for patients who are repatriated from the MTC maintaining 'pull.' • To provide advice and work as part of the MDT to ensure appropriate management of TU patients and those repatriated from the MTC. • To develop and maintain links with the MTC and TUs across the network incl. the network rehabilitation lead. • Develop links across neighbouring health boards. • To continue developing a map of other relevant services in the region, including early links with acute, community resource, primary healthcare and social care services and agencies, ensuing the rehabilitation requirements of discharged TU and MTC patients are being met. • To provide training, education and advice within the MDT in relation to the development of the rehabilitation plan. • To work closely on service development and evaluation with the clinical lead for the TU, Major trauma practitioner(s) and TARN coordinator(s) • To be a member of the therapy teams working within the TU service and work closely with rehabilitation consultants providing outpatient reviews and outreach services in the health board.	**Unmet and requires additional resources**
T16-2D-302 - Access to rehabilitation specialists – Year 2-3 There should be the following allied health professionals with dedicated time to support rehabilitation of trauma patients: • Physiotherapist. • Occupational therapist. • Speech and language therapist. • Dietician. • Pyschologist	**Unmet and requires additional resources**

Balanced teams are required between the above therapies as traumatic injuries present with an extensive range of conditions. Therefore the therapeutic expertise required needs to be comparable with that of the MTC. This includes complex cognitive and communicative assessment and multiple limb injuries. It is unlikely that traumatic injuries as an isolated speciality will provide the necessary expertise and it will be essential for teams to provide cover for neurological conditions to ensure that the expertise necessary is provided within the team. This model will support the repatriation of other complex neurological conditions for 'care with treatment closer to home.'	
T16-2D-302 - Access to rehabilitation specialists In place for day 1 - Availability of a consultant in Rehabilitation Medicine providing outreach in all TUs, including interest in spinal - and neuro-rehabilitation (including telephone advice to rehabilitation coordinators and therapists) Key roles include: • Management of complex conditions in adults of working age. • Special interest in musculoskeletal, amputee medicine, spinal injury and neurological rehabilitation. • Manage risk and facilitating complex discharge. • Coordinate the team goals working with physiotherapy, occupational therapy, psychology, speech and language therapists, nutrition team, orthotists, prosthetist etc. • Assess capacity and managing behavioural issues after injury. • Usual to link with many specialities – including palliative care. • Provide community support including benefits and advice around home adaptations. • Vocational rehabilitation support. • Support specialist nursing home placements. Rehabilitation consultants will provide 4 sessions support for the TUs. This will consist of a ward round, a multidisciplinary team meeting, outpatient clinic with time to support relatives and relevant SPA. HDUHB, SBUHB, CTMUHB and ABUHB will require 4 sessions each. PTHB will require support within outpatient services as no inpatient facility. C&VUHB TU to be met from within MTC rehabilitation service. This equates to 17 additional sessions for TUs. 10 sessions would be provided from the additional appointment and 7 sessions from reorganisation of existing sessions. There is currently one trainee and HEIW have agreed to support the proposal to appoint an additional trainee. It is anticipated that trainees would rotate between the specialist rehabilitation units and the TUs. Additionally, North Wales currently has no dedicated rehabilitation facility and expansion of trainees may provide trained consultants for development of this model. This would strengthen support to the trauma units and provide a variety of expertise.	**Unmet and additional resources required**

Essential Quality Indicator	Currently met/unmet/partially met
T16-2D-302 - Access to rehabilitation specialists – in place for Day 1 Directory and referral guidelines for rehabilitation services (to be provided locally and supported by network) including: • Pain management. • Psychology/neuropsychology. • Mental health/psychiatry. • Specialised rehabilitation. • Specialised vocational rehabilitation. • Surgical appliances. • Orthotics and prosthetics. • Wheel chair services.	**Unmet and will be fully met through network protocol**
T16-2D-302 - Access to rehabilitation specialists – Year 2 – 3 Input of psychology/neuropsychology providing both an in-reach and outreach service to patients in the Health Board. It is accepted that psychological support for patients and families is a core component of a major trauma service for adults and children and that it is essential that it be embedded within the team rather than a standalone service. The network requires a visible psychological model of care and a component of the care should provide support for the staff within the service. There is an established network of peer support for psychology across the region and this should provide a solid platform on which to develop psychological services within the trauma units. The support for patients and families after trauma requires expertise across a wide clinical field from Post-Traumatic Stress Disorders to detailed neuropsychological assessment. It is essential that the relevant expertise be contained within the network to cover the broad range of psychological presentations. Linking with local rehabilitation services is essential to achieve the breadth and depth of complexity expertise required to support all patients and families affected by trauma. This service will add value to wider presentation other than major trauma. The need for psychological support was integral to the aftermath of a number of mass casualty events in the UK over the last few years.	**Partially met and could be fully met with additional resources**
T16-2D-303 – Rehabilitation plan – in place for Day 1 All patients should receive a rehabilitation assessment including barriers to return to work. Where a plan is required, this should be completed within 72 hours. The plan should be updated prior to discharge and a copy given to the patient All patients repatriated from the MTC should have their plan reviewed and updated at the trauma unit. Requires additional resources (i.e. rehabilitation coordinators and therapists). Standardised plan being developed by rehabilitation working group.	**Unmet and could be fully met through network protocol and additional resources**

Essential Quality Indicator	Currently met/unmet/partially met
Additional standard – Orthogeriatric review – Year 3 - 5 Review by a ST3/equivalent or above in orthogeriatric medicine, geriatric medicine or care of elderly medicine as soon as possible and definitely within 72hrs of admission. In keeping with the case for change, health boards have been asked to consider how this could be achieved (e.g. reviews undertaken by major trauma practitioners under supervision of care of the elderly consultant, given shortage of orthogeriatric workforce).	**Unmet and could be fully met by additional resources**

8.4 Additional Service Specification

8.4.1 'Care with Treatment Closer to Home' (CWTCH)

A key early priority for the network board is the development of 'care with treatment closer to home' (CWTCH). As described in the case for change, timely repatriation of patients to an appropriate environment remains an issue in NHS Wales. Without adequate patient flow out of specialist centres, the MTC at UHW and TU with specialist services at Morriston Hospital will struggle to automatically accept new patients. The constraints to timely repatriation were considered as part of a patient flow workshop. The next steps are described below which will need to be in place for Day 1 (unless otherwise stated):

- Acceptance of the principle that origin health boards are responsible for their patients, irrespective where they are being treated. Automatic acceptance will be treated in the same way in both directions.
- Early communication between major trauma and rehabilitation coordinator services across the system, giving notification of patients that need repatriation and their requirements. Single point of access for repatriations. Thus, helping to create a 'pull' rather than a 'push' model.
- Use of clinical informatics to enhance patient held records (e.g. discharge and rehabilitation plan) and trauma tracking (Year 1).
- A simple, easy-to-use policy with escalation measures, in which the ODN is given operational authority, augmenting any revisions undertaken to the All Wales Repatriation Policy. The network policy will require endorsement by the Chief Executive Officer of each health board.
- Building confidence in medical and nursing staff accepting patients back from specialist care, through creation of an appropriate 'landing pad' as described below. This will form the basis of a further workshop in 2019.

If the above package of interventions is successful in delivering timely repatriation whilst ensuring the highest level of patient outcome and experience, its principles could be scaled up to other areas where repatriation is currently a problem.

8.4.2 'Landing Pad' Configuration

The 'landing pad' describes the environment to which major trauma patients will return once their specialist care is complete (e.g. at the MTC). It includes the structures in place to support and enhance the confidence of medical and nursing staff in managing patients in the recovery, rehabilitation and

re-enablement phases of their journey. This will include patients who return to a local hospital or community. A small group of patients with complex conditions will return from the MTC to the 'landing pad' whilst waiting for specialist rehabilitation and once specialist rehabilitation is complete.

In deciding the location of the 'landing pad,' the programme team (including the network rehabilitation lead) have undertaken a number of meetings with all health boards and have provided the following guidance on the requirements for a 'landing pad':

- Inpatient beds with appropriate medical and surgical ward cover including out of hours. Surgical input to include availability of orthopaedic and general surgical review. Input from other specialties may also be required (e.g. ENT, ophthalmology and urology). Access to input from care of the elderly services will be essential.
- Access to diagnostics (e.g. CT and MRI), to aid detection of complications.
- The presence of the multidisciplinary team as indicated above supporting the 'landing pad' including consultants in Rehabilitation Medicine, major trauma practitioners, rehabilitation coordinators and balanced therapy teams.
- Network led training and education for medical and nursing staff in tracheostomy management, spasticity management, bowel and bladder care and management of behavioural disorders. Face-to-face training augmented by online delivery.
- A low stimulation environment is important to consider, with an ability to dim lighting and nurse in a low-level bed. This environment can reduce the need for additional nursing support.
- A meeting space for multidisciplinary team/family meetings.
- Appropriate wheelchair provision for short-term loans.

In considering the 'landing pad,' health boards were asked to consider the following points:

- In most cases and based on the specification for a 'landing pad' provided above, health boards were asked to consider that their TU(s) become the 'landing pad' for the health board. If not, consideration needed to be given to suitability of an alternative location in line with the guidance already provided, with appropriate mitigations. Whilst the aspiration is to have a single ward for these patients, allowing a concentration of expertise, this is unlikely to be possible by year one.
- In accordance with the All Wales Repatriation Policy, patients should already be returning to health boards (except a few with complex conditions); therefore, these do not represent new patients in the system and does not necessarily represent new capacity. Of course, this needs to be carefully balanced against the unprecedented pressures on unscheduled and social care, and the impact on capacity.
- Most TUs will see fewer patients in totality (as the number of acute patients from health boards to MTC will exceed the number of patients returning from the MTC to the health boards). Therefore, in most cases there will be no requirement for new capacity. There are some exceptions to the above, but uplift in these health boards should be proportionate to the need.
- The data presented in Appendix 1 on the bed requirements for the 'landing pad' represents a worst-case scenario. This represents the maximum number of beds required at the landing pad within existing TU capacity. Most patients will go for specialist rehabilitation from the MTC, so transfers of these patients from the MTC to the 'landing pad' will be minimum. A minimal number of patients may also go from specialist rehabilitation to the 'landing pad.'

- The true size of the 'landing pad' could be accurately quantified at this stage of the programme to determine any additional infrastructure and nursing requirements but in year one, the picture is likely to become clearer.

Based on the above, a phased approach to the development of a 'landing pad' has been agreed, where's health boards identify beds within key admitting specialties (e.g. care of the elderly, stroke, neurology, and trauma and orthopaedics), with the multidisciplinary team providing outreach. In year one, accurate data will be collected to objectively quantify the need for a single 'landing pad' and this will be subject to future planning (see Appendix 17).

8.4.3 Paediatric Rehabilitation

With respect to specialist paediatric rehabilitation, this is described in the MTC case. It consists of multidisciplinary team led by a neurologist with an interest in rehabilitation at the Noah's Ark Children's Hospital of Wales, Cardiff. This team supports admissions requiring complex rehabilitation and works closely with neurology, paediatric intensive care and general paediatrics. Rehabilitation for children with non-neurological injuries at UHW is less formalised and is led by either therapy services, general paediatricians or trauma and orthopaedics. The function of this rehabilitation model will be reviewed in year one to assess whether additional resources may be required. Currently there is no capacity for organised outreach and this is a recognised as a service need. However, most children will be repatriated home from the MTC and not the hospital 'landing pad.' Additional resources for consultants in rehabilitation medicine will allow outpatient reviews as part of the outreach service, linking in with the specialist paediatric rehabilitation team in Cardiff.

Children will be repatriated to local paediatric services and supported by existing community paediatric services. The additional rehabilitation support planned for TUs will support transition of affected children in the TUs back to the community. The coordinator role will be important here. In year one and two as new therapists are introduced, health boards will develop a broader skill mix with these therapists to manage children with specific rehabilitation requirements.

8.5 Summary of Quality Indicator Assessment and Information Requests

As part of the TU designation process, an initial summary of key gaps against quality indicators and service specification was provided to Chief Executive's in November 2018, at the WHSSC Joint Committee.

From the analysis, a number of quality indicators are already being met by the TUs or could be met through the provision of network policies and internal re-organisation of resources. Where additional resources are required as indicated above, these resources will be introduced using a phased approach. The analysis revealed that there was commonality between all TUs with respect to additional resource requirements.

Following the Gateway review, a phased introduction of additional resources is summarised below, with details provided in Appendix 18:

In place for Day 1	Year 1 – business case development (implemented years 2 – 3)	Year 2 – business case development (implemented years 3 – 5)
health board trauma clinical lead – already in place	Balanced therapies: Physiotherapy Occupational therapy Speech and language therapy Dietetic Podiatry Orthotics	Orthogeriatric review
Major trauma practitioner(s) - Band 7 - 1.5 WTE/TU (5 day service)	Psychologist/neuropsychologist	
Rehabilitation coordinator(s) – Band 7 - 1.5 WTE/TU (5 day service)	Level 2 training requirements for nurses	
TARN coordinator(s) – Band 4 – 1.0 WTE/TU		
Additional rehabilitation consultant for network (4 sessions/HB/week, PTHB – 1 session/week)		

Subsequently, all health boards were asked to develop their submissions for the Programme Business Case and any associated cases based on the above.

In order to provide assurance that the TU components of the Programme Business Case were internally scrutinised, the programme team provided written and verbal feedback on initial submissions from health boards, followed by further challenge at a network board meeting on 24 June 2019. Following the Gateway review, face-to-face meetings were held with all health board network board members to discuss and agree the key enabling requirements and approach to the 'landing pad.' Subsequent to each meeting, a summary of the discussion was sent to each health board. It was agreed that health boards would consider and provide a written response to the proposals and to confirm their intentions to appoint in-year to the key enabler roles to include in 2020/21 and subsequent Integrated Medium Term Plans (IMTPs) and to address in year resourcing.

At the time of writing, all health board network board members have confirmed their support for the key enabling requirements and approach to the 'landing pad' and discussions are underway in relation to inclusion in IMTPs and in year resourcing.

8.6 Cardiff and Vale University Health Board

The following is a summary of the health board's resource. The health board's TU is the University Hospital of Wales. The resource requirements set out here are because UHW already meets most of the TU quality indicators and service specification outlined above, through existing resources and staffing.

0.1 whole time equivalent clinical lead from March 2020 (consultant) for TU capability 0.5 whole time equivalent major trauma practitioners (band 7) 0.5 whole time equivalent rehabilitation coordinators (band 7)
Landing pad – UHW, no new additional resources for day 1

8.7 Swansea Bay University Health Board

The following is a summary of the health board's resource. The health board's TU is Morriston Hospital. Specialist services are considered in section 8.12.

0.1 whole time equivalent clinical lead from March 2020 (consultant) 1.5 whole time equivalent major trauma practitioners (band 7) 1.5 whole time equivalent rehabilitation coordinators (band 7) 1.0 whole time equivalent TARN coordinators (band 4) in addition to 0.5 WTE (band 4) already in place
0.4 whole time equivalent rehabilitation consultant
Landing pad – Morriston Hospital, no new additional resources for day 1

8.8 Aneurin Bevan University Health Board

The following is a summary of the health board's resource requirements. The health board's TUs are the Royal Gwent Hospital and Nevill Hall Hospital. The health board is taking a pragmatic approach ahead of the planned centralisation to a single TU site with the opening of the Grange University Hospital in 2021.

0.1 whole time equivalent Clinical lead from March 2020 (consultant) 1.5 whole time equivalent major trauma practitioners (band 7) 1.5 whole time equivalent rehabilitation coordinators (band 7) 1.0 whole time equivalent TARN coordinators (band 4)
0.4 whole time equivalent rehabilitation consultant – the requirement for consultant rehabilitation resource will be considered as part of the second phase review of clinical models including the overarching rehabilitation model and therefore not included here
Landing pad – Royal Gwent Hospital and Nevill Hall Hospital in the interim, no new additional resources for day 1

8.9 Hywel Da University Health Board

The following is a summary of the health board's resource requirements. The health board's TU is Glangwili General Hospital (GGH).

0.1 whole time equivalent Clinical lead from March 2020 (consultant) 1.5 whole time equivalent Major trauma practitioners (band 7) 1.5 whole time equivalent Rehabilitation coordinators (band 7) 1.0 whole time equivalent TARN coordinators (band 4)
0.4 whole time equivalent Rehabilitation consultant
Landing pad – GGH, no new additional resources for day 1 (although the health board aspires to develop a 10 bedded dedicated landing pad in future years
In addition for day 1, the health board aspires to provide an additional 1 session for clinical leadership, 2.5 whole time equivalent physiotherapists (band 6) and 1 extra theatre session/week in anticipation of the increased flow to GGH within the health board

Bronglais General Hospital and Withybush Hospital have been designated rural trauma facilities by the health board and within the context of the network, some of which will be patients from Powys. These facilities will need to maintain the ability to assess and manage major trauma patients. Given their rural geographical location, the following measures will be put in place once the network is operational:

- A network pre-hospital triage tool to guide decision-making and trauma desk facility to provide remote support and prioritisation of face-to-face training for ambulance personnel operating in these regions. The pre-hospital triage tool will provide a safety net that patients with airway compromise or catastrophic haemorrhage will be taken to the nearest Emergency Department. Nonetheless, the above measures will support ambulance personnel taking some patients, where appropriate, to the TU at GGH.
- Confirmation of 24/7 availability of EMRTS, providing pre-hospital critical care, supporting local trauma teams and retrieval of patients to the MTC at UHW or TU with specialist services at Morriston Hospital.
- Remote telemedicine to guide management of trauma teams in rural trauma facilities ahead of arrival of EMRTS.
- An operational policy between the TU and rural trauma facilities, forming part of the network operational policy.

It is anticipated that rural trauma facilities will have a vital role to play in the network. With the above measures in place, it is expected providers will be supported and major trauma patients will receive a higher standard of care than they do currently.

8.10 Cwm Taf Morgannwg University Health Board

The following is a summary of the health board's resource. The health board's TUs are Prince Charles Hospital and Princess of Wales Hospital. Additional resource requirements for the two TUs have been combined below.

0.1 whole time equivalent Clinical lead from March 2020 (consultant) 3.0 whole time equivalent Major trauma practitioners (band 7) 3.0 whole time equivalent Rehabilitation coordinators (band 7) 1.0 whole time equivalent TARN coordinators (band 4)
0.4 whole time equivalent Rehabilitation consultant
Landing pad – Royal Glamorgan Hospital - no new additional resources for day 1

8.11 Powys Teaching Health Board

Powys Teaching Health Board has no acute hospital. All of the health board's major trauma cases will be managed by an MTC or TU outside of the health board's geographical catchment area. The health board's contribution to maintaining the trauma network will be through enabling repatriation of trauma cases for rehabilitation. Rehabilitation services in the health board are currently geared towards the elderly and those with chronic diseases. Trauma rehabilitation requires a subtly different approach and holistic organisation, which may not be best served by managing trauma patients alongside elderly and chronic disease patients. The health board may well be seeking to commission a 'landing pad' from neighbouring health boards, albeit patient numbers will be small. This remains a work in progress.

In relation to community-based rehabilitation, the health board has identified the following additional resources, augmenting existing services.

0.5 whole time equivalent Rehabilitation coordinators (band 7)
0.1 whole time equivalent Rehabilitation consultant

8.12 Specialist Services Support to the Major Trauma Centre

The following specialist services have been considered within the context of Morriston Hospital, as a TU with specialist services and the role it will play within the network to support the MTC to meet specific quality indicators.

8.12.1 Orthoplastic Surgery

The Welsh Centre for Burns and Plastic Surgery is located at Morriston Hospital. Currently there is no routine provision of emergency surgery by a plastic surgeon at UHW. A number of major trauma patients taken to the MTC will require the input of plastic surgeons. This is in keeping with requirements of a consultant plastic surgeon to be available for emergency cases within 30 minutes of the patient's arrival (T16-2B -113). Furthermore, the MTC should provide a comprehensive musculoskeletal trauma service and facilities to support all definitive fracture care and allow joint emergency orthoplastic management of severe open fractures as specified in British Orthopaedic Association Standards for Trauma and Orthopaedics (BOAST 4) guidelines (T16-2C -110).

In summary, the quality indicators indicate that for open fractures:

- A combined orthopaedic and plastic surgical approach should be undertaken for the initial debridement of the wound and stabilisation of the fracture.
- Heavily contaminated wounds require immediate debridement. Within 12 hours for isolated high energy, open fractures. Within 24 hours for all other low energy, open fractures.
- Definitive soft tissue closure or coverage should be achieved within 72 hours of injury if it cannot be performed at the time of debridement, again using a combined orthopaedic and plastic surgical approach.

Performance against these standards is monitored by TARN. In response to this, both UHW and Morriston Hospital have worked collaboratively to develop and agree a clinical service model, supported by the network board:

- Multi-system trauma patients with concurrent orthoplastic requirements – will be taken to the MTC (direct as informed by the pre-hospital triage tool or transferred from TU/LEH). Recommendations made following the professional peer review indicated that the provision for a plastic surgical presence at the MTC was an absolute day 1 requirement.
- Patients with isolated crush injury/ mangled limb/ partial or complete amputation (above wrist or ankle)/ major degloving – will be taken to Morriston Hospital (direct as informed by the pre-hospital triage tool or transferred from TU/LEH).
- Patients with isolated open lower limb (tibia/ankle/foot) fracture – recommendations derived from the professional peer review indicated that this element of the pathway could be phased for the following reasons:
    - In year 1 – the current pathways will be maintained and there will be no change in patient flow. The transfer of isolated open lower limb fractures will not be included in the pre-hospital triage tool. The reasons for this include that whilst this is an important patient

group, they are not major trauma patients and the provision of plastic surgical input into multi-system trauma patients at the MTC takes priority. Furthermore, historically, English trauma networks phased this aspect of service development. A significant proportion of isolated open lower limb fractures are transferred to Morriston Hospital already either directly or by secondary transfer.

- End of year 1 – consideration will be given to additional resource requirements to allow direct transfer of significant isolated open lower limb fractures direct from scene to Morriston Hospital. This will take into consideration any capacity released through the increased major trauma workload at the MTC, which would previously have been undertaken at Morriston Hospital.

Activity data was used to determine the resource requirements to deliver a plastic surgical presence at the MTC. Based on population data, the level of orthoplastic surgery cases requiring admission to the MTC is likely to be approximately 24 cases +/- six per annum. However, as evidenced by other MTC's there may be wider plastic surgical input once the service is established. Hendrickson *et al* (2016) demonstrated that 14% of MTC cases required plastic surgical input. Furthermore, of 227 patients an average of 3.7 procedures were carried out per admission. Given the wider benefit of establishing a plastic surgical service at the MTC it is likely that the number of cases predicted above is underestimated.

Initially the presence of a plastic surgeon will be provided for 5 days per week for 12 hours per day, in order to undertake combined orthoplastic cases, multidisciplinary team meetings and complex fracture clinics. It is accepted that this provision does not meet the quality indicators; however, out of hours and at weekends, the orthopaedic surgeon at the MTC will discuss all cases as appropriate with the plastic surgeon on call at Morriston Hospital. Patients requiring soft tissue closure or coverage either will receive this at the MTC or be transferred to Morriston Hospital, based on their clinical presentation.

The resource requirements to establish the plastic surgery service at the MTC is 4.0 WTE consultant plastic surgeons and 5.0 WTE middle grades as assessed by the professional peer review process.

8.12.2 Spinal Trauma Surgery

Currently there are three hospitals that provide spinal surgery: UHW, Morriston Hospital and the Royal Gwent Hospital. Following discussions between the three sites, a clinical service model for spinal trauma surgery was agreed as summarised below:

- All patients with suspected or confirmed spinal trauma and new neurology (paralysis) – direct or transfer from TU/LEH to the MTC (Spinal Cord Injury Centre). This is being addressed through the MTC case.
- Spinal fractures that require operative fixation with no neurology:
  - UHW – refer to respective spinal team locally for operative fixation.
  - Morriston Hospital and Royal Gwent Hospital – refer to respective spinal teams at Morriston Hospital and Royal Gwent Hospital.
  - Patients in Hywel Dda University Health Board hospital – refer to Morriston Hospital spinal team (transfer within 48hrs from initial admission).
  - Patients from Cwm Taf Morgannwg Health Board hospital – refer to UHW spinal team (transfer within 48hrs from initial admission).

The only change in current flows will be to Morriston Hospital. This is reflected in the Swansea Bay University Health Board case and opens up the opportunity to improve the emergency provision of

spinal surgery as a whole for South West and West Wales, which is supported by the network board and will further decompress the UHW, for non-traumatic spinal emergencies that it is otherwise currently expected to manage.

8.12.3 Thoracic Trauma Surgery

The current provision of thoracic surgery is split across Morriston Hospital and UHW. Following an independent panel review and public consultation in relation to the future provision of thoracic surgery across the region, it was concluded that Morriston Hospital should be a single site for thoracic surgery. This decision post-dated the designation process for the MTC in Cardiff and questioned the ability for the standard to be met that a thoracic surgeon to be available within 30 minutes for an emergency case at the MTC (T16-2B -113). There are a number of clinical scenarios, which may require the input of a thoracic surgeon. WHSSC have agreed an interim solution (see Appendix 16) and this will ensure adequate thoracic surgical presence at the MTC for emergency cases, as the MTC is likely to be operational prior to the centralisation of thoracic surgery. Now a decision has been reached on this provision, the network board will work with both health boards to develop a clinical service model for emergency, urgent and subacute cases. Within this, consideration will be given as to the model for rib fixation and referral for complications of thoracic trauma.

8.12.4 Pelvic Trauma Surgery

Current provision of urgent (i.e. next day) definitive fixation of the pelvis across the region is limited. UHW (based on self-assessment) have two surgeons with interest in pelvic surgery. Morriston Hospital has one with recognition that recruitment has been challenging. None of the other health boards has dedicated pelvic surgeons. The network board has recommended that all urgent isolated pelvic and acetabular fractures as referred to the MTC and the MTC accepts transfers as clinically appropriate for definitive fixation, noting that most of these will be next day referrals. The additional resource requirements have been confirmed in the MTC case.

9 Financial Case

9.1 Introduction

The purpose of this section is to set out the totality of costs (revenue and capital) and proposed funding arrangements to enable NHS Wales and Welsh Government to assess the total amount required, as well as the phasing of the service and supporting capital requirements. The section sets out the required investment in work towards meeting the quality indicators and service specification standards for major trauma, as well as the uplift of activity at the Major Trauma Centre (MTC).

9.2 Context

The Welsh Government issued clear planning guidance and financial direction to all health boards in a report to the NHS Wales Executive Board in December 2018. This formed part of the financial settlement from 2019/20 onwards, as outlined below:

Welsh Government directions:

- It is our expectation that the NHS in Wales will view the establishment of a trauma network and MTC as a significant priority. As such, we will be expecting Health Boards to invest strategically in this service. We are aware that provision has not been made so far within the WHSSC prioritisation for the recurrent revenue funding requirements for the service. The Health Boards have been provided with an uplift in their funding from 2019/20 and it is the expectation that this uplift will enable the implementation of strategic service developments such as major trauma to be supported.
- To aid the development of this work, we have established an internal Welsh Government policy board to facilitate cross department working, scrutiny and challenge. We are conscious there are significant time and resource constraints in relation to the delivery of this project and we expect the internal policy board to be utilised to provide collective advice and scrutiny to assist the trauma network as it develop its programme business case, policies etc. We do of course accept that it will not be possible to deliver the entirety of the project by 2020 and we will look to work with NHS colleagues to agree a sensible programme, which can deliver benefits to patients in a phased way.
- We have provided advice to the trauma network on the structure and business case process to deal with both the capital and revenue consequences arising from the Major Trauma programme. There is an expectation that an overall programme business case will be developed setting out the case for change, as well as the high-level service and revenue consequences. This does not negate the need for individual health boards to develop any individual capital business cases required to support local implementation – where known, these are reflected within the programme business case; these should be flagged with capital and estates officials within Welsh Government, as soon as possible, in line with normal processes including within health board IMTPs.
- There is an expectation set out in the national audit programme that all Health Boards should submit data to the Trauma Audit Research Network **(TARN)**. Historically, Health Board participation rates in the audit have been variable. Participation in this audit is vital to the successful implementation of the trauma network. As such, Welsh Government will be paying much closer attention to this audit and we expect all health boards to review their participation and make the improvements necessary to ensure their full participation.

- The trauma network and MTC must be developed within the NHS Wales **policy context** and as such, account must be taken of existing and emerging policies such as the national work on transfers for critically ill patients. This will avoid duplication of effort within the project.
- It is also important that any service development relating to the trauma network such as investment in rehabilitation services be considered in the **wider service context** such as the development of neuro-rehabilitation and services to support patients with a prolonged disorder of consciousness.
- Finally, we understand there have been discussions about the future commissioning model for major trauma services in South Wales, West Wales and South Powys. The NHS in Wales operates as a planned healthcare system, and it would be **inappropriate for an internal market approach** such as tariffs to be used to support this development. Any commissioning mechanisms or framework must therefore work within the NHS Wales context and should not be unnecessarily bureaucratic.

9.3 Phasing

In assessing the need for investment in the development of the network, significant consideration has been given to the need for phasing, for both financial and operational reasons.

There is a difference between the MTC and the TUs in terms of phasing. Investment in the MTC needs to be more frontloaded, because of the need to achieve quality indicators and meet the service specification at an early stage, in order to provide the maximal benefit to the most seriously injured patients, the majority of whom will go to the MTC. By contrast, the TU resource requirements will reflect a much more phased approach, where subsequent business cases may be required, where appropriate, to meet quality indicators and elements of the service specification that cannot be met from day one.

The frontloading of resources at the MTC is also a reflection of the shift in learning and evidence base, from trauma systems nationally and internationally. This includes the need from day 1 for 24/7 trauma team leadership in the MTC, the presence of a poly trauma unit and hyper acute rehabilitation. C&V UHB will also be providing a combined adult and paediatric MTC, thus there are two sets of quality indicators to be met, with some areas of overlap and others requiring distinct resources.

It is evident that in the seven years since the establishment of the English trauma networks, there has been a substantial increase in pressure on unscheduled care. Thus, the financial case presented here is a reflection of a system already under strain, where demand often outstrips resources, leading to resources being depleted to undertake existing work.

Within the MTC case there is phasing for workforce against incremental changes in predicted activity. This is not reflected in the totality of the network revenue implications, as after year one, WAST revenue costs fall significantly.

Finally, all health boards (except C&V UHB as the MTC) will see less moderate and major trauma in totality. Whilst it is difficult to quantify releasable workforce, it is possible for health boards to consider releasable Emergency Department admissions, ward bed days, theatre sessions and critical care bed days, in terms of accepting the financial position.

9.4 Revenue Costs

9.4.1 Summary of Revenue Costs

Following the provision of information against the agreed phasing of clinical and service standards, Health Boards prepared an estimate of revenue costs and these are summarised in the table below:

Summary of Revenue Costs

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

The revenue implications are further broken-down below:

Summary Revenue Costs of Network					
	2019/20	2020/21	2021/22	2022/23	2023/24
	£000s	£000s	£000s	£000s	£000s
Aneurin Bevan (Trauma Unit)	£51	£205	£205	£205	£205
Cwm Taf Morgannwg (Trauma Unit)	£103	£471	£471	£471	£471
Cardiff and Vale Major Trauma Centre	£922	£10,099	£10,594	£10,594	£10,594
Cardiff and Vale Major Trauma Paediatrics	£0	£481	£629	£629	£629
Cardiff and Vale (Trauma Unit)	£0	£69	£69	£69	£69
Hywel Dda (Trauma Unit)	£62	£247	£247	£247	£247
Swansea Bay (Trauma Unit)	£62	£247	£247	£247	£247
Swansea Bay Operational Delivery Network	£119	£496	£508	£513	£515
Swansea Bay Specialist Services	£150	£910	£910	£910	£910
Powys (Repatriation and Rehabilitation Facility)	£10	£40	£40	£40	£40
WAST	£58	£1,201	£635	£640	£640
Total NHS System Revenue	**£1,536**	**£14,465**	**£14,553**	**£14,562**	**£14,564**

The above costs have been derived through an iterative process of reviewing the gap between commissioning expectations and provided costs. It is important to stress that the TU costs presented do not include all of the costs associated with moving in a phased manner to full TU compliance with quality indicators and all aspects of the service specification. Such additional costs, which are not currently known, will need to be subject to additional TU specific business cases over the period of implementation.

The local trauma unit costs for Hywel Dda UHB reflect the key enabling posts for Day 1, however the Health Board aspires to invest in an additional clinical leadership session, 2.5 whole time equivalent physiotherapists and an additional theatre session per week to meet an anticipated demand upon GGH. Further rehabilitation investment has also been identified. The Health Board are looking to develop 10 landing pad beds, which will be phased in year 1 and year 2. The revenue costs that the Health Board have identified locally for staffing of these additional rehabilitation and landing pad staffing costs over and above the costs in the case is £8k in 2019/20, £268k in 2020/21 and £1,457k in 2021/22.

Furthermore, SBUHB have confirmed that the ongoing cost for expanding the South West Wales Spinal Service will be managed between HDUHB and SBUHB.

The above costs include recurring funding already released in-year (as part year costs) during 2019/20 for key enabling posts and preparation for Day 1. This funding, as shown below, has been approved in two tranches through the WHSSC Joint Committee process (therefore signed-off by all Health Board Chief Executives):

Tranche	**2019/20 part year funding (£000s)**	**Full year funding from 2020/21 (£000s)**
Tranche 1	675,000	1,993,000
Tranche 2	441,000	3,006,000
Total	**1,116,000**	**4,999,000**

***** Released subject to approval of the programme business case to allowed recruitment processes to commence in the meantime

The preferred MTC model also creates the potential for further efficiencies to be delivered at the trauma units who will in future be transferring current activity to the MTC. Further work will be undertaken by the finance group to assess how such opportunities can be realised in practice. Possible opportunities include reduced in patient stays and reduced front door activity. It will be important that health boards have systems in place to capture these potential benefits as they will need to re-deploy resources internally into improved landing pad activities to enable timely repatriation from the MTC.

9.4.2 Summary of Revenue Funding Arrangements

The finance sub group agreed that the figures in the sub section above would form the basis of the initial distribution, subject to further work to determine if there was an appropriate direct contribution to the MTC costs in relation to the C&VUHB's own trauma unit costs. The distribution would then be subject to review in the light of actual utilisation patterns experienced in year one and beyond and the subsequent application of the agreed risk sharing principles for regional services.

9.4.3 Benchmarking

The costs of the MTC were benchmarked against real world finance and activity data from the flow of the North Wales population to the Stoke MTC. The method to determine this benchmark used detailed actual charges for a complete financial year for a whole population in order to base it on a reliable and representative case mix. The charges included in the comparator included the full costs of critical care, all procedure costs from core specialty activity and the best practice tariff charges payable under the English PBR system. All charges were at 2018/19 prices and reflected national tariff rules together with any variation needed for local prices. The resulting dataset only included those cases that ultimately attracted major trauma best practice tariffs to ensure a like for like comparison. The dataset comprised 105 cases which included 45 for MTC level 1 and 60 cases for the higher severity level MTC level 2. The average unit prices were £23,576 per case for MTC level 2 (ISS>15) and £12,083 per case for MTC level 1 (ISS 9<15) with an overall average of £18,650 per case. These benchmark units' costs have been applied to business case activity as follows to illustrate a range of expected values:

ISS 9-15 – moderate	Assumed current position	@ Average Tariff Cost £	Year 1	@ Average Tariff Cost £	Year 1 Additional Cases	Additional Cases @ Average Tariff Cost £	Year 2	@ Average Tariff Cost £	Year 3	@ Average Tariff Cost £
Direct to MTC	154	1,860,782	206	2,489,098	52	628,316	231	2,791,173	256	3,093,248
Transfer TU to MTC	11	132,913	58	700,814	47	567,901	58	700,814	66	797,478
Total	165	1,993,695	264	3,189,912	99	1,196,217	289	3,491,987	322	3,890,726
ISS >15 – major	Assumed current position		Year 1				Year 2		Year 3	
Direct to MTC	284	6,695,584	306	7,214,256	22	518,672	341	8,039,416	368	8,675,968
Transfer TU to MTC	49	1,155,224	219	5,163,144	170	4,007,920	219	5,163,144	193	4,550,168
Total	333	7,850,808	525	12,377,400	192	4,526,592	560	13,202,560	561	13,226,136
ISS >9 – candidate	Assumed current position		Year 1				Year 2		Year 3	
Direct to MTC	438	8,556,366	512	9,703,354	74	1,146,988	572	10,830,589	624	11,769,216
Transfer TU to MTC	60	1,288,137	277	5,863,958	217	4,575,821	277	5,863,958	259	5,347,646
Combined Direct to MTC & Transfer TU to MTC	498	9,844,503	789	15,567,312	291	5,722,809	849	16,694,547	883	17,116,862

The new MTC will be delivering the full range of activities across ISS 9<15 and ISS>15 and hence both should be taken together in comparing to expected costs for the MTC. In making a like for like comparison with the MTC business case the following also needs to be taken into account:

- The existing cost base for the MTC at UHW. Including baseline costs for trauma, emergency care department costs and critical care.
- The majority of isolated neurosurgery cases will be dealt with as per the current pathway under the neurosciences contract.
- The major trauma pathway from the Stoke centre includes agreed standards for appropriate discharge back to local services within the BCUHB area. Patients with an ISS>15 had an

average length of stay of 10.9 days (non-neurosurgery cases excluding critical care). Critical care length of stay averaged 4.0 days.

- The new UHW MTC will be meeting the requirements for increased activity which is anticipated to rise each year. The value of additional activity delivered over the period would be equivalent to circa £5.7m to year 1 (+291 cases); £6.8m to year 2 (+291+60 cases); and £7.5m to year 3 (+291+60+34 cases).

- The new UHW MTC total activity including baseline will deliver activity valued at £15.6m (year 1 - 789 cases); £16.7m (year 2 - 849 cases), £17.1m (year 3 - 882 cases).

Unit Costs

The costs forecast for the MTC, Specialised Services and ODN components of the business case total £11.984m in year 1, £12.640m in year 2 and £12.645m in year 3. Activity is forecast to increase to 789 cases by year 1, 849 by year 2 and 883 by year 3. Resulting incremental units costs are therefore £15,189 for year 1, falling to £14,888 for year 2 and £14,320 by year 3. These incremental costs are within the comparator derived from the costs of the benchmark service of £18,650 per case. However, inclusion of baseline costs set out below are likely to take the gross overall unit cost to above the benchmark level.

The baseline contracting currencies used by CVUHB to contract for major trauma lack detail, vary between health boards and it is difficult to match TARN activity data retrospectively to contracting data. Hence it has not has been possible for CVUHB to place an accurate value on the current baseline. However, the following baseline unit cost data is useful in comparing the above incremental cost of the MTC to the benchmark comparator:

- CVUHB current non elective trauma unit prices average at £3,960 per case.

- CVUHB critical care unit prices average £1,935 per day with a marginal rate of £1,225 per day.

- Emergency unit contracts are on a block basis hence no unit cost data is available.

9.4.4 Financial Risk Sharing

The financial risk share arrangements for the Major Trauma Centre, Swansea Bay Specialist Services and Wales Ambulance Services NHS Trust are based on WHSSC standard formula, the impact of which is outlined below:

Health Board	Risk Share
Cardiff and Vale UHB	20.77%
Swansea Bay UHB	18.44%
Cwm Taf Morgannwg UHB	17.23%
Aneurin Bevan UHB	25.36%
Hywel Dda UHB	16.80%
Powys THB	1.40%
Total	**100.00%**

The required revenue funding from each health board on the risk share basis, plus all currently known local costs for the development of the TUs is reflected below:

Summary of funding of Trauma Network by Health Board					
Reflects local Trauma Unit / Rehabilitation costs plus share of Major Trauma Centre, Specialist Services and WAST Pre-hospital care					
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Aneurin Bevan	£353	£3,549	£3,571	£3,573	£3,574
Cwm Taf Morgannwg	£308	£2,743	£2,758	£2,759	£2,760
Cardiff and Vale	£247	£2,808	£2,826	£2,828	£2,829
Hywel Dda	£262	£2,462	£2,477	£2,479	£2,479
Powys	£27	£225	£226	£226	£226
Swansea Bay	£281	£2,678	£2,695	£2,696	£2,697
WAST (2019/20 funded by Welsh Government, year 1 onwards by Health Boards)	£58	£0	£0	£0	£0
Total NHS System Revenue	**£1,536**	**£14,465**	**£14,553**	**£14,562**	**£14,564**

EASC have confirmed that the funding for the 2019/20 costs for the WAST business case will be funded by Welsh Government. The risk share calculations are assumed to be the same as WHSSC. Year 1 revenue implications are being considered within the context of this programme business case.

9.4.5 Outstanding Issues Impacting on Revenue Costs and Apportionment

The costs and funding shares above do not take account of the several factors outlined below, as sufficient information is not yet available:

- Increased RTA income to C&VUHB resulting in lower net costs, offset by equivalent reduced RTA income to other health boards. This has no net overall effect to NHS Wales, but does result in a change to the financial impact on each health board. The planned approach to reflect this is to monitor changes in RTA income during 2020/21 by the health board, and adjust net costs and commissioning flows to reflect the changes identified.
- The impact of the planned earlier repatriation of patients from the MTC to TUs/'Landing Pads' for repatriated patients is taken account of in the business case in respect of the projected additional patients triaged to the MTC, but is not taken into account in respect of earlier repatriation of existing major trauma patients treated at UHW. Therefore, if the implementation of the repatriation protocol and pathway is fully successful, there would be a reduction to bed requirements within the MTC from that assumed in the business case. Conversely, if earlier repatriation is not achieved, there would be an increase in the bed requirement. The level and timing of repatriation will be monitored during year one, and consideration given whether the bed planning and associated resourcing plans need to be amended in year two.
- The phasing of costs is based on a 1 April 2020 implementation, with all additional year 1 staffing being in place by this date. It is inevitable that there will be a degree of slippage which will reduce year 1 costs to some extent. Tracking of the additional costs during year 1 will be put in place until all staff and associated costs are being incurred, and only actual costs incurred will be funded.
- The costs do not include capital charges associated with capital expenditure (see also below). It is assumed that these will be funded directly by the Welsh Government as with all capital schemes.
- There are areas within the MTC business case where further review of detailed staffing plans and costs is still being undertaken (largely around ED consultant numbers). These could

potentially impact year 2, but would not impact on year 1. The final outcomes of this review will then be reflected in the year 2 costs.

- There may be further operational efficiencies resulting from the introduction of the Paediatric TU which could reduce local beds requirements within UHW. It is important that these potential further efficiencies are tracked and benefits shared appropriately.
- The costs included in the SBUHB case for specialised services include the significant overhead of locating up to four plastic surgeons at the MTC. In practice, in order to fully utilise this resource, there is likely to be a change the balance of activity undertaken at the current SBUHB plastic surgery service and at the MTC. This may result in an offset in costs from a reduction in activity and cost at the SBUHB service, but this cannot be accurately determined at this time until the actual case mix of the MTC activity becomes clearer.
- The SBUHB specialised services business case includes the cost of five middle grades at 100%, assuming no deanery funding. This has not been approved in principle by WHSSC Joint Committee at this point, but is included for planning purposes.
- The Cardiff MTC case reflects additional revenue costs of £352k that are expected to arise following submission of the capital case to Welsh Government. These figures have not been approved in principle by WHSSC Joint Committee at this point but are included for planning purposes.

9.5 Contracting Arrangements

WHSSC, working with the finance sub group of Health Boards, will continue to develop contracting arrangements that will determine an appropriate contracting and funds flow model that will replace the current trauma income flows into C&VUHB. A system will be designed which will continue to provide baseline income which is not duplicated by the addition of the MTC business case funding. This will be a complex process as there is significant uncertainty as to the value of current income flows and the overlap of these with MTC designated activity.

9.6 Capital Costs

9.6.1 Summary of Capital Costs

Strategic capital funding of £6,414m through Welsh Government (rather than locally funded through discretionary capital) is outlined below:

Programme Capital Requirements					
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
MTC Cardiff & Vale (MTC Construction and Equipment)	£5,426				
Hywel Dda Trauma Unit (West Wales General)			£1,252		
Capital Total	**£5,426**	**£0**	**£1,252**	**£0**	**£0**

C&VUHB has identified the following 2019/20 capital requirements for estate and equipment:

Cardiff & Vale Capital Requirements 2019/20

	Construction	Equipment	Total
	£000s	£000s	£000s
Emergency Unit - Resus Bay Equipment Costs	£0	£134	£134
Extension, resus, streaming and triage bay refurbishment	£436	£0	£436
Room alterations to provide additional minors capacity	£150	£0	£150
Interim refurbishment of Poly trauma Unit (PTU) 14 beds	£1,109	£383	£1,492
Critical Care bed expansion – Equipment only	£0	£194	£194
Theatres – Capital equipment inc plastics	£0	£1,100	£1,100
Theatres - Image Intensifier	£0	£120	£120
Replacement scanner for Emergency Unit	£600	£1,200	£1,800
	£2,295	**£3,131**	**£5,426**

Further C&VUHB capital requirements for the construction and equipping of a major trauma theatre are being developed by the Health Board. The expected timeline for submission of these detailed cases is reflected in the timetable of business cases. The estimated future capital requirement for the MTC theatres at the time of publication is in the region of £20-25m. Note that this is an integrated capital scheme which includes the vascular hybrid theatres and this will considered within a full business case submission by C&VUHB.

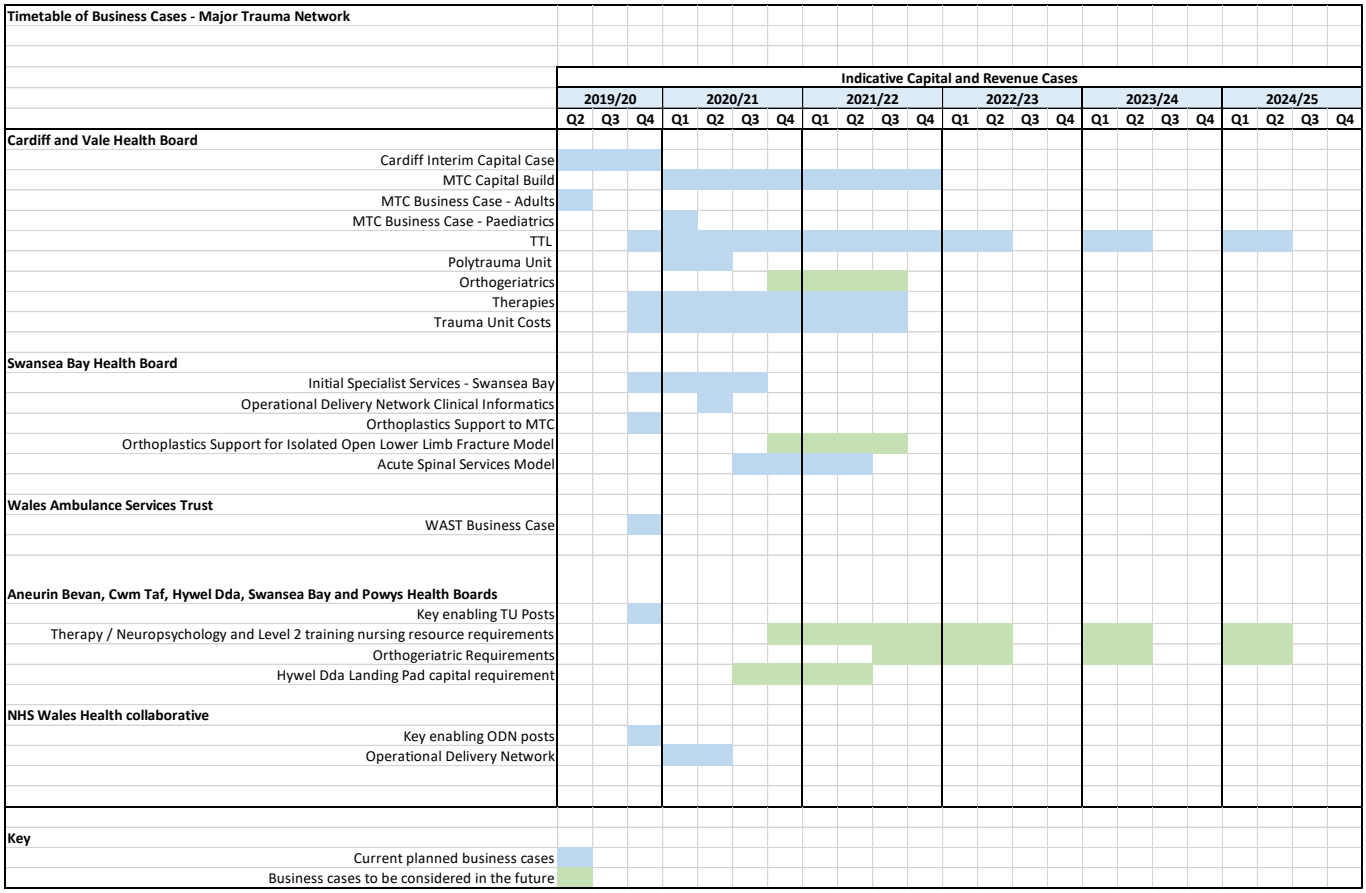
Hywel Dda University Health Board has identified £1,252k for the development of a 10 bedded 'landing pad' in year 2 (2021/22) at Glangwilli Hospital, Carmarthen. However, it is envisaged that the year 1 approach will be in keeping with all other Health Boards, with consideration given to a dedicated 'landing pad', as appropriate, following a period of evaluation of actual activity.

9.6.2 Capital Charges

C&VUHB has indicated that there will be a summary of capital charges once the Capital, Estates and Facilities Division of Welsh Government has confirmed the final capital award. C&VUHB expect that that there will be Welsh Government funding for these capital charges.

9.7 Timetable of Future Business Cases

The timetable of future revenue and capital business cases that will be prepared by the appropriate organisations is outlined below and is further considered in the management case chapter. Whilst at this stage it is difficult to quantify, this gives an indication of the potential cases that would need to be considered as part of the phased network development.


Timetable of Business Cases - Major Trauma Network
Indicative Capital and Revenue Cases
2019/20
2020/21
2021/22
2022/23
2023/24
2024/25
Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Cardiff and Vale Health Board
Cardiff Interim Capital Case
MTC Capital Build
MTC Business Case - Adults
MTC Business Case - Paediatrics
TTL
Polytrauma Unit
Orthogeriatrics
Therapies
Trauma Unit Costs
Swansea Bay Health Board
Initial Specialist Services - Swansea Bay
Operational Delivery Network Clinical Informatics
Orthoplastics Support to MTC
Orthoplastics Support for Isolated Open Lower Limb Fracture Model
Acute Spinal Services Model
Wales Ambulance Services Trust
WAST Business Case
Aneurin Bevan, Cwm Taf, Hywel Dda, Swansea Bay and Powys Health Boards
Key enabling TU Posts
Therapy / Neuropsychology and Level 2 training nursing resource requirements
Orthogeriatric Requirements
Hywel Dda Landing Pad capital requirement
NHS Wales Health collaborative
Key enabling ODN posts
Operational Delivery Network
Key
Current planned business cases
Business cases to be considered in the future

10 Economic Case

10.1 Introduction

There are two sections in this Economic Case, the first describing the costs effectiveness and value for money of establishing a trauma network for South Wales, West Wales and South Powys, based on evidence from comparable systems. The second section of this chapter summarises the range of options considered as part of the historical work undertaken to develop a preferred operational model for achieving the stated investment objectives, offering the best value for money, based on both qualitative and quantative analysis. This was undertaken in accordance with HM Treasury guidance. Within the context of this, a 'do nothing' option was considered.

More recently, it is important to note that in relation, to developing the stated clinical service model, the approach has been based largely on phasing of pre-defined quality indicators and service specification over a period, rather than considering a range of options per se. This is mainly because the development of quality indicators and service specification lends itself better to a phased approach rather than an options appraisal. Furthermore, as decisions were taken in March 2018 to proceed with the development of the network and decisions were then taken in relation to the location of the MTC, it was not possible to consider a 'do nothing' option moving forward.

Nonetheless, the programme has where possible, looked at options in the context of individual business case submissions. Examples of this include considering a range of options in terms of developing a consultant trauma team leader rota at the MTC (see Appendix 16), plastic surgical provision at the MTC and SWOT (strength, weakness, opportunity, threat) analyses in relation the configuration of trauma desk function and face-to-face training by the Welsh Ambulance Service.

Thus, this chapter sets out the case based the best available evidence and both current and historical options appraisal of operational and clinical modelling.

10.2 Evidence from Established Trauma Systems

Major trauma networks in England have resulted in an 18% increase in the probability of surviving trauma for the 54 million population of England. This equates to around 500 additional survivors per year. Pre-hospital triage and transfer protocols have resulted in a significant increase in patients treated at an MTC from 13,358 in 2011 to 26,486 in 2016. Networks have also facilitated rapid dissemination of evidence-based practice. Independent, socioeconomic analysis has calculated the cost effectiveness of the system at £2,500 per Quality Adjusted Life Year (QALY).

With enhanced investment across the trauma pathway (including rehabilitation), there is evidence of improvements in functional outcome, a reduction in ongoing healthcare requirements and improving ability to return to work. Gabbe *et al* (2015) demonstrated that 10 years after introducing the Victorian State Trauma Service, there was a cost saving per case of $633,446 in 2010-2011 compared with 2001-2002, owing to increased disability-free years.

Taylor *et al* (2012) demonstrated that Helicopter Emergency Medical Services working within the context of a mature trauma system resulted in a reduction in hospital mortality leading to a cost per life saved of $1,566,379 in all patients: $533,781 in patients with serious injury and $519,787 in patients with traumatic brain injury. The cost savings are not related to just additional patients who survive, but to all patients who survive. With improvements in rehabilitation, enhancements in functional recovery will be seen across a wide group of patients.

Furthermore, there are a number of studies demonstrating cost effectiveness of rehabilitation interventions. Wood *et al* (1999) demonstrated an estimated lifetime saving in the cost of care of over £1 million for each patient receiving neuro-rehabilitation with good functional outcome. The same trend has been demonstrated in other studies related to the provision of neurorehabilitation.

With an estimated 14 additional lives saved across the network per year, this is likely to equate to a cost per life saved of approximately £17 million, with the economic benefits from improving functional outcomes to be quantified as part of the benefits realisation plan.

A critical question that the network board has considered is whether the establishment of the network will be a cost effective intervention and bring value. Given the required additional investment to improve quality of care through meeting higher standards of care, this is an important question to consider. This issue can be considered through two distinct, but related, lenses:

- For a given investment, what is the likely return on that investment?
- For a given investment, what is the value that the network will bring?

In demonstrating the above, it is important to demonstrate how these elements will be measured in the context of major trauma.

10.3 Cost Effectiveness

In relation to the return on investment, there is consistent national and international evidence indicating that the establishment of trauma networks is costs effective.

Durham *et al* (2006) evaluated the cost effectiveness of mature trauma system in Florida, and demonstrated costs per lives saved comparable to or lower than other major public health expenditures.

Rotondo *et al* (2009) demonstrated a similar experience. It is important to note that these early studies focused on the economic benefit of lives saves and not necessary on the whether those patients that survived had a poor functional outcome and the refore increased the burden of disease. However, it is clear from more recent evidence that survival does not necessarily increase the disability burden. With enhanced investment across the trauma pathway (incl. rehabilitation), there is evidence of improvements in functional outcome and therefore, reducing ongoing healthcare requirements and improving ability to return to work. Gabbe *et al* (2015) demonstrated that after 10 years of introducing the Victorian State Trauma Service, there was a cost saving per case of $633,446 in 2010-2011, compared with 2001-2002, owing to increased disability free years.

If the focus turns to an MTC, within a mature trauma system, then investment in the MTC in itself is cost-effective, with evidence of a 5 to 15 fold return on investment for each patient successfully returned to work. In terms of cost per life year saved, regionalised MTC care costs significantly less than the provision of renal dialysis, breast cancer treatment or the percutaneous or surgical management of coronary artery disease and is cost-effective when compared with the provision of other medical interventions (Mackenzie *et al*, 2010, Seguin *et al*, 1999, Zarzaur *et al*, 2010). Mackenzie *et al* prospectively demonstrated cost effectiveness of MTC's in the United States with a Quality Adjusted Life Years (QALY) of $36,961 (US system costs).

Whilst mature international systems give a clear signal towards cost-effectiveness, the challenge remains of how comparable are they with trauma systems in the UK, which will be more similar to the South Wales Trauma Network. A recent UK based study sheds some light on this issue. An NHS England economic evaluation of regional trauma networks was published in 2013. Over the period of the study, there was an increase in the number of patients surviving major trauma and QALY increased as a

result. It also noted that, on average, the NHS investment appears to range between £5,241 - £5,679 per additional QALY gained. This suggests that the introduction of English trauma networks has been cost effective, given that it is significantly under the NICE QALY threshold for cost effectiveness of £20,000. Based on the expected number of 'candidate' major trauma patients (2,112) across the entire South Wales Trauma Network, the investment is significantly below the NICE QALY threshold of £20,000 (£6,896 per additional QALY gained), comparable with other interventions (e.g. hip and knee replacements). Whilst comparison with NHS England is challenging, given differences in how healthcare is commissioned, there is a clear signal that, by applying the NHS England quality indicators and service specification, to a comparable level of costs effectiveness in NHS Wales based on the NICE QALY threshold could be achieved.

It should also be noted that, in the 7-9 years that have elapsed since the English trauma networks have been developed, there has been ongoing investment and incentivisation of the system, based on lessons learnt. These investments have been slow to progress, but started in rehabilitation and TUs. There have been further enhancements in standards (e.g. Orthogeriatric assessments, poly-trauma wards). It is clear that with investment planned across the pathway for the South Wales Trauma Network, it is predicted that there will be a greater gain in terms of returning survivors to higher levels of function and this will allow them to contribute positively to the economy. Therefore, the cost effectiveness demonstrated in England is likely to be further enhanced. There is also a range of benefits to wider rehabilitation services as the investments and raising of standards in rehabilitation, driven by the establishment of the South Wales Trauma Network, will positively impact a wider range of patients and services.

As discussed in chapter three and based on experience of enhanced survival in NHS England, approximately an extra 14 lives will be saved per year, over and above the current position. For the given investment, this would equate to a cost of lives saved of approximately £17 million per year. Thus, the service will pay for itself in terms of economic benefit. What is more challenging to understand, is the totality of improvement in functional outcomes for all survivors with investment across the pathway, and how this could lead to cost avoidance in long term rehabilitation and social care. Whilst predicting that the network will be cost effective, how this could be objectively measured needs further consideration.

With investment across the pathway and the requisite clinical informatics requirements, development of the South Wales Trauma Network presents a unique opportunity to evaluate the cost effectiveness of the whole system and not just its component parts in isolation. The development of a research programme, not just including TARN and TARN PROMS/PREMS data, but longer term outcomes, will give the network an opportunity to identify reductions in health and social care utilisation, leading to a broader evaluation of economic value. Material links with academic centres such as Swansea University already exist, through the Secure Anonymised Information Linkage (SAIL) Databank, and network opportunities with the Victorian State Trauma Service (above), present attractive opportunities for the network. Of course, some key aspects need to be in place in order to be able undertake a long-term evaluation of any system. Firstly, a strong appetite for research, with a robust platform for collecting high quality data, secondly, time for a stable and mature system to develop and finally, getting the building blocks in place for the system to work collaboratively and in synchrony. These are key aims of the network and align with key investment objectives.

10.4 Value of the Network

Linked to cost effectiveness of the network, value will come from realising benefits, which form a significant part of chapter three and has been developed further in the management case, into a

comprehensive benefits realisation plan. Whilst it is imperative that the network focuses on the key investment objectives of improving survival and functional outcomes, one of the areas that will be measured are the wider system benefits. This will focus on the enhancing and adapting of existing and new roles within the workforce, cross health board working arrangements, the development and deployment of highly specialised posts and natural improvements in other areas of healthcare (e.g. spinal surgery, plastic surgical capability, and rehabilitation of non-traumatic complex neurological problems). It is helpful that there will be a fundamental shift in the way networks operate in Wales, with the opportunity for others to benefit from the learning that will take place during the lifetime of the programme and beyond. Whilst difficult to quantify, qualitative analysis of these benefits will be undertaken to demonstrate wider value.

10.5 Options in Developing the Operational Model

10.5.1 Development of options/recommendations for the location of the Major Trauma Centre

Initial work

In late 2014, the NHS Wales Health Collaborative was asked by the Chief Executives in NHS Wales to develop a service model for a major trauma network for South Wales, West Wales and South Powys.

North Wales and North Powys were not included in the project. Betsi Cadwaladr University Health Board was already part of the North West Midlands and North Wales Major Trauma Network, with patients in North Wales having access to the major trauma centre in North Staffordshire. Patients in North Powys also benefit from being part of the North West Midlands and North Wales Major Trauma Network and access treatment and care via the trauma unit in Shrewsbury. Some patients in Powys are also served by the Birmingham, Black Country, Hereford and Worcester Trauma Network.

A Project Board was established, supported by a Clinical Reference Group (CRG). The service model for major trauma services for adults and paediatrics was developed by the CRG, in line with the NHS England standards for major trauma, and approved by the Project Board in May 2015, with further work on phasing undertaken more recently.

Option Appraisal

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

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

The workshop considered five options:

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

The benefit criteria applied at the workshop were:

Benefit Criteria	Definition/Coverage	Weighting %
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 South Wales Plan 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 European Working Time Directive (EWTD) and clinical training standards; Attracts and retains an excellent workforce across all staff groups; Delivers the critical mass required to achieve full benefit from resources and investment; Does not destabilise other clinical services / developments; Provides business continuity and service contingency in the event of a major incident, etc.	25
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 MTC and trauma units; Avoidable transfers minimised.	15
Total		**100**

The participants in the workshop determined that the preferred option was a MTC on a single site based within the region and supported by a number of TUs:

Option	Base option appraisal (out of 200)	Reverse weighting		Equal weightings (out of 200)	Non average scores for detailed sub benefits (out of 1,020)	Non average scores AND equal weightings (out of 920)	Individual group scores		Add 5% to option 2 (up to maximum) (out of 200)
		a. With Strategic Fit weighted higher (out of 200)	b. With Access weighted highest (out of 200)				Groups 1 / 3 / 5 (out of 200)	Groups 2 / 4 / 6 (out of 200)	
1. Do nothing	34.2	43.3	45.0	40.0	167.5	180.0	18.5	49.8	34.2
2. Single site - UHW	176.5	169.4	168.8	172.0	910.0	800.0	177.3	175.7	184.9
3. Single site - Morriston	179.7	176.8	177.1	177.3	922.5	820.0	180.3	179.0	179.7
4. Dual site - UHW & Morriston	107.7	118.1	123.8	118.0	527.5	530.0	94.5	120.8	107.7
5. Outsourced service	89.8	84.3	88.3	86.3	472.5	410.0	94.7	84.8	89.8

Full sensitivity analyses are included in Appendix 7.

The workshop did not result in a recommendation on a preferred location for the MTC. However, in identifying the preference for a single site, Morriston Hospital, Swansea and University Hospital of Wales (UHW), Cardiff, were assessed to be the only two hospitals in the region that could potentially meet the criteria for a major trauma centre, due to the specialist nature of the service and the need for it to be co-located with relevant specialist services. This aligns with the analysis presented the above table.

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

The Independent Panel

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

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

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

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

The Independent Panel was asked to undertake the following:

- Review the service model and specification for major trauma services for adults and paediatrics, across the region.
- Consider supporting evidence from Abertawe Bro Morgannwg UHB and Cardiff and Vale UHB for the provision of a MTC at Morriston Hospital, Swansea or the University Hospital of Wales (UHW), Cardiff as part of the major trauma network for the region
- Provide an independent view on the two options for the location of the MTC.
- Provide a view on the phasing of any implementation requirements and priorities for investment within a MTC.
- Advise on the impact on remaining services at Morriston Hospital and UHW Hospital in the event they are not identified as the MTC.
- Advise on the preferred location of a MTC for the region.

Recommendations from the Independent Panel for a Major Trauma Network

After considering the evidence, the Independent Panel made the following five recommendations in their report:

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

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

- Clinical interdependencies, i.e. the services that need to be available at the location of the MTC, as set out in the relevant standards
- Critical mass, i.e. the minimum number of people needed to make a service, in this case major trauma, sustainable.
- Travel times: The Panel considered the geography of Wales and concluded that, with the provision of a major trauma centre in the region, individuals would be more likely to survive a major trauma, regardless of the time it takes to travel to the MTC.

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

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

in principle, to the above recommendations of the Independent Panel as the basis for a formal consultation.

Consultation Process

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

The consultation process took place between November 2017 and February 2018.

The outcome of the consultation was analysed and the recommendations developed as a result, i.e. to support the recommendations of the independent panel (detailed above), were reported and approved by the six health boards in the region in March 2018.

10.5.2 Designation of Trauma Units

With clarity on the location of the Major Trauma Centre (MTC) at University Hospital Wales, a decision was made by Network Board to commence the process for Trauma Unit (TU) designation, in order to inform programme-planning, preparation for delivery and ensure rapid implementation.

In May 2018, the network board requested that Health Boards complete a baseline assessment against NHS England quality indicators for those hospitals that were being proposed as 'candidate Trauma Units.' Information was provided as to which indicators needed to be met for day one and which could follow once operational.

Following due diligence and scrutiny, recommendations for TU designation were made in November 2018 to WHSSC Joint Committee and endorsed. In respect of Hywel Dda, a period of engagement was undertaken from June to August 2019 on TU designation, which resulted in recommendations being reported to and supported by the health board in September 2019.

TU designation has been based on which hospitals most closely comply with the NHS England quality indicators and service specification, and achieve alignment with health boards existing and future plans, as follows:

Cardiff & Vale University Health Board	
University Hospital Wales (UHW) - Adult and Paediatric TU	Rationale: it is important that in addition to being an MTC, UHW's TU capability is considered separate from its MTC capability. UHW has been chosen due to availability of onsite services and specialities that are not available at Llandough hospital.

Swansea Bay University Health Board	
Morriston Hospital – Adult and Paediatric TU (with specialised services to be considered in subsequent programme planning)	Rationale: the independent panel review indicated that Morriston Hospital would be a large TU. The designation is in line with the current local and regional role in providing trauma care and in line with the emerging clinical strategy for the Health Board.

Aneurin Bevan University Health Board	
Royal Gwent Hospital – Adult and Paediatric TU	Rationale: Royal Gwent Hospital and Nevill Hall Hospital will be designated TUs to cover the interim period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Health Board. As such, a pragmatic approach will be required on how additional TU requirements are met during the short interim period and this will form part of the implementation phase of the network development. The Health Board has indicated that they will consider, in principle, the impact on patients within the region without a nearby TU and how this could be managed through network protocols.
Nevill Hall Hospital – Adult and Paediatric TU	
Grange University Hospital – Adult and Paediatric TU	

Cwm Taf Morgannwg University Health Board	
Prince Charles Hospital – Adult and Paediatric TU	Rationale: Prince Charles Hospital is the only potential site between South Powys and the M4 corridor. The area covered by the Health Board is often sites of high-speed road traffic collisions and major trauma.
Princess of Wales (POW) Hospital – Adult and Paediatric TU	Rationale: in anticipation of the move the management of POW hospital from the former ABM UHB to Cwm Taf Morgannwg UHB from April 2019, both outgoing and incoming Health Boards supported the designation of POWH as a TU.

Royal Glamorgan Hospital will be a Local Emergency Hospital for the purposes of major trauma.

Hywel Dda University Health Board	
Glangwilli General Hospital – Adult and Paediatric TU	Rationale: this is the only hospital available with all the requisite specialities and support services on site. There is a longer-term plan for a single TU within the Health Board to be developed at a new hospital on a site between St Clears and Narberth. The designation of Glangwilli General Hospital as the interim TU was approved in September 2019 following a period of engagement conducted by Hywel Dda UHB

Bronglais General Hospital and Withybush General Hospital will be rural trauma facilities for the purposes of major trauma.

Powys Teaching Health Board	
No TU	Rationale: there are no acute hospitals in Powys Teaching Health Board. Trauma patients will utilise existing patient flows into neighbouring Health Boards and England (e.g. TU at Hereford General Hospital). The development of Prince Charles Hospital and Nevill Hall Hospital as TUs will support Powys patient flows pertaining to the management of major trauma patients. The expansion of the EMRTS will also support this population.

The designation of TUs will be reviewed after the first year of being operational and national annual trauma peer review.

11 Commercial Case

This section of the Programme Business Case (PBC) outlines the proposed procurement requirements in respect of the preferred way forward, as determined by the South Wales Major Trauma Network service configuration.

Establishment costs that are not capital are all under £50,000 and will be subject to NHS Standing Financial Instructions. All expected procurements in 2019/20 are likely to be based on closed tenders or three quotations. The procurement route for all equipment identified within the Cardiff and Vale UHB case will be through existing All-Wales framework agreements.

Capital infrastructure cases for the Major trauma Centre (MTC), Hywel Dda Trauma Unit and any requirements from Swansea Bay UHB for specialist supporting services will follow Welsh Government capital investment processes agreed directly between Welsh Government and the relevant health board.

The capital identified by the health boards is outlined in the table below:

Programme Capital Requirements					
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
MTC Cardiff & Vale (MTC Construction and Equipment)	£5,426				
Hywel Dda Trauma Unit (West Wales General)			£1,252		
Capital Total	**£5,426**	**£0**	**£1,252**	**£0**	**£0**

The Cardiff and Value UHB capital requirement is outlined below:

Cardiff and Vale UHB Capital Requirements 2019/20

	Construction	**Equipment**	**Total**
	£000s	**£000s**	**£000s**
Emergency unit - Resus bay equipment costs	£0	£134	£134
Extension, resus, streaming and triage bay refurbishment	£436	£0	£436
Room alterations to provide additional minors capacity	£150	£0	£150
Interim refurbishment of Polytrauma Unit (PTU) 14 beds	£1,109	£383	£1,492
Critical Care bed expansion – equipment only	£0	£194	£194
Theatres – Capital equipment including plastics	£0	£1,100	£1,100
Theatres - image intensifier	£0	£120	£120
Replacement scanner for emergency unit	£600	£1,200	£1,800
	£2,295	**£3,131**	**£5,426**

The enabling infrastructure development in Cardiff and Vale UHB will be procured via a separate contract arrangement through Cardiff and Vale UHB and Welsh Government. The total value of these works is approximately £5.4m, with the largest contract element being £1.2m. These contracts will be awarded following procurement processes that will be managed by the procurement and capital estates function of Cardiff and Vale UHB.

The estimated future capital requirement for the MTC theatres at the time of publication is in the region of £20-25m. Note that this is an integrated capital scheme which includes the vascular hybrid theatres.

Hywel Dda UHB has identified £1.25m for the development of a 10 bedded landing pad in Year 2 (2021/22) at Glangwili General Hospital, Carmarthen. However, it is envisaged that the Year 1 approach will be in-keeping with all other health boards, with consideration given to a dedicated landing pad, as appropriate, following a period of evaluation of actual activity.

11.1 Risk Transfer

This section provides an assessment of how the associated risks might be apportioned between the service and contractors. Cardiff and Vale UHB will develop a full risk-transfer matrix through the capital infrastructure business cases that will be required for the final MTC business solution.

11.2 Procurement strategy

The approach to procurement is set-out above, with the acquisition of capital assets to be discharged through existing NHS Supply Chain frameworks.

11.3 IFRIC 12 / FRS5 Accountancy Treatment

This business case describes the totality of investment required for the establishment of the South Wales Major Trauma Network. The purchase and construction of assets within the network will be held on the balance sheet of each purchasing organisation.

11.4 HM Treasury Guidance.

It is recommended that Cardiff and Vale UHB take guidance from the HM Treasury relating to IFRIC 12, which is guidance only applying to infrastructure.

Because the programme will not have any ownership of assets deployed across the network there will be no need to apply Treasury Guidance on treatment of the assets and whole life costs through this business case. The schedule of capital equipment/schemes identified as requirements by Cardiff and Vale UHB and Hywel Dda UHB will need to take account of the requirements of the HM Treasury rules.

12 Management Case

12.1 Introduction

The management case sets out the 'achievability' of the programme. Its purpose, therefore, is to build on the preceding chapters by setting out, in more detail, the actions required to ensure the successful delivery of the trauma network against the agreed investment objectives and timeline. To achieve this, it sets out the programme management arrangements and implementation plan. It gives details of the commissioning arrangements and considers how these will affect the organisational and clinical governance arrangements once the network is operational.

This chapter also sets out the current programme management arrangements, handover arrangements to the Operational Delivery Network (ODN) and post programme assurance and evaluation. Finally, it describes the arrangements for benefits realisations and risk management over the programme timeline in detail.

12.2 Current Programme Management Arrangements

12.2.1 Programme Sponsorship

The NHS Wales Health Collaborative (the Collaborative) has hosted the programme for the implementation phase, which includes programme planning and preparation for delivery. It has been agreed that Swansea Bay University Health Board, will host the ODN, in keeping with the recommendations of the independent panel review. The WHSSC Joint Committee confirmed this decision at its meeting on 26 March 2019.

In order for the Collaborative to enable health boards to successfully deliver this service change, it has taken the following approach in the organisation and management of the programme:

- The programme has adopted the general principles of PRINCE-2 methodology in managing the programme's activities and outputs and will meet the requirements of the WHC (2006): 001, Capital Investment Manual, NHS and Treasury Guidance, and any subsequent guidance that may be issued during the programme's lifespan.
- The project has used NHS standard documentation and products, where these are available, and has sought to benefit from experience and best practice from other NHS programmes.
- Specialist professional and technical advisers were employed for those activities where the necessary skills and experience were not otherwise available within the programme. The transfer of skills and knowledge from specialist advisers to the programme team was achieved, wherever possible and appropriate.

The above approach will continue to be utilised as the programme progresses. In managing the programme, the Collaborative aims to:

- Deliver the programme on time.
- Ensure effective and proactive lines of accountability and responsibility for the programme deliverables.
- Establish stakeholder involvement at all stages.

12.2.2 Programme Structure and Reporting

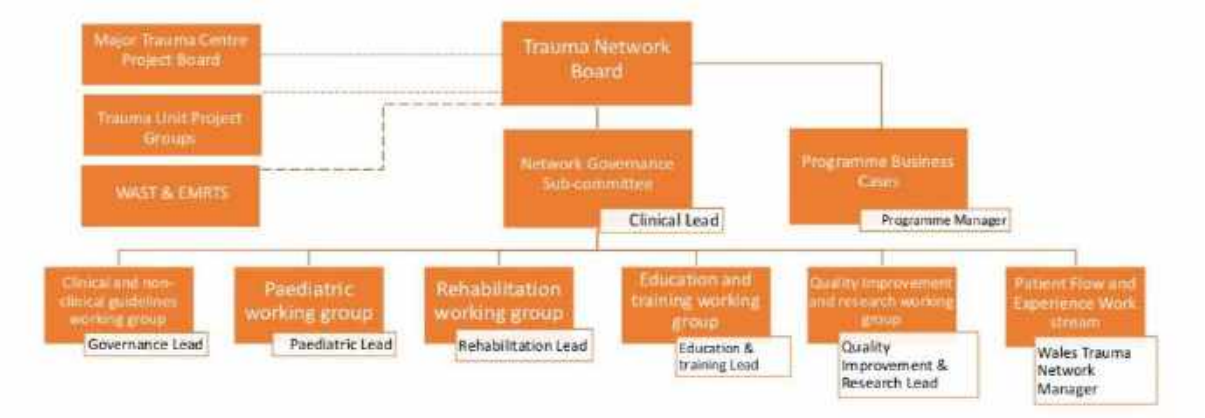
Trauma Network Board and Overarching Structure

Following approval of the recommendations of the independent panel review by health boards, the trauma network board was established in May 2019 and meets monthly (see Appendix 19 for terms of reference and full membership). The Senior Responsible Officer (SRO) for the programme is Tracy Myhill, Chief Executive Officer, Swansea Bay University Health Board. The SRO and Dr Mark Ramsey, Medical Director, Morriston Hospital, jointly chair the network board. The network board is made up of senior clinical and managerial representation from all participating organisations including health boards, WAST and EMRTS. It also has representation from WHSSC, EASC, therapies and Welsh Government.

The network board is responsible for:

- Establishing and delivering a programme for the development of a high quality, safe and effective trauma network for the population of South Wales, West Wales and South Powys.
- Providing strategic direction and advice to the programme.
- Delivering the programme on time and to budget.
- Ensuring effective and proactive lines of accountability and
- Ensuring programme deliverables, including approval of pathways, policies and procedures.
- Ensuring that decisions are taken through correct channels and that wider communication with senior NHS management is functional.
- Ensuring continuing commitment to stakeholder support.
- Monitoring and risk management of the programme.
- Establishing user involvement at all stages of the programme.

The network board is accountable to, and reports to, the WHSSC Joint Committee for the activities outlined above. The figure below illustrates the governance arrangements of the programme:



Internal Programme Governance Structure

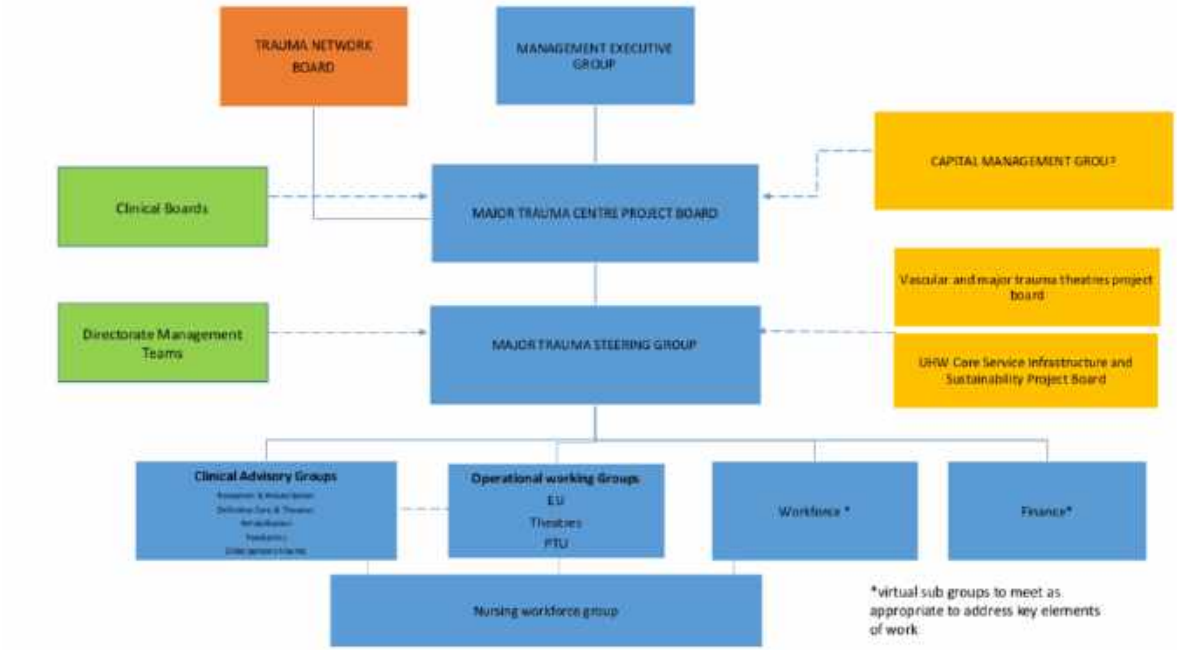
Within the internal governance structure, all members of the team are accountable to the Director of the Collaborative. A programme business case team has been created, consisting of the network clinical lead, head of planning for the Collaborative, programme manager and administrative support. In addition, a number of working groups have been created, led by respective network leads. The

groups draw upon the experience of clinicians and managers from across the region. Responsibilities of these groups include:

- Clinical and non-clinical guideline working group – development of trauma management guidelines.
- Paediatric working group – development of paediatric specific guidelines, addressing safeguarding issues and input into paediatric trauma education and training.
- Rehabilitation working group – operational planning, key workforce enablers, rehabilitation plans and advising on the 'landing pad' configuration.
- Education and training working group – developing a strategy in partnership with HEIW as well as development and quality assurance of products (see chapter 5).
- Quality improvement and research working group – supporting improvement in TARN data collection, as a platform for quality improvement and research initiatives. Developing metrics for quality assurance and commissioning.
- Patient flow and experience working group – specific focus on 'care with treatment closer to home'.

The working groups report to the monthly network governance subcommittee, chaired by the network clinical lead (see Appendix 20). The governance subcommittee consists of the network leads, MTC/TU clinical leads, pre-hospital representatives, senior managers and external peer representation from North Wales and NHS England. The purpose of the committee during the implementation phase is to provide review and scrutiny of the work undertaken by working groups. The subcommittee is accountable and responsible to the network board. It reports to the network board through the network clinical lead.

MTC Programme Governance Structure



The MTC programme structures indicated above are operational and report to the network board in respect of programme delivery and, within Cardiff and Vale University Health Board, to the Management Executive Group. The Executive Director for Planning is the SRO for the MTC programme. The network clinical lead sits on the MTC project board.

Health board and Pre-Hospital Programme Governance Structures

Each health board has established a trauma project group to support implementation of trauma services within its catchment area, which reports to the network board. A member of the health board's executive team chairs the group in most cases. In order to ensure consistency of the scope of each group, the network board supplied each health board with generic terms of reference. Each health board has also established a rehabilitation group, feeding into the network rehabilitation working group. Finally, a joint rehabilitation group has been established between Swansea Bay University Health Board and Hywel Dda University Health Board to determine how a collaborative rehabilitation model could be developed.

In relation to pre-hospital services, the governance arrangements for the Welsh Ambulance Service NHS trust (WAST) sit within the planning directorate and for EMRTS with its clinical and operational board. These also report to the network board. WAST has also nominated individuals to all relevant working groups. Internally, WAST has established a major trauma project group, which is constituted of all personnel who represent the organisation at the above external boards and task and finish groups. This project group will meet monthly until the network goes live.

The network has asked all participating organisations to provide a structured written report to each network board meeting. Each report outlines progress towards developing the service specification and quality indicators, confirms adherence to the network implementation plan and highlights key areas of local risk. These reports enable the network board to understand the cumulative risk and support health boards to mitigate specific risks.

Welsh Government Trauma Policies Group

In November 2018, a trauma policies group was established, bringing together policy leads relevant to major trauma services and including representation from NHS capital and revenue finance teams. The policies group meets monthly, chaired by Professor Chris Jones, Deputy Chief Medical Officer, Welsh Government. The meetings provide a forum in which the Collaborative programme team, WHSSC and the MTC programme team have an opportunity to present aspects of the development with policy leads, who provide support, challenge and scrutiny. All information presented at the policy group is discussed first at the trauma network board.

Programme Resource

In order to progress the development of the trauma network, resources were secured from Welsh Government in order to appoint into a number of key enabling posts in December 2018. Welsh Government has funded these posts and appointments have been made to them on a non-recurrent basis until the end of March 2020. This is reflected in the financial case (Chapter 9). The requirements for ongoing resources are described within organisational requests (Chapters 5, 6, 7 & 8). The table below provides an outline of existing appointments and additional posts, with additional posts being funded from the resources secured through Welsh Government:

Collaborative	Network clinical lead – existing fixed term appointment Critical care and trauma network manager (CCTN) – existing appointment Project support officer – existing appointment Programme manager – additional post, appointed Network lead positions (governance, paediatric, rehabilitation, training and education, quality improvement and research) – additional posts, all appointed

MTC	Programme director – additional post, appointed Clinical lead and deputy clinical lead HR support – additional post General manager Administrator
All other Health Boards/WAST	Programme manager and project support officer – SBUHB and HDUHB, additional posts Programme manager and project support officer – CTMHB, ABUHB and PTHB, additional posts health board clinical leads (2 for CTMUH), additional posts, partially appointed WAST planning officer, additional post, appointed
WHSSC	Planning lead – additional post, appointed Finance lead – additional post

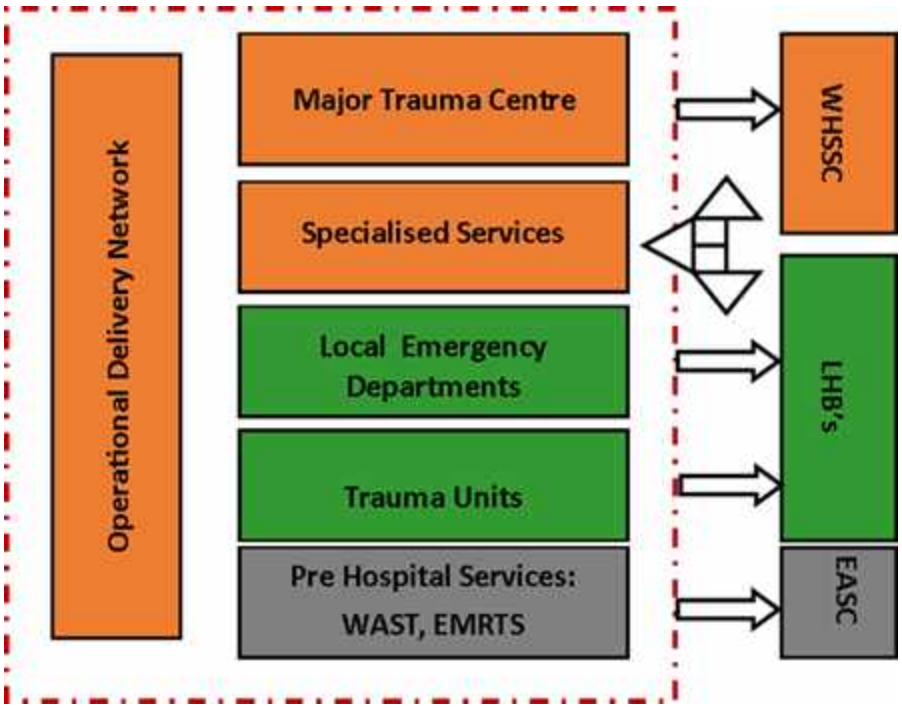
In addition to the above programme, resource was secured for early deliverables in relation to training and education, specifically in relation to surgical skills training. This is outlined in Chapter 5.

12.3 Commissioning Arrangements

At the September 2018 meeting of the WHSSC Joint Committee, members agreed the scope of the commissioning framework for Major Trauma (MT) which can be summarised as:

- An Operational Delivery Network (ODN) to be established to oversee the delivery of trauma services to the population of South Wales, West Wales and South Powys.
- The ODN and Major Trauma Centre at University Hospital of Wales will be commissioned by the Welsh Health Specialised Services Committee.
- Emergency Ambulance Services Committee (EASC) will commission WAST and the EMRTS.
- Health boards will be responsible for local commissioning.
- Existing trauma commissioning arrangements for Betsi Cadwaladr University Health Board will be retained.

The commissioning responsibilities for the major trauma functions held by NHS organisations within the network is illustrated in the diagram overleaf.



As illustrated above, the health boards retain the commissioning responsibility for the Trauma Units.

Under this model, the performance management arrangements would mirror those of services currently commissioned by the two Joint Committees of WHSSC and EASC respectively (see below).

12.3.1 Commissioning Responsibility for Pre-hospital Services

The Emergency Ambulance Services Committee (EASC) commissions WAST and the EMRTS. EASC includes the National Collaborative Commissioning Unit as one its functions. EASC consists of a joint committee that acts on behalf of all health boards in undertaking its function.

Ambulance commissioning in Wales is a collaborative process, underpinned by a national collaborative commissioning quality and delivery framework. All seven health boards have signed up to the framework. Emergency ambulance services in Wales are provided by a single national organisation, WAST.

The framework puts in place a structure that is clear and directly aligned to the delivery of better care. The framework introduces clear accountability for the provision of emergency ambulance services and sees the Chief Ambulance Services Commissioner (CASC) and EASC acting on behalf of health boards and holding WAST to account as the provider of emergency ambulance services.

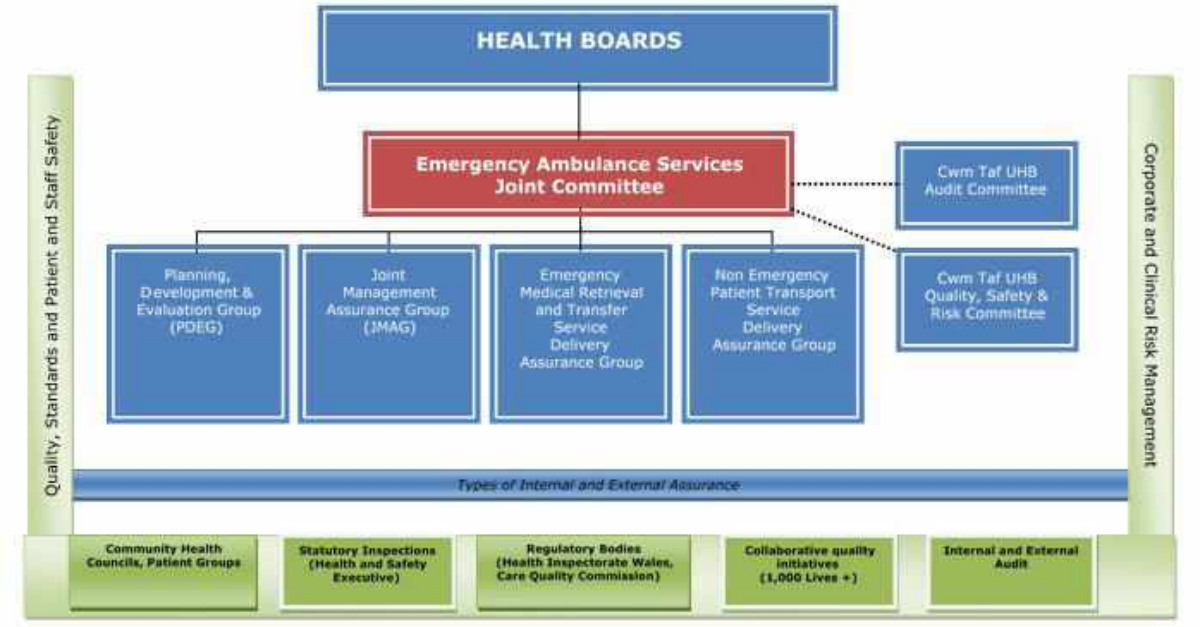
The Emergency Ambulance Services Committee ("Joint Committee") is made up of the chief executives of the seven health boards, **Chief Ambulance Service Commissioner** (CASC) and an independent chair, both appointed ministerially.

The seven health boards in Wales are required under legislation to work jointly to exercise functions relating to the planning and securing of emergency ambulance services. The CASC exercises these duties on behalf of the Joint Committee. EASC supports the commissioning intentions and the financial envelope required to improve and deliver ambulance services across Wales.

The National Collaborative Commissioning Unit (NCCU) is responsible to the CASC for the delivery of services to EASC. This entails ensuring that safe, effective and timely services are delivered. It also includes the creation, development, operation, refresh and evaluation of National Collaborative

Commissioning: Quality & Delivery Frameworks for ambulance services within NHS Wales covering Emergency Ambulance Services, Non-Emergency Ambulance Services and Emergency Medical Retrieval Transport Services.

EASC Governance Framework



12.3.2 Local Health Board Commissioning Responsibility

Each health board will retain the commissioning responsibility for its local trauma services.

The following hospitals were approved as adult and paediatric TUs, following a recommendation by WHSSC Joint Committee and health boards:

- UHW, Cardiff – TU function for its own population.
- Morriston Hospital, Swansea – TU with specialist services
- Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Aneurin Bevan University Health Board)
- Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend.
- Glangwili General Hospital

Royal Glamorgan Hospital, Llantrisant, will be a local emergency hospital (LEH) within the network structure

Bronglais General Hospital, Aberystwyth and Withybush General Hospital, Haverfordwest will be rural trauma facilities for the purposes of major trauma.

The commissioning arrangements for the Major Trauma Centre at UHW and the Trauma Unit at Morriston Hospital are complex, as within both of these hospitals there are specialised services,

commissioned by WHSSC on behalf of health boards, and non-specialised services, directly commissioned by the health boards. This is illustrated in the tables below.

Commissioning Responsibilities for Acute Phase

	Acute phase (continuum into ongoing care and reconstruction)																
	Emergency radiology ED	MRI 24/7	Teleradiology MTC <>TUs	General Surgery	Ophthalmology	ICU	Theatres / Anaes	Orthopaedic surgery	Plastic surgery	24/7 Interventional radiology	Vascular/ endovasc surgery	Cardiothoracics	Max-facial surgery	Neurosurgery	Spinal surgery	Liver surgery	Burns
MTC	**H**	**M**	**H**	**H**	**H**	**M**	**M**	**H**	**W**	**M**	**H**	**W**	**H**	**W**	**H**	**W**	**W**
TU	**H**	**M**	**H**	**H**	**H**	**M**	**M**	**H**	**W**	**M**	**H**	**W**	**H**	**W**	**H**	**W**	**W**

Commissioning Responsibilities for Ongoing Phase and Reconstruction

	Ongoing care and reconstruction									
	Radiology – MRI, IR, angiography	Critical care	Rehabilitation	Specialist rehabilitation	Specialist acute pain service	Craniofacial trauma support	Haematology	Obs/gynae	Respiratory physiotherapy (for pneumothoraces, chest drain and thracheostomies)	Complex peripheral nerve support
MTC	**M**	**M**	**H**	**W**	**M**	**W**	**H**	**H**	**H**	**H**
TU	**M**	**M**	**H**	**W**	**M**	**W**	**H**	**H**	**H**	**H**

Key

W	WHSSC
H	Health Board
M	Mixed – elements of WHSSC and Health Board commissioning

12.3.3 Commissioning of the Operational Delivery Network

The ODN team hosted by Swansea Bay UHB will be commissioned by WHSSC through an agreed SLA, and underpinned by quality and performance indicators. Managerial/executive responsibility is provided by the chief executive of the host organisation.

Each organisation participating in the trauma network will discharge its clinical and managerial responsibilities within its own organisational structures.

In addition, the ODN will be performance managed and benchmarked through national peer review and TARN submissions (TARN submission is mandatory for all Health Boards under the annual national clinical audit and outcome review annual plan).

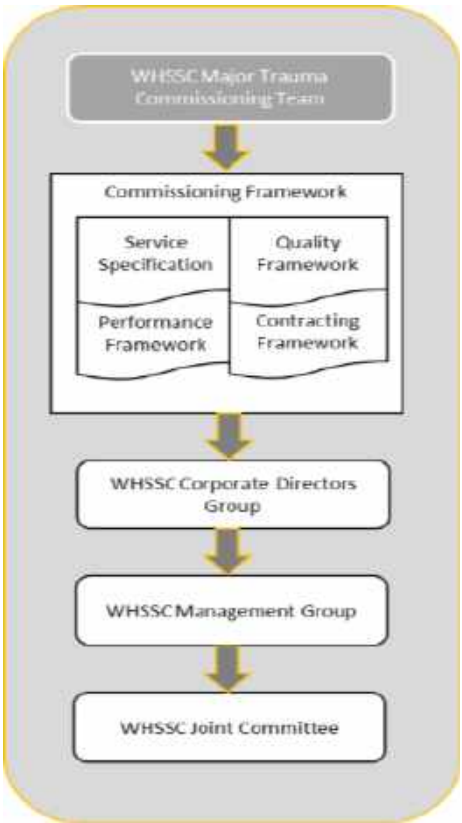
12.3.4 WHSSC Organisational Structure

The **WHSSC Joint Committee**, whose membership is made up of an independent chair, independent members, the seven Health Board Chief Executives and other officers, has overall responsibility for the joint planning of specialised services and financial performance of WHSSC on behalf of health boards. Requests for approval of decisions at Joint Committee level are often informed by the **WHSSC Management Group**, which is made up of commissioners and finance representatives from each health board and provides a scrutiny and assurance function to items such as performance reports and business cases requesting funding.

Internally, the **WHSSC Corporate Directors Board** meets monthly to monitor performance and assess cases before progressing to Management Group and/or Joint Committee.

Beneath this, the WHSSC planning function is delivered through a speciality-based model of commissioning teams with representatives from planning, finance, quality and medical representatives. A **major trauma commissioning team** has been established and will work alongside the other commissioning teams, which include neurosciences, cardiac and the renal network, which is a commissioning network hosted by WHSSC.

The diagram below illustrates the WHSSC decision making process.



The Joint Committee is established as a Statutory Sub Committee of each of the health board in Wales. It is led by an Independent Chair, appointed by the Minister for Health and Social Services, and membership is made up of three Independent Members, one of whom is the Vice Chair, the chief executives of the Local Health Boards, Associate Members and a number of Officers.

Whilst the Joint Committee acts on behalf of the seven health boards in undertaking its functions, the responsibility of individual health boards for their residents remains and they are therefore accountable to citizens and other stakeholders for the provision of specialised and tertiary services.

12.3.5 Roles and Responsibilities of Commissioners

The table below sets out the roles for WHSSC, EASC, and the Major Trauma Network in developing and implementing the core elements of the commissioning framework.

	WHSSC	**EASC**	**Trauma Network**
Commissioning	Scrutinising and approving the business cases for the Major Trauma Centre Scrutinising business cases for Trauma Units and rehabilitation services, to ensure alignment with MTC and Network – providing advice to the commissioning health boards Monitoring the quality and performance framework for the MTC, TU, Network and Rehabilitation Services Clarifying and developing the role of Morriston Hospital as a large trauma unit and provider of national and regional specialised services Developing financial framework Developing contracting framework across the network Developing commissioning policies and future service specifications for the MTC, TUs, and the Network	Scrutinising and approving the business cases for WAST and EMRTs Performance monitoring/management of WAST and EMRTs	Supporting the development of business cases for the Major Trauma Centre, WAST and EMRTs Supporting the implementation and monitoring of the quality and performance framework Ensuring compliance with the commissioning policies

			and service specifications across the Network
Operational and Governance	Approving the operational and governance structure for the wider network including the TUs Boards Approving the designation criteria for TUs		Developing the operational and governance structure for the network and Trauma Unit Boards Designating of TUs
Delivery	Scrutinising and approving (through the WHSSC Joint Committee in partnership with EASC) the pathways for: • Pre-hospital assessment • Acute trauma care • Acute rehabilitation • Rehabilitation and re-ablement	Working in partnership with WHSSC to scrutinise and approve (as appropriate) the pathways for: • Pre-hospital assessment • Acute trauma care • Acute rehabilitation • Rehabilitation and re-ablement	Developing the pathways for: • Pre-hospital assessment • Acute trauma care • Acute rehabilitation • Rehabilitation and re-ablement

12.3.6 Contracting Framework

As part of the commissioning framework, WHSSC will develop a contracting framework for the MTC, with health boards retaining the responsibility for developing their own contracting arrangements for the Trauma Units.

WHSSC is responsible for implementing the contracting framework for both the MTC and the trauma ODN. This framework will ensure that health boards appropriately contribute to the cost of the MTC and the trauma ODN and that there is appropriate 'risk sharing' between health board commissioners and the providers for the operating costs of the MTC which will include adjustment for variation in performance and cost of delivery.

The WHSSC Finance sub group, made up of representatives from the seven health boards, considered options for contracting the MTC and agreed that a block contract with variations would be the preferred method in the formative years of the MTC.

This option sees an agreed block fee to cover the availability of the service, varied by agree d rebates for under-performance and/or any service unavailability or cases declined.

Once there is more certainty around staff appointment profiles, which are the most significant component of MTC costs, and clear outcomes from submission of data including through TARN, the preference of commissioners is to move to a cost and volume contract that would initially be tested in shadow form. The fixed component would be designed to recognise the importance of availability of key service inputs. The variable component would ensure a method that adapts the payments by commissioners to account for actual cost of delivery and performance level variation.

In both phases of implementation of the contracting framework, there will have to be clear information available to commissioners detailing actual staffing levels. Failure to recruit or retain staff at funded levels would trigger an appropriate financial adjustment.

12.3.7 WHSSC Quality and Performance Monitoring

Commissioning teams are responsible for developing service specifications and policies that guide individual services and outline the key performance and quality indicators and standards that the service is expected to adhere to. WHSSC is responsible for the service specifications for both the MTC and the ODN.

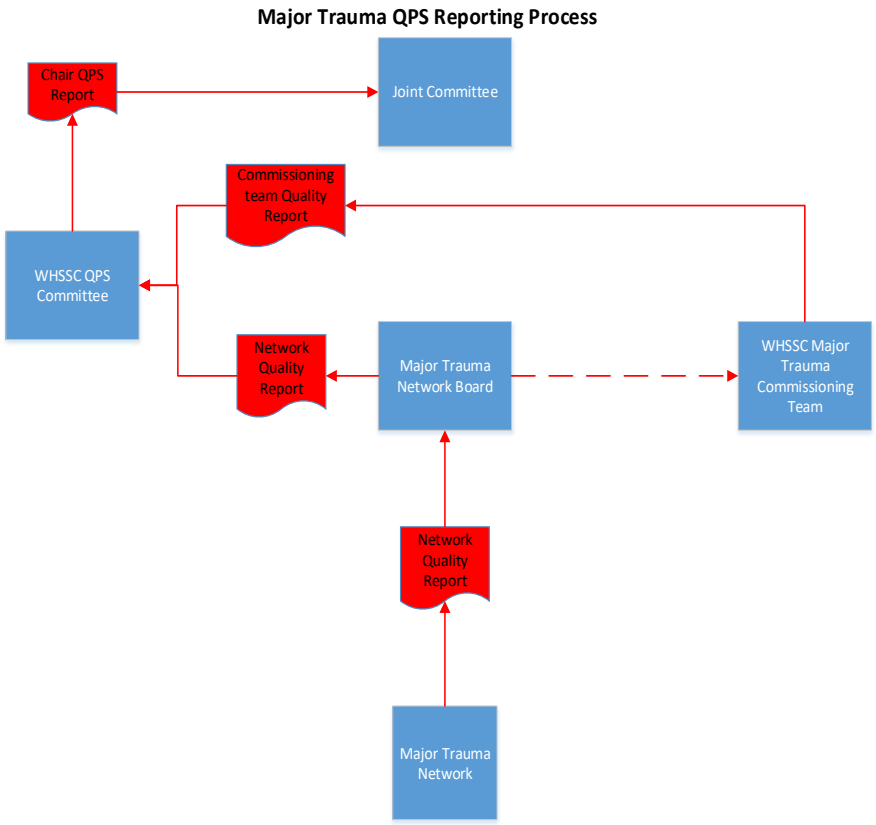
Service specifications are important in clearly defining the core requirements that WHSSC expects to be in place for providers to offer evidence-based, safe and effective services and importantly ensure equitable access to services for Welsh patients. They describe the service to be provided, and the quality of service that WHSSC expects to be delivered. The specification also sets out the way in which the quality of the service will be measured, and how it will be monitored by WHSSC.

The consultation on the Major Trauma Network was informed by the NHS England Outcome Measures, with the assumption that these will be adopted upon implementation. These outcome measures are based upon the NHS England Service Specification which was developed by the NHS England Clinical Reference Group for Major Trauma.

Joint Committee, following the advice of the Major Trauma Network Board, has agreed to develop a service specification and outcome measures that are appropriate for NHS Wales but informed by the NHS England Outcome Measures.

The development of the service specification and outcome measures will be undertaken through the established WHSSC processes, using the policy and service specification consultation process, the WHSSC Management Group scrutiny process, and approval through the Joint Committee.

The WHSSC Major Trauma Commissioning team will work with the ODN to establish regular performance meetings and monitoring returns so that the network and MTC performance against these specifications can be monitored and shared as part of the monthly performance reports to Management Group and quarterly performance reports to Joint Committee.



WHSSC will work closely with Swansea Bay University Health Board (SBUHB) as the host of the trauma ODN, to ensure that major trauma is a standing item on the regular executive-led meetings that it holds with SBUHB to discuss quality, finance and performance issues.

12.4 Implementation and Mobilisation

12.4.1 Implementation Planning Activity

The independent panel recommended that a trauma network with a clinical governance infrastructure should be quickly developed, and that a clear and realistic timetable should be put in place to ensure it was established. In the Autumn of 2018, the network board developed an implementation plan.

There are multiple component parts to the Trauma Network and as part of the implementation and preparation for go live, tranches of funding have been released in order that recruitment can take place for MTC capability to be in place before the triage tool is made live. It is the triage tool that will determine which patients should go to the MTC and so until the system is ready, the tool remains inactive.

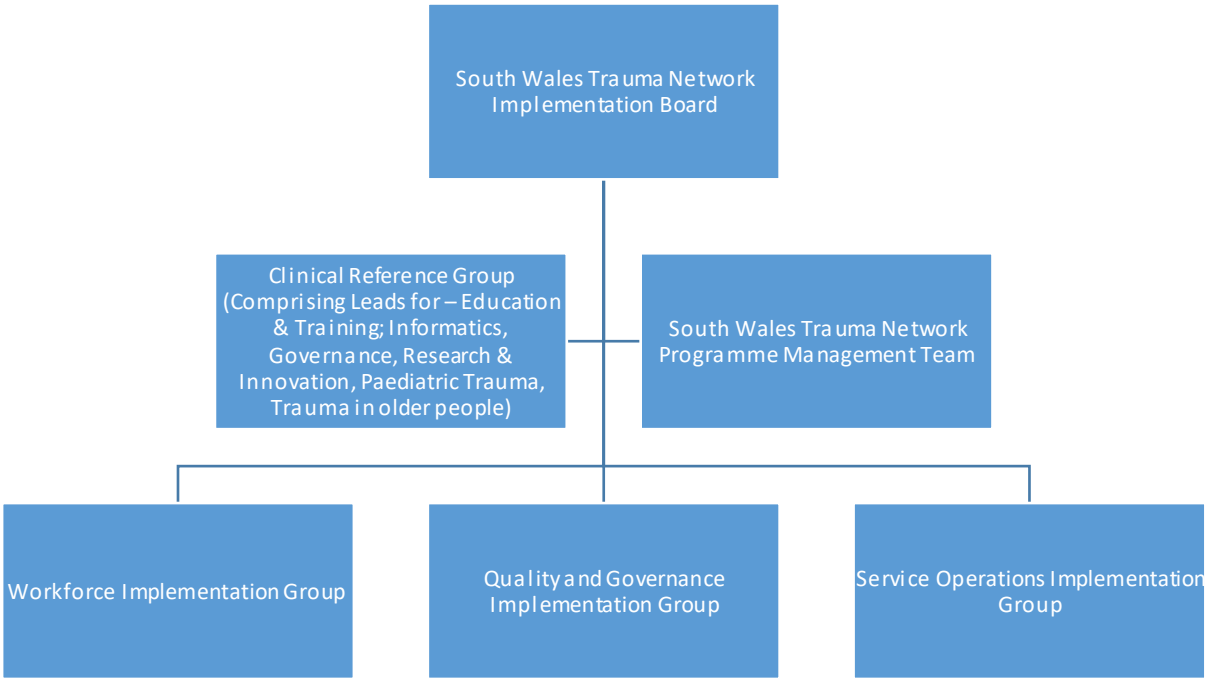
The ambition is for the network to go live on the 1st April 2020. However, final confirmation of this will be determined through the structure set out below and then agreed and signed off in conjunction with the lead commissioner by the implementation board.

12.4.2 Implementation Structure and Management Arrangements

As the network moves from its planning phase to implementation and operational delivery, hosting of the network will shift from the Collaborative to SBUHB. Draft implementation arrangements are illustrated below:

A robust and methodological programme arrangement will continue to be applied but the roles and representation across the programme will need to be amended as the focus moves from planning to execution.

The organisational structure for implementation is shown below:



12.4.3 Populating the Structure

The personnel involved in supporting and delivering implementation need to be balanced between seniority, service operational representation and ensuring all participating organisations are equitably represented.

Nominated Membership for Implementation

Implementation Board:

Meeting Frequency: 6 weekly

Chair: Tracy Myhill, Chief Executive SBUHB

Membership: One executive member representing each of the following:

- WHSSC
- EASC
- EMRTS
- Aneurin Bevan UHB

- Cardiff and Vale UHB
- Cwm Taf Morgannwg UHB
- Swansea Bay UHB
- Powys THB
- Hywel Dda UHB
- Welsh Ambulance Services NHS Trust
- Network Manager
- Programme Manager
- National Clinical Lead

Programme Team:

Frequency: Monthly

Chair: Network Manager

- Programme Manager
- 5 x sub group managerial leads
- 5 x clinical leads (incl. Network clinical lead)

Each Subgroup:

Frequency: Monthly

- 1 x clinical chair
- 1 x managerial lead (deputy chair)
- 1 x rep from each of the six health boards and WAST
- Programme Manager

Each participating organisation will be asked to identify up to five representatives, in order to ensure each sub group is appropriately representative of the system.

12.4.4 Critical Path

Following agreement of the indicative timeline, the network board set out a critical path in relation to the development of the programme business case and associated health board business case information.

The current implementation plan has been further developed and is in keeping with detailed implementation plans for the different elements.

For trauma units, these will be developed as part of the next phase of implementation , based on the overarching principles.

The timeline for approval of the Programme Business Case is outlined below:

Workstream	Task Name	Responsibility	Finish Date	07/10/2019	14/10/2019	21/10/2019	28/10/2019	04/11/2019	11/11/2019	18/11/2019	25/11/2019	02/12/2019	09/12/2019	16/12/2019	23/12/2019	30/12/2019
Approval Timeline	Final review / scrutiny of draft PBC in readiness for reporting to Network Board; engage with HB/WAST reps as required	Executive Strategy Group	14/10/2019													
	Sign-off final PBC and draft IMTP content; prepare for combined HB/WAST Board Briefing	Trauma Network Board	21/10/2019													
	Progress update and briefing on arrangements for HB/WAST Board Briefing	Collaborative Executive Group	22/10/2019													
	Brief on the content of the PBC, service phasing, quality, cost, risks, mitigations, in preparation for formal receipt at Board Meetings in November.	Combined Health Board / WAST Board Briefing	23/10/2019													
	Final review of PBC / preparation for reporting to Boards / Welsh Government	Executive Strategy Group	w/c 28/10/2019													
	Welsh government Scrutiny	Welsh Government	W/C 21/10/2019 and W/C 28/10/2019													
	Gateway 3 Review	Programme Team	28/10/2019													
	Briefing for CHC	Programme Team	w/c 04/11/2019													
	Receive final PBC / preparation for Board meetings / internal briefings within Health Boards / WAST	Health Board/WAST - Executive / internal governance meetings	w/c 04/11/2019 and w/c 11/11/2019													
	Papers issued by Health Boards / WAST for Board meetings	Health Board/WAST Board meetings	w/c 18/11/2019													
	Health Boards / WAST to receive PBC for approval and draft IMTP sections for approval	Health Board/WAST Board meetings	w/c 25/11/2019													
	Special meeting to agree commissioning for pre hospital component of PBC	EASC (Note - consider joint meeting for EASC and WHSSC JC)	w/c 02/12/2019 or 09/12/2019													
	Special meeting to agree commissioning for MTC, specialised services and ODN	WHSSC Joint Committee	w/c 02/12/2019 or 09/12/2019													

The current implementation plan for the South Wales Major Trauma Network:

Workstream	Task Name	Responsibility	Sep-19					Oct-19				Nov-19				Dec-19					Jan-20				Feb-20				Mar-20					
			02/09/2019	09/09/2019	16/09/2019	23/09/2019	30/09/2019	07/10/2019	14/10/2019	21/10/2019	28/10/2019	04/11/2019	11/11/2019	18/11/2019	25/11/2019	02/12/2019	09/12/2019	16/12/2019	23/12/2019	30/12/2019	06/01/2020	13/01/2020	20/01/2020	27/01/2020	03/02/2020	10/02/2020	17/02/2020	24/02/2020	02/03/2020	09/03/2020	16/03/2020	23/03/2020	30/03/2020	06/04/2020
ODN Implementation	Appointment of key in-year enabling posts for ODN	SBUHB																																
	Confirmation of funding for year 1 and ingoing posts for ODN	WHSSC																																
	Handover plan for ODN	Programme																																
	ODN Governance arrangements finalised	Programme																																
	ODN Management Team in place and infrastructure established	SBUHB																																
	ODN operational policy developed	Programme																																
	Patient Flow - 'care with treatment closer to home' policy approved	Programme / ODN																																
	Clinical and non clinical policies produced and approved	Programme / ODN																																
	Paediatric policies and pathways produced and approved	Programme / ODN																																
	Training and Education for go live	Programme / ODN																																
	Training resource for year 1 onwards	WHSSC																																
	Rehabilitation including prescription approved and directory of services ready	Programme / ODN																																
	Clinical informatics requirements ready	Programme / ODN																																
	QI, audit and research - all HBs completed TARN dataset (backdated 1 year from go live) and all Health Boards completing respective dashboards.	Health Boards																																
	MTC readiness visit																																	
	TU readiness visits																																	
	Pre-hospital readiness visit																																	
Pre-hospital	Senior Paramedic - Trauma Desk Begin Employment	WAST																																
	E Learning go live	WAST																																
	All staff trained and E learning training completed	WAST																																
Trauma Units with specialist services ie Morriston Hospital	Recruitment of key enabling posts in order to meet Day1 service specification and quality indicators																																	
	Identified 'landing pad' for repatriating patients within existing infrastructure																																	
	Agree internal organisational governance structure																																	
	Implement network policies and pathways																																	
	Training and education to reach to Day 1 requirements																																	
	Recruitment of additional plastic surgical staff to support MTC (Consultants and Middle Grades)																																	
	Phased implementation of South West Wales spinal service model in year 1 and 2																																	
All other Trauma Units	Recruitment of key enabling posts in order to meet Day1 service specification and quality indicators.																																	
	Identified 'landing pad' for repatriating patients within existing infrastructure																																	
	Agree internal organisational governance structure																																	
	Implement network policies and pathways																																	
	Training and education to reach to Day 1 requirements																																	
	Operational arrangements in HDUHB with rural trauma facilities																																	

12.4.5 Summary of Critical Enablers for 'Go Live'

Chapter 5 provides details of the minimum requirements that need to be completed and/or in place before the ODN can become operational. These are summarised at a high level below and will inform the assurance process undertaken by the programme team and the collation of a detailed cross-organisational implementation plan. This will also assist with understanding the cumulative programme risk.

ODN	Transition and handover of ODN to SBUHB Agree organisational governance structure and role of ODN ODN management team Day 1 requirements for the following undertaken and/or in place: • Service specification and quality indicators (see chapter 5) • Clinical informatics requirements (see chapter 5) • Training and education products (see chapter 5)
Commissioners	WHSSC contracting arrangements Quality assurance framework
Pre-hospital	24/7 EMRTS in South Wales (phase 1 development) Trauma desk capability (covering peak hours of activity) Pre-hospital triage tool and 'silver trauma triage' tool Online training on triage tool Resource availability for additional ambulance journeys
MTC (UHW)	Interim additional infrastructure requirements (emergency unit, poly-trauma ward, theatre capacity and critical care) Recruitment of key enabling posts in order to meet Day 1 service specification and quality indicators (see chapter 7) Agree internal organisational governance structure Implement network policies and pathways Clinical informatics requirements Training and education to reach to Day 1 requirements
TU with specialist services (Morriston Hospital)	Recruitment of key enabling posts in order to meet Day 1 service specification and quality indicators (see chapter 8) Identified 'landing pad' for repatriating patients within existing infrastructure Agree internal organisational governance structure Implement network policies and pathways Clinical informatics requirements Training and education to reach to Day 1 requirements

	Recruitment of additional plastic surgical staff to support MTC (Phased implementation of spinal and orthoplastic model in year 1 and 2)
All other TUs	Recruitment of key enabling posts in order to meet Day1 service specification and quality indicators (see chapter 8) Identified 'landing pad' for repatriating patients within existing infrastructure Agree internal organisational governance structure Implement network policies and pathways Clinical informatics requirements Training and education to reach to Day 1 requirements Operational arrangements in HDUHB with rural trauma facilities

12.5 MTC/Health Board TUs/Pre-Hospital Readiness for Go Live

All quality assurance processes should include a mechanism to gather qualitative data from services to support identification of unforeseen issues as well as to ensure that all staff from front line through to senior management feel supported by the programme team in implementing the required changes. The process will also afford TU teams an opportunity to ask questions and seek clarification directly from clinical and managerial leads working in or on behalf of the programme team.

It is proposed that unit readiness visits are conducted as a collaborative exercise to enable individual health boards to receive constructive feedback on their state of readiness. This will enable the programme team to better understand each local service and specific issues, as well as being able to identify network wide issues that need resolution or escalation.

Consideration of the terms of reference for such visits will be needed. It is proposed that structuring visits around the patient pathway will provide a practical way of tangibly assessing local readiness. There should be enough time and space to enable free discussion of local issues and risks and how they might be resolved or mitigated.

12.6 Post Go Live: Operations and Governance

12.6.1 Challenges of Designing the Organisational Structure

There are a number of key challenges for the ODN in relation to the above organisational structure that the network board will need resolve before it transitions into an ODN board, and prior to the network becoming operational. The network governance subcommittee has explored these. A number of hypothetical scenarios that could arise help to illustrate the challenges and the role of the ODN board within the proposed organisational structure. These reflect challenges to the system raised through the process of peer and programme assurance reviews:

MTC acceptance variation

The ODN is alerted to an issue of significant variation of acceptance of patients from scene to the MTC, despite the presence of an automatic acceptance policy. The issue has been raised by the ambulance service. On discussion with MTC colleagues, it is suggested that the quality of the information conveyed to the MTC on passing a pre-alert is the cause of the problem. Despite some intervention by the ODN to improve the situation, the issues persist. The ODN escalates the issue to the respective commissioning bodies, but no single entity can confirm responsibility. The ODN is left with no influence over the problem and the issue remains unresolved.

Urgent transfer to the MTC

A TU contacts the ODN stating that a 45 year old male with an isolated pelvic fracture has been waiting four days for an urgent transfer to the MTC. The standard states that the patient should have been transferred within two calendar days. Despite the patient being accepted for transfer, bed capacity in the MTC appears to be constrained due to significant winter pressures in the unscheduled care system. The ODN tries to contact the Chief Operating Officer in the MTC on behalf of the TU, but the issue remains unresolved.

Delay in transfers of care

The MTC manager contacts the ODN stating that over the last two months they have had several delayed discharges of care to one particular TU. Currently, five patients at the MTC have been waiting in excess of two weeks for transfer from the time of completion of specialist care. This is causing considerable pressure on beds for new patients at the MTC. Despite the presence of an automatic repatriation policy agreed by all health boards, patient flow is becoming an increasing problem. The ODN discusses the issue with the Chief Operating Officer in the TU and learns that there are no appropriate beds available and, as such, the hospital is no longer able to accept patients back to their 'landing pad.' The ODN discusses the issue with WHSSC, but as commissioning of beds in the TU falls outside their remit they are unable to help, despite trying to intervene. The ODN is unable to resolve the issue and the problem continues, with a detrimental impact on patients and their families.

Pre-hospital trauma triage

A lack of adherence to the triage tool in a region has led to a concern from the MTC to the ODN. Despite several educational interventions, the problem persists. The reasons seem to be multifactorial, due to the inappropriate triage by ambulance personnel and advice given by the nearby TU. This is affecting patients, who are subject to delayed transfer to the MTC. The ODN attempts to investigate the issue through facilitation, but both the ambulance service and TU deny that they are the cause. In the proposed structure, whilst the ODN gives a view on the issues and develops an action plan, this advice is not followed. Given the commissioning arrangements in place, no single entity can confirm responsibility. The ODN has no further influence on the matter. Subsequently there is a serious adverse incident, which could have been prevented had the ODN been able to ensure practice changed.

Community rehabilitation and ongoing care

Despite the placement of rehabilitation coordinators and therapists in a TU as part of the network development, the MTC makes the ODN aware of several patients who have returned from the MTC to the community with ongoing rehabilitation needs that have received no community rehabilitation. On further assessment, it appears that the TU's resources put in place for major trauma are mostly used for other patients groups (e.g. isolated neck of femur fractures, strokes). The ODN discusses the issue with the directorate manager in the TU, but does not manage to convince the manager that the position should change. Furthermore, adherence to TARN PROMS/PREMS is limited. Despite making suggestions to improve the situation, the ODN has no influence over the outcome and the problems continue.

TARN case completeness and quality

Despite resourcing a full time TARN coordinator, case ascertainment and accreditation in a TU remains poor. TARN informs the ODN that the TU is an outlier for mortality and would like to understand if this is an issue of data completeness. Despite several requests for further information from the TU, TARN has not managed to make progress. WHSSC are concerned that this may be affecting MTC performance, but are unable to help, as this falls outside their remit of specialist commissioning. The ODN approaches the TU to find that the TARN coordinator is used to undertake other audits in the clinical audit department and therefore is only available two days a week for TARN. On suggesting that the TARN coordinator is full time on TARN data collection, the TU state that this is not possible. The problem continues and the ODN has no way of determining the performance of the TU.

The above scenarios are hypothetical and not exhaustive but represent a sample of issues that are likely to arise, with an impact on the effectiveness of the network and on trauma patients. They provide a compelling case for optimising organisational structure from the outset. From these scenarios, the following themes have emerged:

- Complex commissioning arrangements with multiple commissioning bodies involved, risking a lack of accountability across the pathway. There is a disconnect between these and the ability to visualise the entire patient pathway.
- The ineffectiveness of the trauma ODN board acting solely in a facilitative/advisory capacity in relation to clinical and operational governance issues. An inability to be effective at maintaining 'operational delivery', given the complexity of commissioning arrangements and multiple providers.

The design must recognise the system of incentivisation and internal market forces does not exist in NHS Wales. It has also been confirmed that incentivisation and internal market forces will not be utilised as part of the commissioning framework of the trauma network.

12.6.2 Overview of Structure

The organisational governance structure must ensure clear lines of accountability and responsibility across the pathway in order to achieve the best possible outcomes and experience for patients. This should align with the network's mission statement of 'saving lives, improving outcomes, making a difference.'

The arrangements must create an environment in which all components of governance are delivered openly and transparently. In addition, all providers must contribute equally and positively to the governance activities of the network.

Whilst some aspects of the organisational governance arrangements are clear, others present a level of complexity, which will challenge the effectiveness of the network to deliver as a whole and across the trauma pathway. The following outlines the current position with respect to organisational governance:

Three commissioning bodies:

- WHSSC – principal commissioning body, commissioning and performance management of the ODN, MTC and other specialist services supporting the MTC.
- EASC – commission and performance manage WAST and EMRTS.
- LHB Commissioner – commission and performance manage health boards.

Mechanisms will need to be in place to ensure accountability across the pathway. Following consideration of the scale of the challenge for operations in a live scenario, the need to embed the network within a robust structure that is owned at an executive level, the following arrangements have been derived. They reflect the views of the network board and service partners. They also reflect similar arrangements for managing trauma networks in the UK and beyond.

The network clinical governance structure will consist of the following boards/groups. This structure has been based on comparable networks in England and Scotland. Full details will be included in the network operational policy.

- Trauma Network Delivery Assurance Group (DAG) - top level system oversight and ownership, meets bimonthly in first year and quarterly thereafter. Chaired by WHSSC or independent member, accountable through WHSSC Joint Committee.
- Trauma Network Clinical & Operations Board (COB) - operational delivery, and responsible for ensuring timely escalation, management and resolution of operational issues. Meets monthly, chaired by a lead Chief Operating Officer. Will have a performance management function and maintain operational authority.

These two key groups will ensure delivery against the commissioning framework, the escalation of issues, learning and achievements into the senior leadership structure of the NHS. These groups are supported by the following core groups, through which the COB and DAG can discharge and commission their responsibilities.

- Network Governance Group
- Network Workforce Group
- Network Informatics Group

These Groups will oversee, support and receive outputs from a number of workstreams.

- Network work streams:
    - Clinical and non-clinical policies.
    - Paediatrics.
    - Education and training (in partnership with HEIW).
    - Rehabilitation.
    - Quality improvement, innovation and research.
    - Trauma in older people.
    - Injury prevention.

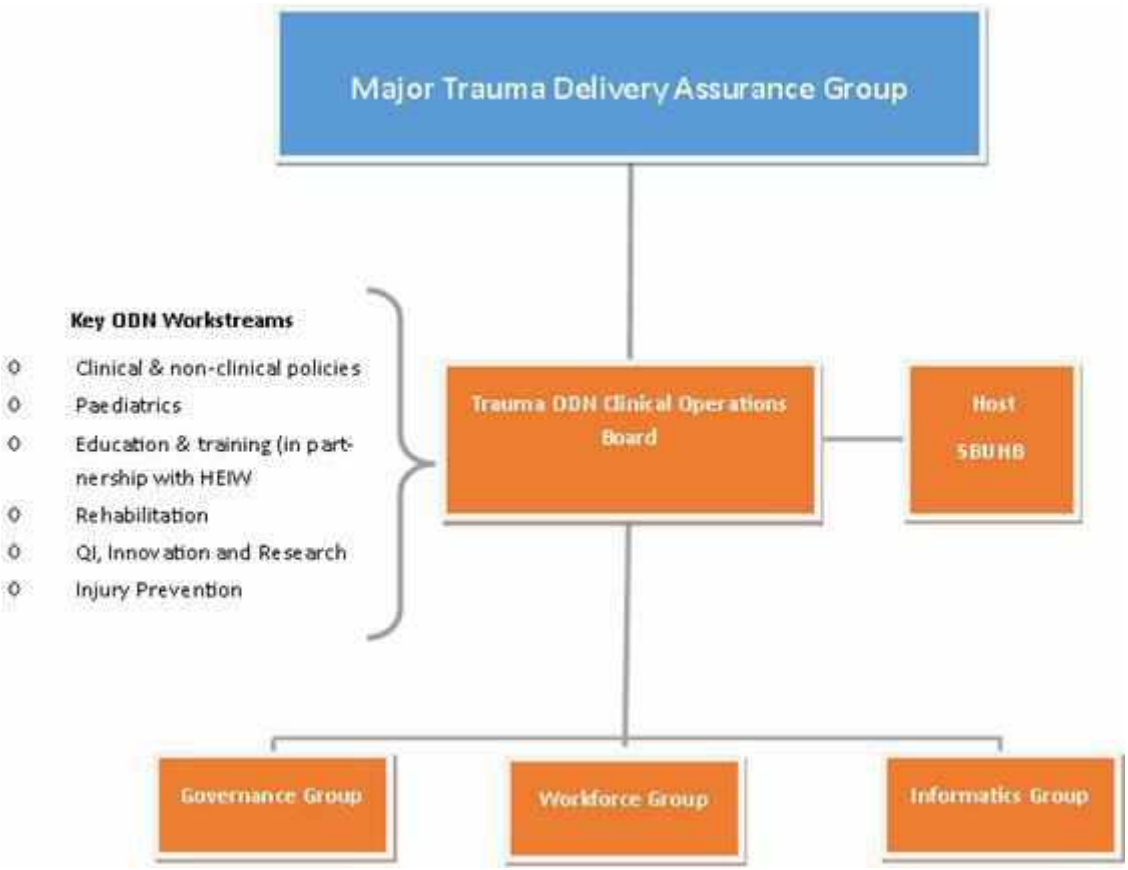
- Weekly teleconference between ODN and MTC clinical and operational management team.
- Monthly network teleconferences with ODN and network clinical and operational management teams.

Swansea Bay UHB will host the ODN. Swansea Bay will provide all organisational supporting arrangements and so the ODN will escalate, through Swansea Bay UHB, matters which pertain to enabling or support functions for the delivery of the network. These include (but are not restricted to):

- HR and workforce
- Financial and procurement
- Project and programme management
- Health and safety
- Statutory and mandatory training for ODN staff
- Risk and incident management
- Planning and managerial support

The ODN is, through the Delivery Assurance Group, accountable to WHSSC Joint Committee and the DAG will escalate directly to Joint Committee through the WHSSC structure, matters that pertain to commissioning and service delivery, planning and performance or any wider system related issues (e.g. patient flow, workforce risks and issues, approval for service change).

ODN Operating Structure:



12.6.3 Trauma Network Delivery Assurance Group (DAG)

The trauma network DAG will meet bimonthly in the first year and then quarterly thereafter and be accountable for and oversee the delivery of whole patient pathway on behalf of the relevant commissioning bodies. The board will be responsible for ensuring effective clinical pathways of care between all providers in the network. In doing so, it will receive reports from the network Clinical Operations Board and Governance Group. The board will approve all work undertaken by providers and network working groups, pertaining to clinical governance.

Furthermore, in aligning with the NHS England service specification and quality indicators, the board takes its steer from the NHS England clinical reference group (CRG), a national forum of experts on trauma care. Presently, Wales is not represented on the national CRG and it is an important step for the programme to seek representation.

12.6.4 Trauma Network Clinical Operations Board

The trauma network COB will meet monthly and oversee operational delivery of the whole pathway. It will actively manage performance and operational matters, being responsible for the development of the necessary plans and strategies to ensure ongoing sustainable service delivery. It will ensure that the schedule of business cases identified in this programme business case are delivered. It will oversee the closure and post programme evaluation and benefits realisation plan, as well as being responsible for developing the workforce and facilitating the development of network wide roles and ways of working.

12.6.5 Network Governance Group

The network governance group will meet quarterly after the adult and paediatric clinical quality review meeting. The group will review themes emerging from all reporting in to the network structure (including risk management). It will generate lessons and recommendations to share across the network and check that these are completed. It will also provide review and challenge to all work undertaken by providers and network working groups, prior to approval by the COB. Finally, the group will review governance issues pertaining to the Veterans Trauma Network.

The following list outlines minimum reporting criteria to the network governance group (this list is not exhaustive and providers will be encouraged to report any issues pertaining to clinical governance):

- All cases discussed in provider Morbidity and Mortality (M&M) meetings.
- All unexpected survivors and unexpected deaths.
- All cases where a complaint or concern is raised within a provider organisation.
- All cases discussed in adult and paediatric clinical quality reviews.
- All clinical incidents and serious adverse incidents raised by providers (minimum criteria set through network central incident reporting using the DATIX incident reporting system). These will still be reported through health board governance processes.
- TARN MTC and TU dashboards (incl. TARN PROMS/PREMS).
- Specific operational data impacting on clinical effectiveness and patient safety.
- The number and proportion of patients transferred directly to MTC, including cases of significant under- and over-triage in a pre-hospital setting.

- The number and proportion of patients that have an acute secondary transfer (within 12 hours) from a TU to MTC.
- The proportion of urgent transfers that occur within two calendar days.
- The number of patients with ISS ≥15 managed definitively within a TU and details of outliers.
- The number of patients where repatriation from MTC exceeds 48 hours from referral.
- Feedback of other networks relevant to major trauma (e.g. critical care)
- Peer review – the ODN has confirmed its intention to participate in the NHS England annual trauma peer review outlined below.

The frequency will be defined in the network operational policy, linked with the network informatics procedures.

The following outlines the outputs of the network governance sub-committee:

- Quarterly network report for network board and commissioning bodies. (Including performance and quality reviews)
- Annual internal and external facing network report.
- Quarterly lessons learnt bulletin from themed reviews, incident and serious adverse incident reporting shared with all providers.
- Urgent clinical and operational alerts (including changes in pathways and polices).
- Annual peer review report.
- Annual MTN conference.
- Annual performance and quality reviews with commissioners.

12.6.6 Adult and Paediatric Clinical Quality Review Meetings

These quarterly meetings aim to provide an open forum for sharing and discussion of clinical cases amongst multidisciplinary health care professionals who have been involved or wish to attend and learn. They will immediately precede the network governance group meeting. Specific themed criteria will be developed, but any provider in the patient's journey with concerns or questions (from the point of injury to rehabilitation and/or discharge) will be able to highlight cases for discussion.

These meetings will generate outcomes requiring input from the MTC and TU governance structures and network working groups, which will be agreed through the network governance group.

The ODN will also provide representation at the MTC clinical quality review meetings (or equivalent).

12.6.7 MTC Clinical Governance Structure

The MTC trauma board will oversee the activity of the MTC critical care huddle, TARN assessment meetings, morbidity and mortality meetings and the clinical governance, audit and quality committee. These will feed into the network governance group as indicated above.

12.6.8 TU Clinical Governance Structure

The TU trauma boards will oversee the activity of TARN assessment and morbidity and mortality meetings. The TU clinical governance structure will be responsible for overseeing the clinical governance of LEHs within the health board as appropriate. These will feed into the network governance group as indicated above.

12.6.9 Pre-Hospital Trauma Governance Group

Given the number of providers involved in the delivery of pre-hospital trauma care across the region, a pre-hospital trauma governance group will be established to oversee clinical governance issues pertaining to major trauma. This group will review the effectiveness of the pre-hospital triage tool, trauma desk and manage any issues raised by providers pertaining to pre-hospital care. WAST is the main pre-hospital provider for the network and provides a named representative to report into the network governance group as well as responses to the adult and paediatric clinical quality review meetings held by the network.

12.6.10 Weekly/Monthly Teleconferences

A weekly teleconference will be held between the ODN and MTC clinical leads and respective managers. Once a month these will occur between the ODN and network clinical and operational management teams. These will be used an opportunity to identify immediate clinical governance issues which require immediate clinical and operational alerts or sign post further discussions within provider organisations or the network structure. A structure will also include monthly conference calls with the North West Midlands and North Wales Trauma Network and an opportunity to undertake joint governance meetings at least six-monthly. This will set the trajectory for collaborative working and future planning.

12.6.11 Trauma Peer Review Process

Participation in the annual peer review process will be an important component of the quality assurance process and a key marker for whether additional investment in major trauma services across the region delivers improvements in clinical effectiveness and governance, and areas for improvement. The NHS England annual peer review process, undertaken by the quality surveillance team, has a record for delivering successful reviews in England and Northern Ireland. It is recommended that the NHS England review process be adopted for the South Wales Trauma Network for the following reasons:

- The review is carried out consistently in line with NHS England quality indicators and service specification for major trauma, which the network will be adopting with appropriate variation for the Welsh system. This provides an opportunity for benchmarking with networks elsewhere.
- It aligns with North Wales, who participate in peer review as part of their quality assurance process with the North West Midlands and North Wales Trauma Network.
- It is a driver for service development and quality improvement.
- It provides focus on coordination within and across organisations, following the patient pathway.
- It is clinically led with user and carer involvement from the outset.

The process has three phases – a pre-review visit, review day and post review. Pre-review requires completion of a self-declaration against quality indicators and an evidence upload. This is followed by a five-hour review day. Post peer review, a report is written with a categorisation of review findings. This is sent to the provider and relevant commissioners. If any serious concerns are raised, separate notification is sent directly to the chief executive of the provider and copied to relevant commissioners.

The first review of the ODN, MTC, TUs and pre-hospital providers is expected to be undertaken at the end of year 1, with further reviews guided by the results of the first.

12.6.12 Collaborative Working with North Wales

There is significant learning from the experiences from North Wales, which is part of the North West Midlands and North Wales Trauma Network.

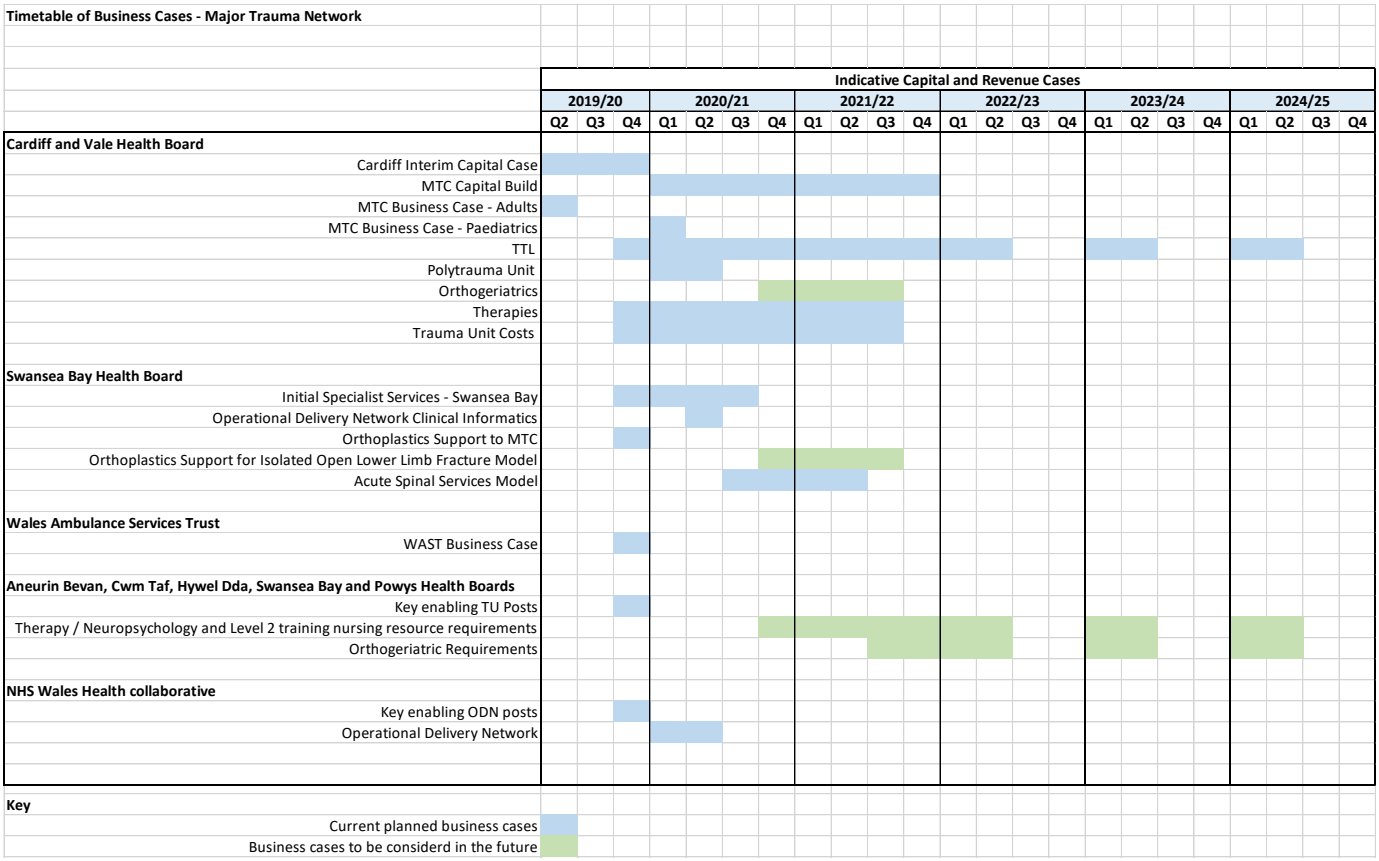
There are opportunities for improving governance including shared learning from both good and sub-optimal practice. This includes improving quality of care and learning from processes in this network even where processes may vary slightly but where pathways and solutions may be transferable. The same is true for network pathways and polices. This also includes good practice and methodologies in relation to TARN data and analysis. Furthermore, North Wales has had experience of participation in national peer review and the South Wales trauma network to participate in this process, but also learn from the experiences in North Wales, to explore challenging areas at the outset. The training and education working group for the network will also gain an understanding from North Wales in relation to key deliverables. North Wales currently runs a two day trauma team course, which has helped TUs comply with nursing standards for trauma training. North Wales has also looked at strategies for improving patient satisfaction and capturing feedback from trauma patients, especially those who go through the MTC.

Finally, in terms of the development of the rehabilitation model in South Wales, learning will be shared with North Wales in terms of the development of their local model.

12.7 Business Cases Supporting Implementation and Achievement of Standards

12.7.1 Schedule of Business Cases

The PBC provides a framework for all associated major trauma business cases. The following schedule shows the quantum of anticipated business cases expected:



The above schedule reflects the position as at September 2019 and will be subject to change. The future plans for business cases from the health boards are difficult to forecast and articulate at this stage. The change in patient flows to health boards will impact on demand for cases such as rehabilitation and the impact can only be fully understood when the network has gone live and TARN data has been collected.

12.8 Evaluation – Post Implementation

12.8.1 Post Programme Assurance and Evaluation

The outline arrangements for post implementation review (PIR) and project evaluation review (PER) have been established in accordance with best practice and are as follows:

Post-project evaluation is a mandatory requirement for all NHS bodies who are undertaking a project of this scope and scale.

This section of the PBC sets out the plans, which, the programme team has put in place to undertake a thorough and robust post-project evaluation.

12.8.2 Framework for Post-Project Evaluation

Following the handover of the network to SBUHB the Collaborative is committed to ensuring that a thorough and robust post-project evaluation (PPE) is undertaken at key stages in the process to ensure that positive lessons can be learnt from the programme that will be of value for wider system learning. The lessons learnt will be of benefit to:

- The Collaborative – in using this knowledge for future projects.
- Health boards, pre-hospital services and commissioners – to inform their approaches to future major projects.
- The NHS more widely – to test whether the approaches used in this programme have been effective.

PPE also sets in place a framework within which the agreed benefits realisation plan can be tested to identify which benefits have been achieved and which have not.

NHS guidance on PPE has been published and the key stages, which are applicable for this project, are:

- Evaluation of the various processes put in place during implementation.
- Evaluation of the project in use shortly after the development is operational.
- Evaluation of the project once the developments are well established.

Once the handover is completed the ODN will draw up detailed plans for evaluation at each of these stages in consultation with its key stakeholders. This section will also set out how these arrangements will be managed, how information will be disseminated and on what timescale.

12.8.3 Evaluation – Implementation

The objective of this stage is to assess how well and effectively the project was managed from the time of PBC approval through to the commencement of operational commissioning.

It is considered that this should be undertaken six months following operational commissioning of the development.

The evaluation at this stage will examine:

- The effectiveness of programme management.
- Communications and involvement during implementation.
- The effectiveness of the working arrangements established by the network board.
- Support during this stage from other stakeholder organisations – Welsh Government, health boards, WHSSC and EASC.

12.8.4 Evaluation – Project in Use

It is proposed that this stage of the evaluation be undertaken up to 12 months after the completion of operational commissioning of the scheme in order that as many of the lessons learnt are still fresh in the minds of the programme team and other key stakeholders.

The objective of this stage will be to assess how effectively the project was managed during the operational commissioning phase and into the actual operation of the new development.

The evaluation at this stage will examine:

- The effectiveness of programme management.
- Communications and involvement during commissioning and into operations.
- The effectiveness of the working arrangements established by the programme board.
- Support during this stage from other stakeholder organisations – Welsh Government, health boards, WHSSC and EASC.
- Overall success factors for the project in terms of cost and time.
- Extent to which it is felt the development meets users' needs – from the point of view of patients and staff.

It should be noted that in order to provide an appropriate comparator to the final point in this section, a similar survey should be undertaken and compared to staff and patient engagement exercises undertaken during the course of the programme. This will help the service to gauge the level of satisfaction with the existing service. In this way, increases in satisfaction can be directly measured, although it is recognised that a direct comparison will not be possible as the exact respondents will not be the same.

12.8.5 Evaluation – Project is Well Established

It is proposed that this evaluation is undertaken about two to three years following initiation of commissioning. The objective of this stage will be to assess the effectiveness of project management during the implementation of the new development. The evaluation at this stage will examine:

- The effectiveness of the working arrangements established by the lead commissioner (WHSSC) and the ODN.
- Extent to which it is felt the development meets users' needs, from the point of view of patients and staff.

It is envisaged that participation in national peer review of the whole system at the end of Year 2 will form part of this evaluation.

12.8.6 Management of the Evaluation Process

The ODN will manage the process in partnership with the lead commissioner (WHSSC).

All evaluation reports will be made available to all participants in each stage of the evaluation once the ODN and WHSSC management processes have endorsed the report.

The ODN management team will undertake the majority of the work.

The costs of the final post-project evaluation, once the new working practices are fully established, will be borne by the ODN and are not included in the costs set out in this PBC.

The ODN will seek to ensure that they keep abreast of projects that have been fully evaluated when in use and which have utilised the latest PPE guidance. The ODN will then take a view of the extent to which external support is required.

12.9 Programme Assurance

The South Wales Trauma Network is planned to go live operationally in April 2020. Health board services are currently finalising the resource requirements that they will need to invest in service change to meet the phased quality indicators and service specification over the next five years as set out by the trauma network board. They are also working through the requirements of their own designated TUs. Go live carries a high degree of risk. National changes to patient flow will occur because of the implementation of this service change.

12.9.1 Aspects of Assurance

There are three key elements to providing robust assurance so that the service can launch. These are:

- Programme Business Case – as a blueprint for implementation and a record of the decision making process and governance (planning diligence).
- MTC/TU/pre-hospital state of readiness for launch.
- Testing of the network's business continuity plan.

Based on the outputs of these elements, the network board will report to the WHSSC Joint Committee in February 2020, to seek the authority to go live in April 2020.

12.9.2 Gateway Review of Programme Business Case (PBC)

The OGC Gateway Review 0: Strategic Assessment took place in July 2019. There were 11 clearly outlined actions were identified by the Gateway Team that had to be taken-forward to address an overall delivery confidence assessment of Red / Amber. The recommendations are outlined below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status/Comment
1.	The Programme Board and Programme Team should assess whether the current phasing and go-live date is affordable and achievable.	C- Critical	Do now	Closed/Complete
2.	Close out the gap between the programme team specification of minimum day 1 requirements and current Health Board Business Cases and further develop planning assumptions for each phase to progressively meet Trauma Standards.	E- Essential	Do by end 10/19	Closed/Complete
3.	Undertake a critical scrutiny of all current Health Board and WAST Business Cases and design the process for the preparation and scrutiny of revised submissions.	E- Essential	Do by end 10/19	Closed/Complete
4.	Ensure the PBC sets out all capital requirements, including all proposed new MTC investment.	E- Essential	Do by end 10/19	Closed/Complete
5.	Confirm with Health Boards their commitment to funding of this programme via WHSSC (for the MTC and ODN) and their own direct investment (in TUs and rehabilitation).	C- Critical	Do by end 10/19	Closed/Complete
6.	Clearly set out the composite approval process for the PBC and associated revenue and capital funding including the roles of WG, WHSSC, EASC and Health Boards and document this as part of an integrated approval and assurance plan for the programme.	E- Essential	Do by end 09/19	Closed/Complete
7.	Secure additional leadership capacity in the Programme Team to drive even more whole system collaborative working and the delivery and integration of the Major Trauma Network.	C- Critical	Do now	Closed/Complete
8.	Develop on a collaborative basis a detailed plan for the full implementation of the programme and its constituent projects, including dependencies milestones and critical path up to the point when major trauma standards are being met.	E- Essential	Do by end 10/19	Closed/Complete (programme phasing)
9.	Review the Programme Board structure which will be needed to drive forward the implementation phase, following approval of the PBC	E- Essential	Do by end 10/19	Complete
10.	The Programme should develop a co-ordinated and collaborative approach to developing a skilled network workforce, including recruitment, training and development, rotations, shared appointments and short term requirements.	C- Critical	Do now	Complete – Principles agreed and published
11.	Develop the governance structure and operational authority for the Operational Delivery Network (ODN) and clear lines of accountability between the MTC and the ODN, and between them and the HBs.	E- Essential	Do by end 10/19	Governance and accountability arrangements described in ODN chapter

To support this, the Executive Strategy Group was formed, with executive planning, finance and workforce input, in support of the programme team and to provide assurance to the SRO. An action plan was drafted and, where appropriate), working groups were formed to directly address the 11 actions. A professional peer review was arranged to review the MTC, Specialist Services, Trauma Units, Pre-hospital care and Operational Delivery Network planned to consider appropriate phasing.

The Gateway Assurance of Action Plan (AAP) took place in September 2019. Whilst significant progress had been made and acknowledged against the actions outlined in the Strategic Assessment that took place in July a delivery confidence assessment of Red/ Amber was concluded by the Gateway Team. Since this review the outstanding critical recommendations below have been addressed in the context of this business case. The full recommendations are outlined below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status
1.	Establish whether all the relevant recommendations derived from the Professional Peer review have been accurately reflected in the latest Major Trauma Centre and SBUHB Specialist Services Business Cases.	C- Critical	Do now	Complete
2.	Seek an approach to close any gap in the initial service specification and affordability expectations between WHSSG and the Major Trauma Centre and SBUHB Specialist Services.	C- Critical	Do now	Complete
3.	Model the timing of recruitment to assess the service specification to which the network can operate from 1st April 2020 and include in the PBC.	E- Essential	Do by 15/10/19	Key enabling posts identified, funded and out to recruitment
4.	Determine the operating, accountability and governance structure for the ODN.	E- Essential	Do by 15/10/19	Proposals drafted and out for consultation/agreement between Chief Operating Officers, Chief Executives and Trauma Programme Board.

Following the AAP review, outstanding critical actions were completed and remaining actions were noted to be progressing well as outlined above. The Gateway 3 Review: Investment Decision took place between the 28 - 30 October 2019. This Gateway review has provided a delivery confidence assessment of amber green. This indicates that 'successful delivery appears probable. However constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.' The review recognised that two major activities were happening in parallel: the completion and approval process for the PBC and mobilisation for go live. It reported that, since the AAP review, substantial progress had been made with both the PBC and implementation plans.

The review team made the following recommendations:

Ref No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status
1.	Establish the timeline and plan for achieving the standards for TARN data recording on a timely basis across the network.	Recommended	Do by 01/20	Working plan developed and signed off by network board (see Chapter 5) and risk assessment. Significant progress being made
2.	Set out in the PBC the likely scale of future capital investment needed in the new MTC trauma theatre.	E- Essential	Do now	Complete. Estimated capital range included in updated PBC.
3.	Provide guidelines for each HB on the specific commitments being entered into by them in approving the PBC.	E- Essential	Do now	To be confirmed via core board report
4.	Confirm the processes for Swansea Bay SS, TU and ODN, and other HB TUs to self-assess their readiness to proceed with operational mobilisation and go-live of the MTN.	E- Essential	Do by 12/19	Detailed requirements of evidence for readiness have been drafted and visits to Health Boards are being planned.
5.	Identify, map out and regularly communicate those elements of the new MTN which will be in place at initial go-live and those which will be added in the period following go-live.	E- Essential	Do by 12/19	This is highlighted in the PBC and will be part of the implementation arrangements and communication plan
6.	Publish a timetable and arrangements for implementation, including the standing down of the existing programme structure and the standing up of new mobilisation and implementation structure.	E- Essential	Do by 12/19	Included in PBC and to be adopted in Health Board plans
7.	Establish the detailed clinical decision making process to confirm that the MTN is safe to take live, together with the final MTN Board decision making process.	E- Essential	Do now	Meeting held with MDs to give steer, and will be agreed via Joint Committee
8.	Expand the approach to the management and reporting of recruitment to include the Plastic Surgeons and other posts in the Trauma Network.	E- Essential	Do by 12/19	Confirmed at the Executive Strategy Group and led by the Workforce Group
9.	Develop more clarity about how the MTC and each TU, working with the ODN, will practically operationalise the policy to repatriate patients from the MTC.	C- Critical	Do now	Draft document developed, consultation underway with network board, COOs and MDs. Following which will be

Ref No.	Recommendation	Urgency (C/E/R)	Target date for completion	Status
				discussed with Welsh Government, with a plan to test in Jan/Feb 2020

12.9.3 MTC/Health Board TUs/Pre-Hospital Readiness for Go Live

All quality assurance processes should include a mechanism to gather qualitative data from services to support identification of unforeseen issues as well as to ensure that all staff from front line through to senior management feel supported by the programme team in implementing the required changes. The process will also afford TU teams an opportunity to ask questions and seek clarification directly from clinical and managerial leads working in or on behalf of the programme team.

It is proposed that unit readiness visits are conducted as a collaborative exercise to enable individual health boards to receive constructive feedback on their state of readiness. This will enable the programme team to better understand each local service and specific issues, as well as being able to identify network wide issues that need resolution or escalation.

Consideration will be needed on the terms of reference for such visits. It is proposed that structuring visits around the patient pathway would provide a practical way of tangibly assessing local readiness. This would require support by both a structured set of service aspects to cover, in order that the approach of the visits is consistent. There should also be enough time and space to enable free discussion to afford sufficient time and focus on local issues and how they might be resolved, or risks appropriately mitigated.

12.9.4 Testing of Business Continuity Arrangements

One of the critical tasks for the programme team will be to coordinate the development of comprehensive contingency arrangements for the network board to deploy if necessary on day 1. This will be informed by the visits and documented contingencies as well as with wider national strategic considerations (e.g. fit with Civil Contingencies Act and Welsh Government national Emergency Planning functionality).

A timetable for the programme assurance process is provided below:

Aspect	Activity	Lead	Due date for completion
PBC gateway review	Planning of review scope and terms of reference with Welsh Government Investment and Infrastructure planning colleagues	Rhys Blake, NHS Health Collaborative Ian Gunney, Welsh Government	End of May 2019
	MT Network Board agree Terms of Reference and Scope	Tracy Myhill, SRO, programme	June 2019

	Execution of review	Gateway team	July 2019
State of readiness visits (subject to ODN readiness)	Planning of visit scope, required documentation and process	Dindi Gill, Network Clinical Lead Jennifer Thomas, Network Rehabilitation Lead Jeremy Surcombe	End of October 2019
	Approval of scope of and process for visits	Network Board	November 2019
	Undertake visit - MTC	Programme Team and any specialist advisors recommended through the board	Mid December 2019
	Undertake visits – TUs/pre-hospital	Programme Team and any specialist advisors recommended through the board	January - February 2020
	Produce visit report also to inform business continuity test exercise	Programme Team	End of February 2020
Business continuity plan testing	Planning of test exercise	Programme Team & external facilitator	End of December 2019
	Approval of ToR	Network Board	December 2019
	Undertake exercise	Network	January 2020
Contingency Planning for Go Live	Define principles of contingency planning for the network and trigger points for activation	Programme Team & Network Board	November 2019
	Activation of contingency plan depending on feedback from organisations as appropriate	Network Board	January – March 2020

12.10 Benefits Realisation Plan

In the case for change chapter, a list of benefits was described against key investment objectives. These investment objectives included health gain, equity, clinical and skills sustainability and value for

money. In May 2019 a benefits realisation workshop was held, involving a broad group of stakeholders. These included representation from pre-hospital services, health boards, commissioners and Welsh Government. Using information gathered from the workshop, a comprehensive benefits realisation plan has been developed. The plan is divided into the four overarching strategic themes, based on the investment objectives. These are broken down to identify key supporting actions, timeframes for delivery and responsibility/accountability for delivery and review of benefits. Each measurable benefit has been assigned a unique number for recognition and monitoring purposes. The timeframe given indicates the earliest that data will be available to determine whether a benefit has been realised or not. The benefits realisation plan will be used in a number of ways:

- Formal evaluation of the network.
- Subsequent quality assurance and/or peer review processes.
- Commissioning framework.

Strategic Benefit – Health Gain

Strategic Benefit	Benefits Number/Description	Actions Necessary to Realise Benefits	Measurement	Target date for demonstrating benefit	Responsible for delivering benefits	Accountable
Health Gain	001/Improving survival	Introduction of inclusive trauma network Improve TARN data collection to ensure accurate survival scoring Ensure at least 1 year of baseline data collection before ODN operational	TARN probability of survival (quarterly/annual reports for network wide and all providers) Additional survival rate TARN case ascertainment and accreditation	March 2023	ODN providers	WHSSC/EASC/health board commissioning
	002/Improving functional outcomes	Develop an inclusive trauma network with a focus on all aspects of the rehabilitation pathway Improve TARN PROMS data collection to ensure baseline data available	TARN PROMS (quarterly/annual reports network wide and all providers) PROMS baseline data (1 years) before rehabilitation model operational	March 2025	ODN providers (specifically rehabilitation providers)	WHSSC/health board commissioning

			Example provided in Appendix 21 & Appendix 22			
	003/Improving timeliness and quality of clinical care.	Establish network policies and pathways (incl. automatic acceptance policy to MTC)	TARN MTC and TU dashboards/ quarterly and annual reports. Quarterly and annual network TARN reports Focused TARN quarterly and annual reports (e.g. orthoplastics, paediatrics) Benchmarking against national average	March 2021	ODN providers	WHSSC/EASC/health board commissioning
Health Gain	004/Improving patients experience	Multiple levels of intervention through introducing the inclusive trauma network (based on learning from patient experience workshop)	TARN PROMS/PREMS (patient experience component) Example provided in Appendix 23. Frequency on usage of patient centred communication tool (e.g. application)	March 2023	ODN providers	WHSSC/EASC/health board commissioning

			Patient surveys (themed annually)			
	005/Enhancing injury prevention	Development of injury prevention strategy in conjunction with Public Health Wales	Number of injury prevention schemes undertaken Quantify prevention of injury/death/ disability	March 2023	ODN providers	Welsh Government
	006/More coordinated response at incidents or mass casualty events	Integration of mass casualty plans in to network operational structure	Record of debriefs and learning from table top/live exercises undertaken with network	March 2022	ODN providers	WHSSC/EASC/health board commissioning
	007/Improved data collection.	Implement TARN working plan	Network wide improvement of TARN case ascertainment to 80% and accreditation to 95% (incl. all providers) Contribution of all providers to TARN PROMS/PREMS	March 2021	ODN providers	WHSSC/EASC/health board commissioning

Strategic Benefits - Equity

Strategic Benefit	Description	Actions Necessary to Realise Benefits	Measurement	Target/ Date	Responsible for delivering benefits	Accountable
Equity	008/Equity of access to specialist care	Implementation of pre-hospital triage tool and automatic acceptance policy to MTC (incl. rapid secondary transfer)	TARN data: The number and proportion of patients transferred directly to MTC/TU with specialist services. The number and proportion of patients that have an acute secondary transfer (within 12 hour) from a TU to MTC/TU with specialist services. The proportion of urgent transfers that occur within two calendar days. The number of patients with ISS ≥15 managed	March 2021	ODN providers	WHSSC/EASC/health board commissioning

			definitively within a TU.			
	009/More appropriate patient flow	'Care with treatment closer to home' policy Landing pad configuration in health boards	All wales repatriation database: Number of repatriations exceeding 48hrs from when ready by origin health board.	March 2021	ODN providers	WHSSC/EASC/health board commissioning
	010/Equity of care for trauma in older people	Trauma in older people pathways developed and early geriatric assessment	Number of patients 65yr and over who have a clinical frailty score documented by a geriatrician within 72 hours of admission.	March 2023	ODN providers	WHSSC/health board commissioning
	011/Equity of care for veterans returning to Wales in line with England	Implement the veterans trauma network in Wales	Number of veterans referred and reviewed by the network	March 2021	ODN management	WHSSC/health board commissioners

Strategic Benefit: Clinical Skills and Sustainability

Strategic Benefit	Description	Actions Necessary to Realise Benefits	Measurement	Target/ Date	Responsible for delivering benefits	Accountable
Clinical Skills & Sustainability	012/Improved multiprofessional training and education	Implementation of network training and education programme	Number of training and education events held split by type Number of online modules completed by providers Number of users of triage tool and trauma APP Number of calls made to trauma desk (where decision making supported)	March 2021	ODN providers	WHSSC/EASC/health board commissioners
	013/Enhanced engagement of the MTC with the wider network	Strategy for supporting wider network	Number of engagement sessions led by MTC	March 2021	MTC	WHSSC
	014/Enhance new recruitment across the region	Implementation of an inclusive network Workforce strategy	Identified staffing recruited Number of joint appointments made	March 2020 onwards March 2020 onwards	ODN providers ODN management	WHSSC/EASC/health board commissioners

			Number of rotational appointments made Publication of strategy			
	015/Improved staff retention	Workforce strategy	Turnover rates	March 2021	ODN providers	WHSSC/EASC/health board commissioners

Strategic Benefit: Value for Money

Strategic Benefit	Description	Actions Necessary to Realise Benefits	Measurement	Target/ Date	Responsible for delivering benefits	Accountable
Value for Money	016/Economic benefits of enhanced survival, functional outcome and return to work	Develop an inclusive trauma network with a focus on all aspects of the rehabilitation pathway	TARN PROMS (quarterly/annual reports network wide and all providers) Economic output (e.g. quality adjusted life years – using the secure online data linkage bank	March 2025	ODN providers	WHSSC/EASC/health board commissioners
	017/Reduced secondary transfers (observed over time, but not initially)	Implementation of pre-hospital triage tool and automatic acceptance policy to MTC	Secondary transfer ambulance conveyance rates Number of secondary trauma transfers undertaken by EMRTS/hospital transfer team Cost savings from above	March 2023	WAST/EMRTS/health boards	EASC/health board commissioners

	018/Reduced length of stay in critical care	Implementation of MTC	Reduced length of stay (TARN/ICNARC datasets)	March 2023	ODN	WHSSC/EASC/health board commissioners
	019/Flexible working across health boards boundaries	Agree HR protocols to enable cross-health boards working	Number of new posts created working across organisations and joint policies	March 2021	ODN providers	WHSSC/EASC/health board commissioners
	020/Benefits to other part of the healthcare system	Development of an inclusive network overlapping with other areas of strategic development	Number of other services directly benefitting from investment in major trauma services	March 2021	ODN providers	WHSSC/EASC/health board commissioners

12.11 Risk Management Plan

Programme risks are managed through each network board where an updated risk register is presented at each meeting. As the programme transitions towards go live and services begin to mobilise, risk management will continue to be an important governance element of the new implementation structure.

12.11.1 Future Risk Profile and Plan

There are a number of sources of risk identification as a consequences of the activities of programme planning for implementation. A number of key activities will follow the submission of this case to WHSSC Joint Committee. These are:

- **Risk plan to manage non delivery or overachievement of benefits realisation plan**

  NHS Wales is making a substantial investment in this service, so it is imperative that the benefits undergo a full risk assessment. That risk assessment will then be signed off by the network board and shared with commissioners and will be formally logged as a handover document to the ODN.

- **Risks emerging from Trauma Unit site visits**

  TU readiness is essential to the maintenance of effective patient flow and achievement of benefits and improved outcomes. Each TU will receive a tailored report and an assessment on the escalation of additional risks identified through site visits will be made in advance of the final business continuity test (which may serve to mitigate or remove some of those risks).

- **Risks identified through business continuity exercise**

  Staff working in EDs are managing services under an acute degree of strain. Winter will invariably bring significant pressures on the teams expected to deal with repatriation and management of their own cases not determined as MTC referrals by WAST. The business continuity exercise will test a number of scenarios already set out as case vignettes in this chapter. A full report of the business continuity exercise will include risk assessments from site visits, benefits plan analysis and business continuity testing.

12.12 Communication/Stakeholder Engagement Plan

A comprehensive communication/ stakeholder engagement plan was developed in 2018, indicating key stakeholder groups and how communication would be managed, both during the implementation and operational phases of the programme. The schedule of stakeholders was developed from the work undertaken to identify stakeholders as part of the public consultation process. Feedback in relation to this document has been received from health board engagement leads. Integral to the strategy is the responsibility for health boards to regularly update their respective local stakeholders in relation to this development. Currently an action plan is being developed to support the broader strategy. This includes a division of key stakeholder groups e.g. patients, families and carers, health boards, pre-hospital services, commissioning bodies, Welsh Government, academic institutes and colleges and third sector organisations. Within the context of each stakeholder, a description will be provided of key activities and messages, the modality through which these will be communicated, sequencing of the plan and identification of the lead organisation.

12.13 List of Specialist Advisors

Given the specialist nature of this strategic development, the programme has made extensive use special advisors throughout its work programme. The special advisors listed below have been fundamental to assurance of the programme and in addition to network board membership.

- Pre network board establishment
- Clinical Reference Group Membership
- Independent Panel Membership
- Post network board establishment
- National
    - Professor Chris Moran – National Clinical Director, Major Trauma NHS England
    - Professor David Lockey – Clinical Director, Severn Trauma Network and Interim Clinical Lead, South Wales Trauma Network (2017-2018)
    - Dr Martin McKechnie – National Clinical Director, Scottish Trauma Network
    - Kate Burley – Associate Director, Scottish Trauma Network
    - Dr Sally Lewis – National Clinical Lead for Value-Based and Prudent Healthcare
- Orthoplastic Trauma
    - Professor Ian Pallister – T&O consultant, Morriston Hospital
    - Mr Dean Boyce, Consultant Plastic Surgeon, Morriston Hospital
    - Mr Hywel Dafydd - Consultant Plastic Surgeon, Morriston Hospital
    - Mr James Lewis – Trauma & Orthopaedic Consultant, UHW
- Spinal Trauma
    - Mr Navin Verghese, Spinal Consultant, Morriston Hospital
    - Mr Sashin Ahuja, Spinal Consultant, UHW
    - Mr James Cordell-Smith, Spinal Consultant, Royal Gwent Hospital `
- Spinal Rehabilitation
    - Mr Sreedhar Kolli – Spinal Rehabilitation Consultant, Rookwood Hospital
- Thoracic Trauma
    - Mr Douglas West, Thoracic surgery consultant, University Hospitals of Bristol
- TARN
    - Antoinette Edwards – Executive Director, TARN
    - Laura White – Operations Director, TARN
    - Professor Fiona Lecky – Research Director, TARN
- Evidence based review
    - Dr Rowenna Morris-Clarke – Anaesthetist, Swansea Bay UHB

August 2019 Peer Review

The August 2019 Professional Peer Review had input from the following:

- **Major Trauma Centre Case**
  - Mr Rob Faulconer, Consultant Vascular Surgeon, Plymouth Hospitals NHS Foundation Trust
  - Dr Ben Walton, Consultant ICM and Anesthetics, North Bristol NHS Trust
  - Dr Richard Hall, Consultant in Emergency Medicine, University Hospital of North Midlands NHS Trust
  - Dr Steve Novak, Consultant in Rehabilitation Medicine, North Bristol NHS Trust
  - Dr Judith Allanson, Consultant in Neurorehabilitation, Cambridge University Hospitals NHS Trust
  - Dr Giles Haythornthwaite, Consultant in Paediatric Emergency Medicine, Clinical Lead for the Paediatric Major Trauma Centre, Named Doctor For Child Safe-Guarding
- **Specialist Services**
  - Mr Shehan Hettiaratchy - Plastic and Reconstructive Surgeon, Imperial College, Trust trauma lead and lead surgeon; consultant plastic, hand and reconstructive surgeon, Imperial College Healthcare NHS Trust
  - Miss Loz Harry, Consultant Plastic Surgeon, Queen Victoria Hospital
  - Mr Mark Wilson, Consultant in Neurosurgery and Pre-Hospital Care Specialist, Imperial College Hospital
- **Trauma Units**
  - Dr Ash Basu, Consultant Emergency Physician, Betsi Cadwaladr University Health Board
  - Dr Adam Wolverson, Consultant in Intensive Care Medicine and Anaesthesia, United Lincolnshire Hospitals NHS Trust
  - Dr Steve Novak, Consultant in Rehabilitation Medicine, North Bristol NHS Trust
- **Pre-Hospital**
  - Dr Phil Cowburn, Acute Care Medical Director, South West Ambulance Services NHS Foundation Trust
- **Operational Delivery Network**
  - Mr Steve Cooke, Network Manager, West Midlands Trauma Network
  - Dr Louisa Stacey, Major Trauma Centre Manager and Thames Valley Trauma, Vascular, and Spinal Networks Manager, Oxford University Hospitals
- **Therapies**
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13 Conclusions and Recommendations

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

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

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

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

The network board was established in May 2018 and set out a robust case, aligning with both national and international strategic drivers for change. The case for change is compelling, with the prospect of benefits realisation aligned closely with key investment objectives of health gain, equity, clinical and skills sustainability, and value for money, including economic benefits. Thus, where indicated, a value-based healthcare approach has been applied.

The network board has overseen the development of the structure of the network, comprised of the following elements:

- An Operational Delivery Network (ODN) hosted by Swansea Bay University Health Board
- An adult's and children's MTC at UHW, Cardiff
- An adult and paediatric TU with specialist services at Morriston Hospital, Swansea
- Six adult and paediatric TUs at the following locations:
    - UHW, Cardiff
    - Royal Gwent Hospital, Newport and Nevill Hall Hospital, Abergavenny (period until the Grange University Hospital is fully operational from April 2021, at which point the Grange University Hospital will become the site of a single designated TU for the Aneurin Bevan University Health Board)
    - Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend
    - Glangwili General Hospital, Carmarthen

- Rural trauma facilities at Bronglais General Hospital, Aberystwyth, and Withybush General Hospital, Haverfordwest
- A Local Emergency Hospital at Royal Glamorgan Hospital, Llantrisant

The network board has also developed a phased clinical and operational model, based on the NHS England quality indicators and service specification for major trauma services. All providers and relevant commissioning bodies have agreed this model and requisite resource requirements, following several tiers of internal and external reviews, as outlined below:

- An ODN and management team hosted by Swansea Bay University Health Board. This includes requirements set out for network clinical informatics and training and education.
- Pre-hospital requirements for the Welsh Ambulance Service NHS Trust (WAST), including additional ambulance conveyances, the development of a national trauma desk function and an educational programme. The agreed first phase of the Emergency Medical Retrieval and Transfer Service Cymru (EMRTS) expansion to 24/7, from April 2020, is described within this case for completeness.
- Requirements for the combined adult and paediatric MTC at UHW, including the 24/7 presence of a consultant trauma team leader, the establishment of a polytrauma ward, additional theatre/critical care capacity, a plastic surgical service and a model of hyper-acute rehabilitation.
- Key enabling resources for TUs and an approach to the 'landing pad' for patients returning from the MTC for care with treatment closer to home.

The case describes the delivery of absolute requirements for Day 1, but also the schedule of business cases that will follow as part of the phased introduction of the network. In doing so, the case also sets out a timeline for implementation of the network (and composite parts) on 1 April 2020, with the ODN management team being put into place in January 2020. Whilst this presents an ambitious timeline, the programme in committed to achieving this.

In order to manage implementation, the case describes a revised implementation structure, commissioning and organisational governance arrangements and workforce principles to maximise positive benefits of recruitment for the wider healthcare system. Finally, a focus is placed on giving the ODN operational authority, particularly in relation to the repatriation of patients from the MTC and maintaining patient flow across the network.

The network board recommends that health boards, commissioners and the Welsh Government endorse this Programme Business Case, the agreed structure and the requisite phased resource requirements for the establishment of the South Wales Trauma Network, serving the population of South Wales, West Wales and South Powys, so that it can proceed with implementation.

The programme team would like to thank all contributors for their time and advice in developing this complex and challenging Programme Business Case.

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Abbreviations

ABUHB	Aneurin Bevan University Health Board
AHP	Allied Healthcare Professional
AIS	Abbreviated Injury Scale
APLS	Advanced Paediatric Life Support
APP	Advanced Paramedic Practitioner
AEMT	Advanced Emergency Medical Technician
ASD	Air Support Desk
ATLS	Advanced Trauma Life Support
BCUHB	Betsi Cadwaladr University Health Board
BOAST	British Orthopaedic Association Standards for Trauma and Orthopaedics
CAG	Clinical Advisory Group
CCC	Clinical Contact Centre
CCP	Critical Care Practitioner
CHC	Community Health Council
CRG	Clinical Reference Group
CT	Computerised Tomography
CTMUHB	Cwm Taf Morgannwg University Health Board
C&VUHB	Cardiff and Vale University Health Board
CWTCH	Care with Treatment Closer to Home
DGH	District General Hospital
DSTS	Definitive Surgical Trauma Skills
EASC	Emergency Ambulance Service Committee
ED	Emergency Department
EMRTS	Emergency Medical Retrieval and Transfer Service Cymru
EMT	Emergency Medical Technician
EPALS	European Paediatric Advanced Life Support
ETC	European Trauma Course
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
ICD-10	International Classification of Diseases, Tenth Revision
IMTP	Integrated Medium Term Plan
ITS	Inclusive Trauma System
ISS	Injury Severity Score

LEH	Local Emergency Hospital
MRI	Magnetic Resonance Imaging
MTC	Major Trauma Centre
NEPTS	Non-Emergency Patient Transfer Service
NHSWHC	National Health Service Wales Health Collaborative
NMTNG	National Major Trauma Nursing Group
NWMNWTN	North West Midlands and North Wales Trauma Network
NWIS	National Health Service Wales Informatics Service
ODN	Operational Delivery Network
PACU	Post-Anaesthetic Care Unit
PBC	Programme Business Case
PEDW	Patient Episode Database for Wales
PER	Project Evaluation Review
PIR	Post-implementation Review
PPE	Post-project Evaluation
PTHB	Powys Teaching Health Board
PREMS	Patient Reported Experience Measures
PROMS	Patient Related Outcome Measures
QI	Quality Improvement
SBUHB	Swansea Bay University Health Board
SCIC	Spinal Cord Injury Centre
SRO	Senior Responsible Officer
SWP	South Wales Programme
SWTN	South Wales Trauma Network
TARN	Trauma Audit and Research Network
TNCC	Trauma Nursing Core Course
TTL	Trauma Team Leader
TTM	Trauma Team Member
TU	Trauma Unit
UHW	University Hospital of Wales
VTN	Veterans Trauma Network
WAACT	Wales Air Ambulance Charity Trust
WAST	Welsh Ambulance Service NHS Trust
WATcH	Wales and West Acute Transport for Children Service
WCP	Welsh Clinical Portal
WCRS	Welsh Care Records Service

WHSCC	Welsh Health Specialised Services Committee
WPAS	Welsh Patient Administration System
WPRS	Welsh Patient Referral Service
WRRS	Welsh Results Reporting System

Glossary of Terms

Case Ascertainment

Proportion of patients submitted to Trauma Audit and Research Network (TARN) compared to expected number based on Patient Episode Database for Wales (PEDW) dataset. Marker of data completeness.

Case Accreditation

Proportion of key fields completed for each patient and submitted to TARN. Marker of quality of data submitted.

Computerised Tomography (CT)

A scanning technique that uses x-rays to take highly detailed images of the body.

Critical Care

Refers to two related processes. Firstly, 'critical' refers to discernment or recognition of a crucial and a decisive turning point, the deterioration of the patient's condition, followed, secondly, by 'care' (i.e. intervention including resuscitation and transport to a critical care service). Critical care resuscitation and treatment interventions include a complex range of general and specialty procedures, supports and diagnostic procedures. Thus, the critically ill patient benefits from appropriate and timely critical care in the health system with a greatly increased probability of survival.

Definitive Care

The care that is rendered to conclusively manage a patient's condition, such as full range of preventive, curative acute, convalescent, restorative, and rehabilitative medical care.

Injury Severity Score

An anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (head, face, chest, abdomen and extremities including pelvis, external). Only the highest AIS score in each body region is used. The three most severely injured body regions have their score squared and added together to produce the ISD score. An ISS of 9-15 implies moderate trauma and an ISS>15 implies major trauma. An ISS>9 implies 'candidate' major trauma.

The ISS is calculated retrospectively once the patient's injuries are fully known.

Inter-Hospital Transfer

Primary Transfer

A transfer where a patient is retrieved from a pre-hospital environment.

Secondary Transfer

A planned transfer of a patient to a local facility as a result of capacity issues or for the ongoing repatriation of the patient.

Hyper- Acute Secondary Transfer

A transfer where a patient is retrieved from a hospital environment. This is for a time critical, life threatening condition. This may occur when a patient has acutely deteriorated or following a patient self-presenting or being transported to the hospital due to the paramedic crew making the decision that further ongoing transport would have endangered the life of the patient. This is also known as a delayed primary transfer.

Landing Pad

The environment to which major trauma patients will return once their specialist care is complete (e.g. at the MTC). It includes the structures in place to support and enhance the confidence of medical and nursing staff in managing patients in the recovery, rehabilitation and re-enablement phases of their journey.

Level 1 and 2 Trauma Nursing Competency

The levels of competency required for nurses engaging in the care of adult and paediatric major trauma patients. These have been developed by the National Major Trauma Nursing Group.

Local Emergency Hospital

A hospital in a Trauma Network that does not routinely receive acute trauma patients. It has processes in place to ensure that, should this occur, patients are appropriately transferred to a Major Trauma Centre or Trauma Unit.

Major Incident

A significant event, which demands a response beyond the routine, resulting from uncontrolled developments in the course of the operation of any establishment or transient work activity. The event may cause, or have the potential to cause either:

- Multiple serious injuries, cases of ill health (either immediate or delayed), or loss of life.
- Serious disruption or extensive damage to property, inside or outside the establishment.

Major Trauma

Serious, and often multiple, injuries where there is a strong possibility of death or disability.

Major Trauma Centre

A multi-specialty hospital, on a single site, optimised for the provision of trauma care, integrated with the rest of the Trauma Network.

Mass Casualty Incident (MCI)/

Any incident in which emergency medical services resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties. Sometimes called a multiple-casualty incident or multiple-casualty situation.

Pre-hospital Care

Covers a wide range of medical conditions, medical interventions, clinical providers and physical locations. Medical conditions range from minor illness and injury to life threatening emergencies. Pre-hospital interventions, therefore, also range from simple first aid to advanced emergency care and pre-hospital emergency anaesthesia. Care providers may be lay first responders, ambulance professionals, nurses or physicians of varying backgrounds. All of this activity can take place in urban, rural or remote settings and is generally mixed with wider out-of-hospital and unscheduled care.

Probability of Survival

This is calculated for each injured patient and retained on the TARN database. This allows comparative outcome analyses for hospitals and for other groups of patients to be performed.

Reablement

A short and intensive service, usually delivered in the home, which is offered to people recovering from an injury to promote and maximise independence.

Rehabilitation

A process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living.

Rehabilitation Plan

A plan used to document the rehabilitation needs of severely injured patients (ISS score ≥9) and identify how they will be addressed.

Retrieval

The use of expert medical teams to assess, stabilise, package and subsequently transport a patient from one site to another. The aim is the delivery of critical care equivalent to that provided at a major hospital facility.

Rural Trauma Facility

Used to describe the role of Bronglais General Hospital and Withybush General Hospital as part of the Trauma Network. These hospitals do not meet the quality indicators and service specification of a Trauma Unit, however, given their relatively rural location, will receive disproportionally more major trauma compared to a Local Emergency Hospital. These hospitals will need to maintain the ability to assess and treat major trauma patients, before onward transfer to the Major Trauma Centre or nearest Trauma Unit, as appropriate.

Specialist Rehabilitation

The total active care of patients with complex disabilities by a multiprofessional team who have undergone recognised specialist training in rehabilitation, led/ supported by a consultant trained and accredited in rehabilitation medicine.

Trauma

Physical injuries of sudden onset and severity, which require immediate medical attention.

Trauma Care Pathway

The process through which care is provided for patients who have suffered Major Trauma. Specifically, it describes the location and capability of each facility within the inclusive trauma system and outlines the ambulance bypass protocols and thresholds for transferring patients to more specialist units. The pathway has several stages, including pre-hospital care, acute care and surgery, ongoing care and reconstruction and specialised and local rehabilitation. Within the pathway, hyper-acute rehabilitation starts early. Two additional components have been added: injury prevention and social care.

Trauma Network

The collaboration between the providers commissioned to deliver trauma care services in a geographical area. The term is interchangeable with the terms 'Trauma Operational Delivery Network' and 'Inclusive Trauma System'.

Trauma Unit

A hospital in a Trauma Network that provides care for most injured patients.

Wales Trauma Network

The Value of a Major Trauma Network – An Evidence Based Review

Author(s): Dr Rowenna Morris-Clarke, Anaesthetist, Swansea Bay UHB

Date: June 2019 **Version:** 2.0

Summary and key points for discussion: This paper provides a summary of an evidence based review undertaken to establish the value of a major trauma network and has informed the case for change.

Review History: reviewed by Dindi Gill, Clinical Lead, Wales Trauma Network

Draft Number & version		Author/ Editor	Date
1	1.0	Dr Rowenna Morris-Clarke	June 2019
2	2.0	Dindi Gill	June 2019

Background

The evidence base that we currently have consistently demonstrates that severely injured patients are 15-20% less likely to die if admitted to a major trauma centre than if admitted to another hospital.[1] From this, in 2010 a document supporting the development of major trauma networks was published by the NHS clinical advisory group. One of its main points being the recommendation of enhanced care teams being available 24/7 to provide care to a major trauma patient.[2] Taking this evidence on board, in April 2012 NHS England established 16 regional trauma networks and created a series of major trauma centres surrounded by feeding trauma units. In October 2018 Scotland followed suit and opened its first trauma centre in Aberdeen, with Ireland still debating their own trauma network.

A Major trauma Centre within the trauma network, will see an increase in patient numbers to this specialist hospital, an increases survival but does not lead to increase in burden of disease. With specialist care and subsequent specialist rehabilitation, trauma centres also provide the potential to increase return to work rates or return to a normal daily life. Such possibilities only exist with the correct rehabilitation and support services.

A literature search was carried out with the help of Library Services at Morriston Hospital, searching several databases including Medline for papers showing the impact of a major trauma network across the world. Guidelines were also included in this search and also those papers referenced in the guideline.

The evidence base is displayed in the following headings:

- Major Trauma Centre, Trauma Units, Local Emergency Hospitals
- Pre-hospital care and retrieval
- Acute Emergency Care and Surgery
- Ongoing Care and Reconstruction
- Rehabilitation

1. Celso et al. A Systematic Review and Meta-Analysis Comparing Outcome of Severely Injured Patients Treated in Trauma Centers Following the Establishment of Trauma Systems. Trauma 2006 Vol iss 2 pp371-378
2. NHS Clinical Advisory Group. Regional Networks for Major Trauma. September 2010 http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Emergencymedicine/Regionalnetworksformajortrauma.pdf

The Major Trauma Network: Major Trauma Centre, Trauma Units and Local Emergency Hospitals

Reference	Type of study/aims	Key results	Conclusions
McDermott et al **Management deficiency and death preventability of road traffic accidents before and after a new trauma care system** **Journal of trauma, injury, infection and critical care.** **J Trauma. 2007 Aug;63(2):331-8**	Regional retrospective data analysis in Victoria Australia. This study compares potentially preventable death rates of road crash fatalities who received treatment before (1997–1998) and after (2002–2004) organization of a major trauma network.	ED admissions increased from 34% to 62% ($p < 0.05$). More patients were attended by Advanced Trauma Life Support paramedics ($p < 0.05$) and scene times increased ($p < 0.05$). Patients admitted within 1 hour decreased from 70% to 45% ($p < 0.05$) – longer transport times to MTS by road. The mean number of deficiencies per patient including those contributing to death was decreased ($p < 0.05$). The preventable death rates decreased from 36% to 28% (22% relative risk reduction). Patient demography and injury severity were unchanged.	Since the introduction of The new Victorian trauma care system, there has been a significant decrease in deficiencies including those contributing to death and a decrease in preventable death rates. The marked improvement has been largely consequent to an increase in admissions to MTS. Despite a longer time at the crash site and longer transport times to the specialist hospital, outcomes for trauma patients had improved.
Moran et al **Changing the System - Major Trauma Patients and Their Outcomes in the NHS (England) 2008–17** **EClinicalMedicine 2–3 (2018) 13–21**	A longitudinal series of annual cross-sectional studies of care process and outcomes from April 2008 to March 2017 Data was collected through the national clinical audit of major trauma care.	Analysis carried out on 110,863 patients admitted to 35 hospitals Major Trauma networks were associated with significant changes in - increased numbers treated in Major Trauma Centres - more consultant led care and more rapid imaging - patient factors (an increase in older trauma) - changes to clinical care Increase of 0.08% per quarter more survivors, so for every 1000 patients per year, 30 more were	This report demonstrates the multilevel changes which have occurred to provide excellent clinical care, which has subsequently lead to an increase in number of lives saved following major trauma.

		surviving. This was without and increased length of hospital or ICU stay.	
Gabbe et al **Improved functional outcomes for major trauma patients in a recognized trauma system 2015** **Ann Surg 2012;255:1009–1015**	Retrospective data analysis of all patients admitted following trauma from 2006-2009 in state of Victoria, Australia. The author collected data regarding a patient's mortality and their functional outcomes following trauma. Data was collected from 138 trauma-receiving hospitals and 3 major trauma centres in Victoria, Australia, following their implemented regional trauma system in 2000.	There were 4986 patients older than 18 years. In-hospital mortality decreased from 11.9% in 2006–2007 to 9.9% in 2008–2009. 86% were successfully followed up at 12month Of those 80% reported functional limitations, but the odds of better functional outcome increased in the years studied following the trauma network formation. Cases managed at major trauma services (MTS) achieved better functional outcome (AOR: 1.22; 95% CI: 1.03, 1.45). Female gender, older age, and lower levels of education demonstrated lower adjusted odds of better outcome	Since implementing a major trauma network, there has been an annual decline in mortality. Risk-adjusted functional outcomes improved over time, i.e. not only were more patients surviving, they were doing so with less disability. A point to note is that cases managed at Major trauma centres, usually the most severely injured, demonstrated better functional outcomes.
Metcalfe et al **Effect of regional trauma centralization on volume injury severity and outcomes of injured patients admitted to trauma centres** **Br J Surg. 2014 Jul;101(8):959-64**	A retrospective study looking at trauma patients admitted to 4 hospitals, before and after becoming major trauma centres in London in March 2012.	Impact upon the four hospitals following intuition of the trauma network: - Patient volume increased from 442 to 1326 which is a 200% increase - operations from 349 to 1231 -253% - critical care bed-days from 1100 to 3704 - 237% - total hospital bed-days from 7910 to 22 772 – 188%. - Patient age increased on MTC designation from 45·0 years before March 2012 to 48·2 years afterwards (P = 0·021),	This large regional study demonstrates the impact upon a hospital once it becomes a major trauma centre. The volume of patient arriving at ED, having operations and spending time in critical care dramatically increase to over 200% in most cases. This is about the national average of a 20% increase, explained possibly but the location of these hospitals.

		- Penetrating injuries increased 1·8% to 4.1% - Fewer patients required secondary transfer to a MTC from peripheral hospitals (19·9 versus 16·1 per cent; P = 0·100). - There were no significant differences in total duration of hospital stay, critical care requirements or mortality. - Significant increase, from 55·5% to 62·3% (P < 0·001), in the proportion of patients coded as having a 'good recovery' at discharge	More patients were arriving at the appropriate hospital first time, avoiding the need for secondary transfer which can delay treatment and expose the patient to a second transfer. Although no mortality benefit was demonstrated within 6 months of establishing this trauma network, early detectable advantages included improved functional outcome at discharge.
Gabbe et al **The Effect of an Organized Trauma System on Mortality in Major Trauma Involving Serious Head Injury: A Comparison of the United Kingdom and Victoria, Australia. Annals of surgery January 2011 - Volume 253 - Issue 1 - p 138–143**	Retrospective data analysis of Uk trauma data (TARN) and Victoria state trauma registry (VSTR), following implementation of its trauma network. Mortality outcomes following major trauma involving serious head injury managed in the two registries between 2001 to June 2006 was collected and analysed.	A total of 4064 (VSTR) and 6024 (TARN) cases were provided for analysis. Chance of death following major trauma in the UK was significantly higher than that for Australia. [odds ratio = 2.15, 95% confidence interval = 1.95–2.37]. Both countries showed similarities in the profile of major trauma patients, with a predominance of blunt trauma related to road trauma and falls, and comparable data registries. In particular risk of mortality was significantly lower for severe head injuries in Australia. In the two groups 17% of patients died in Australia versus a staggering 30.8% in UK.	In the two groups 17% of patients died in Australia versus a staggering 30.8% in UK. Management of the severely injured patient with an associated head injury in where an organized trauma network is absent, was associated with increased risk of death compared.
Simons RU et al 1999 Impact on Process of Trauma Care Delivery 1	Prospective study before and after implementing a dedicated trauma service for patients with	Differences between preprogram and post program performance were assessed	What this study implies is that the major trauma network goes further to improve patient care, by employing a dedicated

Year after the Introduction of a Trauma Program in a Provincial Trauma Centre **Journal of trauma Issue: Volume 46(5), May 1999, pp 811-816**	multisystem injuries at major trauma centres. It is proposed that Trauma care is necessarily multidisciplinary, and to be optimal, appropriate integration of the care process and prioritization are required.	Results: Trauma unit average length of stay decreased from 10.15 days initially to 9.66 and 9.14* days at 6 and 12 months, thus reducing bed occupancy and reducing costs. Improved survival was also demonstrated by Trauma and Injury Severity Score methodology with z score achieving significance compared with Major Trauma Outcome Study outcomes after program implementation.	multidisciplinary team focusing on the process of care, developing a dedicated trauma service to manage the more seriously injured patients.
McKee et al **Right treatment at the right time in the right place** **Ann Surg 2015;261:558–564**	Canadian based study where due to geography, access to trauma centres require lengthy transfer times. Prospective study before and after a new trauma system was implemented creating secondary trauma centre	21,772 major trauma patients were included. Implementation of the new system of trauma care was associated with a decline in transfers directly to level I trauma centres [risk ratio (RR) = 0.91; 95% confidence interval (CI): 0.88–0.94; P < 0.001] and an increase in transfers from level III to level I centres (RR = 1.10; 95% CI: 1.00–1.21; P = 0.04). These changes in trauma care occurred in conjunction with a 12% reduction in the hazard of mortality (hazard ratio = 0.88; 95% CI: 0.84–0.98; P = 0.003) and a decrease in mean trauma patient hospital length of stay by 1 day (95% CI: 1.02–1.11; P = 0.02) after adjustment for differences in case mix	This study demonstrates the importance of getting the distance and spatial arrangement of trauma centres correct, in order for it to have a benefit upon patient outcomes. By differing levels of trauma centres, patients were now reaching an immediate point of care faster.
Hay et al **The impact of the Major Trauma Network: will trauma units continue to treat complex foot and ankle injuries?**	Retrospective analysis of the epidemiology of foot and ankle injuries, using the Gloucestershire trauma database, from a trauma unit with a population of 750,000 Following the introduction of National trauma Networks in April, it was	Frequency of complex foot and ankle injuries was 4.2% before and 7.5% after the network commenced, showing no significant change. There was no statistically significant change in the numbers of patients with complex foot and ankle injuries treated by application of external fixators in this trauma unit. Analysis of TARN data revealed that only 18% of patients with foot and ankle injuries taken to the MTC had an ISS ≥ 16. The majority of these patients were identified as	This study showed that trauma related injuries will continue to present to trauma units within the Major trauma network. This has to be taken into consideration when planning services appropriately, ensuring trauma units do not lose services that they will continue to require.

Dec 2014 Vol 45, Issue 12, p 2005-2008	predicted that with severely injured patients being transferred to the regional Major Trauma Centre (level 1), trauma units (level 2) would no longer manage certain trauma related specialties thereby obviating the need for them.	requiring plastic surgical intervention for open fractures (69%) or were polytrauma patients (43%). Only 4.5% of patients had isolated, closed foot and ankle injuries.	
Gabbe et al **Reduced population burden of road transport-related major trauma after introduction of an inclusive trauma system** **Ann Surg 2015 Mar; 261 (3) pp 565-72**	Aim to describe the burden of transport-related serious injury in Victoria, Australia, since introduction of an integrated trauma system. Retrospective data collection of all road and major trauma-related deaths from coroner and trauma registry data for July 2001 – June 2011. Disability-adjusted life years, combining years of life lost and years with disability were calculated.	Incidence of transport-related deaths decreased. Incidence of hospitalized major trauma increased. Years of life lost decreased by 43%. Years with disability increased by 32% but with an overall 28% reduction in disability-adjusted life years over the decade. The study also showed significant cost saving when taking this into account.	This study demonstrates that since Victoria, Australia introduced their trauma system, the burden of trauma related disease has decreased. Despite the increase in hospitalisation of trauma patients, they demonstrated a decrease in disability burden. So conclude that increase survival in this situation does not lead to an overall increase in nonfatal injury burden.

Pre-hospital Care and Retrieval

Reference	Type of study/Aims	Key results	Conclusions
D.C.Engel, A.Mikocka-Walus, P.A.Cameron, M.Maegele Pre-hospital and in-hospital parameters and outcomes in patients with traumatic brain injury: A comparison between German and Australian trauma registries. **Injury Vol41, Issue 9, Sept 2010, p901-906**	Retrospective observational study comparing two forms of trauma systems, taking into account injury severity and population demographics – the main difference being the Australian prehospital and major trauma network.	10,183 cases (5665 German, 4518 Australian) were included Mortality was significantly higher amongst German patients even when adjusted for demographics, injury severity and in- and pre-hospital parameters. German patients had a longer hospital and ICU stay.	Underpins the importance of an integrated system of specialist prehospital care and retrieval providing efficient and rapid stabilization and transfer to a major trauma centre. How this can then have knock on effect the effect of improving chance of survival and decreasing hospital stay.
Preston J.FedorMD, BrianBurns, MichaelLauria, ClareRichmond Major Trauma Outside a Trauma Centre: Prehospital, Emergency Department, and Retrieval Considerations. EMCoNA Vol36,Issue 1, Feb2018, p203-218	Overview of the role of the prehospital care teams and retrieval services. Observational study comparing with up to date protocols.	Incoming Emergency Medical Services crews often have crucial information about trauma mechanism, contributing factors, specific injuries, effect of treatment, key timings, personal details, and more. -Set up the resuscitation area for success and know the equipment and team capabilities. -Create and rehearse emergency department and hospital procedures -Extensive radiological and laboratory evaluation is often unnecessary and may delay access to definitive care. -Request transfer/retrieval as soon as the need for higher level of trauma care is presumed. A standard preretrieval process (with checklist) can make the	Care of the critically injured begins well before the patient arrives at a large academic trauma centre. It is important to understand the continuum of care from the point of injury in the prehospital environment, through the local hospital and retrieval, until arrival at a trauma centre capable of definitive care. This article highlights the important aspects of trauma assessment and management outside of MTC.

		transition of the patient out of the emergency department safer and more efficient	
Bryce N.Taylor, Niki Rasnake, Kelly McNutt, Catherine Lindsay McKnight, Brian J.Daley. **Rapid Ground Transport of Trauma Patients: A Moderate Distance from Trauma Centre Improves Survival** **Journal of Surgical Research** **Volume 232, December 2018, Pages 318-324**	Retrospectively analysis of patients brought to a level I trauma centre who were admitted with blunt traumatic injuries between 2010 and 2015 Two groups existed HEMS and ground transport GEMS. Data was collected for trauma patients' vital statistics, transport times and mortality were analyzed.	400 subjects were included in the analysis of patients - 212 HEMS patients and 188 in the GEMS group. HEMS had a higher mortality rate at 0.184 and GEMS at 0.101, which was statistically significant ($P = 0.019$). When 606 subjects meeting the first step of the NFTG or with a pulse greater than 110 beats per minute were analyzed, the results were statistically significant ($P < 0.001$), with the HEMS category having a higher mortality rate at 0.154 and the GEMS category having a lower mortality at 0.056.	This highlights the challenges in transporting patients to the nearest trauma centre. This London based prehospital study is located over an area where ground transport may be the fastest. However, they do recognize that there may be a subset of patients at these distances who could benefit from HEMS response, particularly if the flight crew can offer more advanced and specialized techniques. This study only analyzed the patients within a moderate distance of the trauma centre and at longer distances or in different environments, HEMS transport may indeed minimize the scene to ED time. With the EMRTS having access to both ground and air retrieval Wales, they will be able to supply the major trauma network in a similar way.
Prehospital care **Impact of introducing a major trauma network on a regional helicopter emergency medicine service in the UK** **McQueen C, et al. Emerg Med J 2014;31:844–850**	Retrospective review of the clinical audit database for a 6-month period after the launch of the West Midlands Major trauma network on 26 March 2012. Non trauma requests were excluded from the analysis. The team then	The proportion of HEMS activations for trauma cases was similar in both cohorts (70.84% before MTN vs 71.57% after MTN). The proportion of mission cancellations was significantly lower after the launch of the network (23.71% vs 19.03%). Significantly more scene attendances resulted in interventions by HEMS crews after the MTN launch (44.66% vs 56.92%).	The relevance of this study to the Welsh trauma network, is to demonstrate the affect upon our existing EMRTS helicopter service once a specialist trauma network has been established. This study shows that the impact in a positive one upon an already established and funded system. Since the introduction of the West Midlands MTN, they are able to better equip to target cases involving

	reviewed the corresponding period for the previous year for comparison.		significant injury, and show a reduction in mission cancellations.
Taylor et al **The cost-effectiveness of physician staffed Helicopter Emergency Medical Service (HEMS) transport to a major trauma centre in NSW, Australia** **2012** **Injury, Int. J. Care Injured 43 (2012) 1843–1849**	St George Hospital NSW Retrospective cost analysis over 11 year period looking at mortality and cost per life saved, cost per life-year saved at one year and over a patient's lifetime respectively in three patient groups – all patients, seriously injured and traumatic brain injury patients.	Results showed HEMS to be more costly but more effective at reducing in-hospital mortality. When modelled over a patient's lifetime, the improved mortality associated with HEMS led to a cost per life year saved of $96,524, $50,035 and $49,159 in the three patient groups respectively. Sensitivity analyses revealed a higher probability of HEMS being cost effective in patients with serious injury and TBI.	HEMS transport to a major trauma centre is more costly initially for obvious reasons, and those who have more life threatening injuries will go on to need specialist care and therefore increased cost. However, with HEMS intervention combined with treatment at a major trauma centre, there is an improved mortality leading to an estimated cost per life saved between $519,787 and $1,566,379 and an estimated cost per life year saved between $49,159 and $96,524. The estimated cost effectiveness of HEMS improved in patients with more serious injuries and in patients with traumatic brain injury
SInclair et al **Clinician tasking in ambulance control improves the identification of pre hospital critical care team tasking** **Injury 2018 May pp897-902**	Retrospective cohort study over 2 years Pre and post implementation of pre-hospital critical care trauma team clinician led dispatch of PHCCT for potential trauma patients	99,702 trauma related calls were made, including 495 major trauma patients with an ISS >15, and a total of 454 dispatches of a PHCCT. Following the introduction of a PHCCT clinician staffed trauma desk The sensitivity for major trauma was significantly increased from 11.3% to 25.9%. (95% CI 7.4%-21.4%, $p < .001$).	This study supports the use of a trauma desk, recommending that a PHCCT clinician should be located in ambulance control to aid early identification of trauma patients and direct the response.

Acute Emergency Care and Surgery

Reference	Type of study/aims	Key results	Conclusions
Kehoe et al **The changing face of major trauma in the UK** **EMJ Vol 32 Issue 12 pp911-915**	Retrospective observational data analysis of major trauma from the Trauma Audit Research Network from 1990 to 2013. The aim was to describe the changes in the demographics of trauma over the 13 years.	The mean of age of major trauma in 1990 was 36.1, with the largest age group being 0-24. Most common cause was road traffic collision. By 2013 the mean age had increased to 53.8 with the single largest group being 25-50 year olds and then the over 75s (26.9%). The most common mechanism was now low falls.	The face of trauma has changed over the 13 years in this study, highlighting that over 25% of trauma is now in the >75 years olds. The specific needs of the elderly must be considered in the design of major trauma services for significant improvements in trauma to be seen.
Baarr LV et al **The effect of becoming a major trauma centre on the outcomes for elderly hip fracture injury** **Injury. 2015 Feb;46(2):384-7**	Retrospective data analysis over 1 year. The aim of this study was to ascertain whether becoming an MTC has affected outcomes for elderly hip fracture patients at one institution in England since 2012. 824 patients aged ≥60 years who sustained 841 consecutive hip fractures over a two-year period were included.	There were 381 fractures during the year prior to (pre-MTC group), and 460 fractures during the year after (post-MTC group) becoming an MTC. Outcomes analysed were time to theatre, length of acute hospital stay, post-operative complications, and mortality at 30, 120 and 365. There was no difference seen in the average length of stay before or after MTC established (13 days vs 14 days, p=0.2888). In the post-MTC group, there was a significant increase in delay to theatre (25.5h vs 31.5h, p<0.0001) There was a significant increase in post-operative medical complications (29.7% vs 37.6%, p=0.0160). There was no statistically significant difference in overall mortality rates, however 30-day mortality rose from 4.7% to 8.0% (p=0.0678).	What this study suggests in comparison to the national Hip fracture audit data, is that a newly appointed MTC, with increased demands upon its existing infrastructure, can have an impact upon its existing services. Whether there are other factors attributable to the increase in postoperative complications and 30 day mortality seen in this study, it may still be of benefit to recognize the possibility of a negative impact that such increase in demand on services can cause. It highlights the need for preparation and readiness for

			the changes in becoming an MTC.
Batrich et all **Impact on an acute trust after opening a major trauma centre** **BJ of hospital medicine Feb2013 Vol 74 no2 p64-65**	Observation analysis editorial of the London major trauma network following its implementation Discussion regarding how the hospital has changed	Increased workload has had a major impact on all departments with the need for full rotas. Consultant Trauma is now based onsite 24/7 and this also has rota and financial implications for the trust. ED need to be well equipped, large enough to cope with multiple traumas and care delivered by senior clinicians. Radiology workload increased with need for increase image interpretation, the radiologist became part of the trauma team. Expansion of theatres with dedication trauma theatre was needed to cope with the workload. Hospital bed number and ICU bed number increased. A dedication rehabilitation consultant with a focus on rehab prescription and funding were essential.	Dedication trauma facilities at the major trauma centre results in better outcomes for severely injured trauma patients. However there is need for modification of working practices by staff in many specialties to facilitate a rapid response for the most severely injured. This observational report brings to light some of the changes that may need to be implemented in order to facilitate the same positive outcomes seem in MTC trauma patient studies.
Davenport RA et al **A major trauma centre is a specialty hospital not a hospital of specialties.** **Br J Surg. 2010 Jan;97(1):109-17**	An Observational multimodal study was performed using the database from the Trauma Audit and Research Network (TARN) for England and Wales, the Royal London Hospital (RLH) trauma registry and the US National Trauma Databank (NTDB) with an analysis of preventable deaths from trauma.	Mortality from critical injury at the RLH was 48 per cent lower following dedicated trauma service establishment. (P = 0·001). Overall mortality rates were unchanged for acute hospitals (4·3 versus 4·4 per cent) and other multispecialty hospitals (8·7 versus 7·3 per cent). Preventable death rates fell from 9 to 2 per cent (P = 0·040) and significant gains were made in critical care and ward bed utilization	Directly comparing large hospitals receiving trauma with a multitude of specialties on site, versus one which has a dedicated trauma service shows that a benefit in mortality comes from this dedicated acute care bundle, dedicated staff, protocols and facilities. This is suggestive of how Wales' MTC can follow suit to decrease preventable deaths related to trauma.

	Aim: A dedicated trauma service within a hospital (RLH) receiving major trauma improved mortality of trauma patients		
McKechnie PS et al **Time to CT and Surgery for HPB Trauma in Scotland Prior to the** **Introduction of Major Trauma Centres** **World J Surg. 2017 Jul;41(7):1796-180**	Retrospective study to assess the time taken to CT and Emergency Surgery for trauma patients with an injury to Liver, Spleen or Pancreas prior to the introduction of Major Trauma Centers (MTCs) in Scotland.	In Scotland the goal time to CT is within 60 minutes. In England this is 30 minutes. This study shoes that prior to MTC initialization, only 27% of patient were receiving this level of care. Median time to urgent surgery was 199.5 minutes.	We would expect that after a hospital adopts the role of a MTC, that there is an availability of specialized services and facilities. This study highlights the use of a CT scanner which is vital in the rapid diagnosis of trauma, and enables appropriate care, quickly. Also the speed at which a patient can receive emergency surgical care. This is in-keeping with European studies which shows a reduction in time by 38% post MTC.

Ongoing Care and Reconstruction

Reference	Type of study/aims	Key results	Conclusions
Ali et al **Experience of managing open fractures of lowers limbs in MTC** **Ann R Coll Surg Engl. 2015 May; 97(4): 287–290**	April 2012 the John Radcliffe Hospital in Oxford became a major trauma centre (MTC). Multistep audit of compliance with BOAST 4 was conducted to assess referral patterns, timing of surgery and outcomes (surgical site infection rates), to determine changes following local intervention and the establishment of the MTC.	Following development of MTC: There was an increase in the proportion of patients receiving definitive fixation median time from injury to soft tissue cover fell from 6.0 days to 3.5 days (p=0.051) median time from definitive fixation to soft tissue cover fell from 5.0 days to 2.0 days The deep infection rate fell from 27% to 8%	This small study shows the benefit of the improved ongoing and definitive care to patients at a major trauma centre as written.
Yip et al **Capacity planning for the implementation of major trauma centres** **https://publishing.rcseng.ac.uk/** **doi/pdf/10.1308/rcsbull.2016.122**	Retrospective review was performed to analyse Cambridge University Hospitals NHS Foundation Trust for the first full year of activity since acquiring MTC status (1 April 2012 – 31 March 2013) Primary outcome measures were time of additional theatre usage and additional bed days (recorded as length of stay).	Our results give an estimate of the minimum resources required in the first year of becoming a MTC for a population of 5.9 million in a rural region. Major trauma is unpredictable, and there is a natural ebb and flow of workload. A MTC is always on standby, which requires added resources. As a 24-hour emergency service is to be provided, more staff are needed. This affects all departments involved in the trauma pathway.	An additional one-day orthopaedic trauma list and three extra beds are needed for the increased number of patients admitted to the MTC during the first year of its inception.
HAQ J et al **Implementation of an oral and maxillofacial surgery trauma team in a major trauma centre** **Haq, J. et al.**	Retrospective data analysis of Oral and maxillofacial (OMF) services in Kings College London, following its designation as a Major trauma centre. An integrated oral and maxillofacial team of the week	To assess the effect of the new system as an MTC, they compared the duration of stay between 1 October and 31 January 2011-2012 with the same period in 2012-2013. The mean total duration of stay had decreased significantly by 0.84 days (p =	OMF services are integral part of the trauma team. Kings College London adapted their services as they became a Major trauma centre, which had the net result of reducing

British Journal of Oral and Maxillofacial Surgery , Volume 55 , Issue 4 , 396 - 399	was created in 2012, with the aim to provide a consultant-led, emergency service dedicated to acute care.	0.03), the mean delay to operation had decreased by 0.3 days, and the mean postoperative stay had decreased by 0.5 days.	the total duration of stay. Improving services improves patient's outcomes and has cost benefits for the centre.
Hendrickson S et al **Plastic surgical operative workload in major trauma patients following establishment of the major trauma network in England: A retrospective cohort study.** **J Plast Reconstr Aesthet Surg. 2016 Jul;69(7):881-7. doi: 10.1016/j.bjps.2016.02.003. Epub 2016 Feb 12**	Retrospective data analysis of the TARN database, compared with historical data of a London hospital pre MTC designation in 2013	In 2013 Of the 2606 trauma calls, 416 patients required surgical intervention. 29.3% of these patients (n = 122) were operated on by plastics. Emergency general extremity referrals increased from an average of 65/year to 484/year in the period 2011 to 2013, whilst plastics operative workload increased from an average of 53 cases/year to 407/year in the same period. This represents a more than sevenfold increase in the plastic surgery operative workload.	In this London MTC there was a 7 fold increase in emergency plastic surgery activity following designation of major trauma centre status. plastic surgical operative workload is at least on par with other tertiary surgical specialties The quantity of plastic surgical operative workload in major trauma must be considered when planning major trauma service design and workforce provision, and for plastic surgical postgraduate training.

Rehabilitation

Reference	Type of study/Aims	Key results	Conclusions
Specialist Rehabilitation in the Trauma pathway: BSRM core standards Version 1.4 – October 2013 **https://www.bsrm.org.uk/downloads/bsrm-core-standards-for-major-trauma-24-10-13-version1.4newlogo-forpublication-finalforweb-checked1-12-14.pdf**	The British Society of Rehabilitation Medicine has guidelines on major trauma rehabilitation, recommending all those with an ISS of ≥9 should receive specialist rehabilitation. The recommendations given in this guideline are important for trauma services planning. Many areas of the Uk have focused on the acute care elements of the pathway. However, this guideline suggests that rehabilitation is key, both for supporting individual patients' needs and increasing flow to remove bottle-necks in the acute patient pathway.	Key points from the guideline: - After trauma many patients will need input from rehabilitation services including from rehabilitation consultants. - input may be limited to assessment, giving advice and setting expectations, and possibly organising relatively simple interventions. - A significant number of patients will have more complex needs requiring more prolonged input from a multidisciplinary team with expertise, and a smaller group will need more prolonged specialist rehabilitation (in- or out-patient). - There is now a substantial body of trial-based evidence and other research to support both the effectiveness and cost-effectiveness of specialist rehabilitation. - Despite their longer length of stay, the cost of providing early specialist rehabilitation for patients with complex needs is rapidly offset by longer-term savings in the cost of community care, making this a highly cost efficient intervention. - Application of a rehabilitation prescription	Specialist rehabilitation is a critical component of the Trauma Care Pathway without which the Major Trauma networks will inevitably fail. From this guideline, it is suggested that Rehabilitation Medicince Consultants play a vital role in the Major Trauma Centres, and should be closely involved both at a clinical level and in the planning and delivery of services across all parts of the Major Trauma Networks.

Spreadborough et al 2018 A study of outcomes of patient Rx at a UK MTC for mod-severe injuries	Retrospective population based Norway study, examining return to work outcomes and associated factors with following major trauma.	With care and rehabilitation in a MTC, 66% of patients with moderate to severe injuries return to work. Patients experiencing minor or major trauma received high levels of medical benefits.	There are more aspects to rehabilitation that trauma patients benefit from - Psycho-social/physical and functional health
The National Clinical Audit of Specialist Rehabilitation following major Injury (NCASRI) **https://www.hqip.org.uk/wp-content/uploads/2018/02/SbAilk.pdf**	Ongoing quality improvement program by the British Society of rehabilitation medicine. In England, in the absence of central guidance on what form the rehabilitation prescription should take, individual MTCs had each developed their own systems with little commonality between them.	A 'Rehabilitation Prescription' (RP) was a requirement for the enhanced 'best practice' tariff in the MTCs, but the mandated data collection comprised just 4 data fields in the TARN database. Fewer than half the MTNs complied with the national recommendation for consultants in Rehabilitation Medicine (RM) to be appointed to provide clinical and strategic leadership of acute trauma rehabilitation services, and many MTCs had little or no input from RM consultants at any level.	New and emerging sets of guidelines with national audits. BRSM aims to bring together MTCs to deliver excellence for patients experience trauma. It is likely Wales should take advise form these guidelines when expanding and developing their rehabilitation services to accommodate and improve the major trauma centre for Wales
Khan F et al **Systematic review of multidisciplinary rehabilitation in patients with multiple trauma** **BJS Jan 2012 Volume99, IssueS1** **Supplement: Trauma Supplement** **p88-96**	Systematic review using MEDLINE, Embase and several other databases including Studies that compared multidisciplinary rehabilitation intervention in multiple trauma survivors with routinely available local services or lower levels of intervention, or studies that compared multidisciplinary care in different settings	No randomized and/or controlled clinical trials were identified. 15 observational studies involving 2386 participants with injuries were included. The Grading approach assessed methodological quality as 'poor' in all studies. Patients with low functional scores showed improvement after rehabilitation,	This review has highlighted the lack of high-quality studies for effective multidisciplinary rehabilitation in survivors of multiple trauma.

		however, they were unable to resume their pre-trauma level of activity. Functional ability was significantly associated with motor independence on admission and early acute rehabilitation, which contributed to a shorter hospital stay.	
Wood RL et al **Clinical and cost effectiveness of post-acute neurobehavioural rehabilitation.** **Brain Injury 1999;13(2):69–88.**	Cohort study analyzing rehabilitation for brain injury patients	76 patients with brain injury were followed up following discharge. People who have received rehabilitation with a minimum of 6 months rehabilitation, many severely damaged individuals can progress to less dependent placements in the community, and maintain higher levels of social activity (independence) with fewer hours of care support. This paper deduced this can amount to a per capita lifetime reduction of over 1 million pounds per annum in the cost of supporting such people in the community. Factors affecting outcome were time between injury and the beginning of rehabilitation Longer periods of rehabilitation (beyond 12 months for the most seriously disabled) is not associated with a better outcome.	The appropriate cognitive and behavioural rehabilitation following severe brain injury led to an increased rate of return to independence. Thus in this paper, led to estimated life-time savings in the cost of care of over £1 million.
Slade A et al **A randomised controlled trial to determine the effect of intensity of therapy on length of stay in a**	Randomised controlled single blind study based in Leeds, comparing a controlled trial of standard (n = 81) versus intensive (n = 80) rehabilitation.	Findings: - Higher intensity rehabilitation was associated with increased staff costs - A significantly shorter length of stay was seen (mean reduction 14 days)	A small randomized control trail displaying that whilst rehabilitation can be expensive for the health care system, on

neurological rehabilitation setting. **J Rehabilitation Med 2002;34(6):260–66.**		- The result, an overall saving of £1,737 per patient in the net cost of providing the rehabilitation programme.	analysis there is actually an over net cost saving.

Summary of Findings

The benefits and consequences of implementing a Major Trauma network are summarized in several papers. Since implementation of major trauma networks across England in 2012 and Scotland following suit in 2018, we are seeing promising early data from the UK population cohort.

What we can extrapolate from the tables mentioned is as follows:

Benefits

- A reduction in preventable deaths.
- More consultant led care.
- Increase in survival seen in UK studies since MTN establishment.
- Better functional outcome from trauma patients admitted to a major trauma centre
- Less need for secondary transfers
- Trauma continues to present at trauma units, so not all services will need to be centralised. (Major trauma centre is a specialist hospital not a hospital of specialties)
- Opportunities for education and training,

Problems

- Increase in hospital workload – some studies quoting between 20 and 200%
- Increase in theatre operating/demand
- Increase in bed occupancy
- Knock on effect for existing trauma waiting for theatre – some studies demonstrating an increase in mortality for hip fractures at 30 days
- Studies quoting 25% of trauma is in the over 65year olds, with Wales' aging population this poses its own specific set of demands and the need to design the health care system around the population
- An increase in demand for all surgical specialties involved within the trauma team – example given -oral and maxillofacial, Plastics
- Rehabilitation for trauma patients - increase demand for psycho-social and functional rehabilitation to decrease burden and improve socioeconomic outcomes

Conclusions

The importance of a major trauma network and major trauma centre for our health care system here in Wales is represented in these examples given above. It shows what our health care system should be in order to deliver an excellent level of care, improve quality of lives and continue to advance with the rest of the World in a modern health care system design. In order for Wales to succeed in this goal, the NHS Wales needs to take in to consideration the challenges of establishing a major trauma centre or face failing at the first hurdle. It goes further than simply designating one hospital as a Major trauma centre. The hospital will need to change and adapt in order to be in a position to cope with these challenges. The level of care given at our new major trauma centre will need to be in keeping with the level of care given in London and Victoria Australia, in order for our trauma patients to experience the benefits mentioned in these studies, and also, so not to have an impact on the existing services and inpatients. Examples as to how

this is achieved are more consultant led care, increase in capacity/facilities, education and training.

When you look at a major incident such as the Manchester Arena Bombings, you can see that trauma patients flow through the hospital was in waves in a ripple effect on the rest of the health care system.[3] Now this is obviously an extreme event, however it does demonstrate a trauma patient's pathway through a care system and the levels of stress on a system. The first wave hitting the emergency and radiology departments, within hours the second peak of activity is in theatre suite, followed by days in the intensive care and weeks in hospital, with these patients needing return trips to theatre for definitive surgery in the days and weeks following the initial injury. These patients, in order to leave hospital need the next phase which is a level of rehabilitation to facilitate their transition from ICU to ward and eventually home.

In order for there to be a continuous flow of patients through the trauma centre, there will need to be staged rehabilitation and discharge planning to accommodate new patients arriving at ED. With the increase in pressure on the system, there needs to be an adequate 'back door' so that the system does not become over loaded and under pressure so much so, that the dedicated level of care becomes difficult to provide. Trauma is the main cause of significant disability in adults of working age, and according to the World Health Organization (WHO), trauma is associated with moderate to severe disability for over 45 million people each year worldwide. Trauma, therefore has a huge socioeconomic burden. In order to get the working man back to work, Wales needs to include the Specialist Rehabilitation in the trauma pathway, British Society of Rehabilitation Medicine Core standards. Trauma CAG advised that every patient with ISS $\geq$9 in either a Major Trauma Centre or a Trauma unit should have their needs for rehabilitation assessed, and that a rehabilitation prescription should be provided for all patients with rehabilitation needs. The Specialist Rehabilitation in the Trauma pathway: BSRM core standards Version 1.4 October 2013, gives Trauma centres guidance as how to set about tackling this challenge with a multidisciplinary approach and the application of a rehabilitation prescription. With rehabilitation in trauma patients so variable throughout the trauma networks of England, the quality evidence base for it is missing at present. It is hoped with the guidance and ongoing audit and data collection by the British Society of Rehabilitation Medicine, more evidence will be gathered.

The final point to be made from this discussion is that of 'Silver Trauma' – trauma in the over 65 year olds. Greater than 25% of trauma now effects people aged 65 years old and older, and is increasing each year. In many cases this may only involve a fall from standing. This subset of trauma patients will bring with them their own specific needs and challenges which will need to be addressed in order for these patients to thrive at Wales' Major trauma centre.

3. NHS Confederation: When tragedy strikes. Reflections on the NHS response to the Manchester Arena bombing and Grenfell Tower fire pdf
https://www.nhsconfed.org/-/media/Confederation/Files/Publications/When-tragedy-strikes-report-June-2018-WEB.PDF

SBAR – Predicted data activity for the Wales Trauma Network

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Distributed to: Wales Trauma Network Board

Date: 20th May 2019 | **Version:** 9.0

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Draft Number & version		Author/ Editor	Date
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2	2.0	Dindi Gill/Melissa Rossiter/Mark Dickinson	17th January 2019
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7	7.0	Edited by Dindi Gill/Melissa Rossiter/Cath Wood	14th February 2019
8	8.0	Edited by Dindi Gill/David Rawlinson/Stuart Gill	12th May 2019

9	9.0	Edited by Dindi Gill/Rhys Blake	20th May 2019

SITUATION

The Trauma Network commissioned an analysis of current and predicted activity to inform future planning assumptions for the development of the network. This work was undertaken by Gareth John, NWIS and Andrew Nelson, Information and Performance Manager, Cardiff and Vale University Health Board. This paper describes the nature of the modelling undertaken; it's underpinning assumptions and builds on an earlier version. Following on from the network meeting on the 21st January 2019, network board members were asked to share version 3 of the paper with relevant colleagues in their own organisation and provide feedback. The current iteration reflects the feedback received, where appropriate. A table summarising the feedback and responses is provided as an Appendix and should be read in conjunction with this paper.

The Network Board is asked to note these assumptions and approve the data set as a single data source for all Health Boards when undertaking service planning in advance of the go live of the Trauma Network.

BACKGROUND

Early predicted activity data in relation to trauma was captured as part of:

Firstly, basic modelling work undertaken during the Major Trauma consultation process in 2017. This modelling estimated that the total number of major trauma cases across the network was approximately 1,500.

Secondly, the basic modelling was complemented by the EMRTS Strategic Outline Programme population based modelling in 2014. The latter was supported by Peter Oakley the then Clinical Lead for Major Trauma, University Hospitals of North Midlands Major Trauma Centre (Stoke) and the South Wales Collaborative.

Subsequently, the Network Board identified the need to undertake a more in depth analysis of current and predicted activity to inform the planning of the Trauma Network. A number of strategies have been adopted to achieve this:

1. Approached the Trauma Audit Research Network (TARN) – to calculate the expected number of patients from observed, modelling against comparable English Trauma Networks.

   OUTCOME – **predicted change for our network did not fit with what would happen in practice.**

2. Population based approach was undertaken (Dindi Gill/Melissa Rossiter) with application of the overall observed change in flow for NHSE following the regionalisation of Major Trauma care in 2008 (Moran *et al* 2018).

   OUTCOME – **many assumptions, crude estimations and predicted change appeared low in comparison with experience in NHS England in isolation of further detailed analysis**

3. The Network Board commissioned Gareth John, NWIS and Andrew Nelson, Information and Performance Manager, Cardiff and Vale Health Board to undertake a detailed analysis of current and predicted activity when the Trauma Network becomes operational

OUTCOME - **Data set best fit with experience in NHS England.**

Based on above it was decided to go ahead with presenting Strategy 3, as it provides the most robust methodology and analysis

ASSESSMENT

TARN datasets

Figure 1: TARN data reported 2016-17 including percentage case ascertainment for the Wales Trauma Network sites split by Injury Severity Score (ISS).*

Site	1-8	9-15	>15	Total	% Case ascertainment**
Morriston	138	253	197	588	**114%**
POW	14	18	17	49	24%
Aneurin Bevan HB	0	1	0	1	0%
UHL (Llandough)	9	7	5	21	35%
UHW	122	181	335	638	89%
PCH	85	111	50	246	**111%**
Royal Glam	52	84	48	184	**96%**
Bronglais	45	60	35	140	**150%**
Glangwilli	16	22	3	41	16%
Withybush	1	0	0	1	1%
Total	**482**	**737**	**690**	**1909**	**64%**

Purpose of above is to illustrate the variability in the case ascertainment and therefore the challenges in using existing TARN data for making baseline planning assumptions. It is noted that the experience of the English Trauma Networks is that case ascertainment has significantly increased since their establishment and improved the reliability of their datasets.

*Injury Severity Score – Retrospective anatomical score that measures the overall severity of injured patients (ISS 1-8 – minor trauma, ISS 9-15 – moderate trauma, ISS>15 – major trauma).
** Case ascertainment – patients submitted to TARN compared to expected based on Patient episode data for Wales (PEDW), where case ascertainment exceeds 100%, this indicates that more cases have been submitted to TARN than expected based on PEDW.

TARN inclusion criteria

1. **Trauma patients: Irrespective of age**
2. **Who fulfil <u>one</u> of the following length of stay criteria:** In hospital for ≥3 days, admitted to a critical care area (regardless of length of stay - LOS), transferred out for specialist care or repatriation* (total LOS ≥3days), transferred in for specialist care or repatriation* (total LOS ≥3 days), deaths (including deaths in ED
3. **AND whose <u>isolated</u> injuries meet one of a number of criteria**

Figure 2: Expected cases modelled on TARN data reported 2016-17 (Table 1) using hospitals with good case ascertainment

Site	1-8	9-15	>15	Total
Morriston	143	227	147	517
Princess of Wales	58	91	59	209
Aneurin Bevan HB	161	255	166	582
UHL (Llandough)	9	7	5	21
UHW	122	181	335	638
PCH	61	97	63	221
Royal Glam	53	84	55	192
Bronglais	26	41	27	94
Glangwilli	70	111	72	254
Withybush	41	65	42	148
Total	**744**	**1159**	**971**	**2876**

Based on TARN data submissions 2016-17, modelling was undertaken using the 4 hospitals with highest TARN case ascertainment. These are highlighted in Table 1 as in **bold**. UHW was excluded in order to avoid bias (tertiary referral hospital).

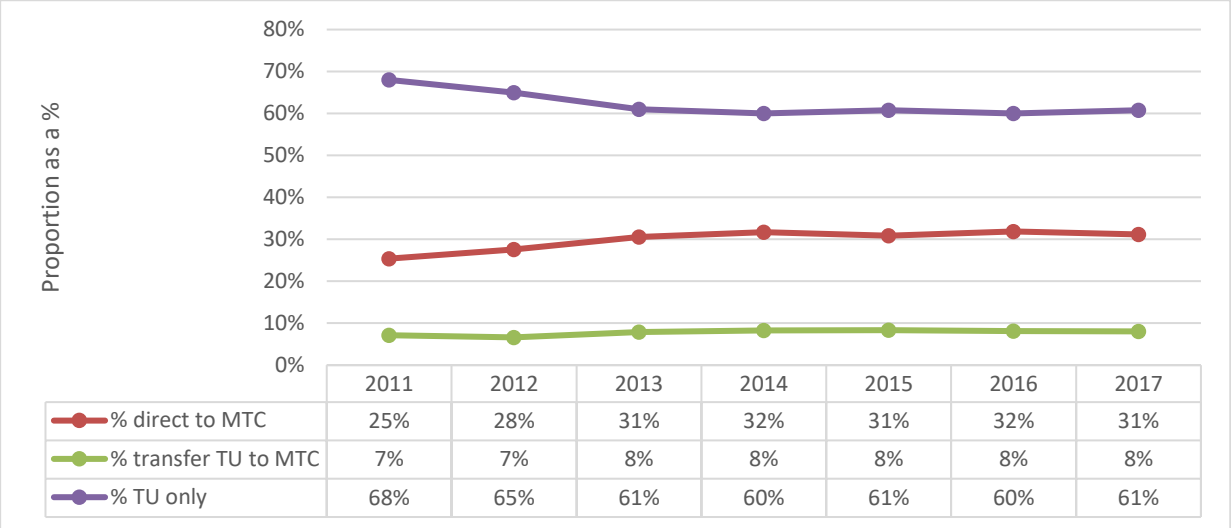
It should be noted that the above dataset is presented as cases and <u>not</u> hospital spells. Therefore, although useful for benchmarking, direct comparison between the TARN dataset and subsequent analyses based on hospital spells is not possible.

It should also be noted that it is likely that since April 2015, a change in the flow of moderate and major trauma patients has already occurred given the introduction of a 12hr EMRTS.

Changes in flow of patients across the English Trauma Networks (2011-2017) used for predicting local change

In version 3 of this paper, the 2017 change in flow data was used from the English Networks, rather than the incremental change by year. Most of the English Trauma Network became operational in April 2012. Thus, TARN were approached to understand the change in flow from 2011-2017 and the potential change is illustrated in Figure 3 and 4 below:

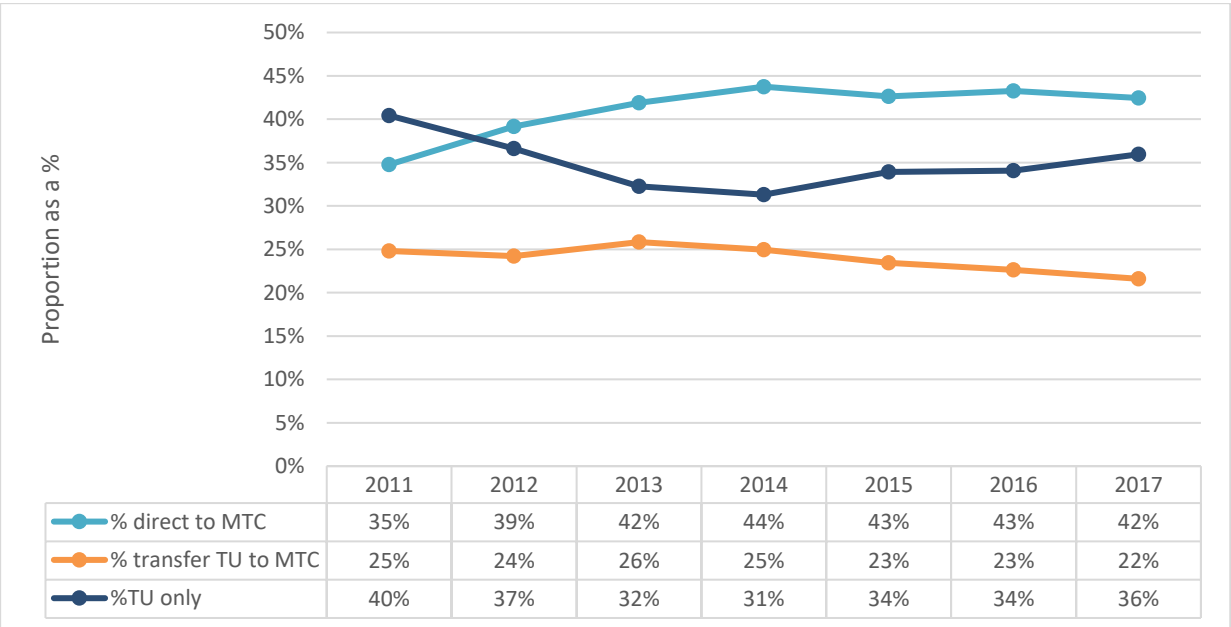
Figure 3: Total TARN cases reported (ISS 9-15), by 'patient pathway' over time



	2011	2012	2013	2014	2015	2016	2017
% direct to MTC	25%	28%	31%	32%	31%	32%	31%
% transfer TU to MTC	7%	7%	8%	8%	8%	8%	8%
% TU only	68%	65%	61%	60%	61%	60%	61%

From the above the proportion of moderate trauma cases taken direct to MTC's from 2011 to 2013 increased then reached a steady state.

Figure 4: Total TARN cases reported (ISS >15), by 'patient pathway' over time



	2011	2012	2013	2014	2015	2016	2017
% direct to MTC	35%	39%	42%	44%	43%	43%	42%
% transfer TU to MTC	25%	24%	26%	25%	23%	23%	22%
%TU only	40%	37%	32%	31%	34%	34%	36%

MTC – Major Trauma Centre TU – Trauma Unit

From the above the proportion of major trauma cases taken direct to the MTC's from 2011 to 2013 increased then reached a steady state. The proportion of major trauma cases transferred from TU's to MTC's is falling.

Based on the above, the proportions for 2011 – 2013 were taken forward to predict the change in flow in the subsequent analyses, as by 2013 the proportions for direct to MTC reached a steady state.

Whilst a steady state appears to have been reached with respect to the above proportions, the overall number of moderate and major trauma cases reported to TARN appear to be increasing (approx. 10%/year for major trauma) and have not reached a steady state. This is likely due to the improvements in case ascertainment through the introduction of the English Trauma Networks.

The TARN dataset was then used to model the current positon for moderate and major trauma, which has indicated that the assumed current position for South, Mid and West Wales pre-dates 2011 as illustrated below and forms the basis of subsequent analyses:

Figure 5: Assumed current proportions for South, Mid and West Wales and years 1, 2 and 3 (corresponding to 2011, 2012 and 2013) for moderate and major trauma by 'patient pathway'

ISS	'Patient pathway'	Assumed current position	Year 1	Year 2	Year 3 & steady state
9-15	% direct to MTC	22	25	28	31
9-15	% transfer TU to MTC	0	7	7	8
9-15	% TU only	78	68	65	61
>15	% direct to MTC	32	35	39	42
>15	% transfer TU to MTC	6	25	25	22
>15	% TU only	62	40	36	36

KEY ASSUMPTION(S)

1. Whilst providing an indication of the average experience across the differing English Trauma Networks, direct correspondence with Professor Chris Moran (National Clinical Director for Trauma - NHS England) indicated that it would be acceptable to use this information to inform the predicted change in flow across the Wales Trauma Network, given the similarities in population and accident rates with England.

2. Although a change in the proportion of cases by ‘patient pathway’ may actually be occurring, this may be a reflection of the increase in cases reported to TARN over time. The modelling does not take into account this increase in reporting.

Modelled predicted change by hospital spells

Patient episode data for Wales (PEDW) was obtained from NWIS for 2017 to calculate current activity. Current activity was defined as the number hospital spells and NOT number of cases so the subsequent analyses cannot be directly compared with Figures 1 and 2. ICD-10 codes were translated into TARN codes, in order to present a breakdown by ISS. Furthermore, hospital spells were used rather than number of cases, as a more accurate metric for making planning assumptions.

A complex modelling algorithm was developed in order to inform the data presented for current activity; this was 'developed' on 5 years of C&V Health Board data. Specialist cases undertaken at Morriston Hospital are acknowledged to be missed by this approach: as a consequence volumes at Morriston Hospital will be slightly understated **but** the proportion and volumes of patients whose flow changes maybe more accurate. These specialist cases are being assessed as part of the orthoplastic work stream.

Further analysis was undertaken to predict the change in flow, in line with the assumed current position for South, Mid and West Wales and using the proportions for the English Trauma Networks for 2011, 2012 and 2013 (presented in Figure 5).

These analyses are presented in the Figures below, with the following assumptions applied.

KEY ASSUMPTION(S)

1. One hospital spell covers the activity whilst a patient remains within that hospital for a continuous length of time (if they go out to another hospital and come back, that equates to three spells for the patient, even if within 1 year).

2. Flow predictions based on maximum stay of 21 days (Moran *et al*, 2018 - where data from 5 years of experience in England indicated a median length of stay of 15 days for all patients – IQ range 5-19).

3. Where the length of stay for the original spell exceeded 21 days, the spell was split across the two sites (e.g. if MTC & TU - both received a count).

4. Hospital spells in non-district general hospital settings were excluded as it was assumed that patient flow would not change significantly for this cohort. These numbers were neglible.

5. The average change in flow across the English Trauma Networks has been applied equally to all Welsh hospitals, irrespective of there being some geographical and epidemiological variation between regions. In reality the proportion of direct transfers to the MTC will be higher the closer the patient is the MTC.

6. The change in flow has been modelled on the basis that the location of the 'candidate' TU's is as agreed. Further analysis has been undertaken by the Hywel Dda trauma task and finish group, based on the version 7 approved dataset, to inform local changes in patient flow based on the assumption that Glangwilli General Hospital will be the interim 'candidate' trauma unit for planning purposes (in anticipation of a new hospital being built in the Health Board). Thus, for the purposes of further analysis, Withybush Hospital and Bronglais General Hospital are assumed to be LEH's.

7. Princess of Wales Hospital will be the nearest 'candidate' TU to Royal Glamorgan Hospital. CT Health Board and C&V Health Board will need to confirm their position on the latter to agree any variance against this rule.

8. In addition to using the change in flow for the English Trauma Networks, further modelling was undertaken based on head injuries and patients >70 years of age, assuming that for major trauma patients that remain in a TU, 60% have a head injury and 60% are >70 years of age (Source: Moran C, London Trauma Conference, 2018). No other modelling was undertaken against any other parameters (e.g. length of stay, case mix etc.).

9. Whilst the proportional change used is based on cases reported to TARN, the analyses has been applied to hospitals spells.

10. There is significant variation in the standard of clinical coding across the Health Boards, which may impact on the above analysis.

Figure 6: Assumed current position and predicted activity UHW (presented as median hospital spells where hospital is first receiver) for moderate (ISS 9-15), major (ISS >15) and 'candidate' (ISS >9) major trauma

ISS 9-15 – moderate	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	154	206	231	256
Transfer TU to MTC	11	58	58	66
% TU only	660	561	536	503
Total	825	825	825	825
ISS >15 – major	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	284	306	341	368
Transfer TU to MTC	49	219	219	193
% TU only	542	350	315	314
Total	875	875	875	875
ISS >9 – candidate	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	438	512	572	624

Transfer TU to MTC	60	277	277	259
% TU only	1202	911	851	817
Total	**1,700**	**1,700**	**1,700**	**1,700**
Combined Direct to MTC & Transfer TU to MTC	**498**	**789**	**849**	**883**

Figure 7: Assumed current position and predicted activity all other hospitals (presented as median hospital spells where hospital is first receiver) for 'candidate' (ISS >9) major trauma

Original Hospital	Current Assumed Position	Change in flow Year 1	Change in flowYear 2	Change in flow Year 3
Morriston (total spells)	**318**	**318**	**318**	**318**
Stays at current	308	225	203	201
Transfer TU to MTC	10	76	74	68
Direct to MTC		17	41	49
Glangwilli (total spells)	**107**	**107**	**107**	**107**
Stays at current	107	72	82	69
Transfer TU to MTC		25	15	17
Direct to MTC		10	10	21
NHH (total spells)	**134**	**134**	**134**	**134**
Stays at current	132	111	98	90
Transfer TU to MTC	2	15	20	15
Direct to MTC		8	16	29
PCH (total spells)	**133**	**133**	**133**	**133**
Stays at current	130	92	84	84
Transfer to MTC	3	32	33	27
Direct to MTC		9	16	22
POW (total spells)	**118**	**118**	**118**	**118**
Stays at current	116	94	79	81
Transfer TU to MTC	2	18	22	16
Direct to MTC		6	17	21
Royal Gwent (total spells)	**159**	**159**	**159**	**159**
Stays at current	157	119	114	99
Transfer TU to MTC	2	31	26	34
Direct to MTC		9	19	26
Royal Glam (total spells)	**134**	**134**	**134**	**134**
Stays at current	132	108	98	90
Transfer TU to MTC	2	24	26	21

Direct to MTC		2	10	23
Withybush (total spells)	**103**	**103**	**103**	**103**
Stays at current	100	76	80	69
Transfer TU to MTC	3	20	16	17
Direct to MTC		7	7	17
Bronglais (total spells)	**56**	**56**	**56**	**56**
Stays at current	56	40	38	39
Transfer TU to MTC		14	11	6
Direct to MTC		2	7	11

By providing a breakdown of hospital spells by the 'patient pathway' visualisation is provided of the extent of the potential duplicated hospital spells per patient.

As part of the analysis, an attempt was made to use a previously developed pre-hospital triage tool and how this could be retrospectively applied to a small sample of WAST Patient Care Record data (obtained through NWIS), to determine how flow might change. This analysis did not generate meaningful results and has not been carried forward to inform planning assumptions.

However, the data provided in Figure 7 can be used by WAST to understand the potential increase in the number of ambulance journey's (both by direct transfer to the MTC or transfer from TU to MTC) to inform planning assumptions.

Figure 8: Modelled current and predicted bed occupancy (LOS ≥3days)

	Beds Occupied - Current			**Year 1**			**Year 2**			**Year 3**		
	5%ile	50%ile	95%ile*	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile
University Hospital Of Wales	23	30	38	42	47	53	45	50	56	46	52	58
Morriston Hospital	7	13	19	8	10	12	7	10	12	7	10	12
Glangwilli General Hospital	4	7	11	8	11	13	8	10	12	7	10	12
Nevill Hall Hospital	2	6	10	3	5	6	3	5	6	3	4	6
Prince Charles Hospital	2	5	9	2	4	5	2	3	5	2	3	5
Princess Of Wales Hospital	4	7	11	7	9	11	7	9	11	6	9	11
Royal Gwent Hospital	4	8	13	4	6	8	4	6	8	4	6	7
The Royal Glamorgan Hospital	2	5	10	0	0	1	0	0	1	0	0	1
Withybush General Hospital	2	4	8	0	0	1	0	1	1	0	1	1
Bronglais General Hospital	1	3	6	0	0	1	0	0	1	0	0	1

*95%ile is equivalent to 80% bed occupancy threshold

Modelled current and predicted bed occupancy – Level 2 and Level 3 beds

Due to the inconsistencies in collating ITU bed day data across Wales it is recognised individual Health Board level interrogation of Ward Watcher may provide more meaningful data to predict bed occupancy. However, it is anticipated that the only unit requiring additionality following regionalisation will be UHW.

Figure 9: Assumed current position and predicted activity UHW (presented as median hospital spells where hospital is first receiver) for moderate (ISS 9-15) and major (ISS >15) – under 16 years of age (paediatric population)

	Assumed current position	Year 1	Year 2	Year 3
ISS 9-15	22	27	30	33
ISS >15	53	55	56	60

KEY ASSUMPTION(S)

1. That paediatric cases follow the same proportional change observed across the dataset illustrated in Figure 5.

Modelled predicted flow from MTC to the 'landing pad' ('Care with Treatment Closer to Home').

1. Experience demonstrates that currently few patients are being repatriated in a timely manner from specialist centres. Most either go home or on to specialist rehabilitation form the specialist centre. Furthermore, TARN do not record a transfer unless the patient is undergoing surgery in the receiving unit. Length of stay (LoS) data is equally challenging, as there is significant variation according to the clinical issues and across health boards (given differences in community rehabilitation and access to social care). This has introduced an added challenge to quantify these flows.

2. In order to address this issue the following additional work has been undertaken:

    - UHW TARN data (Apr – Sept 2018, 6mths data) taken with a break down by resident postcode. Excellent case ascertainment (>90%) recorded during this time.
    - Used this data to quantify origin Health Board numbers. An estimation provided based on 28% population split due to Health Board boundary change in April 2019 (between formally ABMU and CTU Health Boards).
    - Figure doubled to give an estimate of annual cases broken down by origin Health Board.
    - Figure 7 in attached data paper used to estimate additional flow to UHW broken down by origin Health Board (year 1 figures used).
    - Powys Teaching Health Board data added to CTM UHB – small numbers.
    - UHW 12mth baseline data added to additional flows to MTC to give total flows to MTC (incl. baseline and additional cases).

- Using data below from the Southmead Trauma Centre, Bristol on flow of patients – calculated minimum (20%) and maximum (34%) return to origin Health Board. For the maximum return broken down by subgroups:

Whilst the rehabilitation model and epidemiology may be slightly different, discharge data from the Southmead Trauma Centre, Bristol, gives an idea of the disposition of adult (16 years or over) patients who leave the MTC, in order to assess the number of patients returning to each Health Board and impact of 'care closer to home.'

	%
Rehabilitation	14 (6.4% specialist rehabilitation requirements
Other acute hospital	20
Home (own)	52
Home (relative or other carer)	4
Mortuary	7
Nursing home	3

Rehabilitation – specialist rehabilitation and acute rehabilitation – 14% (approx. half require complex rehabilitation – neuro/spines)
Other acute hospitals – ongoing medical care and/or physio/OT/discharge planning - 20%

LHB of patient	TARN UHW (6mth baseline data)	UHW (12mth baseline data)	Additional flows to MTC (from Figure 7)	Total flows to MTC (baseline and additional)	Total flows back (assuming 20% return)	Total flows back (assuming 34% return)
SBUHB	25	50	93	143	29	49
ABUHB	44	88	73	161	32	55
C&VUHB	226	452	N/A	N/A	90	154
CTMUHB	36	72	105 + 16 = 121	193	39	66
HDUHB	29	58	78	136	27	46
PTHB	8	16	Added to CTM figures	N/A	N/A	N/A

LHB of patient	Total flow back (assuming 34% return)		
	Ongoing medical care and/or physio/OT /discharge planning	Level 2 rehabilitation	Awaiting specialist rehabilitation (neuro/spinal)
SBUHB	29	11	9
ABUHB	33	13	9
C&VUHB	92	35	27
CTMUHB	40	15	11
HDUHB	28	10	8

3. Based on this, minimum and maximum flow backs to the origin Health Board are still less than additional flows to MTC (except in LHB's where TU configuration dictates), therefore these numbers to do not represent increasing capacity within the origin Health Board, but are to be used to determine bed requirements in any given area. The actual number returning is likely to sit somewhere between the minimum and maximum returns.
4. From the C&V UHB TARN dataset the body regions with most severe injury were as follows to help understand the type of patients that might be received back:

Most severely injured body region	Total
Abdo	3.1%
Chest	16.7%
Face	1.3%
Head	33.1%
Limbs	20.3%
Multiple	13.1%
Other	0.8%
Spine	11.8%
Grand Total	**100.0%**

5. LoS data is difficult to quantify for these patients, however, experience gained for English trauma networks has informed an estimation based on actual flow. The average LoS to be used for planning assumptions is 6 weeks per patient. This has been used to calculate the following 80% equivalent bed occupancy based on a 34% return:

LHB of patient	Bed occupancy
SBUHB	7
ABUHB	8 (initially split across 2 TU's)
C&VUHB	20
CTMUHB	10 (split across 2 TU's)
HDUHB	7
PTHB	N/A

6. It should be noted critical care transfers from the MTC to TU's are limited. It also recognised that it is difficult from the dataset to calculate the percentage of patients who will require a non-medical vs. a medical escort for transfer.

ASSUMPTIONS

1. That the assumed number of trauma patients seen at UHW in 6mths will be double for that seen in 12mths. It is also assumes that the UHW data is representative of annual data from the Health Board in terms of patient mix.
2. That the pattern of return for patients to the origin Health Boards mirrors that of the Severn Trauma Network. However, this is likely to be accurate given discussions with other networks.

3. That currently no trauma patients are repatriated to the origin Health Board hospitals, which is unlikely to be the case.
4. Those South Powys patients who require ongoing in-hospital care will return to CTUHB – numbers small.
5. Does not account of LoS variation between Health Boards and patient groups.

Modelled Predicted Patient Flows - Hywel Dda (provided by Stuart Gill)

Subsequent to version 8.0, the approved dataset was used to carry out further analysis by the Hywel Dda trauma task and finish group, to inform local changes in patient flow based on the assumption that Glangwilli General Hospital will be the interim 'candidate' trauma unit for planning purposes (in anticipation of a new hospital being built in the Health Board). Thus, for the purposes of further analysis, Withybush Hospital and Bronglais General Hospital are assumed to be LEH's. This dataset has been approved locally to inform planning assumptions and summarised in the Health Board up date to the Network Board on the 18th March 2019.

Bronglais General Hospital TARN data was been used as this provided the fullest data set with 150% predicted case ascertainment for the year 2017-2018. A draft pre-hospital triage tool was applied to this dataset.

This analysis was then used to generate estimates of patients for transfer and destination:

1. Conservative estimate – only including Definite and Probable.
2. Maximum estimate – including Definite, Probable and Possible.

A further assessment based on likely destination was made:

1. Conservative estimate TU admissions – Cases in the above conservative estimate confidently predicted to need TU care.
2. Maximum estimate TU admissions- Cases in the above maximum estimate, where predicted destination was TU or equivocal (MTC/TU or LEH/TU).

Predicted destination upon transfer

Predicted Destination	Number of cases	% of total (97)
MTC	27	28%
TU	14	14%
MTC/TU	13	13%
LEH/TU	10	10%

Predicted maximum/minimum to TU

	Number of cases	% of total (97)
Transfer to TU Max	37	38%
Transfer to TU conservative	13	13%

Predicted flow of patients into GGH in the event of GGH being the only TU for Hywel Dda

GGH as Candidate TU

Year	1	2	3
Network data, predicted to remain (current admissions)	72	82	69
Maximum increase	73	75	70
Minimum increase	23	23	22
Total max	145	157	139
Total min	95	105	91

The maximum increase constitutes approximately 6 additional patients per month or 1-2 per week being admitted to the TU (0.4 -1.44/week).

In addition, an analysis was performed on the remaining minor trauma cases (ISS<9) that were admitted to Bronglais comprising 32 cases with the highest ISS being 8, one ISS 5 and the remainder being 4. Only TARN injury descriptors were used as part of the analysis, WCP/PAS were not interrogated.

This revealed an additional 9 patients (in the year 2017-2018) who, due to injury pattern may have been triaged to the TU by the ambulance service. This was done to illustrate a potential "worst case scenario" of volumes of patients being taken to the TU.

"Worst case scenario"

Highest possible volumes	Year 1	Year 2	Year 3
Increase	82	84	79
Total cases	154	166	195

The worst-case scenario gives a similar increase in terms of admissions per week. (1.5 – 1.6).

This dataset was used to inform planning assumptions for Glangwilli General Hospital and WAST within the Health Board.

RECOMMENDATIONS

The Network Board are:

1. Asked to note the summary of the methodology/key assumptions and approve the use of the modelling in relation to repatriation to inform capacity planning for the 'landing pad.'

REFERENCE(S)

Moran *et al* (2018). Changing the system – Major Trauma Patients and their outcomes in the NHS (England) 2008-17. *The Lancet*, Vol 2, p13-21.

ACKNOWLEDGEMENTS

Acknowledgments to the significant contributions of Gareth John and Andrew Nelson in undertaking the above detailed analyses.

Acknowledgements also to Victoria Le Grys, MTC and Network Manager, Severn Trauma Network for provided the repatriation data.

Quality Surveillance Team

Major Trauma Services
Quality Indicators

MAJOR TRAUMA QUALITY INDICATORS

Introduction

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. Data from the Trauma Audit and Research Network (TARN) dataset will be used to support the review of the quality indicators alongside information submitted direct from major trauma services.

Reviewing the Major Trauma Network

Network Governance Quality Indicators
The Network Governance indicators are the responsibility of the Network Director and should be applied to both adult and children's services. Each network will be reviewed once in conjunction with its constituent centres and units.

Pre- Hospital Care Quality indicators
There are pre-hospital services which provide services to more than one major trauma network. Each service will be reviewed once in conjunction with its constituent networks, centres and units.

Major Trauma Centre Quality indicators - Adult and Children's.
The quality indicators for major trauma centres are divided into 3 sections
Reception and Resuscitation
Definitive Care Quality indicators
Rehabilitation Quality indicators
The responsibility for the quality indicators lies with the major trauma lead clinician for the trust.
Where there is a combined adult and children's centre it is expected the centre will be reviewed once against both adult and children's quality indicators. This will enable the service to demonstrate how they fulfil both roles.

A major trauma centre that is also a trauma unit for children's major trauma will only be reviewed against the relevant major trauma centre quality indicators.

Major Trauma Quality indicators for Trauma Units
The quality indicators for trauma units are divided into 3 sections
Reception and Resuscitation
Definitive Care Quality indicators
Rehabilitation Quality indicators
The responsibility for the quality indicators lies with the major trauma lead clinician for the trust.

Network Quality Indicators

The following quality indicators should be applied to both adult and children's services.

Number	Indicator	Data source
T16-1C-101	Network Configuration	Self declaration
T16-1C-102	Network Governance Structure	Self declaration
T16-1C-103	Patient Transfers	TARN report
T16-1C-104	Network Transfer Protocol from Trauma Units to Major Trauma Centres	Self declaration
T16-1C-105	Teleradiology Facilities	Self declaration
T16-1C-106	The Trauma Audit and Research Network (TARN)	TARN report
T16-1C-107	Trauma Management Guidelines	Self declaration
T16-1C-108	Management of Severe Head Injury	TARN report
T16-1C-109	Management of Spinal Injuries	Self declaration
T16-1C-110	Emergency planning	Self declaration
T16-1C-111	Network Director of Rehabilitation	Self declaration
T16-1C-112	Directory of Rehabilitation Services	Self declaration
T16-1C-113	Referral Guidelines to Rehabilitation Services	Self declaration
T16-1C-114	Rehabilitation Education Programme	Self declaration
T16-1C-115	Network Patient Repatriation Policy	TARN report

Network Quality Indicators - Descriptors

Number	Indicator	Data Source
T16-1C-101	**Network Configuration**	**Self declaration**
Descriptor	*Notes*	*Evidence required*

The network configuration should be identified including the following constituent parts:
• *pre – hospital services including:*
  ○ *ambulance services;*
  ○ *air ambulance services;*
  ○ *enhanced care services;*
• *hospitals including:*
  ○ *major trauma centre(s);*
  ○ *trauma units;*
  ○ *local emergency hospitals;*
• *rehabilitation services including;*
  ○ *specialist centre(s);*
  ○ *local hospital services;*
  ○ *community services.*
		Operational policy including a map and details of the major trauma network configuration.

T16-1C-102	**Network Governance Structure**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The major trauma network should have a clinical governance structure which includes: • *the name of the network director;* • *the name of clinical governance lead, if this is not the network director;* • *details of the governance structure;(1)* • *there should be regular clinical governance meetings that have an agenda and recorded minutes.*	*(1)The structure should demonstrate links to the governance structure of the host trust*	*Operational policy specifying name of the clinical governance lead and structure*

T16-1C-103	Patient Transfers	TARN Report
Descriptor	*Notes*	*Evidence required*
The network should undertake a review of patient transfers which includes: • *the number and proportion of patients transferred directly to MTC, this should include cases of significant under and over pre-hospital triage;* • *the number and proportion of patients that have an acute secondary transfer (within 12 hour) from a trauma unit to a major trauma centre;* • *the proportion of urgent transfers that occur within 2 calendar days;* • *The number of patients with ISS ≥15 managed definitively within a trauma unit.* *Feedback of the review should be presented at a major trauma network meeting.*		*TARN report* *Annual report detailing the review*
T16-1C-104	**Network Transfer Protocol from Trauma Units to Major Trauma Centres**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a network protocol for the safe and rapid transfer of patients to specialist care. *The transfer protocol should specify:* • *transfer for adults is carried out by a team that have been trained in the transfer of patients; (1)* • *a structured checklist is completed for the transfer;* • *Standardised documentation should be used by trauma units and major trauma centres.* *There should be involvement of the regional paediatric critical care transfer service in defining the transfer protocol for children.*	*(1)Anaesthesia, Intensive Care and Pre-Hospital Emergency Medicine all include transfer training in their curricula*	*Operational policy including the protocol* *Annual report with details of the audit of transfers*

T16-1C-105	Teleradiology Facilities	Self declaration
Descriptor	*Notes*	*Evidence required*
There should be teleradiology facilities between the major trauma centre and all the trauma units in the network allowing immediate image transfer 24/7.		*Operational policy*

T16-1C-106	The Trauma Audit and Research Network (TARN)	TARN report
Descriptor	*Notes*	*Evidence required*
All MTCs and TUs should participate in the TARN audit, together with any local emergency hospitals (LEH) that are members. *Data completeness and accreditation figures should be reviewed at network audit meetings and plans put in place to improve on the figures* *The TARN audit should be discussed at the network audit meeting at least annually and distributed to all constituent teams in the network, the CCGs and area teams.*	*local emergency hospitals (LEH) should be encouraged to participate.*	*TARN data completeness and data quality for all services in the network.*

T16-1C-107	Trauma Management Guidelines	Self declaration
Descriptor	*Notes*	*Evidence required*
There should be network agreed clinical guidelines for the management of: • *emergency anaesthesia within the emergency department;* • *emergency surgical airway;* • *resuscitative thoracotomy;* • *abdominal injuries;* • *severe traumatic brain injury;* • *open fractures;*	*Where there are national guidelines it is expected these are included in the guidelines* *(1)RCR guidelines*	*Operational policy including the guidelines.*

• *compartment syndrome;* • *vascular injuries;* • *penetrating cardiac injuries;* • *spinal cord injury;* • *severe pelvic fractures including urethral injury;* • *chest drain insertion;* • *analgesia for chest trauma with rib fractures;* • *CT imaging;* • *Imaging for children;(1)* • *Interventional radiology;* • *Non accidental injury in the child.*		
T16-1C-108	**Management of Severe Head Injury**	**TARN report**
Descriptor	*Notes*	*Evidence required*
All patients with a severe head injury should be managed according to NICE guidance Head injury: assessment and early management (CG176 –January 2014)		*TARN report*
T16-1C-109	**Management of Spinal Injuries**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a network protocol for the management of spinal injuries which covers: 1. *protecting and assessing the whole spine in adults and children with major trauma including that:* • *all spinal imaging should be reviewed and reported by a consultant radiologist within 24 hours of admission;*	*Where there are national guidelines it is expected these are included in the protocol.* *This may be a single protocol or separate protocols for adults and children.*	*Operational policy including the protocol.*

• *all patients with spinal cord injury have their neurology documented on an ASIA chart;* • *all spinal cord injuries with neurological deficit should be discussed with the network spinal service within 4 hours of diagnosis.* 2. *resuscitation and acute management of spinal cord injury, agreed with the linked Spinal Cord Injury Centre(SCIC), and available in all emergency departments that may receive patients with spinal cord injury. These must include:* • *skin care,* • *gastric care,* • *bowel care* • *bladder care* 3. *emergency transfer of spinal injuries*		

T16-1C-110	**Emergency Planning**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The network should have an emergency plan for dealing with a mass casualty event that is reviewed and updated annually.		*Operational policy including the emergency plan.*

T16-1C-111	**Network Director of Rehabilitation**	**Self declaration**
Descriptor	Notes	Evidence required
There should be a network director for rehabilitation with experience in trauma rehabilitation. The director should have an agreed list of responsibilities and time specified for the role.		Operational policy including the name and agreed list of responsibilities of the trauma network director of rehabilitation.

T16-1C-112	Directory of Rehabilitation Services	Self declaration
Descriptor	*Notes*	*Evidence required*
There should be a network directory of rehabilitation services		*Operational policy including the directory of rehabilitation services.*
T16-1C-113	**Referral Guidelines to Rehabilitation Services**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The should be network agreed referral guidelines for access to rehabilitation services		*Operational policy including referral guidelines*
T16-1C-114	**Rehabilitation Education Programme**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a network rehabilitation education programme for health care professionals.		*Annual report including details of programme*
T16-1C-115	**Network Patient Repatriation Policy**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a network agreed policy for the repatriation of patients transferred to the MTC which should include: • *patients are transferred to the trauma units within 48 hours of request;* • *local contact details for each trauma unit;* • *the provision of ongoing care and non-specialised rehabilitation by the trauma units.* • *patients requiring transfer from MTC to MTC should be transferred within 48hrs of request.(1)*	*(1)This applies for out of region transfers the local MTC will liaise with their local TU for repatriation*	*Operational policy including the policy.*

Pre- Hospital Care Quality indicators

Introduction

The following quality indicators should be applied to both adult and children's services.

Number	Indicator	Data source
T16-2A-101	**Pre Hospital Care Clinical Governance**	**Self declaration**
T16-2A-102	**24/7 Senior Advice for the Ambulance Control Room**	**Self declaration**
T16-2A-103	**Enhanced Care Teams available 24/7**	**Self declaration**
T16-2A-104	**Clinical Management Protocols**	**Self declaration**
T16-2A-105	**Hospital Pre-Alert and Handover**	**Self declaration**

Pre- Hospital Care Quality indicators - Descriptors

Number	Indicator	Data Source
T16-2A-101	**Pre-Hospital Care Clinical Governance**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The pre-hospital providers should be part of the clinical governance structure for the network and send a representative to the network governance meetings.	*This should enable two way feedback and learning between services*	*Attendance at network meetings*
T16-2A-102	**24/7 Senior Advice for the Ambulance Control Room**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be an advanced paramedic or a critical care paramedic present in the ambulance control room 24 hours a day. *This senior clinician should have 24/7 telephone access to pre-hospital consultant advice consultant*		*Operational policy.*
T16-2A-103	**Enhanced Care Teams available 24/7**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
Enhanced care teams should be available in the pre-hospital phase 24/7 to provide care to the major trauma patient *The enhanced care team should be one or more of the following:* • *Advanced / critical care paramedic/practitioners* • *BASICS doctors* • *HEMS team* • *A Merit Service*		*Operational policy including details of enhanced care provision.*

T16-2A-104	Clinical Management Protocols	Self declaration
Descriptor	*Notes*	*Evidence required*

There should be protocols in place for the pre-hospital management of major trauma patients which includes:
• *airway management*
• *chest trauma*
• *pain management for adults and children including advanced analgesia options i.e. Ketamine;*
• *management of major haemorrhage including:*
  ○ *the administration of tranexamic acid*
  ○ *application of haemostatic dressings*
  ○ *application of tourniquets.*
  ○ *application of pelvic binders*
		Operational policy including the protocols

T16-2A-105	**Hospital pre-alert and handover**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a network wide agreed pre-alert system with effective communication between pre-hospital and in-hospital teams. *This should include documented criteria for trauma team activation and patient handover.*		*Operational policy including the details of the pre-alert system and documentation.*

ADULT MAJOR TRAUMA CENTRE QUALITY INDICATORS

Reception and Resuscitation		
Number	**Indicator**	**Data source**
T16-2B-101	Trauma Team Leader	TARN report
T16-2B-102	Trauma Team Leader Training	Self declaration
T16-2B-103	Emergency Trauma Nurse/ AHP	TARN report
T16-2B-104	Trauma Team Activation Protocol	Self declaration
T16-2B-105	24/7 Surgical and Resuscitative Thoracotomy Capability	TARN report
T16-2B-106	24/7 CT Scanner Facilities and on-site Radiographer	TARN report
T16-2B-107	CT Reporting	TARN report
T16-2B-108	24/7 MRI Scanning Facilities	TARN report
T16-2B-109	24/7 Interventional Radiology	TARN report
T16-2B-110	24/7 Access to Emergency Theatre and Surgery	TARN report
T16-2B-111	Damage Control Training for Emergency Trauma Consultant Surgeons	Self declaration
T16-2B-112	24/7 Access to On-site Surgical Staff	TARN report
T16-2B-113	24/7 Access to Consultant Specialists	TARN report
T16-2B-114	Dedicated Orthopaedic Trauma Operating Theatre	Self declaration
T16-2B-115	Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries	TARN report
T16-2B-116	Trauma Management Guidelines	Self declaration
T16-2B-117	Critical Care Provision	Self declaration
T16-2B-118	24/7 Specialist Acute Pain Service	Self declaration
T14–2B-119	Administering Tranexamic Acid	TARN report
Definitive Care		

Number	Indicator	Data source
T16-2C-101	Major Trauma Centre Lead Clinician	Self declaration
T16-2C-102	Major Trauma Service	Self declaration
T16-2C-103	Major Trauma Coordinator Service	Self declaration
T16-2C-104	Major Trauma MDT Meeting	Self declaration
T16-2C-105	Dedicated Major Trauma Ward or Clinical Area	Self declaration
T16-2C-106	Formal Tertiary Survey	Self declaration
T16-2C-107	Management of Neurosurgical Trauma	TARN report
T16-2C-108	Management of Craniofacial Trauma	Self declaration
T16-2C-109	Management of Spinal Injuries	TARN report
T16-2C-110	Management of Musculoskeletal Trauma	TARN report
T16-2C-111	Management of Hand Trauma	Self declaration
T16-2C-112	Management of Complex Peripheral Nerve Injuries	Self declaration
T16-2C-113	Management of Maxillofacial Trauma	Self declaration
T16-2C-114	Vascular and Endovascular Surgery	Self declaration
T16-2C-115	Designated Specialist Burns Care	Self declaration
T16-2C-116	Patient Transfer	TARN report
T16-2C-117	Network Patient Repatriation Policy	Self declaration
T16-2C-118	Specialist Dietetic Support	Self declaration
T16-2C-119	24/7 Access to Psychiatric Advice	Self declaration
T16-2C-120	Patient Information	Self declaration
T16-2C-121	Patient Experience	Self declaration
T16-2C-122	Discharge Summary	Self declaration

T16-2C-123	**Rate of Survival**	**TARN report**
Rehabilitation		
Number	**Indicator**	**Data source**
T16-2D-101	**Clinical Lead for Acute Trauma Rehabilitation Services**	**Self declaration**
T16-2D-102	**Specialist Rehabilitation Team**	**Self declaration**
T16-2D-103	**Rehabilitation Coordinator Post**	**Self declaration**
T16-2D-104	**Specialist Rehabilitation Pathways**	**Self declaration**
T16-2D-105	**Key worker**	**Self declaration**
T16-2D-106	**Rehabilitation Assessment and Prescriptions**	**TARN report**
T16-2D-107	**Rehabilitation for Traumatic Amputation**	**Self declaration**
T16-2D-108	**Referral Guidelines to Rehabilitation Services**	**Self declaration**
T16-2D-109	**Clinical Psychologist for Trauma Rehabilitation**	**Self declaration**
T16-2D-110	**RCSET Dataset**	**RCSET**

ADULT MAJOR TRAUMA CENTRE QUALITY INDICATORS - Descriptors

Reception and Resuscitation			
Number	**Indicator**		**Data Source**
T16-2B-101	**Trauma Team Leader**		**TARN report**
Descriptor		Notes	Evidence required
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.			Operational policy including agreed responsibilities. TARN report
T16-2B-102	**Trauma Team Leader Training**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
All trauma team leaders should have attended trauma team leader training.		*Training can be national or provided in-house*	*Annual report*
T16-2B-103	**Emergency Trauma Nurse/ AHP**		**TARN report**
Descriptor		*Notes*	*Evidence required*
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*		*Guidance is found on the TQUINS resource page Tquins resources*	*Operational policy including details of training* *TARN report*

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	**Trauma Team Activation Protocol**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a Trauma Team Activation Protocol		*Operational policy including the protocol*
T16-2B-105	**24/7 Surgical and Resuscitative Thoracotomy Capability**	**TARN report**
Descriptor	*Notes*	*Evidence required*
There should be a surgical and resuscitative thoracotomy capability within the trauma team and available 24/7		*Operational policy including a list of all appropriate trained consultants.* *TARN report* *The consultant rota should be available for peer review visit*

T16-2B-106	**24/7 CT Scanner Facilities and on-site Radiographer**		**TARN report**
Descriptor		*Notes*	*Evidence required*
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.*		*Trauma CT is the diagnostic modality of choice where patients are stable enough for transfer to CT.* *Where the CT scanner is located outside of the department there should be a protocol for the safe transfer and care of major trauma patients.*	*Operational policy* *TARN report.*
T16-2B-107	**CT Reporting**		**TARN report**
Descriptor		*Notes*	*Evidence required*
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.*			*The protocol.* *TARN report*
T16-2B-108	**24/7 MRI Scanning Facilities**		**TARN report**
Descriptor		*Notes*	*Evidence required*
MRI scanning should be available 24/7			*Operational policy* *TARN report*
T16-2B-109	**24/7 Interventional Radiology**		**TARN report**
Descriptor		*Notes*	*Evidence required*
Interventional radiology should be available 24/7 within 30 minutes of a request.			*TARN report*

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.*		*Operational policy.*
T16-2B-110	**24/7 Access to Emergency Theatre and Surgery**	**TARN report**
Descriptor	Notes	Evidence required
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.		Operational policy TARN report
T16-2B-111	**Damage Control Training for Emergency Trauma Consultant Surgeons**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
All general surgeons who are on the emergency surgery rota should be trained in the principles and techniques of damage control surgery		*Operational policy including list of surgeons trained.* *Annual report with details of the training.*
T16-2B-112	**24/7 Access to On-site Surgical Staff**	**TARN report**
Descriptor	*Notes*	*Evidence required*
The following staff should be available on site 24/7: • *a general surgeon ST4 or above;*		*Operational policy*

• *a trauma and orthopaedic surgeon ST4 or above;* • *an anaesthetist ST4 or above;* • *a neurosurgeon ST2 or above.*		*Medical staffing rotas should be available for PR visit.* *TARN report*
T16-2B-113	**24/7 Access to Consultant Specialists**	**TARN report**
Descriptor	*Notes*	*Evidence required*
There following consultants should be available to attend an emergency case within 30 minutes • *emergency department physicians;* • *a general surgeon;* • *an anaesthetist;* • *an intensivist;* • *a trauma and orthopaedic surgeon;* • *a neurosurgeon;* • *an interventional radiologist;* • *a radiologist;* • *a plastic surgeon;* • *a cardiothoracic surgeon;* • *a vascular surgeon;* • *a urology surgeon;* • *a maxillofacial surgeon;* • *an ENT surgeon.*	*An individual may fulfil more than one of the roles on the list, compatible with their discipline and status.* *There should be written pathways for the safe management of patients in place for any specialties that do not meet the requirement.*	*Operational policy* *TARN report* *Consultant rotas should be available for PR visit*

T16-2B-114	Dedicated Orthopaedic Trauma Operating Theatre	Self declaration
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy Including the specified number of hours per week* *The theatre timetable should be available for PR visit*
T16-2B-115	**Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries**	**TARN report**
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy including the names of the surgeons.* *TARN report* *Reviewers to enquire of facilities.*
T16-2B-116	**Trauma Management Guidelines**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The MTC should agree the network trauma management guidelines as specified in T16-1C-107. *The MTC should include relevant local details.*		*Operational Policy.*

T16-2B-117	Critical Care Provision	Self declaration
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy*
T16-2B-118	**24/7 Specialist Acute Pain Service**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.		Operational policy Including pain management pathways
T16-2B-119	**Administration of Tranexamic Acid**	**TARN report**
Descriptor	*Notes*	*Evidence required*
Patients with significant haemorrhage should be administered Tranexamic Acid within 3 hours of injury and receive a second dose according to CRASH-2 protocol.		*TARN report.*

Definitive care			
Number	**Indicator**		**Data Source**
T16-2C-101	**Major Trauma Centre Lead Clinician**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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.			*Operational policy*
T16-2C-102	**Major Trauma Service**		**Self declaration**
Descriptor		Notes	Evidence required
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.		*This may be on a daily or weekly basis*	Operational policy Including names of the consultants.
T16-2C-103	**Major Trauma Coordinator Service**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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.*		*This post can be shared with the rehabilitation coordinator.*	*Operational policy* *Including the names of the coordinators.*

T16-2C-104	Major Trauma MDT Meeting		Self declaration
Descriptor		*Notes*	*Evidence required*

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:
• *a trauma co-ordinator*
• *a physiotherapist*
• *clinical staff for:*
  ○ *major trauma service*
  ○ *orthopaedics*
  ○ *general surgery*
  ○ *neurosurgery*
  ○ *critical care*
  ○ *radiology*
 	
Accommodation for the meeting should include facilities for:
• *Video/teleconferencing*
• *PACS*
			Operational policy

T16-2C-105	**Dedicated Major Trauma Ward or Clinical Area**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
There should be a separate major trauma ward or clearly identified clinical area where major trauma patients are managed as a cohort			*Operational Policy*
T16-2C-106	**Formal Tertiary Survey**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
All major trauma patients should have a formal tertiary survey completed to identify missed injuries.			*Annual report*

The survey should be recorded in the patient's notes.			
T16-2C-107	**Management of Neurosurgical Trauma**		**TARN report**
Descriptor		*Notes*	*Evidence required*
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.*		*Referral to neurosurgery can be by telephone consultation or email*	*Operational policy* *TARN report*
T16-2C-108	**Management of Craniofacial Trauma**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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.*			*Operational policy*

T16-2C-109	Management of Spinal Injuries	TARN report
Descriptor	*Notes*	*Evidence required*
The MTC should agree the network protocol for protecting and assessing 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.*	*If access to the SCIC outreach service is identified as an issue by the MTC, audit data should be made available indicating the delays.*	*Operational policy* *Examples of ASIA charts and management plans should be available at PR visit* *TARN report*
T16-2C-110	**Management of Musculoskeletal Trauma**	**TARN report**
Descriptor	*Notes*	*Evidence required*
There should be trauma orthopaedic surgeons who spend a minimum of 50% of their programmed activities in trauma. *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.*	*Reference NICE guideline – Major Trauma (NG39)*	*Operational policy* *TARN report*

T16-2C-111	Management of Hand Trauma	Self declaration
Descriptor	*Notes*	*Evidence required*
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*		*Operational policy including details of hand surgery specialists and therapists.*
T16-2C-112	**Management of Complex Peripheral Nerve Injuries**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy including a list of surgical specialists /name of tertiary referral centre.*
T16-2C-113	**Management of Maxillofacial Trauma**	**Self declaration**
Descriptor	Notes	Evidence required
There should be on site maxillofacial surgeons with access to theatre for the reconstruction of maxillofacial trauma.		Operational policy Surgical rotas should be available at PR visit

T16-2C-114	**Vascular and Endovascular Surgery**		**T Self declaration**
There should be facilities for open vascular and endovascular surgery, including EVAR, available 24/7.			Operational policy
T16-2C-115	**Designated Specialist Burns Care**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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.*			*The clinical guideline for treatment of burns including the referral pathway*
T16-2C-116	**Patient Transfer**		**TARN report**
Descriptor		*Notes*	*Evidence required*
The MTC should agree the network protocol for patient transfer T16-1C-104			*Operational policy* *TARN report*
T16-2C-117	**Network Patient Repatriation Policy**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
The MTC should agree the network policy for the repatriation of patients. T16-1C-115			*Operational policy*
T16-2C-118	**Specialist Dietetic Support**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
There should be a specialist dietician with specified time for the management of major trauma patients.			*Operational policy.*

T16-2C-119	**24/7 Access to Psychiatric Advice**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be 24/7 access to liaison psychiatric assessment services.		*Operational policy.*
T16-2C-120	**Patient Information**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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)		*Operational policy. Details and examples of written information should be available for PR visit*
T16-2C-121	**Patient Experience**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The MTC should participate in the TARN PROMS and PREMS	*From 2017 the TARN Proms report will provide evidence of participation*	*Operational policy*
T16-2C-122	**Discharge summary**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*	*ref Nice guideline- Major Trauma (NG39)*	*Operational policy Examples of the discharge summary should be available for PR visit*

T16-2C-123	**Rate of Survival**	**TARN Report**
Rehabilitation		
Number	**Indicator**	**Data Source**
T16-2D-101	**Clinical Lead for Acute Trauma Rehabilitation Services**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.		*Operational policy including the name and agreed list of responsibilities.*
T16-2D-102	**Specialist Rehabilitation Team**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a multidisciplinary specialist rehabilitation team which should include: • *Consultant in rehabilitation medicine* • *Physiotherapist* • *Occupational therapist* • *Speech and language therapist* • *Dietitian* • *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*		*Operational policy including details of the team*

• *surgical appliance services* • *orthotic services* • *prosthetic services* • *wheelchair services*			
T16-2D-103	**Rehabilitation Coordinator Post**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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.*			*Operational policy including names of the rehabilitation co-ordinators.*
T16-2D-104	**Specialist Rehabilitation Pathways**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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*		*Describe any specialist vocational rehabilitation services available. If not available give details of planned developments*	*Operational policy including details of the team and the number of specialist rehabilitation beds.*
T16-2D-105	**Key worker**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
All patients requiring rehabilitation should have an identified key worker to be a point of contact for them, their carer/s or family doctor.			*Operational policy*

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	**Rehabilitation Assessment and Prescriptions**		**TARN report**
Descriptor		*Notes*	*Evidence required*
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*		*(1) Deputy may be a nurse or AHP Band 7 or above with a rehabilitation role or a Speciality Trainee in Rehabilitation Medicine at ST4 or above* *Some MTCs have designated specialist Level 1 &/or 2 rehabilitation beds, in which case patients may be transferred directly into those beds, so the specialist RP may then be part of routine UKROC data collection on transfer.*	*Operational policy* *TARN report*

T16-2D-107	Rehabilitation for Traumatic Amputation	Self declaration
Descriptor	*Notes*	*Evidence required*
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;*		*Operational policy including the name of the linked centre and outreach service, analgesia guidelines and list of psychologists available.*
T16-2D-108	**Referral Guidelines to Rehabilitation Services**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The MTC should agree the network referral guidelines for access to rehabilitation services T16-1C-113		*Referral guidelines*
T16-2D-109	**Clinical Psychologist for Trauma Rehabilitation**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*	*Where there is no clinical psychologist the trauma rehabilitation services should provide detail on how they access advice from a clinical psychologist.*	*Operational policy including the name and agreed responsibilities of the clinical psychologist.*
T16-2D-110	**BSRM Core Standards for Specialist Rehabilitation in the Trauma Pathway**	**RCSET**
Descriptor	*Notes*	*Evidence required*
.For patients identified as having category A or B needs, & so potentially		*Operational policy including network rehabilitation*

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.*	*The RCS-ET helps to identify the "R" point, & where ongoing trauma care may be provided in a TU. In some NTNs the role of TUs is for emergency ED care only.*	*pathways*

CHILDREN'S MAJOR TRAUMA QUALITY INDICATORS

These quality indicators should be applied to all children's major trauma centres. Where this is combined with an adult service, teams may submit a common set of evidence required documentation which includes reference to both adults and children. However they will still be required to assess against both adults and children's quality indicators. Where there is a stand-alone children's major trauma centre the team is only required to assess against this set of quality indicators.

Reception and Resuscitation		
Number	**Indicator**	**Data source**
T16-2B-201	**Trauma Team Leader**	**TARN report**
T16-2B-202	**Trauma Team Leader Training**	**Self declaration**
T16-2B-203	**Emergency Trauma Nurse/ AHP**	**TARN report**
T16-2B-204	**Trauma Team Activation Protocol**	**Self declaration**
T16-2B-205	**24/7 Surgical and Resuscitative Thoracotomy Capability**	**TARN report**
T16-2B-206	**24/7 CT Scanner Facilities and on-site Radiographer**	**TARN report**
T16-2B-207	**CT Reporting**	**TARN report**
T16-2B-208	**24/7 MRI Scanning Facilities**	**TARN report**
T16-2B-209	**24/7 Interventional Radiology**	**TARN report**
T16-2B-210	**24/7 Access to Emergency Theatre and Surgery**	**TARN report**
T16-2B-211	**Damage Control Training for Emergency Trauma Consultant Surgeons**	**Self declaration**
T16-2B-212	**24/7 Access to Consultant Specialists**	**TARN report**
T16-2B-213	**Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries**	**TARN report**
T16-2B-214	**Trauma Management Guidelines**	**Self declaration**
T16-2B-215	**Critical Care Provision**	**Self declaration**
T16-2B-216	**24/7 Specialist Acute Pain Service**	**Self declaration**
T16-2B-217	**Administering Tranexamic Acid**	**TARN report**

Definitive Care		
Number	**Indicator**	**Data source**
T16-2C-201	Major Trauma Centre Lead Clinician	Self declaration
T16-2C-202	Major Trauma Coordinator Service	Self declaration
T16-2C-203	Major Trauma MDT Meeting	Self declaration
T16-2C-204	Identification of Social and Welfare Needs	Self declaration
T16-2C-205	Formal Tertiary Survey	Self declaration
T16-2C-206	Management of Neurosurgical Trauma	TARN report
T16-2C-207	Management of Craniofacial Trauma	Self declaration
T16-2C-208	Management of Spinal Injuries	TARN report
T16-2C-209	Management of Musculoskeletal Trauma	TARN report
T16-2C-210	Management of Hand Trauma	Self declaration
T16-2C-211	Management of Complex Peripheral Nerve Injuries	Self declaration
T16-2C-212	Management of Maxillofacial Trauma	Self declaration
T16-2C-213	Designated Specialist Burns Care	Self declaration
T16-2C-214	Patient transfer	TARN report
T16-2C-215	Specialist Dietetic Support	Self declaration
T16-2C-216	24/7 Access to Psychiatric Advice	Self declaration
T16-2C-217	Patient Information	Self declaration
T16-2C-218	Patient Experience	TARN report
T16-2C-219	Discharge Summary	Self declaration
T16-2C-220	Network Patient Repatriation Policy	Self declaration
Rehabilitation		

Number	Indicator	Data source
T16-2D-201	Clinical Lead for Acute Trauma Rehabilitation Services	Self declaration
T16-2D-202	Specialist Rehabilitation Team	Self declaration
T16-2D-203	Rehabilitation Coordinator Post	Self declaration
T16-2D-204	Specialist Rehabilitation Pathways	Self declaration
T16-2D-205	Key worker	Self declaration
T16-2D-206	Rehabilitation Assessment and Prescriptions	TARN report
T16-2D-207	Rehabilitation for Traumatic Amputation	Self declaration
T16-2D-208	Referral Guidelines to Rehabilitation Services	Self declaration
T16-2D-209	Clinical Psychologist for Trauma Rehabilitation	Self declaration

CHILDREN'S MAJOR TRAUMA QUALITY INDICATORS - *Descriptors*

Reception and Resuscitation			
Number	**Indicator**		**Data source**
T16-2B-201	**Trauma Team Leader**		**TARN report**
Descriptor		*Notes*	*Evidence required*
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.*		*The consultant trauma team leader need not be on site* *It is recommended the MTC undertake an audit of the numbers of major trauma*	*Operational policy including agreed responsibilities.*
T16-2B-202	**Trauma Team Leader Training**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
All trauma team leaders should have attended trauma team leader training.		*Training can be national or provided in-house*	*Annual report*
T16-2B-203	**Emergency Trauma Nurse/ AHP**		**TARN report**
Descriptor		*Notes*	*Evidence required*
There should be a paediatric registered nurse/AHP of band 7 or above available for 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.		*Guidance is found on the TQUINS resource page* [*Tquins resources*]	*Operational policy* *TARN report*

All nursing/AHP staff caring for a trauma patients should have attained the paediatric competency and educational standard of level 1. (as described in the National Major Trauma Nursing Group guidance).		
T16-2B-204	**Trauma Team Activation Protocol**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy Including the protocol*
T16-2B-205	**24/7 Surgical and Resuscitative Thoracotomy Capability**	**TARN report**
Descriptor	*Notes*	*Evidence required*
There should be a surgical and resuscitative thoracotomy capability within the trauma team and available 24/7		*Operational policy including a list of all appropriate trained consultants.* *TARN report* *The consultant rota should be available for peer review visit*
T16-2B-206	**24/7 CT Scanner Facilities and on-site Radiographer**	**TARN Report**
Descriptor	*Notes*	*Evidence required*
The MTC should agree and implement the network imaging protocol for children. *There should be CT scanning located in the emergency department and*	*Where the CT scanner is located outside of the department there should be a protocol for the safe transfer of major trauma patients to and from the scanner.*	*Operational policy Including the protocol* *TARN report*

available 24/7. *There should be an on-site radiographer available 24/7.to prepare the CT scanner for use.*			
T16-2B-207	**CT Reporting**		**TARN report**
Descriptor		*Notes*	*Evidence required*
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;* • *scans should be reported by a consultant paediatric radiologist within 24 hours.*			*The protocol.* *TARN report*
T16-2B-208	**24/7 MRI Scanning Facilities**		**TARN report**
Descriptor		*Notes*	*Evidence required*
MRI scanning should be available 24/7			*Operational policy* *TARN report*
T16-2B-209	**24/7 Interventional Radiology**		**TARN Report**
Descriptor		*Notes*	*Evidence required*
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.*			*Operational policy.* *TARN report*

T16-2B-210	24/7 access to Emergency Theatre and Surgery	TARN report
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy* *TARN report*
T16-2B-211	**Damage Control Training for Emergency Trauma Consultant Surgeons**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
All general surgeons providing emergency surgery should be trained in the principles and techniques of damage control surgery.		*Operational policy including list of surgeons trained.* *Annual report with details of the training.*
T16-2B-212	**24/7 Access to Consultant Specialists**	**TARN report**
Descriptor	*Notes*	*Evidence required*
The following consultants should be available to attend an emergency case within 30 minutes: • *a general paediatric surgeon;* • *a paediatric anaesthetist;* • *a paediatric intensivist;* • *a paediatric neurosurgeon.*	*An individual may fulfil more than one of the roles on the list, compatible with their discipline and status.* *Where general surgeons provide both paediatric and adult emergency surgery, this should be indicated.* *There should be written pathways for the safe management of patients in place for any specialties that do not meet the requirement.*	*Operational policy* *TARN report* *Consultant rotas should be available for PR visit*

T16-2B-213	Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries	TARN Report
Descriptor	*Notes*	*Evidence required*
There should be specialist surgeons and facilities (theatre/equipment) available to provide fixation of pelvic ring injuries within 24 hours. *There should be cover arrangements in place for holidays and planned absences.*	*This need not be on site*	*Operational policy including the names of the surgeons.* *TARN report* *Reviewers to enquire of facilities.*
T16-2B-214	**Trauma Management Guidelines**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The MTC should agree the network trauma management guidelines as specified in T16-1C-107. *The MTC should include relevant local details.*		*Operational policy.*
T16-2B-215	**Critical Care Provision**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
In exceptional circumstances if children are cared for on an adult ITU prior to transfer to a PICU: 4. *there should be guidelines for the temporary management of children that comply with the minimum standards of the paediatric intensive care society;* 5. *there should be safe transfer / retrieval pathways;* 6. *the unit should be part of a paediatric intensive care network.*		*Operational policy*
T16-2B-216	**24/7 Specialist Acute Pain Service**	**Self declaration**

Descriptor		*Notes*	*Evidence required*
There should be a 24/7 specialist paediatric acute pain service for major trauma patients.			*Operational policy including pain management pathways*
T16-2B-217	**Administration of Tranexamic Acid**		**TARN report**
Descriptor		*Notes*	*Evidence required*
There should be a policy that patients with significant haemorrhage should be administered Tranexamic Acid within 3 hours of injury according to RCPCH guidelines			*TARN report*
Definitive Care			
Number	**Indicator**		**Data source**
T16-2C-201	**Major Trauma Centre Lead Clinician**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
There should be a lead clinician for the Major Trauma Centre (MTC) who should be a paediatric consultant with managerial responsibility for the service and time specified in their job plan.			*Operational policy*
T16-2C-202	**Major Trauma Coordinator Service**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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 with experience in paediatric trauma*		*This post can be shared with the rehabilitation coordinator.* *For combined adult / children's centres, the post may cover both adults and children.*	*Operational policy* *Including the names of the coordinators.*

T16-2C-203	Major Trauma MDT Meeting	Self declaration
Descriptor	*Notes*	*Evidence required*

There should be a single weekly MDT meeting for the presentation and discussion of all major trauma patients following admission.
The meeting should include:
• *major trauma lead clinician*
• *trauma co-ordinator*
• *a physiotherapist*
• *occupational therapist*
• *speech and language therapist*
• *youth worker*
• *play therapist*
• *psychologist*
• *safe-guarding representative as required*
• *additional clinical staff as appropriate*
  ○ *orthopaedics*
  ○ *general surgery*
  ○ *neurosurgery*
  ○ *critical care*
  ○ *radiology*
 	
Accommodation for the meeting should include facilities for
• *Video/Teleconferencing*
• *PACS*
		Operational policy

T16-2C-204	**Identification of Social and Welfare Needs**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be identified members of the team who are trained to assess the		*Operational policy*

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.*		*Reviewers should enquire at PR visit*
T16-2C-205	**Formal Tertiary Survey**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a protocol specifying that all major trauma patients should have a formal tertiary survey to identify missed injuries. *The major trauma service should audit the implementation of the protocol.*		*Annual report including results of the audit.*
T16-2C-206	**Management of Neurosurgical Trauma**	**TARN report**
Descriptor	*Notes*	*Evidence required*
The MTC should have the following neurosurgical provision: *i) neuroradiology;* *ii) on site neuro critical care;* *iii) a paediatric neurosurgical consultant available for advice to the trauma network 24/7;* *iv) a senior neurosurgical trainee of ST4 or above available on site 24/7;* *v) all neurosurgical patient referrals should be discussed with a paediatric*	*Referral to neurosurgery can be by telephone consultation or email*	*Operational policy* *TARN report* *The consultant rota should be available for PR visit.*

neuro consultant; *vi) all decisions to perform emergency neurosurgery for trauma are discussed with a paediatric neuro consultant;* *vii) facilities available to allow neurosurgical intervention within 1 hour of arrival at the MTC.*		
T16-2C-207	**Management of Craniofacial Trauma**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy*
T16-2C-208	**Management of Spinal Injuries**	**TARN report**
Descriptor	*Notes*	*Evidence required*
The MTC should agree the network protocol for protecting and assessing the whole spine in 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.*	*If access to the SCIC outreach service is identified as an issue by the MTC, audit data should be made available indicating the delays.*	*Operational policy* *Examples of ASIA charts and management plans should be available at PR visit* *TARN report*

T16-2C-209	Management of Musculoskeletal Trauma	TARN report
Descriptor	*Notes*	*Evidence required*
There should be paediatric orthopaedic surgeons. *The MTC should provide a comprehensive musculoskeletal trauma service with paediatric orthopaedic surgeons and facilities to support all definitive fracture care and allow joint emergency orthoplastic management of severe open fractures as specified in BOAST 4 guidelines.*	*Reference NICE guideline – Major Trauma (NG39)*	*Operational policy* *TARN report*
T16-2C-210	**Management of Hand Trauma**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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*	*These need not be on site*	*Operational policy including details of hand surgery specialists and therapists.*
T16-2C-211	**Management of Complex Peripheral Nerve Injuries**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy including a list of surgical specialists /name of tertiary referral centre.*

T16-2C-212	**Management of Maxillofacial Trauma**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
There should be on site maxillofacial surgeons with access to theatre for the reconstruction of maxillofacial trauma.			*Operational policy Surgical rotas should be available at PR visit*
T16-2C-213	**Designated Specialist Burns Care**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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.*			*The clinical guideline for treatment of burns including the referral pathway*
T16-2C-214	**Patient Transfer**		**TARN report**
Descriptor		*Notes*	*Evidence required*
The MTC should agree the network protocol for patient transfer T16-1C-104			*Operational policy*
T16-2C-215	**Specialist Dietetic Support**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
There should be a specialist dietician with paediatric experience with specified time for the management of major trauma patients.			*The policy.*

T16-2C-216	24/7 Access to Psychiatric Advice		Self declaration
Descriptor		*Notes*	*Evidence required*
There should be 24/7 access to liaison paediatric psychiatric assessment services.			*Operational policy.* *The psychiatric on call rota should be available for PR visit*
T16-2C-217	**Patient Information**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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)			*Operational policy.* *Details and examples of written information should be available for PR visit*
T16-2C-218	**Patient Experience**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
The MTC should participate in the TARN PROMS and PREMS		*From 2017 the TARN Proms report will provide evidence of participation*	*TARN completion*
T16-2C-219	**Discharge summary**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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 braces and casts)* • *Follow-up clinic appointments* •		*ref Nice guideline- Major Trauma (NG39)*	*Operational policy* *Examples of the discharge summary should be available for PR visit*

T16-2C-220	Network Patient Repatriation Policy	Self declaration
Descriptor	*Notes*	*Evidence required*
The MTC should agree the network policy for the repatriation of patients. *T16-1C-115*		*Operational policy*

Rehabilitation

Number	Indicator	Data source
T16-2D-201	**Clinical Lead for Acute Trauma Rehabilitation Services**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a named lead clinician for acute trauma rehabilitation services who should have experience in children's rehabilitation and have an agreed list of responsibilities and time specified for the role.		*Operational policy including the name and agreed list of responsibilities.*
T16-2D-202	**Specialist Rehabilitation Team**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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		Operational policy including details of the team

• 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-203	**Rehabilitation Coordinator Post**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*	*This post can be shared with the major trauma coordinator.* *This can be a combined post for adults and children*	*Operational policy including names of the rehabilitation co-ordinators.*
T16-2D-204	**Specialist Rehabilitation Pathways**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be referral pathways to the following specialist rehabilitation that meet the individual needs of the child and their family whilst in the MTC and include transition into community services:		*Operational policy including details of the team and the number of specialist*

• *neurological injuries including brain injuries* • *spinal injuries* • *complex musculoskeletal injuries* • *education and vocational rehabilitation for patients with or without brain injury*			*rehabilitation beds.*
T16-2D-205	**Key worker**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
Each patient 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 in the rehabilitation prescription.*			*Operational policy*
T16-2D-206	**Rehabilitation Assessment and Prescriptions**		**TARN report**
Descriptor		*Notes*	*Evidence required*
All patients should receive a rehabilitation assessment. Where a prescription is required this should be completed within 72 hours.			*Annual report including TARN report*
T16-2D-207	**Rehabilitation for Traumatic Amputation**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
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*			*Operational policy including the name of the linked centre and outreach*

patients with amputation; • *pain management of acute amputation, including phantom limb pain;* • *specialist paediatric psychological services for patients who suffer acute, traumatic amputation.*		*service, analgesia guidelines and list of psychologists available.*
T16-2D-208	**Referral Guidelines to Rehabilitation Services**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The MTC should agree the network referral guidelines for access to rehabilitation services T16-1C-113		*Operational policy*
T16-2D-209	**Clinical Psychologist for Trauma Rehabilitation**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*	*Where there is no clinical psychologist the trauma rehabilitation services should provide detail on how they access advice from a clinical psychologist.*	*Operational policy including the name and agreed responsibilities of the clinical psychologist.*

MAJOR TRAUMA QUALITY INDICATORS FOR TRAUMA UNITS

Reception and Resuscitation		
Number	**Indicator**	**Data source**
T16-2B-301	Trauma Team Leader	TARN report
T16-2B-302	Emergency Trauma Nurse/ AHP	TARN report
T16-2B-303	Trauma Team Activation Protocol	Self declaration
T16-2B-304	Agreement to Network Transfer Protocol from Trauma Units to Major Trauma Centres	TARN report
T16-2B-305	24/7 CT Scanner Facilities	TARN report
T16-2B-306	CT Reporting	TARN report
T16-2B-307	Teleradiology Facilities	Self declaration
T16-2B-308	24/7 Access to Surgical Staff	TARN report
T16-2B-309	Dedicated Orthopaedic Trauma Operating Theatre	Self declaration
T16-2B-310	24/7 access to Emergency Theatre and Surgery	TARN report
T16-2B-311	Trauma Management Guidelines	Self declaration
T16-2B-312	Transfusion Protocol	Self declaration
T16-2B-313	Administration of Tranexamic Acid	TARN report
Definitive Care Quality indicators		
Number	**Indicator**	**Data source**
T16-2C-301	Major Trauma Lead Clinician	Self declaration
T16-2C-302	Trauma Group	Self declaration
T16-2C-303	Trauma Coordinator Service	Self declaration
T16-2C-304	Management of Spinal Injuries	TARN report

T16-2C-305	**Management of Multiple Rib Fractures**	**TARN report**
T16-2C-306	**Management of Musculoskeletal Trauma**	**TARN report**
T16-2C-307	**Designated Specialist Burns Care**	**Self declaration**
T16-2C-308	**Trauma Unit Agreement to the Network Repatriation Policy**	**Self declaration**
T16-2C-309	**Patient Experience**	**Self declaration**
T16-2C-310	**Discharge Summary**	**Self declaration**
T16-2C-311	**The Trauma Audit and Research Network (TARN)**	**TARN report**
T16-2C-312	**Rate of Survival**	**TARN Report**
Rehabilitation Quality indicators		
Number	**Indicator**	**Data source**
T16-2D-301	**Rehabilitation Coordinator**	**Self declaration**
T16-2D-302	**Access to Rehabilitation Specialists**	**Self declaration**
T16-2D-303	**Rehabilitation Prescriptions**	**TARN report**

MAJOR TRAUMA QUALITY INDICATORS FOR TRAUMA UNITS – *Descriptors*

Reception and Resuscitation			
Number	**Indicator**		**Data source**
T16-2B-301	**Trauma Team Leader**		**TARN report**
Descriptor		*Notes*	*Evidence required*
There should be a trauma team leader of ST3 or above or equivalent NCCG, with an agreed list of responsibilities available within 5mins, 24/7. *There should also be a consultant available in 30 minutes.* *The trauma team leader should have been trained in Advanced Trauma Life Support (ATLS) or equivalent.* *There should be a clinician trained in advanced paediatric life support available for children's major trauma.*			*Operational policy including agreed responsibilities.* *TARN report*
T16-2B-302	**Emergency Trauma Nurse/ AHP**		**TARN report**
Descriptor		*Notes*	*Evidence required*
There should be a nurse/AHP available for major trauma 24/7 who has successfully attained or is working towards the adult competency and educational standard of level 2 as described in the National Major Trauma Nursing Group guidance. *In units which accept children;* *There should be a paediatric registered nurse/AHP available for paediatric*		*Guidance is found on the TQUINS resource page* [*Tquins resources*]	*Operational policy* *TARN report*

major trauma 24/7 who has successfully attained or is working towards the paediatric competency and educational standard of level 2 as described in the National Major Trauma Nursing Group guidance. *All nursing/AHP staff caring for a trauma patients should have attained the competency and educational standard of level 1. In units that accept paediatric major trauma, this should include the paediatric trauma competencies (as described in the National Major Trauma Nursing Group guidance).*		
T16-2B-303	**Trauma Team Activation Protocol**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy including the protocol.*
T16-2B-304	**Agreement to Network Transfer Protocol from Trauma Units to Major Trauma Centres**	**TARN report**
Descriptor	*Notes*	*Evidence required*
The trauma unit should agree the network protocol for the transfer of patients from trauma unit to major trauma centre.		*Operational policy*
T16-2B-305	**24/7 CT Scanner Facilities**	**TARN report**
Descriptor	*Notes*	*Evidence required*
There should be CT scanning available within 60 minutes of the trauma team activation.	*Whole body CT is the diagnostic modality of choice where adult patients are stable enough for transfer to CT.*	*Operational policy* *TARN report*

T16-2B-306	CT Reporting	TARN report
Descriptor	*Notes*	*Evidence required*
There should be a protocol for trauma CT reporting that specifies there should be a provisional report within 60 minutes.		*Operational policy* *TARN report*
T16-2B-307	**Teleradiology Facilities**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The trauma unit should have an image exchange portal that enables immediate image transfer to the MTC 24/7.		*Operational policy specifying details of portal used*
T16-2B-308	**24/7 Access to Surgical Staff**	**TARN report**
Descriptor	*Notes*	*Evidence required*
The following staff should be available within 30 minutes 24/7: • *a general surgeon ST3 or above, or equivalent NCCG;* • *a trauma and orthopaedic surgeon ST3 or above or equivalent NCCG;* • *an anaesthetist ST3 or above or equivalent NCCG.*		*Operational policy* *TARN report* *Medical staffing rotas should be available for PR visit.*
T16-2B-309	**Dedicated Orthopaedic Trauma Operating Theatre**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be dedicated trauma operating theatre lists with appropriate staffing available 7 days a week.		*Operational policy Including the specified*

The lists must be separate from other emergency operating.		*number of hours per week*
T16-2B-310	**24/7 access to Emergency Theatre and Surgery**	**TARN report**
Descriptor	*Notes*	*Evidence required*
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.*		*Operational policy* *TARN report*
T16-2B-311	**Trauma Management Guidelines**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The trauma unit should agree the network clinical guidelines specified in T16-1C-107 *The trauma unit should include relevant local details.*		*Operational policy.*
T16-2B-312	**Transfusion Protocol**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a protocol for the management of massive transfusion in patients with significant haemorrhage.		*Operational policy*

T16-2B-313	Administration of Tranexamic Acid	TARN report
Descriptor	*Notes*	*Evidence required*
Patients with significant haemorrhage should be administered Tranexamic Acid within 3 hours of injury and receive a second dose according to CRASH-2 protocol.		*TARN report*
Definitive Care		
Number	**Indicator**	**Data source**
T16-2C-301	**Major Trauma Lead Clinician**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a lead clinician for major trauma, who should be a consultant with managerial responsibility for the service and a minimum of 1 programmed activity specified in their job plan.		*Operational policy*
T16-2C-302	**Trauma Group**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The TU should have a trauma group that meets at least quarterly. *The membership should include:* • *major trauma lead clinician;* • *executive board representation;* • *ED medical consultant* • *ED nurse* *representation from:*		*Operational policy*

• *radiology* • *surgery* • *anaesthetics* • *critical care* • *trauma orthopaedic surgeons*			
T16-2C-303	**Trauma Coordinator Service**		**Self declaration**
Descriptor		*Notes*	*Evidence required*
There should be a trauma coordinator service available Monday to Friday for the co-ordination of patients. *The coordinator service should be provided by nurse or allied health professionals.*		*This post can be shared with the rehabilitation coordinator.*	*Operational policy Including the names of the coordinators.*
T16-2C-304	**Management of Spinal Injuries**		**TARN report**
Descriptor	*Notes*		*Evidence required*
The trauma unit should agree the network protocol for protecting and assessing 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.*		*If access to the SCIC outreach service is identified as an issue, audit data should be made available indicating the delays.*	*Operational policy* *TARN report* *Examples of ASIA charts and management plans should be available at PR visit*

T16-2C-305	**Management of Multiple Rib Fractures**	**TARN report**
Descriptor	*Notes*	*Evidence required*
There should be network agreed local management guidelines for the management of multiple rib fractures including: • pain management including early access to epidural; • access to surgical advice. •		Operational policy TARN report
T16-2C-306	**Management of Musculoskeletal Trauma**	**TARN report**
Descriptor	*Notes*	*Evidence required*
There should be guidelines for: • *isolated long bone fractures;* • *early management of isolated pelvic acetabular fractures;* • *peri-articular fractures;* • *open fractures.* *The guidelines should include:* • *accessing specialist advice from the MTC;* • *imaging and image transfer;* • *indications for managing on site or transfer to the MTC.*	*Where there are nationally agreed guidelines, e.g. BOAST, it is recommended that these are adopted for use locally.* *Ref NICE Guideline – Major Trauma (NG39)*	*Operational policy* *TARN report*

T16-2C-307	Designated Specialist Burns Care	Self declaration
Descriptor	*Notes*	*Evidence required*
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.*		*The clinical guideline for treatment of burns including the referral pathway*
T16-2C-308	**Trauma Unit Agreement to the Network Repatriation Policy**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
The trauma unit should agree the network repatriation policy T16-1C-115 *There should be a protocol in place for identifying a speciality team to accept the patient. The protocol should include the escalation process in the event of there not being access to a specialty team.*		*Operational policy*
T16-2C-309	**Patient Experience**	**Self declaration**
The MTC should participate in the TARN PROMS and PREMS	*From 2017 the TARN Proms report will provide evidence of participation*	*Operational policy*
T16-2C-310	**Discharge Summary**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
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*	*Nice guideline- Major Trauma (NG39)*	*Operational policy* *Examples of the discharge summary should be available for PR visit*

specialist equipment such as; wheel chairs, braces and casts) • *Follow-up clinic appointments* • *Contact details for ongoing enquiries.*		
T16-2C-311	**The Trauma Audit and Research Network (TARN)**	**TARN report**
Descriptor	*Notes*	*Evidence required*
The trauma unit should participate in the TARN audit. *The results of the audit should be discussed at the network audit meeting at least annually and distributed to all constituent teams in the network, the CCGs and area teams.*		*TARN report*
T16-2C-312	**Rate of Survival**	**TARN Report**
Rehabilitation		
Number	**Indicator**	**Data source**
T16-2D-301	**Rehabilitation Coordinator**	**Self declaration**
Descriptor	*Notes*	*Evidence required*
There should be a rehabilitation coordinator who is responsible for coordination and communication regarding the patient's current and future rehabilitation including oversight of the rehabilitation prescription. *This rehabilitation coordinator should be a nurse or allied health professional.*	*This role may be shared with the trauma co-ordinator role*	*Operational policy including name of the rehabilitation co-ordinator.*

T16-2D-302	Access to Rehabilitation Specialists	Self declaration
Descriptor	*Notes*	*Evidence required*
There should be the following allied health professionals with dedicated time to support rehabilitation of trauma patients: • *physiotherapist* • *occupational therapist;* • *speech and language therapist* • *dietician* *There should be specified referral and access pathways for* • *rehabilitation medicine consultant* • *pain management* • *psychology/neuropsychology assessment (1)* • *mental health/psychiatry* • *specialised rehabilitation* • *specialist vocational rehabilitation* • *surgical appliances* • *orthotics and prosthetics* • *wheel chair services.*		*Operational policy*

T16-2D-303	Rehabilitation Prescriptions	TARN report
Descriptor	*Notes*	*Evidence required*
All patients should receive a rehabilitation assessment including barriers to return to work. Where a prescription is required this should be completed within 72 hours. *The prescription should be updated prior to discharge and a copy given to the patient* *All patients repatriated from the MTC should have their prescription reviewed and updated at the trauma unit.*		*Operational policy TARN report*

Appendix

1.1 Definitions

In this document the definitions used are as follows.

Clinical Advisory Groups (CAGs) – Five clinical advisory groups were established in order to produce this advice, each covering a separate aspect of the care pathway as follows:

- Pre-hospital and inter-hospital transfers
- Acute Care and Surgery
- Ongoing Care & Reconstruction
- Rehabilitation
- Network Organisation (incl. governance)

Major Trauma – NHS Choice defines 'Major Trauma' as multiple, serious injuries that could result in disability or death. These might include serious head injuries, severe gunshot wounds or road traffic accidents. Major Trauma is defined in the scientific literature using the Injury Severity Score (ISS), which assigns a value to injuries in different parts of the body and totals them to give a figure representing the severity of injury. An ISS greater than 15 is defined as Major Trauma. This would include serious injuries such as bleeding in the brain or a fracture of the pelvis and cases of multiple injuries; however, this definition does not include all those who should benefit from the regionalisation of trauma care.

This document refers to severely-injured patients, meaning those who have suffered potentially life-threatening or life-changing physical injuries, i.e. all those who could benefit from regional networks. Psychosocial consequences of such injuries are common but patients suffering such symptoms in isolation without injury as a result of a "traumatic experience" are not covered.

Inclusive Trauma System – An Inclusive Trauma System (ITS) describes a model in which commissioners; providers, public health representatives and other stakeholders of trauma care in a geographical region collaborate to plan, provide and manage the treatment of people injured as a result of Major Trauma.

The ITS is responsible for all aspects of trauma care, from the point of injury to rehabilitation, as well as for injury prevention. Each ITS comprises of one or more 'Trauma Networks' (see definition below). The ITS also features:

- a population-based approach to the assessment of need and the provision of treatment.
- a role for every hospital and provider of care.
- provision for the speedy transfer of patients between facilities, particularly where the severely injured have been under triaged away from the Trauma Centre.
- a quality assurance structure that penetrates across the region and to each stage of care, which underpins providers' clinical governance processes, identifies inadequate performance in order to support its correction and ultimately can apply sanctions where this does not occur. It also informs commissioners about the quality of care being delivered.

The Royal College of Surgeons advises that the ITS should have in place a plan which sets out the

detail of the 'Trauma Care Pathway' (TCP) for the region.

Trauma Care Pathway – This is the process through which care is provided for patients who have suffered Major Trauma; specifically, it describes the 'the location and capability of each trust/hospital within the ITS and outlines ambulance bypass protocols and thresholds for transferring patients to more specialist units'.

Trauma Network – A Trauma Network (TN) is the name given to the collaboration between the providers commissioned to deliver trauma care services in a geographical area. At its heart is the 'Major Trauma Centre'. A TN should include *all* providers of trauma care, particularly: pre-hospital services, other hospitals receiving acute trauma admissions (Trauma Units), and rehabilitation services. The TN has appropriate links to the social care and the voluntary/community sector. While individual units retain responsibility for their clinical governance, members of the Network collaborate in a Quality Improvement programme.

Major Trauma Centre – A Major Trauma Centre (MTC) is a multi-specialty hospital, on a single site, optimised for the provision of trauma care. It is the focus of the Trauma Network and manages all types of injuries, providing consultant-level care.

- It is optimised for the definitive care of injured patients. In particular it has an active, effective trauma Quality Improvement programme. It also provides a managed transition to rehabilitation and the community.
- It takes responsibility for the care of all patients with Major Trauma in the area covered by the Network. It also supports the Quality Improvement programmes of other hospitals in its Network.
- It provides all the major specialist services relevant to the care of major trauma, i.e. general, emergency medicine, vascular, orthopaedic, plastic, spinal, maxillofacial, cardiothoracic and neurological surgery and interventional radiology, along with appropriate supporting services, such as critical care.

The Royal College of Surgeons cite research advising that such centres should admit a minimum of 250 critically injured patients per year

Trauma Unit – A Trauma Unit (TU) is a hospital in a Trauma Network that provides care for most injured patients and:

- is optimised for the definitive care of injured patients. In particular, it has an active, effective trauma Quality Improvement programme. It also provides a managed transition to rehabilitation and the community.
- has systems in place to rapidly move the most severely injured to hospitals that can manage their injuries.
- may provide some specialist services for patients who do not have multiple injuries (e.g. open tibial fractures). The Trauma Unit then takes responsibility for making these services available to patients in the Network who need them. Other Trauma Units may have only limited facilities, being able to stabilise and transfer serious cases but only to admit and manage less severe injuries.

Local Emergency Hospital (not designated as TU) – The Local Emergency Hospital (LEH) is a hospital in a Trauma Network that does not routinely receive acute trauma patients (excepting minor injuries that may be seen in an MIU). It has processes in place to ensure that should this occur patients are appropriately transferred to an MTC or TU. It may have a role in the rehabilitation of trauma patients and the care of those with minor injuries.

1.2 Glossary

ASIA	American Spinal Injury Association
BASICS	British Association for Immediate Care
BOAST	British Orthopaedic Association Standard for Trauma
CAG	Clinical Advisory Group
CCG	Clinical Commissioning Group
CRASH-2 Trial	Clinical Randomisation of an Antifibrinolytic in Significant Haemorrhage
CT	Computerised Tomography
EVAR	Endovascular Aneurysm Repair
HEMS	Helicopter Emergency Ambulance Service
ICNARC	Intensive Care Audit and Research Centre
ISS	Injury Severity Score
ICU /ITU	Intensive Care Unit
MERIT	Medical Emergency Response Incident Team
MRI	Magnetic Resonance Imaging
MTC	Major Trauma Centre
MTN	Major Trauma Network
PACS	Picture Archiving and Communication System
PICNET	Paediatric Intensive Care Network
PICU	Paediatric Intensive Care Unit
RCPCH	Royal College of Physicians in Child Health
SCI	Spinal Cord Injury
TARN	Trauma Audit and Research Network
TU	Trauma Unit

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

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

	• Timely access for patients to the 'definitive place of treatment' to avoid delays in the patient pathway • Services that meet national clinical and workforce standards • Access to senior medical advice and treatment 24/7 for major trauma patients • Service models underpinned by realistic and deliverable workforce models • Stable medical teams that deliver high-quality patient care in an effective environment in which to train and educate the next generation of doctors • Integration of care and effective relationships with other health professions • An appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs • Early access to rehabilitation assessments and to ensure that patients are moved through the system appropriately

Service Aims & Objectives	**To improve the quality and safety of care for patients by:** • Providing a comprehensive system of specialist care for people who have suffered serious injury (major trauma) through the delivery of a regional trauma network • Improving the functionality, health and psychological well-being in those patients who survive their traumatic injuries, increasing their quality of life • Ensuring that services meet agreed national clinical and workforce standards. • Always meeting fundamental standards of care • Valuing patient experience as much as clinical effectiveness • Ensuring responsibility for each patient's care is clear and communicated • Providing effective and timely access to care, including appointments, tests, treatments and moves out of hospital • Ensuring robust arrangements for transferring care are in place • Tailoring services to meet the needs of individual patients, including vulnerable patients • Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment • Ensuring the quality of the system is monitored and subject to a process of continuous quality improvement. • Reducing avoidable deaths in the population of patients who would previously have died of their injuries

	To improve the sustainability of services to patients by: • Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate. • Developing clinical roles to provide future workforce flexibility • Ensuring the population has access to major trauma services within a reasonable timeframe • Planning capacity to meet demand and providing appropriate resources across the network • Ensuring the network is kept under continuous review and responds to changes in relevant strategies, standards and policies
	To improve access for patients by: • Delivering a system based on a pathway of care from the pre-hospital phase through acute care, ongoing care and rehabilitation and a return to socio-economic functioning • Ensuring effective triage and assessment of emergencies to enable conveyance by the most appropriate means to the most appropriate destination according to agreed criteria • Improving information and support to patients and families to encourage them to be active participants in their care

2.2 National Clinical Standards

Following initial review, the following reports, standards and guidance have been identified. The key publication is the NHS Clinical Advisory Groups Report (September 2010)*
This list will be developed through the Clinical Reference Group:

*Regional Networks for Major Trauma: NHS Clinical Advisory Groups Report (September 2010)
http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Emergencymedicine/Regionalnetworksformajortrauma.pdf
http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf

Major trauma care in England: National Audit Office (February 2010)
http://www.nao.org.uk/wp-content/uploads/2010/02/0910213.pdf

Standards of practice and guidance for trauma radiology in severely-injured patients: Royal College of Radiologists (2011)
https://www.rcr.ac.uk/docs/radiology/pdf/BFCR(11)3_trauma.pdf

The British Orthopaedic Association Standards for Trauma (BOAST)
http://www.boa.ac.uk/publications/boa-standards-for-trauma-boasts/

BOAST 4: The management of severe open lower limb fractures
http://www.boa.ac.uk/publications/boast-4-the-management-of-sever-open-lower-limb-fractures/

Management of People with Spinal Cord Injury: NHS Clinical Advisory Groups Report (August 2011)
http://www.mascip.co.uk/sci-roadmap.aspx (This report is hosted on this site)

Brain Trauma Foundation guidelines for head injury care
https://www.braintrauma.org/coma-guidelines/searchable-guidelines/

Triage, assessment, investigation and early management of head injury in children, young people and adults: NICE Guideline - Head injury (CG176)
http://guidance.nice.org.uk/CG176

Rehabilitation after critical illness: NICE Guideline (CG83)
http://publications.nice.org.uk/rehabilitation-after-critical-illness-cg83

Specialist rehabilitation in the trauma pathway: British Society of Rehabilitation Medicine (BSRM) core standards version 1.2 (January 2013)
http://www.bsrm.co.uk/publications/BSRM%20Core%20standards%20for%20Major%20Trauma%2030-5-13.pdf

Rehabilitation for patients in the acute care pathway following severe disabling illness or injury: BSRM core standards for specialist rehabilitation (October 2014)
http://www.bsrm.co.uk/publications/Specialist%20rehabilitation%20prescription%20for%20acute%20care%2028%2011%202014%20JA%20%20ap1%20redrawn.pdf

Together for Health – A delivery plan for the critically ill: Welsh Government (2013)
http://wales.gov.uk/docs/dhss/publications/130611deliveryen.pdf

Regional Trauma Networks – NHS Clinical Advisory Group on Major Trauma Workforce, Centre for Workforce Intelligence (March 2011)
http://www.cfwi.org.uk/publications/nhs-clinical-advisory-group-on-major-trauma-workforce/@@publication-detail

National burn care standards: National Network for Burn Care (Revised 2013)
http://www.britishburnassociation.org/downloads/National_Burn_Care_Standards_2013.pdf

NHS England: NHS Standard Contract for Major Trauma Services (all ages) (2013)
http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf

Note: NICE is developing five pieces of guidance relating to trauma, with expected publication dates in June and October 2015 (to be confirmed). Each piece of guidance will focus on a different aspect of trauma care.

- Complex fractures: assessment and management of complex fractures (including pelvic fractures and open fractures of limbs)
- Fractures: diagnosis, management and follow up of fractures (excluding head and hip, pelvis, open and spinal)
- Major trauma: assessment and management of airway, breathing and ventilation, circulation, haemorrhage and temperature control.
- Spinal injury assessment: assessment and imaging of patients at high risk of spinal injury
- Trauma services: service delivery of trauma services

3. Service Model

3.1 Service overview

The aim of the service is to provide care to major trauma patients, characterised by an Injury Severity Score (ISS) >15 and most patients with moderately severe trauma(ISS>8), from the point of injury to rehabilitation. Calculation of the ISS requires a full diagnostic work-up and so the service is designed around the triage of patients at the point of wounding, to identify “candidate major trauma patients” on the basis of mechanism of injury and assessment of their symptoms and physical signs. The Major Trauma Centre (MTC) will have all the services available to receive and manage seriously injured adults and children. Patients who have been incorrectly triaged to, or have self- presented with serious injury at a hospital within the network, will be rapidly transferred to the MTC. In addition, some patients will need treatment in the MTC which will require transfer in within the first 2 days following injury.

Following assessment and initial treatment at the MTC or TU, children requiring intensive care will be received at the Children’s Hospital for Wales which provides Paediatric Intensive Care Unit (PICU) facilities. See http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf - annex 1 for standards for provision of services for children.

The service is designed to deliver high quality specialist care to patients of all ages starting from the pre-hospital phase, through admission to the MTC, with full assessment and diagnostics in the emergency department. This may be followed by operative treatment and an episode in the critical care unit and ward. Rehabilitation will be required for a number for patients, and this rehabilitation will start in the MTC and continue through specialist rehabilitation or local rehabilitation services.

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).

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Service Aims & Objectives	**To improve the quality of rehabilitation for patients by:** • Providing a comprehensive system of specialist and local rehabilitation for people who have suffered serious injury (major trauma) through the delivery of a regional trauma rehabilitation network; • Improving the functionality, health and psychological well-being in those patients who survive their traumatic injuries, increasing their quality of life; • Ensuring that services meet agreed national clinical and workforce standards; • Always meeting fundamental standards of care/treatment; • Valuing patient experience as much as clinical effectiveness; • Ensuring responsibility for each patient's care is clear and communicated; • Providing effective and timely access to rehabilitation at all levels; • Ensuring robust arrangements for transferring treatment are in place; • Tailoring services to meet the needs of individual patients, including vulnerable patients; • Supporting staff to ensure that they have the appropriate skills, experience and commitment to provide effective assessment, advice and/or treatment; and • Ensuring the quality of the system is monitored and subject to a process of continuous quality improvement.
	To improve the sustainability of services to patients by: • Providing robust staffing arrangements that comply with employment legislation (e.g. Working Time Directive) and meet the requirements of the Deanery/General Medical Council for clinical training and supervision where appropriate; • Developing clinical roles to provide future workforce flexibility; • Ensuring the population has access to major trauma services within a reasonable timeframe; • Planning capacity to meet demand and providing appropriate resources across the network; and • Ensuring the network is kept under continuous review and responds to changes in relevant strategies, standards and policies.

	To improve access for patients by: • Delivering a rehabilitation system based on a pathway of care from acute care, ongoing care and rehabilitation and a return to socio-economic functioning; and • Improving information and support to patients and families to encourage them to be active participants in their rehabilitation.

3 Service Model

Network Delivery

There will be a Network Clinical Lead for Rehabilitation Services to coordinate the development and delivery of rehabilitation services and long-term support in the community, and the delivery of comprehensive and effective rehabilitation to meet the needs of traumatically injured patients, irrespective of their age.

Discharge planning, continuing care and rehabilitation

Patient transfer

- There should be cross network agreements and adequate resources to ensure that once specialist trauma care has been completed, patients can be transferred to the care of a service which is able to meet their ongoing care and/or rehabilitation needs.
- There should be a formal handover back to the local therapy team (including ALAS) via an identified therapy lead at the provider unit. The responsibility should be on the local team to ‘pull’ patients back to local services. This must be achieved in a timely manner with adequate notice to plan and support transition. The local therapy team should visit the patient at the provider unit as part of transfer planning. The transfer should be followed up with a visit from the provider therapy team following transfer.
- A discharge summary must be provided to support the patient’s transfer to an alternative healthcare setting or the community.
- Ongoing access to advice from provider therapy teams as required.

Communication

- There will be effective communication between all those responsible for the patient's care, the patient and where appropriate their family and other carers.
- Patients will be provided with a full range of condition-specific information in appropriate formats.
- A directory of services and resources should be developed relating to rehabilitation and ongoing care to facilitate referral and access to these services. Links with the local authorities and third sector are integral to the rehabilitation model.

Audit, data management, governance and quality improvement

- Representatives from services within the rehabilitation network will meet regularly to examine performance through formal governance processes.
- A central database is required to monitor and measure rehabilitation outcomes.
- Use of the Network rehabilitation prescription will be mandated.

Workforce

- A defined team to manage on-going patient care, including a key worker (also referred to as trauma and rehabilitation coordinator) to support patients through the pathway and into rehabilitation.
- Specialist nursing and allied health professional trauma roles.
- Able to facilitate practice of and independence in functional activities by the patient, and undertake activities with the patient as advised, by the rehabilitation team.
- An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.

- All patients needing rehabilitation input or monitoring to be under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation. A specialty trainee registrar at St4 or above in rehabilitation may deputise for a consultant on occasion.
- There should be rehabilitation and care coordinator posts throughout the network.
- There should be an adequately skilled and resourced multi-disciplinary rehabilitation team in all of the network's services. Multi-disciplinary teams should include: physiotherapists, occupational therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living.

Specialist rehabilitation is the total active care of patients with complex disabilities by a multi-professional team who have undergone recognised specialist training in rehabilitation led/supported by a consultant trained and accredited in rehabilitation medicine (Ref BSRM standards).

The aim of the rehabilitation service is to provide rehabilitation appropriate to the level of injury in the right setting. It will start in the Major Trauma Centre and continue through specialist or local rehabilitation services. To provide a holistic pathway of care, service requirements are as follows:

Early/Hyper Acute Phase Rehabilitation

• A defined service for early/hyper acute trauma rehabilitation service which meets the needs of patients with ISS >8.
• All patients have an initial rehabilitation prescription within 2-4 calendar days of presentation. The prescription may identify no further need for rehabilitation, may recommend monitoring or may require full active engagement of the wider rehabilitation team.
• Rehabilitation starts as soon as is appropriate after admission, typically in the critical care setting (and certainly within 72 hours), and continue at the intensity required, and for as long as is necessary, to enable patients to achieve their functional potential.

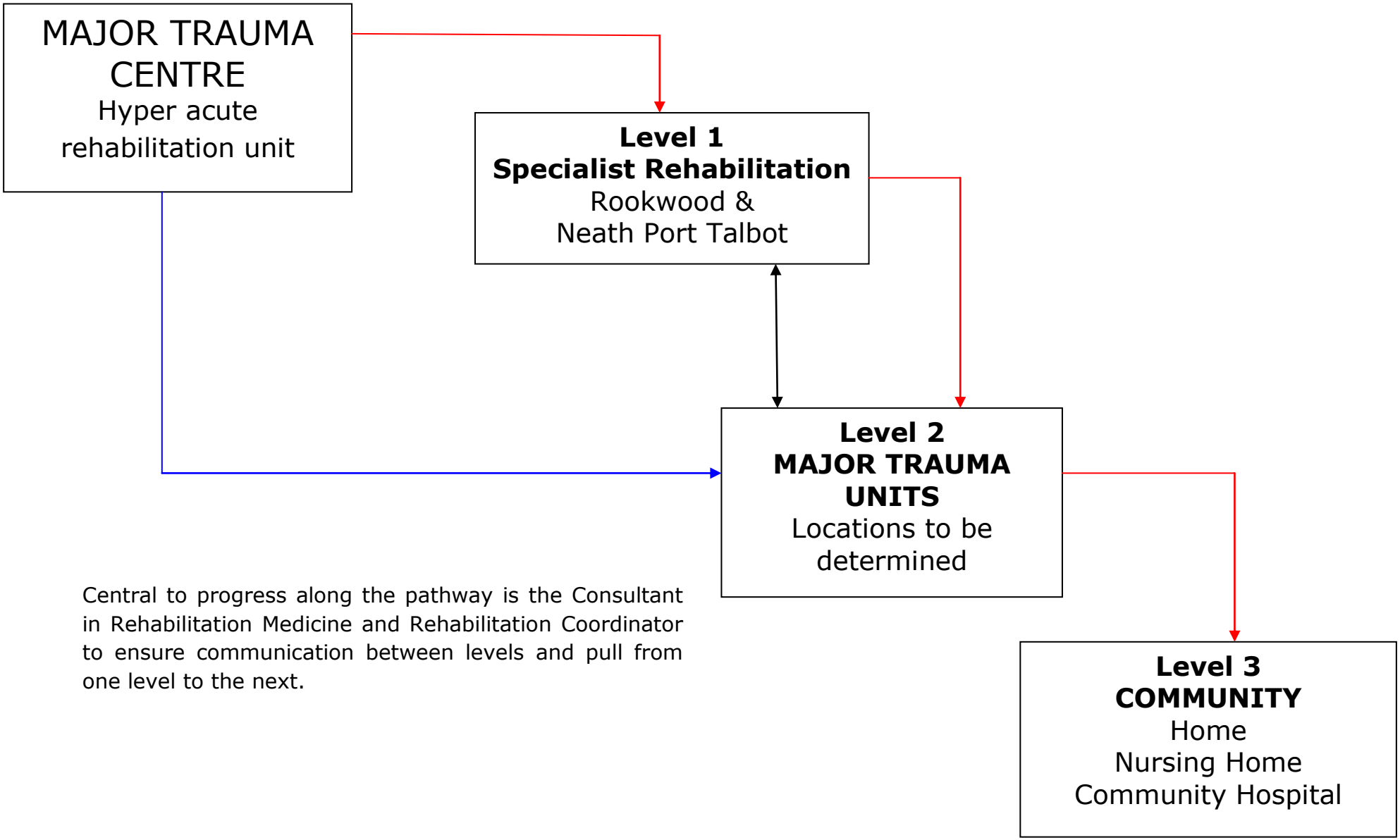
• The prescription for rehabilitation reflects the assessment of the physical, functional, vocational, educational, cognitive, psychological and social rehabilitation needs of a patient.
• An initial assessment by the relevant members of a specialist rehabilitation team (including nurses and therapists) to add to the medical review.
• All patients receive early phase rehabilitation and all other actions identified in the rehabilitation prescription; if action or input cannot be delivered, the reason is recorded and intervening action is undertaken.
• All patients needing rehabilitation input or monitoring are under the care of a consultant-delivered team that includes rehabilitation nurses, allied health professionals and a consultant in rehabilitation medicine or alternative consultant with skills and competencies in rehabilitation.
• This team meets weekly to discuss all patients within its scope. A consultant attends over 80% of meetings and continues to provide supervision and support to trainees and the team.

Rehabilitation phase (ongoing specialised and local rehabilitation)

• Trauma patients receive routine screening of rehabilitation needs and appropriate levels of care and rehabilitation at all points along their care pathway.
• Provider therapy teams provide access to rehabilitation assessment seven days a week.
• A discharge summary describing the patient's injuries, care received and ongoing needs and plans are provided at the time of discharge or transfer. This includes the rehabilitation prescription.
• There are rehabilitation and care coordinator posts in place. Each patient has an identified key worker to be a point of contact for them, their carers or family doctor and to ensure delivery of their personal prescription for rehabilitation.
• Vocational rehabilitation is a key component of the rehabilitation service.
• There is an adequately skilled and resourced multi-disciplinary rehabilitation team. Multi-disciplinary team includes: physiotherapists, occupational

therapists, orthotics, prosthetics, speech & language therapists, psychology and dieticians who are specialised in the care of poly trauma patients.
• Policies for nutritional management are in place.
• Use is made of VC/telehealth technology to support the rehabilitation phase, enhancing shared care arrangements between generic providers of rehabilitation and the specialist trauma rehabilitation teams.
• The needs of families and carers in all phases of major trauma rehabilitation are considered, including the distances that may be incurred in travelling.

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.

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 (UHW) 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;	35

	Clinical effectiveness, including:- • Delivers improved outcomes for patients; • Supports R&D; • Improves consistency in clinical practice.	
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 European Working Time Directive (EWTD) and clinical training standards; Attracts and retains an excellent workforce across all staff groups; Delivers the critical mass required to achieve full benefit from resources and investment; Does not destabilise other clinical services / developments; Provides business continuity and service contingency in the event of a major incident, etc.	25
Access	Access to services is optimised Service capacity will meet demand in a timely way Service will be delivered in an appropriate environment Suitable and timely transport for transfers between the major trauma centre and trauma units; Avoidable transfers minimised.	15
	Total	**100**

PROCESS

The non financial option appraisal will be undertaken through a stakeholder workshop.

The workshop will be independently chaired and will be facilitated by the South Wales Health Collaborative. Workshop participants, clinical and managerial, will be invited from each of the six health boards (Aneurin Bevan, Abertawe Bro Morgannwg, Cardiff & Vale, Cwm Taf, Hywel Dda and Powys) and the Welsh Ambulance Services NHS Trust. Each health board and WAST will be allocated a maximum number of attendees (for health boards calculated as 2 representatives per 100,000 population and with 5 representatives from WAST) and will be expected to manage their representation across a range of specialities/disciplines directly involved in or supporting a major trauma centre service. Patient representatives will be invited through third sector support groups and fair

geographical coverage will be sought. The CHCs will be invited to attend the workshop in an observer capacity.

Given the expected number of participants at the workshop, attendees will be allocated to one of six groups on arrival. This will be to ensure as much of a balance as possible on each of the groups between organisations, specialities and disciplines. Each group will then subsequently consider in detail a selected number of the above benefit criteria.

Before undertaking the detailed non financial option appraisal scoring, the workshop will:

- Receive a presentation to:
    - Describe the process to develop the service model, highlighting the infrastructure requirements and co-interdependencies
    - Explain the benefit criteria and weighting
    - Set out the options for the configuration of the major trauma network
    - Confirm the process for scoring
    - Describe how the results will then be collated and how the sensitivity analysis will be undertaken, as a post-workshop activity.

Scoring

The workshop will then need to undertake the detailed non financial option appraisal, through a scoring exercise. This will be as follows:

Each of the options being appraised will need to be allocated scores relating to how well or not it fulfils or delivers against each of the agreed criteria. To do this, each of the main, key benefit criteria above will be considered in detail through a range of "sub criteria", with each option being appraised then scored either 0, 1 or 2 for each of these sub criteria: 0 will indicate that the option does not deliver the relevant sub benefit at all, 1 partially delivers it and a score of 2 delivers this fully. These scores will then be averaged for each of the main key benefits, resulting in each being scored out of a total of 2, to give an unweighted total out of 10, for each option. Where possible, this will be informed by hard data and be evidence based and objective, although it is inevitably also going to include a degree of professional judgement. ***Appendix 1*** provides an example of the detailed and, consolidated scoring sheet following this exercise.

Each of the six groups will focus on a selected number of the main benefit criteria and will only score each of the options, for each of the sub benefits as above for each option, for these. This will be as follows, grouped to ensure that the weighted criteria are as equally spread across all of the participants as possible:

- Groups 1&2 – Quality and Safety;
- Groups 3&4 – Equity and Sustainability/future proofing
- Groups 5&6 – Strategic Fit and Access

The scoring for each of the options and categories being considered by each of the groups, for each of the relevant benefit criterion being considered, will need to be provided by each group, based on a consensus view. To assist in this, scoring sheets will be provided and each group will include an independent member to assist in facilitating this scoring.

POST WORKSHOP

When averaged and then consolidated, each of the above scoring for each benefit for each option being appraised will then have the above agreed weighting applied (by multiplying the average scores for each benefit by the weighting) to enable both a weighted and un-weighted outcome to be determined. This will then confirm a preferred option from a non financial appraisal point of view, and also how all of the evaluated options rank and how close any of them are between each other, in meeting the benefit criteria. All this will be vital information to use in conjunction with the subsequent financial appraisal in determining the overall preferred option. This will then be consolidated and completed to feed back to the Project Board, at which it is also expected that a consistency check of the outcomes of the scoring exercise will be undertaken. This will also then be shared with all participants of the workshop, as soon as possible.

Following the completion of this stage of the process, the outcomes will also be tested further through a sensitivity analysis, designed to assess how sensitive the outcome is to changes in some of the input criteria and data. As a minimum, this will review the outcome by:

- Reverse weighting: this will test how sensitive the outcome is to the weighting that has been applied to the benefit criteria. It does so by completely reversing the weighting, so that the highest weighted criteria becomes the lowest, the second highest the second lowest and so on.

- Equal weighting: similar to the above in terms of testing the sensitivity of the weighting applied, this will assume an equal weighting for each of the criteria, and what the resulting scores and ranking of options would therefore be.

- Reviewing the 2nd ranked option: this tests the sensitivity of the preferred option, through potentially two additional analyses. Firstly, it adds a marginal increase in score

(typically 5-10%) to each and every criteria for the 2nd ranked option, to see if this would affect the preferred option outcome. If it does not, it then also goes on to test what increase in such scoring would be required to affect this.

All of this will also be undertaken in preparation for the Project Board meeting, to feed into this discussion and also inform the subsequent required financial appraisal. Subject to a final non financial option appraisal outcome at this stage, the detailed financial appraisal will then be undertaken, following any further sub option appraisal focussing on the whole major trauma network and pathway, to determine the overall preferred option.

The results will be fully captured in the resulting business case.

Appendix 1

South Wales Health Collaborative

Major Trauma Network Project

Draft proposed scoring mechanism for non financial option appraisal

Proposed scoring for each sub / detailed benefit:-

0 Option does not deliver benefit
1 Option partially delivers benefit
2 Option fully delivers benefit

Main benefit criteria	Detailed benefit being apprised / scored within each	Scores				
		Option 1 Do nothing	Option 2 Single site - UHW	Option 3 Single site - Morriston	Option 4 Dual site - networked service	Option 5 Outsourced
Quality & Safety (35)	Meets agreed clinical, quality and safety standards					
	Compliance with legislation, regulations and accreditation standards / performance					
	Supports rapid adoption of best practice					
	Clinical effectiveness, including:-					
	Delivers improved outcomes for patients					
	Supports R&D					
	Improves consistency in clinical practice					
	Sub total Quality & Safety gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Quality & Safety score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Equity (10)	Service meets potential differential impact on protected groups					
	Timeliness of access to specialist care for all patient groups					
	Improvements in standards for specific patient groups					
	Sub total Equity gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Equity score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Strategic Fit (15)	Services delivered within network of integrated care					
	In line with outcomes of the SWP and other emerging service models					
	Does not destabilise other clinical services / developments					
	Sub total Strategic Fit gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Strategic Fit score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Sustainability / Future proof (25)	Availability of appropriately trained and skilled workforce					
	Service provided by a workforce which is "fit for purpose", re EWTD and clinical training standards					
	Attracts and maintains an excellent workforce across all staff groups					
	Delivers the critical mass required to achieve full benefit from investment					
	Does not destabilise other clinical services / developments					
	Provides business continuity and service contingency in the event of a major incident, etc					
	Sub total Sustainability / Future proof gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Sustainability / Future proof score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Access (15)	Access to services is optimised					
	Service capacity will meet demand in a timely way					
	Service will be delivered in an appropriate environment					
	Suitable and timely transport for transfers between major trauma centre/s and trauma units					
	Avoidable transfers minimised					
	Sub total Access gross score	**0**	**0**	**0**	**0**	**0**
	Number of sub benefits	0	0	0	0	0
	Average Access score for weighting (out of a maximum of 2)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
	Total gross unweighted scores	**0**	**0**	**0**	**0**	**0**
	Total average unweighted scores (out of a total of 10)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Appendix 1 (cont'd)

South Wales Health Collaborative

Major Trauma Network Project

Draft proposed scoring mechanism for non financial option appraisal

Summary

Benefit criteria	Option 1 – Do nothing			Option 2 – Single site - UHW			Option 3 – Single site - Morriston			Option 4 – Dual site - networked service			Option 5 – Outsourced		
	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score	Average Score	Weighting	Weighted score
Quality & Safety	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!	#DIV/0!	35	#DIV/0!
Equity	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!	#DIV/0!	10	#DIV/0!
Strategic Fit	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!
Sustainability / Future proof	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!	#DIV/0!	25	#DIV/0!
Access	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!	#DIV/0!	15	#DIV/0!
Total (out of 10 / 200)	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**	**#DIV/0!**	**100**	**#DIV/0!**

SOUTH WALES HEALTH COLLABORATIVE

MAJOR TRAUMA NETWORK DEVELOPMENT

OUTCOME OF NON FINANCIAL OPTION APPRAISAL FOR MAJOR TRAUMA CENTRE – JUNE 2015

PURPOSE

The purpose of this paper is to provide the outcomes of the non financial option appraisal exercise and scoring of the short list of options 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, detail the rationale captured for each of the scores provided and present a detailed sensitivity analysis that has been undertaken subsequent to the scoring exercise. This will then confirm the initial preferred option(s), and the ranking of all options appraised, from a non financial perspective.

It is expected that the vast majority of the contents detailed within this paper will then form part of the subsequent business case for the future provision of a Major Trauma Network in south and west Wales and south Powys.

INTRODUCTION

A detailed non financial option appraisal has been undertaken, for the previously agreed short list of options available 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. This was undertaken through a detailed scoring exercise, as part of a multidisciplinary workshop made up of a wide ranging group of stakeholders on 3rd June 2015. The event was independently chaired by Dr Peter Oakley, Consultant in Major Trauma, Royal Stoke University Hospital.

Whilst within the context of the preparation of a business case for the overall development of a major trauma network in the region, this option appraisal was to:

- Consider the number and siting of a major trauma centre to serve the population of South and West Wales and South Powys.

It was assumed that consultant-led emergency departments would 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 clinical reference group (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 considered:

- 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.

As with many appraisals, it was accepted that there was inevitably an element of professional judgement and assessment in completing this exercise and, therefore, it was important that this exercise was undertaken through a stakeholder approach. As much as possible, the scoring was objectively undertaken based on evidence and data, and as such a detailed briefing pack was provided to all participants in advance of the day (22nd May), with further information provided on the day in the form of a range of introductory presentations.

The overall process involved a sequential and systematic approach covering:-

- Benefit criteria selection;
- Weighting of criteria to reflect their relative importance;
- Consideration of the options and scoring against the identified criteria at a detailed level, and
- (Subsequent to the workshop), consolidation and analysis of the results and a detailed and robust sensitivity analysis, to test and ensure the robustness of the conclusions.

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 for transfer.

To undertake the detailed non financial option appraisal exercise, 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 had been agreed through the Project Board and Collaborative Board:

High-level Options

- Option 1 – Do nothing
- Option 2 – Single site – University Hospital of Wales
- Option 3 – Single site – Morriston Hospital
- Option 4 – Dual site – University Hospital of Wales and Morriston Hospital
- Option 5 – Outsourced service- no Major Trauma Centre in South Wales

A range of detailed information to support the workshop and the resulting non financial option appraisal scoring exercise had been provided to attendees in advance of the day. This included:-

- An option appraisal briefing paper;
- Confirmation of the option appraisal process;
- The detailed service model and supporting standards and guidance;
- A range of baseline activity data;
- Baseline self-assessments from UHW, Morriston and Southmead Hospital, Bristol
- Draft equality impact assessment evidence paper
- Travel time maps

On top of this, the workshop was provided with a range of presentations on the day, to further set the context for the non financial option appraisal scoring. Provided by the South Wales Health Collaborative team, Emergency Medical Retrieval & Transfer Service (EMRTS), North Midlands and North Wales Trauma Network and the Clinical Leads for the project, this included-

- Setting the context and purpose of the option appraisal workshop
- An introduction from Dr Peter Oakley, Consultant in Major Trauma, Royal Stoke University Hospital and independent workshop chair
- Patient outcomes / reducing population impact

- Service model – overview of pathway - Pre-hospital care, acute care, ongoing care and reconstruction
- Lessons learned from north Wales
- Baseline activity and modelling the options
- Introduction to the option appraisal process

Key definitions within the options

It was important to ensure that there was absolute clarity and confirmation of what was meant by each option, to enable a robust evaluation and appraisal of each of the options. The following definitions were therefore also provided.

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 (UHW) 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.

BENEFITS CRITERIA

Through the Project Board, the following five key benefits were identified to assess the options available for the future Major Trauma Centre(s) for south, mid and west Wales. Further detail as to what is included within each of these is provided in ***Appendix 1***.

Through detailed discussions at the Project Board, the following weighting, out of 100, was also agreed for each of the following benefit criteria categories:-

Criteria	Weighting
Quality and Safety	35
Equity	10
Strategic Fit	15
Sustainability/Future Proof	25
Access	15
Total	**100**

NON FINANCIAL OPTION APPRAISAL SCORING

The detailed non financial option appraisal scoring was undertaken by a wide ranging group of stakeholders at a workshop held on 3rd June 2015.

This required six separate groups on the day, made up of a cross section of organisational and discipline representatives, to assess and determine scores for one or two of the above criteria, ensuring that as equal weighting of the results as possible were considered by each group. Each criteria/group of criteria was considered by two groups.

Agreed scoring mechanism

Each of the options being appraised was therefore allocated a score relating to how well (or not) it was considered that it fulfils or delivers against each of the agreed criteria. To do this, each of the main, key benefit criteria above was considered in detail through the range of "sub criteria" detailed in appendix 1, with each option being appraised then allocated a score of 0, 1 or 2 for each of these sub criteria, where:-

- 0 indicates that the option does not deliver the relevant sub benefit at all;
- 1 partially delivers it and
- 2 delivers this fully.

Where possible, this was all informed by the data provided before and on the day, although it was inevitable that some of the scoring was also going to include a degree of professional judgement.

Each of the six groups focussed on a selected number of the main benefit criteria and only scored each of the options, for each of the sub benefits as above, for these. These were as follows, grouped to ensure that the weighted criteria were as equally spread across each of the participating groups as possible:

- Groups 1 and 2 – Quality and Safety (35%);
- Groups 3 and 4 – Equity and Sustainability/future proofing (35%);
- Groups 5 and 6 – Strategic Fit and Access (30%).

Each group also had an independent facilitator to help assist in facilitating the group, the scoring and recording of decisions on a scoring sheet that was also provided. The scoring for each of the options for each of the relevant benefits criteria was discussed in detail and a consensus score was agreed by the group.

These scores have now been averaged for each of the group scoring the relevant criteria and by the above main key benefits, resulting in each benefit being scored out of a total of 2, giving an unweighted total out of 10, for each option. These have also now had the above agreed weightings 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 provides an initial preferred option(s) 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 benefits criteria. This will therefore also determine an initial short list of options, to be subject to a sub option appraisal for the delivery of this short list, and the detailed financial option appraisal.

Detailed notes of the discussions were also captured and recorded, providing a rationale for each of the scores given to each of the options, for each of the benefits criteria considered.

Full details of those who attended this workshop and undertook this non financial option appraisal scoring is provided in ***Appendix 2***.

NON FINANCIAL OPTION APPRAISAL RESULTS

The resulting raw and weighted scores and consequent rankings for each of the options are summarised in the tables below:-

Option scores - not weighted

	Average score - unweighted						
Option	Quality & Safety	Equity	Strategic Fit	Sustainability / future proof	Access	Total score (out of 10)	Rank
1. Do nothing	0.0	0.5	0.3	0.7	0.5	**2.0**	**5**
2. Single site - UHW	1.9	1.7	1.7	1.8	1.6	**8.6**	**2**
3. Single site - Morriston	1.9	1.8	1.7	1.8	1.7	**8.9**	**1**
4. Dual site - UHW & Morriston	0.8	1.0	1.3	0.9	1.9	**5.9**	**3**
5. Outsourced service	1.1	1.0	0.5	0.8	0.9	**4.3**	**4**

Option scores - weighted

	Average score - weighted						
Option	Quality & Safety	Equity	Strategic Fit	Sustainability / future proof	Access	Total score (out of 10)	Rank
1. Do nothing	0	5	5	17	8	**34**	**5**
2. Single site - UHW	67	17	25	44	24	**177**	**2**
3. Single site - Morriston	67	18	25	44	26	**180**	**1**
4. Dual site - UHW & Morriston	26	10	20	23	29	**108**	**3**
5. Outsourced service	38	10	8	21	14	**90**	**4**

Appendix 3 provides some further details of the calculations used to derive the above tables.

These results show that **Options 2 and 3** scored very similarly and are clearly the initial preferred options from a non financial perspective, subject to the sensitivity analysis below.

The resulting short list from this exercise is further summarised in the table below, set against the do nothing option as a comparator:-

Shortlisted options - with weighted scores (and compared to do nothing)

		Shortlisted options	
	Option 1 Do Nothing	Option 2 Single site - UHW	Option 3 Single site - Morriston
Quality & Safety	0	67	67
Equity	5	17	18
Strategic Fit	5	25	25
Sustainability / future proof	17	44	44
Access	8	24	26
Total (out of 200)	**34**	**177**	**180**
Rank	**5**	**2**	**1**

SCORING RATIONALE

As noted above, each group was also required to provide some detailed rationale for the basis of their scoring, and any key assumptions made in doing so. These are detailed below.

GROUP 1

MAIN BENEFIT: QUALITY & SAFETY

The group considered a number of general discussion points, before embarking on the detailed scoring, as follows:

- There was a discussion around accessibility – the group was informed however that there was another workshop group looking specifically at this;
- There was some recognition that neurosurgery is interlinked with paediatrics and paediatric trauma;
- It was accepted that it was difficult to look at single site options without also knowing which hospitals are trauma units (TUs);
- Travel times were considered to be a 'safety' issue;

- If the major trauma centre (MTC) was located in Cardiff, it was considered that there would need to be significant investments required for West Wales; TUs would be required in South (West) Wales to support the MTC;
- The ability to describe the deliverable system would have a positive outcome for recruitment;
- Referrals 'in' to the MTC needed to be a "push" system, and
- It was considered that the network would need investment from the edges of West Wales into the MTC i.e. not just in the MTC

Sub-benefit – meets agreed clinical, quality and safety standards – it was considered that the current service was not currently based on the agreed standards and therefore Option 1 was scored "0". For the single site options within south Wales, the group considered issues regarding accessibility. Both of the options were scored "2", but it was noted that this was on the basis of the network meeting the standards of required investment, including in the trauma units. Issues regarding neurosurgery and the way in which it interlinked with Paediatric Intensive Care (PICU) and rehabilitation were noted under Option 3. Option 4 scored "0" as it was considered that neither site would meet the standards. Option 5, the outsourced option, scored "1" and members noted safety issues due to accessibility. The training issues presented by this option were also considered to be significant.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Meets agreed clinical, quality and safety standards	0	2	2	0	1

Sub-benefit – compliance with legislation, regulations and accreditation standards/performance – training issues were also noted within this sub-benefit. Option 1 did not deliver the benefit and was therefore scored "0". Options 2 and 3 were considered in the same way as the previous sub-benefit and therefore scored "2" for each option. Option 4 was scored as "0". Option 5 considered that rehabilitation would be situated outside Wales, and there was no training recognition in Wales for Emergency Medicine with this option, and was therefore scored "1".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Compliance with legislation, regulations and accreditation	0	2	2	0	1

Sub-benefit – supports rapid adoption of best practice – again, the issues noted within the first sub-benefit were also relevant to this sub-benefit. Option 1 was scored "0" on the basis that the option did not deliver the benefit. Options 2 and 3 were considered to fully meet the benefit and therefore scored "2". Option 4 did not meet the benefit and scored "0". Option 5 would fully meet the benefit only if this was within the context of a network, and on this basis it scored "2".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Supports rapid adoption of best practice	0	2	2	0	2

Sub-benefit – delivers improved outcomes for patients – the current position, Option 1, was not considered to meet the benefit of improving outcomes for patients and this was therefore scored "0". Options 2 and 3 scored "2" for this sub-benefit. Option 4 was considered to partially meet the criteria and scored "1". Option 5 also scored "1", as it it would not deliver the benefit for the whole population of South Wales.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Delivers improved outcomes for patients	0	2	2	1	1

Sub-benefit – supports R&D – Option 1 did not meet the benefit of supporting R&D and was scored "0". Options 2 and 3 were scored "2" as having the potential to support R&D but it was acknowledged that investment would be required. Option 4 was also scored "2", as it was considered that the option would support R&D, but it was noted that it may not improve the outcomes overall. Option 5 was scored "1", as it was noted that an outsourcing option would present difficulties within different health care systems.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Supports R&D	0	2	2	2	1

Sub-benefit – improved consistency in clinical practice – Option 1 scored "0" for this sub-benefit. Options 2 and 3 scored "2" as they were both considered to provide the opportunity to improve consistency in clinical practice. Option 4 was scored "0" because it would require

operating on two different sites. Option 5 was scored "1" as it was not considered to be 'plugged in' to the whole system.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Improves consistency in clinical practice	0	2	2	0	1

GROUP 2

MAIN BENEFIT: QUALITY & SAFETY

Before undertaking the detailed scoring for each of the sub benefit criteria for options being considered, a few initial discussions and assumptions were undertaken and made in relation to the options overall, the supporting information provided in advance of the day and in relation to any of the specific options being considered. These included:-

- A confirmation of the full support for the expansion of EMRTS to a 24/7 service;
- In relation to the single site – UHW option, it was noted that due to the geographical concerns and the impact access would have on safety standards, etc that any such option would need to see the continuation and likely expansion of Trauma Units in west Wales, especially in Carmarthen, including surgical cover;
- It was noted that the activity information provided in advance of the workshop had not included any injury based geographical data, but was population based from a geographical perspective, although it was also noted that all of the modelling work to project the impact on MTCs had been population based, and which had been consistent and, if anything more advanced, than previous exercises had been based on, including the north Wales development with Stoke. The previously highlighted limitations in the current activity data submitted to TARN and the resulting elements of the current service being "unknown" clearly contribute to the ability to be able to provide such an analysis in full.

Sub benefit – meets agreed clinical, quality and safety standards – Option 1 scored poorly in that it was considered that the current service delivery does not meet all of the CRG agreed clinical standards. The two single site options within south Wales (Options 2 and 3) scored well, on the assumption that these options meant that these sites would then be able to deliver to the standards, including the co and interdependent services, as prescribed. This would include plastic surgery in relation to UHW, neurosurgery (including rehab) and Paediatric Intensive Care Unit

(PICU) (currently provided within the Children's Hospital for Wales) in relation to Morriston and Interventional Radiology services and 24/7 trauma Emergency Department consultant presence in relation to both. Option 4 scored less well due to the reduced activity numbers on each site affecting the critical mass required to sustain quality and safety, plus likely transfer issues in relation to the identification of major head injuries. Option 5 scored poorly as the travel times and resulting access issues were considered to likely have a significant impact on safety, it was noted that this option would likely have a detrimental effect on training within NHS Wales and the future provision therefore of a quality service, and the wider impact this might have on other specialities. It was also noted that this would likely be the least favourable option in relation to the public perspective of the NHS in Wales.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Meets agreed clinical, quality and safety standards	0	2	2	1	0

Sub benefit – compliance with legislation, regulations and accreditation – it was considered that Option 1 would again score poorly as we are not currently delivering standards in full. For the same reasons as above, and based on the same assumptions, Options 2 and 3 scored well. Option 4 scored a "1" as it was stated that this option would not be ideal from this perspective and there was a potential for there to be a waste / split of resources. Option 5 scored well, as an established Major Trauma Centre.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Compliance with legislation, regulations and accreditation	0	2	2	1	2

Sub benefit – supports rapid adoption of best practice – it was noted that the key word within this sub criteria was the ability to rapidly adopt best practice. Option 1 again scored a "0" as it was considered that the infrastructure is not currently in place to do so, and that there is currently no major trauma network serving the region. All other options scored a "1", but for slightly different reasons. It was agreed that Options 2 and 3 should provide the structures and process in place to do this, but again there was some concerns over the ability to do so rapidly, linked to the achievability of these options. Option 4 would have some more

challenges to do so but should be achievable within a networked infrastructure, whereas with Option 5 is was considered that the rapid adoption could be challenging due to the external nature of the service being provided, within a differing healthcare system and through a commissioning / performance management arrangement and mechanism.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Supports rapid adoption of best practice	0	1	1	1	1

Sub benefit – clinical effectiveness – delivers improved outcomes for patients – Option 1 was considered to not be able to score well here as it was noted that the key word within this criteria was improved outcomes, with the assumption therefore that continuing to deliver the service in its existing form would be unlikely to see improvement. On similar bases to the above, it was considered that Options 2 and 3 would score well, based on the evidence provided in terms of the establishment of a single site MTC. As such, Option 4 scored less well, with the expectation of some mixed improvements. Option 5 also only scored a "1" as it was felt that, whilst there would be some short term improvements and gains, the longer term impacts on other services and the training issues previously highlighted would at the very least offset much of this improvement.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Delivers improved outcomes for patients	0	2	2	1	1

Sub benefit – clinical effectiveness – Supports R&D – some of the evidence previously explored and presented on the day contributed to Option 1 scoring a "0" here, including the current levels of submission of data to TARN and the ability of the current systems in place to support research and development (R&D). Whilst Options 2 and 3 scored well, as it was considered that these provided the critical mass and activity numbers to allow for good quality audit and research data, it was noted that there was likely to be a loss of academic output from the site not chosen as the MTC in each of the relevant options. Option 4 scored less well as there will be less activity undertaken per site, felt not able to provide the critical mass on which to support robust audit and R&D. Option 5 also scored a "1" as, whilst it was noted that an outsourced, well established MTC would be well set up to undertake robust R&D, concerns

were expressed as to how much Welsh health boards and universities would be able to access this and benefit.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Supports R&D	0	2	2	1	1

Sub benefit – clinical effectiveness – Improves consistency in clinical practice – again Option 1 scored a "0" as the key considered within this sub criteria was the ability to improve consistency, with the do nothing / no change option not considered to deliver this. Options 2 and 3 again both scored well as it was considered that the single site option within south Wales would be the best options to expect to see a significant improvement in the consistency of the clinical practice and services provided. Option 4 scored a "1" as it was expected that, within an established network arrangement, this would see at least some improvement from the status quo, but not as much as within a single site solution. Option 5 also scored a "1" as the group had some concerns with the split in clinical practice across differing health systems, the resulting links between the MTC and the trauma units and links to the resulting rehab pathways, again however noting that an established MTC should provide at the very least improvement in clinical practice within the acute phase.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Improves consistency in clinical practice	0	2	2	1	1

Average scoring for QUALITY & SAFETY

The resulting average scores, for the two groups who considered Quality & Safety, are therefore as follows:-

QUALITY & SAFETY	Option 1	Option 2	Option 3	Option 4	Option 5
Meets agreed clinical, quality and safety standards	0.0	2.0	2.0	0.5	0.5
Compliance with legislation, regulations and accreditation	0.0	2.0	2.0	0.5	1.5
Supports rapid adoption of best practice	0.0	1.5	1.5	0.5	1.5

Delivers improved outcomes for patients	0.0	2.0	2.0	1.0	1.0
Supports R&D	0.0	2.0	2.0	1.5	1.0
Improves consistency in clinical practice	0.0	2.0	2.0	0.5	1.0

GROUP 3

MAIN BENEFIT: EQUITY

Sub benefit – service meets potential differential impacts on protected groups – the group considered that there was no discrimination in the way services were currently provided and each patient's needs were assessed and met based on their clinical condition. Whilst not a protected characteristic, the needs of those whose first language is Welsh were considered. The discussion developed to acknowledge the needs of diverse communities, noting that there were other language needs that need to be considered and accommodated by service providers. The group also considered the impact on visitors and it was considered that option 5 would present the greatest challenge in this respect. The group scored Option 1 as "0" due to the lack of a major trauma centre and major trauma network structure, the variability in service delivery and the lack of monitoring. Options 2 and 3 were both considered to be an improvement on the current position and scored "2". Option 4 was also considered to be an improvement on the current position but as the service would be provided across two sites there would remain the potential for variability in patient management and was therefore scored "1". Option 5 also scored "1" due to implications for the provision of services in the Welsh language and the different equality standards and legislation that apply in England. There was also consideration of the differences in communication arrangements and relationships with local agencies.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Service meets potential differential impacts on protected groups	0	2	2	1	1

Sub benefit – timeliness of access to specialist care for all patient groups – there was a lengthy discussion in regard to the relative travel times to the options for the MTC. Population densities were highlighted as were the needs of rural communities. The needs of children were raised and it was noted that the Paediatric Intensive Care Unit was located at the Children's Hospital for Wales, Cardiff, and this had been confirmed in

the service model as a fixed point. A strong view was expressed at the requirement for dedicated neurosurgery and concerns expressed should this be provided through outreach. The discussion in regard to access for rural communities highlighted the importance of the role of trauma units within the major trauma network structure. Option 1 again scored "0" on the basis that there is no major trauma network or centre in place and, therefore, no associated protocols. As a consequence, access to some specialties must be through a tertiary referral rather than through automatic acceptance by an MTC working within an established network. Options 2, 3 and 4 all scored "1". Strong views were expressed in regard to both Option 2 and Option 3 but from different perspectives and therefore neither was felt to fully meet this criteria. Option 4 was scored "1" as services would be split across two sites. Option 5 scored "0" as it was considered that travel times by road were too long and also in consideration of the impact on visitors.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Timeliness of access to specialist care for all patient groups	0	1	1	1	0

Sub benefit – improvements in standards for specific patient groups – the group considered that, as there is currently no major trauma structure or centre, Option 1 should score "0" as retaining the status quo may not lead to improved standards. Options 2 and 3 were both scored "2" as a single site MTC would provide the critical mass required in terms of patient numbers enabling clinicians to gain expertise in patient management. Likewise, Option 5, as an established MTC, was scored "2". Option 4 scored less well as each site would not have the recommended critical mass and resources would be split.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Improvements in standards for specific patient groups	0	2	2	1	2

MAIN BENEFIT: SUSTAINABILITY / FUTURE PROOF

Sub benefit – availability of appropriately trained and skilled workforce – Option 1 was scored "1" in acknowledgment of current resources for treating trauma patients but that this would improve through the establishment of a MTC. Whilst the advantages of a single

site were discussed and acknowledged there was significant debate about neurosurgery and plastics. Whilst the need for plastics was acknowledged, it was argued that there were fundamental differences in the role of neurosurgery and the requirement for this at the receiving hospital. Reference was made to the presentation and activity data and the high percentage of major trauma cases with head injuries. There was also a discussion regarding opportunities for training and the potential negative impact on trauma units and the sustainability of services was therefore considered reliant on staff movement between sites. Options 2 and 3 were therefore both scored "1". Option 4 was also scored "1" due to the lack of critical mass and the split of resources across two sites. Although Option 5 is an established MTC, it was noted that not all services were co-located and therefore the group scored this a "1".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Availability of appropriately trained and skilled workforce	1	1	1	1	1

Sub benefit – service provided by a workforce which is 'fit for purpose', re EWTD and clinical training standards - Option 1 was scored "0" as it does not fully meet the workforce requirements for an MTC. Options 2 and 3 both scored "2" as the establishment of an MTC would create the required critical mass at a single site and the workforce model would be developed to meet the standards. Option 5 also scored "2" as it is an established MTC. Option 4 scored "1" due to the split of resources that would be required across two sites.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Service provided by a workforce which is 'fit for purpose', re EWTD and clinical training standards	0	2	2	1	2

Sub benefit – attracts and maintains an excellent workforce across all staff groups – the absence of a major trauma network and centre led the group to score Option 1 as "0". Options 2 and 3 were each scored "2" as they would provide a single site MTC and the critical mass this would provide would facilitate the development of experience and expertise amongst all staff groups in the management of major trauma patients. Option 4 would split resources across two sites and whilst this

would be provided within a major trauma network structure it was not considered as attractive to the future workforce and therefore scored "1". Whilst Option 5 provided a single site MTC, its location outside Wales was a concern and a risk to the workforce for the wider network and therefore this option was scored "0".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Attracts and maintains an excellent workforce across all staff groups	0	2	2	1	0

Sub benefit – delivers the critical mass required to achieve full benefit from resources and investment – the current service configuration does not meet the critical mass required and therefore Option 1 scored "0". Likewise, Option 4 scored "0" due to the split of patient management across two sites. Options 2, 3 and 5, as single site options, were each scored "2".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Delivers the critical mass required to achieve full benefit from resources and investment	0	2	2	0	2

Sub benefit – does not destabilise other clinical services/developments – Option 1 was scored "1" as all the required services are available but not on the same site. The potential for workforce attrition was raised and it was considered that the current configuration would not attract and retain the required workforce. Options 2 and 3 each scored "1" as co-locating services on one site could destabilise those on the other. In this context, particular note was made of the current locations for neurosurgery and plastics. Option 4 was scored "1" as a dual site configuration may not attract and retain the required workforce. Option 5 was scored "0" as concern was expressed at the potential impact of the centralisation of services outside Wales on the sustainability of other clinical services within Wales. The potential impact on trainees was also raised.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Does not destabilise	1	1	1	1	0

other clinical services/developments					

Sub benefit – provides business continuity and service contingency in the event of a major incident etc – Option 1 was scored "1" in acknowledgement of current established arrangements for responding to major incidents. Options 2, 3 and 4 all scored "2" as the establishment of new arrangements for major trauma would enhance the current arrangements and provide additional resilience. Option 5 scored "0" as it was considered that a service outside Wales may not be able to respond as effectively to a major incident in Wales. Issues in respect of major incident training were raised as well as a potential reduction in critical care capacity depleting resilience within Wales.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Provides business continuity and service contingency in the event of a major incident etc.	1	2	2	2	0

GROUP 4

MAIN BENEFIT: EQUITY

General discussion points:-

- The group felt that the scoring mechanism did not allow the differentiation between options – an example of this was when considering the access implications for Morriston and UHW and it was felt that a larger scale would provide the opportunity to differentiate between the options more effectively;
- There would be a detrimental impact on services in Wales if the MTC was outsourced to Bristol. This is because there would be an impact on trainees and the ability to recruit to services within Wales if there was no MTC in Wales;
- There would need to be a commissioning arrangement established with Bristol and issues associated with this would need to be worked through.

Sub benefit – service meets potential differential impacts on protected groups – it was suggested that the service meets the requirements of the patient as they present; given the nature of the service, care provided within the immediate setting is based on clinical need and the interventions required by the patient at that time. However,

it was acknowledged that the service did not necessarily meet all the requirements of the patient later in the pathway. It was noted that there were potential differential impacts on those patients requiring specialist care, such as the elderly. The protected characteristics were noted and it was agreed that there was scope for improvement within the current 'do nothing' option and this was therefore scored as "1". Options 2 and 3 were considered to be an improvement on the current position and therefore scored "2" – it was noted that the new service model for the MTC would be supported by a network and a pathway for rehabilitation which sought to meet all of the needs of patients, and would need to take into account any specific implications for protected groups. It was also considered that a new MTC arrangement would improve recruitment, and this would further improve the services provided. Option 4 was also considered to be an improvement to the current position, with the development of a pathway and so scored "2" similarly. Option 5 was noted in terms of implications for access and this could potentially impact on some groups. It was also noted that outsourcing to Bristol could have implications for Welsh language care provision; this was therefore scored as "1".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Service meets potential differential impacts on protected groups	1	2	2	2	1

Sub benefit – timeliness of access to specialist care for all patient groups – the group noted that not all services were provided within one site currently, but that services were provided within the current emergency departments and the 'do nothing' option was therefore scored as "1". There was a detailed discussion regarding access for both of the single site options and Option 2 was scored as "1" because it was felt that access to UHW from the West of Wales was difficult and therefore it could not score a "2". The availability of EMRTS as a 12 hour service, in good weather only, was noted and the split in EMRTS/WAST activity (25%/75% split respectively) was highlighted. Some members of the group felt very strongly that Morriston provided a better geographical coverage and with the new service model, the site would have all services required for an MTC. However, a similarly strong view was expressed that patients from Powys and East of Cardiff would not have appropriate access to Morriston, given the travel times, and the impacts on repatriation and rehabilitation for patients was noted. On balance, it was agreed that because Morriston was considered as providing better access than UHW, and half marks were not acceptable, this option could only be scored a "2", to demonstrate that it was considered more accessible than UHW. The dual

site option would not provide all of the services required on both sites, and the WAST difficulties in ensuring that patients were directed to the right place were noted. It was not felt that this met the criteria and was therefore scored as "0". Option 5 was also considered to score poorly in terms of access, and did not provide the geographical coverage required, especially for patients west and north of Cardiff. This was therefore scored as "0".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Timeliness of access to specialist care for all patient groups	1	1	2	0	0

Sub benefit – improvements in standards for specific patient groups – there was some discussion around the specific patient groups referred to, and the group assumed that the development of an MTC would provide an improvement in services for all patients. Option 1 was scored "1" because services were currently being provided by emergency departments, and some improvements could be made even if the service stayed as it was. Options 2, 3 and 5 would all provide the opportunity for services to be delivered from one MTC site, and so an improvement in standards would be seen by choosing these options and were all scored as "2"; it was noted that Bristol would be expected to have a good compliance with TARN data. The dual site option was scored "1".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Improvements in standards for specific patient groups	1	2	2	1	2

MAIN BENEFIT - SUSTAINABILITY AND FUTURE PROOF

Sub benefit – availability of appropriately trained and skilled workforce – Option 1 was considered and it was noted that there were currently recruitment issues. This was therefore scored as "1". It was assumed that the development of an MTC on one site, with all of the required specialties, would increase the ability to recruit into the service. There would be an improvement in training, as emergency medicine trainees could rotate through the MTC and also train in the TUs. There would be perceived benefits for all specialties. Both of the single site options were therefore scored a "2". The dual site option would present difficulties for developing MTC status and it was not clear how the skills

could be developed for trainees if not all services were provided on one site. This was therefore scored as "1". Option 5 was scored against the criteria in terms of Bristol's ability to deliver an appropriately trained and skilled workforce and therefore it scored "2". However, it was acknowledged that the outsourcing option would have a significant detrimental impact on Wales' ability to recruit across all specialties.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Availability of appropriately trained and skilled workforce	1	2	2	1	2

Sub benefit – service provided by a workforce which is 'fit for purpose' re EWTD and clinical training standards – all the specialties were currently vulnerable and so the current position was scored as "1". The development of one MTC would require a 24/7 consultant rota with immediate availability for trauma. It was assumed that more consultants would be required to deliver this model, but the presence of an MTC within Wales would encourage more doctors to want to work in Wales and to be a part of the developing service. Therefore both single site options were scored "2". The dual site option would make it harder to recruit and it was felt that this would present a worse situation than the current one. This was therefore scored "0". Option 5 was scored as "1" because there was a recognition of potential implications for workforce capacity within the outsourced option, whilst recognising that the Bristol workforce was not known. This was therefore scored "1". As above, however, it was noted that outsourcing to Bristol would leave Wales vulnerable.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Service provided by a workforce which is 'fit for purpose', re EWTD and clinical training standards	1	2	2	0	1

Sub benefit – attracts and maintains an excellent workforce across all staff groups – Option 1 did not provide the opportunity to attract and maintain the workforce currently across all staff groups; progress was noted regarding the improvements made in Morriston trauma care. Both single site options scored "2" because they were considered to provide greater opportunities to attract and maintain the best workforce within the MTC. It was noted that in some specialties, such

as radiology, there were national difficulties in recruiting and the development of an MTC may not resolve all of these issues; however these were specialist issues and should not influence the scoring enough to reduce it to "1". It was felt that whichever site was not chosen as the MTC would experience difficulties in recruitment as a result. The dual site option was seen as a dilution and not an attractive prospect for the future workforce and was therefore scored as "1". It was noted that one of the hospitals would need to be identified as the lead for the network, and this would influence recruitment. As above, there was a concern that the system in Bristol could be overloaded and it was also noted that commissioning a service from England would not allow full control over the services provided and the workforce. ITU issues were noted and the activity numbers were acknowledged.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Attracts and maintains an excellent workforce across all staff groups	1	2	2	1	1

Sub benefit – delivers the critical mass required to achieve full benefit from resources and investment – the current service did not deliver the critical mass required and so this scored "0". Options 2 and 3 provided the opportunity to reduce the number of sites the specialist services were being delivered on and therefore increase the number of patients being treated, so both scored "2". Option 4 would not provide the critical mass and would require more resources so this scored a "1". Option 5 would not provide the opportunity to manage the investment being made, and the numbers of patients could be over the critical mass required.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Delivers the critical mass required to achieve full benefit from resources and investment	0	2	2	1	1

Sub benefit – does not destabilise other clinical services/developments – the current position was scored as "1" as the system was currently running, but it was recognised that all services are not currently provided on both sites. Options 2 and 3 were both scored "1", as several of the same issues applied in that centralising all services on one site could destabilise those provided on the other. Also, it was

acknowledged that change will always potentially destabilise services for a period of time, whilst this is being worked through. Specific issues were noted in Option 2 and it was noted that if all plastic surgery services were transferred to UHW, this would destabilise the service at Morriston. Likewise, specific issues were noted for Option 3 if neurosurgery was transferred to Morriston and this would destabilise services in UHW. Specific issues were noted for paediatric neurosurgery in this instance, and this would need to be taken into consideration. The dual site option was scored as "1", because this option would not allow for the provision of all services on both sites and this would potentially destabilise other services. The outsourcing option was considered to provide a worse position as moving patients to Bristol could potentially cause a knock-on effect, therefore destabilising services; this was therefore scored as "0".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Does not destabilise other clinical services/developments	1	1	1	1	0

Sub benefit – provides business continuity and service contingency in the event of a major incident etc – Option 1 was scored as "1", as it partially met the benefit of business continuity and service contingency. Recent examples of the two ED responses to major incidents were noted. Options 2 and 3 were seen as an improvement, and therefore scored "2". It was noted that centralising services on one MTC would provide the opportunity to triage patients to one place where all specialist care was provided. By having a network arrangement, there was a need to ensure that the skills of the trauma units were maintained and that this could support the MTC in times of a major incident. Option 4 would not provide business continuity, as there were opportunities for incorrect triage and confusion. Option 5 scored "0" in this instance, as it was felt that this did not provide business continuity and it was considered that it would not be able to respond effectively to a major incident in Wales.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Provides business continuity and service contingency in the event of a major incident etc.	1	2	2	1	0

Average scoring for EQUITY

The resulting average scores, for the two groups who considered Equity, are therefore as follows:-

EQUITY	Option 1	Option 2	Option 3	Option 4	Option 5
Service meets potential differential impacts on protected groups	0.5	2.0	2.0	1.5	1.0
Timeliness of access to specialist care for all patient groups	0.5	1.0	1.5	0.5	0.0
Improvements in standards for specific patient groups	0.5	2.0	2.0	1.0	2.0

Average scoring for SUSTAINABILITY AND FUTURE PROOF

The resulting average scores, for the two groups who considered Sustainability and future proof, are therefore as follows:-

SUSTAINABILITY AND FUTURE PROOF	Option 1	Option 2	Option 3	Option 4	Option 5
Availability of appropriately trained and skilled workforce	1.0	1.5	1.5	1.0	1.5
Service provided by a workforce which is 'fit for purpose', re EWTD and clinical training standards	0.5	2.0	2.0	0.5	1.5
Attracts and maintains an excellent workforce across all staff groups	0.5	2.0	2.0	1.0	0.5
Delivers the critical mass required to achieve full benefit from resources and investment	0.0	2.0	2.0	0.5	1.5
Does not destabilise other clinical services/developments	1.0	1.0	1.0	1.0	0.0
Provides business continuity and service contingency in the event of a major incident etc.	1.0	2.0	2.0	1.5	0.0

GROUP 5

MAIN BENEFIT: STRATEGIC FIT

Sub criteria – services delivered within network of integrated care – Option 1 was not considered to be an integrated network and delivered poor, substandard outcomes; it therefore scored "0". Option 2 and 3 were considered and, in order to score "2", it needed to be assumed that the options could deliver in practice. It was recognised that both Options 2 and 3 were likely to score similarly against this and other criteria and that the respective financial implications of moving the required services would be important. Under Option 2, it was recognised that burns and plastics are not at UHW, but many other clinical interventions are there and complement the model (including Paediatric ICU). This option could ensure delivery of services within a network of integrated care. There was a strong view that the service should primarily be managed and delivered in Wales. The rationale for scoring Option 3 was broadly as for Option 2, although different services are in place (e.g. burns and plastics) and different services would need to be re-provided or moved. This option could ensure delivery of services within a network of integrated care. There was a strong view that the service should primarily be managed and delivered in Wales. There was not enough difference between the advantages and disadvantages of Options 2 and 3 to lead to a difference in the score on a three point scale and so both were scored "2". Option 4 would deliver more integration than current arrangements, but would be very hard to achieve full integration. It would impact on the sustainability of the ambulance service as it would provide logistical difficulties. It was therefore scored "1". In considering Option 5, the group considered how well this worked in North Wales and were there too many differences to make a direct comparison. It was noted that it would also impact on ambulance services, by drawing ambulances out of Wales. There were concerns about integration of rehabilitation and the overall care pathway. It could probably result in greater integration than now, but could not be integrated to the same extent as an 'in house' single site option; this was therefore scored "1".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Services delivered within network of integrated care	0	2	2	1	1

Sub criteria – in line with outcomes of the SWP and other emerging service models – Option 1 did not align with or address the rationale and outputs from the South Wales Programme and therefore

scored "0". Options 2 and 3 were considered to provide a good alignment with the overall direction of the South Wales Programme. It was noted that there was nothing to choose in this regard between Options 2 and 3 and therefore both scored "2". Option 4 provides some alignment with the South Wales Programme and therefore scored "1". Option 5 was considered and members noted that the South Wales Programme recommendations were about strengthening services in Wales and did not advocate movement of key services to England. This therefore scored "0".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
In line with outcomes of the SWP and other emerging service models	0	2	2	1	0

Sub criteria – does not destabilise other clinical services/developments – Option 1 would not address current recruitment issues, which threaten to destabilise current services and so scored "0". Option 2 meant that centralising in Cardiff would stabilise other Cardiff services, but could destabilise services in Swansea. Likewise, centralising in Swansea would stabilise other Swansea services, but could destabilise services in Cardiff. In both cases, it was considered that the impact on other services would need to be managed very carefully with hub and spoke options investigated for services that major trauma depends upon, but which are only on one site. It was also noted that additional trauma cases could destabilise elective work. There was not enough difference between the advantages and disadvantages of Options 2 and 3 to lead to a difference in the score on a three point scale. Both options therefore scored "1". Option 4 would not destabilise services in Cardiff and Swansea, but could destabilise WAST. This option would not necessarily have a positive stabilising effect in Cardiff or Swansea. This therefore scored "1". Option 5 would potentially destabilise a range of services in Cardiff and Swansea and may also destabilise exiting services in Bristol by stretching capacity. This therefore scored "0".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Does not destabilise other clinical services/developments	0	1	1	1	0

MAIN BENEFIT: ACCESS

Sub criteria – access to services is optimised – after discussion the group agreed to focus consideration on the issue of access to appropriate services having arrived at the relevant location, rather than on issues of travel time. Under Option 1, the current service does not provide optimised access to appropriate services and this option therefore scored "0". The group considered that it should be possible to ensure optimised access to appropriate services under Options 2 and 3 and so both options scored "2". Under Option 4, some services would be available in Cardiff and some in Swansea and some patients may require services in both locations. This option therefore scored "1". Under Option 5 it was considered that it should be possible to ensure optimised access to appropriate services and the option therefore scored "2".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Access to services is optimised	0	2	2	1	2

Sub criteria – service capacity will meet demand in a timely way – under Option 1, it was noted that the service is currently failing to meet demand in a timely way and this will deteriorate as a result of recruitment problems; this was therefore scored "1". Options 2 and 3 meant that consolidation should allow appropriate staffing and facilities to be provided to meet capacity in a timely way; both of these options scored "2" on this basis. In considering Option 4, there was a significant discussion as to whether this should score as highly as a single site option. If configured well, this should still be able to meet capacity in a timely way and, although possibly not optimised to the extent of a single site option, the gap was not big enough to have a lower score on a three point scale; this therefore scored "2". Under Option 5, consolidation should allow appropriate staffing and facilities to be provided to meet capacity in a timely way and so this was also scored "2".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Service capacity will meet demand in a timely way	1	2	2	2	2

Sub criteria – service will be delivered in an appropriate environment – in the current situation, some, but not all, patients get treated in an appropriate environment; this was therefore scored "1". It was noted that it should be possible to create an appropriate environment in any single or dual site solution and therefore Options 2, 3 and 4 scored

"2". Option 5 also reflected this and it was noted that the current environment in Bristol is appropriate and so this was also scored "2".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Service will be delivered in an appropriate environment	1	2	2	2	2

Sub criteria – suitable and timely transport for transfers between a major trauma centre/s and trauma units (note: Grayham McLean not present for this discussion) – after discussion, the group agreed to consider all aspects related to travel time under this sub-criterion. Under Option 1, current transport arrangements to and between sites were not sufficiently timely and this scored "0". There was considerable discussion, informed by the isochrone maps about travel distances, and travel times. An issue was whether and how to balance population sizes when assessing the impact of longer travel times and whether there was enough of a difference between Cardiff and Swansea to justify a differential score on a three point scale. Ultimately, this question went to a vote, with the majority thinking that Cardiff should score lower ("1") than Swansea ("2") because of some very long travel times from West Wales. Under Option 2, Cardiff was felt by the majority to be not sufficiently central to score "2", with the main concerns being in relation to long journey times from parts of West Wales. It received, therefore, a majority score of "1" with the caveat that there was a minority score suggestion of "2". Under Option 3, Swansea was thought to be well positioned to serve the whole of South Wales and so scored "2". Option 4 was scored "2" as these two sites would give good coverage to the whole of South Wales and good links to the relevant trauma units. In Option 5, there would be unacceptable travel distances / times from much of West Wales to Bristol and so this was scored "0".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Suitable and timely transport for transfers between a major trauma centre/s and trauma units	0	1	2	2	0

Sub criteria – avoidable transfers minimised – there was much discussion about this sub criterion, including in relation to the types of transfers that should be included (e.g. 'transfers from MTUs to MTCs and

transfers between MTCs). The statistics were felt to be complicated and paint a somewhat confusing picture. Ultimately, the two single site options were felt to be inseparable on a three point scale ("1"), whilst two sites was felt to minimise unnecessary transfers ("2"). In Option 1, the current arrangements generated too many transfers and this was therefore scored "0". Based on statistics provided, Option 2 would not minimise transfers and was scored "1" (changed from an initial "2" after discussions). Similarly, Option 3 would not minimise transfers and so also scored "1". Option 4 was considered and, based on statistics provided, this would minimise transfers so it scored "2". Option 5 would not minimise transfers and scored "0".

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Avoidable transfers minimised	0	1	1	2	0

GROUP 6

MAIN BENEFIT: STRATEGIC FIT

Sub benefit – Services delivered within a network of integrated care – Options 2-4 scored well as there was an assumption that integrated care would be built into the creation of a formalised trauma network. For option 1, there was acknowledgement that there was currently some degree of integration and co-operation between hospitals, but there was a lack of formality in terms of protocols, pathways, acceptance criteria. Option 5 scored well as an established MTC within a trauma network, although it was acknowledged that this was conditional on meeting additional clinical service interdependency criteria over and above those stated in the baseline self-assessment.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Services delivered within a network of integrated care	1	2	2	2	2

Sub benefit – In line with the outcomes of the South Wales Programme and other emerging service models – Options 2-4 scored well as there was an assumption the outcomes of the SWP would be taken into account in the creation of the trauma network. For option 1, even though the physical location of the hospitals were consistent with the outcomes coming out of SWP, it was felt that a do nothing model

might be at odds with the new service models emerging from the SWP and was marked down accordingly. Option 5 scored a "0" as outsourcing is clearly not the approach being agreed for the vast majority of other services across south Wales. It was also considered that this option would actively damage recruitment / retention of staff within Wales.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
In line with the outcomes of the SWP and other emerging service models	1	2	2	2	0

Sub benefit – Does not destabilise other clinical services / developments – despite what might be expected, Option 1 scored poorly as it was considered the effect the current service has on training and recruitment and retention of staff will result in an inevitable destabilisation of the service. Options 2 and 3 scored better, with an acceptance that, in whichever option there would still be some disruption to some services (Plastic Surgery in the case of UHW and Neurosurgery in the case of Morriston). Option 4 also scored a "1" as it was also noted that the service could be configured to limit destabilisation, but skills would not be as good as in a single MTC. Option 5 scored a "0" as it was considered that this option would actively damage recruitment / retention of staff within Wales.

Agreed scores provided:-

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Does not destabilise other clinical services / developments	0	1	1	1	0

MAIN BENEFIT: ACCESS

Sub benefit – Access to services is optimised – Option 1 scored a "1" as it was noted that access to current services is probably adequate, but that the service then provided is not in either a dedicated MTC or operating within a trauma network. Option 2 also scored a "1" as it was noted that west Wales would require a solution, especially if there is any further reduction in services in the TUs. Option 3 similarly scored a "1" with it being noted that SE Wales might not be fully covered, whereas Option 4 scored well purely from an access / travel time perspective, especially if the isochrones are extended to 60 minutes. Option 5 however scored poorly.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Access to services is optimised	1	1	1	2	0

Sub benefit – Service capacity will meet demand in a timely way – do nothing scored poorly here as it was considered that demand is not currently being met appropriately – linked to the case for change. Options 2, 3 and 4 all scored well, on the assumption that services in each of these options would be designed to appropriately meet demand. Option 5 however scored a "0" as the group did not believe that Bristol would be able to absorb all the additional activity from South Wales over and above its current workload.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Service capacity will meet demand in a timely way	0	2	2	2	0

Sub benefit – Service will be delivered in an appropriate environment – all options apart from do nothing scored well here, on the assumption that the service will be designed (or in the case of Option 5, commissioned) to fulfil this. Option 1 however scored poorly as it is not currently considered that the service is being delivered in an appropriate environment in all cases.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Service will be delivered in an appropriate environment	0	2	2	2	2

Sub benefit – Suitable and timely transport for transfers between major trauma centre/s and trauma units – Option 1 scored a "1" as there is no current formalisation for of the triage / transfer process or universal acceptance protocols, etc. Again Options 2, 3 and 4 scored well, on the basis that services would be designed to deliver this, within the wider network, including the TUs. Option 5 scored less well than these three however on the assumption that the service will be designed to optimise this but longer travel times mean that the option is less favourable than Options 2, 3 and 4.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Suitable and timely transport for transfers between major trauma centre/s and trauma units	1	2	2	2	1

Sub benefit – Avoidable transfers minimised – Option 1 scored a "1" as it was accepted that the current configuration does limit the number of transfers, but the appropriateness of this was also challenged and there are no current formal triage / transfer protocols. Options 2 and 3 similarly scored a "1" as evidence from Stoke suggested that the mere existence of a network would actually increase the number of secondary transfers into the MTC and also that the over-triaging of cases directly the centre would increase the number of subsequent "step down" transfers. The group struggled with the idea of what constituted an "avoidable transfer" and therefore the score is more a reflection of secondary transfers as a whole. Option 4 scored well simply due to there being fewer expected secondary transfers as a whole Option 5 however again scored a "0" as the number of transfers would be the highest and the actual Ambulance distances would the greatest by a significant margin.

Agreed scores provided:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Avoidable transfers minimised	1	1	1	2	0

Average scoring for STRATEGIC FIT

The resulting average scores, for the two groups who considered Strategic Fit, are therefore as follows:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Services delivered within network of integrated care	0.5	2.0	2.0	1.5	1.5
In line with outcomes of the SWP and other emerging service models	0.5	2.0	2.0	1.5	0.0
Does not destabilise other clinical services/developments	0.0	1.0	1.0	1.0	0.0

Average scoring for ACCESS

The resulting average scores, for the two groups who considered Access, are therefore as follows:-

	Option 1	Option 2	Option 3	Option 4	Option 5
Access to services is optimised	0.5	1.5	1.5	1.5	1.0
Service capacity will meet demand in a timely way	0.5	2.0	2.0	2.0	1.0
Service will be delivered in an appropriate environment	0.5	2.0	2.0	2.0	2.0
Suitable and timely transport for transfers between a major trauma centre/s and trauma units	0.5	1.5	2.0	2.0	0.5
Avoidable transfers minimised	0.5	1.0	1.0	2.0	0.0

SENSITIVITY ANALYSIS

A detailed sensitivity analysis was undertaken to look to both test the initial preferred option(s) emerging from above scoring and the overall robustness of the process. This included:

- Reverse weighting: this tested how sensitive the outcome was to the weighting that has been applied to the benefit criteria. It did so by completely reversing the weighting, so that the highest weighted criteria became the lowest, the second highest the second lowest and so on. As the baseline weighting included two criteria (Strategic Fit and Access) with a weighting of 15 (in a total number of criteria of 5), two versions of this reversed weighing analysis was undertaken – within which each of these were weighted higher.

- Equal weighting: similar to the above in terms of testing the sensitivity of the weighting applied, this assumed an equal weighting for each of the criteria, and what the resulting scores and ranking of options would therefore be.

- An approach whereby, instead of averaging the scores of the detailed sub benefit criteria for each main key criteria, these are instead just added together and provided as a gross total. What this effectively does therefore is provide some additional weighting to the main criteria which has more sub criteria than others, reflecting the existence of this additional detail in the resulting scoring.

- A version where the above gross scores (as opposed to the average scores) also have the equal weightings (as opposed to the agreed weightings) applied – effectively a combination of the previous two analyses.

- Considering the impact on the scores by reviewing these by the individual group scores ascertained, as opposed to averaging the scores from the two groups which appraised the relevant benefit criteria.

- Reviewing the 2nd ranked option: this tested the sensitivity of the initial number one ranked option by adding a marginal increase in score (5%) to each and every criteria (up to the maximum available) for the 2nd ranked option, to further test the sensitivity of the initial number one ranked option and see if this would affect this outcome.

In all of these analyses, both of the initial preferred options (Options 2 and 3) and the ranking of the remaining options remains the same. As would be expected given the result of the base appraisal, when a 5% increase is added to each and every score (up to the maximum score possible) to the 2nd ranked option from the base appraisal (Option 2) this does then marginally make this the number 1 ranked option, further indicating the closeness between these two. When reviewing the individual group scores (as opposed to averaging them) this does make some marginal difference to the options ranked 3 – 5, in terms of both the total and closeness of the scoring and, in one case, the resulting ranking. In all cases, however, none of the options ranked three and below score anywhere near the top two ranked options.

Overall, therefore, these sensitivity analyses also indicate the robustness of the non financial option appraisal that has been undertaken, and the resulting scoring and outcome from the base appraisal.

This is all summarised in the table below, with details provided in ***Appendix 4.***

Option	Base option appraisal (out of 200)	Reverse weighting		Equal weightings (out of 200)	Non average scores for detailed sub benefits (out of 1,020)	Non average scores AND equal weightings (out of 920)	Individual group scores		Add 5% to option 2 (up to maximum) (out of 200)
		a. With Strategic Fit weighted higher (out of 200)	b. With Access weighted highest (out of 200)				Groups 1/3/5 (out of 200)	Groups 2/4/6 (out of 200)	
1. Do nothing	34.2	43.3	45.0	40.0	167.5	180.0	18.5	49.8	34.2
2. Single site - UHW	176.5	169.4	168.8	172.0	910.0	800.0	177.3	175.7	184.9
3. Single site - Morriston	179.7	176.8	177.1	177.3	922.5	820.0	180.3	179.0	179.7
4. Dual site - UHW & Morriston	107.7	118.1	123.8	118.0	527.5	530.0	94.5	120.8	107.7
5. Outsourced service	89.8	84.3	88.3	86.3	472.5	410.0	94.7	84.8	89.8

CONCLUSION – NON FINANCIAL OPTION APPRAISAL

Given the results of the detailed non financial option appraisal presented above and in appendix 3, and the impact of the sensitivity analyses carried out above, and detailed in appendix 4, it is considered that, **Options 2 and 3 – One Single Site, either at UHW or Morriston**, are the initial preferred options for the provision of a dedicated Major Trauma Centre for South and West Wales and South Powys, from a non financial perspective.

It is proposed therefore that these form the shortlist which, along with Option 1 – Do Nothing (retained as a baseline) will be subject to a sub option appraisal and subsequent detailed service analysis, costing and financial evaluation that will form the financial appraisal of these options.

The final preferred option will, at the very least, therefore be dependent on this detailed service analysis, costing and financial option appraisal undertaken on this shortlist, in conjunction with the results of this non financial option appraisal, including an assessment of cost per weighted benefit.

Appendix 1

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 European Working Time Directive (EWTD) and clinical training standards; Attracts and retains an excellent workforce across all staff groups; Delivers the critical mass required to achieve full benefit from resources and investment; Does not destabilise other clinical services / developments; Provides business continuity and service contingency in the event of a major incident, etc.	25
Access	Access to services is optimised Service capacity will meet demand in a timely way Service will be delivered in an appropriate environment	15

	Suitable and timely transport for transfers between the major trauma centre and trauma units; Avoidable transfers minimised.	
	Total	**100**

Appendix 2

Stakeholders who undertook non financial option appraisal scoring

Group 1 – who appraised and scored Quality and Safety

NAME	TITLE	REPRESENTING
Paul Edwards	Consultant Surgeon	AB UHB
Simon Davies	Radiology	ABM UHB
John Martin	Consultant in Neurosurgery	C&V UHB
Ruth Alcolado	Consultant	CWM TAF UHB
Dr Gordon Milne	Consultant Anaesthetist GGH	HD UHB
Dr Iain Robertson-Steel	HDCC	HD UHB
Ian Langfield	Assistant Director of Planning	WHSSC
Ronan Lyons		Public Health Wales
Amanda Farrow	Head of School for Emergency Medicine	Wales Deanery

Group 2 – who appraised and scored Quality and Safety

NAME	TITLE	REPRESENTING
Ian Morris	Assistant Director of Planning	AB UHB
Ami Jones	Consultant Anaesthetist/ITU/EMRTS	AB UHB
Sarah Hemington-Gorse	B&P	ABM UHB
Khitish Mohanty	Consultant Orthopaedic Surgeon	C&V UHB
Michael Obiako	Consultant and Lead Clinician in Emergency Medicine	CWM TAF UHB
Joy Singh	Consultant Surgeon, GGH	HD UHB
Zoe Goodacre	Network Manager	South East Wales Critical Care Network
Rhys Thomas	Joint National Director	EMRTS Cymru
Adrian Sugar	Consultant Surgeon	ABM UHB

Group 3 – who appraised and scored Equity and Sustainability/future proofing

NAME	TITLE	REPRESENTING
Julie Poole	Directorate Manager, Orthopaedics	AB UHB
Kate Wright	Consultant A&E	AB UHB
Mark Pritchard	Trauma Consultant	ABM UHB
Hywel Dafydd	B&P	ABM UHB
Graham Shortland	Medical Director	C&V UHB
Leigh Davies	Consultant in Colorectal Surgery	C&V UHB
Richard Jones	Assistant Medical Director	CWM TAF UHB

Donna Edwards	Clinical Lead Nurse, PPH	HD UHB
Richard Lee	Head of Clinical Services	WAST
Voirrey Manson	Senior Equality Manager	Centre for Equality & Human Rights

Group 4 – who appraised and scored Equity and Sustainability/future proofing

NAME	TITLE	REPRESENTING
Sallyann Haynes	Senior Nurse – Scheduled Care	AB UHB
Ed Valentine	Consultant A&E	AB UHB
Peter Matthews	ITU	ABM UHB
Dougie Russell	MSK	ABM UHB
Jo Mower	ED Consultant	C&V UHB
Andrew Gordon	Consultant Radiologist	C&V UHB
Andrew Jenkins	Deputy Director Medical & Clinical Services	WAST
Amy Griffiths	Headway Merthyr Tydfil Branch Secretary	Headway Merthyr Tydfil

Group 5 – who appraised and scored Strategic Fit and Access

NAME	TITLE	REPRESENTING
Catherine Williams	Nurse Practitioner	AB UHB
Sian Jenkins	Finance Business Partner - Contracting	AB UHB
Ian Pallister	MSK	ABM UHB
Marie Davies	Assistant Director of Planning	C&V UHB
Prof Tim Rainer	Professor in ED Department	C&V UHB
Glenn Clewer	Consultant Trauma & Orthopaedics	CWM TAF UHB
Chris White	Chief Operating Officer	CWM TAF UHB
Grayham Mclean	Unscheduled Care Lead	WAST
Paul Worthington		Board of CHCs

Group 6 – who appraised and scored Strategic Fit and Access

NAME	TITLE	REPRESENTING
Sam Hamworth-Booth	Physiotherapy Senior Manager	AB UHB
Dindi Gill	ED / Anaes	ABM UHB
Nick Wilson-Jones		ABM UHB
Jenny Thomas	Consultant in Rehabilitation	C&V UHB
Gavin Clague	Consultant Radiologist	CWM TAF UHB
Jeremy Williams	Consultant in EM	HD UHB
Rita Stuart	Service Delivery Manager Orthopaedics and rheumatology	HD UHB
Dr Geoffrey	Medical Director	WHSSC

Carroll		
Tania Lee	Outreach Worker, Headway Cardiff	Headway Cardiff
Wyn Lewis		Wales Deanery

Each group was also independently facilitated as follows:-

Group 1	Sue O'Keeffe	North Wales Critical Care & Trauma Network
Group 2	Chris Turley	NHS Wales Health Collaborative
Group 3	Rosemary Fletcher	NHS Wales Health Collaborative
Group 4	Jo Williams	NHS Wales Health Collaborative
Group 5	Mark Dickinson	NHS Wales Health Collaborative
Group 6	Gareth John	NHS Wales Informatics Service

Appendix 3

South Wales Health Collaborative

Major Trauma Network Project

Scores from non financial option appraisal workshop re MTC - 3 June 2015

Detailed non financial option appraisal scoring - weighted

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total gross score (out of 200)	Rank
	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score		
1. Do nothing	0.0	35	0	0.5	10	5	0.3	15	5	0.7	25	17	0.5	15	8	**34**	**5**
2. Single site - UHW	1.9	35	67	1.7	10	17	1.7	15	25	1.8	25	44	1.6	15	24	**177**	**2**
3. Single site - Morriston	1.9	35	67	1.8	10	18	1.7	15	25	1.8	25	44	1.7	15	26	**180**	**1**
4. Dual site - UHW & Morriston	0.8	35	26	1.0	10	10	1.3	15	20	0.9	25	23	1.9	15	29	**108**	**3**
5. Outsourced service	1.1	35	38	1.0	10	10	0.5	15	8	0.8	25	21	0.9	15	14	**90**	**4**

Appendix 4

Major Trauma Network Project

Scores from non financial option appraisal workshop re MTC - 3 June 2015

Sensitivity analysis 1 - reverse weightings

1a - With Strategic Fit weighted higher:-

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 200)	Rank
	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score		
1. Do nothing	0.0	10	0	0.5	35	18	0.3	25	8	0.7	15	10	0.5	15	8	**43.3**	5
2. Single site - UHW	1.9	10	19	1.7	35	58	1.7	25	42	1.8	15	26	1.6	15	24	**169.4**	2
3. Single site - Morriston	1.9	10	19	1.8	35	64	1.7	25	42	1.8	15	26	1.7	15	26	**176.8**	1
4. Dual site - UHW & Morriston	0.8	10	8	1.0	35	35	1.3	25	33	0.9	15	14	1.9	15	29	**118.1**	3
5. Outsourced service	1.1	10	11	1.0	35	35	0.5	25	13	0.8	15	13	0.9	15	14	**84.3**	4

1b - With Access weighted higher:-

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 200)	Rank
	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score		
1. Do nothing	0.0	10	0	0.5	35	18	0.3	15	5	0.7	15	10	0.5	25	13	**45.0**	5
2. Single site - UHW	1.9	10	19	1.7	35	58	1.7	15	25	1.8	15	26	1.6	25	40	**168.8**	2
3. Single site - Morriston	1.9	10	19	1.8	35	64	1.7	15	25	1.8	15	26	1.7	25	43	**177.1**	1
4. Dual site - UHW & Morriston	0.8	10	8	1.0	35	35	1.3	15	20	0.9	15	14	1.9	25	48	**123.8**	3
5. Outsourced service	1.1	10	11	1.0	35	35	0.5	15	8	0.8	15	13	0.9	25	23	**88.3**	4

Appendix 4 (cont'd)

Major Trauma Network Project

Scores from non financial option appraisal workshop re MTC - 3 June 2015

Sensitivity analysis 2 - average weightings

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 200)	Rank
	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score		
1. Do nothing	0.0	20	0	0.5	20	10	0.3	20	7	0.7	20	13	0.5	20	10	**40.0**	5
2. Single site - UHW	1.9	20	38	1.7	20	33	1.7	20	33	1.8	20	35	1.6	20	32	**172.0**	2
3. Single site - Morriston	1.9	20	38	1.8	20	37	1.7	20	33	1.8	20	35	1.7	20	34	**177.3**	1
4. Dual site - UHW & Morriston	0.8	20	15	1.0	20	20	1.3	20	27	0.9	20	18	1.9	20	38	**118.0**	3
5. Outsourced service	1.1	20	22	1.0	20	20	0.5	20	10	0.8	20	17	0.9	20	18	**86.3**	4

Sensitivity analysis 3 - non average scores

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 1,020)	Rank
	Gross score (out of 12)	Weight (out of 100)	Weighted score	Gross score (out of 6)	Weight (out of 100)	Weighted score	Gross score (out of 6)	Weight (out of 100)	Weighted score	Gross score (out of 12)	Weight (out of 100)	Weighted score	Gross score (out of 10)	Weight (out of 100)	Weighted score		
1. Do nothing	0.0	35	0	1.5	10	15	1.0	15	15	4.0	25	100	2.5	15	38	**167.5**	5
2. Single site - UHW	11.5	35	403	5.0	10	50	5.0	15	75	10.5	25	263	8.0	15	120	**910.0**	2
3. Single site - Morriston	11.5	35	403	5.5	10	55	5.0	15	75	10.5	25	263	8.5	15	128	**922.5**	1
4. Dual site - UHW & Morriston	4.5	35	158	3.0	10	30	4.0	15	60	5.5	25	138	9.5	15	143	**527.5**	3
5. Outsourced service	6.5	35	228	3.0	10	30	1.5	15	23	5.0	25	125	4.5	15	68	**472.5**	4

Major Trauma Network Project

Scores from non financial option appraisal workshop re MTC - 3 June 2015

Sensitivity analysis 4 - non average scores and equal weightings

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 920)	Rank
	Gross score (out of 12)	Weight (out of 100)	Weighted score	Gross score (out of 6)	Weight (out of 100)	Weighted score	Gross score (out of 6)	Weight (out of 100)	Weighted score	Gross score (out of 12)	Weight (out of 100)	Weighted score	Gross score (out of 10)	Weight (out of 100)	Weighted score		
1. Do nothing	0.0	20	0	1.5	20	30	1.0	20	20	4.0	20	80	2.5	20	50	**180.0**	**5**
2. Single site - UHW	11.5	20	230	5.0	20	100	5.0	20	100	10.5	20	210	8.0	20	160	**800.0**	**2**
3. Single site - Morriston	11.5	20	230	5.5	20	110	5.0	20	100	10.5	20	210	8.5	20	170	**820.0**	**1**
4. Dual site - UHW & Morriston	4.5	20	90	3.0	20	60	4.0	20	80	5.5	20	110	9.5	20	190	**530.0**	**3**
5. Outsourced service	6.5	20	130	3.0	20	60	1.5	20	30	5.0	20	100	4.5	20	90	**410.0**	**4**

Sensitivity analysis 5 - individual group scores

5a - Groups 1 / 3 / 5:-

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 200)	Rank
	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score		
1. Do nothing	0.0	35	0	0.0	10	0	0.0	15	0	0.5	25	13	0.4	15	6	**18.5**	**5**
2. Single site - UHW	2.0	35	70	1.7	10	17	1.7	15	25	1.7	25	42	1.6	15	24	**177.3**	**2**
3. Single site - Morriston	2.0	35	70	1.7	10	17	1.7	15	25	1.7	25	42	1.8	15	27	**180.3**	**1**
4. Dual site - UHW & Morriston	0.5	35	18	1.0	10	10	1.0	15	15	1.0	25	25	1.8	15	27	**94.5**	**3**
5. Outsourced service	1.2	35	41	1.0	10	10	0.3	15	5	0.8	25	21	1.2	15	18	**94.7**	**3**

Major Trauma Network Project

Scores from non financial option appraisal workshop re MTC - 3 June 2015

5b - Groups 2 / 4 / 6:-

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 200)	Rank
	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score		
1. Do nothing	0.0	35	0	1.0	10	10	0.7	15	10	0.8	25	21	0.6	15	9	**49.8**	**5**
2. Single site - UHW	1.8	35	64	1.7	10	17	1.7	15	25	1.8	25	46	1.6	15	24	**175.7**	**2**
3. Single site - Morriston	1.8	35	64	2.0	10	20	1.7	15	25	1.8	25	46	1.6	15	24	**179.0**	**1**
4. Dual site - UHW & Morriston	1.0	35	35	1.0	10	10	1.7	15	25	0.8	25	21	2.0	15	30	**120.8**	**3**
5. Outsourced service	1.0	35	35	1.0	10	10	0.7	15	10	0.8	25	21	0.6	15	9	**84.8**	**4**

Sensitivity analysis 6 - add 5% (up to maximum score) to Option 2

Option	Quality & Safety			Equity			Strategic Fit			Sustainability / future proof			Access			Total weighted score (out of 200)	Rank
	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score	Average score (out of 2)	Weight (out of 100)	Gross score		
1. Do nothing	0.0	35	0	0.5	10	5	0.3	15	5	0.7	25	17	0.5	15	8	**34.2**	**5**
2. Single site - UHW	2.0	35	70	1.8	10	18	1.8	15	26	1.8	25	46	1.7	15	25	**184.9**	**1**
3. Single site - Morriston	1.9	35	67	1.8	10	18	1.7	15	25	1.8	25	44	1.7	15	26	**179.7**	**2**
4. Dual site - UHW & Morriston	0.8	35	26	1.0	10	10	1.3	15	20	0.9	25	23	1.9	15	29	**107.7**	**3**
5. Outsourced service	1.1	35	38	1.0	10	10	0.5	15	8	0.8	25	21	0.9	15	14	**89.8**	**4**

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**

Financial Assessment – Capital costs

At this stage it is possible to predict the capital impact of accommodating the MTC only in indicative terms.

For Morriston, Swansea a range of scenarios have been worked up to provide the additional capacity modelled from the activity flows and assumed Length of Stays and the assessed costs of these options are included in the table below:-

Morriston Swansea – indicative capital cost options

	Additional Capacity £000	CT Option £000	Total £000
Option 1	12,837	3,087	15,924
Option 2	14,307	3,087	17,394
Option 3	9,880	3,087	12,967

For UHW, Cardiff the estimate is that circa £23m capital resources could be required. This estimate is specific to the site at UHW and attempts to be realistic given the context of other changes and capital works, which are underway at the current time or being planned. If UHW was designated as an MTC then the solution and resultant costs could be quite different.

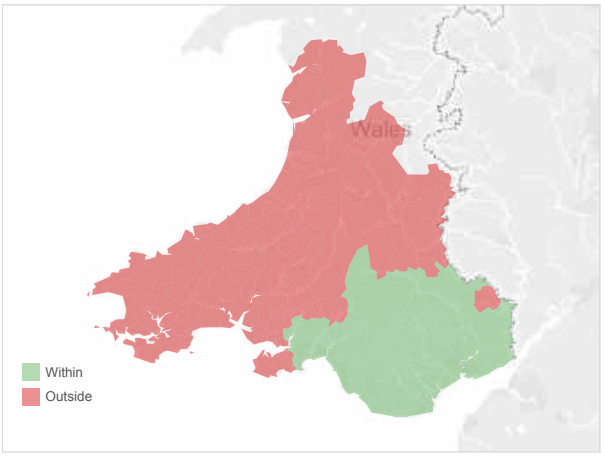
Choose Major Trauma Centre(s)
University Hospital Of Wales

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

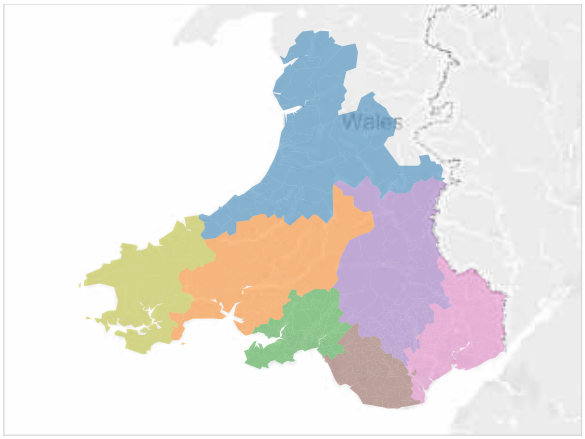
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	13	23	14	11	24	430	12	536
Candidate Major Trauma	11	16	28	16	13	28	477	14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

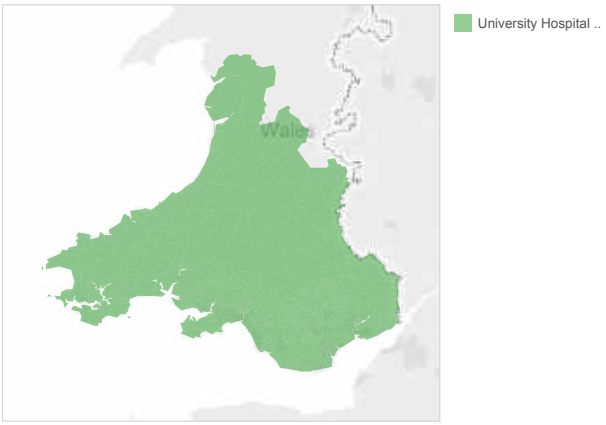


	Population	% Population
Within	1,886,846	80.09%
Outside	468,929	19.91%

TU Catchment



MTC Catchment



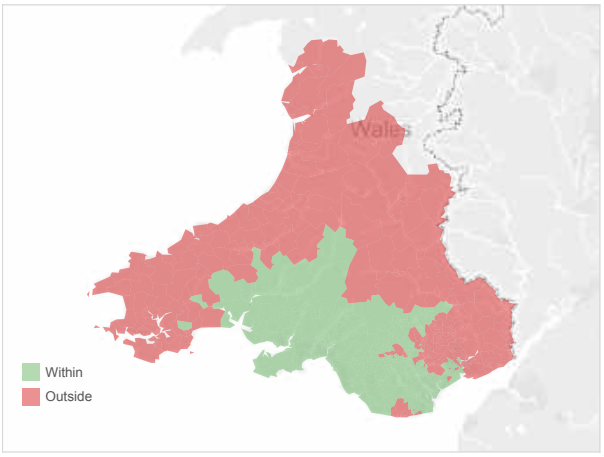
Choose Major Trauma Centre(s)
Morriston Hospital

Choose Trauma Unit(s)
Multiple Values

Forecasted Activity for Scenario

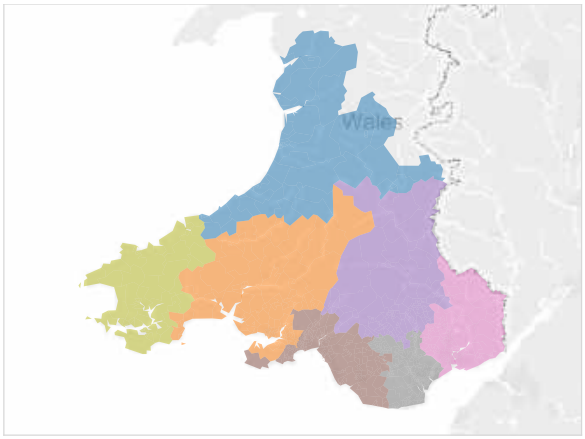
	Bronglais General Hospital	Glangwili General Hospital	Morriston Hospital	Prince Charles Hospital	Princess Of Wales Hospital	Royal Gwent Hospital	University Hospital Of Wales	Withybush General Hospital	Grand Total
Major Trauma	10	11	422	15	15	38	29	12	553
Candidate Major Trauma	11	13	460	18	18	46	35	14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

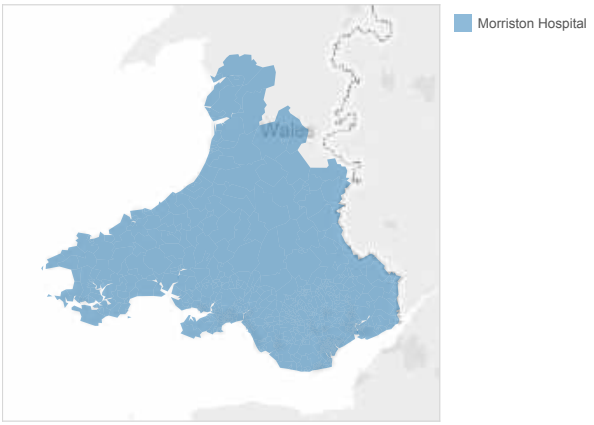


	Population	% Population
Within	1,612,535	68.45%
Outside	743,240	31.55%

TU Catchment



MTC Catchment



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

Major Trauma Network Consultation Plan

Author: Rachel Hennessy, Programme Director

Date: 31st October 2017

Version: 2

Publication/ Distribution:

- www.publichealthwales.org/majortraumaconsultation

Purpose and Summary of Document:

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

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

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

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?

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.

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 will include 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 (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. Support will be provided by the Health Collaborative team to coordinate planned events where appropriate.
National bodies/organisations	A list of national bodies/organisations will be drawn up by the health Collaborative and a copy of the consultation pack sent to these organisations by the Health Collaborative. It is proposed a number of consultation events will be set up across the region, to which the national bodies will be invited to attend.
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) and individual local authorities will be engaged by the Health Collaborative.
People with protected characteristics	An Equality Impact Assessment (EqIA) has been undertaken to consider how the major trauma proposal impacts on individuals with protected characteristics. The EqIA will be updated to reflect responses received as part of the consultation.
Other Stakeholders	This will include a number of specialist groups who may have an interest in major trauma. 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

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 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	Consultation documents will be shared through local health board networks on line and hard copies provided where appropriate.

local organisations	
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 be shown 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
Frequently Asked Questions	An initial list of frequently asked questions will be drafted and made available as a technical document on the website. This list will be updated on a weekly basis pending further frequently asked questions.

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.

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 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.

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

Lead: Rachel Hennessy, Programme Director

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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).

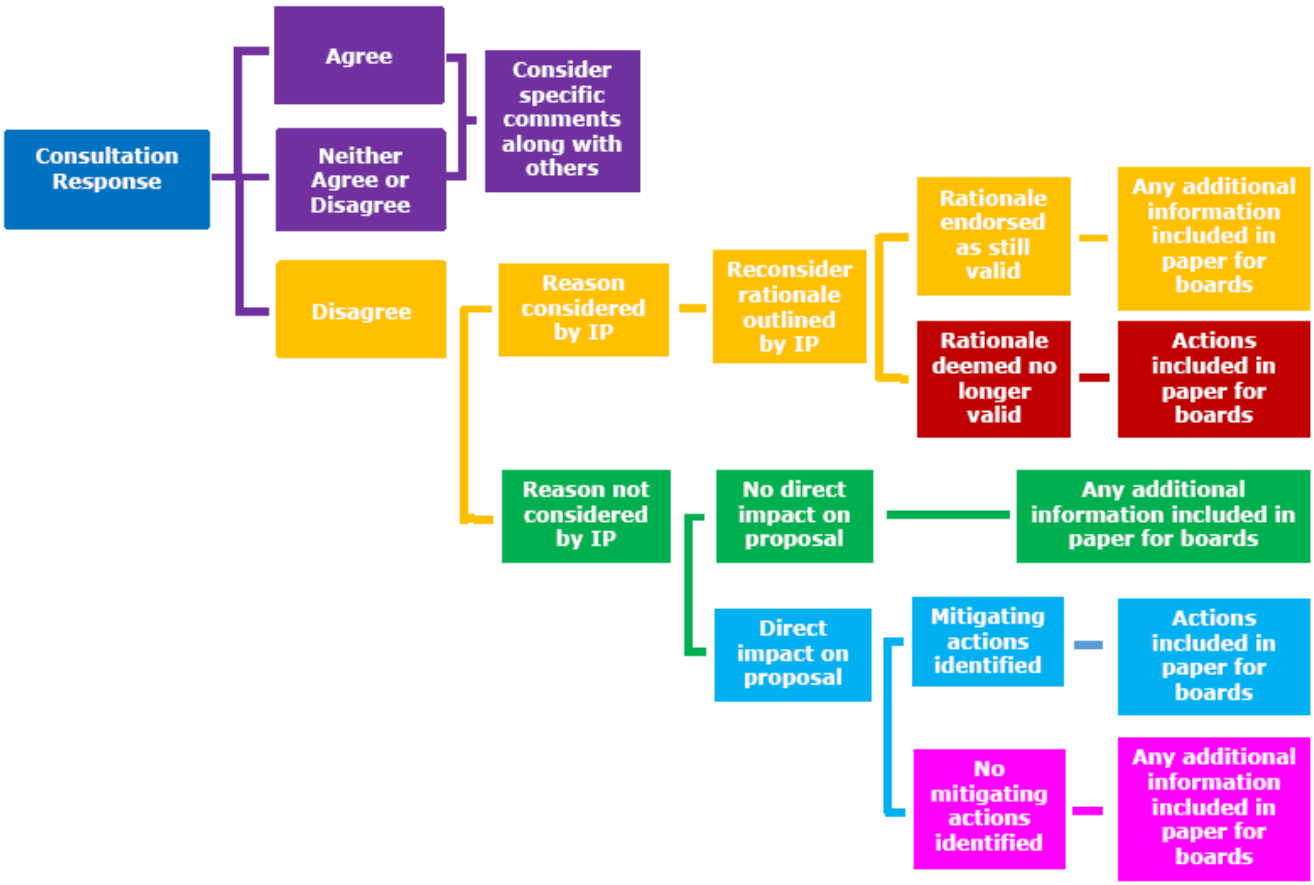
6 Framework for analysis of consultation responses

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.

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).

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

- 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.

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.

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.

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.

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.**

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.

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.

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.**

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.

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.

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.	

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.**

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.

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.

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.

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.

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.

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".

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.	

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**.

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
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 - Anal
Supporting Document 13	Post Consultation Equality Impact Assessment (EqIA)	Supporting Document 13 - Post

Major Trauma Recommendations following Professional Peer Review

Author: Executive Strategy Group, Major Trauma

Date: 19/8/19	**Version:** 0.4

Purpose and Summary of Document:

To set out recommendations for consideration as part of the response to the commissioned external professional peer review of the South, Mid and West Wales Major Trauma Network, which took place on 13th August 2019.

The recommendations included here have been derived by the Executive Strategy Group based on consideration of the discussions that took place at the professional peer review. The recommendations were further refined based on feedback from the C&V UHB MTC project board held on 15th August. The Trauma Network Board received these recommendations at its meeting on the 19th August 2019 and this report to the Collaborative Executive Group summarises the Trauma Network Board's position and seeks the endorsement of Chief Executives.

The recommendations in relation to the MTC and specialist services have been agreed by the Network Board in principle, and will now be considered by both Cardiff and Vale and Swansea Bay Health Boards

through reviewing and reassessing their business cases accordingly. This may lead to further justification from either Health Board as to where this may present a challenge.

Recommendations in relation to Trauma Units (to include the key enabling posts and the landing pad requirements), pre-hospital care and the Operational Delivery Network were fully endorsed by the Trauma Network Board.

This report to the Collaborative Executive Group summarises the Trauma Network Board's recommendations following the professional peer review and seeks the endorsement of Chief Executives.

1 Introduction

In line with HM Treasury best practice, the Programme Business Case for the South, Mid and West Wales Major Trauma Network was put through a formal Gateway review in July. The review was part of a wider assurance process set out by the Network Board in order to plan the network development, inform commissioning decisions and to inform readiness for the service to be able to go live.

The review produced a number of recommendations, of which four were deemed to be critical. 2 required immediate action and 2 were for completion by end October 2019. These are set out below:

a) The Programme Board and Programme Team should assess whether the current phasing and go-live date is affordable and achievable. (Immediate)

b) Confirm with Health Boards their commitment to funding of this programme via WHSSC (for the MTC and ODN) and their own direct investment (in TUs and rehabilitation). (By end October 2019)

c) Secure additional leadership capacity in the Programme Team to drive even more whole system collaborative working and the delivery and integration of the Major Trauma Network. (Immediate)

d) The Programme should develop a co-ordinated and collaborative approach to developing a skilled network workforce, including recruitment, training and development, rotations, shared appointments and short term requirements (By end October 2019)

The Network Board agreed at its July Board meeting that the current phasing was neither affordable nor achievable. The SRO for the programme has appointed a senior support group comprising executive and senior management from across the system thus addressing a) and c).

The remaining two critical recommendations are less straightforward and will require whole system support to address within the timeframes required. To facilitate this in an objective and constructive manner, an external professional peer review panel was established. This took place on 13th August and all organisations were well represented and fully engaged in the process.

The purpose of the professional peer review panel was to provide objective external scrutiny and to:

- Receive advice and constructive challenge on the current proposals
- Receive advice on how quality indicators and service specification could be introduced using a phased approach including advice on day 1 requirements

The output is a set of recommendations intended to enable participating organisations to identify where and how developments could be phased or constructed differently in order to lead to refinement of business case submissions.

This paper sets out the clinical, service, quality and safety recommendations which were derived as outcomes from the day.

Recommendations

Session 1 - Major Trauma Centre

1) TTL Rota

An absolute commitment to achieve a 24/7 consultant TTL rota (with resident on call overnight) 7 days per week by the end of year 3.

That the starting point for Day 1 is a 16hrs consultant TTL rota (8am – 12am), to cover the period of maximum activity 7 days per week. From 12am – 8am that provision should be met by an ST4 plus or equivalent, 7 days per week, with non-resident ED on-call consultant telephone advice available.

That appropriate mitigations are put in place (e.g. 24/7 EMRTS, retaining a single point of access/automatic acceptance overnight and discussion of cases with on call consultant). In addition, that network TTL training is offered to all C&VUHB ED registrars.

That the resource requirements set out for Day 1 are both cost effective and deliverable, whether the model is delivered in-house or involving the wider network.

In recognition that this is a key standard, the MTC business case features the incremental resource requirements to meet the full standard over years 2 and 3 with an ability built-in to the commissioning agreement that this can be up-scaled earlier if significant issues arise through the ongoing review process.

That there is proportionality in relation to the additional resource requirements between what features in the MTC business case and what sits within the HB plans to expand the pool of EM consultants in line with Royal College of Emergency Medicine standards.

2) Paediatric TTL Rota

An absolute commitment to achieve a paediatric consultant TTL rota until 12am 7 days per week by the end of year 3.

That the starting point for Day 1 needs to include a phased approach to this. For example, covering until 10pm 7 days a week and / or basing the day 1 requirement on activity data.

That appropriate mitigations are put in place to support those on the TTL rota from the wider trauma team.

In recognition that this is a key standard, the MTC business case features the incremental resource requirements to meet this standard over year 2 and 3 with an ability built-in to the commissioning agreement that this can be up-scaled earlier if significant issues arise through the ongoing review process.

That there is proportionality in relation to the additional resource requirements between what features in the MTC business case and what sits within the HB plans to expand the pool of paediatric EM consultants in line with Royal College of Emergency Medicine standards.

3) Middle grade provision

Whilst the experience is that many MTCs did not increase ED middle grade numbers, based solely on establishing themselves as MTCs, middle grade provision should be sufficient to ensure overnight coverage in keeping with the year 1 recommendation in point 1 and 2. Any additional middle grade resource for overnight provision should feature as part of wide HB plans.

That there is proportionality in relation to the additional resource requirements between what features in the MTC business case and what sits within the HB plans to expand the pool of middle grades anyway in line with Royal College of Emergency Medicine standards.

4) ED nursing provision

The case needs to reflect a 1:2 ED nursing ratio in resus, with appropriate support augmented from across the hospital where possible. Overlap between adult and paediatric nursing should be reflected in any additional resource requirements.

5) Polytrauma Ward

That this is key Day 1 requirement for the MTC and that this area is appropriately ‘protected’ and ‘ring fenced.’

Current modelling of beds is based on a LoS of 18 days equating to 14 beds in the current MTC case. Based on a predicted reduction in LoS, albeit that it will take time to occur and improved repatriation (see key enabling roles in TUs), recommendation that the HB consider starting with a polytrauma ward staffed to provide 10 beds from day 1. This should be reflected in revised AHPs resourcing of the ward (incl. nursing staff and therapists).

Experience of the Bristol modelling indicated a total of 10-14 beds with the 4 beds being placed and supported in the T&O element of the case. The totality of beds would benchmark with the Bristol modelling as a starting point.

A clear agreement with WHSSC that if needed; the staffing could be increased for extra 4 beds in year 1. Based on a review at the end of year 1, a decision would taken to uplift the number of beds or maintain the current position for year 2 and 3.

The inability to provide senior clinical leadership 7 days per week. This should be explored further in the context of reduced hours of work per day.

A further benchmarking exercise should be undertaken using information obtained from Bristol, with respect to the development of a polytrauma ward with the aim of this supporting the above recommendations.

6) Theatres

That the number of theatre sessions appear appropriate.

Further consideration is given to refining the number of sessions through improving theatre efficiency and that this is presented the revised case.

Further consideration is given to refining the number of sessions through utilisation of 2 full day plastic surgical lists per week for major trauma, when not being used for plastic surgery.

7) Critical Care

That the number of critical care beds appears appropriate benchmarked with NHS England of 3 extra beds as part of the MTC development on day 1.

8) Radiology

Modelling appropriate with MSK radiologist removed from the business case (in keeping with the views of the panel).

Any additional radiology requirements would be considered after year 1 following peer review as part of the programme.

9) Rehab component (from combined written feedback from Alex Ball/Judith Allanson/Steve Novak)

1 additional WTE MTC rehabilitation consultant appears to be appropriate, but in order to ensure sustainability; some sessions should be shared across a number of consultants (as demonstrated in the TU consultant provision).

1 additional clinical psychologist an important workforce requirement.

Physiotherapy input into paediatric rehabilitation noted and supported.

Further urgent review required in relation to therapy requirements outlined and take advice from DoTHs to see how this could be undertaken.

Session 2 - Specialist Services supporting the MTC

A key requirement for there to be a plastic surgery service established at the MTC and that this is a Day 1 requirement and this should be the priority for the MTN.

There is an agreement to commence this from Day 1 as a 12hr, 5 days per week service (Mon-Friday), with the panel agreeing the mitigations outside of these hours and at weekends. The mitigation for out-of-hours and weekend cover would be outlined in the orthoplastics clinical service model document.

2 full day orthoplastic lists, equivalent to 4 sessions in total recommended per week in line with the current business case.

Need to recruit 3.0 new WTE consultant plastic surgeons for onsite presence as indicated above at the MTC, with equivalent registrar support.

Business case needs to demonstrate the case for change (benchmark to illustrate current deficits, the wider group of patients that would benefit from plastic surgery presence in the MTC and the evidence base for enhanced workload).

Subsequent business case developments in year 2 and 3 to include:

- Consideration of the model for isolated open lower limb fractures in light of year 1 MTN experience (therefore for Day 1 current position to be maintained and no change in the flow of these patients).
- The development of a 7-day plastic surgical presence at the MTC.

MTC to consider advertising one of their major trauma nurse practitioners roles with an interest in orthoplastics.

A review of the spinal trauma model will be undertaken urgently.

Session 3 - Trauma Units

Appropriate number of TUs across the network.

Appropriate level of mitigations being put in place for rural areas (e.g. Pembrokeshire, Ceredigion), in the absence of nearby TU or MTC.

The key enabling posts of the proposed TU resource of clinical lead, TARN co-ordinator, major trauma practitioner/coordinator, rehab coordinator and rehabilitation consultant input seen as appropriate and ensure the correct patient flow through the system.

Landing pad principles supported.

Flexibility of phasing of subsequent business case developments with respect to therapies, psychology, orthogeriatrics etc.

HBs given a choice to create flexible overlapping roles between major trauma practitioner/rehab coordinators.

Session 4 - Pre-hospital

The transport, transfer and the repatriation-enhanced conveyances was observed by the panel as being appropriate, with a clear review required at the end of year 1, to determine if level appropriate.

Temporal or geographical phasing of MTN not supported but there are 2 aspects of managing flow and capacity. Firstly tightening of the pre-hospital triage tool – tool to be refined following breakout session between WAST and professional peer reviewer. Secondly, the development of a trauma desk.

Recommended that having a trauma desk was an essential Day 1 requirements and the shared function with the EMRTS ASD appropriate overnight. However, WAST case needs to clearly articulate the function and benefits of the desk, and potentially the wider value that it will add? Phasing of the trauma desk ahead of the MTN becoming operational and the change in the patient flow.

Online training in relation the triage tool appropriate.

That face-to-face training needs to be more focused (e.g. on specific equipment) and that the training is evaluated at the end of year 1, before commencing further training in year 2 and 3, given concerns raised of seconding train the trainers, costs and questions of compliance of staff, even in the presence of backfill.

Develop a delivery plan of all components.

Session 5 – Operational Delivery Network (ODN)

Resource requirements for the ODN should be revised in conjunction with SBUHB (as the host organisation). This will look to remove some posts, reconsider some banding and roles (particularly director, service development). Data analyst should be more senior and entitled service improvement manager)

The function of the Clinical Informatics team should be further reviewed to focus on improvement of TARN data and co-ordination across the MTC and TUs. There should be focus on the development of patient-held records. The business case should be phased over a 5-year period.

The training proposals were seen as appropriate. It was recommended that an in year training programme was produced that covered the network region and mapped against trauma standards. Recommended that there were two half-day conferences to cover the complete patient pathway and as wide a range of delegates attend as possible.

It was agreed that there needed to be further consideration of the governance arrangements in particular around patient flow and repatriation. Whilst it was recognised that there is not a PBR and best practice tariff approach that would translate to Wales, it was considered necessary that there would be some arrangements that could be tested with CEOs of the Health Boards.

The governance arrangements should have executive-level sign-up across all the Health Boards in the network with MOUs. There should be a ‘top forum’ for the ODN

and hold account the ODN. It was observed that the host organisation as a service provide and lead for the ODN needed in the context of firming-up the governance arrangements.

Appendix

WALES TRAUMA NETWORK PROFESSIONAL PEER REVIEW

Date Tuesday 13th August 2019

Location Copthorne Hotel, Copthorne Way Culverhouse Cross, Cardiff CF5 6DH

	Agenda Item	**Lead/ Skype Details**
09:15	**Welcome and Introductions**	Dindi Gill
09:30	**Major Trauma Centre** • Mr Rob Faulconer, Consultant Vascular Surgeon, Plymouth Hospitals NHS Foundation Trust • Dr Ben Walton, Consultant ICM and Anesthetics, North Bristol NHS Trust • Dr Richard Hall, Consultant in Emergency Medicine, University Hospital of North Midlands NHS Trust • Dr Steve Novak, Consultant in Rehabilitation Medicine, North Bristol NHS Trust • Dr Judith Allanson, Consultant in Neurorehabilitation, Cambridge University Hospitals NHS Trust **Referring to Document 1**	PSTN:01495 793600 WHTN:01891 3600 Conference ID: 34914672
Coffee		
12:00	**Specialist Services** • Mr Shehan Hettiaratchy - Plastic and Reconstructive Surgeon, Imperial College, Trust trauma lead and lead surgeon; consultant plastic, hand and reconstructive surgeon, Imperial College Healthcare NHS Trust • Miss Loz Harry, Consultant Plastic Surgeon, Queen Victoria Hospital **Referring to Documents 2, 3 & 4**	PSTN:01495 793600 WHTN:01891 3600 Conference ID: 83136894
Lunch		

14:00	**Trauma Units** • Dr Ash Basu, Consultant Emergency Physician, Betsi Cadwaladr University Health Board • Dr Adam Wolverson, Consultant in Intensive Care Medicine and Anaesthesia, United Lincolonshire Hospitals NHS Trust • Dr Steve Novak, Consultant in Rehabilitation Medicine, North Bristol NHS Trust **Referring to Documents 2, 5, 6 & 7**	PSTN:01495 793600 WHTN:01891 3600 Conference ID: 62370238
15:00	**Pre-Hospital** • Dr Phil Cowburn, Acute Care Medical Director, South West Ambulance Services NHS Foundation Trust **Referring to Documents 8 & 9**	PSTN:01495 793600 WHTN:01891 3600 Conference ID: 34069127
16:00	**Operational Delivery Network** • Mr Steve Cooke, Network Manager, West Midlands Trauma Network • Dr Louisa Stacey, Major Trauma Centre Manager and Thames Valley Trauma, Vascular, and Spinal Networks Manager, Oxford University Hospitals **Referring to Document 10**	PSTN:01495 793600 WHTN:01891 3600 Conference ID: 78969127
17:00	**Close**	

Clinical Informatics Approach

Author(s): David Rawlinson

Distributed to: Wales Major Trauma Network

Date: 20/09/2019	**Version:** 1.6

Review History:

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1	1.0	David Rawlinson	09/06/2019
	1.1	David Rawlinson	11/06/2019
	1.2	David Rawlinson	20/06/2019
	1.3	David Rawlinson	26/06/2019
	1.4	David Rawlinson	27/06/2019
	1.5	David Rawlinson	30/06/2019
	1.6	David Rawlinson	20/09/2019

Clinical Informatics approach

Informatics support is essential to improving patient outcomes through both direct support for patient care and indirectly through improving efficiency of the administration of the patient pathway. Making use of existing systems, and harnessing ongoing developments and the future plans of NHS Wales, the informatics programme seeks to reduce the burden of data entry on clinicians and administrative staff, and ensure timely, accurate information is available to patients, clinicians, and management structures, as well as commissioners.

The work stream will seek to work with health boards, trusts, and NWIS to assess the current situation, including mapping information flows relating to major trauma patients, and look at the short, intermediate and long term expectations of the network and how informatics can support this. It will also reach out to the wider UK and internationally to look at best practice and the lessons learned. This approach has been presented to Trauma Governance Sub-committee.

In the context of Wales informatics, significant progress has been made recently with the roll out and expansion of national systems allowing cross boundary access to patients records. This provides a unique opportunity to build on existing technologies, and use routinely collected data to track trauma patients in the network.

Some of the systems are listed below, and will be important in supporting the patient pathway:

- MIS C3 Ambulance control system
- WAST Anoto e-Pen system, Corpuls live monitor telemedicine capability
- EMRTS Clinical database, RDT Telemedicine capability
- Emergency department systems
- Welsh Care Records Service (WCRS)
- National Data Repository (NDR)
- Welsh Clinical Portal (WCP)
- Welsh Patient Referral Service (WPRS)
- Welsh Results Reports Service (WRRS)
- Welsh GP Record
- Patient Knows Best (PKB)
- National PROMS/ PREMS programme
- Unscheduled Care Dashboard
- NCCU Benchmarking toolkit

In addition Wales also has access to unparalleled health informatics research and evaluation support from Swansea University including the Swansea Anonymised Information Linage (SAIL).

A brief overview of how informatics can support the various stages of the patient journey are outlined below, and it is intended that all will be integrated to provide a seamless electronic record.

In addition to the membership of the trauma network working groups, the following organisations and individuals have been consulted during the development of this document

NAME	ROLE	ORGANISATION
MATTHEW JOHN	Associate Director of Informatics	SBU
RACHAEL POWELL	Assistant Director of Research, Audit and Service Improvement	WAST
KEVIN WEBB	Head of Clinical Audit & Effectiveness	WAST
CRAIG GARNER	Information Governance Manager	WAST
MARIA STOLZENBERG	Assistant Head of Risk and Assurance, Patient Feedback Team	SBU
MARTIN DAVIS	IM&T Development	CAV
KATE BLACKMORE	Area Manager for EMS CCC (Interim)	WAST
DANIEL PHILLIPS	Director of Informatics Planning Management	Velindre
RHIDIAN HURLE	MD/ CCIO	NWIS
LEE MORGAN	Head of Information Services	SBU

Contents

An overarching trauma informatics system

As part of the MTC preparations the Major Trauma Project Board in Cardiff & Vale UHB are developing a bespoke database system in house, and have offered the system to the wider network as a way of improving data collection and tracking patients through the pathway (Appendix 1). A proof of concept is also included in Appendix 2. This has been well received by the network board, and it has been identified that for this to be achieved a number of areas will need to be considered:

1. The hosting of the system (separate instances vs CAV vs national infrastructure vs cloud etc..)
2. Development required including
    a. Integrations with varied systems across LHB's
    b. Integrations with national systems such as NDR, WCRS, RADIS, WLIMS etc..
3. Information governance arrangements
4. User access control and administration (who adds and removes users from the system across the network)
5. System training arrangements
6. Access audit and surveillance (NIASS)
7. Service management including routine business, change requests and future developments (whole network approach)

A work programme will be established to implement a central trauma specific electronic patient administration system. The system will aim to identify patients at the earliest opportunity, ideally pre-hospital, or in the emergency department, and start to track the patient's journey through the pathway. It will integrate with local and national systems in use across NHS Wales, and provide the relevant near real time information to all involved in the management of the pathway. This includes clinicians, managers, clinical audit and administrative staff. It will also link with systems used to communicate with patients to facilitate PROMS/ PREMS. A cohort of the patients who are TARN eligible will then be fed into the TARN database. This approach will allow Wales to hold its own trauma registry for operational management, with potential for service evaluation, additional audits and research. With a scope wider than the TARN criteria, it will provide unique opportunities to improve service delivery and facilitate injury prevention activities. The system will also support clinical governance process through tracking of case reviews.

Key features of the system will include:

- Provider model allowing each HB to integrate with systems where the differ from the national landscape, allowing for the varying stages of transition and developments.

- Hosting on the national infrastructure

- Federated development model to ensure all partners are involved in the development and reduce the reliance on any one health board or organisation.

It should be highlighted that for pre-hospital providers, and TU/ MTC, there are not new data flows relating to this project, but the system aims to improve accessibility of the data to improve patient care. e.g. a patients ambulance record is currently handed over to hospital staff and ultimately forms part of the hospital record. It may also be scanned into a document management system and enter onto national systems, as well as be manually audited by TARN audit staff.

A high level overview of the anticipated landscape of the systems is included in Figure 1

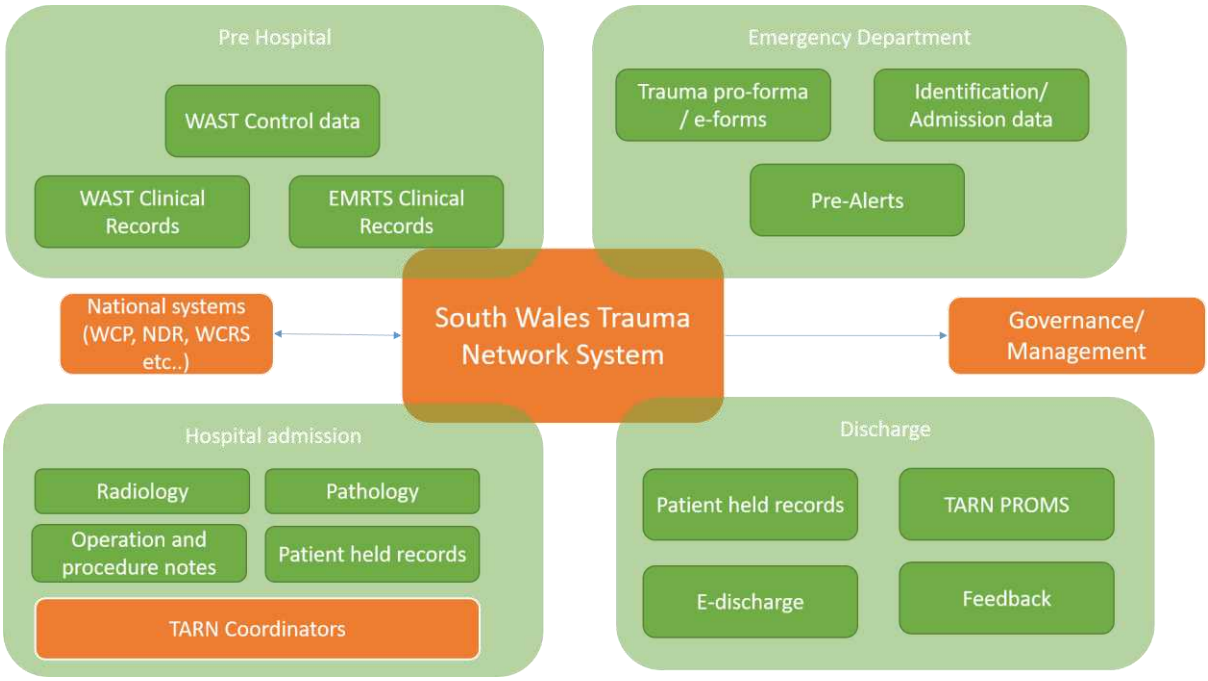


Figure 1 Overview

The following stages of the patient pathway are detailed below, with brief discussion a about how they will interact with the information systems:

Pre-hospital – WAST/EMRTS

As the majority of major trauma patients first access health care via the 999 system, it is important any informatics approach starts with the pre-hospital providers WAST and EMRTS. This can provide and early record of a candidate major trauma patient entering the system, and should ideally aim to identify patients where possible at the time of call or first clinical contact. Retrospective matching of patients should take place in cases where the patient is unknown. Starting at this point facilitates a multitude of potential actions such as use of trauma triage tools, senior clinical decision making support, logistical support, clinical apps, accurate pre-alerting of primary and secondary receiving centres, efficient radiology (such as direct to CT), early blood product transfusion and remote advise to clinicians. There is also opportunity to improve the enhanced pre-hospital TARN dataset here, and also reduce the burden on TARN coordinators.

It is important to remember that the majority of this data is already routinely shared with secondary care through the transfer of paper records and printouts or scans of records and so the data flow is not new. The information forms part of the patients health records. In addition operational metrics are also available through data linkages to the individual health boards for performance management purposes.

Emergency Departments

Identification of candidate patients in ED is important to continue tracking the patient's journey, and may be achieved through the use of routinely collected data. An analysis of systems in use, and mapping of datasets will be required within the network, and where gaps exist, the programme will seek to supplement these ensuring high compliance with a core dataset. In some cases this may be achievable with routinely collected data from existing systems, in others it may require manual data collection, or development of existing systems. Through use of already available systems such as WCP, there are already opportunities to improve the care delivered to patients through access to patient's

medical history (primary and secondary care). For tertiary centres, access to live clinical information from primary hospitals such as radiology and blood results can also be facilitated to aid planning and assist with advice given by the centres. Radiology and clinical image transfer systems already exist but improvements may be considered in the logistics and compatibility of these systems to ensure timely image transfer. Future developments may also include telemedicine support for TU/ LEH.

In-hospital

As the patient's journey continues, additional data collected such as radiology, operation and procedure notes, as well as organ support information is collected and is vital to providing a complete picture of the patient's progress. There also exists opportunities to tie into other national work-streams such as e-prescribing, e-flow, e-ICU (CCIS) and any other emerging technologies.

E-discharge

As the patient transitions between levels of care and subsequently home it is important that timely and accurate transfer of information takes place. This includes communication with rehabilitation services, primary care, and most importantly the patient. It is envisaged that in line with emerging practices within wales, and the wider UK that patient held electronic records are used. Systems such as PKB which are being used in Wales and across the UK provide such a platform, and when integrated with national systems provide seamless transfer of information that the patient is in control of. Evidence points to this improving compliance with rehabilitation, and also improved patient satisfaction. It also provides an opportunity to collect data pertaining to PREMS and PROMS from patients which can improve compliance with TARN PROMS, but also facilitate continuous service improvement, reduce the administration burden for providers, and also provide data to support economic evaluation of the service provided.

Implementation

It is recognised the work plan is ambitious given the short time frames to “go-live”, and ongoing existing work streams in an already stretched informatics landscape. In addition, although important, major trauma makes up a very small proportion of the overall workload in NHS Wales, and will be competing with other established projects which impact far greater number of patients (e.g. introduction of new emergency department systems, implementation of electronic records in WAST).

Thus, a phased approach will need to be taken, and phased over 5 years. An illustration of the essential and desirable deliverables are included below, subject to change once formally handed over to the ODN.

Year	Essential	**Desirable**
19/20 (in place for day 1)	• Data sharing agreements in place • Pre-hospital patient reports from WAST & EMRTS to be available to TARN coordinators & Network office no more than 4 weeks following incident • WAST/EMRTS to be flagging potential major trauma cases on control systems • Up to date pre-hospital operational data available for interrogation and business intelligence dashboards • Network information "app" live • Trauma tool "app" live • All TU's to upload trauma pro-forma to document management systems that interface with national repository • CAV to be using the network trauma information system pro-actively • Network incident reporting system short form live and process in place for handling cross boundary/ organisational incidents • Call recording available for non-emergency case discussions/ referrals • All TARN coordinators to have access to national instance of Welsh Clinical Portal • Network data analyst in post (training/ development with stakeholders)	• Patient held records (for rehabilitation prescription) functioning • Capture of additional trauma cases in systems that are not TARN eligible, but of interest for injury prevention and service planning e.g. death at scene in HB's that have capacity (i.e. are already up to date with retrospective data collection)
20/21	• Integration with national systems complete (to include operation notes, emergency department systems, all radiology, pathology results) • Transition to electronic clinical data capture in emergency department (replacement of trauma paper pro-forma) CAV • Patient held records (for rehabilitation prescription) functioning for MTC patients	• Transition of other TU's to electronic data capture • Export of year 1 & year -1 data to SAIL
21/22	• Patient held records (for rehabilitation prescription) functioning for MTC patients + 2 TU's	

22/23	• Patient held records (for rehabilitation prescription) functioning for MTC patients + 4 TU's	• Patient held records (for rehabilitation prescription) functioning for 6 TU's
23/24	TARN integration 1. TARN to have direct access to the network trauma information system data including all relevant linked data to complete a TARN submission. 2. Network to have direct link to TARN data to augment data already available within NHS held datasets e.g. addition of Ps, ISS etc… in operational dashboards. 3. PROMS data to be linked back into welsh systems, and in turn into National data repository 4. Export of dataset to SAIL with 3 complete years of network operation, and to include PROMS, and TARN metrics.	• Patient held records (for rehabilitation prescription) functioning for all 8 TU's

Other areas for Network Support

A number of areas have also been identified that will require support:

Central Incident Reporting

The development of a central incident reporting system (e.g. DATIX) that allows cross border investigation of incidents and facilitates statuary reporting and escalation where required to WG.

- Automatic population from the trauma system when cases are flagged e.g. M&M, critical incident etc…
- An easy to use short form for use by the network to log incidents

Discussions have taken place with the incident reporting manager in SBU who is also overseeing the procurement of a national system, and these elements can be accommodated.

Call recording

Whilst early parts of the patient pathway e.g. trauma desk decisions and conference calls will be routinely recorded, it has been identified that it would be advantageous to record calls between units relating to repatriations to facilitate the governance process and improve accountability. On a basic level this is the provision of a recorded line, and it is likely that this will require an office hours administrative function to setup calls and log them against a patient in the trauma system to ensure traceability. In the rare event of out of hours discussions then this could be conducted through the trauma desk, recognising its primary responsibility is in the coordination of the emergency stages the trauma pathway.

Welsh Patient Referral Service (WPRS)

As patients transition between stages of the pathway and institutions, if is desirable that any communication relating to this is recorded on the trauma informatics system, but conducted through existing e-referral process available via the national systems. This includes repatriations and rehabilitation.

Network development and dissemination of information

An auditable document management system should be available for the development and version control of network guidance e.g. Sharepoint

Tools for accessibility of network guidance, contacts, and communications should be available and accessible through networked computers within the NHS and ideally on work and personal mobile devices used by clinicians.

Notes on specific areas

WCP

The Welsh Clinical Portal provides a unique opportunity to provide a single point of access to trauma patient's records from pre-hospital through to rehabilitation. Any systems holding patient data should provide data into the NDR and WCRS which will be consequently visible to users of WCP who may not have access to the bespoke trauma systems. This would apply to the trauma informatics system where it is implemented, but will also mitigate any delays e.g. in a TU, as any trauma related documentation should be uploaded by them through existing systems. It is essential that all staff have access to this, and specifically in respect of TARN coordinators, access to the national instance, which provides enhanced visibility of information across health board boundaries.

Research

Swansea University has a long history of supporting trauma research on an international level, and with existing data linkages through SAIL this provides an unparalleled opportunity to research trauma in Wales. There is opportunity to benchmark against international services. The trauma informatics system should be capable of providing an export to SAIL through the split file process. A key to successfully matching patients in SAIL is ensuring a high compliance with NHS numbers being recorded, and so this could be used as a measure of data quality in the day to day management of the system.

Patient held records

In order to facilitate ongoing care of patients following their acute admission, there is growing evidence that patient held records improve compliance with ongoing treatment plans. When in electronic format they also enhance communication between clinicians and patients, and potentially improve patient satisfaction. They also facilitate further contact to enhance collection of PROMS and

PREMS. An example of such a system is Patients Know Best (PKB). This is a patient held record system that is now established in NHS Wales, and is integrated with the infrastructure, although not currently used in Trauma care. It is however used to good effect in the south west of England and has proven itself to be a valuable tool to improve quality discharge in trauma. The system is already in use in CAV and SBUHB, which may represent a cost saving with regards to licencing. Additional licences would need to be purchased to cover TU's that enter patients onto the system

Some integration work would also be required to ensure the system functions efficiently with the trauma informatics system.

Alternatively there are other providers, and scope for in house, or a hybrid approach. Further work is required in the immediate term to determine the best approach, but for the purposes of financial planning a worst case scenario is illustrated in the appendix and ROM costs.

Trauma tool App

There is a desire to produce an app that will allow clinicians to apply the trauma triage tool in both the training environment and in clinical practice. This follows best practice exhibited elsewhere in the UK (SCAS/ Wessex network, Scotland under development, North West). This supports ongoing work to mobilise the pre-hospital workforce, and use technology to positively support the patient pathway. In addition data relating to usage of the app can be use to support the operational management of the network. This app can be produced in-house or commissioned from one of the existing providers in the UK. An example of a proposal from a current provider, Volatile State Ltd is attached in Appendix 4.

Information App

Distinct from the trauma tool app, which is a clinical decision making tool, there is a requirement to make network documentation easily available to any clinician involved in accessing the network. This must be accessible on multiple platforms, and content will be managed by the network office. A potential solution already widely used by NHS staff in Wales is “Induction”. This is already established in a number of English NHS major trauma networks, and provides ready access to guidance and contact details. Alternatively an in-house app may be developed, or a mobile view of a website may provide adequate functionality, and be managed by the communications manager.

Pre-hospital providers

WAST requirements

Trauma Desk/ Control staff

- Flagging of cases on the CAD that are potential major trauma
- Recording whether the trauma triage tool was used or not

Operational data access

- Provision of a data SQL view relating to trauma cases to include fields such as incident number, date, time, location, postcode, LHB, staff names and skill level, callsigns, time of resource arrival/ left scene/ arrival at hospital, destination hospital and LHB, clinic attended, nature description, call category, problem text, flag status, trauma triage tool used etc…

Clinical Audit & Health Records

- Provision of un-redacted patient report form image to the network office, either via secure email or direct upload to the trauma patient administration system (timeframes TBC)
- Structured data view mapped to core TARN data fields and Welsh Trauma registry (TBC) following clinical coding, on a monthly basis
- Corpuls data (e.g. physiological trends) (desirable)
- Identification of patients that are deceased outside of hospital where possible, to facilitate post-mortem requests by the network office.

Overall, the aim would be to automatically “push” records into the trauma system at the earliest opportunity, but it is recognised this will likely be tied into developments such as further phases of CAD, and the ePCR project/ ePEN replacement and so a degree of manual data transfer is to be expected initially. This may have additional staff resource requirements in the case of health records/ clinical audit departments workload.

EMRTS requirements

Operational

Air Support desk staff – working closely with the trauma desk (model TBC), and ensuring accurate data entry into CAD and trauma system.

EMRTS Informatics/ clinical audit

Provision of an SQL view to link pre hospital records to the trauma system

Provision of unredacted exports from ePCR and digital copies of any associated paper records either to the network office, either via secure email or direct upload to the trauma patient administration system

NWIS / CAV/ SBU

Working with CAV and SBU to facilitate the following works, or providing an alternative solution

1. Hosting of the trauma informatics system SQL database and application
2. Integration with
    a. NIASS
    b. MPI
    c. WCRS
    d. NDR
    e. RADIS
    f. WLIMS
    g. WEDS
    h. Welsh Patient Referral Service (WPRS)
3. Service desk support
4. SAIL upload support through existing split file process

Estimated resource requirements & ROM costs

An estimate of resource requirement and ROM costs is provided here to aid financial planning, and is subject to change as the work progresses with formal project management. It should be noted that work is not in established work plans, and crosses multiple stakeholders with complex integration work required in some areas. Each stakeholder may also incur additional resource requirements to complete the work, not detailed here.

Other requirements

- Other incidental expenses such as provision of computer and telecoms equipment for network office staff are included in other areas of the business case.

- ICT support costs and the organisation that incurs them will depend on the final architecture of the network trauma information system

- Network data analyst and TARN coordinators that are instrumental to high quality data collection and analysis are covered elsewhere.

- Education and training ICT requirements are covered elsewhere.

Appendix 1

South, Mid & West Wales Major Trauma Network – Informatics & Database

Leigh Davies

Clinical Governance Lead – Major Trauma Network

Situation

The development and implementation of the major trauma network and major trauma centre, together with a requirement for the collection and submission of TARN audit data from across the network area has resulted in the need to develop a regional solution for the acquisition and management of data from across the Major Trauma Network.

This will enable the network, MTC and trauma units to understand the work load for which they are responsible, their outcomes and the patients across the network waiting for repatriation to their base trauma unit. In addition, the submission of TARN data across the network will be improved and allow the network to understand the workload across the network and changes over time which will allow the network to amend and adjust the system to maximise outcomes and improve efficiency to ensure that patients get the best system possible with minimum waste.

Background

The development of a South, Mid & West Wales trauma network has been in development for a number of years and is now being implemented across the region with the project being led from the NHS wales collaborative. Within this project are a number of Welsh Health Boards each with a designated trauma unit and one with the Major Trauma Centre (Cardiff & Vale) the overarching body responsible for the management of the South, Mid & West Wales major trauma service will be the Major Trauma network. Further interactions with the Welsh ambulance service NHS Trust and the Emergency Medical

Retrieval and Transfer Service (EMRTS) will also play a significant part within the major trauma service.

As a complex organisation with interactions between each of these bodies, there will be a requirement for an over-arching data system which allows each organisation to understand it's patient volumes, the location of each of the patients it has responsibility for, the outcomes for those patients and support in submitting each organisations data to the TARN audit.

Traditionally, each organisation in the Welsh NHS has maintained control of their own data management as the need to interact between organisations has been limited. More recently, data management has become more centralised as the utility of sharing data across the region has been recognised as of increasing utility.

The development of the trauma network together with planning for trauma units in each Health Board and the development of the Major Trauma Centre in Cardiff presents an opportunity for the development of a single data management system across the network which will fulfil the needs of each of the organisations involved to maximise data acquisition and allow use of that data to maximum effect.

Assessment

Currently, as part of the development of the Major Trauma Centre in Cardiff, it was recognised that current data management for major trauma patients was lacking which resulted in a lack of clarity on the volume of patients being treated for major trauma and their outcomes in a timely manner. TARN data submissions were ultimately completed but not within the required timeframes and there was lack of confidence across the network on the total volumes of patients and the severity of injuries and a poor understanding of their total medical needs. As such, this makes the planning for the MTC more challenging. As a result of this, an early decision by the Major Trauma Project Board in Cardiff & Vale UHB was made to initiate a Major Trauma Database system which will acquire data on major trauma patients in a prospective and timely manner, allowing early TARN data submission, an understanding of the patient load/volumes and their needs, and to support outcome measures including PROMs.

Currently, C&VHB is developing this database system using their in-house IT department and the system is being designed and built by the IT service as a bespoke package for the MTC to achieve the needs stated above. This system will be based on a SQL server system which allows access from across the health board on all NHS computers but protected from inappropriate access using appropriate security to maintain data security as per Caldicott and GDPR principles.

It would seem that there are requirements for a similar system to manage patient data and outcomes across the network.

Recommendation

There appears to be an opportunity to maximise data management and data sharing to allow best flow of patient information and outcomes across the network if the network was to adopt a system of data management that integrates across the network, the MTC and the trauma units simultaneously.

It would therefore be appropriate that the Major Trauma Network adopts the same system for MT data management that is being developed by the MTC and this system is adapted for use across the network, such that data is shared appropriately and at the same time maintained in a secure manner consistent with current data protection principles.

The development of the current MTC system will allow the Trauma units to understand the patients in the pipeline which are awaiting repatriation to local hospitals and facilitate their significant role in the Major Trauma Network in “Pulling” their patients from the MTC in order to maximise patient flow and allow patients to recover and rehabilitate as locally as possible to home once their treatment in the MTC is completed.

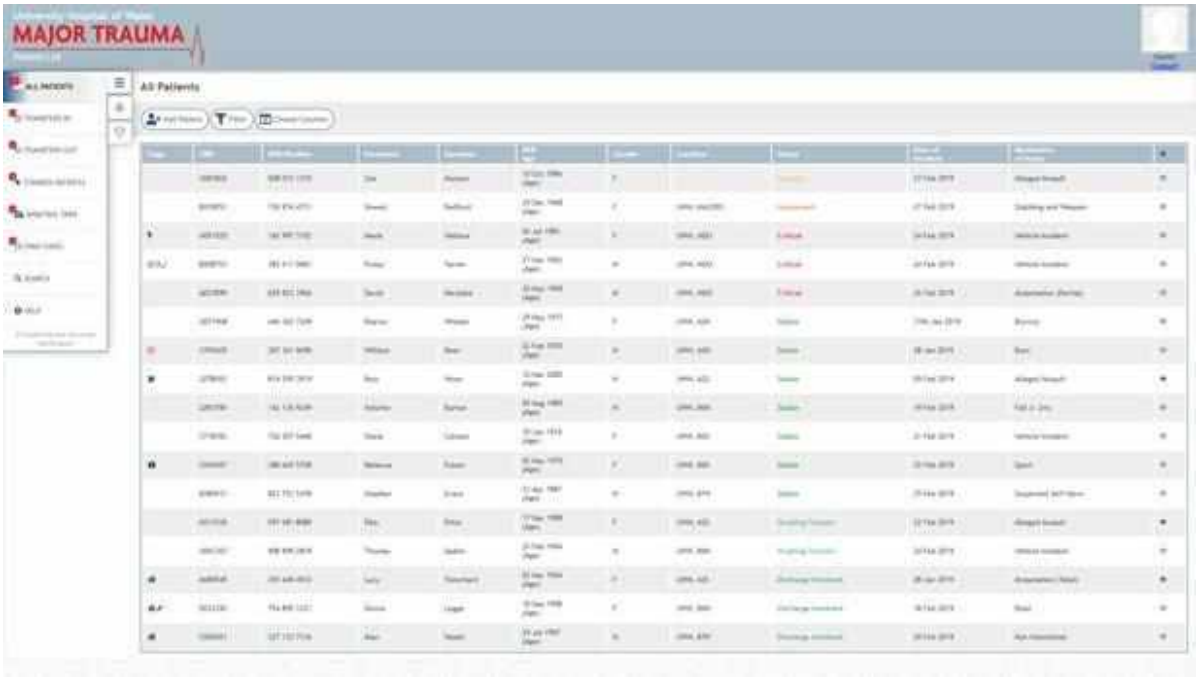
Appendix 2 – Trauma informatics system proof of concept

The following is a demonstration of proof of concept of the trauma informatics system and is subject to change. With thanks to Martin Davis, CAV IM&T development.

Patient Lists

This is the first screen that people will see once they've logged in; it shows a list of the patients currently receiving care within the hospital/health board to which the users account has been associated. Information presented includes basic demographics, the location of the patient within the hospital, their current status (i.e. Inbound, Assessment, Critical, Stable, Awaiting Transfer, Discharge Imminent, etc.), the date and mechanism of injury. A series of icons in the first column can convey information stored about this patient in the underlying PAS (i.e. stroke, dementia, end of life, etc.) if the PAS supports such things. The final column allows individual users to "star" a patient, a convenient way to easily track patients that are under that individuals care.

In a busy hospital this could become a long list, so there are menu options on the left-hand side that allow you to view categorised sub-sections of the list such as "Transfers In", "Transfers Out" and "Starred Patients". There are other menu options for patients that are no longer receiving care, but still require their record to be available, including "Awaiting TARN" (for patients that have been discharged, but not yet uploaded to TARN) and "M&M Cases" for patients whose cases need to be reviewed in an M&M scenario. "Search" and "Help" complete the options on the main navigation.



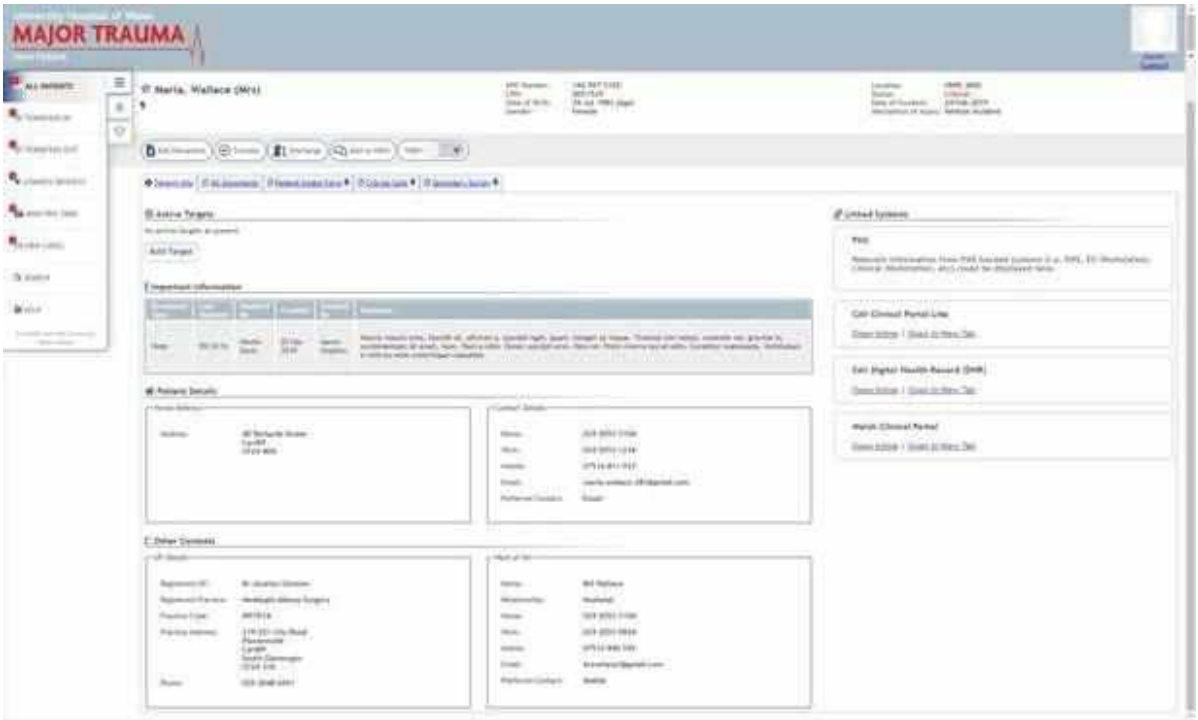
This is the “Transfers In” view – it shows the same information as the main view, but in addition includes a clock in the first column to show how much time is left in the transfer window. This is a “target” that is created by the system in response to a transfer request, similar targets are initiated in other parts of the system, i.e. when a patient is discharged, a target is created to ensure their TARN submission is completed on time. Users can also create bespoke targets to remind them, for example, to check a patients observations every 2 hours.

Patient Record

This is the patient record as seen when opening it from any of the patient lists. The top banner contains all the summary information from the list (with the exception of targets), while the toolbar below offers ways of interacting with the record – i.e. “Add Document”, “Transfer”, “Discharge”, “Add to M&M” – and a toggle-button to indicate if this patient meets the criteria for TARN. The options presented here will vary with the state of the patient record, so only relevant options will be presented – i.e. you can’t transfer a patient once they’ve been discharged, etc.

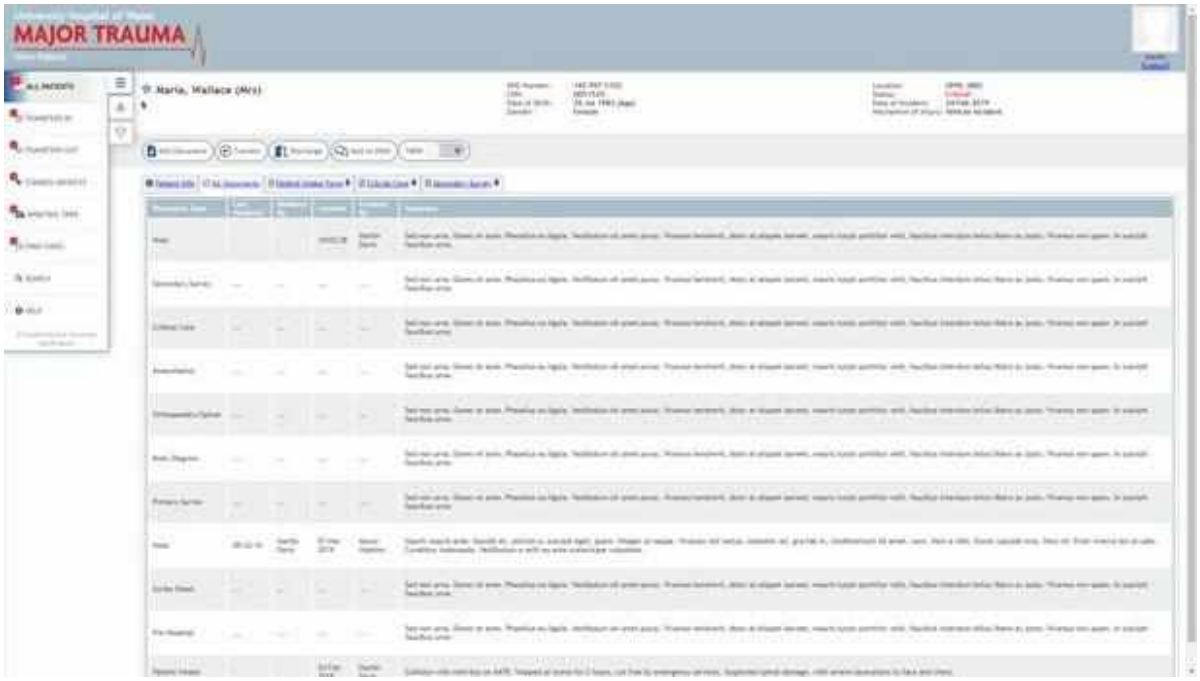
Below the toolbar are a series of tabs. Each patient will have at least two tabs – one for a summary record of the patient, and another for showing a list of all documents associated with the patient – though other tabs may be available to offer quick access to relevant documents, at the users’ discretion.

The summary record tab is split into two columns – the first provides access to any active “targets” for the patient, along with a button to create a new target, a list of “Important Documents” (things that anyone dealing with the patient may need to know – i.e. allergies, or a DNR), and a series of boxes containing contact information for the patient, next of kin and GP (all pulled from the underlying PAS, if available). The second column will display patient information pulled from related systems, and will therefore vary from one health board to another, though I expect most health boards will have access to a link that will open the patient record in the Welsh Clinical Portal.



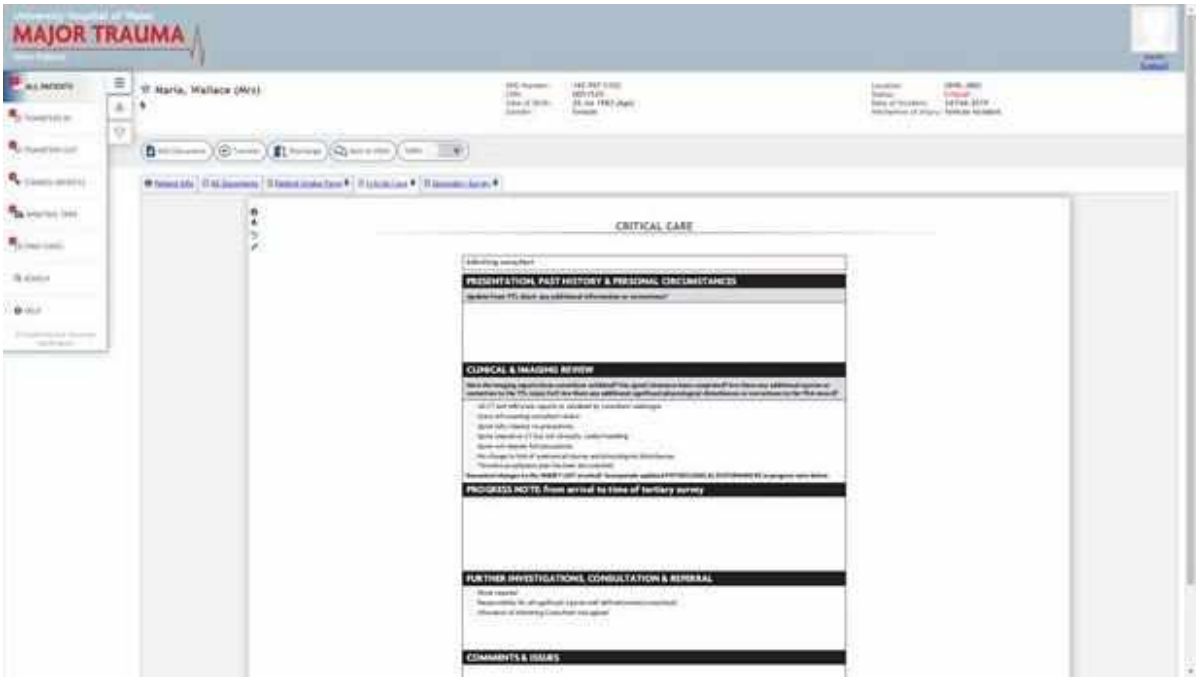
The “All Documents” tab shows a chronological list of all documents that have been added to the

patient record, showing the type of document, when it was created and by whom, when it was last updated and by whom, and a brief textual summary of the document. Clicking on an entry will open the document in its entirety.

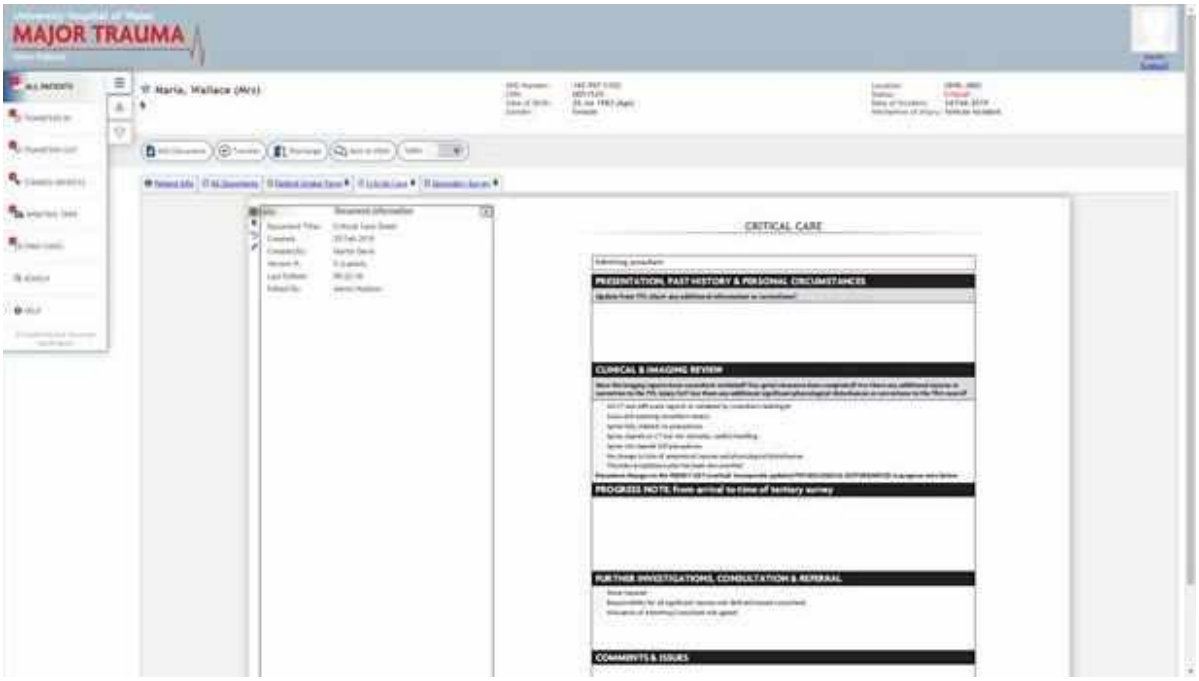


Document View

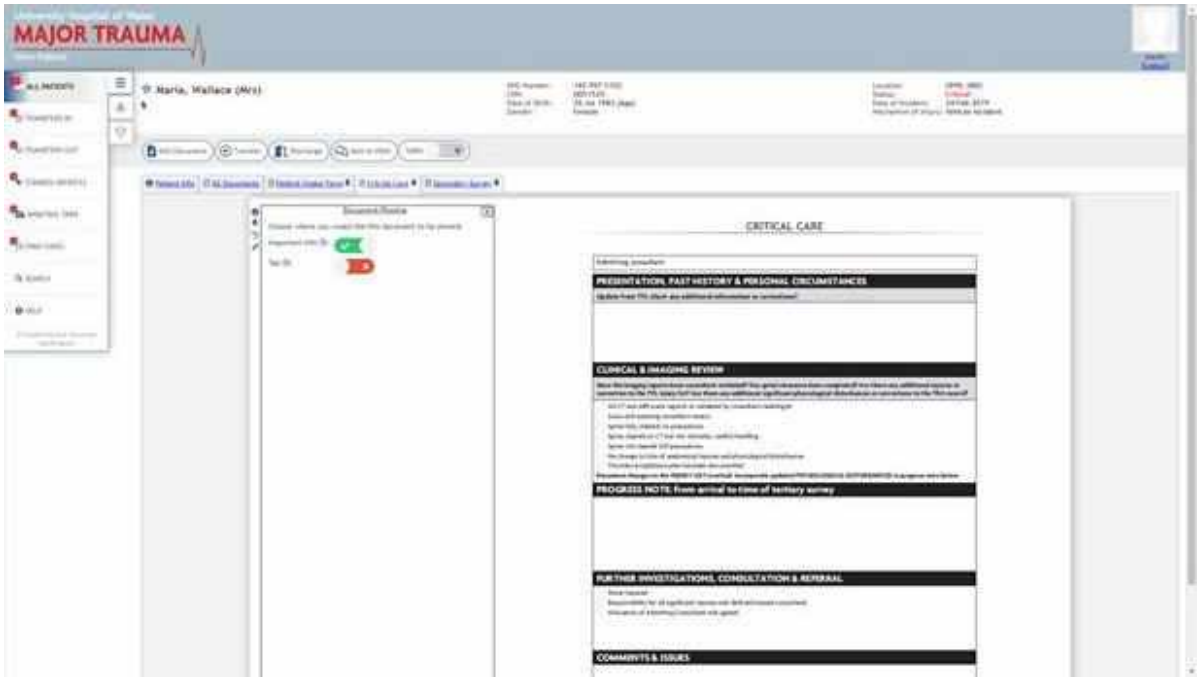
This shows a document in its default read-only state. There are a series of small icons on the left of the document that allow you to interact with it…



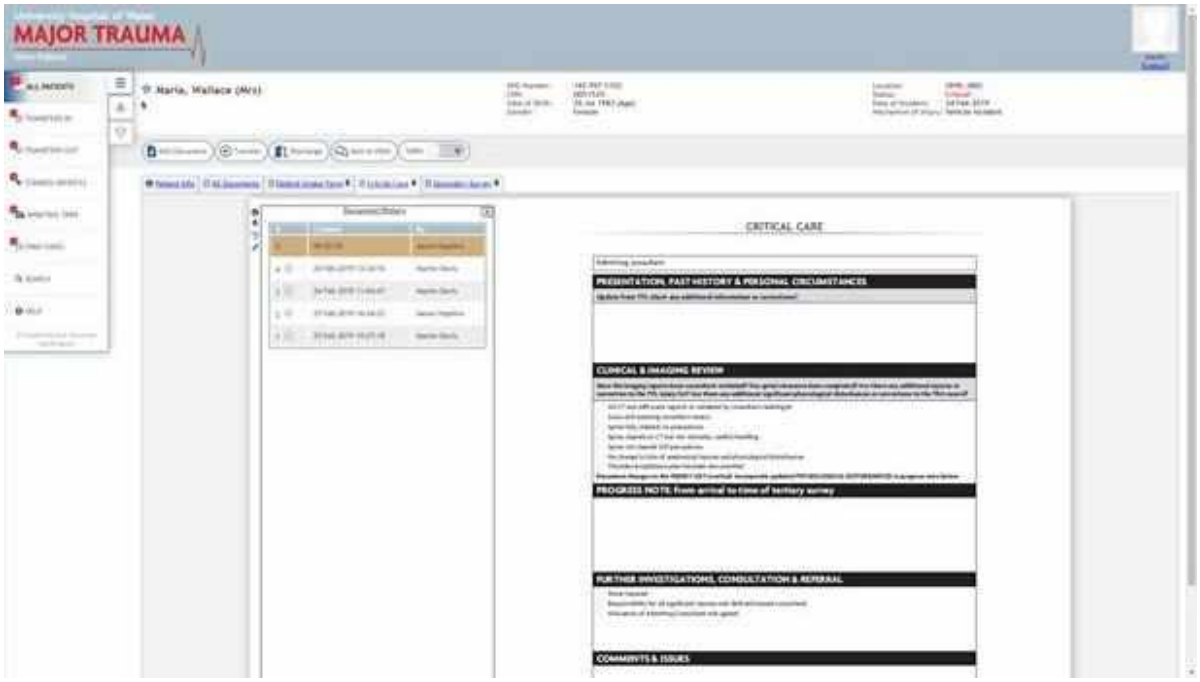
…clicking on one opens a small side panel to show additional information. The first icon provides a brief summary of the document activity – i.e. author, editors, number of versions, etc.:



The second allows you to control whether the document appears as a tab or important document on the patient record:

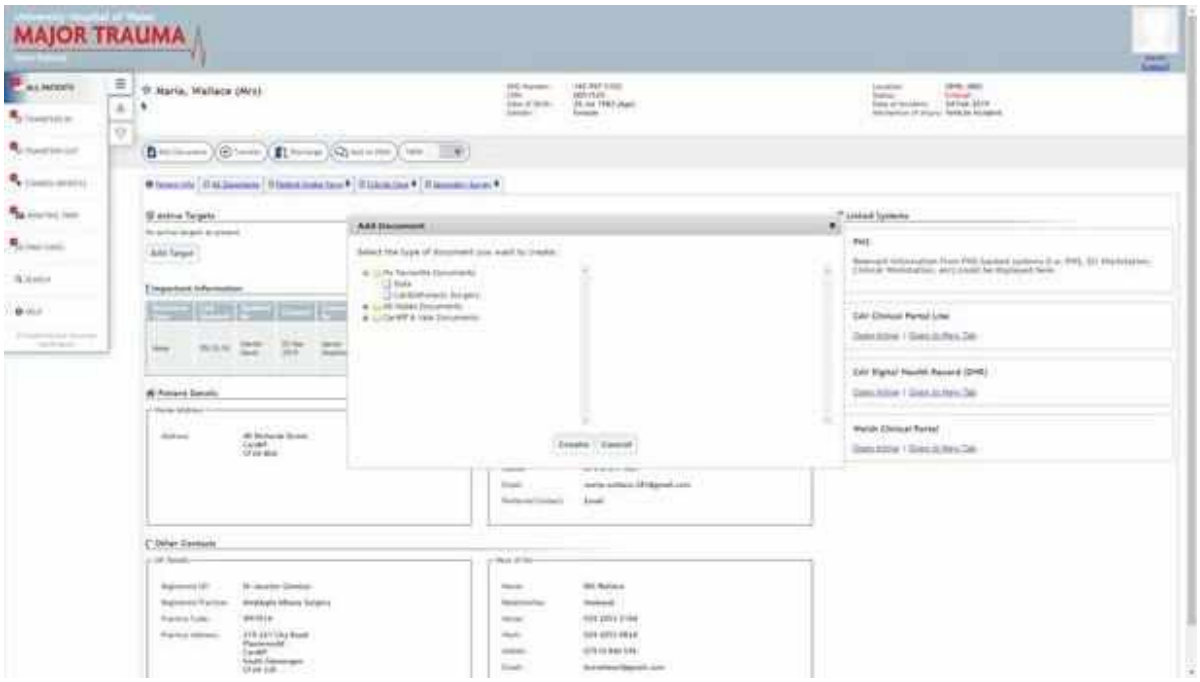


The third shows you a list of all edits that have been made to the document, and allows you to quickly view an older version so you can see what the document looked like at a given point in time. The final icon allows you to open the document for editing.

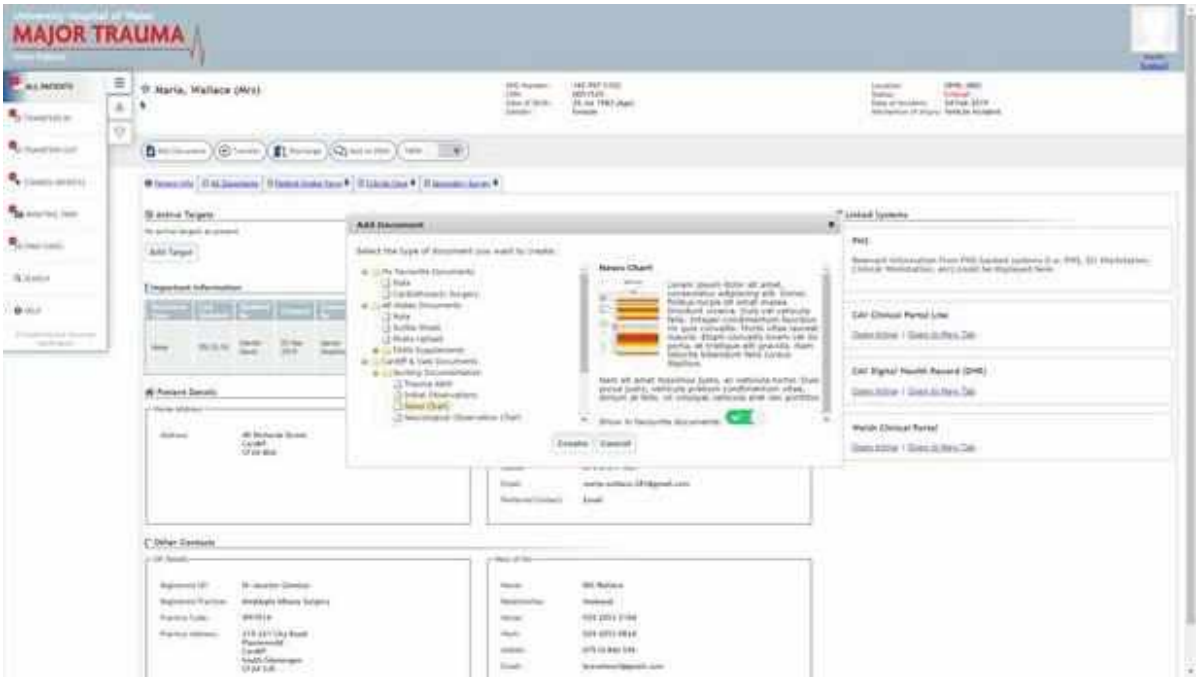


Adding a Document

From the main patient record, the “Add Document” toolbar button allows you to add a new document to the patient record. The expectation is that there will be many different document types available in the system, so they will be presented in a hierarchical/grouped fashion to make it easier to find what you’re looking for. Document types that you use a lot can be added to a “favourites” list, which is presented first, to save you having to go hunt for them.



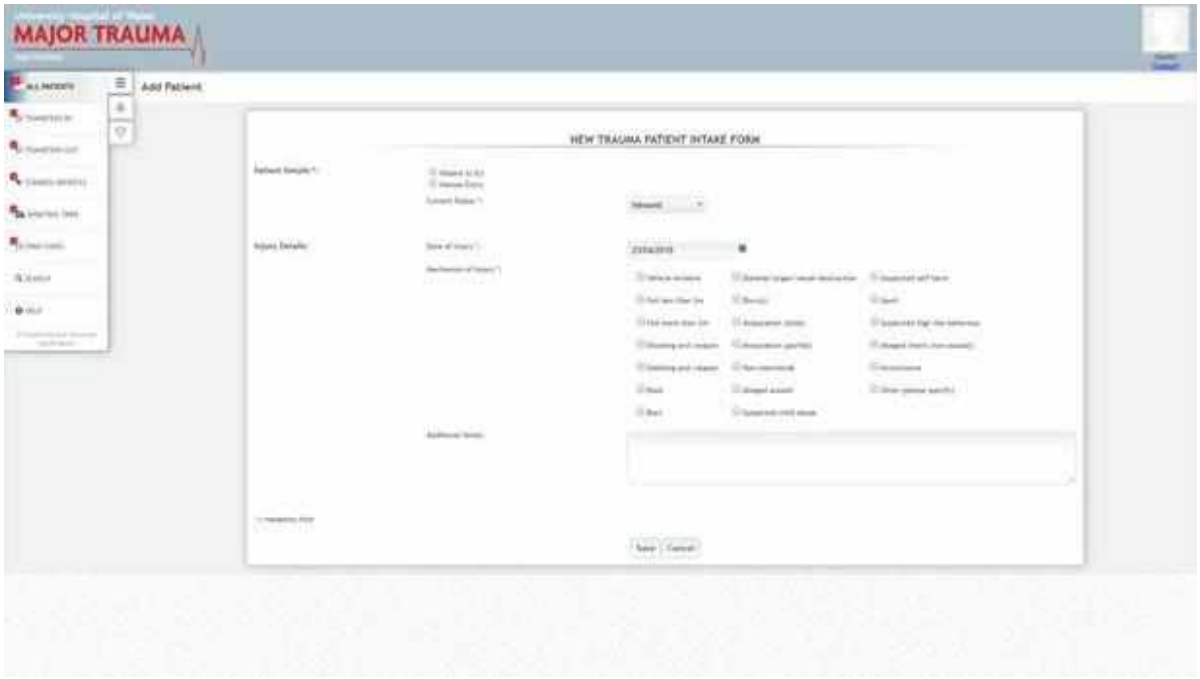
Selecting a document type will show you a small preview of that document along with a description of what the document is and how it should be used. Clilcking the “Create” button will create a new document of the selected type, and take you to it in edit mode.



The term “document” might make you think of flat word-type documents, but they don’t need to be – a document can be anything that contains patient-related information, and can be as interactive as needed. Below is an example of a “Scribe Sheet” document, which is used to capture activity in a busy setting (i.e. in resus, which doctors attended, which medications were given, etc.). Activity is written into the small text box on the left of the screen (which grows, as necessary, as you type in it) and when the [Enter] key is pressed, the text is transferred to the right hand pane where it is automatically time stamped and attributed to the author.

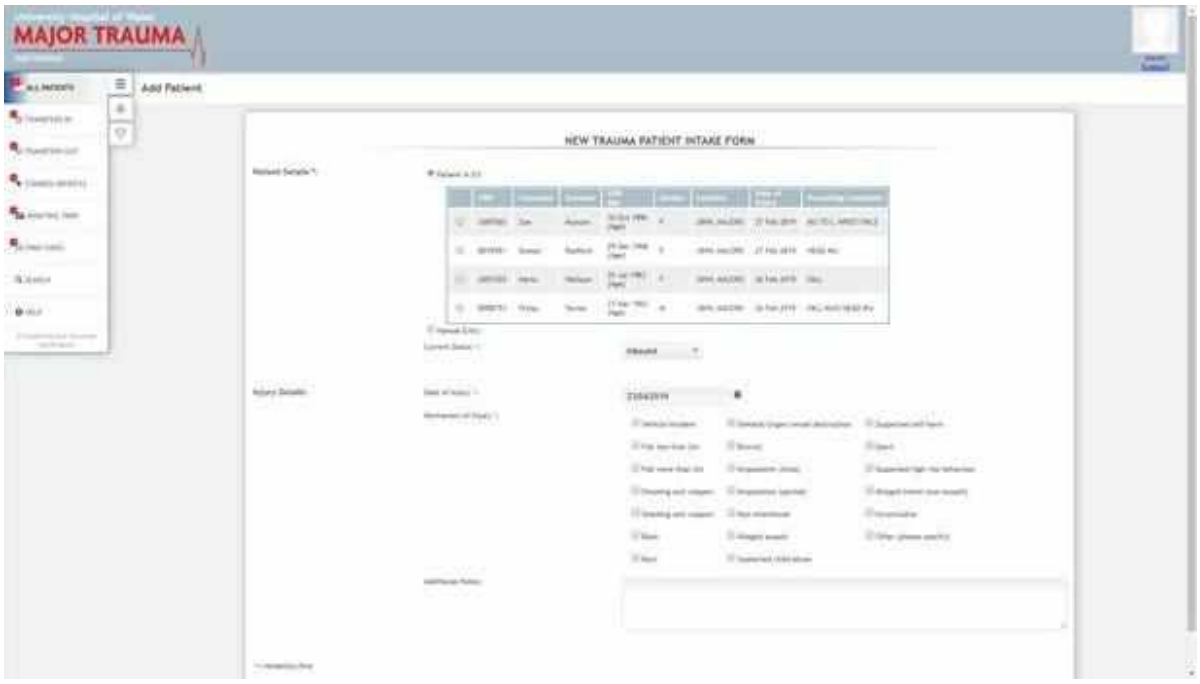
Add Patient

Adding a patient to the system (from a toolbar button on any patient list) also creates a document, and shows how integration with other systems can be achieved within the document paradigm. Initially presenting a simple form to capture the details of the patient and the circumstances surrounding their injury, it can expand to show information from related systems.



If you're adding the patient after the fact (i.e. the patient has already arrived in the emergency unit)

you can quickly view a list of patients currently recorded in the underlying EU system, and pull across their demographics and other related information:



If you're adding a patient in response to a call from the ambulance team, you can free-text in the patient details that are known and use that to search the underlying PAS to find a matching record (giving access to GP and next of kin information, etc.):

Appendix 3 – PKB proposal

Pricing proposal for Wales Major Trauma Network

June 2019

Patients Know Best (PKB) standard price for departmental deployments would be £30,000 per annum. For the Major Trauma Centres (MTC), PKB have agreed a price of £10,000 per annum. This includes major trauma patients who are treated at a MTC who then may be repatriated/transferred. Any receiving site within each network could also be set up with a team for access to these transferred/repatriated patients.

Any major trauma unit also wishing to register their own patients on PKB would be charged an additional £2,000 per annum.

The breakdown of this would be as follows:

Site	Price per unit	total
MTC	£10,000	£10,000
X8 Major Trauma Units	£2,000	£16,000
Total	-	£26,000

All prices are exclusive of VAT.

Cardiff and Vale University Health Board Business Case

Title	Adult and Paediatric Combined Major Trauma Centre Business Case		
		Date Last Updated	30/10/2019
Accountable Executive	Abigail Harris, Director of Strategy and Planning	**Lead /Project Manager** **Clinical Lead**	Victoria Le Grys, Programme Director Dr Melissa Rossiter
Clinical /Service Board or Department	Specialist Services Clinical Board/Strategic & Service Planning Department		

1. Executive Summary

Annual Revenue Requirement	**Current Year 2019/2020 (£000)**	**2020/2021 (£000)**	**2021/2022 (£000)**
Adult MTC	921.80	10,098.51	10,593.61
Paediatric MTC	0	480.60	628.60
Total revenue	**921.80**	**10,579.11**	**11,222.21**
Capital Requirement	**£5,426,295**	Theatre – tbc Polytrauma expansion - tbc	

1.1 Overview

This business case seeks approval to invest in services across the Adult and Paediatric pathways of care for seriously injured patients treated at Cardiff and Vale University Health Board (CAV UHB) in order to establish a combined Adult and Paediatric Major Trauma Centre (MTC) for the South Wales Trauma Network in April 2020.

The MTC business case sets out areas where both capital and revenue investment will be required in order to meet both national Adult & Children's MTC quality indicators and/or capacity for a predicted activity uplift.

The case has been separated into two distinct sections (7 & 8) covering Adult and Paediatric MTC requirements. Where possible, proposed models combine investment across both adult and paediatric patients in order to minimise cost impact.

Each section has an overview of each core specialty in the patient pathway identifying current models of care and a proposed model based on meeting the relevant MTC quality indicators over years 1 and 2 as well as meeting the predicted activity uplift.

The case for increased provision should be considered in relation to delivery of the MTC standards for the totality of the Major Trauma activity. Where there are requirements to increase service provision relating to activity only this has been clearly identified in the specialty section of the case.

1.2 National Major Trauma quality indicators

A review of Trauma Unit (TU) standards demonstrates that CAV UHB already meet, 86% of the national TU standards. A plan has been developed as a part of the local IMTP process in order to meet the remaining 4 standards and is currently going through local Health Board Processes.

A gap analysis identified that a number of MTC quality indicators are currently achieved by CAV UHB as a regional specialist centre including access to Neurosurgery, Interventional Radiology and Spinal surgery. Those not met are listed in section 5.5. The case sets out each section clearly identifying related quality indicators and the proposed model to meet these standards.

Note: Resources for Plastic Surgery are not included in the MTC case and are within the case for specialist services submitted by Swansea Bay University Health Board.

1.3 Activity summary

Section 5.2 sets out the current and expected activity that has been used as a basis for service planning. This was taken from an agreed set of data assumptions commissioned by the Wales Trauma Network and signed off at Network Board in February 2019. This modelling utilised NWIS and TARN data as well as observed changes in English Network flows to provide a predicted model for the whole network to use in planning.

In relation to University Hospital of Wales (UHW), current activity is modelled at 385 Major Trauma patients and 164 moderate trauma. The first year predicts an overall uplift of 294 candidate major trauma patients coming from other Health Boards within the Network. This can be broken down into 193 Major Trauma patients with an additional 101 patients classified as 'overtriage' in the first year after go live. This equates to a 50% uplift in Major Trauma patients with a 35% overtriage rate.

Further specialty level activity modelling has been challenging to obtain due to the complex nature of the clinical injuries and pathways for this patient group and lack of TARN data submitted across all of the Health Boards.

1.4 Financial summary

The Health Board believes that the costs identified represent the minimum current investment that is required to allow the Health Board to deliver the additional modelled volumes and standards expected of an MTC with appropriate phasing as supported by external peer review and scrutiny.

It is expected that the costs within the case will present a loss when reviewed against income comparisons from NHS E. This is comparable to other MTC designations. Two similar combined Adult and Paediatric MTCs in Oxford and Southampton both confirmed they launched with a gap between costs required to go live as an MTC and the expected income through activity and Best Practice Tariff.

This is also evidenced in standalone Paediatric MTCs where incidence of Major Trauma are small and, therefore, income related to this, not sufficient to support the delivery of MTC standards.

1.4.1 Efficiencies

The modelling within this document is based on current efficiencies and working practices. Further opportunities to deliver improvements in productivity and efficiency within the major trauma patient pathway through new ways of working and streamlined patient pathways have been reviewed and it is agreed that there has been significant work undertaken by the Health Board to date and any further efficiencies may not be realised immediately.

Anecdotally, there is recognition that other MTCs in England have delivered improvements in efficiency such as theatre times and in some specific patient groups, length of stay. It should be noted that these improvements have been realised five years post implementation and networks and systems develop and improve.

A review of LOS efficiencies was undertaken as part of a review of the proposed Polytrauma Unit. Published evidence shows that a reduction in LOS was not seen in the English MTC's post MTC launch and introduction of an automatic acceptance and repatriation system (C Moran, 2018). Therefore, starting with a bed base that is lower than the modelled 50th percentile is a risk for MTC capacity upon go live and agreements for increase in bed capacity in year will be required.

The design and delivery of service improvements will form a fundamental part of the on-going clinical governance of the MTC. Service improvements will be informed by and defined at a network level. Post implementation service efficiency and productivity will also be reviewed via benchmarking with other Centres.

1.4.2 Adult MTC revenue

Revenue Costs	In Year 19/20		Day 1 20/21		2021/22	
Summary	**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Specialty						
MTC Directorate	4.2	59.7	8.5	440.9	8.5	440.9
Emergency Unit	9.1	151.4	15.8	1238.6	26.3	1965.7
Radiology	0.0	0.0	8.0	417.0	8.0	417.0
Theatres and Anaesthetics	21.6	343.8	26.4	1674.5	26.4	1442.5
Acute Pain	0.0	0.0	0.0	0.0	0.0	0.0
Critical Care	0.0	0.0	26.9	1787.8	26.9	1787.8
Poly Trauma Ward	38.9	233.4	55.9	2637.3	55.9	2637.3
Trauma & Orthopaedics	3.5	103.7	5.5	528.4	5.5	528.4
Spinal surgery	0.0	0.0	0.0	0.0	0.0	0.0
Vascular surgery	0.0	0.0	0.0	0.0	0.0	0.0
General Surgery	0.0	0.0	2.1	178.4	2.1	178.4
Maxillofacial Surgery and ENT	0.0	0.0	0.0	0.0	0.0	0.0
Neurosurgery	0.0	0.0	1.0	55.1	1.0	55.1
Thoracic Surgery	0.0	0.0	1.0	134.0	1.0	134.0
Rehabilitation	2.0	29.8	19.5	1006.5	19.5	1006.5
Total	**79.3**	**921.8**	**170.5**	**10098.5**	**181.0**	**10593.6**

1.4.3 Paediatric MTC revenue

Revenue Costs	In Year 19/20		Day 1 20/21		Day 1 20/21	
Summary	**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Specialty						
MTC	0	0	0.1	12.6	0.1	12.6
Emergency Unit	0	0	5.3	323.90	7.3	471.90
Radiology	0	0	0	0	0	0
Theatres	0	0	0	0	0	0
Acute Pain	0	0	0	0	0	0
Critical Care	0	0	0	0	0	0
Ward	0	0	0	0	0	0
Rehabilitation	0	0	2.9	144.1	2.9	144.1
Total	**0**	**0**	**8.3**	**480.60**	**10.3**	**628.60**

1.4.4 Capital costs

In line with a phased implementation approach there are developments within the current timelines that are an absolute requirement for operational readiness and those that can be safely enabled once the MTC is operational; the former are listed below:

1. Sufficient adult resuscitation capacity
2. Additional theatre capacity
3. Poly Trauma Ward capacity
4. Uplift in Critical Care capacity

Accepting that not all the capital and estates timelines are aligned to an April 2020 'go live', an assessment of alternative solutions to each of the absolute requirements for operational readiness has been discussed at the MTC Project Board, UHB Management Executive and Network Board.

It has been agreed that the solutions proposed for all workstreams are acceptable in principle, as a solution for year 1 starting April 2020. With this in mind there will be a requirement for a release of funds 'in year' in order to begin the capital works. Along with these, equipment costs have been identified, and together these are detailed in the table below. These have been submitted to Welsh Government for consideration.

Year 1

Area	Cost
Emergency Unit - Resuscitation bay Equipment costs Extension, resus, streaming and triage bay refurbishment Room alterations to provide additional minors capacity	£133,975 inc VAT £436,440 inc VAT £150,000 inc VAT
Interim refurbishment of Poly trauma Unit (PTU) 14 beds Equipment	£1,108,880 inc VAT £383,000 inc VAT
Critical Care bed expansion – Equipment only	£194,000 inc VAT

Theatres – Capital equipment inc plastics	£1,100,000 inc VAT
Theatres - Image Intensifier	£120,000 inc VAT
Replacement CT Scanner for EU Room requirements	£1,200,000 inc VAT £600,000 inc VAT
Total Cost required Inc. VAT	**£5,426,295**

Year 2

Theatres

In order to ensure sufficient operating capacity, a Capital business case is being developed, alongside a programme of work for Vascular services, to deliver a new theatre from April 2021. This will deliver a dedicated operating space to ensure that Major Trauma cases can be treated safely in a timely manner as the activity increases, and to meet all national guidelines and standards.

Timescales for submission of the case are:

February 2020 – OBC

September 2020 – FBC

Construction completion – June 2021

Polytrauma Ward

In order to ensure that the Polytrauma Ward meets standards including IP&C there will be a requirement to expand across into the other half of the planned ward. There will be no additional revenue costs associated with this. A separate BJC will be submitted to Welsh Government in year 1.

Area	Cost
Major Trauma Theatre	Construction – tbc Equipment costs - tbc
Poly trauma Unit (PTU) Expansion	Construction – tbc Equipment costs - tbc
Total Capital cost required	**tbc**

1.5 Workforce summary

Additional staff across a number of professional groups will be required to establish CAVUHB as a MTC in April 2020, with the largest groups being Nursing, Healthcare Support Workers and Medical Staff. Whilst MTC status should attract and help to retain staff not only to the MTC but to the Network, it is recognised that this is a significant challenge to the delivery of the MTC by April 2020. In addition, CAVUHB recognises the potential impact upon recruitment and retention of staff in other Health Boards and thus is committed to collaboration as part of a network to ensure that skills and development of staff can be maximised within the network. There is a network workforce group supporting development of recruitment plans and this will include a number of cross –UHB joint

appointments and rotational posts to ensure that skills and training can be maximised across the network.

A full time recruitment support post has been recruited to, supported by the head of workforce and OD to drive the recruitment strategy and ensure Clinical Boards are supported fully throughout the recruitment process.

An overview of the CAV UHB workforce planning is presented in section 12. The below table sets out an overview of staff groups.

Staff Group	WTE
Medical Staff	29.5
HCSW	37.65
Registered Nurses	85
AHPs, Scientists & Techs etc.	27.5
Admin and Clerical	11
Total	**191**

1.6 Benefits and Risks

There are a number of risks in relation to both the delivery of the Network and MTC. Network risks are set out in Management chapter of the Network Programme business case. The MTC benefits and risks include significant risks related to workforce and capacity detailed in section 7.

In considering this case, the risks to go live should be carefully considered against the benefits that have been highlighted.

1.7 Planning and Assurance Process

Planning Process for specialties

This case has been developed with strong involvement from all core specialities. Service Planning Templates have been completed by each of the Directorates at CAV UHB along with face to face meetings with the MTC project team. Where possible benchmarking has been used and in addition to this a number of MTC visits have taken place to take learning in the set-up of services. This has supported the Directorates to review their current service and supported planning against:

1. The expected increase in activity following Network 'go live'
2. The relevant National MTC Quality Indicators.

The planning templates completed covered both Adult and Paediatric indicators. However a separate template was completed by the Paediatric team and signed off by Women and Children's Clinical Board for indicators specific to Paediatric Major Trauma.

Internal assurance and approval

In order to provide assurance to the Network Board, WHSSC and Welsh Government that the MTC components of the Network Programme Business case have been internally scrutinised the following were agreed and have taken place:

1. Clinical Board sign off

Completed templates have been reviewed and signed off by the relevant Clinical Board. By signing, the Board provided assurance that due diligence has been undertaken in completion of the template, and that the revenue implications of the pathways are understood and relate solely to the national MTC Quality Indicators for the totality of Major Trauma patients and/or uplift in major trauma activity.

2. CAV UHB Executive Assurance panel

A panel was convened to ensure overarching scrutiny and assurance of Clinical Board elements of the business case before it was submitted to an internal Major Trauma business case approval group.

3. MTC Business Case Approval

Final internal sign off of business case at combined Major Trauma Project Board/ Business Case Approval Group meeting.

4. Further Business case revisions based on external feedback

A number of external reviews of the case have now taken place and all feedback has been considered by Clinical Boards and submitted for discussion at an Executive UHB panel. The changes following feedback are highlighted in green in the financial tables of the case.

5. Executive Scrutiny Panels

There have now been 3 panels convened who have reviewed each round of revisions to the case and provide any further challenge and scrutiny as well as discussions around assurance and risks to revisions and reductions to areas of the MTC case.

2. Introduction and Background

In March 2018, all 6 regional Local Health Boards fully endorsed the recommendations of an independent expert panel review, which indicated that:

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

The main purpose of this business case is to establish the need for investment in CAV UHB as a part of a wider Network Programme Business case against agreed MTC standards and activity which will:

- Enable the delivery of a Major Trauma Centre in April 2020
- Enable the delivery of a Major Trauma Network for South, West and Mid Wales
- Improve survival rates for seriously injured patients
- Improve longer term outcomes for seriously injured patients
- Have a positive impact on the wider health system in Wales

Initial work delivered at Cardiff and Vale UHB:

- Designation of CAV UHB as the MTC following a tendering process
- Develop an initial understanding of organisational changes to meet the specification
- Develop an understanding of the financial consequences of taking on major trauma designation
- Produce initial analysis of UHW's compliance with the national MTC specification and Quality Indicators
- Delivery of immediate investment to recruit into key leadership roles as well as MT nurse practitioners and submission data to TARN
- Development of a Major Trauma Centre Project Board and Steering Committee
- Development of a Major Trauma Directorate within the Specialised Services Clinical Board

3. Summary Strategic Context

Trauma is the leading cause of death among children and young adults aged 44 years and under.[1] After a number of reports documenting poor and inconsistent standards of UK trauma care, the NCEPOD report Trauma, Who cares? was published documenting a number of recommendations in 2007. These included the establishment of major trauma centres and regional trauma networks. These recommendations saw the roll out of Major Trauma Networks in England in 2012 followed by Scotland in 2018.

The development of the trauma network aligns itself with a number of national drivers specific to Wales, as summarised below[2]:

- **1000 Lives Improvement** – with a focus on 3 areas: Enabling the NHS and social care to deliver sustainable, seamless and person centred pathways of care, use patient safety as a driver to reduce variation, inequity and harm in care delivery and increase quality improvement capacity and capability.
- **NHS Wales Service Change Plans** – NHS Wales is undergoing a series of changes focusing on the reshaping of acute clinical services, with the view to changing the delivery of some services. This includes centralisation of specialist care (e.g. for patients who sustain cardiac arrests and regain a pulse), with the rationale of delivering improved clinical outcomes and ensure services remain sustainable in the face of challenges in the medical workforce. LHB specific examples include Hywel Dda University Health Board plans for Transforming Clinical Services and the development a single acute hospital in Aneurin Bevan University Health Board.
- **National Programme for Unscheduled Care** – The aim of this is to redesign unscheduled care processes across the total patient journey and to alleviate pressure within the system including the current programme work being undertaken by the National Collaborative Commissioning Unit (e.g.

[1] https://www.wales.nhs.uk/ourservices/unscheduledcareconditions/trauma
[2] Network Programme Business case (draft) 2019

the Emergency Department Quality and Delivery Framework).

- **A Healthier Wales: Our Plan for Health and Social Care (2018)** The aims of this paper are to provide health and social care services in the future that includes:
  - When people need help work with them and their loved ones to find out what is best for them and agree how to make those things happen - 'person- centred approach';
  - Will use the latest technology and medicines to help people get better, or to live the best life possible if they aren't able to get better.

More specifically, there are clear links between the establishment of a MTC and CAV-UHB Strategic Goals in its *Shaping our Future Wellbeing* Strategy 2015-2025. The Strategy sets out objectives that link directly with the delivery of a MTC:

1. Reduce Health inequalities
2. Have an emergency care system that provides the right care, in the right place, first time
3. Be a great place to work and learn
4. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology
5. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives.

4. The Major Trauma Centre role within the wider Network and opportunities for Collaboration

As a part of its role within the network, it is crucial that the MTC effectively collaborates with all other organisations within the trauma network system in order to ensure benefits for patient's right across the pathway.

Experience in England has demonstrated that Trauma Units have over time become deskilled in major trauma. This is a situation that the South Wales Trauma Network is keen to avoid and the role of the MTC will important in supporting and developing the network as it matures. The Major Trauma Centres key role and responsibilities are set out in the 2013 Major Trauma Service Specification (D15/S/a) and in relation to support and collaboration within the wider network include:

Clinical advice & leadership roles

The MTC will provide clinical advice to other providers within the network. This will include; in pre-hospital stage and whilst patients are awaiting transfer to the MTC for definitive treatment or following acute care when the patient is discharged to on-going specialised or local rehabilitation services.

There are a number of roles within this business case that will be key enablers to ensure that effective advice and support is available 7 days a week. These include, Trauma Team Leaders, Advanced Nurse

Practitioners and Rehabilitation Consultant, Consultant AHP and Coordinators. The MTC recognises the value of sharing experience across the Network and is committed to the provision of posts which allow for rotation through both TU's and the MTC. There are clear opportunities within the Rehabilitation posts for providing outreach and support to TU's.

Training, Audit & Quality Improvement

The MTC will commit to being actively engaged and contributing to the Trauma Network, particularly in operational requirements, training, governance and audit. The MTC has a role to ensure that all organisations within the network are actively engaged and supported as a part of and effective trauma Quality Improvement programme.

There are a number of opportunities for the MTC to act as a hub for training provision within the network working with the Network lead for training. This will be vital to minimise impact of deskilling in local Trauma Units over time.

This includes the development of leadership and faculty for key 'in house 'training programmes including Trauma Team Leader and Trauma Team member, nursing and scribe training as well as ward skills and rehabilitation. There is also an opportunity to develop outreach programmes to deliver training locally and host annual events similar to those delivered by other MTC's within England and Scotland.

Trauma Team Leaders working as a part of a network model, will also be key to the continued development of trauma team skills within trauma units. These shifts within the MTC will provide clinicians working in TU's with regular exposure to trauma cases (see below).

Rotational posts & joint appointments

Joint appointments in key areas will be considered in order to ensure the development of the MTC does not destabilise other Health Boards services and this is aligned with the principles of workforce recruitment into to the MTC. This will bring benefits to the wider network, which CAVUHB is committed to as part of its critical role in the network.

There is also an opportunity for rotational posts within the Polytrauma Unit. This would include staff employed both within CAV UHB and within Trauma Units to ensure expertise can be spread to the network. The Polytrauma Unit will be key in providing delivery of training and up skilling staff in the definitive care of seriously injured patients.

The ability for Major Trauma Practitioners and Rehabilitation coordinators from around the region to spend time in the MTC will ensure that good links can be made between teams that will support the effective flow of patients within the Network

Audit and Quality Improvement

The additional TARN coordinator roles within the business case will support the timely and quality entry of a large percentage of network data into the National Audit. In turn, this will be key for developing an audit programme for the centre, which develops in collaboration with the network and organisations within it. There is also a role for TARN coordinators at the MTC to support colleagues within the network in relation to training and development.

Rehabilitation

The MTC will provide early/hyper acute rehabilitation as well as a managed transition to rehabilitation and the community. Key roles within this case such as the rehabilitation consultant, Consultant AHP, lead therapist & nurse for Major Trauma as well as Psychologist will integrate into the network to support wider programmes of quality improvement, training and education.

Collaboration with other specialist services

There are a number of interdependent services and specialties required to work in partnership to deliver seamless and high quality care. In particular, the services delivered for Major Trauma patients with orthoplastic requirements will need close joint working between CAV UHB and SB UHB to ensure the care delivered is to an excellent standard regardless of where the patient is treated. It is proposed that one of the Major Trauma Practitioners will be recruited with an interest in Orthoplastics to ensure a strong link with the Regional Centre for Burns and Plastics in Morriston and enabling collaborative rotational working, training and education between the two centres.

Patient flow and access to services

The MTC is committed to ensuring that patient flow is maximised to ensure that quality benefits set out in section 6 of the case can be realised. This includes commitment to an automatic acceptance policy ensuring 24/7 access to specialist services. It is essential this is aligned with an automatic repatriation/transfer of care policy.

The MTC also supports a network approach and its role in the delivery of care closer to home following completion of the MTC phase of treatment. This includes clear and timely information to both LHB's, patients and their families as well as a clear point of communication including escalation so that patient flow can be maintained, pull back to the originating HB is promoted and patient experience is maintained.

The MTC will take part and lead in governance around this which includes collecting accurate and timely data so that this can be utilised to inform governance and recognises the importance of the ODN having operational authority in the escalation processes and that commissioning will support this in a timely way.

5. Summary Current Service Provision

5.1 Overview

This section sets out the current activity assumptions for CAV UHB as a specialist provider as well as factors impacting on current activity. It provides an overview on capacity assumptions as well as an overview of MTC and TU quality indicators not currently met by the UHB.

Lastly it helpfully sets out a brief comparison to other UK Major Trauma Networks, the current pressures on the system and changes that have taken place since these networks went live in 2012.

5.2 Activity assumptions

CAV UHB currently receives and treats around 40% of all Major Trauma (ISS>15) patients within the network region. This equates to approximately 300 cases, with a further 200 cases treated who are moderately injured (ISS 9-15). Network modelling suggests that in its first year as an MTC CAV UHB will treat 54% more patients, an additional 294 candidate trauma patients. These candidate Major Trauma patients can be broken down into 2 categories, Major Trauma (ISS>15) and moderate trauma (ISS 9-15) which is often described as 'false positive' or 'overtriage'. Year 2 and 3 data modelling suggests a smaller incremental increase in activity. See Figure 1.

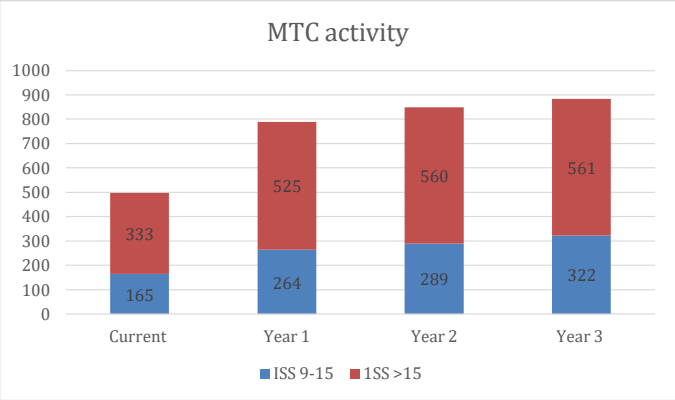


Figure 1. Predicted activity increase to the MTC Years 1 – 3, Predicted data activity for the Wales Trauma Network 2019

Network data analysis shows changes in network flow in the first three years with the number of patients bypassing directly to the MTC rather than transferring increasing as the network develops. Figure 2.

ISS 9-15 – moderate	Assumed current position	Year 1	Year 2	Year 3
Direct to MTC	154	206	231	256
Transfer TU to MTC	11	58	58	66
% TU only	660	561	536	503
Total	825	825	825	825
ISS >15 – major	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	284	306	341	368
Transfer TU to MTC	49	219	219	193
% TU only	542	350	315	314
Total	875	875	875	875
ISS >9 – candidate	**Assumed current position**	**Year 1**	**Year 2**	**Year 3**
Direct to MTC	438	512	572	624
Transfer TU to MTC	60	277	277	259
% TU only	1202	911	851	817
Total	1,700	1,700	1,700	1,700
Combined Direct to MTC & Transfer TU to MTC	**498**	**789**	**849**	**883**

Figure 2. Predicted change in activity flows for Network, Predicted data activity for the Wales Trauma Network 2019

In relation to predicting activity by predominant specialty, this is a challenge that is recognised nationally. Due to the complex nature of the clinical pathways and the lack of TARN data submitted across all of the health boards it is difficult to predict the predominant specialty of patients with multiple trauma including impact on specialties in terms of workload in theatres. Discussions (supported by Professor Moran) with other MTC's in England and benchmarking against Nottingham and Bristol MTC's show that this increase is variable but that a large percentage of the increased workload impacts on Trauma and Orthopaedics. This is reflected in the case and will be reflected in the theatres utilisation plan.

5.2.1 Paediatric MTC activity

The predicted uplift in paediatric Major Trauma cases is shown a as 'sub set' of the above data and is shown in figure 3:

	Assumed current position	Year 1	Year 2	Year 3
ISS 9-15	22	27	30	33
ISS >15	53	55	56	60

Figure 3. Predicted data activity for the Wales Trauma Network 2019

There are significant problems with the paediatric data captured in TARN in relation to:

1. Capturing all paediatric trauma cases. The TARN database only includes data from patients who have a length of stay greater than 3 days. From data collected in England it is recognised there are a number of patients with ISS 9-15 & ISS >15 who have a LOS < 3 days. For this reason new inclusion criteria for TARN is being piloted in a number of MTC's in England at present.

2. The injury severity score (ISS) is an adult tool that fails to accurately reflect the pattern of paediatric injuries.

We can therefore assume that activity may be more than predicted, as reflected by experiences within the Bristol Royal Hospital for Children, and shared at the Wales Trauma Network Peer Review panel, August, 2019. This will need to be monitored by adding to TARN those cases with a LOS <3 days. Whilst there is a national piece of work being led by the Trauma Audit Research Network to include these patients in future, currently these cases are not currently being reflected in any performance indicators (i.e. quality dashboards, survival rates).

During the first year an analysis of TARN data will be undertaken by both the network and MTC to assess both under and overtriage of patients for transfer to the MTC. This will provide an indication of whether activity modelling in the planning phase was accurate, and allow further planning for year 2.

5.2.2 Activity comparisons to England

The activity flows have a steeper trajectory that those shown in England and therefore activity is less likely to be phased over the 5 years. There are 3 main factors impacting on this:

1. Wales is one of the only areas outside of London with a 24/7 Consultant-led Helicopter Emergency Medical Service meaning that senior decision making at the scene will identify more Major Trauma Patients than without.
2. With the development of Major Trauma Networks within the last 10 years and decision making tools such as the trauma triage tool more widely available, seriously injured patients are more widely recognised by frontline staff including paramedics meaning that there has been an increase.
3. Data completeness in MTCs for the first 1-2 years post go live was more variable in England as systems embedded. Therefore this is likely to have under-represented the actual increase in activity.

5.3 Capacity requirement assumptions – ward beds, theatre sessions and critical care beds

Following the overarching Network data modelling, further local data analysis was undertaken to identify capacity requirements for year 1 (figure 4). This was based both on total numbers but used a number of local data sources including Ward Watcher, TheatreMan and a number of specialty specific clinical databases (e.g. Neurosurgery, Maxillofacial Surgery) plus some specific clinical reviews of LHB TARN data.

Due to the variable nature of unscheduled care activity modelling has necessarily taken account of not only average attendances but peaks in flow (particularly for the Emergency Unit and Theatres) and also current delays for Major Trauma patients accessing theatres.

5.3.1 Ward beds

The table below shows the modelled current and predicted bed occupancy relating to major trauma patients. The number of beds by percentile, shows the number of beds needed for major trauma patients for that percentage of days of the year. For example, it is modelled that for current activity levels 30 dedicated beds would be enough for major trauma patients 50% of the time and that 38 beds would be enough 95% of the time.

Figure 8: Modelled current and predicted bed occupancy (LOS ≥3days)

	Beds Occupied - Current			Year 1			Year 2			Year 3		
	5%ile	50%ile	95%ile*	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile	5%ile	50%ile	95%ile
University Hospital Of Wales	23	30	38	42	47	53	45	50	56	46	52	58

Figure 4. Predicted data activity for the Wales Trauma Network 2019 – excludes critical care beds.

Comparing the beds required for year 1 suggest an increase of between 15 (5th centile) and 19 beds (95th centile) in year 1 with a further 3 beds in year 2. Note that this has been based upon current LOS for all ISS >9 patients at UHW. Published evidence shows that a reduction in LOS was not seen in the English MTCs post MTC launch and introduction of an automatics acceptance and repatriation system. 'Overall median length of stay in acute care was unchanged from initially 10 (IQR 5–21) to finally 9 (5 to 19) days.' (C Moran, 2018). In order to reduce the costs in the case a reduction from 18 beds to 14 beds has been accepted by the Health Board for day 1.

The impact of repatriation within and outside the network will play an important role in determining the efficacy of the Polytrauma Unit and provide mitigation for risks associated with starting with a smaller number of beds than has been modelled. There is an All Wales Repatriation Policy currently in place and the issues around operationalising the policy are well recognised. Whilst it is recognised that work is ongoing at Network level to improve repatriations, this falls outside of the sole remit of Cardiff and Vale and cannot be relied upon to have any definite impact upon length of stay until it is tried and tested.

The largest uplift in patients is expected to occur in the first year particularly as EMRTS has been approved to extend to 24/7 cover in line with the MTN go live. It is anticipated that the uplift in beds and critical care capacity will be needed for day 1. An analysis of the 2018 UHW dataset from TARN provided a baseline for where seriously injured patients are currently being treated in UHW (Figure 6). Around 20% of the current major trauma patients treated at UHW have significant multiple injuries and require polytrauma unit care, this equals 6 beds. As highlighted, it is a challenge to accurately predict activity by specialty. It would not be sensible to apply the percentage uplift to all specialties for example as UHW currently receives the large majority of major trauma patients requiring neurosurgical intervention. After discussion with MTC's in England, it assumed that UHW will predominantly see an increase in patients with multisystem injuries requiring multispecialty input as well as a smaller increase in those patients with severe isolated orthopaedic injuries.

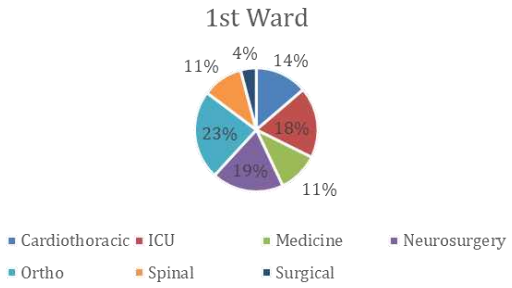


Figure 6. 2018 adult UHW TARN data, first ward.

Paediatric TARN data shows a large proportion of orthopaedic and surgical patients with a much smaller percentage of patients care for under neurosurgical wards. Due to the smaller number of patients predicted in year 1 it is not expected this percentage split will change dramatically but this will be audited.

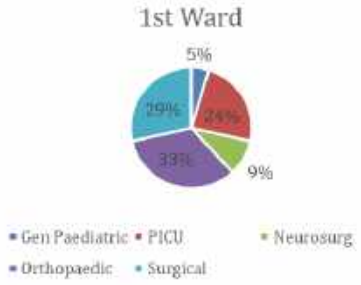


Figure 7. 2018 Paediatric UHW TARN data, first ward

5.3.2 Theatre sessions and critical care beds

It was recognised within the Network data paper that further analysis would be required in relation to impact on Critical Care and theatres. This was undertaken following a LHB review of Ward Watcher.

The table below shows the modelled requirements for current major trauma activity at UHW and compares it to the modelled requirements in year 1 and year 2.

		Current	Year 1	Increase	Year 2	Increase
		Predicted Median	Predicted Median	Increase on 2017-18 (Median)	Predicted Median	Increase on 2017-18 (Median)
Theatre time (weekly)	Cases (patients)	7.8	12.6	4.4	13.0	5.2
	Hours operating	26.7	43.7	14.4	43.8	17.2
CriticalCare	Total Beds	3.0	5.8	2.8	6	3

Figure 5. Local UHB data review April 2019

The modelling suggests that on average an additional 14.4 hours of theatre sessions (median) will be required based on average operating for theatre cases. A review of the range between 5th percentile and maximum from current shows a range of between 6.39 and 9.24 sessions. A total of 9 sessions has been planned to account for increased activity and to protect existing theatres during peak times of activity.

There is further work being undertaken to review where the sessions will be timetabled and against which specialty. It is likely these will be in Trauma and Orthopaedics and CEPOD.

In addition to this, there is a requirement for dedicated Orthoplastics lists in order to meet BOAST 4 guidelines for stabilisation and cover of open fractures. This was supported during a peer review of the plastics components of the CAV UHB and SBUHB case. All day lists are required sue to the complexity of the cases and the frequency (twice per week) are required in order to meet standards for definitive coverage.

Critical care modelling has estimated an uplift by 3 beds. The sections on theatres and critical care, which follow, explain what has been planned for in these areas.

5.4 MTC quality indicators

An analysis has been undertaken reviewing current CAV UHB services against the agreed national quality indicators. Appendix A sets out the gap analysis against these indicators. There are 98 standards in total, 52 adult standards and 46 Children's standards. Whilst there are a number of these standards that are being met of partially met with current activity levels, there are 38 key indicators that are not currently met (note that some below are adult and paediatric indicators) :

1. T16-2B-101/201 – 24/7 Consultant Trauma Team Leader
2. T16-2B -103/203 - Emergency Trauma Nurse
3. T16-2B-107 – CT reporting
4. T16-2B -113 - 24/7 Access to Consultant Specialists
5. T16-2B-115/213 Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries
6. T16-2B-118/216 - 24/7 Specialist Acute Pain Service
7. T16-2C-102 Major Trauma Service (Consultant led)
8. T16-2C-103 /202 7 day Major Trauma Coordinator Service
9. T16-2C-104/203 Major Trauma MDT Meeting
10. T16-2C-105 Dedicated Major Trauma Ward
11. T16-2C-110 /209 Management of Musculoskeletal Trauma including management of open fractures
12. T16-2C-113 /212 Management of Maxillofacial Trauma
13. T16-2C -118/215 Specialist Dietetic Support
14. T16-2C-121/218 - Patient Experience – Trauma Audit Research Network (TARN) PROMS and PREMS
15. T16-2D-101/201 Clinical Lead for Acute Trauma Rehabilitation
16. T16-2D-103 /203 Rehabilitation Coordinator
17. T16-2D-105/205 Keyworker
18. T16-2D-106 /206 Rehabilitation Assessment and Prescriptions

19. T16-2D-102/202 Specialist Rehabilitation Team
20. T16-2D-109 Clinical Psychologist for Trauma Rehabilitation
21. T16-2C-101- Major Trauma Centre lead clinician
22. T16-2C-201 - Paediatric Major Trauma Centre lead clinician
23. New Indicator for 2019 - All patients 65 years or older have a Clinical Frailty Scale completed within 72 hours of admission by a geriatrician.

The ability to meet the above will place CAV UHB in a strong position to deliver the benefits as outlined in the Network programme business case. Similar to MTCs in England, there are a number of indicators that will not be met on day 1 and a phased implementation will be required. They are as follows:

1. T16-2B-201 – Paediatric 24/7 Consultant Trauma Team Leader
2. T16-2B -203 – Paediatric Emergency Trauma Nurse
3. T16-2B-107 – CT reporting within time frames, this will be monitored during year 1
4. T16-2B-216 - 24/7 Specialist Acute Pain Service (for paediatrics)
5. New Indicator for 2019 - All patients 65 years or older have a Clinical Frailty Scale completed within 72 hours of admission by a geriatrician.

5.5 Trauma Unit quality indicators

A review of the 28 TU Indicators showed that all but 4 indicators are already met and funded by CAV UHB.

1. T16-2C-301 Major Trauma Lead Clinician
2. T16-2C-303 Major Trauma Coordinator Service
3. T16-2D-301 Rehabilitation Coordinator
4. T16-2D-303 Rehabilitation Prescriptions

There will be a separate submission via CAV UHB IMTP process to include both time for a nurse practitioner and rehabilitation coordinator for local Cardiff and Vale patients who stay on in UHW following their MTC treatment, they will be responsible for coordinating their care, liaising with community and rehabilitation providers and the provision of rehabilitation prescriptions for the local population.

Whilst there is a TU standard to have a lead for trauma this role will be subsumed within the MTC trauma lead role as is the case with MTC's in England.

5.6 Comparisons to other UK Major Trauma Networks

It is important to draw out the changes that have taken place since the establishment of English Trauma Networks and the key learning that can be taken from these.

English networks were established between 2010 and 2012. Since then, understanding of trauma care has progressed significantly so that the standards expected, and requirements for major trauma patients have

increased substantially. This is reflected in the publication of NICE guidelines and British Society of Rehabilitation Medicine standards along with enhanced national service specifications for major trauma. For example, these now describe a requirement for a dedicated specialist ward which is recognised to contribute positively to patient outcomes and satisfaction. This is also supported by the Peer Review of this case.

Additional lessons learned since 2010 include: Firstly, the recognition of the importance of embedding rehabilitation early in the clinical pathway, both in terms of patient outcomes and also to facilitate flow from the MTC back to the TUs and care closer to home. Secondly, the impact of trauma in older patients. It is recognised that there will be increases in all age groups, particularly in people aged 65-84 and 85+.

Thirdly, there have been changes in the delivery of Paediatric trauma care. Advice from the Network Paediatric Lead following the NHS England Clinical Reference Group (March 2019) was that centres with a mixed model of paediatric/ adult trauma are struggling to deliver consistently on quality of care. In 2012, when most Trauma Networks went live, the sub-Speciality of Paediatric Emergency Medicine was barely established compared with the current widespread and increasing provision in terms of Consultant numbers and scope of practice. Paediatric Trauma is considered an important part of the role of these Consultants and any model of delivery should seek to take account of both this distinct patient group, with differing patterns of injury and specific needs, and the changes in PEM sub-specialisation, in order to deliver the highest standard of care and importantly in order that staff be recruited and retained.

Whilst these changes bring clear patient-centred benefits there is also emerging evidence of value in terms of impact upon length of hospital stay and recruitment and retention of staff. However, developing complex services of this nature, which invest in the whole system in the context of current system demands, necessarily increase requirements for resourcing. The latter is reflected in the disparity of investment seen in the development of Trauma Networks in other devolved nations such as Scotland that recently saw almost £30m of new investment per year.

6. Case for Change

It should be recognised that major trauma patients are already being managed across our healthcare system including in specialist centres; therefore, the development of a trauma network represents a significant service change, but not a new service development. Thus, the programme has been developed based on strengthening existing clinical services through re-organisation, introducing new pathways and enhancing clinical and operational governance. Furthermore, requirements for additional resources have been considered within the context of enhancing existing service specification and improving the standard of care for all Major Trauma patients.

Key benefits are identified using an evidence based approach and lessons learnt from both national and international experience. These are described in detail in the Network Case for change chapter.

The overarching investment objective of a trauma network for the population of South, Mid and West Wales can be summarised by the network's mission statement **'Saving Lives, Improving Outcomes, Making a Difference'.**

Furthermore, key investment objectives defined by Welsh Government are referenced throughout this business case with added value that could be delivered. These include:

- **Health gain**: improving patient experience and outcomes.
- **Equity**: where people of highest health needs are targeted first.
- **Clinical and skills sustainability**: reducing service and workforce vulnerabilities and demonstrating solutions that are flexible and robust to a range of future scenarios.
- **Value for money**: demonstrating the least costly way of generating the anticipated benefits.

Summary of service gaps

The network chapter case for change sets out the service gaps across the network, more specifically the following gaps are identified for CAV UHB as a MTC (those related to MTC Quality indicators are highlighted in section 4):

- There is currently no MTC for Adult or Paediatric patients in the South, West and Mid Wales region.
- There is no single point of access into CAV UHB as a specialist centre for major trauma cases.
- Although there is an All Wales repatriation policy in place, there is currently limited repatriation or transfer of patients to their local hospital following specialist treatment with unnecessary delays for patients awaiting care closer to home.
- Consultant led services are not 24/7 in the Emergency Department phase of the patient pathway.
- There is limited capacity for treating the current number of seriously injured patients who are brought to CAV UHB, this is evident in areas such as the Emergency Unit and theatres.
- There is no dedicated ward or area where multiply injured patients are managed and cared for as a cohort
- There is a lack of consistent coordinated care and clear communication with seriously injured patients and their families/carers.
- There is limited availability and inconsistency in the availability of hyper-acute rehabilitation for seriously injured patients
- Audit data is entered onto the national audit (TARN) but time to submission is not to MTC requirements of 25 days from discharge.
- There is no multidisciplinary approach to governance, quality improvement, research and audit at present.
- Seriously injured patients are not currently provided with any rehabilitation plan/prescription.
- Also, the critical care unit at UHW is recognised as being under strain

In addition to those benefits detailed in the case for change section of the network programme business case, the expected quality benefits for attending the MTC are set out below:

- Patients will receive a service that delivers the highest possible care for patients 24 hours a day, seven days a week
- Reduction of 20% in preventable deaths as measured by the National Trauma Audit Research Network (TARN).
- Improved functional outcome
- Improved patient and carer experience through increased coordination of care and communication around expected pathway and ongoing care plan.

7. Adult Major Trauma Centre

7.1 Major Trauma Directorate

The Major Trauma Directorate will be a newly formed team sitting within and accountable to the Specialist Services Clinical Board. The Directorate Management team will be led by a Lead Clinician, General Manager and senior Nurse. The team will ensure that appropriate clinical and corporate governance structures are in place to realise the philosophy of care to:

"Deliver exceptional care for major trauma patients. This care should be of the highest quality, delivered with respect and dignity in a safe environment. It should be individually tailored for the needs of each patient and will involve their carers and relatives."

The care will be delivered in a coordinated way involving multiple different specialities and organisations across the network.

This management team will be key in leading and developing services across the adult and paediatric Major Trauma pathway including oversight of adherence to national standards, annual peer review and compliance with national performance indicators through a quarterly dashboard. The Directorate Management Team will be required to facilitate patients through the pathway across the whole network and cross border. It is important to highlight that this team will not just support the inpatient stay of an additional 1 uplift or 3 totality of Major Trauma patients per day. The Directorate has a key role in ensuring service and flow through the whole pathways, i.e. follow up, repatriation, escalation, across specialties and organisational boundaries. The team will also provide a lead role in supporting the Network.

There is benchmarking to show that having a separate team for the management of the Major Trauma service is consistent across England. Often the management role is mixed similar to the model we have proposed to combine the role alongside the managerial lead for Critical Care. Not all teams in England have the lead nurses, Major Trauma Coordinators and TARN coordinators sitting within the team but all are funded through MTC income. This is a model which was praised in peer review in Bristol MTC. It's important that the directorate itself is seen as distinctly separate to a single speciality Directorate such as T&O or EU, due to the number of specialties involved in the management of major trauma patients.

Relevant MTC indicators

- **T16-2C-101 -** *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 -103/ T16-2C-202**- *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.*
- **T16-2D -103/ T16-2D-203 -** *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 -105/T16-2D-205 -***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

Workforce required

Clinical Leads for the MTC and Governance (0.4 WTE) are in post and recurrent funding for the 0.3 WTE sessions is included within the workforce plan. The governance session has been reduced to 1 session from go live.

A 0.5 WTE band 8a senior nurse for Major Trauma will be a key member of the Directorate Senior Management Team working closely with the Clinical Director and General Manager. The senior nurse will facilitate a culture of safety and innovation. They will be responsible for the professional direction of Nursing/Clinical services across the Major Trauma pathway ensuring optimum standards of patient care. This includes the implementation of nursing competencies. The lead nurse role will also be the professional lead to all of the registered and non-registered nursing workforce of Poly Trauma Unit and liaising as appropriate with Clinical Boards, other Specialties, other MTCs and TU's to ensure standards of care and delivered and upheld. The Senior Nurse will be responsible for all aspects of workforce for their team including management of sickness absence, disciplinary and capability issues.

Major Trauma Coordination – There are currently 2 WTE Major Trauma Practitioners in post using non-recurrent WG monies for Major Trauma. In total 4.2 WTE band 7 nurse practitioners and 2 WTE rehabilitation coordinators are required to cover both adult and paediatric major trauma patients with the practitioners covering 7 days a week. The rehabilitation coordinator costs can be found in the rehabilitation section of this case. These roles will be key to ensuring effective flow into (non-emergency secondary transfers) and through the MTC as well as providing a crucial role in the coordination and communication with patients, their families and local TUs and healthcare providers.

TARN Audit - 2 WTE band 4 TARN coordinators are required as an uplift on the existing 1 WTE band 5 coordinator to ensure that the increase in data requirements is met and that it is both accurate and

timely. This will ensure that performance against national indicators and survival rates are reliable. All activity should be captured within 25 days of discharge or death as standard for an MTC, as opposed to the current 40 days for a trauma unit. There is a requirement for these posts to start pre go live to ensure all baseline data is entered and that pre go live MTC dashboards can be established.

A General Manager for Major Trauma and Critical Care has already been appointed using non-recurrent WG monies for Major Trauma. From go live 0.5 WTE of this post will be required to continue to lead the Directorate Management Team, be operationally responsible for the Polytrauma Unit and liaise with colleagues within the component sub-specialties at CAVUHB as well as across the WTN. The role will ensure that robust governance structures of evaluation are in place, and that accurate and timely data in submitted to TARN. Benchmarking with other MTCs has taken place and both the time and banding of the role is comparative with similar sized MTC's. In most MTC's this role is not combined with a network role, specifically when the Operational Delivery Network is not hosted by the MTC.

Administrative support – 1 WTE band 3 is required to provide admin support the Major Trauma Directorate.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
MTC Directorate		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Clinical Leads*				0.3	36	0.3	36
		0	**0**	**0.3**	**36**	**0.3**	**36**
AHP							
Rehabilitation Co-ordinator	7						
		0	**0**	**0**	**0**	**0**	**0**
Nursing							
Senior Nurse – Major Traum	8A			0.5	32.1	0.5	32.1
Major Trauma Practitioners	7			2	110.2	2	110.2
Major Trauma Practitioners	7	2.2	30.3	2.2	121.2	2.2	121.2
		2.2	**30.3**	**4.7**	**263.5**	**4.7**	**263.5**
Admin & Clerical							
General Manager*	8C			0.5	46.1	0.5	46.1
Lead TARN co-ordinator	5						
TARN co-ordinators	4	2	29.4	2	58.8	2	58.8
Administration officer*	3			1	24.4	1	24.4
		2	**29.4**	**3.5**	**129.3**	**3.5**	**129.3**
Non Pay							
					12.1		12.1
					12.1		**12.1**
Total		**4.2**	**59.7**	**8.5**	**440.9**	**8.5**	**440.9**

* Indicated posts are already recruited to using WG non-recurrent funds for major trauma. Therefore, funding is not sought for these posts in 2019/20.

Highlighted areas show where areas have been reduced or changed following feedback from external panels.

7.2 Adult Emergency Unit

Relevant MTC Indicators

- **T16-2B-101-** *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.*
- **T16-2B -102 -** *All trauma team leaders should have attended trauma team leader training.*
- **T16-2B -104 -** *There should be a Trauma Team Activation Protocol –- for paediatrics the trauma team should include medical staff with recognised training in paediatrics and paediatric trained nurses with experience in trauma.*
- **T16-2B -105 -** *There should be a surgical and resuscitative thoracotomy capability within the trauma team and available 24/7*
- *The Emergency Department consultants should be available to attend an emergency case within 30 minutes*
- **T16-2B -103 -** *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). 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.*

  All nursing/AHP staff caring for 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.

It is anticipated that these indicators will be met on day 1 with agreement of the proposed model:

Current Service

In 2017-18 there were 151,722 total Emergency Unit (EU) attendances in UHW of whom 34,218 were children. The uplift in overall patients categorised as 'majors', seen in 2018-19, compared with 2010-11 when the English Trauma Networks went live, was 61,510.

Infrastructure

- 6 adult Resuscitation room beds, 1 dedicated Paediatric resuscitation bay
- 16 'majors' trollies split into 2 areas
- 1 ambulance assessment/ majors assessment nurse area
- 1 triage room
- 4 minor injury assessment areas
- 5 'majors' ambulatory assessment areas
- 1 treatment room for ambulatory care
- 1 psychiatry room
- 1 co-located CT scanner

The current establishment does not allow for care to be delivered to MTC standards for current major trauma patients and the additional predicted increase in activity of 294 patients in the first year and a slower year on year increase. There are also risks associated with the launch of the MTC for the Emergency Unit and potential impact on other service users (see section 13).

Workforce

Medical
At present consultants are not available within 5 minutes of a trauma call 24/7. There are currently 11.2 WTE adult consultants providing cover 08:00 – 22:00 with on-call from home (within 30mins) outside of these hours. Weekend cover x2 is 12:00 – 22:00. The current establishment would not allow an increase beyond these hours.

Current middle grade establishment is for 10 ST3/4+. At least two middle grades (ST3+) are required throughout a 24/7 period of which one must be ST4+. The role of EU middle grades in the trauma team is essential both as trauma team providers and supervised TTLs.

Nursing

Current resuscitation establishment base for 6 beds:

- 1 band 7 level 2 trained resus coordinator
- 2 band 6 staff nurses
- 1 band 5 staff nur
- se
- 1 band 3 HCSW

Proposed model

Infrastructure

A significant number of the additional trauma patients coming to UHW following go live will require care in a fully equipped resuscitation bay. The current the resus area of the EU in UHW has provision for 6 adult resuscitation bays and 1 dedicated paediatric bay. Modelling undertaken on current resuscitation utilisation shows that an additional resuscitation bay will be required to appropriately treat MTC patients expected in year 1.

In addition to an increase in major trauma there will be changes to emergency flows with the introduction of EMRTS service to 24/7 from April 2020. This growing pressure on the department means that there is an opportunity to ensure plans are congruent and do not impact on other flows or capacity within the wider Emergency Unit.

Therefore, two streaming bays in Majors will be repurposed to create a resus bay. In order to maintain streaming and flows in the wider Emergency Unit the relocation of the Booking in office into a small extension will allow for a triage room to be moved and 1 streaming bay to be created (see plans for further details). In order to mitigate the loss overall of 1 streaming bay the physio room and staff rooms will be repurposed to provide capacity for minors and mitigate the loss of the 1 streaming bay.

Timeline
Construction period Q3/4 2019

Costs

Area	Cost 19/20
Emergency Unit , resuscitation bay Equipment costs Emergency extension, resus, streaming and triage bay refurbishment Room alterations to provide additional minors capacity	£133,975 inc VAT £436,440 inc VAT £150,000 inc VAT
Total	£720,415 inc VAT

Workforce

Consultants

To meet standards an appointment of 6 WTE adult consultants with a start date of January 2020 are required to staff a 24/7 TTL rota for go live, and an additional 4.11 WTE adult consultants required in the second year. This uplift over the first 2 years will ensure delivery of 24/7 consultant TTL presence in EU through a resident on call (from 00:00-08:00) rota from April 2020. A phased approach has been requested to allow for staged recruitment, recognising potential difficulties in recruiting suitable individuals. For clarity the phasing described requires that in the first 12 months the frequency of resident night shifts will be higher than would be sustainable in the long term. The latter explains the apparent discrepancy in Consultant uplift in relation to year 2 activity.

The MTC is committed to a collaborative approach for the delivery of the TTL rota with a minimum of 4 WTE Consultants to be jointly appointed with other Health Boards. This provides opportunity to work at the MTC and maintain their skills. This will also ensure that good working relationships are maintained across the network, and will support the maintenance of a robust and sustainable workforce at a senior level. This would also ensure that benefits of investments into these new posts can be shared across the network.

The Health Board consider that derogation from this standard from day 1 poses an unacceptable risk to patients should the above model not be supported. The safety risk is particularly pertinent as the majority of activity uplift will be observed in year 1 rather than phased. In addition, an examination of TARN data shows that the particular demographic and acuity of Major Trauma patients presenting overnight does not differ to those during the day.

This is one of the main standards that MTC's in NHSE aimed to meet for designation and is one which is consistently raised as a risk at peer review as an immediate risk in NHSE when it is not met.

The financial modelling has been done as a part of an examination of the resource requirements to run a 16 hour on site Consultant TTL rota with ST3 on site from 12.00 to 08.00 has shown that it would in fact be less safe and more expensive than 24 hour Consultant led TTL cover.

Should 24/7 TTL cover not be achieved through the recruitment to the required number of consultant posts the Health Board would work closely with the network to ensure that standards could be met or robustly mitigated ready for day 1.

Speciality Doctors

Junior doctors provide a key role in management of trauma as members of the trauma team. This is an essential component of the training of future emergency medicine physicians and trauma team leaders.

Following recommendations from the external peer review, the middle grade components for both adults and paediatrics have been removed from this case. However, should the 24/7 Consultant Trauma Team Leader component of the business case not be supported it will be essential that the junior doctor workforce and appropriate consultant support for this workforce is increased and funded through this case in order to go live. Further supporting information has been provided as a response to the Executive Strategy group recommendations following peer review of the case.

Nursing

The workforce plan is based on current and predicted number of major trauma patients per day:

	Patients per day
Current	1.3
YEAR 1	2
YEAR 2	2.3
YEAR 3	2.5

The workforce plan also reflects the nursing requirement to manage 1 major trauma patient:

- 1 staff nurse to assist with airway and breathing interventions
- 1 staff nurse to assist with circulation and any other specialist interventions the patient may require i.e. splinting
- 1 staff nurse to operate the rapid infuser in approximately 2/3 of all major trauma cases
- 1 health care support worker to scribe

There is current provision for 1:2 nurse to patient ratio care based on a 6-bedded resuscitation area. The additional 1 resuscitation bed capacity requires an uplift of:

Phase 1 - This is to support the additional 1 trauma bed and additional activity from go live:

- 5.6 WTE Band 6 to provide an additional registered nurse 24/7 in this area; and
- 3 WTE Band 3 HCSW to provide an additional HCSW 24/7.

The HCSW posts are vital for the functioning of the nursing trauma team. They will be the "scribe" within the team, which is essential in gathering TARN data and vital information about the patient and their condition, that the trauma team rely on. The HCSW also has a pivotal role in the massive haemorrhage protocol activation. The current establishment for HCSW would not facilitate us meeting the requirements of them being part of the trauma team.

Phase 2 – 5.56 WTE Band 5, This is to support the additional 2.3 then 2.5 patients per day in the following 2 years of major trauma status.

5.56 WTE Band 5 (it should be highlighted that this additional workforce should ideally be at a band 6 level with training up to level 1 and 2. This compromise has been made on the understanding that the 1 clinical educator is in post in order to bring the individuals up to the level of competence required.)

These establishment figures are required to provide safe, effective patient care and management, with the likely hood of 2 trauma calls being managed concurrently, this will be in addition to our current demand.

Further development in years 3 & 4

It is recognised that there is a requirement for a phased approach to MTC implementation. Whilst recognising this and accounting for activity modelling showing a majority uplift in year, the nursing components within the Emergency Unit have been phased over the first two years. However, activity and performance against national quality indicators will be audited during the first year of MTC establishment and there may be a requirement for further uplift to nursing staff in years 3 and 4.

1.0 WTE clinical Educator will be appointed for the MTC and a part of this resource will be allocated for the Emergency Unit to provide all staff with Level 1 training to ensure an understanding of how trauma team works in EU, it covers the use of specialised equipment; correct Level 1 training effects outcomes for patients. The training will be provided promptly with regular refresher updates within the department.

Administrative and Clerical

0.2 WTE Secretarial support will be required for each new consultant appointment.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
Adult EU		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultants – Emergency Medicine		3.5	102.7	6	701.6	10.1	1,182.20
Specialty Doctors							
		3.5	**102.7**	**6**	**701.60**	**10.1**	**1,182.20**
Nursing							
Registered nurse	6	5.6	48.7	5.6	281	5.6	281
Registered nurse	5	0	0	0	0	5.6	224.8
Health Care Support Worker	3			3	89.2	3	89.2
		5.6	**48.7**	**8.6**	**370.2**	**14.2**	**595**
Admin & Clerical							
Medical secretaries	4			1.2	32.5	2	54.2
				1.2	**32.5**	**2**	**54.2**
Non Pay							
					134.3		134.3
					134.3		**134.3**
Total		**9.1**	**151.4**	**15.8**	**1238.6**	**26.3**	**1965.7**

* Please note the highlighted areas confirm where the case has been reduced following review

7.3 Radiology, Medical Physics and Labs

Relevant MTC indicators

- **T16-2B -106** *-There should be CT scanning located in the emergency department and available 24/7.*
- *There should be an on-site radiographer available 24/7to prepare the CT scanner for use*
- **T16-2B -107** *- 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** *-MRI scanning should be available 24/7*
- **T16-2B -109 -** *Interventional radiology should be available 24/7 within 30 minutes of a request*

  Interventional radiology should be located within operating theatres or resuscitation areas.
- **T16-2B -113 -** *A radiologist should be available to attend an emergency case within 30 minutes*

Currently the 'hot report' and radiological report within 1 hour are not met for Musculoskeletal patients.

Current service

There is a hot report documented by radiology registrars with a 1 hour detailed report delivered by consultant radiologists in hours and radiology registrars out of hours. The hot report has not been consistently delivered within 5 minutes and likewise the 1 hour radiological report from start of scan is also not delivered consistently across all the sub-specialities within the required timeframe. Without the addition of an MSK Radiologist this element of the standard will continue to remain unmet.

CT scanner
The current CT located in the EU does not have a 2 metre table nor the capability for whole body scanning without moving the patient.

Interventional Radiology suites
The IR service currently has 2 IR suites which both have state of the art units with CT and 3D capabilities.

Workforce
The current service in radiology is run across a number of subspecialties (e.g. Neuroradiology, Musculoskeletal (MSK) and Paediatrics). The workforce model in radiology amongst other staff groups includes:

Radiologists: 42.5 WTE
Radiographers: 181.89 WTE

In terms of the delivery to the current patients, out of hours the rapid report is delivered through the registrar workforce and is currently validated by a consultant radiologist the next day. During normal working hours the rapid reporting is the responsibility of the consultant radiologist workforce.

Interventional Radiology
A regional interventional radiology service has been in operation since early 2019 providing a 24/7 Consultant led service for major trauma. This rota is supported by a team of IR nurses and radiographers. As it is a regional rota it cannot assure consistently delivering to the MTC standard of Radiologist availability within 30mins due to travel times.

Capital requirements

There is a requirement for a replacement CT scanner in the emergency department, the current scanner is not fit for purpose and does not enable full body scanning. It is anticipated that the works and procurement can be completed prior to go live. Funding for this has already been secured through the All Wales Capital replacement scheme.

Replacement CT Scanner in EU	Equipment - £1,200,000 Room requirements - £600,000

Workforce required
To meet the standards of the MTC there would need to be a change in the workforce model to ensure availability of staff for the expected turnaround times for investigations in CT and theatres. The lead radiographer has worked closely with the theatres team in planning of the theatres sessions.

Radiographers
The radiographer workforce has been removed in year 2 following feedback from external review panels. This will be audited in year one to assess requirement for additional radiographers in year 2.

<u>Year 1 additional staff required</u>

- 2 WTE band 6 for CT
- 1 WTE Band 5 for CT/theatres
- 1 WTE Band 5 for trauma theatre
- 1 WTE Band 5 for CEPOD theatres
- 20 hours overtime at time and a half 52 weeks of the year (weekend extra trauma theatres)

Consultant Radiologists
Based on the additional activity modelling and review of local TARN data approximately 75% of major trauma patients require a CT scan with over 50% of patients receiving an emergency scan. Therefore, an increase in the on call allowance will be required for body and MSK radiologists. This will impact 23 staff at 0.5 sessions. Total requirement minimum 11 sessions for go live day 1. 1 WTE Consultant radiologist has been removed from the case following feedback from external panels. Please note that this will impact on the ability to report MSK images within an hour as per quality indicator T16-2B -107. This will be audited during year 1.

Blood Bank – An increased use of the blood bank will require 1 WTE band 5 for cross matching.

Laboratories – the uplift has been reviewed and it has been agreed that the uplift will be absorbed within the existing team.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
Radiology		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultants				1.1	143	1.1	143
			0	**1.1**	**143**	**1.1**	**143**
AHPs and Scientists							
Clinical Scientist	7			0.5	25	0.5	25
Biomedical Scientist	5			1	32	1	32
Radiographer	7			0	0	0	0
Radiographer - CT	6			2	82	2	82
Radiographer	5			3	135	3	135
Radiology Assistant	2			0	0	0	0
			0	**6.5**	**274**	**6.5**	**274**
Total			**0**	**7.6**	**417**	**7.6**	**417**

*Highlighted sections of the above table reflect reductions and changes to the case following external review.

7.4 Theatres and Anaesthetics

Relevant MTC indicator

- **T16-2B -110** - *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.*

This indicator is currently met. Increase in activity will require additionality in theatre sessions as set out below.

As the development of the new operating theatre will not be completed by April 2020, additional emergency theatre sessions will need to be provided from within the current main theatre suite. Note that Neurosurgery emergency cases are carried out in CEPOD theatres and Paediatric Major Trauma cases are currently operated on adult lists on the UHW site.

Theatre Sessions – Day 1 - April 2020

As the development of the new operating theatre will not be completed by April 2020, additional sessions will need to be provided from within the current main theatre suite. 9 sessions provides capacity for more than the modelled median of hours required (see section 5) but takes into account peaks in activity and current delays for MT cases. The 9 sessions will be a mix of additional T&O sessions and general CEPOD sessions. Exact specialty split will be agreed at the Theatres Operational working group as a part of the programme. Benchmarking in the like MTCs is being used to inform the model.

In addition to the above capacity, the directorate will make capacity for two dedicated all day orthoplastic operating lists on a Tuesday and Thursday to ensure time for complex combined cases. These will be spaced through the week to maximise adherence to BOAST 4 standards.

Review of current theatre utilisation

A review of current utilisation and efficiency of both CEPOD and trauma theatres was undertaken showing effective utilisation of both and an oversubscription for emergency theatres at present, with Major trauma patients not meeting the required operative timescales.

Additional workforce requirements (Day 1 - April 2020)

AfC Band	WTE
Band 2	5.19
Band 3	8.46
Band 5	6.66
Band 6	2.17
Consultants	3.75
Total	**26.23**

Consultants

Typically the job plans are based on a 7:3 split as per the Welsh Contract, in terms of recruitment we would advertise posts which were a mixture of elective and Emergency (Major Trauma) work spread between Consultants with a special interest in Major Trauma – pure Trauma workload would be unattractive to recruitment. The Trauma workload is based upon a 52 week delivery apart from orthoplastics which would be 50 weeks.

Nursing

They are based on our agreed establishment for emergency theatres and therefore match all other emergency lists we run.

Porters

An additional porter has been allocated at various points through the day to ensure there is no impact on other lists through the introduction of major trauma.

HSDU posts

The HSDU posts are based on feedback from the Sterilisation and Decontamination Manager at CAV UHB. Trauma trays can have hundreds of pieces on them so sterilisation will be increased. Due to increases in weekend working there is a requirement to ensure that kit is processed so it doesn't impact the following day.

Theatres Equipment

A full list of equipment has been collated to ensure the expected additional patients and a variation of complex injuries can be treated appropriately. Colleagues from Swansea Bay Hospital have supported this with inclusions for plastics. These have been tested with the theatres team from Bristol MTC who have confirmed that kit identified is proportionate to that utilised for their MT patient cohort.

Year 2 (April 2021)

The Directorate envisages Year 2 (April 2021) to be the time when the fully functioning service for Theatres and Anaesthetics is implemented. This will see a dedicated Theatre for Major Trauma as part of the theatre plan for the vascular hybrid theatre. The Outline Business Case for this theatre complex is currently being developed. Once live, a full assessment against activity will be required.

There is work ongoing to scope the revenue requirements for this theatre. However, it is recognised that there will be an increase in establishment to ensure the mid-long term sustainability of a fit for purpose MTC.

There is currently work ongoing to review the revenue requirements for this theatre and there will be an executive level scrutiny process set out for these costs.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
Theatres		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultant Anaesthetists		3.8	120.0	3.8	480.0	3.8	480.0
		3.8	**120.0**	**3.8**	**480.0**	**3.8**	**480.0**
Nursing							
Registered nurse / ODP	6	2.2	39.1	2.2	78.2	2.2	78.2
Registered nurse / ODP	5	6.7	95.9	6.7	191.8	6.7	191.8
Registered nurse / ODP	3	6.5	66.2	6.5	132.3	6.5	132.3
HCSW / ODP	2	2.4	22.7	2.4	45.3	2.4	45.3
		17.8	**223.8**	**17.8**	**447.6**	**17.8**	**447.6**
Operational services							
HSDU	3	0.0	0.0	2.0	45.8	2.0	45.8
Porters	2	0.0	0.0	2.2	43.1	2.2	43.1
		0.0	**0.0**	**4.2**	**88.9**	**4.2**	**88.9**
Admin & Clerical							
Receptionist	2	0.0	0.0	0.6	11.0	0.6	11.0
		0.0	**0.0**	**0.6**	**11.0**	**0.6**	**11.0**
Non Pay							
General non-pay			0.0		295.0		295.0
Theatre equipment (non-capitalisable)					352.0		120.0
			0.0		**647.0**		**415.0**
Total		**21.6**	**343.8**	**26.4**	**1674.5**	**26.4**	**1442.5**

7.5 Acute pain

Relevant MTC indicators

- **T16-2B -118 -** *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).*

This indicator is currently met for adult patients but will require additional workforce to ensure this can continue to be met for year 1 activity uplift. The costs for an uplift in 1 WTE have been removed from the case based on feedback from external panel reviews of the case and this service will be audited during year 1.

Current Service

The Acute Pain Service provides cover to all clinical inpatient areas including Critical care. The service also provides cover to the paediatric patients however this provision is limited as it has developed over time without the associated funding being invested. This is being reviewed as part of the internal CAV UHB process.

The service is predominantly nurse led by a team of Clinical Nurse Specialists (CNS). Medically the cover is provided by the duty obstetric anaesthetist in UHW with out of hours and weekend cover being provided by the general on call anaesthetist in UHL. The team is comprised of 8.44 WTE CNSs (x2 WTE Band 6s and 6.44 WTE Band 7s). CNS service provision in UHW is 08.00-08.00 Monday to Friday, 08.00-06.00 Sat and 08:00-08.30 Sun. The majority of moderately and severely injured polytrauma patients require Pain Service review with subsequent timely management and appropriate intervention. Management includes neuraxial blockade and an available anaesthetist will therefore be sought to facilitate such treatment.

7.6 Critical Care

The Adult Critical Care Service in Cardiff is the busiest in Wales, caring for around 1500 patients a year. It supports a number of regional tertiary services including neurocritical care, spinal injuries, haem-oncology, maxillo-facial, vascular, thoracic and upper gastro-intestinal surgery.

No specific related MTC indicators

Current Model

Infrastructure

Critical Care currently has 32 staffed Level 3 equivalent beds (on the assumption that WG non-recurrent investment in 2018/19 in 6 beds at UHW becomes recurrent), with 28 at UHW and 4 at UHL. The units provide Secondary Care to Cardiff and Vale patients and Tertiary Care to patients across South Wales.

Workforce

Scientific Practitioner Band 6	3.61
Consultant (M&D)	16.00
Specialty Registrar (M&D)	16.00
F2 foundation year 2 (M&D)	2.00
F1 foundation year 1 (M&D)	1.00
Nurse Consultant Band 8C	0.60
Nurse Manager Band 8A	2.00
Nurse Manager Band 8B	1.00
Registered Nurse Band 5	152.91
Registered Nurse Band 6	96.55
Registered Nurse Band 7	13.00
Registered Nurse Band 8A	2.00
Nursing HCA/HCSW Band 2	25.99
Nursing HCA/HCSW Band 3	3.76
	285.36

There are currently no on-call commitments, as consultants are part of a rota which provides resident full night shift cover.

Proposed model

Infrastructure
Based on the activity modelling for the first year following MTC go live there is a requirement for an additional 3 beds for expansion of critical care to 31 beds on the UHW site. This will require capacity release within UHW. There are no capital build requirements to enable opening of the new beds but there will be requirement for equipment.

The uplift of 3 beds is comparable to the number of beds opened in other MTC's for launch with Nottingham and Oxford both opening 3.

Workforce
The uplift in workforce relates solely to accommodating the additional activity predicted as a result of go live as an MTC. The workforce model has been reduced from the GPICS (Guidelines for the Provision of Intensive Care Services) Standards following external scrutiny of the case.

Consultant
1 WTE consultant

Registrars
1 WTE registrar

Nursing
The nursing workforce identified in the workforce plan will provide frontline nursing for 3 Level 3 patients to ensure safe and effective care is delivered.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
Critical Care		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultant Intensivists		0	0	1	137.1	1	137.1
Registrars		0	0	1	94.8	1	94.8
		0	**0**	**2**	**232.0**	**2**	**232.0**
Nursing							
Advanced Critical Care Practitioner	8A	0	0	0.5	32.1	0.5	32.1
Practice Educator	6	0	0				
Registered nurse	7	0	0				
Registered nurse	6	0	0	9	492.2	9	492.2
Registered nurse	5	0	0	12	527.3	12	527.3
HCSW	2	0	0	2.85	79.5	2.85	79.5
		0	0	**24.35**	**1,131.1**	**24.35**	**1,131.1**
Other roles							
Psychologist	8C	0	0				
Pharmacist	8A	0	0				
Technician	6	0	0				
		0	0	**0**	**0**	**0**	**0**
Admin & Clerical							
Administrator	4	0	0	0.5	14.7	0.5	14.7
		0	**0**	**0.5**	**14.7**	**0.5**	**14.7**
Non Pay							
General					27		27
Clinical					383		383
					410		**410**
Total		**0**	**0**	**26.85**	**1,787.78**	**26.85**	**1,787.78**

*Highlighted areas in costing reflect reduction or changes following external panel feedback.

It is important to note that the additional 3 Level 3 beds proposed were entirely supported by the external peer review. Similarly, this model has the full support of Welsh Government. Welsh Government have been explicit that the development of these three beds is a component part of their ongoing strategy to expand Critical Care and is completely discrete from other investments they have made into Critical Care across Wales within this financial year.

7.7 Poly Trauma Unit (PTU)

Relevant MTC indicators

- **T16-2C -102** - *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 -104** - *There should be a single daily multi-specialty meeting for the presentation and discussion of all new major trauma patients following admission.*
- **T16-2C -105** - *There should be a separate major trauma ward or clearly identified clinical area where major trauma patients are managed as a cohort*
- **T16-2D -102** - *There should be a multidisciplinary specialist rehabilitation team*

If the proposed model below is agreed all of the above indicators will be met day 1.

Benchmarking

Some benchmarking has been undertaken with other Centres who have a dedicated Major Trauma Ward.

Stoke – Stoke's ARTU unit, launched in 2015 with 26 beds. This combines a Level-1 specialist rehabilitation unit (10 beds) and a polytrauma ward (16 beds, including 8 Level-1 critical care beds) with 4 trained staff on a shift. The total number of TARNable cases is comparable to that predicted for UHW in year 1 in addition to this, at the time of implementation Stoke had 500 cases of ISS>15 which is the same as predicted to flow to CAV UHB in year 1. Stoke are consistently one of the best performing MTC's for survival rates.

Nottingham – a dedicated polytrauma unit with 18 beds, of which a large percentage are level 1 beds. The acceptance criteria are similar to those proposed for the CAV UHB PTU with patients with less complex injuries or those easily managed under the care of a single specialty, still being admitted under that main specialty rather than to the PTU. The demographic of patients admitted to Nottingham MTC is comparable to UHW.

Bristol - does not currently have a ward but are in the planning stages for both a Major Trauma and hyper acute rehabilitation unit similar to Stoke's model. An initial audit has been received and reviewed which identifies the number of patients admitted to an inpatient bed at any one time who would be suitable for the polytrauma ward and hyper acute rehabilitation. This ranges from 4 to 20 per week with a median of 12 with an average LOS of 16 days but does not identify the number of beds required. A crude calculation would indicate that 27 beds would be required for this unit. For UHW we would not anticipate requiring a unit of this size as a proportion of the patients will flow to existing wards and specialist rehabilitation beds. However, it is reassuring to note that the modelled LOS is similar to that in an established MTC.

Proposed model for UHW

The adult PTU will include a level 1 polytrauma facility (6 beds) and a step-down level 0 ward area (8 beds). The PTU beds will be ring-fenced to protect capacity. This will cover the predicted uplift for all specialties apart from a number of isolated orthopaedic major trauma injuries which will be better managed under trauma and orthopaedics. A clear list of admission and exclusion criteria has been developed and recently ratified at a stakeholder workshop. The clinical modelling has shown that the

ward will take polytrauma patients but also some isolated significant injuries including chest injuries and some non-operable head injuries. Clinical adjacencies have been carefully considered with the PTU closely located to important supporting services such as operating theatres.

The proposed model provides the beds for the predicted increase in capacity but by collocating then allows CAVUHB to meet the MTC adult quality indicator and is in line with the relevant NICE guideline on Major Trauma Service Delivery (NG40, February 2016) which recommends the provision of a dedicated major trauma service for patients consisting of the following:

- A dedicated major trauma ward for multisystem injuries
- A designated consultant available for contact 24/7 who has responsibility and authority for the hospital trauma service and leads the multidisciplinary team
- Acute specialist rehabilitation services
- Acute specialist services for paediatric and elderly populations
- A named member of clinical staff assigned at each stage of the care pathway to coordinate the patient's care.

The Unit will also provide a base for hyper-acute rehabilitation. Benefits of the model include early access to rehabilitation and an integrated multi-disciplinary team approach. This has been demonstrated to optimise health outcomes and reduce harm, improve patient and family experience, producing substantial savings in on-going care costs across healthcare systems, and relieving pressure in services.[3]

It is anticipated that the development of a dedicated facility for complex major trauma will improve the quality of care delivered and be an incentive for recruitment and an opportunity to develop and retain a workforce with specialist expertise.

Consultant model

There will be a MTC Coordinating Consultant (MTCC) of the week on a 1:8 rota Monday – Friday 8-5pm. Following recommendations from the recent Wales Trauma Network peer review this model is currently being reviewed to evaluate extension to a 7 day provision without incurring increased costs. It is likely that this would include a morning ward round on both weekend days to provide senior decision making and opportunities for progression of care, discharge etc. There is an understanding from General Surgery, Trauma & Orthopaedics and Critical Care that additional appointments/or uplift in job plans requested and costed as a part of this MTC business case will be required to support this rota. Once the Trauma Team Leader rota is confirmed it is also likely that a small number of EU new consultant appointments may also allow sessional support to this rota. 0.6 sessions has been added in order to support this as a gap. The MTCC will lead the PTU and MDT on a rotational basis and will coordinate the major trauma response for each patient admitted, ensuring that clinical and holistic needs are met.

[3] Stokes et al (2017) https://bmjopen.bmj.com/content/6/9/e012112

Nursing

There will be no planned junior doctor workforce on the PTU although there will be support from the 1 WTE surgical registrar when required (as per section 5.1.11 of the case). The PTU Nursing workforce reflects this and the requirements for the 6 high care patients (level 1) based on GPIC standards and the 10 ward patients. The non-registered workforce are imperative to deliver the highly complex care that is required for this case mix of patients. 2 x WTE Band 7 RGN's, one of which is the Band 7 Sister/Charge Nurse the other will deliver the educational agenda including mandatory major trauma competencies that are required in line with standards for all nurses across major trauma services.

A significant proportion of admissions to PTU will have traumatic brain injuries or other forms of cognitive impairment. Based on the experience of centres in England these patients require enhanced supervision, known commonly as –"specialling by an RMN". These posts have been included as it is more cost effective to fund them substantively at plain rates rather than book them ad hoc at enhanced rates. Upon consideration of the external feedback we have downgraded the banding of the posts from a Band 3 to a Band 2.

Psychology

The psychology posts have been reduced to a band 8a following external feedback which is commensurate with benchmarking in England. This will be monitored during the first year.

Administrator

The primary function is to support the ward sister in the administrative duties required to run the ward , such as preparing rosters, submitting actuals to payroll, preparing staff letters in relation to sickness interviews, preparing recruitment documentation, organising notes to respond to concerns, minute taking including on behalf of the Directorate Management Team, ordering stock, supporting repatriation process with site, and is integral to release the clinical teams to care for frontline patients.

Ward receptionist

The existing calculation for workforce is based on having receptionist cover 8am until 8pm. Due to the nature of the emergency admissions to the PTU Patients & their families will need to be greeted and given information as far as possible on arrival, and supported through this traumatic time. In recognition of external feedback these hours have been reduced to 8-6pm but this will impact on the above service.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
Poly Trauma Unit		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultant surgeon sessions		0	0	0.6	75.4	0.6	75.4
		0	**0**	**0.6**	**75.4**	**0.6**	**75.4**
Nursing							
Advanced Nurse Practitione	7	5.7	90.3	5.7	361.2	5.7	361.2
Practice Educator	7	1	27.6	1	55.1	1	55.1
Sister / Charge nurse	7	1	4.6	1	55.1	1	55.1
Registered nurse	6	9	40.4	9	484.2	9	484.2
Registered nurse	5	14.2	51.2	14.2	614.6	14.2	614.6
Enhanced supervision	3						
HCSW	2	8	19.3	19.9	574.9	19.9	574.9
		38.9	**233.4**	**50.8**	**2,145.10**	**50.8**	**2,145.10**
Other roles							
Psychologist	8C						
Psychologist	8A	0	0	1	64.2	1	64.2
Pharmacy technician	5	0	0	0.5	18.8	0.5	18.8
		0	**0**	**1.5**	**83**	**1.5**	**83**
Admin & Clerical							
Administrator	4	0	0	1	29.4	1	29.4
Ward receptionists	2			2	46.6	2	46.6
		0	**0**	**3**	**76**	**3**	**76**
Non Pay							
General					73.8		73.8
Clinical					184		184
					257.8		**257.8**
Total		**38.9**	**233.4**	**55.9**	**2,637.30**	**55.9**	**2,637.30**

*Highlighted areas in the cost table reflect reductions following feedback.

7.8 Trauma & Orthopaedics

Relevant MTC Indicators

- **T16-2C -110** - *There should be trauma orthopaedic surgeons who spend a minimum of 50% of their programmed activities in trauma.*
- **T16-2C -112 -** *There should be facilities and expertise for the management of complex peripheral nerve injuries, including brachial plexus.*
- **T16-2B -115 -** *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*
- **T16-2C -104 -** *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: Orthopaedics*

If the below model is agreed the indicators will be met day 1.

Current Model

Infrastructure
Beds – total 83 across trauma and orthopaedics
Theatre lists - 25 sessions
Outpatient clinics – 5 trauma per week plus 2 specialist clinics & 2 hand clinics

Medical Workforce
Consultant staff - 13.5 WTE
Junior doctors - 6 STs, 4 CTs and 4 F1s. 2 Clinical fellows and require 2 Trauma Fellows in addition.

Proposed Model

Infrastructure
Outpatient Clinics
1 x additional complex trauma clinics per week
2x Orthoplastic clinics per month to run synchronically with the above.

Workforce

Medical
3.5 WTE new trauma trained consultants are required to develop a 2-tier on call system for consultants with 6 consultants doing a week long 8am-8pm MTC on call. These trauma trained consultants will aim to attend MDTs, participate in MT ward rounds and carry out the complex outpatient clinics. They will also cover day time MT operating lists and coordinate repatriation. They will have no elective commitments in their on call week. The rest of the consultants will provide DGH level on call service from 5 pm till 8 AM as they do currently. It is anticipated that 1 of these appointments will specialise in pelvic reconstruction.

Nursing
Outpatient Clinics – 0.33 WTE band 5 Trauma Clinic Nurse will be required to support the additional sessions and associated uplift in patients. Similarly, 0.33 WTE band 2 Trauma Clinic Healthcare Support Worker will also be required to support.

7.9 Orthoplastics service

Relevant MTC Indicators

- **T16-2C -110 -** *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.*

For year one, Swansea Bay UHB will recruit the additional plastic surgeons required to deliver a combined orthoplastic service at the MTC for those patients who are unable to safely transfer to the Regional Centre for Burns and Plastics.

2 all day operating lists will be required per week in order to ensure that the standards for coverage of open fractures can be met. If the Network Clinical Model for Orthoplastics includes a change in flow of isolated complex limb injuries to SBUHB CAVUHB would agree support the service with the delivery of 1 all day list per week and cover of annual leave. This could be supported through the job plans for the additional 3.5 WTE consultants in this case.

N.b. Resources for Plastic Surgery are not included in the MTC case. It is intended that they are included within the Swansea Bay UHB case.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
Trauma & Orthopaedics		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultants Surgeons		3.5	103.7	3.6	471.6	3.6	471.6
		3.5	**103.7**	**3.6**	**471.6**	**3.6**	**471.6**
Nursing							
Registered nurse	5	0	0	0.2	9.1	0.2	9.1
HCSW	2	0	0	0.2	6.3	0.2	6.3
		0	**0**	**0.4**	**15.4**	**0.4**	**15.4**
Admin & Clerical							
Medical Secretary	4	0	0	1.5	36.4	1.5	36.4
		0	**0**	**1.5**	**36.4**	**1.5**	**36.4**
Non Pay							
General					5		5
Clinical					0		0
					5		**5**
Total		**3.5**	**103.7**	**5.5**	**528.4**	**5.5**	**528.4**

*Highlighted areas in the cost table reflect reductions following feedback.

7.10 Spinal Surgery

The Spinal service at UHW is delivered by seven spinal consultants, providing a 24 hour 7 days a week on call spinal surgery service. They are supported by a robust junior medical team including one nurse practitioner. The consultants are available on site within 30 minutes and there is resident orthopaedic registrar cover in place 24/7. Emergency orthopaedic trauma and CEPOD theatres are available with dedicated trained staff. The Rookwood Spinal Injury Unit is situated in Cardiff close to the Centre and the rehabilitation physicians provide an in reach service.

Planning against activity confirms that the increase for spinal surgery will be subsumed as a result of the following:
1) Additional capacity on the Polytrauma Unit
2) Reduction in length of stay for existing and new patients through the network repatriation policy
3) Patients from Hywel Dda UHB with unstable spinal fractures (and without spinal cord injury) undergoing fixation in SBUHB as per agreed Network pathway.
There will need to be regular audit of overtriage to confirm that modelling predictions are correct.

7.11 Vascular Surgery

Relevant MTC indicator

- **T16-2C -114 -** *There should be facilities for open vascular and endovascular surgery, including EVAR, available 24/7.*

During normal working hours the 3 Cardiff based vascular surgeons provide emergency cover, with out of hour's services being provided by the South East Wales Vascular network (currently 9 Surgeons from CAV, Cwm Taf Morgannwg (CTM) and AB University Health Boards). The service has support from the general surgical on-call surgical middle and junior teams and has a ward base of 38 beds. The vascular team has access to regular elective theatre lists and the CEPOD theatre for emergencies. There are plans to centralise the Vascular service at Cardiff in 2020. At present there are no identified needs for the launch of MTC based on the predicted uplift in activity and developments at CAVUHB.

7.12 General Surgery

Relevant MTC indicators

- **T16-2B -111** - *All general surgeons who are on the emergency surgery rota should be trained in the principles and techniques of damage control surgery*
- **T16-2B -113** – *There following consultants should be available to attend an emergency case within 30 minutes: a general surgeon*
- **T16-2B -112** - *The following staff should be available on site 24/7:*
  a general surgeon ST4 or above;
- **T16-2C -104** - *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: general surgery*

If the proposed model below is agreed the above indicators will be met day 1. Currently there is no MDT for polytrauma patients and not all general surgeons are trained in damage control surgery. Whilst there is a general surgical registrar on site, there is also a lack of general surgical presence at Trauma Calls in the emergency department currently the below model will support the improvement of this.

Current Service

Infrastructure
Currently the General Surgery department has beds housed on 4 wards in UHW comprising 117 bed spaces.
Theatre lists for Major trauma patients currently would involve the use of the CEPOD theatres of which there are 2 per day available 24/7 if required. There are no specific major trauma clinics provided by General Surgery.

Workforce
There are currently have 16 Consultant surgeons providing General Surgery on-call cover using a split upper and lower GI on-call 1:8 during the week and 1:16 at weekends and at night (single consultant covering all aspects of emergency general surgery). The service is supported by a number of trainees ST4 or greater trainees who work a 1:14 rota covering 24/7.

Proposed model

Consultants

In order to support the MT service, it is anticipated that 2 Consultant General surgeons will be released from their current role on a rotational basis to provide cover on the Major Trauma Co-ordinating Consultant rota (MTCC), provide support to complex outpatient clinics, and provision of surgery out of hours (including SPA time).Therefore, General surgery will require 5 sessions per week or 0.6 WTE consultants

Registrars

In order to meet the requirement around the multi-disciplinary meeting it will be necessary to appoint an additional registrar level trainee to attend the daily meeting and provide senior decision-making support to the ANP tier on the PTU to all PTU patients. It is proposed that this duty is rotated between the general surgery ST trainees to provide experience to the whole cadre of ST trainees whilst on placement at UHW.

Revenue Costs	Band	In Year 19/20		Day 1 20/21	
		WTE	Cost	WTE	Cost
Medical					
Consultant surgeons		0.0	0.0	0.6	74.7
Specialty Doctor		1.0	52.3	1.0	89.7
		1.0	**52.3**	**1.6**	**164.4**
Admin & Clerical					
Medical Secretary	4	0.0	0.0	0.5	14.0
		0.0	**0.0**	**0.5**	**14.0**
Total		**1.0**	**52.3**	**2.1**	**178.4**

7.13 Maxillofacial Surgery & ENT

Related MTC Indicator

- **T16-2C -113** - *There should be on site maxillofacial surgeons with access to theatre for the reconstruction of maxillofacial trauma.*
- **T16-2C -108** - *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.*

Current Service

Consultants

The consultant-led Maxillo-facial trauma service at UHW has 6 consultants (includes 4 WTE oral & maxillofacial consultants, x1 oral surgery consultant, 1 OMFS vacancy). It provides a full Maxillo-facial reconstructive service and supports cranio-facial reconstructive surgery in combination with neurosurgery, ENT and ophthalmic surgical services. The service is supported by a 24/7, three tier on call system, with the first tier resident, the second tier available within 15 mins, and the Consultant tier within 20 minutes. Upon recruitment to the 6th consultant vacancy dedicated time can made available in consultant job plans

for trauma management and all other clinical activities are cancelled so that the team is fully consultant led during a trauma week on-call. As the Neurosurgery team is on site, there is a dedicated craniofacial team of neurosurgeons as well as Maxillofacial surgeons who work together on complex cases

Junior Doctors
There are 7 middle grades involved with the on-call rota: x3 maxillofacial registrars, x3 staff grades, x1 locum middle grade. 8 first on-call, 12 hour shifts with split nights. Currently we have x1 junior covering the wards on weekends and covering the Emergency Unit. There are existing plans for a three-tier rota to ensure emergency surgery provision and trauma clinic time. There is already funding for an additional 1 WTE consultant a registrar to support this and there are plans in place to recruit to the consultant post.

7.14 Neurosurgery

Relevant MTC indicators

- **T16-2C -107 -** *The MTC should have the following neurosurgical provision:*

  On-site neuroradiology;

  on site neuro critical care;

  a neurosurgical consultant available for advice to the trauma network 24/7;

  a senior neurosurgical trainee of ST4 or above;

  all neurosurgical patient referrals should be discussed with a consultant;

  all decisions to perform emergency neurosurgery for trauma are discussed with a consultant;

  Facilities available to allow neurosurgical intervention within 1 hour of arrival at the MTC.

The above indicators are currently met.

Current service
There are currently 11 WTE Neurosurgeons plus one academic consultant, as well as an established middle grade tier.

Proposed model
Planning against activity confirms that the increase for neurosurgery will be small and subsumed by both additional capacity on the Polytrauma Unit and a reduction in length of stay for existing and new patients through the network repatriation policy. There will need to be regular audit of overtriage to confirm that this modelling is correct.

Workforce required
Whilst the number of patient needing neurosurgical intervention is not expected to increase significantly, there will be an increase in those patients with an associated brain injury that will not be operable but will require the support and expertise of a brain injury nurse. There is a requirement for 1 x WTE band 7 Traumatic Brain Injury Nurse Specialist to join 1 WTE existing nurse specialist to work as a team to provide specific support to patients in the PTU and across the whole clinical pathway outside of the Neurosurgical bed base. This will also ensure that annual leave and sickness can be covered.

Revenue Costs	Band	In Year 19/20		Day 1 20/21	
		WTE	Cost	WTE	Cost
Nursing					
Clinical Nurse Specialist	7	0.0	0.0	1.0	55.1
Total		**0.0**	**0.0**	**1.0**	**55.1**

7.15 Thoracic Surgery

Relevant MTC indicator

- *A cardiothoracic surgeon should be available to attend an emergency case within 30 minutes.*

Current Service

Workforce
5 WTE cardiac & 3 WTE thoracic surgeons (including 1 locum).The service is not able to provide 24/7 consultant cover for thoracic surgery. Consultant thoracic cover is provided over 18 days per month. The remaining sessions are facilitated by the cardiac surgeons who provide advice on the management of emergency admissions. There is dedicated middle grade cover provided on a 24/7 basis.

Proposed model

Activity
The current service anticipates that it will be able to absorb the activity (25-30 cases) associated with the MTC.

Required workforce
In order to meet the standard a 4th surgeon will be required to provide 24/7 on call. To facilitate the 1:5 rota, an associate specialist with the appropriate skills to manage major thoracic trauma will be dedicated to the thoracic surgery rota.

It is important to appreciate that the service is currently involved in a process to re-locate thoracic surgery to a single site at Morriston Hospital, Swansea. Discussions are ongoing in terms of providing management for the single site and cover for the MTC.

Revenue Costs	Band	In Year 19/20		Day 1 20/21	
		WTE	Cost	WTE	Cost
Nursing					
Consultant		0.0	0.0	1.0	134.0
Total		**0.0**	**0.0**	**1.0**	**134.0**

7.16 Geriatrician Service

Relevant MTC indicator

- *All patients 65 years or older have a Clinical Frailty Scale completed within 72 hours of admission by a geriatrician (defined as Consultant, Non-Consultant Career Grade (NCCG) or Specialist Trainee ST3+).*
  N.B This is a new adult MTC indicator for 2019 and will not be met day 1

Current service

Workforce

There are currently 2 WTE orthogeriatricians providing direct patient care within the Trauma and Orthopaedic Directorate, In addition, there is plan to recruit 1 WTE to provide similar support in General Surgery.

Proposed Model

It is recognised that the development of the MTC will pose challenges both in relation to older patients who have specific requirements and also in terms of recruitment as these posts are historically hard to appoint. It is however an opportunity for innovative collaborative working to develop a service which will cover MT patients across the pathway. Options currently being explored include a supporting out-reach model of clinical nurse specialists, and shared sessions in conjunction with care of the elderly consultants as part of ongoing work on frailty pathways. Careful audit of the service is required following go live to assess patient requirements and impact on the service.

7.17 Rehabilitation

Relevant MTC indicators

- **T16-2D-101** - *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** - *There should be a multidisciplinary specialist rehabilitation team*
- **T16-2D -106** - *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.*
- **T16-2D -107 -** *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;*
- **T16-2D -109** - *The trauma rehabilitation service should include a clinical for the assessment and treatment of major trauma patients. Inpatient and outpatient clinical psychology services should be available.*

If the proposed model is approved the above indicators will be met day 1.

Current Specialist Rehabilitation Services

The following describes the current Specialist Rehabilitation Services in the Region, which is provided to patients after their stay in an acute hospital setting. Current services for acute patients is limited, there is an established weekly in-reach service to UHW for spinal injury, traumatic brain injury and amputee patients from the Rookwood specialist rehabilitation consultants. The teams review patients in all wards.

Long term specialist rehabilitation for patients after their acute hospital episode is firmly established within the UHB at Rookwood Hospital. The supra-regional Spinal Injury and the South East Wales regional Acquired Brain Injury Units are both based within the Health Board. There are established links with the amputee service, posture and mobility service, driving assessment centre and electronic assistive technology services which are co-located with the inpatient beds.

A specialist multidisciplinary Neurorehabilitation service led by 2 Consultant Neurologists (1.0 WTE Rehabilitation component) provides inpatient (22 beds) as per service specification by WHSCC. The inpatient ward can support only 2 patients with tracheostomies at any given time due to governance and staffing considerations.

2 Traumatic brain injury clinics are provided per month by 1 Consultant in Neurorehabilitation (0.5 WTE). There is an outreach service for University Hospital of Wales only (not including critical care).

(A separate Neurorehabilitation inpatient unit led by 2 Consultant in Rehabilitation medicine provides inpatient (12 bed) at Neath Port Talbot to Swansea bay and West Wales patients).

A specialist multidisciplinary Spinal rehabilitation service at Rookwood led by 2 Consultants in Spinal Injury Rehabilitation provide inpatient rehabilitation (26 beds) as per WHSCC service specification. The staffing arrangements and isolated nature of the facility permit management of 2 patients with tracheostomies at any one time. There is Intensive Care Consultant sessional support to provide assessment and management advice for these patients.

There is an outreach team to South Wales Major hospitals in CAV UHB, AB UHB, CTM UHB and SB UHB.

6 outpatient clinics are provided weekly (including 1 Clinical Nurse Specialist Clinic) are for life long care of spinal injured patients.

A specialist multidisciplinary amputation rehabilitation and outpatients prosthetics service is provided for at ALAS in Rookwood, Cardiff and the Amputee Rehabilitation Centre in Morriston Hospital.

There are 2 clinics for a Consultant in Rehabilitation medicine and a GP with Special interest for Cardiff ALAS.

There is no Consultant on call cover for any of the above sub specialties.

Current acute rehabilitation service within the MTC

- There is currently no clinical lead for acute trauma rehabilitation.
- There are currently no rehabilitation coordinators in post
- Currently rehabilitation prescriptions are not delivered.
- There is no rehabilitation MDT covering all Major Trauma patients

Proposed model

Workforce required for the MTC

Medical

1 WTE consultant & 1 WTE registrar will be required to support the uplift in patients and deliver the above related indicators and activity increase.

The consultant in Rehabilitation medicine will oversee the development of rehabilitation for Major Trauma patients at Cardiff. The post will also oversee and deputise rehabilitation prescription/rehabilitation passports for all patients admitted to Polytrauma ward and other wards in the MTC. The post will also lead a multidisciplinary team on the polytrauma unit covering Monday to Friday 9 am to 5 pm.

The registrar will be funded by HEIW and therefore there are no costs as a part of this case.

Therapy

There is a significant short fall in the therapy service provision across the major trauma specialties. The service is a 5 day service with an emergency physiotherapy service over the weekend to support day 1 post-operative mobilisation for trauma and deteriorating respiratory function across all specialties. In neurosurgery, acute spines and trauma the dietetic, occupational therapy and speech and language therapy services provide an initial assessment, a management plan and very limited rehabilitation and physiotherapy service is able to deliver on average three times a week rehabilitation.

There is currently no occupational therapy or speech and language therapy service provision in critical care. This is significantly below what is recommended by best practice guidance and although patients will be mobilised on the ward by nursing staff, as able, the functional level of many major trauma patients requires at least two members of therapy staff to support early mobilization and seating. There is also a delay in assessment of nutritional needs and patient's ability to self-feed and /or swallow which can lead to unnecessary intervention. Nutritional status has a direct link to clinical outcomes - better provision of nutrition support is associated with an improvement in patient outcomes including functional status and a reduction in healthcare costs.

Patients currently spend significant time in a hospital bed not engaged in purposeful activity and discharge planning will only be carried out if the patient can be discharged from UHW. Although it is recognised that there is a significant shortfall in service provision the therapy posts identified in this business case are to provide a therapy service for the additional beds in trauma, critical care and the poly trauma unit and not to address the shortfall in the current service. However without investment there is no capacity in the current service to provide appropriate level of care that major trauma patients require in the additional beds.

It is envisaged that the therapy lead role, with the support from rehabilitation coordinator, will lead the coordination and management of therapy and delivery of the Rehabilitation Prescription across all major trauma patients in the UHB. They will work closely with the Consultant in Rehabilitation Medicine and the Trauma Coordinators to support major trauma patients accessing timely rehabilitation and to support onward referral to rehabilitation service once patients have left the MTC.

Major Trauma Work Force Position May 2

There are a number of areas identified as requiring an uplift in therapy to provide rehabilitation to the additional major trauma patients and to work within the major trauma multidisciplinary team to support the overall coordination and management of rehabilitation across the MTC. The core areas are set out below:

Commented [BA(M1]: This is more compelling when the figures in the 'Workforce Therapies' powerpoint presentation are seen. Could this section include an overview of current therapy staffing in the hospital, as a baseline and to demonstrate how additional numbers needed will add to existing provision? Some acknowledgement of what is in place already with the large gaps highlighted (e.g. OT and SALT in Neurosurgery and Critical Care) might clarify and strengthen the case.

Poly Trauma Unit:

A multidisciplinary team which includes a physiotherapist, occupational therapist, speech and language therapist, dietician, and clinical psychologist will need to be appointed to manage the rehabilitation for patients in the polytrauma ward. Benefits of the model include early access to rehabilitation and an integrated multi-disciplinary team approach, which have been demonstrated to optimise health outcomes and reduce harm, improve patient and family experience, and reduce length of stay. It is also anticipated that the development of a dedicated facility for complex major trauma will be an incentive for recruitment and opportunity to develop a workforce with specialist expertise.

Role	Band	WTE
Therapy Tech.	3	3.00
Dietetics	7	1.00
SALT	6	0.50
SALT	7	1.00
Physiotherapy	6	1.00
Physiotherapy	7	1.00
Occupational Therapy	6	1.00
Occupational Therapy	7	1.00

Commented [BA(M2]: Some comparison of these figures with current establishment on existing acute specialty wards might be useful, to be clear on how much uplift.

High numbers of qualified staff can be justified on basis of complexity of patients, especially those needing multiple trained therapist to stand and mobilise.

For day 1 as a minimum it has been agreed there is a requirement for physiotherapists and dietetics to provide a 7 day service on the PTU. It is recognised that major trauma patients also require both occupational therapy and speech and language therapy over 7 days but due to current service provision the up lift required is unaffordable within this business case and needs to be achieved incrementally over the next three years. As a minimum this enables us to ensure that all patients will be assessed by a therapist within 24 hours of admission and all required therapies within 72 hours. Patients will receive 5 days of physiotherapy rehabilitation across the 7 days and on average 3-4 times a week occupational therapy and speech and language therapy across 5 days.

Additional 3 Critical Care Beds:

Role	Band	WTE
Dietetics	7	0.5
SALT	7	0.5
Physiotherapy	7	0.8
Occupational Therapy	7	0.8

There is currently no speech and language therapy or occupational therapy funded service in critical care. The additional resource is based on GPICS standards for the additional 3 beds.

7 Day Physiotherapy and Dietetic Service for Major Trauma patients:

Role	Band	WTE
Dietetics	7	0.4
Physiotherapy	6	2.00

The prioritised 7 Day Service based on current service in acute stroke unit will target the following for Major Trauma patients for physiotherapy (in Trauma and PTU) and dietetics:

i. Assessment of all new patients requiring therapy/intervention without delay (on day of referral/within 24 hours of referral)
ii. Assessment/treatment of patients that could potentially be discharged on Saturday, Sunday or Monday if seen by a therapist over the weekend
iii. Treatment/Review of patients who would benefit from early treatment/intervention to prevent loss of function/deterioration and potentially facilitating earlier recovery/discharge

Similar service in acute stroke has demonstrated:

i. **More responsive service:** essential intervention begins without delay.
ii. **Better quality service:** a timely service with treatment at the right time with the right skills. Gaps in the quality of care at the weekends will be reduced as patients will have increased access to therapy services throughout the whole week resulting in enhanced patient experience.
iii. **More efficient service:** workload balanced over a seven day period, facilitating patient flow and reducing length of stay.

In order to realise the full benefit of a therapy 7 day service there needs to be an incremental investment in occupational therapy and speech and language therapy over the next 3 years to achieve the outcomes demonstrated in the stroke 7 day therapy service.

MTC Leadership, Coordination and Delivery of Rehabilitation Prescriptions:

Role	Band	WTE
Therapy Lead for MT	8a	1.00
MT Rehab Coordinator	7	2.00*

*Phased recruitment over year 1 and 2

Commented [BA(M3]: Some comparison of these figures with current establishment on existing acute specialty wards might be useful, to be clear on how much uplift.

High numbers of qualified staff can be justified on basis of complexity of patients, especially those needing multiple trained therapist to stand and mobilise.

Commented [BA(M4]: Some comparison of these figures with current establishment on existing acute specialty wards might be useful, to be clear on how much uplift.

High numbers of qualified staff can be justified on basis of complexity of patients, especially those needing multiple trained therapist to stand and mobilise.

Commented [BA(M5]: Some comparison of these figures with current establishment on existing acute specialty wards might be useful, to be clear on how much uplift.

High numbers of qualified staff can be justified on basis of complexity of patients, especially those needing multiple trained therapist to stand and mobilise.

The therapy lead role, with the support from rehabilitation coordinator, will lead the coordination and management of therapy and delivery of the Rehabilitation Prescription across all major trauma patients in the UHB. They will work closely with the Consultant in Rehabilitation Medicine, Trauma Psychologists and the Trauma Coordinators to support major trauma patients accessing timely rehabilitation and to support onward referral to rehabilitation service once patients have left the MTC. All the peers have these posts that provide clinical and operational leadership to the therapies team.

Therapies development in years 3 & 4

There were two further recommendations from the Peer Review and DoTHS which will not feature in this business case but will be audited and reviewed from launch. This includes delay in turnaround times for measuring and supply of bespoke spinal braces and whether an orthoptist would support this for MTC patients. And consideration of the rehabilitation support workers for the PTU and whether this should include a band 4 post. This is in recognition of the need to phase and regularly audit effectiveness of the service.

Network workforce for Trauma Units

Rehabilitation medicine

Rehabilitation medicine cover is required for the major trauma centre and for the trauma units to meet the relevant standards.

The Network has agreed that rehabilitation medicine sessions are an essential component of the Trauma Units function. They will allow management of local trauma and facilitate repatriation from the MTC. Whilst the second Consultant post will support the network, the individual will need to be recruited into the Specialist rehabilitation consultant pool. The latter is on the advice of the WTN Rehabilitation Lead, reflecting the difficulties with recruitment as an isolated role. It is envisaged that the TU's will be cross-charged for these sessions.

Specialist rehabilitation for spinal injury and neurorehabilitation is commissioned by WHSSC and currently covers 26 spinal beds and 22 neurorehabilitation beds at Rookwood and 12 neurorehabilitation beds at Neath Port Talbot. There are 4.5 WTE equivalent consultant rehabilitation posts and 1 WTE neurology consultant with and interest in rehabilitation. It remains unclear at the time of writing whether WHSSC will commission the rehabilitation medical workforce on behalf of the TUs.

Within the Major Trauma network there is also a senior staff grade rehabilitation post in Swansea Bay UHB and a rehabilitation consultant working within Stroke services in Aneurin Bevan could contribute to the network.

Please note that the cost associated with this post features in the Network section of the PBC.

Consultant sessions within the specialist rehabilitation network

It has been agreed by the Network that each health board should have access to 4 sessions of consultant RM time which would provide a minimum of a ward round, MDT clinic, and outpatient clinic and a session for family meetings/admin and SPA time. Powys would not require 4 sessions as there is no inpatient TU facility but clinics within the locality would be essential.

It is unlikely that a weekly outpatient clinic will be required to meet the trauma demand within health boards and that work could be repatriated from outpatient clinics within specialist rehabilitation to colleagues within the TUs. For example, Traumatic Brain Injury patients from CTM UHB are currently seen in Rookwood, and they could possibly be seen within CTM.

The trauma units are:	HDda	Glangwili (for planning purposes)	4
	CTM	Prince Charles & Princess of Wales	4
	SB	Morriston	4
	AB	The Grange (Neville Hall & Royal Gwent as interim)	4
	C&V	UHW(TU fxn for rehab can be managed within MTC)	0
	Powys	No TU within Powys	1
	MTC	Including Cardiff TU	10

AB UHB and CTM UHB may initially have two TUs. It will not be possible to provide RM support to two TUs within a health board. This configuration equates to a requirement for 27 sessions of consultant time. It is proposed that this is met via 2 new consultant appointments and the reconfiguration of the existing job plans for RM consultants in the region. The nature of the consultant time is likely to be split between spinal injuries and neurorehabilitation. The MTC will require a full time RM consultant supported by existing colleagues to provide cover.

An additional RM post will be required to support the TU RM support. Two additional posts in total would be required with review and reconfiguration of existing specialist rehabilitation sessions to provide the support to ensure that each health board was supported and that flow from the MTC was maximised. There would be 20 “new“ RM sessions and reconfiguration of the existing job plans for RM consultants in the region to provide the additional 7 required for a “go live” position.

There is a need to review existing specialist rehabilitation sessions across the network to provide the support to the TUs with the addition of the additional WTE RM network consultant. It would be sensible to commission these new RM roles through specialist rehabilitation to ensure that there is support for these roles. The health boards receiving TU RM support would be cross charged for the sessions. There is further work to agree how Specialist rehabilitation at NPT would support HD UHB and whether the rehabilitation consultant based at AB UHB who is currently supporting stroke could support the trauma requirements at AB UHB and provide a clinic for Powys.

The above would need rapid discussion with WHSSC as the commissioners of specialist rehabilitation and major trauma. WHSSC are not commissioning the TU function but there would be merit in consideration of commissioning the RM consultant sessions in view of the close relationships between the MTC and TU.

Consultant AHP

A Consultant AHP will add significant value to the Major Trauma network. Peers identified that there is a shortfall in quality research and development in major trauma rehabilitation and this post holder could play a significant role in this area. There will also be a significant role in developing the skills and expertise of therapists working across the network. It is recognised that these patients have complex physical needs but also require significant emotional support in the hyper acute phase of their injury and rehabilitation which continues throughout their journey. This is an important interface role supporting transition into the community. This post will be hosted by the MTC but will be a Network post. There is a precedence for this arrangement with Cancer and All Wales dementia Consultant AHPs.

Role	Band	WTE
Network Consultant AHP	8c	1.00

Commented [BA(M6]: Some comparison of these figures with current establishment on existing acute specialty wards might be useful, to be clear on how much uplift.

High numbers of qualified staff can be justified on basis of complexity of patients, especially those needing multiple trained therapist to stand and mobilise.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
Rehabilitation		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultants				1	125.6	1	125.6
Specialty Doctor		0	0	1	0	1	0
		0	**0**	**2**	**125.6**	**2**	**125.6**
AHP							
Consultant AHP for Network	8c			1	92.2	1	92.2
Therapy Lead	8a	1	16	1	64.2	1	64.2
Rehabilitation Co-ordinators	7	1	13.8	1	55.1	1	55.1
Physiotherapist	7			1.8	99.1	1.8	99.1
Physiotherapist	6			3	140.4	3	140.4
Occupational Therapist	7			1.8	99.2	1.8	99.2
Occupational Therapist	6			1	46.8	1	46.8
Dietetics	7			1.9	104.7	1.9	104.7
Dietetics	6			0	0.0	0	0.0
Speech and Language Therapist	7			1.5	82.7	1.5	82.7
Speech and Language Therapist	6			0.5	23.4	0.5	23.4
Therapy Technician	3			3	73.2	3	73.2
		2	**29.8**	**17.5**	**880.9**	**17.5**	**880.9**
Total		**2**	**29.8**	**19.5**	**1006.5**	**19.5**	**1006.5**

*Please note the Specialty doctor will be funded by HEIW and WG. The Consultant AHP is a network post has been added following peer review and agreement at DoTHS in August 2019.

8. Paediatric Major Trauma Centre

It is important to recognise that the Paediatric MTC, whilst on the same site has a separate Paediatric Emergency Unit which is geographically distinct from the Children's Hospital for Wales which houses the in-patient wards.

Whilst the modelled uplift for Paediatric Major trauma is relatively small as shown in section 5 of the case the impact is likely to be greater than.

Where possible provisions have been planned alongside adult services (and referenced where applicable). However there are some roles required to meet specific Children's MTC indicators which will require distinct resourcing (e.g. Clinical Lead).

8.1 Paediatric Clinical Lead

Relevant indicators

- ***T16-2C-201*** *- There should be a lead clinician for the Major Trauma Centre (MTC) who should be a paediatric consultant with managerial responsibility for the service and time specified in their job plan.*

There is a lead consultant for the development of the MTC services but this time is not currently specified in their job plan and not remunerated. It is therefore proposed that 1 session of clinical time is allocated for this day 1. This position will lead on the overall development of MTC services to meet standards and work jointly with the overall MTC Clinical Lead.

Revenue Costs	Band	In Year 19/20		Day 1 20/21	
		WTE	Cost	WTE	Cost
Medical					
Consultant		0.1	6.3	0.1	12.6
Total		**0.1**	**6.3**	**0.1**	**12.6**

8.2 Paediatric Emergency Unit

Relevant MTC indicators

- ***T16-2B-201*** *- 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. Notes - The consultant trauma team leader need not be on site. It is recommended the MTC undertake an audit of the numbers of major trauma*
- ***T16-2B-202*** *- All trauma team leaders should have attended trauma team leader training.*
- ***T16-2B-204*** *- There should be a Trauma Team Activation Protocol – for paediatrics the trauma team should include medical staff with recognised training in paediatrics and paediatric trained nurses with experience in trauma.*
- ***T16-2B-212*** *- The Emergency Department consultants should be available to attend an emergency case within 30 minutes:*
  T16-2B-203 *- There should be a paediatric registered nurse/AHP of band 7 or above available for 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.*

Current Paediatric Service

It is understood that across the UK, Paediatric services are in some areas provided by a single trauma team covering adults and children. UHW has a mixed delivery model: The paediatric emergency unit is located adjacent to the adult emergency unit and currently shares a reception area. Children are admitted to the Children's Hospital which is geographically distinct from the EU though connected to the main hospital.

As well as the critically injured children, there is an expected significant increase in the number of moderate and minor trauma attending the MTC relating to over triage which is well described in the paediatric population in English MTCs. Having PEM consultants to manage paediatric trauma, allows definitive care to be provided for many of these patients at the front door, ensuring theatre capacity and bed availability remain preserved for more severely injured patients.

The predicted uplift in paediatric patients for the MTC does not take into account secondary transfers which do not currently come through the EU. After MTC 'Go Live' these patients will be coming through the resuscitation room in EU in line with other networks across the UK.

Environment:

- 1 dedicated (ring-fenced) Paediatric resuscitation bay within adult resuscitation area
- 4 trolley spaces (1 of which is protected for step-up/step-down care)
- 1 consultation room (no monitoring/oxygen)
- 1 adolescent room (no monitoring/oxygen, no trolley or examination couch)
- Treatment room (2 examination beds, 1 chair)
- Triage room
- Office
- Dedicated Paediatric waiting area

Workforce

The nursing workforce is distinct from the general nursing workforce however, and the model for medical staffing is also increasingly provided separately by Paediatric Emergency Medicine consultants and adult EM consultants who maintain a special interest rather by the general Emergency Medicine Consultant team.

Medical

There is no dedicated Paediatric Emergency Medicine Trauma Team Leader to attend all trauma in/out of hours There are currently 4.6 WTE Consultant PEM with inconsistent cover between 08:00-22:00 weekdays, 10:00-20:00 at weekends on 1:6 basis, no on-call cover currently. Job plans are not annualised. Paediatric consultants do not do an on-call but have an intensity banding of 1 in order to recognise the antisocial hours and frequent late finishes beyond the time tabled hours.

Inter-hospital transfers to PICU are not currently seen by PED team which has resulted in missed injuries.

There are 4 middle grades, with inconsistent cover daily between 08:00-02:00 and no dedicated junior staff as the service relies on cross-cover from adult side.

Advice from the WTN Paediatric Lead following the NHS England Trauma CRG (March 2019) was that trauma centres with a mixed model of paediatric trauma are struggling to continue to deliver consistently on quality of care. Most Trauma Networks in England went live 8-10 years ago before there were good numbers of Paediatric Emergency Medicine Consultants; since then the sub speciality of Emergency Medicine has grown in number and scope of practice significantly.

Nursing:

- 1 WTE Band 7 team leader in post. Not able to cover 24/7
- 5.56 WTE band 6 staff nurses. Able to have 1 senior cover 24/7
- 11.11 WTE band 5 staff nurses. Able to cover 24/7
- 4 WTE band 7 ENPs
- 1 WTE Play Specialist

Lack of Band 7 nursing tier currently as per MTC quality indicators. The current resuscitation workforce does not allow for the 1:1 care that a major trauma patient requires.

Proposed model

Environment

In order to release the capacity for the adult EU there is a requirement to disaggregate the paediatric resus bay the capital costs for this are set out in the adult section of the case.

Medical workforce

In accordance with national injury and TARN data, the case for paediatric consultant workforce and major trauma has been carefully considered. For 8am-midnight cover 7 days a week and on call we would require 12 WTE Paediatric Emergency consultants, and it is appreciated that this is undeliverable in year 1. In light of this and following recent Peer Review feedback, there has been a revision~~ed~~ of the arrangements to reduce cover in year 1 until 10 pm only. The aim would be to increase these consultant numbers within years 2 & 3 to ensure dedicated PEM TTL cover at peak times of demand (between the hours of 0800-midnight Mon-Fri and for 10 hours/day at weekends) this would require an additional 3 WTE PEM consultants in total. This would provide the guarantee of physicians with the specialist skills, particularly around younger children, safeguarding, imaging and managing families, available at peak times of presentation.

Currently in UHW, the presence of 4.6 WTE PEM consultants currently means that the average EM consultant will rarely manage Paediatric critical injury and can therefore not be expected to maintain the experience and competency to manage all Paediatric trauma. It is well recognised that healthcare providers feel uncertain and anxious when faced with a critically injured child[1] and experience of mixed MTC's in England is that EM colleagues feel increasing uncomfortable managing Paediatric trauma due to the infrequency of cases (from verbal discussion at NHS England trauma CRG group and with

colleagues in Southampton).

A recent publication reviewing all moderate and severe paediatric trauma in England between 2012 and 2017, showed that the 'very youngest infants aged 0.1 year (36.5 days) were the most frequently injured of all ages (0-15 years)'.[2] In addition non-accidental injury and abuse were implicated in 36% of cases[2] and other safeguarding concerns such as neglect or family support issues arise in many more cases. The recognition and early management of NAI is crucial and requires specific training and experience which can be only provided by a Paediatric trained TTL.

The availability of a Paediatric EM trained TTL will also be crucial for discussions around secondary transfers from TU's. Paediatric & PEM colleagues from candidate TU's have expressed concerns about the ability to talk to a Paediatric trained clinician when calling for advice from the MTC. (Verbal discussion in Network Paediatric working group – May 2019 minutes).

The predicted uplift in Paediatric patients does not take into account the fact that currently the secondary transfers do not come through EU. This has led to issues with missed injuries and secondary/tertiary surveys not being completed. After 'Go Live' these patients will be coming through the resuscitation room in EU to be met by a Paediatric TTL.

Nursing staff

The HCSW posts are vital for the functioning of the nursing trauma team. They will be the "scribe" within the team, which is essential in gathering TARN data and vital information about the patient and their condition, that the trauma team rely on. The HCSW also has a pivotal role in the massive haemorrhage protocol activation. The current establishment for HCSW would not facilitate us meeting the requirements of them being part of the trauma team.

Revenue Costs	Band	In Year 19/20		Day 1 20/21		2021/22	
EU		**WTE**	**Cost**	**WTE**	**Cost**	**WTE**	**Cost**
Medical							
Consultants + locum shifts				1.1	204.6	3.1	352.6
Specialty Doctors							
				1.1	**204.6**	**3.1**	**352.6**
Nursing							
Registered nurse	7						
Health Care Support Worker	3			3.6	102.5	3.6	102.5
				3.6	**102.5**	**3.6**	**102.5**
Admin & Clerical							
Medical secretaries	4			0.6	16.8	0.6	16.8
				0.6	**16.8**	**0.6**	**16.8**
Total				**5.3**	**323.90**	**7.3**	**471.90**

*Highlighted areas in the above table show revisions following external panel feedback and recommendations following peer review.

8.3 Radiology

Relevant MTC Indicators

- ***T16-2B-207*** *- 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;
  Scans should be reported by a consultant paediatric radiologist within 24 hours.

The above standards are met however there is currently no presence of a paediatric radiographer in the children's hospital the 1 WTE radiographer has been removed from the case following feedback from the external panel.

8.4 Theatres

Children requiring trauma surgery are currently placed on the mixed adult and paediatric list in main adult theatres. This does not meet the recommendations of the children's framework, Royal College of Anaesthetists or Royal College of Surgeons.

Current theatre lists:

- Orthopaedic elective lists in the children's hospital (approx. 200 cases per year)
- Access to trauma list in main (adult) theatres
- Access to CEPOD list in main (adult theatre)
- No current dedicated paediatric emergency list for T&O in the CHfW
- Whilst there are some theatre sessions that run within the footprint of the Children's Hospital, at present there are no dedicated theatre sessions for paediatric major trauma patients.

In order to support this a business case is being developed by the UHB to extend the operating lists in the Children's hospital to accommodate additional paediatric surgery. This will include provision for paediatric orthopaedic major and moderate trauma which is estimated at 2 sessions per week at a cost of circa £200,000 revenue funding.

Although it is recognised and has been agreed that this cost will not form a part of this overall business case it should be strongly support.

8.5 Acute Pain

Relevant MTC indicator

- ***T16-2B-216*** *- There should be a 24/7 specialist paediatric acute pain service for major trauma patients*

There is currently no separate paediatric acute pain service and this indicator will not be met day 1. There is work ongoing to develop a pain service for the children's hospital. The removal of the 1 WTE

pain nurse from the case will mean any cover for the increase in paediatric Major Trauma cannot be guaranteed.

8.6 Bed capacity

Current Beds:

- 7 ITU beds
- 4 HDU beds
- 29 surgical beds

The majority of Major Trauma patients are managed on surgical wards with a small proportion cared for on medical wards. The 18 extra patients passing through in year three may require an extra surgical bed.

8.7 Rehabilitation

Relevant MTC indicators

- **T16-2D-201** - *There should be a named lead clinician for acute trauma rehabilitation services who should have experience in children's rehabilitation and have an agreed list of responsibilities and time specified for the role.*
- **T16-2D-202** - *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 contacts for the following: pain management specialist, pharmacist, surgical appliance services, orthotic services, prosthetic service.*
- **T16-2D-203** -*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.*
- **T16-2D-206** - *All patients should receive a rehabilitation assessment. Where a prescription is required this should be completed within 72 hours.*
- **T16-2C-215** - *There should be a specialist dietician with paediatric experience with specified time for the management of major trauma patients.*
- **T16-2D-209** - *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.*

Workforce

Medical

There is a requirement to develop services for Paediatric major trauma and the rehabilitation services available. Therefore 1 session of time is proposed in order to meet the above standard day 1. This person will lead on the development and provision of rehabilitation for paediatric major trauma patients. Note this role is related to a distinctly separate indicator for the adult MTC and specifies

experience in paediatric rehabilitation.

Therapists

The rehabilitation coordinator post will be combined with the adult coordinator service but will need to draw on the experience and skills of the rehabilitation team in the Children's hospital.
Rehabilitation MDT team - There is currently a neurorehabilitation team for the children's hospital, this team does not cover those major trauma patients without an associated head injury. These patients will still have access to therapists during their admission but 'whole body rehab' is currently not delivered. It is envisaged that this service will be reviewed over the first year led by the lead consultant and using information collected within the rehabilitation prescription/plan to develop an expansion of this service.

The neuro rehabilitation team currently have no physiotherapist of play specialist as a part of the current MDT as per the indicator. Current team comprises:

- Band 7 nurse 0.5 WTE – Team Lead
- Band 7 SLT – 0.4 WTE
- Band 7 DT – O.5 WTE
- Band 5 OT – 1 WTE
- Band 8b 0.4 WTE psychology
- Band 5 0.21 WTE psychology assistant
- Band 3 2 WTE rehab assistant

Therefore the following posts additional time are proposed in the first year to support standards:

- 1 WTE Physiotherapist
- 1 WTE Play Specialist
- 0.4 WTE Occupational Therapist
- 0.2 WTE Speech and Language
- 0.2 WTE Dietician

Revenue Costs	Band	In Year 19/20		Day 1 20/21	
		WTE	Cost	WTE	Cost
Medical					
Consultant				0.1	12.6
				0.1	**12.6**
AHP					
Physiotherapist	7			1.0	55.1
Occupational Therapist	7			0.4	22.0
Dietetics	7			0.2	11.0
Speech and Language Therapist	7			0.2	11.0
Play Specialist	4			1.0	29.4
			0	**2.8**	**128.5**
Non-pay					
General					3.0
			0		**3.0**
Total			**0**	**2.9**	**144.1**

9 Options Appraisal

Option 1: Don't invest and don't go live

Risks: The impact of not investing in the MTC as per the above proposed models would result in UHW not meeting core specification & quality indicator requirements for MTC launch potentially resulting in:

- Failure to realise reduction in mortality
- Strategic loss in securing position as regional centre of excellence & a major trauma network for south, mid and west Wales.
- Risk of additional uncommissioned activity at UHW when EMRTS move to 24/7 cover for the region.
- Increased operational risk to current services (due to EMRTS expansion as described above)
- Reduced financial risk around funding MTC capital and revenue requirements
- Risk of loss of confirmed commissioning structure for current Major Trauma activity at UHW

Option 2: Partial investment and go live

This would involve either meeting some standards and not others by investing in some areas of the pathway, this is not recommended based on NHS E experience and the case has now been supported by a full Peer Review. Not investing in key areas based on activity (i.e. theatre capacity) risks performance overall for CAV UHB.

- All of the above
- Negative impact on staff morale
- Impact on CAVUHB ability to recruit and retain staff
- Impact on CAV capacity following EMRTS 24/7 go live next year.

Option 3: Investment as per the proposed models.

The recommended option is to approve this business case to allow for C&VUHB to meet both core MTC quality indicators and the predicted uplift in activity for April 2020.

10 Outcomes and Benefits

The following benefits and patient outcomes have been identified during a network benefits and realisation workshop held in May 2019:

Impact on value for money

- Seriously injured people returning to economic productivity
- Reduced length of stay at MTC
- Flexible working across Health Board boundaries
- Streamlining trauma pathway frees up capacity elsewhere in the system

Clinical skills and sustainability

- Attracting staff to work in Wales - clinical, non-clinical and academic.
- Improved staff retention
- Improved training opportunities

Health gain

- Improving survival
- Improving functional outcomes
- Improving timely clinical care and patient experience
- Enhancing injury prevention
- Improved data collection

Equity

- More appropriate patient flow
- Equity of care for veterans with trauma
- Equity of care for trauma in older people

11 Impact on Other Services and Engagement

The designation of MTC status impacts on multiple specialties, services and staff groups across the pathway. It is acknowledged that the launch of the MTC will have a significant impact on the Emergency Unit, Theatres and Critical Care. This must not impact negatively on CAV UHB's ability to provide care to other staff groups or meet current targets in relation to 'Tier 1 and 'Referral To Treatment time'. It is important to highlight that the MTC has to be delivered within the context of a wider acute hospital service and care cannot be to the detriment of other patient groups.

Throughout the planning and internal scrutiny process CAV UHB have taken time to ensure that

impact on current services are minimised. Therefore, it is imperative that the phasing outlined in key areas is supported through any future commissioning framework.
A robust communication and engagement plan has been developed in alignment with the network plan. This will continue once the MTC has gone live, to ensure that positive stories are shared to highlight improvements in care. The development of the Major Trauma service is being communicated using a number of platforms including, face to face meetings, service update notices and publication on our website. In addition, a number of key stakeholder meetings and engagement sessions with staff have been held with future events planned.

All main specialties and staff groups affected have all been consulted in the development of the MTC business case and have been key in developing proposed models against the MTC indicators and agreed network activity data.

Clinician leadership and engagement will be key in service implementation. The service planning includes: The design of new clinical pathways and models of care, the development of data systems, a workforce plan and recruitment programme, a training programme and a governance and quality framework. All of the above will be led by clinicians from across the pathway.

12 Interdependencies

Interdependencies:

1. Operational Delivery Network – delivery of ODN and associated policies and procedures
2. ODN organisations- Full designation of Network trauma Units and pre hospital providers against National specifications and indicators.
3. Commissioners –appropriate commissioning frameworks to be developed
4. Capital funding is required to enable capacity for day 1 go live and will be required to allow for phase two capital projects to deliver.
5. Estates

13 Risks

This section should be read in conjunction with the Network Programme Business case.

High-level Risks to Delivery

Delivery of the MTC is dependent on the following factors being in place:

1. **Recruiting staff with the required skills, experience and qualifications**

Specifically: Emergency Unit, Theatres, Critical Care and ward nursing staff

Likelihood: High in above areas

Mitigating Actions: Network workforce group established to review recruitment process and provide cross organisational support. Recruitment campaigns developed to target specific areas across England. International recruitment campaigns. Joint appointments to Health Boards. Monthly view of

risks with Clinical Boards, CAV UHB Board and Network Board to going live whilst still recruiting to vacancies.

2. **Affordability**

There are both capital and revenue requirements for MTC launch, timely release of funding is required to ensure sufficient workforce can be recruited within the timeframe.

Likelihood: High

Mitigating Actions: There has been a robust internal and external scrutiny process including a peer review with NHS E MTC colleagues and the National Clinical Director for Trauma whereby each area of the case has been discussed in relation to peers and advice has shaped the case.

3. **Network preparedness**:

Specifically: Adequate triage tool to mitigate both undertriage but unexpected overtriage. A tested and specific automatic repatriation policy to ensure capacity at the MTC, coordination service to support effective flow and rehab planning, TARN data baseline and timeliness of submissions to ensure review of the above.

Likelihood: Medium

Mitigating Actions: Continued engagement with the Network at Board and Welsh Government but also good representation and engagement of the UHB at a senior level at network events. Senior representation at the patient flow working group. Testing of the repatriation policy prior to go live.

4. **Commissioning Financial Risk:**

There is a risk that the method by which the UHB is reimbursed as a MTC is significantly different to the cost of the required inputs to meet standards and operational demands. The complexity of the patient group and multiple services that the pathway crosses is complex.

Likelihood: Medium

Mitigating actions: This is best mitigated through an initial framework of block investment in the required fixed resources, and volume-based payments for variable costs (e.g. theatre consumables / drugs).

Such a framework will be dependent on the willingness of the commissioner and LHBs to recognise the uncertainty in establishing an MTC and their risk appetite in committing resources for a period of time whilst implementation is taken forward. It would, however, provide a degree of financial certainty to both provider and commissioner, allowing a period for review of activity flows and compliance. An appropriate framework will likely need to be supported through the WHSSC Management Group.

5. **Procurement**:

Likelihood: Low

Mitigating Actions: Early sign off on costs by Welsh Government required in order to ensure delivery of MTC infrastructure for April 2020

6. **Estates**:

The proposed move of paediatric resus is a compromise to enable go live. There is a longer term risk if UHW does not deliver single point of entry.

A series of 3 ward moves are required to enable capacity to be freed up capacity for the Polytrauma unit prior to winter 2019.

Likelihood: Medium

Mitigating Actions: Early organisation of ward moves to release capacity

Should any of the above experience delays, the ability of the MTC to go live will be effected.

14 Workforce

Additional staff will be required to establish C&VUHB as an Adult and Paediatric MTC in April 2020 and includes the following staff groups:

Staff Group	WTE
Medical Staff	29.5
HCSW	37.65
Registered Nurses	85
AHPs, Scientists & Techs etc.	27.5
Admin and Clerical	11
Total	**191**

A proportion of the staff will be required to commence work prior to the go live date due to the training that will be required in order to ensure they reach the appropriate competency levels within their roles. Whilst some roles will be recruited to reasonably easily, others will be more challenging due to the national shortages within specific staff groups.

Each role has been reviewed to identify how difficult the post will be to recruit to and it will be crucial to work closely with the Network to mitigate the risk of not recruiting on a permanent basis.

A recruitment lead has been appointed and a working group established to ensure that comprehensive plans are in place to enable the UHB to recruit to as many of the roles as possible. A recruitment timeline has been developed for each role ensuring that staff commence at the appropriate times to allow for training. Specific national recruitment campaigns will be held to promote the Network and MTC to encourage applicants from further afield.

There are a number of recruitment events planned ay UHW to recruit staff into nursing and support posts. An initial recruitment event attracted 10 nursing staff into CAV through interest to work on the Polytrauma Unit.

Discussions with the Defence Medical Service (DMS) regarding increased placement of surgical

and nursing staff are underway. The UHB is well placed to undertake this work for increased DMS involvement and placement as it has well-established placements of DMS personnel within the UHB currently.

15 Implementation Plans and Measurement

The implementation plan for MTC delivery is broken down into 2 phases.

Phase 1: Go live April 2020

Key Project Deliverables:

1. **Delivery of a robust BJC to meet predicted activity uplift and MTC standards –** To include phasing where appropriate and to utilise peer review and benchmarking where possible.
2. **MTC Capacity -** To ensure specific capacity across specialties to cope with the increase in demand for day 1 launch (April 2020).To ensure delivery of interim capital plans to support activity demand expected from for day 1 until year 1 April 2021.
3. **MTC workforce** - To ensure that there is sufficient workforce, appropriately trained in place to meet both MTC Quality Indicators and to meet increase in demand from day 1 until Year 1
4. **MTC Quality, Governance** – To ensure there is a robust quality framework delivered including required data and audit of national quality standards and KPI's. To ensure a clear governance structure is agreed and implemented ready for handover to the Specialist Services Clinical Board alongside Major Trauma related policies and overarching Operational Plan.

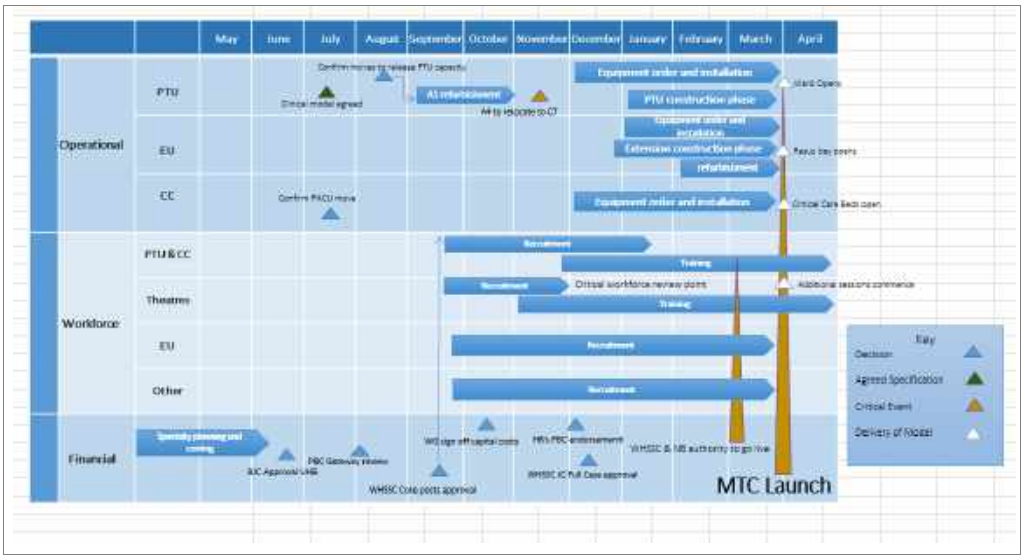
Checkpoints have been planned to regularly review progress against indicators, recruitment plans and capacity increase.

Phase 2: Delivery of required capacity through capital enablers

Key Project Deliverables by end Phase 2:

1. **MTC full Capital infrastructure** – Delivery of full capital theatres infrastructure for April 2021 and expansion of the PTU ward to ensure standards are met.
2. **Delivery of phase 2 workforce** – Development and delivery of phase 2 workforce.

Critical path for Phase 1 of the Project



16 Approval

CAV UHB Business Case Approval Group	
Decision	**Date**
Approve	20/06/2019
Management Executive approval of revisions	11/07/2019
Management Executive approval of revisions	09/09/2019
Management Executive approval of revisions	27/09/2019

Name: Abigail Harris, Director of Planning & SRO for MTC Programme, Len Richards, Chief Executive Officer, Bob Chadwick Director of Finance, Steve Curry, Chief Operating Officer.

Signature: _____ Date: 27/09/2019

3

Wales Trauma Network
Landing pad advice

Author(s): Dindi Gill – Clinical Lead, Wales Trauma Network	
Distributed to: network board members	
Date: 24th June 2019	**Version:** 2.0
Summary and key points for discussion:	
Review History: reviewed by Jenny Thomas, network rehabilitation lead and supported through face-to-face meetings with all LHB network members (July 2019), supported by professional peer review (13th August 2019) and fully endorsed by network board (19th August 2019). Supported by Collaborative Executive Forum (20th August 2019)	

Draft Number & version		**Author/ Editor**	**Date**
1	1.0	Dindi Gill	16th June 2019
2	2.0	Dindi Gill	23rd June 2019
3	3.0		

LHBs have been asked to ensure patients are repatriated for 'care with treatment closer to home' within 48hrs of being fit for discharge from specialist care, in order to ensure flow into specialist care can be maintained. The network are undertaking a series of workshops to develop the following aspects:

- Operational policy to support this.
- Appropriate escalation.
- Preparing an appropriate landing pad.

This briefing provides an outline of the approach to managing the landing pad, recognising that for some LHBs this will pose challenges.

Following the network board on the 24th June 2029, network board members are asked to consider these points in completing their business case submissions and subsequent planning:

1. Recognition that these patients belong to the origin LHB, irrespective of where they are being treated.
2. In most cases and based on the specification for a landing pad provided by Jenny Thomas, LHBs are asked to consider that their TU(s) become the landing pad for the LHB. If not, consideration need to be given to suitability of an alternative location in line with the guidance already provided, with appropriate mitigations.
3. In accordance with the all wales repatriation policy, these patients should already be coming back to the LHB (except a few with complex conditions), therefore these are not new patients in the system and this does not necessarily represent new capacity. Repatriation has simply become the poor cousin in the pecking order of priorities – recognising the unprecedented pressures in unscheduled care and lack of an appropriate level of capacity within social care.
4. Most TUs will see less patients in totality (as the number of acute patients from LHBs to MTC will exceed the number of patients returning from the MTC to the LHBs).
5. Therefore, in most cases there is no requirement for new capacity.
6. Clearly that are some exceptions to the above, but the uplift needs to be proportionate to the need.
7. The data presented on the bed requirements for the landing pad represents a worst-case scenario. This represents the maximum number of beds required at the landing pad within existing TU capacity. Most patients will go for specialist rehabilitation from the MTC, so transfers of these patients from the MTC to the landing pad will be minimum. A minimum number of patients may also go from specialist rehabilitation to the landing pad.
8. The true size of the landing pad cannot be accurately quantified at this stage to determine any additional infrastructure and nursing requirements, but in year 1 the picture will become clearer – this is reflected in the phasing below.
9. Based on the above, a phased approach to the development of a landing pad will be required:

Before Year 1	Year 1	Year 2	Year 3
LHB to identify TU(S) as landing pad or as appropriate. Identify wards, where the following groups of patients can be located (breakdown provided in V9.0 of data paper): - Ongoing medical care/awaiting packages of care – Likely care of the elderly ward(s). - Level 2 rehabilitation – Likely mixed group (care of the elderly or stroke/neurology ward(s)). - Awaiting or from specialist rehabilitation (small numbers) – stroke/neurology ward(s) - Complex ortho fracture patients etc.	Major trauma practitioners/rehabilitation coordinators/therapists to form a team working across these wards, supported by weekly visit by rehabilitation consultant. Education and training provided to nursing staff on these wards, Coordinator services should be in place for day 1. Would suggest a weekly MDT takes place to review all possible ISS>9 patients, incl. transfers back in. Collect data on actual workload and composition of repatriated patients to assess actual impact and determine size and development of 'landing pad.' Without this, it is impossible to accurately determine the need for additional investment.	Delivery of dedicated landing pad within existing infrastructure OR new infrastructure depending upon local service developments and circumstances. Delivery of nursing staffing requirements.	Delivery of dedicated landing pad within existing infrastructure OR new infrastructure depending upon local service developments and circumstances. Delivery of nursing staffing requirements.

just requiring additional nursing care and rehabilitation Create capacity equivalent to size of landing pad across these wards through internal re-organisation and ensure side room availability on stroke/neurology ward(s). Identify specialties based on the above. Minimum requirement for new nursing staff or infrastructure. Management and governance structure agreed. Major trauma practitioners and rehabilitation coordinator team structure to be developed to ensure robust cover of service across these identified wards incl. how these will sit in internal governance structure and be supported by managerial and clinical leads. This should include close working with TARN coordinators. Strategy should also be developed to support the live identification of all ISS>9 patients (both who will stay in TU and those who will require transfer back). Single point of access into TU agreed (ideally via the coordinator or patient access/site team) using internal SOP above to define where patients should be pulled back into. By providing a single point of access but multiple locations of care with an overarching team this ensures good patient flow, continued patient key working and communication	Planning for dedicated landing pad (incl. side rooms/therapy's room) to be developed as appropriate based on the above data. This could include a dedicated space within existing infrastructure OR new infrastructure depending upon local service developments and circumstances. Identify nursing staffing requirements. The outcome might be that one landing pad will not be appropriate for the variation they will see. Colocation of similar groups within specialties will probably occur.			

as well as enhancing the skills of the workforce across the TUs for other patient groups.			

Wales Trauma Network
SBAR - Phased implementation of TUs

Author(s): Dindi Gill – Clinical Lead, Wales Trauma Network	
Distributed to: Network board members	
Date: 13th July 2019	**Version:** 1.0
Summary and key points for discussion:	
Review History: reviewed by Jenny Thomas, network rehabilitation lead, supported through face-to-face meetings with all LHB network members (July 2019), supported by professional peer review (13th August 2019) and fully endorsed by network board (19th August 2019). Supported by Collaborative Executive Forum (20th August 2019)	

Draft Number & version		Author/ Editor	Date
1	1.0	Dindi Gill	13th July 2019
2	2.0		
3	3.0		

Situation

Following the Gateway Review on the 8th-10th July 2019, recommendations of the Gateway Review team indicate that current submissions from LHBs with respect to TU resourcing present both an unaffordable and undeliverable position. Furthermore, there is a need to close out the gap between the programme team specification of minimum day 1 requirements and current LHB business cases and further develop planning assumptions for each phase to progressively meet quality indicators.

This paper outlines the approach to this, in order to successfully deliver the PBC and in the implementation of the network in April 2020.

Background

In March 2019, all LHBs were asked to complete an information request to inform the Programme Business Case (PBC) and local business cases with respect to the phased implementation of TUs. Guidance was provided as to key in year enablers and year 1 and year 2 requirements. A series of

questions were posed by the programme team, in order to identify how key 'gaps' against TU quality indicators could be closed, either through internal re-organisation and/or some additional resources. The information request also clearly stated that any additional resource requirements would need to be handled within the context of LHBs IMTPs for 2019/20 and subsequent years. Consequently, all LHBs were advised to ensure that their Executive teams were sighted on the submissions and were able to confirm that any additional resource requirements would be managed within the LHBs IMTP process for 2019/20. Internal LHB costs would also need to be considered in the context of each LHBs contribution to the costs of the MTC, specialist services and the ODN.

All LHBs provided an initial submission for the PBC. The programme team provided both written and verbal scrutiny of these submissions. Further written scrutiny was provided following the presentation of all business case submissions at the network board on the 24th June 2019, in order to the inform the preparation of a draft PBC head of the Gateway Review in July.

Assessment

The programme team as part of the development of the PBC and the Gateway Review team have undertaken an assessment of each LHB submission. A summary of this is provided below:

1. There was variation in submissions against the guidance provided on in year enablers and year 1 and 2 requirements. Furthermore, there was a lack of consistency in the banding of some roles. Whilst some variation may be a reflect differences between individual LHBs with respect to their baseline position, the differences were marked.
2. The submissions from LHBs varied significantly in their completeness, in particular with respect to therapies. Furthermore, there was limited joint up work demonstrated between LHBs, with respect to specialist roles. Thus, there is significant work yet to be done in terms of reflecting local and cross-LHB rehabilitation requirements.
3. Submissions varied significantly in their justification of additional resources and how this has been evidenced.
4. Significant variation in LHBs approach to their 'landing pad' despite guidance being issued through the network board.
5. No LHBs (except 1) have formally confirmed their position with respect to:
    - The lack of in year funding for key enablers.
    - LHBs position with respect to next year's IMTP and ensuring that early enabling roles will be prioritised within this process.

In order to the address these issues and ensure that the programme can continue to progress, there is a re-alignment required to ensure LHBs now focus on what are the absolute key resource requirements for the network to go live. These are outlined below per TU:

1. Clinical lead - 1 session.
2. TARN coordinator – 1 WTE band 4
3. Major trauma practitioner – 1.5 WTE band 7
4. Rehabilitation coordinators – 1.5 WTE band 7 (both an operational and clinical role)
5. Rehabilitation consultant sessions 4 sessions/week for each LHB to undertake ward reviews, clinics and MDTs.

Following the establishment of this team (alongside a nominated managerial lead e.g. from a T&O directorate and nominated executive operational lead), a foundation will have been built for subsequent developments. The advantage of focusing on the above is as follows:

1. Focusing on key enablers will improve clinical and operational governance, patient flow and manage the risk of patients returning to the LHB from the MTC. These are absolute priorities for the network.
2. Will be deliverable in terms of recruitment, without destabilising other areas, as well as neighboring LHBs. All LHBs will be ultimately recruiting from the same pool of skilled personnel.
3. Given the lack of in year funding, presents a more affordable position with respect to securing central funding from Welsh Government, if this agreed.
4. Given pressures on the IMTP process, presents a more affordable positon to respect to securing ongoing costs through LHB budgets.
5. Should be considered a positive step to meet many of the quality standards for TUs where gaps were identified.
6. A significant advantage compared to where many NHSE TUs were in 2012 and in many cases now.
7. A recognition that this is just the start of the programme to develop the South Wales Trauma Network and even in 2019, not all TU quality indicators are being met in TUs in NHSE.

In light of the above, the PBC will be used to describe the schedule of business cases produced in year 1 and year 2, in order to support subsequent developments of the programme. It is expected that these will be considered by the ODN board and reflected in subsequent LHB IMTPs. These are outlined below:

Year 1

Therapy requirements.

Neuropsychology requirements.

Level 2 training requirements for nursing staff (as appropriate).

Presently none of the LHBs are able to accurately describe their local rehabilitation model with respect to major trauma, how this overlaps with other areas of practice, the predicted workload and how roles could work across the LHBs. Notwithstanding the gaps in current provision of balanced therapies, consideration will first need to be given to how roles could be met through internal re-organisation before additional resources are considered. Thus, more time is required for these elements to be developed and mature. Hence, this should now be considered a year 1 development.

Year 2

Orthogeriatric requirements.

Year 1 deliverables will include a ‘silver’ trauma triage tool to enhance identification of patients and a ‘silver’ trauma guideline. In line with the approach being taken by the MTC, LHBs will be encouraged to look at innovative ways of achieving these standards (e.g. through use of major trauma practitioner) and evaluate how effective these have been. The ODN board will work with HEIW as part of developing a workforce strategy on how Orthogeriatric input could be improved. Thus, if additional resources are required here, decisions will be better informed by evaluating innovative solutions and deliverability of the workforce.

Thus, the programme will used to drive the development of subsequent LHB business cases in year 1 and 2, with respect to the network development, as part of the phased introduction of standards.

In relation to the ‘landing pad’, please follow separate guidance already provided.

Recommendations

The above present both a pragmatic, realistic and consistent solution to the issues raised by the Gateway review team.

Network board members are asked to:

1. Note the above approach.
2. Approve the agreed position with respect to the absolute key requirements for TUs and subsequent schedule of business cases to be considered in year 1 and year 2.
3. Ensure that this is now reflected in LHB submissions, supported by further input from the programme team and assisted by the formation of a scrutiny panel to review all TU cases.

Wales Trauma Network Board Terms of Reference

Author(s): Rachel Hennessy, Professor David Lockey (May 2018)					
Reviewer(s): Rosemary Fletcher, Dindi Gill (September 2018)					
Date: September2018		**Version:** 2.0			
Publication/ Distribution: Trauma Network Board					
Review Date: Approval date: May 2018 Next review date: September 2018					
Purpose and Summary of Document: Terms of reference for the Wales Trauma Network Board for South Wales, West Wales and South Powys. These terms of reference set out the remit of the Board to establish the Network. These will need to be reviewed at the start of implementation (consisting of programme planning and preparation for delivery phases) and before the Network is operational					
The Board/Committee are asked to					
Approve	**X**	**Discuss**	**X**	**Receive**	

Wales Trauma Network Board – Terms of Reference

1. Overview

The Wales Trauma Network Board ("Network Board") will oversee the establishment of a Trauma Network across South Wales, West Wales and South Powys, ensuring the provision of a high quality, safe and effective service for the population.

The Network Board will be responsible for the establishment of policies and protocols to support the successful implementation of the Trauma Network. The Network Board will facilitate closer joint working across the Major Trauma Centre (MTC), Trauma Units (TUs) and develop links with pre-hospital services and provide the basis for the greater involvement of clinicians (doctors, nurses and allied health professionals) and managers in the planning, delivery, evaluation and improvement of trauma care services. The implementation will consist of programme planning and preparation for delivery phases.

2. Objectives

The main objective of the Network Board is to develop a programme for the implementation of an inclusive, collaborative trauma network, adopting the principles of a whole system approach from the point of wounding to recovery for patients across the region.

Detailed objectives of the Network Board are set out below:

- Ensure the development of high quality, safe and effective trauma services for the population of South Wales, West Wales and South Powys
- Lead the development of a consistent and standardised approach to the delivery of trauma services across the region
- Provide strong independent and consistent clinical advice to Health Boards, NHS Trusts, Commissioners and others as appropriate
- Develop and approve network clinical and operational policies, procedures and guidelines to support the establishment and running of the Wales Trauma Network
- Develop service specifications relating to trauma
- Develop common models of care and pathways, which meet national standards and support their implementation, including the development of a trauma triage tool
- Influence collaborative service planning

- Advise on delivering and operating to clinically agreed service standards
- Develop, receive and scrutinise business cases for submission to WHSSC Joint Committee, Health Boards and Welsh Government.
- Agree a process for data sharing between Health Boards and commissioners.
- Review service outcomes, including reviewing outcomes from national registers and databases and developing and monitoring other outcomes measures
- Advise on appropriate ICT infrastructure to support the Network's operational capability
- Undertake peer reviews of services within the Wales Trauma Network
- Ensure all Health Boards report in to the Trauma Audit and Research Network (TARN) database
- Develop a work plan to support the successful implementation of the Wales Trauma Network
- Produce an annual report outlining progress and achievements over the year
- Engage with stakeholders including development of a robust, continuously reviewed, communications and stakeholder engagement strategy
- Develop and maintain a risk register for issues that the Wales Trauma Network are responsible for, understanding the wider risk across the Network.
- Develop the quality and governance agenda including Incident reporting and Mortality and Morbidity reviews
- Develop Education and Continued Professional Development CPD support to the wider trauma network
- Develop strategies for injury prevention which could be implemented across the wider trauma network
- Consolidate the regional and cross network rehabilitation provision.
- Develop pathways to ensure appropriate patient flow through the network

Where disputes arise during the implementation of the Network between providers and this cannot be addressed at a local level this may need to be escalated to the chairs of the Network Board and WHSSC Major Trauma Commissioning Team for resolution.

The standards for a trauma network have been written by the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute for Health and Care Excellence (NICE).

Included within the standards are those services that should be in a major trauma centre, trauma units, and how the network should function. The Wales Trauma Network Board aspire to meet all of the clinical and operational standards as set out by NHS England.

3. Membership

The Network Board comprises representatives from across the Wales Trauma Network. The Network Board membership reflects that implementation is at its planning phase. Membership will be subject to review during the preparation for delivery and delivery phases of the development.

The Network Board is chaired jointly by Tracy Myhill (CEO, ABMU) and Dr Mark Ramsey (Unit Medical Director, Morriston Service Delivery Unit). The tenure will be two years.

Membership of the Network Board comprises:

- Network Clinical Lead
- Network Manager
- NHS Wales Collaborative Director
- Clinical and managerial representative from each Health Board in the Network
- Network Paediatric lead
- Network Rehabilitation lead
- Network Governance lead
- Network Quality Improvement and Research
- Network Education & Training
- Clinical and Managerial representation from WAST
- Clinical and Managerial representation from EMRTS
- MT Commissioning Lead
- MT Commissioning Team Chair
- Emergency Ambulances Services Committee representative
- North Wales representative (North West Midlands Trauma Network)
- Health Education and Innovation Wales
- Therapy group representation
- Nursing group representation
- Paramedic representation

NOTE: not all members are in place at the time of review, but will be in place as the implementation proceeds.

The Network Board will meet monthly in the first instance, and videoconferencing will be made available. Frequency of meetings will be reviewed at six months and ongoing frequency will be decided by consensus of the Board.

The MTC project group has been established at UHW and will report to the Network Board. TU group(s) will also need to be established to take forward the delivery and management of trauma services within their health board area and will also report to the Network Board.

3.1 Roles & Responsibilities

Chair's Responsibilities

- Chair regular meetings
- Approve agenda items for each Board meeting
- Ensure the Network Board develops and agrees a work plan and achieves its objectives and targets
- Conduct meetings within time and hold organisations/members to account for delivery of agreed actions and report on progress to the NHS Wales Collaborative Director

Member Roles

- Work in a collaborative way to support the delivery of major trauma services across the region
- Contribute their specialist knowledge constructively
- Promote network outcomes to others
- Actively pursue network outcomes
- Attend meetings on a regular basis
- Complete delegated actions on time
- Communicate board activity, including the distribution of network board papers, to those they represent in particular to Health Board Executive teams and ensure major trauma developments are reflected in individual IMPT plans.
- Comply with network decisions and policies.
- Timely completion of any declarations of interest.

Administrator Role

- Provide agenda to chair 10 working days before meeting
- Distribute agenda and papers to members 5 working days before meeting
- Circulate formal minutes 10 days after meeting and after Chair's approval

- Provide action list from each meeting
- Record apologies
- Prepare reports
- Communicate correspondence papers, dates etc.
- Completes delegated actions on time
- Chase members to complete agreed actions
- Maintain up to date declarations of interest register for network.

Meeting Protocols

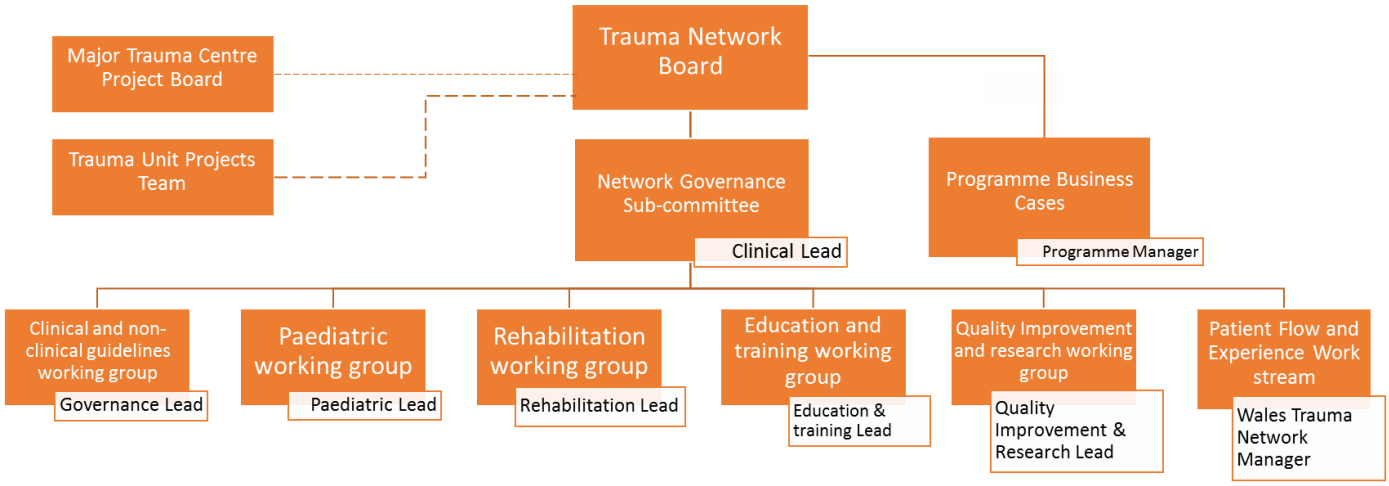
- Agenda items to chair 10 working days before meeting
- Papers distributed 5 working days before meeting
- Members should make every effort to attend each meeting but, in the event they are unable to attend, a representative/deputy may attend who will report back following the meeting
- A minimum of 50 per cent of board members is required for the meeting to be quorate. This will need to include the chair and the Network Clinical Lead or representative of the NHS Wales Collaborative.

4. Accountability, Commissioning and Reporting Arrangements

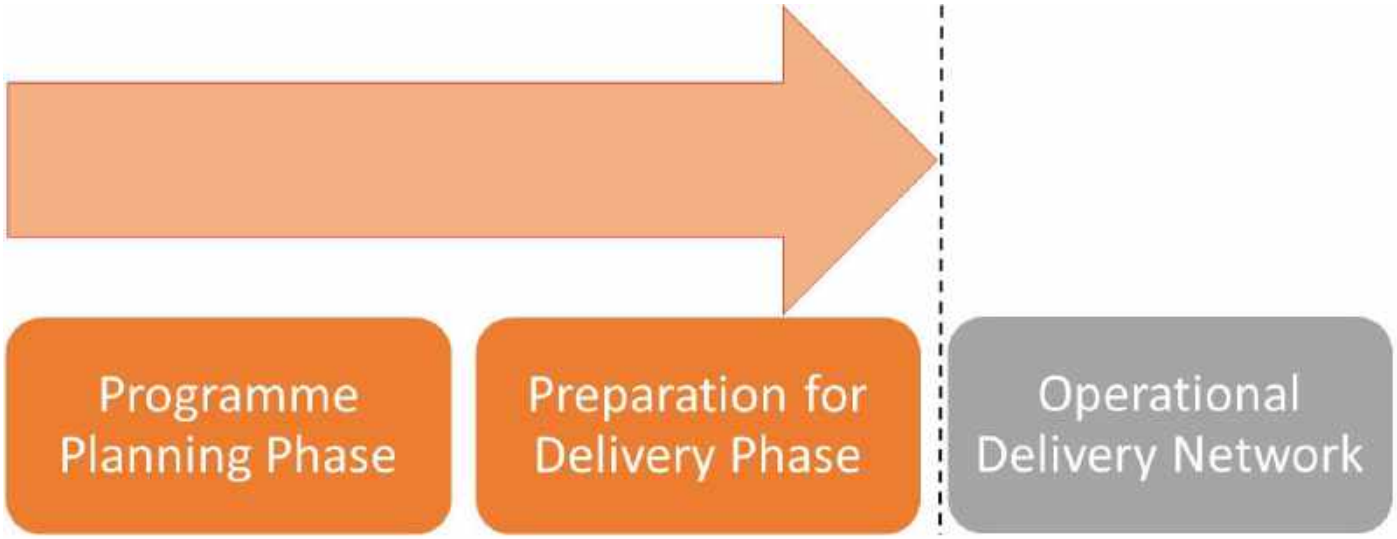
Implementation Phase – the Wales Trauma Network will be hosted by NHS Wales Health Collaborative, commissioned by WHSSC and accountable to WHSSC through a Service Level Agreement which will set out the key deliverables for the implementation phase, together with agreed broad outcome measures. Matters that fall outside the commissioning arrangements and scope of the SLA will be reported via the Collaborative Executive Group.

Operational Phase – the Wales Trauma Network will be hosted by a provider organisation, commissioned by WHSSC and accountable to WHSSC through a Service Level Agreement. As the Network enters operational phase, the SLA will be reviewed and revised, and this will include the development of key performance indicators.

A number of working groups will be established to support the programme planning and preparation for delivery phases as outlined below:



The work steams will be accountable to Network Board and will report to the Network Clinical Lead via a governance subcommittee. All groups will have clear terms of reference and scope.



The above structure does not represent the final structure of the operational network. This will be developed in due course.

5. Review Terms of Reference

The terms of reference will be reviewed annually at minimum and at specific milestones during the implementation stages of the development.

6. Membership List

Tracy Myhill (Chair)	Chief Executive, Swansea Bay UHB
Mark Ramsey (Chair)	Unit Medical Director, Morriston Hospital, Swansea Bay UHB
Joanne Abbott-Davies	Assistant Director of Strategy & Partnerships, Swansea Bay UHB
Ruth Alcolado	Deputy Medical Director, Cwm Taf Morgannwg UHB
Olivia Barnes	Project Support, WAST
Rhys Blake	Head of Planning and Business Support, Public Health Wales
Brian Burgess	Trauma Unit Clinical Lead, Swansea Bay University Health Board
Rebecca Cook	Head of Information Design and Standards Development, NWIS
Nikola Creasy	Paediatric Lead, Trauma Network
Leigh Davies	Governance Lead, Wales Trauma Network
Marie Davies	Assistant Director of Planning, Cardiff & Vale UHB
Ifor Evans	Wales Critical Care and Trauma Network Manager. NHSWHC
Zoe Goodacre	Wales Critical Care & Trauma Network Transitional Lead, NHSWHC
Rosemary Fletcher	Director, NHS Wales Health Collaborative
Claire Fudge	Therapies Representative
Dinendra Gill	Clinical Lead, Wales Trauma Network
Stuart Gill	Consultant Anesthetist, West Wales General Hospital, Hywel Dda UHB
Vickie Harding	Project Support Officer, Wales Critical Care & Trauma Network, NHSWHC
Sian Harrop-Griffiths	Director of Strategy, Swansea Bay UHB
Tersa Humphries	Interim Associate Service Director, Swansea Bay University Health Board
Fiona Jenkins	Executive Director of Therapies, Cardiff and Vale UHB
Ami Jones	Deputy Medical Director, EMRTS
Caroline Lewis	Policy Lead, Welsh Government
Deb Lewis	Service Director - Morriston Hospital Delivery Unit, Swansea Bay UHB
Victoria Le Grys	Programme Director, Cardiff and Vale UHB
Greg Lloyd	Head of Clinical Operations, WAST
Pushpinder Mangat	Medical Director, HEIW
Kath McGrath	Assistant Director of Operations, Cwm Taf Morgannwg UHB
Karen Miles	Director of Planning, Hywel Dda UHB
Orla Morgan	Lead Nurse for Major Trauma, Cardiff and Vale UHB
Kosta Morley	Training and Education Lead, Wales Trauma Network
Ian Morris	Deputy Director of Planning, Aneurin Bevan UHB
Claire Nelson	Acting Assistant Director of Planning, WHSSC
David O'Reilly	Quality and Improvement Lead, Wales Trauma Network
Karen Preece	Director of Planning, WHSSC
David Rawlinson	Clinical Informatics Manager, EMRTS
James Rodaway	Head of Commissioning and Programme Management, NCCU
Melissa Rossiter	Clinical Lead, Major Trauma UHW, Cardiff and Vale UHB
Sarah Spencer	Unit Medical Director, Princess of Wales Hospital, Cwm Taf Morgannwg UHB
Jeremy Surcombe	Programme Manager, Wales Trauma Network, NHSWHC
Jenny Thomas	Medical Director WHSSC

Jeremy Tuck	Deputy Medical Director, Powys Teaching Health Board
Ed Valentine	Accident & Emergency Consultant, Aneurin Bevan UHB
Jonathan Watts	Assistant Director of Strategy and Planning, WAST
Jonathan Whelan	Assistant Medical Director, WAST
Ross Whitehead	Deputy Ambulance Commissioner, EASC
Paul Williams	Trauma Commissioning Lead, WHSSC
Mark Winter	Service Manager, EMRTS
Catherine Wood	General Manager for Critical Care and Trauma, Cardiff and Vale UHB

Wales Trauma Network – Network Governance Subcommittee Terms of Reference

Author(s): Dindi Gill	
Reviewer(s): Network governance sub-committee	
Date: 12th June 2019	**Version:** FINAL
Publication/ Distribution: Network governance subcommittee, trauma network board	
Review Date: Network governance subcommittee 8/5/19 and further review by Jeremy Tuck (Powys network board representative) – 5/6/19, reviewed at subcommittee 12/6/19 and pending 2 additions to membership – finalised	
Purpose and Summary of Document: Terms of reference for the network governance subcommittee for the trauma network covering South, Mid and West Wales. These terms of reference set out the remit of the committee to establish the network. These will need to be reviewed before the network becomes operational.	

The Board/Committee are asked to					
Approve	**X**	**Discuss**	**X**	**Receive**	

Wales Trauma Network Governance Subcommittee – Terms of Reference

1. Overview

The network governance subcommittee will have an important role to play in ensuring South Mid and West Wales Trauma Network delivers a high quality, safe and effective service for the population at risk. It will do this by assuring the quality of its clinical pathways and policies and monitoring the performance of clinical services from point of injury through acute admission, rehabilitation to return of the patient to the highest achievable levels of functional ability. It will act as a subcommittee of the network board.

During implementation of the Trauma Network, the focus of the Governance Subcommittee will be on programme planning and preparation for delivery. The principle output of the subcommittee will be reviews of the enabling policies and guidelines that are being developed by several working groups ensuring that they are grounded in National policies where they exist and on best practice. For example, the National Clinical Advisory Groups, the British Society for Rehabilitation Medicine (BSRM) and the National Institute have written the standards for a trauma network for Health and Care Excellence (NICE). Included within the standards are those services that should be in a major trauma centre, trauma units, and how the network should function. The Wales Trauma Network Board aspire to meet all of the clinical and operational standards as set out by NHS England.

Once the Trauma Network goes live, while clinical policies will change as emerging evidence from practice and research is taken into core practice, the focus of the Governance Subcommittee will be on monitoring performance within the clinical pathway, identifying trends and risks and ensuring that audit loops are closed by demonstrating where change has occurred in response to trend analysis. In this context, it is important to note that trends can be positive and that effort must be invested to identify and export best practice; not just concentrate on the areas that need improvement.

The governance subcommittee provide the Network Board with the evidence that it will need to influence how the contributing Health Boards can improve the quality of trauma services through facilitating closer joint working between pre-hospital services, the Major Trauma Centre (MTC), Trauma Units (TUs), and community based rehabilitation services.

2. Objectives

The unifying purpose of the Governance Subcommittee is to provide assurance to the board that due diligence and corporate governance is being delivered to the highest standards throughout the programme. In more detail; that clinical policies are nested in established national policies and guidelines; are founded on best, evidence-based practice; that clinical performance is being constantly reviewed and improved; that areas of risk have been identified and risk management processes are in place and; that change resulting from audit is implemented.

Detailed objectives of the committee are set out below are set out below:

Implementation

- To provide a final peer review process for clinical policies developed by specialist sub groups.
- To provide the programme executive with the appropriate evidence to enable it to engage with LHB Chief Executive and Medical Directors with a view to implementing best practice across the entire network thus ensuring equitable access to the best quality of care not matter from where within the network the patient has come.
- To review action logs and risk registers of working groups ensuring progress is made in addressing issues and adhering to agreed timelines for implementation and tracking how risks are being mitigated.
- Agree metrics for service performance, quality improvement, commissioning targets and research programmes.

Operational Delivery (it is recognised that these will need to be developed further as the network governance structure is implemented – these objectives are in addition to those provided above)

- To review themes emerging from all incident/case reviews undertaken by providers and ensure lessons/recommendations are shared across the network. To check any actions have been undertaken.
- Review clinical performance within the trauma pathway: *METRICS TO FOLLOW.*

- To provide analysis to the board on Quality Improvement, Audit and Research initiatives.
- Review service outcomes, including reviewing outcomes from national registers and databases and developing and monitoring other outcomes measures.
- Provide additional advice to the board, as necessary, to add additional insights into proposed changes being recommended by specialist sub groups; for example changes in clinical metrics or ICT structures.
- Provide specialist input and assistance into external peer review of services within the network.
- Ensure all Health Boards report in to the Trauma Audit and Research Network (TARN) database
- Contribution to annual report outlining progress and achievements over the year.
- Engage with stakeholders through stakeholder and provider events (incl. conferences).

3. Membership

The Network Governance Subcommittee comprises representatives from across the network. Membership reflects the implementation phase. Membership will be subject to review during the operational delivery phase of the development.

The Network Governance Subcommittee is chaired by the clinical lead of the network.

The Governance Subcommittee vice chair is by the network governance lead

Membership of the Network Board comprises:

- Network Manager
- Network and regional programme manager(s)
- Network Paediatric lead
- Network Rehabilitation lead
- Network Governance lead
- Network Quality Improvement and Research lead
- Network Education & Training lead
- Clinical and managerial representation from the MTC
- Clinical and managerial representation from Health Boards
- Representation from WAST and EMRTS

- Representation from nursing and AHP group.
- North Wales clinical representative (North West Midlands and North Wales Trauma Network)
- Clinical representation from outside Wales (e.g. neighbouring network) – ideally 2 representatives or as appropriate.

Observers and those contributing intermittently to the activity of the Subcommittee will be invited on an individual basis and recorded as such in the minutes.

NOTE: not all members are in place at the time of review, but will be in place as the implementation proceeds.

3.1 Roles & Responsibilities

Chair's Responsibilities

- Chair regular meetings.
- Approve agenda items for each meeting.
- Ensure the Subcommittee agrees a work plan and achieves its objectives and targets.
- Conduct meetings within time and hold organisations/members to account for delivery of agreed actions and report on progress to the network board.

Member Roles

- Work in a collaborative way to support the delivery of major trauma services across the region.
- Contribute their specialist knowledge constructively.
- Promote network outcomes to others.
- Actively pursue network outcomes.
- Attend meetings on a regular basis.
- Complete delegated actions on time.
- Communicate Subcommittee activity, including the distribution of papers, to those they represent.
- Comply with network decisions and policies.

Administrator Role

- Provide agenda to chair 10 working days before meeting.
- Distribute agenda and papers to members 5 working days before meeting.

- Circulate minutes/records of decisions or discussions, updated actions matrix and risks register within 10 days of the meeting and after Chair's approval.
- Provide action list from each meeting.
- Maintain the Sub Committee Risk Register.
- Record apologies.
- Prepare reports.
- Communicate correspondence papers, dates etc.
- Completes delegated actions on time.
- Chase members to complete agreed actions.
- Maintain up to date declarations of interest register for network.

Meeting Protocols

- The network governance subcommittee will meet monthly in the first instance, and videoconferencing will be made available. Frequency of meetings will be reviewed once the network becomes operational.
- Agenda items to chair 10 working days before meeting.
- Papers distributed 5 working days before meeting.
- Circulate minutes/records of decisions or discussions, updated actions matrix and risks register within 10 days of the meeting and after Chair's approval.
- Members should make every effort to attend each meeting but, in the event they are unable to attend, a representative/deputy may attend who will report back following the meeting.
- A minimum of 30 per cent of board members is required for the meeting to be quorate. This will need to include the chair or the vice chair, the governance lead or a suitable representative. In the event of the absence of the chair or vice chair, the chair may nominate an individual to lead the meeting and empower them to make substantive decisions where there is a 60% majority for a voted proposition.

3.2 Values and Behaviours

The group will align itself with the values and behaviours of the NHS Wales Health Collaborative. Subsequently the group will align to the values and behaviours of the host organisation.

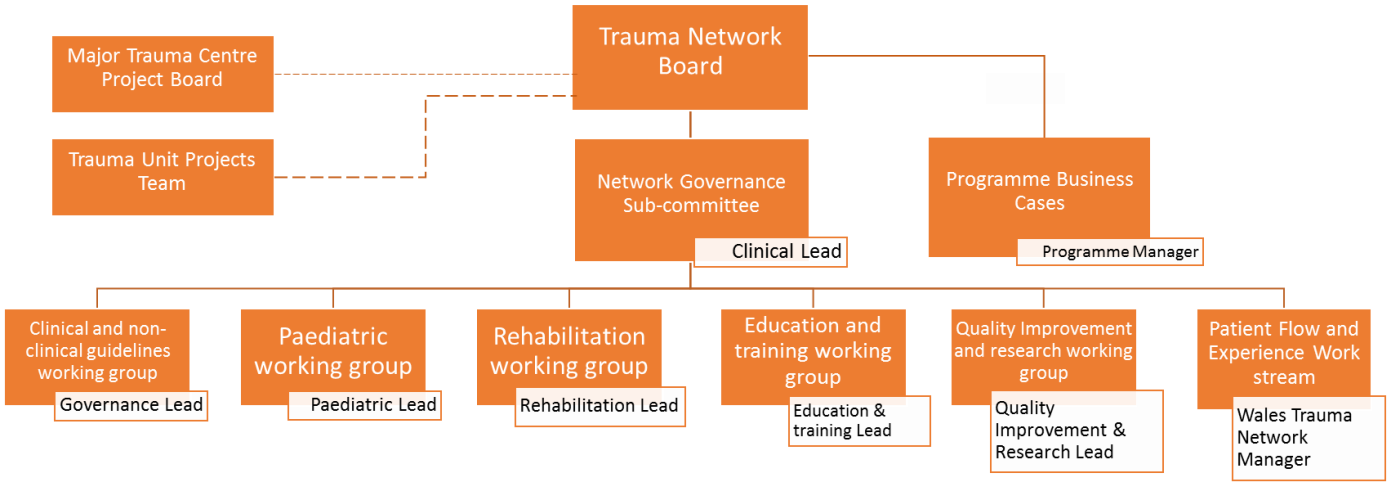
4. Accountability and Reporting Arrangements

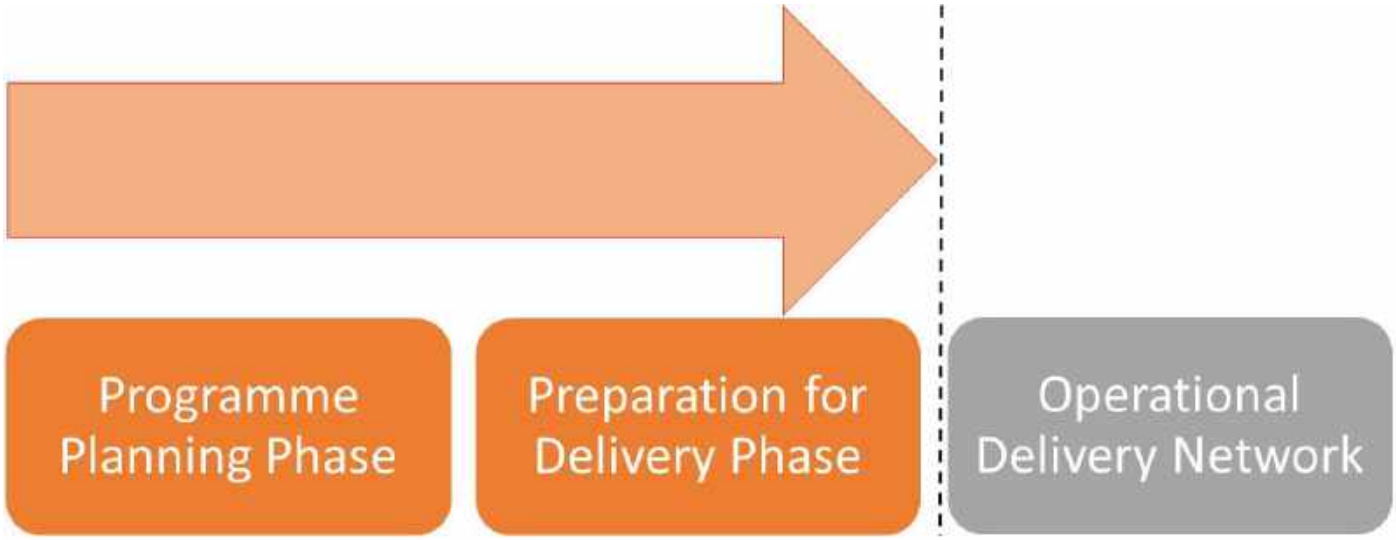
During the implementation and operational phase of the development, the network governance subcommittee will be accountable and responsible to

the network board. It will report to the network board through the clinical lead (chair). For example whilst the governance subcommittee will provide review and scrutiny of policies, final approval will come from the network board.

Network working groups will be accountable to the network board, but will report to the network governance subcommittee.

A number of working groups will be established to support the programme planning and preparation for delivery phases as outlined below:





The above structure does not represent the final structure of the operational network. This will be developed in due course and the position of the network governance subcommittee defined within this.

5. Review Terms of Reference

The terms of reference will be reviewed annually at minimum and at specific milestones during the implementation stages of the development.

Major Trauma Dashboard

Background

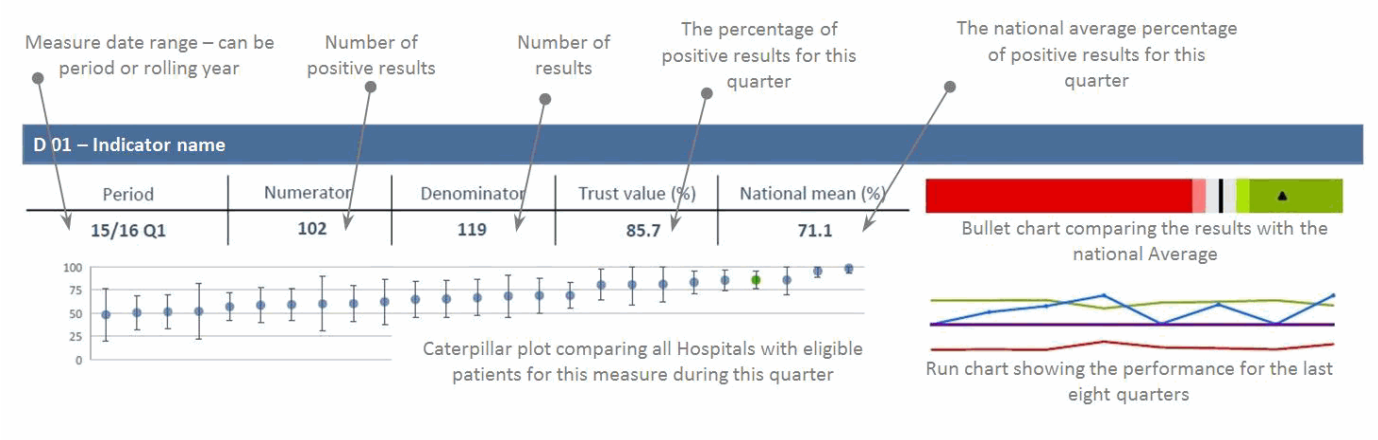
The major trauma dashboard measures have been drawn up and agreed by the Clinical Reference Group (CRG) to reflect what they believe will allow effective benchmarking between Major Trauma Centres in relation to specific measures. The Trauma Audit & Research Network has agreed to analyse and format the information ONLY.

Some measures are based on objective evidence, such as NICE guidance. Others reflect experience from senior clinicians in the trauma networks. Some relate to the quality of data submitted to TARN or to process measures such as time to CT scan or frequency of Consultant-led trauma team. **None of the indicators has an associated target and performance may not be 100%.** The measures are divided into 3 groups:

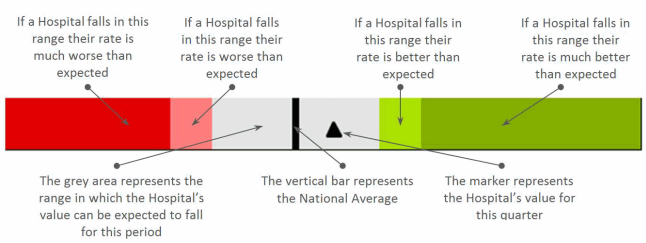
Data Quality: 100% may be expected
Evidence Based Measures and System Indicators: Performance may not be 100% and should be viewed in comparison with other centres

A dashboard support document has been drafted by TARN which explains in detail the numerators and denominators which make up the dashboard. It is recommended that this is read in conjunction with the dashboard.

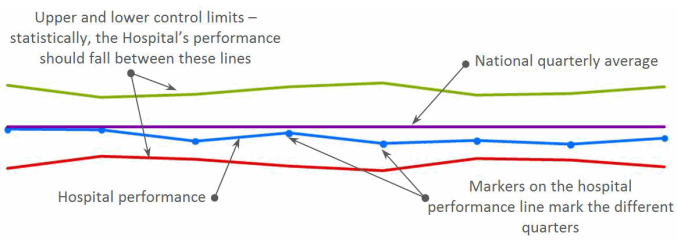
Report Overview



Interpreting Bullet Charts



Interpreting Run Charts



Control Limits Explained

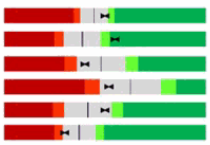
Control limits are put in place in order to better understand the Trust's difference from the national average, and are worked out based on the number of submissions the Trust has for each measure for that quarter. As larger sample sizes produce more accurately reflective averages, the more cases a Trust has for a quarter then the narrower their control limits will be.

The grey area around the national average represents the range of values within which, statistically, the Trust's value should fall based on the number of submissions the Trust has for that quarter.
If the Trust's value falls within any of the coloured areas on the chart then this implies that there is a non-statistical reason for the Trust's distance from the average, i.e. the Trust is doing something specifically better or worse than other Trusts which has influenced its value.

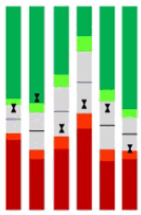
The reason behind control limits being set in this way is so that Trusts can be compared to the national average and to each other regardless of their size or their activity during that quarter. For example, a Trust that has only 10 patients that have CT Scans could have a rate 10% higher than the national average value for 'CT within 30 minutes', but still be within the statistical range in which they would be expected to fall for that many submissions, and as such would appear in the grey area of the chart. A Trust that has 100 CT Scans and a 10% higher rate than national average, however, would fall outside of the much thinner grey area which a sample size of 100 would produce, as the average of larger sample sizes will statistically tend much more closely to the national average. this means that, while the 10 CT Trust's value may well be due to random chance, the 100 CT Trust's consistently high value is probably as a result of better than average practice.

Method Behind Run Charts

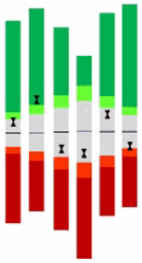
1. The quarterly results are calculated for the last eight quarters



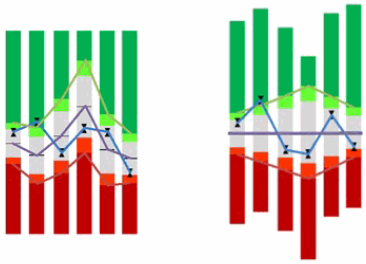
2. The results are ordered horizontally



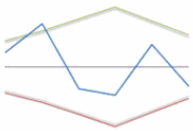
3. National averages are centred as a point of reference



Steps 2 and 3 with the limits, national average and trust performance lines overlaid onto the bullet charts

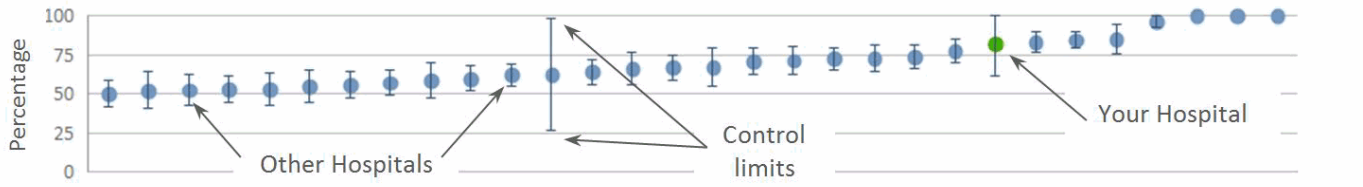


The final result without the bullet charts



Quarterly Comparisons

The quarterly results of each Hospital for each measure are also compared using the chart below. The green marker shows your Hospital's figure, and the blue markers show the figures of each other Hospital. Please note, if a hospital has a numerator of fewer than 6, the control limits will not be displayed for data protection purposes.



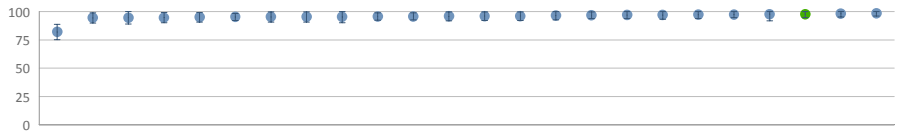
Major Trauma Dashboard
Example Hospital

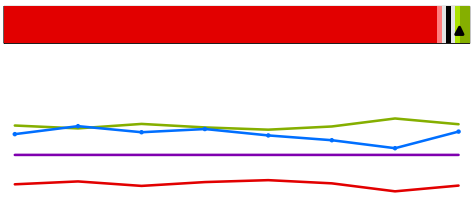
Developed by the Major Trauma Clinical Reference Group
Prepared by the Trauma Audit & Research Network 24/08/2018

Data Quality

MTC 01 - Quality of patient data submitted to TARN

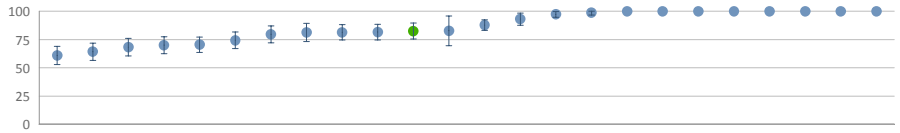
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	214.1	219	97.8	95.5

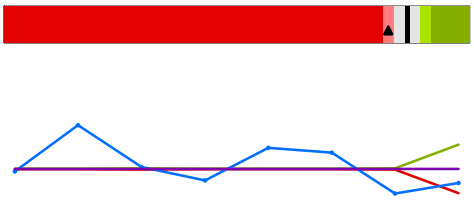




MTC 02a - All TARN eligible patients submitted within 40 days of discharge or death (excluding coroner's cases)

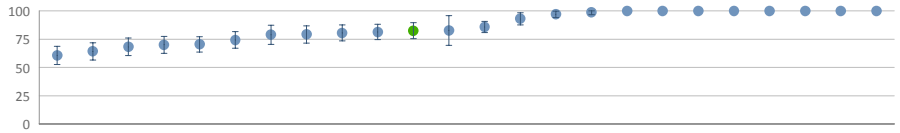
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	215	261	82.5	86.6

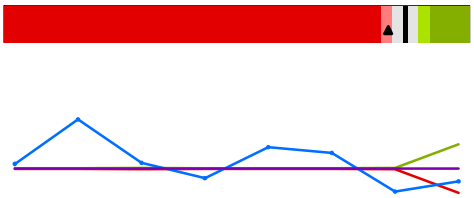




MTC 02b - All TARN eligible patients submitted within 25 days of discharge or death (excluding coroner's cases)

Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	215	261	82.5	86.2

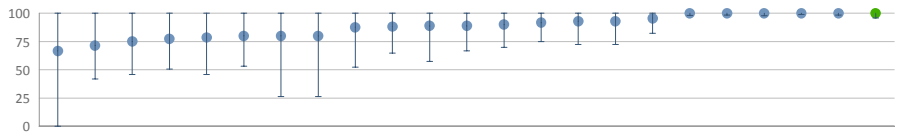


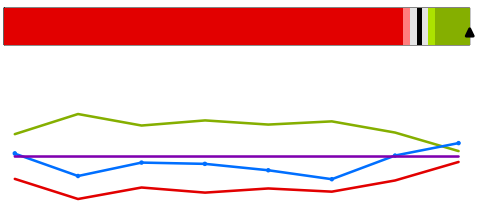


Evidence Based Measures

MTC 03 - Proportion of patients meeting NICE head injury guidelines that receive CT scan within 60 minutes of arrival at MTC

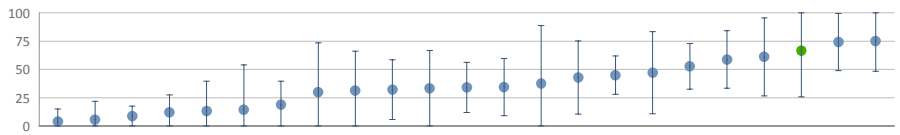
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	7	7	100	89.2

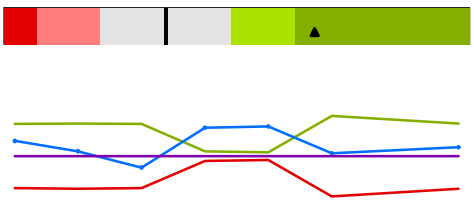




MTC 04 - MTCs deliver definitive cover of open fractures within BOAST 4 guidelines

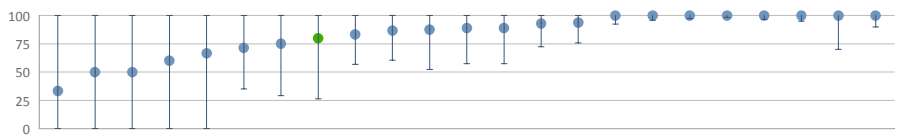
Rolling	Numerator	Denominator	Trust value (%)	National mean (%)
Rolling year	8	12	66.7	34.8

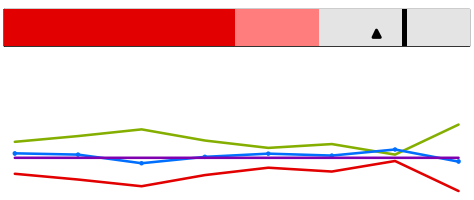




MTC 05 - MTCs administer Tranexamic Acid within 3 hours of incident to patients that receive blood products within 6 hours of incident

Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	4	5	80	86

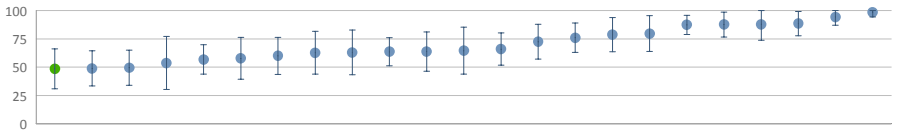


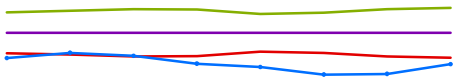


System Indicators

MTC 06 - MTCs deliver consultant led trauma teams ON ARRIVAL for patients with an Injury Severity Score greater than 15

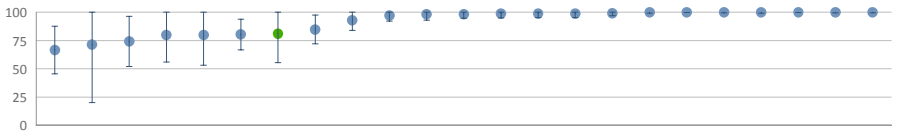
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	35	72	48.6	70.8

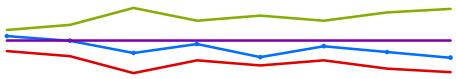




MTC 07 - MTCs deliver consultant led trauma teams ON ARRIVAL for triage positive patients

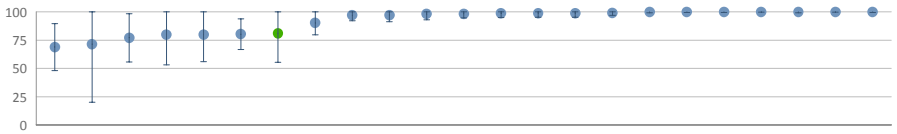
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	17	21	81	94.8

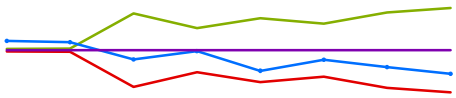




MTC 08 - MTCs deliver consultant led trauma teams WITHIN 30 MINUTES for triage positive patients

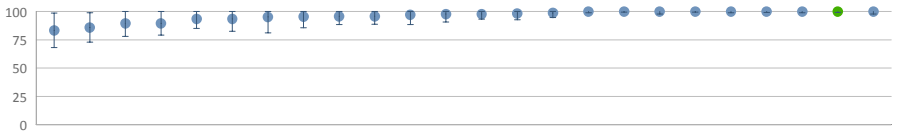
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	17	21	81	95.3

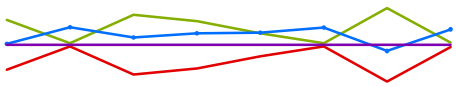




MTC 09 - Rapid access to specialist MTC care - patients transferred to MTC within 2 days of referral request

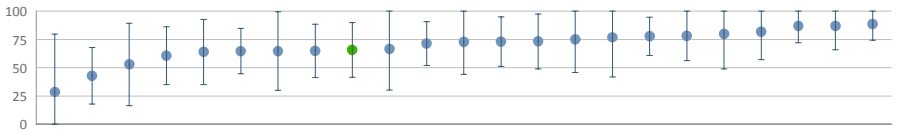
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	46	46	100	95.5

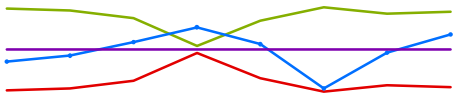




MTC 10 - Proportion of patients with GCS <9 with definitive airway management within 30 minutes of arrival in ED

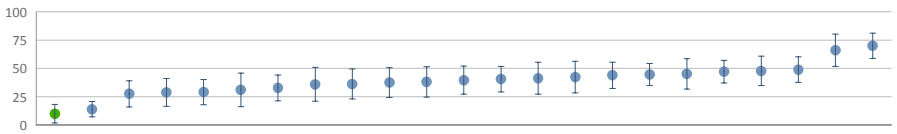
Rolling	Numerator	Denominator	Trust value (%)	National mean (%)
Rolling year	23	35	65.7	71.5

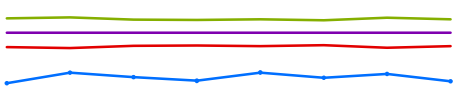




MTC 11 - Proportion of directly admitted patients receiving CT scan within 30 minutes of arrival at MTC

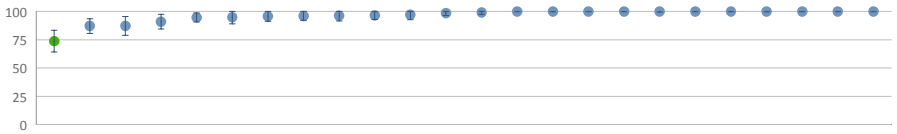
Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	12	121	9.9	39.3

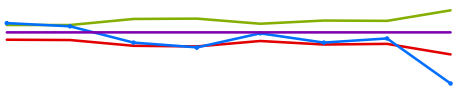




MTC 12 - Proportion of patients with an ISS of more than 8 that have a rehabilitation prescription completed

Period	Numerator	Denominator	Trust value (%)	National mean (%)
18/19 Q1	138	187	73.8	96.1





Major Trauma Dashboard

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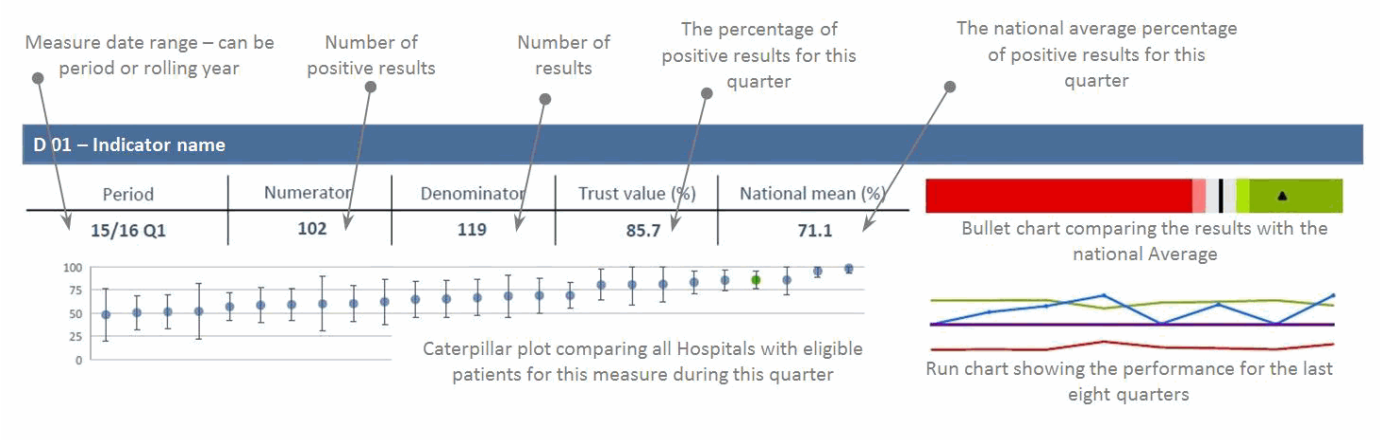
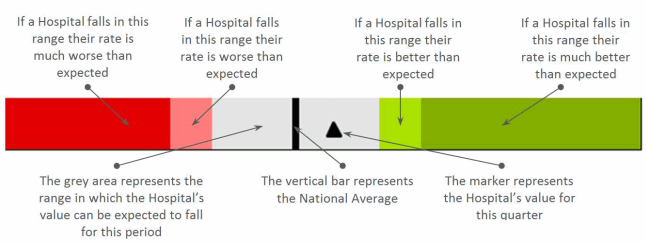
A dashboard support document has been drafted by TARN which explains in detail the numerators and denominators which make up the dashboard. It is recommended that this is read in conjunction with the dashboard.

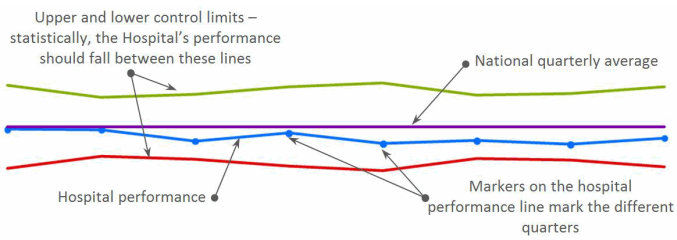
Report Overview



Interpreting Bullet Charts



Interpreting Run Charts



Control Limits Explained

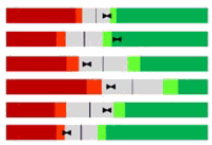
Control limits are put in place in order to better understand the Trust's difference from the national average, and are worked out based on the number of submissions the Trust has for each measure for that quarter. As larger sample sizes produce more accurately reflective averages, the more cases a Trust has for a quarter then the narrower their control limits will be.

The grey area around the national average represents the range of values within which, statistically, the Trust's value should fall based on the number of submissions the Trust has for that quarter.
If the Trust's value falls within any of the coloured areas on the chart then this implies that there is a non-statistical reason for the Trust's distance from the average, i.e. the Trust is doing something specifically better or worse than other Trusts which has influenced its value.

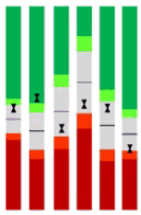
The reason behind control limits being set in this way is so that Trusts can be compared to the national average and to each other regardless of their size or their activity during that quarter. For example, a Trust that has only 10 patients that have CT Scans could have a rate 10% higher than the national average value for 'CT within 30 minutes', but still be within the statistical range in which they would be expected to fall for that many submissions, and as such would appear in the grey area of the chart. A Trust that has 100 CT Scans and a 10% higher rate than national average, however, would fall outside of the much thinner grey area which a sample size of 100 would produce, as the average of larger sample sizes will statistically tend much more closely to the national average. this means that, while the 10 CT Trust's value may well be due to random chance, the 100 CT Trust's consistently high value is probably as a result of better than average practice.

Method Behind Run Charts

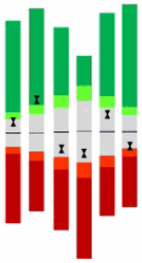
1. The quarterly results are calculated for the last eight quarters



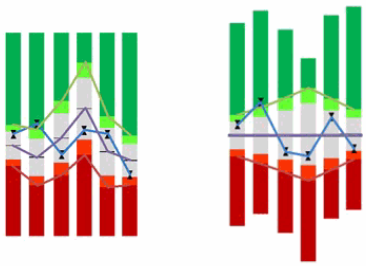
2. The results are ordered horizontally



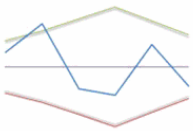
3. National averages are centred as a point of reference



Steps 2 and 3 with the limits, national average and trust performance lines overlaid onto the bullet charts

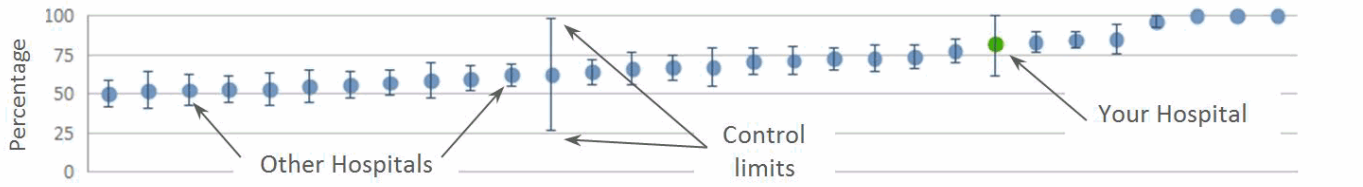


The final result without the bullet charts



Quarterly Comparisons

The quarterly results of each Hospital for each measure are also compared using the chart below. The green marker shows your Hospital's figure, and the blue markers show the figures of each other Hospital. Please note, if a hospital has a numerator of fewer than 6, the control limits will not be displayed for data protection purposes.



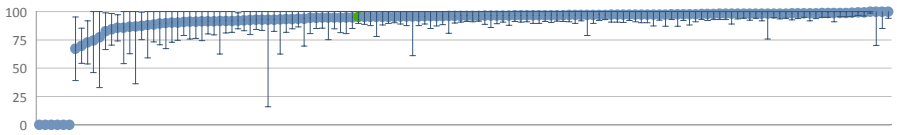
Trauma Unit Dashboard Example

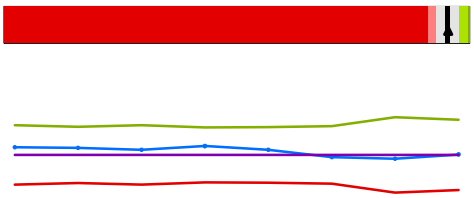
Developed by a working group of clinicians from Trauma Units
Prepared by the Trauma Audit & Research Network 13/08/2018

Data Quality

TU 01 - Quality of patient data submitted to TARN

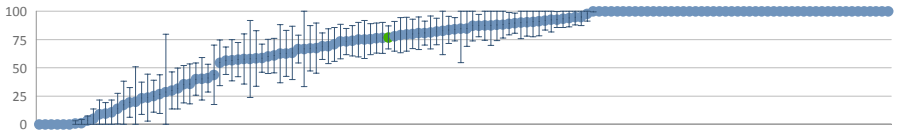
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	113.5	119	95.4	95.3

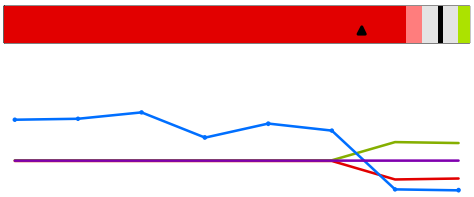




TU 02a - All TARN eligible patients submitted

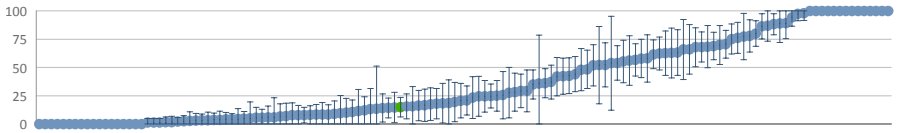
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	119	155	76.8	93.7

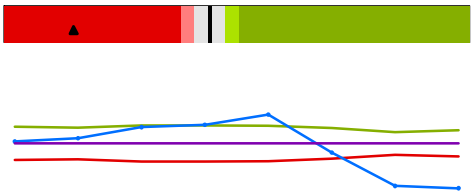




TU 02b - All TARN eligible patients submitted within 40 days of discharge or death (excluding coroner's cases)

Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	23	155	14.9	44.2

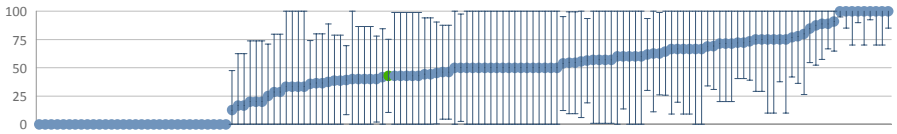


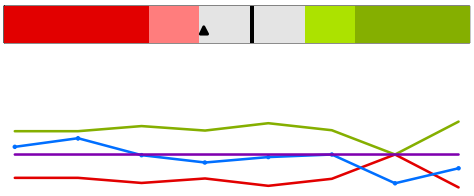


Evidence Based Measures

TU 03 - Proportion of patients meeting NICE head injury guidelines that receive CT scan within 60 minutes of arrival at TU

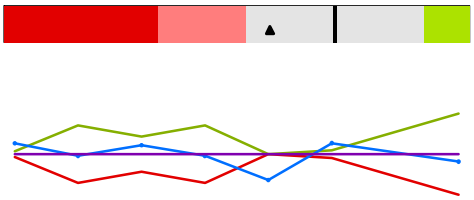
Rolling	Numerator	Denominator	Trust value (%)	National mean (%)
Rolling year	9	21	42.9	53.3





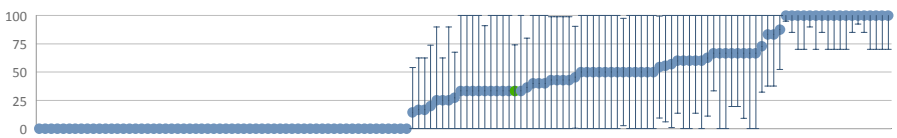
TU 04 - TUs administer Tranexamic Acid within 3 hours of incident to patients that receive blood products within 6 hours of incident

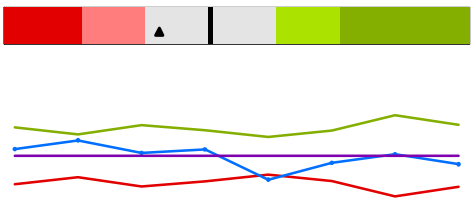
Rolling	Numerator	Denominator	Trust value (%)	National mean (%)
Rolling year	4	7	57.1	71.1



TU 05a - TUs deliver Consultant led trauma teams within 30 minutes with Pre-Alert and/or Trauma Team and ISS > 15 patients

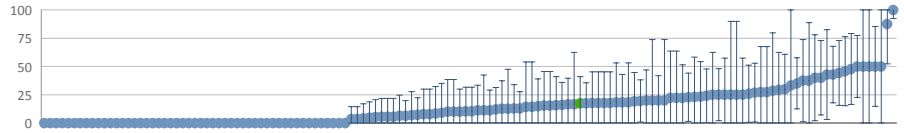
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	4	12	33.3	44.4

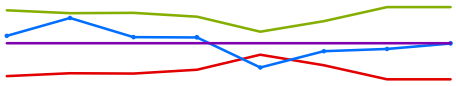




TU 05b - TUs deliver Consultant led trauma teams within 30 minutes for patients with ISS > 15

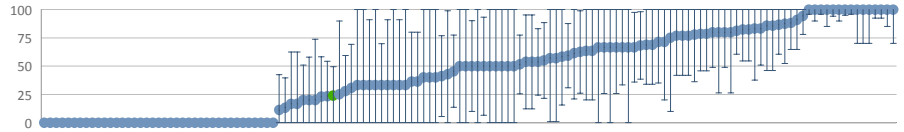
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	4	23	17.4	17.5

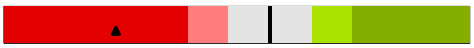


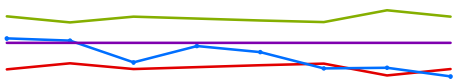


TU 06a - TUs deliver grade STR 3 or above led trauma teams on arrival for Pre-Alert and/or Trauma Team patients

Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	6	25	24	57.1

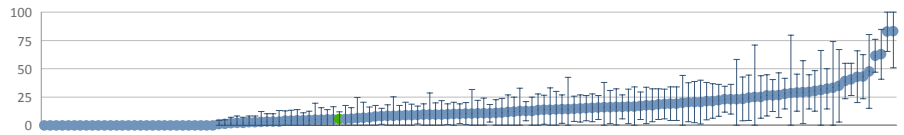


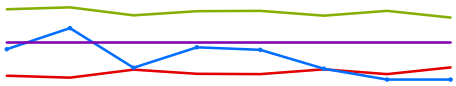




TU 06b - TUs deliver grade STR 3 or above led trauma teams on arrival

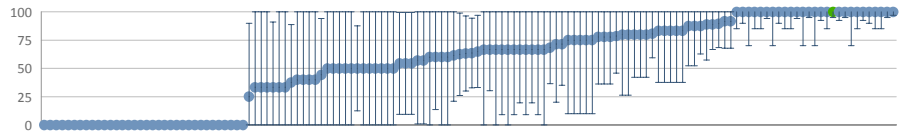
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	6	109	5.5	15.2

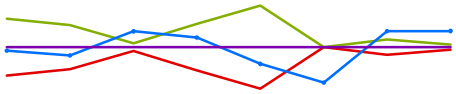




TU 07a - Rapid access to specialist MTC care - patients transferred to MTC within 12 hours of referral request

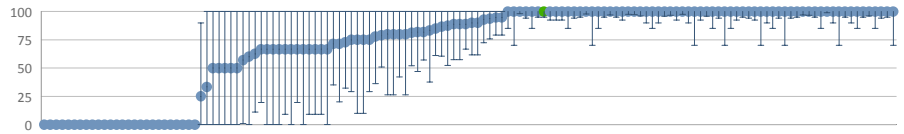
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	6	6	100	68.3

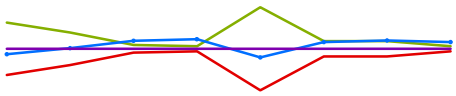




TU 07b - Rapid access to specialist MTC care - patients transferred to MTC within 2 days of referral request

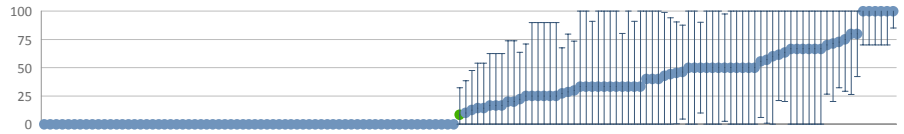
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	6	6	100	86.9

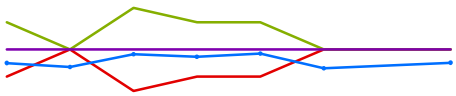




TU 08 - Proportion of patients with GCS <9 with definitive airway management within 30 minutes of arrival in ED

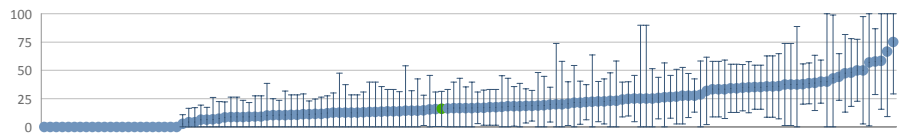
Rolling	Numerator	Denominator	Trust value (%)	National mean (%)
Rolling year	1	12	8.3	33.3

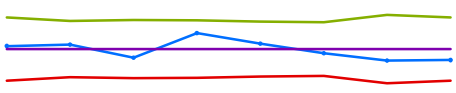




TU 09 - Proportion of directly admitted patients receiving CT scan within 60 minutes of arrival at TU

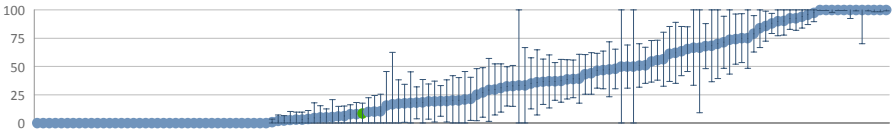
Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	8	50	16	21.4

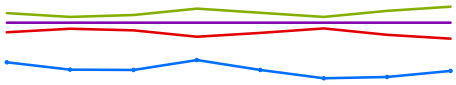




TU 10 - Proportion of patients with an ISS of more than 8 that have a rehabilitation prescription completed

Period	Numerator	Denominator	Trust value (%)	National mean (%)
17/18 Q4	7	83	8.4	36.1





TARN

THE TRAUMA AUDIT & RESEARCH NETWORK

Sample Hospital

Major Trauma PROMs Report

Patients discharged between October 2015 and September 2016

Timetable for report production

Reporting period	Patients discharged between	File received from Quality Health	Report circulated
Q1	July 2015 - June 2016	17 August 2016	1 September 2016
Q2	October 2015 - September 2016	14 October 2016	1 November 2016
Q3	January 2016 - December 2016	13 January 2017	1 February 2017
Q4	April 2016 - March 2017	14 April 2017	2 May 2017

How to interpret the report

Summary

This report reviews the number of completed questionnaires that can be matched to corresponding patients on the TARN database. The matching process is performed by TARN with a data file received from Quality Health Limited once each month. Data Completeness is based on patients submitted to TARN by your hospital and matched to a corresponding PROMs questionnaire.

Exclusions

- All deaths
- Patients under 16 (children will be reported seperately)

Data Completeness

Date Range

to

PROMs Q1 responses

Total number of patients who were approached and completed Q1 (in-hospital questionnaire prior to discharge).

PROMs Q1 completeness

Percentage of trauma patients at your hospital that have a completed PROMS questionnaire and are matched against corresponding eligible patients on the TARN database.

ISS 1 - 8

Patients on the TARN database with an Injury Severity Score (ISS) of 1-8. This is defined as a minor injury.

ISS 9 - 15

Patients on the TARN database with an Injury Severity Score (ISS) of 9-15. This is defined as a moderate to major injury.

ISS > 15

Patients on the TARN database with an Injury Severity Score (ISS) greater than 15. This is defined as a major injury.

Declines Log

The Declines Log should include patients for the following reasons:
- Patient (and carer) who have declined participation
- Patient unable to complete due to language issues
- Patient transferred or discharged before questionnaire given / completed
- Safeguarding issues and / or clinical judgement not to issue a questionnaire
- Patient death
- Unable to complete due to health state

It is important to record these patients so that an accurate data completeness can be calculated.

PROMs median

The national median is generated from 22 major trauma centres and 2 trauma units involved in PROMs during the report period.

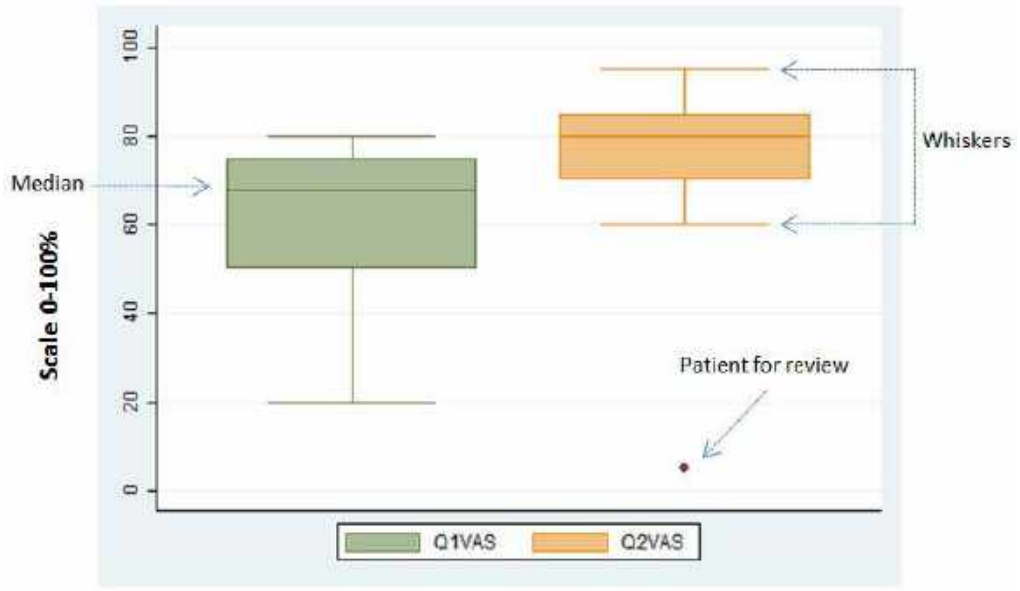
Six month outcome analysis

How your patients rate their health: Visual Analogue Scale (VAS)

The Visual Analogue Scale allows patients to indicate on a scale of 0-100, how good or bad their health is on the day of completing the questionnaire. This can demonstrate whether there is an improvement in the way patients rate their health at 2 time points (in-hospital and 6 months after injury).

Interpreting the Data

The graph contains 2 'box plots'. The green box plot represents the range of how good or bad your patients have rated their health whilst in-hospital. The orange box plot represents this at 6 months after injury.



Median

The line within each box plot represents the average rating recorded by your patients (median) on a scale of 0-100.

Whiskers

These indicate the range (variability) of how good or bad your patients have rated their health on a scale of 0-100.

Patient for review

A red diamond represents a patient who falls outside the typical range of responses given by all of your patients. These types of patients may be worth investigating.

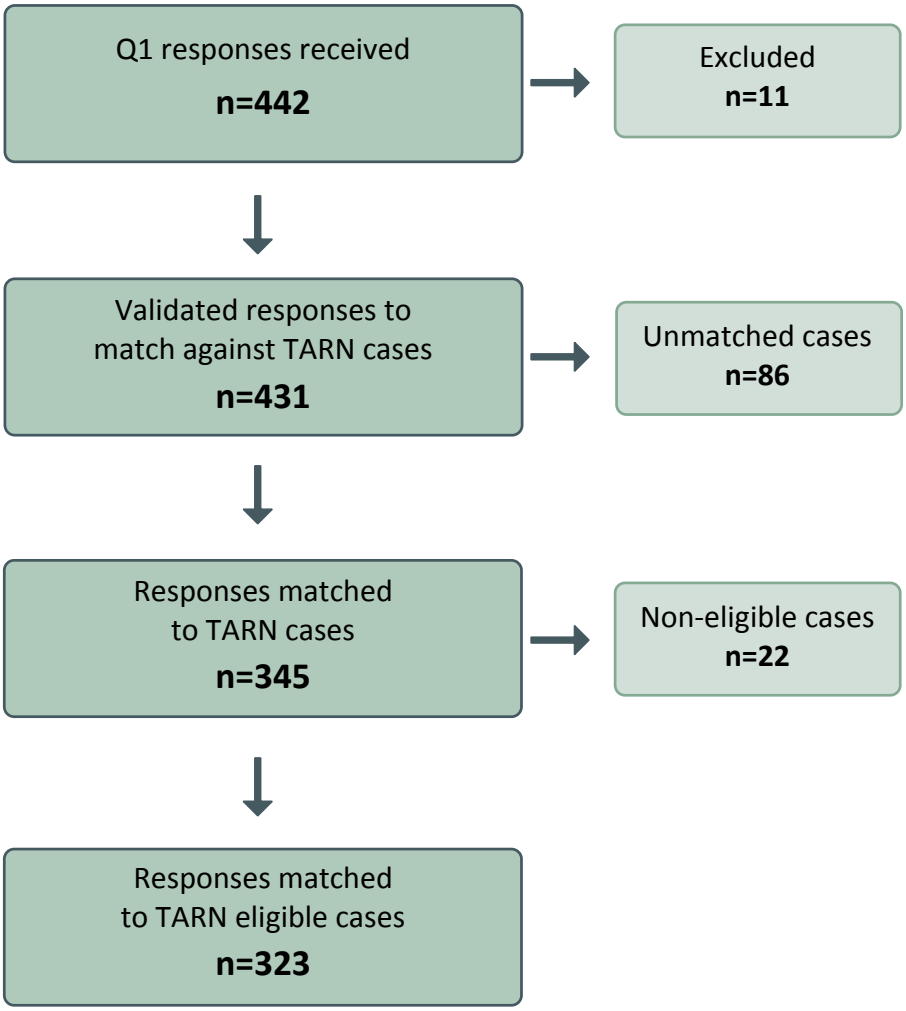
Section I

Data Completeness

Sample Hospital

In-hospital survey responses (Q1): Summary

Patients discharged between October 2015 and September 2016



Excluded

Deceased patients and duplicate PROMs responses are excluded from the matching process.

Unmatched cases

Patients that have completed a questionnaire but it cannot be matched to a corresponding case on the TARN system. This may be due to the following reasons:

- Admitted patients that had eligible injuries but whose length of stay was less than 3 days.
- Admitted patients whose injuries did not meet the TARN inclusion criteria.
- Missing data on the PROMs response (e.g. date of completion, NHS number, date of birth etc).

Non-eligible cases

Questionnaires that have been matched to a TARN submission but are not eligible for data completeness comparison - this includes cases that have been:

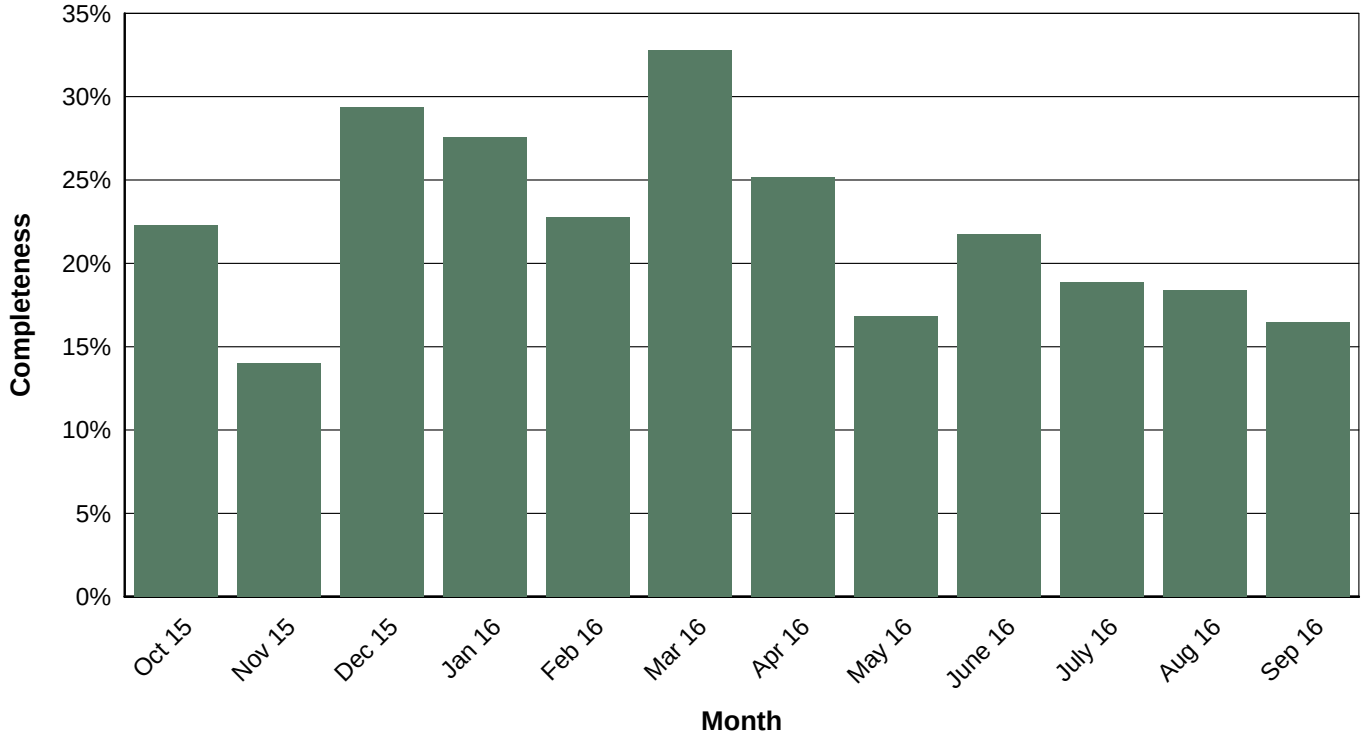
- Rejected as they do not meet the TARN inclusion criteria
- Returned to the data co-ordinator to review missing or inconsistent data
- Marked as non-TARN
- New submissions that have not yet been processed by the TARN team (dispatched cases)

Completeness breakdown

Patients discharged between October 2015 and September 2016

	TARN submissions	PROMs Q1 responses	PROMs Q1 completeness	PROMS median completeness
Overall data completeness	1422	323	22.7%	6.7%

Month	TARN submissions	PROMs Q1 responses	PROMs Q1 completeness	PROMS median completeness
October 2015	148	33	22.3%	16.5%
November 2015	114	16	14%	13.8%
December 2015	143	42	29.4%	15.3%
January 2016	127	35	27.6%	12.6%
February 2016	123	28	22.8%	8.9%
March 2016	116	38	32.8%	12.7%
April 2016	143	36	25.2%	16.1%
May 2016	95	16	16.8%	8.8%
June 2016	124	27	21.8%	13%
July 2016	90	17	18.9%	10.9%
August 2016	114	21	18.4%	10.3%
September 2016	85	14	16.5%	13.8%



Declines log

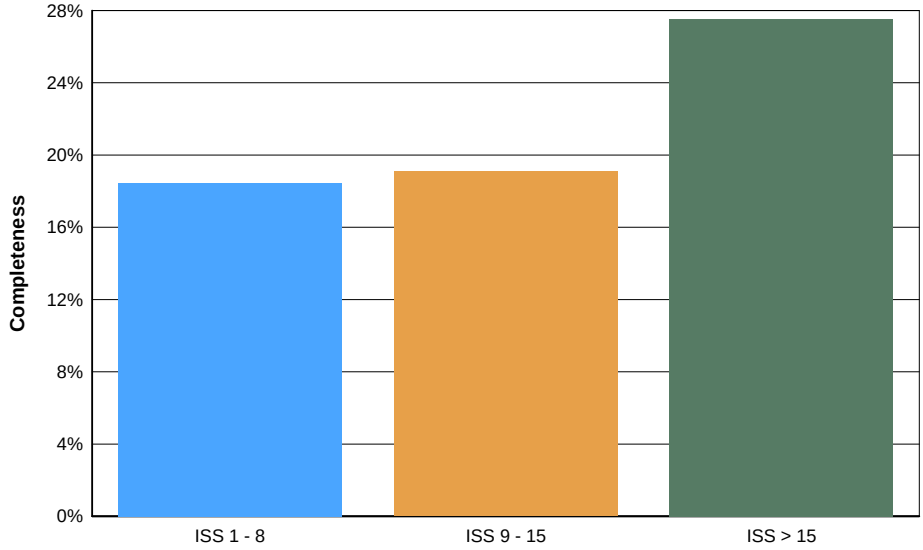
Patients discharged between October 2015 and September 2016

	Patient declines recorded	Declines with NHS number recorded
Declines received	4	4

Returning a declines log with NHS numbers included allows TARN to remove these cases from your denominator and provide you with a more accurate PROMs completeness figure.

Completeness by ISS band

Injury Severity Score	TARN submissions	PROMs Q1 responses	PROMs Q1 completeness	PROMS median completeness
ISS 1 - 8	244	45	18.4%	4.5%
ISS 9 - 15	550	105	19.1%	6.3%
ISS > 15	628	173	27.5%	7.8%



Monthly completeness for ISS > 15 submissions

Month	TARN submissions	PROMs Q1 responses	PROMs Q1 completeness	PROMS median completeness
October 2015	69	19	27.5%	23.9%
November 2015	56	7	12.5%	23.5%
December 2015	61	23	37.7%	18%
January 2016	58	16	27.6%	14.9%
February 2016	53	20	37.7%	14.3%
March 2016	53	22	41.5%	18.4%
April 2016	67	19	28.4%	15.8%
May 2016	38	6	15.8%	10.3%
June 2016	54	12	22.2%	17.3%
July 2016	44	12	27.3%	19.9%
August 2016	47	12	25.5%	17.5%
September 2016	28	5	17.9%	15.4%

Completeness by transfer type

Transfer type	TARN submissions	PROMs Q1 responses	PROMs Q1 completeness	PROMS median completeness
Admission from scene	976	209	21.41%	6.8%
Referral in	390	113	28.97%	7.8%
Transferred out	56	1	1.79%	4.8%

Completeness by body area injured

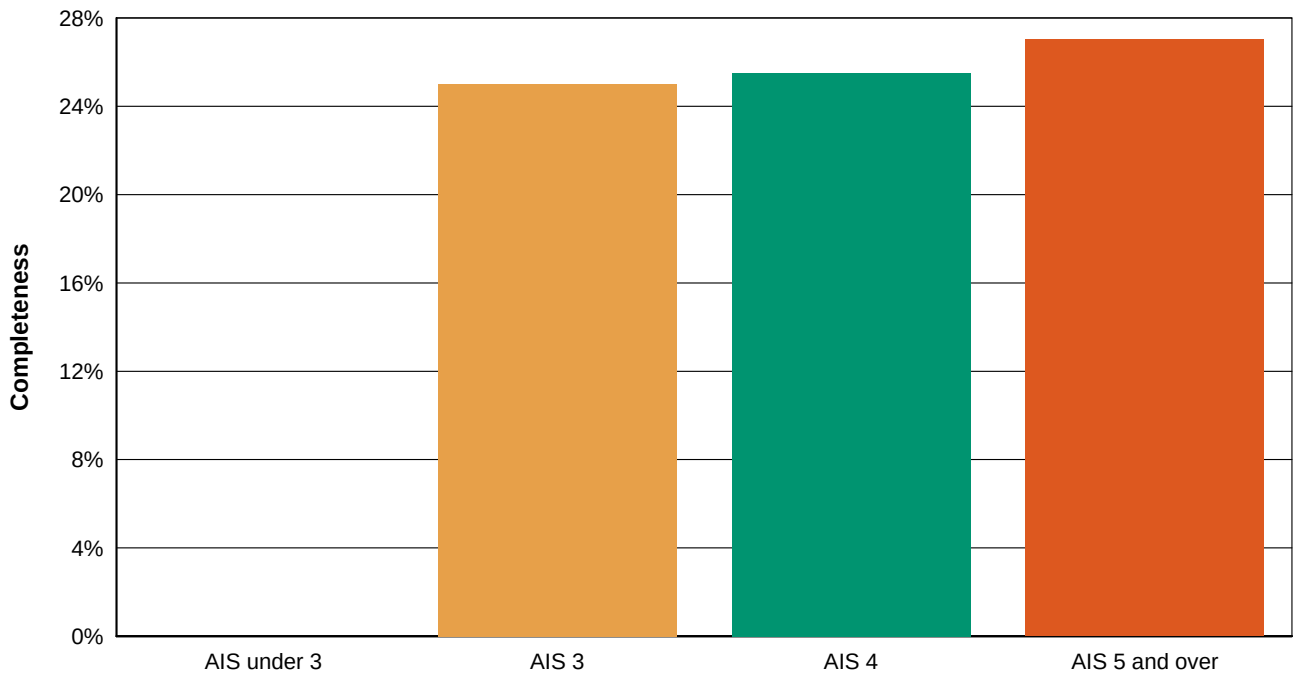
Most severely injured body area	TARN submissions	PROMs Q1 responses	PROMs Q1 completeness	PROMS median completeness
Abdomen	15	1	6.7%	9.1%
Chest	184	31	16.8%	9.1%
Face	18	1	5.6%	7%
Head	523	136	26%	4.6%
Limbs	365	76	20.8%	5.7%
Multiple*	104	20	19.2%	12.9%
Other**	6	1	16.7%	15.5%
Spine	207	57	27.5%	6.8%

* Patients in the multiple category have injuries of equal severity in more than one area.

** Other includes neck injuries and external injuries such as burns and asphyxiation.

Submissions with head as the most severely injured body area

Severity of head injury	TARN submissions	PROMs Q1 responses	PROMs Q1 completeness	PROMS median completeness
AIS under 3	1	0	0%	0%
AIS 3	68	17	25%	7.9%
AIS 4	243	62	25.51%	5%
AIS 5 and over	211	57	27.01%	7.1%



Section II

Six month outcome analysis

Sample Hospital

Timeframe

This report is based on trauma patients who were discharged between **October 2015** and **September 2016** who agreed to participate in PROMs. Questionnaires 6 months after injury are still being returned by patients.

Summary of PROMs questionnaire completion

	Questionnaires completed	Questionnaires matched to cases on TARN	Non eligible cases	Cases used for analysis
In hospital questionnaire (Q1)	431	345 (80%)*	22	323
6 month questionnaire (Q2)	81	75 (93%)*	4	71

* Percentage of questionnaires completed by the patient that were matched to their corresponding case on the TARN database.

Non-eligible cases

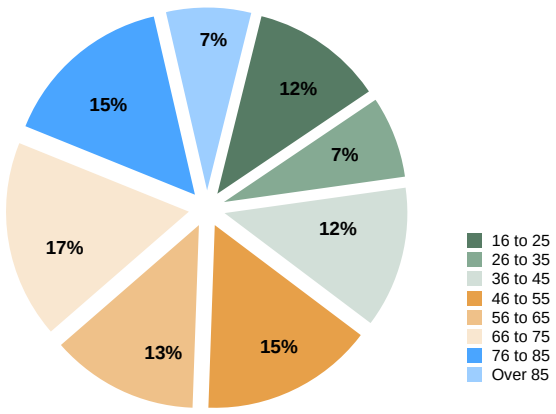
22 cases have been matched to a TARN submission but are not eligible for inclusion in this report, **4** of these cases have a Q2 response that has also been excluded from the analysis. Below is a summary of the current status of these cases. These patients received a Q1 with some returning a Q2.

Status	Q1	Q2
Case returned for review	11	4
Case rejected by TARN	5	0
Case not yet dispatched	3	0
Non TARN case	3	0

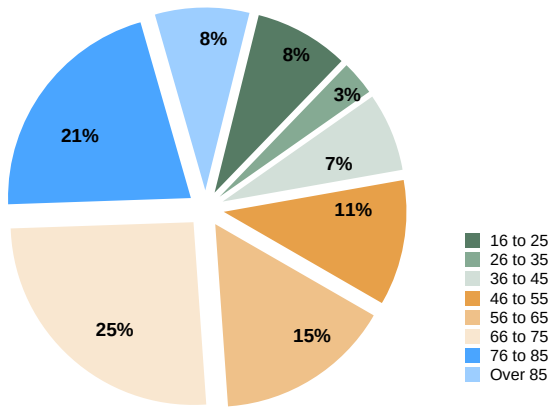
323 cases have been used for comparison in this report, with **71** of these patients having a Q2 follow-up response.

Summary of responses by age band

Q1 responses by age band



Q2 responses by age band



Breakdown of responses by age and ISS

Age band	Total eligible cases	ISS up to 15 N	Q1	%	Q2	% *	ISS over 15 N	Q1	%	Q2	% *
16 to 25	174	86	9	10%	1	3%	88	29	33%	5	10%
26 to 35	121	62	11	18%	0	0%	59	12	20%	2	6%
36 to 45	146	75	17	23%	1	3%	71	23	32%	4	9%
46 to 55	198	104	29	28%	5	8%	94	21	22%	3	6%
56 to 65	215	134	19	14%	5	7%	81	23	28%	6	12%
66 to 75	202	107	26	24%	8	14%	95	30	32%	10	17%
76 to 85	219	121	27	22%	8	11%	98	23	23%	7	12%
Over 85	147	105	12	11%	2	3%	42	12	29%	4	16%

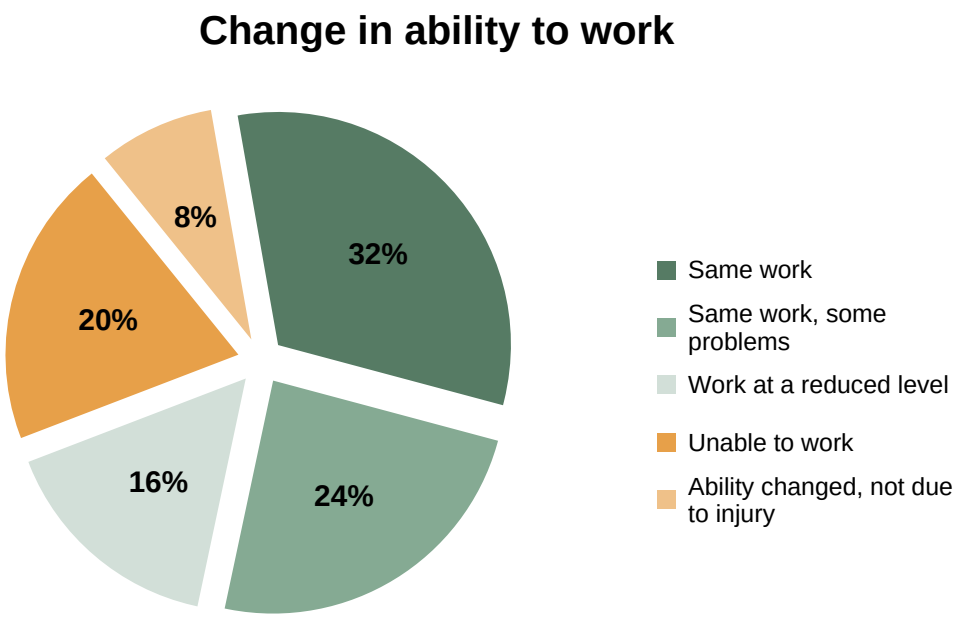
* Percentage of patients whose arrival date was over 6 months ago that have completed a Q2 questionnaire.

Change in ability to work as a result of injury at 6 months (Q2)

Employment status before injury	N	%	PROMs median %
Working	21	30%	46%
Looking for work	1	1%	6%
Studying as a student	3	4%	5%
Retired	36	51%	45%
None of these (e.g. unfit for work)	6	9%	9%
Not stated	4	6%	6%
Total	**71**		

	N
Patients that were working, looking for work, studying or looking after family before their injury	25

Change in ability to work 6 months after injury	N	%	PROMs median %
Still do the same work	8	32%	31%
Still do the same work, but have some problems	6	24%	24%
Still work, but at a reduced level	4	16%	16%
Unable to work, or only able to work in a sheltered workshop	5	20%	31%
Ability to work has changed, but not because of injury	2	8%	7%



Breakdown by most severely injured body area

Most severely injured body area	Same work	Same work, some problems	Work at a reduced level	Unable to work	Ability changed, unrelated to injury	Not stated
Head	47%	13%	13%	13%	13%	0%
Chest	0%	0%	0%	100%	0%	0%
Spine	0%	25%	50%	25%	0%	0%
Limbs	25%	50%	0%	25%	0%	0%
Multiple	0%	100%	0%	0%	0%	0%

Patient experience - In hospital

Were you involved as much as you wanted to be in decisions about your care and treatment?

Response (n=318)	N	%	PROMs median %
Yes, definitely	152	48%	54%
Yes, to some extent	64	20%	25%
Can't say/don't know	93	29%	17%
No	13	4%	5%
Not stated	1	0%	2%

Do you think the hospital staff did everything they could to help control your pain?

Response (n=318)	N	%	PROMs median %
Yes, definitely	269	85%	82%
Yes, to some extent	31	10%	14%
Can't say/don't know	7	2%	2%
No	13	4%	3%
Not stated	3	1%	1%

When you had important questions to ask a doctor, how often did you get answers that you could understand?

Response (n=318)	N	%	PROMs median %
All or most of the time	223	70%	71%
Some of the time	54	17%	19%
Rarely or never	13	4%	4%
I did not ask any questions	31	10%	4%
Not stated	2	1%	1%

Patient experience - 6 months after injury

After leaving hospital, were you given enough care and help from health or social services?

Response (n=70)	N	%	PROMs median %
Yes, definitely	25	36%	36%
Yes, to some extent	17	24%	30%
No	15	21%	18%
I did not need help from health and social services	11	16%	15%
Not stated	3	4%	6%

As far as you know, was your GP given enough information about your condition and the treatment you had at the hospital?

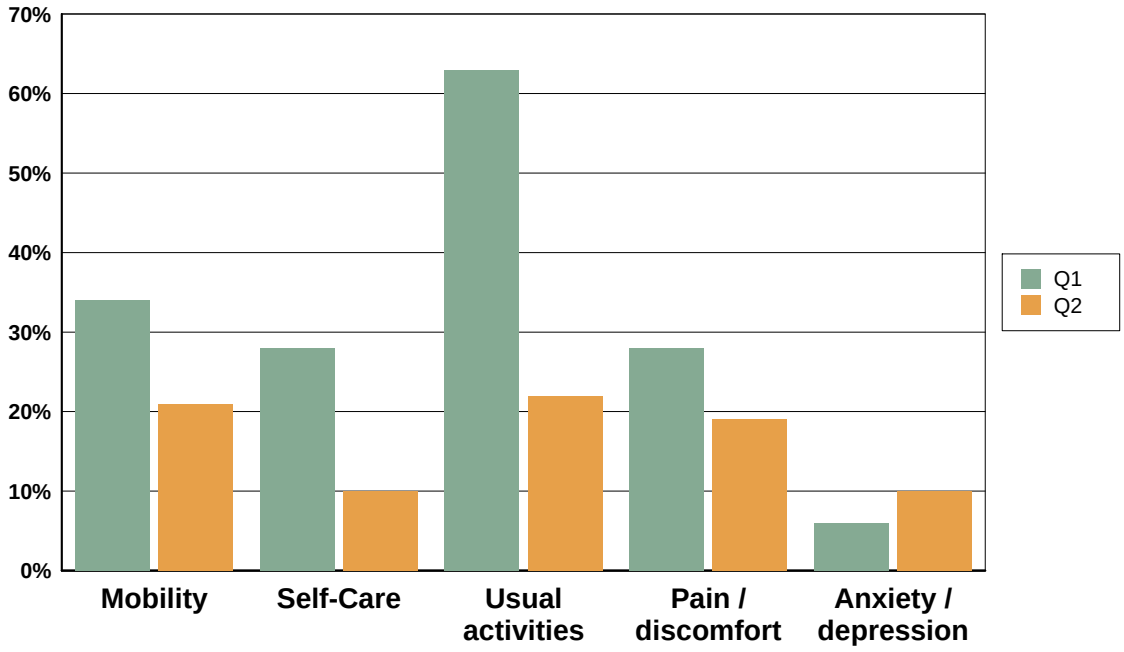
Response (n=70)	N	%	PROMs median %
Yes	43	61%	60%
No	12	17%	16%
Don't know / can't remember	15	21%	22%
Not stated	1	1%	2%

Did the different people treating and caring for you work well together to give you the best possible care?

Response (n=70)	N	%	PROMs median %
Yes, always	40	57%	42%
Yes, most of the time	10	14%	35%
Yes, some of the time	12	17%	17%
No, never	2	3%	6%
Don't know	5	7%	7%
Not stated	2	3%	3%

Patients reporting severe to extreme problems

Category	Matched responses	Severe to extreme problems at Q1 N	Severe to extreme problems at Q1 %	Severe to extreme problems at Q1 PROMs median %	Severe to extreme problems at Q2 N	Severe to extreme problems at Q2 %	Severe to extreme problems at Q2 PROMs median %
Mobility	68	23	34%	51%	14	21%	18%
Self-Care	67	19	28%	32%	7	10%	3%
Usual activities	68	43	63%	63%	15	22%	22%
Pain / discomfort	67	19	28%	22%	13	19%	12%
Anxiety / depression	68	4	6%	6%	7	10%	7%



	N	%	PROMs median %
Patients reporting severe to extreme problems 6 months on	22	32%	32%

Number of categories that patients reported severe to extreme problems

	Patients N	Patients %	Patients PROMs median %	Site median ISS (IQR)	PROMs median ISS (IQR)	Rehab Prescriptions N	Rehab Prescriptions %
In one category	6	27%	50%	16 (16 - 25)	16 (9 - 25)	6	100%
In two categories	5	23%	40%	9 (9 - 16)	13 (9 - 22)	5	100%
In three categories	4	18%	24%	17 (9 - 25)	12 (9 - 29)	4	100%
In four categories	6	27%	17%	9 (9 - 13)	9 (9 - 20)	6	100%
In all five categories	1	5%	8%	25	9 (9 - 9)	1	100%

(Appendix ii contains the TARN submission IDs for these patients)

Visual Analogue Scale (VAS)

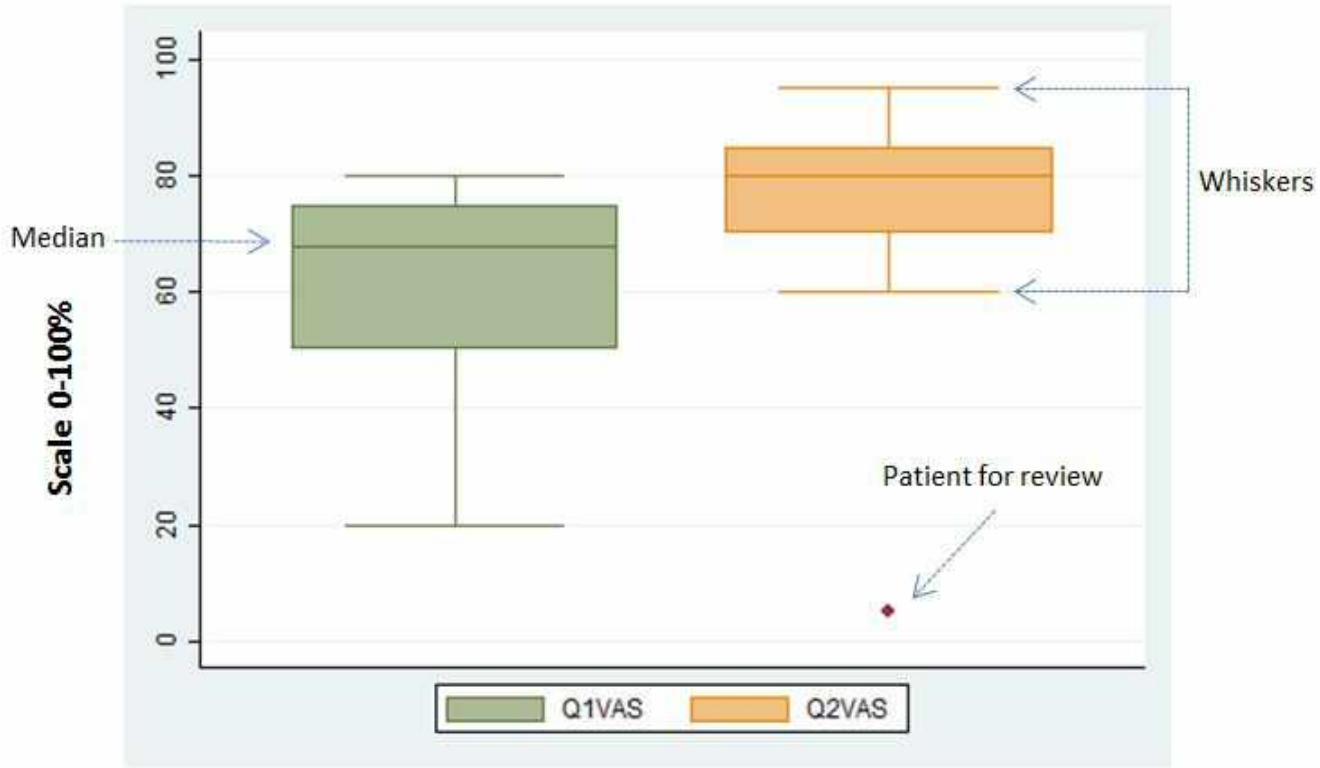
Sample Hospital

	N
Total number of matched cases used in this analysis (where both Q1 and Q2 VAS are available)	67

On a scale of 0-100, your patients on average report an improvement in how **they rate their health** at 6 months .

1 patient falls outside of the typical range of responses and a review is suggested (see appendix i for their TARN submission ID).

This patient has not indicated they do not want to share their information with healthcare professionals involved in their care.



Appendix i: Patients for review (VAS scores)

Submission ID	Q1 VAS score	Q2 VAS score
999900007452	50	5

Patients marked in Grey have already been flagged for review in a previous PROMs report.

Appendix ii: Patients for review (severe to extreme problems 6 months on)

Submission ID	Category	Mobility	Self-care	Usual activities	Pain / discomfort	Anxiety	Rehab prescription
999900004572	One category	0	0	0	1	0	Yes
999900007452	Two categories	1	0	0	1	0	Yes
999900002142	Two categories	1	0	1	0	0	Yes
999900002481	Two categories	0	0	1	1	0	Yes
999900005007	Two categories	1	0	1	0	0	Yes
999900004702	Three categories	1	0	1	0	1	Yes
999900004511	Three categories	1	1	1	0	0	Yes
999900005031	Four categories	1	1	1	1	0	Yes

Patients marked in Grey have already been flagged for review in a previous PROMs report.

Enw'r Pwyllgor / Name of Committee	Quality, Safety And Experience Assurance Committee
Cadeirydd y Pwyllgor/ Chair of Committee:	Professor John Gammon
Cyfnod Adrodd/ Reporting Period:	Meeting held on 3rd October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

- **Delivery of Ophthalmology Plan and Impact on Care and Outcomes for Hywel Dda Patients** – Members received the Delivery of Ophthalmology Plan and Impact on Care and Outcomes for Hywel Dda Patients report. Given that only limited assurance could be taken, it was agreed that a deep dive into Ophthalmology services would be presented to the next QSEAC meeting in December 2019, and that an updated report would be circulated ahead of the meeting, focusing on staff, patient experience and outcomes, including detailed plans for improvements.

- **Quality And Safety Assurance Report and Serious Incidents (SI) Deep Dive Presentation** – Members received the Quality and Safety Assurance Report and Serious Incidents Deep Dive Presentation. Members discussed the underlying reasons behind an SI occurrence and whether high staff turnover, or a lack of staff training and leadership within clinical teams may be factors. Members suggested that proactive steps should be taken to identify concerns earlier, although acknowledged that multidisciplinary discussions take place where staff are now more willing to escalate concerns to senior managers. The Committee also acknowledged that a reinforcement of the basics, including improved communication by medical staff with patients, would be key to driving improvements.

- **Nurse Staffing Levels (Wales) Act - Whole Time Equivalent (WTE) Recalculation** – Members received the Nurse Staffing Levels (Wales) Act - Whole Time Equivalent (WTE) Recalculation report. The Committee received assurance that an appropriate process has been put in place in order to arrive at the revised calculations of the WTE required for the wards identified in the detailed summary provided to the Committee.

- **Being Open Process / Duty of Candour in the NHS** – Members welcomed the Being Open Process / Duty of Candour in the NHS report, providing a platform from the Health Board's perspective to enable further discussions.

- **Update on Out of Hours (OOH) Service Provision** – Members received an update on Out of Hours (OOH) Service Provision during the summer period of 2019. Members acknowledged the challenges with the service, however as the report indicates that the Advanced Paramedic Practitioner (APP) model with the Welsh Ambulance Service Trust (WAST) accounts for 20% of activity, suggested that this new way of working could be transferred to other fragile services. Members welcomed the news that the initiative has received national recognition, with the collaboration successfully shortlisted as a finalist in the 2019 NHS Wales awards.

- **Operational Quality, Safety & Experience Sub-Committee (OSQSESC) Exception Report** – Members received the Operational Quality, Safety & Experience Sub-Committee (OSQSESC) Exception Report from its meeting held on 6th September 2019. Discussion was held on poor attendances at Sub-Committee meetings whilst accepting that the membership of QSEAC, including the Sub-Committees and Groups under its remit, are under review. Given that the Sub-Committee had not been assured in regard to the processes for reducing Hospital Acquired Thrombosis (HAT), Members requested that a detailed report on the next steps for HAT be presented to the next QSEAC meeting in December 2019.

- **Mental Health and Learning Disabilities (MH&LD) Quality, Safety & Experience Sub-Committee Exception Report** – Members received the Mental Health and Learning Disabilities (MH&LD) Quality, Safety & Experience Sub-Committee Exception Report from its meeting held on 9th September 2019. The Committee discussed the impact and outcomes for service users whilst on MHLD waiting lists, and for assurance purposes proposed that an update be included within the next Sub-Committee exception report to QSEAC in December 2019.

- **Effective Clinical Practice Sub-Committee (ECPSC) Exception Report** – Members received the Effective Clinical Practice Sub-Committee (ECPSC) Exception Report from its meeting held on 10th September 2019, and the revised ECPSC Terms of Reference (ToRs) for approval. The Committee discussed variations in performance for Stage 1 mortality reviews on Health Board sites and was advised that this is due to the differing mortuary processes in place across Hywel Dda; once standardised, performance rates should achieve 90%. Give the number of amendments suggested by Members in regard to the revised ECPSC ToRs, it was agreed that these would be approved via Chair's Action.

- **Any Other Business** – the Chair expressed thanks on behalf of the Committee to Mr David Powell, Independent Member, for his contribution and influence as a Member of QSEAC in steering debate to ensure that the Committee remained focused regarding patient safety and quality of services, and wished him well in his retirement.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer /
Matters Requiring Board Level Consideration or Approval:

- None

Risgiau Allweddol a Materion Pryder /
Key Risks and Issues/ Matters of Concern:

- Ophthalmology Services
- Hospital Acquired Infections (HAT)

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:
Adrodd yn y Dyfodol / Future Reporting:
In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified above will be undertaken.
Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:
3rd December 2019.

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Working to Improve the Health of Vulnerable Groups
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sarah Jennings, Director of Partnerships and Corporate Services
SWYDDOG ADRODD: **REPORTING OFFICER:**	Anna Bird, Head of Strategic Partnerships, Diversity and Inclusion Helen Sullivan, Strategic Partnership and Inclusion Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the recent work which is being co-ordinated by the Strategic Partnerships, Diversity and Inclusion Team to improve the health of a number of specific vulnerable groups including; homeless, those with sensory loss, carers, Veterans and Syrian refugees.

Cefndir / Background

Hywel Dda University Health Board (the Health Board) is committed to improving the health and well-being of its population and contributing to the seven national well-being goals, including A Healthier Wales, A More Equal Wales and a Wales of Cohesive Communities. The Health Board's current Strategic Equality Plan and Objectives 2016-2020 gave a commitment to improve equality and equity of access to services for the whole population, thus contributing to a reduction in inequalities specifically for those in protected characteristic groups or who traditionally face barriers to accessing services.

The NHS Delivery Framework includes two specific areas of reporting requirements, and on a bi-annual basis the Health Board submits updates on:

- Progress against the 5 standards that enable the health and well-being of homeless and vulnerable groups to be identified and targeted; and
- Achievements made towards the implementation of the all Wales standard for accessible communication and information for people with sensory loss.

In addition to the above, the Strategic Partnerships, Diversity and Inclusion Team also co-ordinate actions to respond to:

- the Armed Forces Covenant;
- the needs of Carers; and
- the implementation of the Syrian Vulnerable Persons Resettlement Programme.

Asesiad / Assessment

In order to provide assurance to the Board of the work which is on-going to support the health and well-being of specific vulnerable groups, a number of briefing papers have been developed to provide an overview of the current position and planned future actions. Attached are update reports on key areas of activity including:

- Homeless and Vulnerable Groups (Appendix 1)
- Sensory Loss (Appendix 2)
- Delivering Support for Carers (Appendix 3)
- Syrian Vulnerable Persons Resettlement Programme (SVPRP) (Appendix 4)
- Armed Forces Covenant (Appendix 5)

Argymhelliad / Recommendation

The Board is asked to note the progress updates provided for each area of work to support the health and well-being of homeless and vulnerable groups.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Equality Act 2010 Well-being of Future Generations (Wales) Act 2015 Social Services and Well-being (Wales) Act 2014
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	Not applicable

Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	HDdUHB staff time to support progression of actions required to support the health and care needs of vulnerable groups. The ability to deliver services in a range of languages other than Welsh or English will incur additional costs but are essential to ensure that patients are full partners in their care. Services to Carers are currently under pressure with increasing levels of referrals but Health Board budgets to commission third sector early intervention and support have not increased. Identifying a shift of resources from secondary to primary prevention activities is a priority.
Ansawdd / Gofal Claf: Quality / Patient Care:	Improving the well-being of the population is at the forefront of the three key pieces of legislation. Providing person centred care that meets the needs of groups with protected characteristics or who are vulnerable and regularly experience barriers to accessing health services is a key responsibility of the Health Board.
Gweithlu: Workforce:	Implementing the five ways of working required under the Well-being of Future Generations (Wales) Act 2015 and the requirements of the Equality Act 2010 should lead to increased collaboration and integration between services, professionals and communities.
Risg: Risk:	There is a risk that whilst addressing local need, there may be some inconsistency in approach between counties for our wider population. We have a duty to encourage consistency of approach where appropriate in order to minimise inequity. Resourcing the project and delivery groups to drive forward the work described in the reports could be considered an “add on” responsibility by staff and the synergy with achieving Health Boards goals of safe, sustainable, accessible and kind services need to be understood in the context of equality, diversity and inclusion.
Cyfreithiol: Legal:	The Health Board has a statutory duty to implement the requirements of the three key Acts.
Enw Da: Reputational:	There is a statutory duty for the UHB to work in partnership with its three partner local authorities to transform health and care delivery.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	The focus of equality runs throughout the work and aligns to a number of the Well-being goals: A More Equal Wales, A Healthier Wales, A More Prosperous Wales, A Wales of Cohesive Communities. This is an update paper therefore no EqIA screening has been undertaken.

Update on work to support homeless and vulnerable groups
Strategic Partnerships, Diversity and Inclusion Team
November, 2019

This is an update on current activity within Hywel Dda University Health Board (Health Board) and across Carmarthenshire, Ceredigion and Pembrokeshire, against the Welsh Government Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups.

1. Current legislation and evidence

In 2009, Welsh Government launched the Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups and the Health Boards compliance with those standards is reported on twice yearly as part of the NHS Delivery Framework.

The Standards require the Health Board to:

- Collaborate with partner organisations
- Have an understanding of the profile and health needs of homeless and vulnerable people*
- Remove barriers to access to healthcare services
- Produce a Homeless and Vulnerable Groups' Health Action Plan (HaVGHAP)

Other National and local objectives that need to be considered in the development of the HaVGHAP include the Strategy for Preventing and Ending Homelessness, Welsh Government (October 2019), the homelessness strategies for Carmarthenshire, Ceredigion and Pembrokeshire Local Authorities and the Health Board's Health and Care Strategy – A Healthier Mid and West Wales. Current research and evidence is also used to inform the HaVGHAP such as Making a Difference, Housing and Health: A case for investment (2019)[1] and Voices of those with lived experiences of homelessness and adversity in Wales (2019)[2] both published by Public Health Wales.

*As defined by Welsh Government, vulnerable groups are people identified as: homeless, asylum seekers and refugees, gypsies and travellers, substance misusers or EU migrants who are homeless or living in circumstances of insecurity.

2. How the Health Board is supporting homeless and vulnerable groups

It is the responsibility of the Strategic Partnership, Diversity and Inclusion team to report twice yearly to Welsh Government, on progress against the standards, working under the leadership of Sarah Jennings, Director of Partnerships and Corporate Services.

A Homeless and Vulnerable Groups Partnership Forum has been established in order to ensure that compliance with the standards across the Health Board can be

[1] Watson I, MacKenzie F, Woodfine L and Azam S. (2019). Making a Difference. Housing and Health: A Case for Investment. Cardiff, Public Health Wales.

[2] Grey CNB and Woodfine L. (2019). Voices of those with lived experiences of homelessness and adversity in Wales: informing prevention and response. Cardiff: Public Health Wales NHS Trust.

monitored and reported on. Membership includes representation from key areas of the Health Board, with support from the Medical Director. Other partners, including local authority and third sector colleagues, will be invited to future forum meetings.

An update report for the period April 2019 – September 2019 has been submitted to Welsh Government, along with a HaVGHAP. To inform the development of the HaVGHAP, a partial needs assessment has been carried out and pre-existing evidence has been used, such as the Regional Partnership Board's population assessment. The Local Public Health team are supporting the completion of needs assessments for the remaining vulnerable group categories.

It is expected that the HaVGHAP will be a 'living document', used to monitor compliance with the standards and Health Board activity that improves the health and well-being of homeless and vulnerable groups and will be regularly updated, taking in to account new and emerging evidence.

A strong link has been developed with Swansea Bay University Health Board, which has a well-established and mature HaVGHAP and partnership group. This has created the opportunity for shared learning and the potential for partnership projects between both Health Boards.

Following the publication of the Substance Misuse Delivery Plan 2019-22 by Welsh Government and consultation on the 3 year Mental Health Delivery Plan an opportunity to apply for recurrent funding was created for organisations working with those with complex needs, with particular consideration of those that are homeless/vulnerably housed and those with co-occurring substance misuse issues. Therefore, a joint bid was submitted in September by the Health Board, in partnership with each of the Local Authorities for a) Crisis Response Service and b) a "Tier 2" style liaison and mental health intervention service working alongside housing support services such as Housing First. The Health Board and its partners are currently awaiting the outcome of the submission.

It is widely recognised that homeless people and other vulnerable populations experience significant ill-health, often have complex needs and have worse health outcomes than the general population. A recent report by Public Health Wales (2019)[1] highlights that every £1 invested in lifting people out of homelessness could lead to a £2.80 return on investment.

Department for Health (2010) estimated that this population's use of acute hospital services cost four times as much as for the general public. Inpatient services cost eight times as much due to the severity of their health conditions rather than differences in delays for discharge. It also found that this client group are much more likely to be admitted as an emergency.

3. Priorities

The priorities for the next six month reporting period (October 2019-March 2020) are:

- To embed the newly formed Homeless and Vulnerable Groups Partnership Forum to ensure representation across HDUHB services, Local Authority and Third Sector and the prioritisation of key actions.

- Maintain representation at multi-agency partnerships and have two-way feedback on progress and developments between the partnerships and the Homeless and Vulnerable Groups Partnership Forum (HVGPF).
- Completion of needs assessments for homeless and vulnerable groups, to inform the HaVGHAP.
- Scope and commission bespoke training to raise awareness and knowledge of staff regarding homeless and vulnerable groups, following a review of the training needs assessment.
- Submit a bid for funding to Welsh Government's Self-Management and Well-being Fund, to develop a bespoke, culturally sensitive educational package for families being resettled under the Syrian Vulnerable Persons Resettlement Scheme and is delivered by lay tutors who are Arabic speakers
- To support communication with those whose first language is not English – develop cue cards for identifying which language is needed, so that Interpretation services can be used.
- Evaluate the options for improving communication in Primary and Secondary Care settings through online interpretation services. Pilot the chosen options using IQT methodology, with the aim of full roll-out.
- Work in partnership with the current Interpretation Services Provider on recruitment of Arabic speakers in areas across Hywel Dda where availability is low and compromising the ability for face to face interpretation.
- Work with Primary Care colleagues to raise awareness amongst primary care service providers of the national postcode for no fixed abode, to enable those who are homeless to access healthcare services.
- Work with Primary Care colleagues to improve access to services by homeless and vulnerable groups, especially for urgent/same day appointments.

Update on work to support people with sensory loss
Strategic Partnerships, Diversity and Inclusion Team
November, 2019

This is an update on current activity within Hywel Dda University Health Board (Health Board) and across Carmarthenshire, Ceredigion and Pembrokeshire, on how legislation is being implemented and access to healthcare services is being improved for people with sensory loss.

1. Current legislation and evidence

The Equality Act 2010 requires that providers of services (including public bodies) meet the three general duties of eliminating discrimination, advancing equality and fostering good relations across all the protected groups. Disability is one of the protected groups so this includes the need to make reasonable adjustments, such as providing information in accessible formats for those with sensory loss – as not to do so may constitute discrimination and would put individuals at a disadvantage in comparison with those who do not have a sensory loss.

In 2013, the Welsh Government published the All Wales Standards for Accessible Communication and Information for People with Sensory Loss. The Health Board is required to submit twice yearly reports to Welsh Government on compliance with the standards, as part of the NHS Wales Delivery Framework.

The Standards require the Health Board to:

- Assess all public and patient areas, to identify the needs of people with sensory loss
- Assess all public information produced by the Health Board, prior to publication
- Raise staff awareness of the standards and their obligations, to ensure that the standards are met, together with the use of communication systems, how to communicate effectively and providing appropriate communication support.
- Ensure that patients' communication and information needs are recorded on their medical records, there is a flagging system to highlight the recorded needs and that this information is shared as part of the referral process from primary to secondary care
- Have accessible appointment systems
- Use a range of communication models
- Have mechanisms in place to seek and understand the patient's experience and learn from positive and negative feedback
- Have an action plan, to support implementation of the standards

Other drivers for change include:

- The Accessible Information Standard, which specifically applies to GP surgeries in Primary Care and further strengthens the standards that were launched in 2013, to ensure a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of people with sensory loss.
- Speak my Language: Overcoming language and communication barriers in public services which was a report published by the Auditor General for Wales in 2018.

New regulations came into force in September 2018 that require public bodies to ensure websites and mobile apps are more accessible. The full name of the regulations is the Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018. Making a website or mobile app accessible means making sure it can be used by as many people as possible, including those with:

- impaired vision
- motor difficulties
- cognitive impairments or learning disabilities
- deafness or impaired hearing

2. How the Health Board is supporting people with sensory loss and ensuring compliance with legislation

The Strategic Partnership, Diversity and Inclusion team co-ordinates the bi-annual report to Welsh Government, on progress against the standards, working under the leadership of Sarah Jennings, Director of Partnerships and Corporate Services.

A Sensory Loss Partnership Forum has been established in order to ensure that the Health Board complies with the standards and current legislation. Membership includes representation from key areas of the Health Board. Other partners, including local authority and third sector colleagues, will be invited to future forum meetings.

An update report for the period April 2019 – September 2019 has been submitted to Welsh Government, along with a sensory loss action plan.

It is expected that the sensory loss action plan will be a 'living document', used to monitor compliance with the standards and current legislation and will be regularly updated, taking in to account new and emerging evidence and guidelines.

Strong links with the other Health Boards and Third Sector provides the opportunity for shared learning and expertise and partnership working, for example, resources to support the implementation of the Accessible Information Standard were developed by the NHS Centre for Equality and Human Rights, for use by Primary Care teams across Wales.

Those with sensory loss are more likely to be higher users of healthcare services and have complex needs and co-morbidities. Older people with sight loss are almost three times more likely to experience depression than people with good vision. Communication was raised as an issue and a barrier, leading to missed health issues, social isolation and depression (Social Care Wales, 2017)[1]. Therefore, poor communication should be considered a patient safety issue.

Continued engagement with local residents who have sensory loss (such as local deaf centres) ensure their participation in public consultations and identification of needs.

[1] Care and support in Wales: national population assessment report Social Care Wales (2017)

3. Priorities

The priorities for the next six month reporting period (October 2019-March 2020) are:

- Building on the pilot of the Sensory Loss friendly Award, a self-assessment checklist will be developed, to enable patient areas to be assessed. The checklist will be piloted in key patient areas before Health Board wide roll-out.
- An audit of equipment that supports communication, such as hearing loops and personal amplifiers will be undertaken.
- An Accessible Communication and Information policy will be developed which will include requirements for accessible public sector websites and web-based applications.
- Continue to promote the sensory loss e-learning package during induction and Manager Passport Programme and through the Sensory Loss Partnership Forum.
- Increase patient access to My Health Online (MHoL) for managing appointments to all GP practices.
- A task and finish group has been set up to improve the accessibility of appointment systems and develop a range of communication models across Community Nursing.
- In response to feedback received from Llanelli Centre for the Deaf, and with support from a GP cluster, evaluate the options for improving communication in Primary and Secondary Care settings e.g.SMS text and online BSL interpretation services. The chosen options will be piloted using Improving Quality Together (IQT) methodology, with the aim of securing support for full roll-out across the Health Board.
- A follow up survey will be carried out across GP practices to check compliance against the Accessible Information Standard and additional support provided where there is still non-compliance.
- Delivery of awareness raising training in collaboration with Deafblind Cymru, Wales Council of the Blind and colleagues from the Audiology Department during Sensory Loss Awareness Month (November 2019).
- Further training is planned in sensory loss awareness and basic British Sign Language (BSL) for key staff, including PALS, Engagement team and the Strategic Partnerships, Diversity and Inclusion team.

Delivering support for Carers

Progress report for the period:

April, 2019 to September, 2019

Prepared by:

Strategic Partnerships, Diversity & Inclusion Team, Hywel Dda University Health Board on behalf of the West Wales Carers Development Group.

Date: 21st October, 2019.

CONTENTS

1.0 Introduction

This report summarises the activity of the UHB and the West Wales Carers Development Group (WWCDG) for the period 1st April 2019 – 30th September, 2019. The WWCDG is a formal sub-group of the West Wales Regional Partnership Board (RPB) and includes representatives of Hywel Dda University Health Board (Health Board), the three Local Authorities of Carmarthenshire, Ceredigion and Pembrokeshire. There is an open invitation for our three RPB Carer representatives to attend meetings of the WWCDG and they receive all papers to enable comments or views to be considered.

The WWCDG are working in partnership to support Carers by:

- Strengthening the partnership approach at a local level;
- Creating opportunities to enable the third sector to fully participate in the delivery of services for Carers;
- Working collaboratively to use short term funding as a means of testing new ways of working and embedding good practice.

Carers were identified as a key focus of the work of the Regional Partnership Board during 2018/19 and we have worked with the Carer Representatives on our Regional Partnership Board to act as a continued source of feedback and challenge. Carers are a fundamental focus within the West Wales Area Plan 2018-2023 which sets out our communities needs across West Wales and how we will work in partnership to respond to these. We are facing unprecedented changes in Health and Social Care and with an aging population the number of Carers in the region is likely to increase. The Regional Partnership Board is committed to working to deliver support for Carers in our communities in new and innovative ways, and to ensure that the needs of Carers are considered at every stage of their health and social care journey.

This report provides an overview of the work which has been taken forward, utilising the funding provided by Welsh Government, to ensure that Carers priorities are embedded in services across the region. In their budget letter dated 14th March 2018 Welsh Government set out their expectation that health, local authorities and the third sector will work in partnership to support Carers under the Act by:

- Supporting life alongside caring - providing opportunities for Carers to have reasonable breaks from their caring role to enable them to maintain capacity to care, and to have a life beyond caring.
- Identifying and recognising Carers - improving Carers recognition of their role and ensuring they can access the right support.
- Providing information, advice and assistance - providing appropriate advice where and when Carers need it.

The requirements above form the basis of this progress report which provides evidence of progress against each of these areas.

2.0 The needs of Carers in West Wales

The West Wales RPB published its first Population Assessment for West Wales in April 2017 and following this has developed the West Wales Area Plan 2018-2023. A significant amount of information about the needs of the population was gathered through direct citizen engagement. This was further enhanced with the data and outcomes collected during the Carers' Measure work across the region in order to develop a profile of Carers' across West Wales.

The 2011 Census identified that within the West Wales population of 348,000, there is approximately 47,000 Carers. Around 9,000 Carers have been identified either through GPs or Social Services, which demonstrates that many Carers are being identified as a result of their own health or care needs. In addition, over 400 Young Carers are currently being supported in West Wales; these are young people under the age of 18 years old who are caring for siblings and parents.

The West Wales Carers Development Group has continued the work started under the Carers Measure and reports to the West Wales Regional Partnership Board, ensuring that Regional priorities as defined in the West Wales Area Plan are implemented.

3.0 Key developments & progress – over the last period

The WWCDG have established a delivery plan for 2019/20 see annex 1 detailing the activity to be taken forward throughout the year. The delivery plan takes into account the priority areas set by Welsh Government. The key developments and progress are summarised below. (Further detail is provided within subsequent sections of this report).

- Commencement of a regional Employers for Carers membership and establishment of a formal steering group to support the roll out;
- Completion of Phase 3 of the Carers Resilience and Well-being pilot in Ceredigion;
- Roll out of the new Social Care Wales national Carer Aware e-learning course;
- Development of a Carers needs assessment quality assurance framework and audit tool;
- Identifying new and innovative approaches to respite services;
- Launch of the redesigned Investors in Carers scheme;
- Taking forward recommendations from a consultation with Young Carers and Young Adult Carers increasing our understanding of the needs of these groups.

The following sections of the report provide evidence of the progress which has been made both locally and regionally to address the Welsh Government priority areas.

4.0 Supporting life alongside caring

Providing opportunities for Carers to have reasonable breaks from their caring role to enable them to maintain capacity to care, and to have a life beyond caring is a key priority area. To support Carers, a range of activity has been delivered as described below.

4.1 Joint commissioning of respite services

Work has been on-going to look at opportunities for future joint commissioning activity that can provide a driver for change. Initial work identified baselines for financial and contractual commitments across the three local authorities and health board. This highlighted both similarities and differences between areas and created opportunities for further joint commissioning of Carers services between Ceredigion County Council and Hywel Dda University Health Board. It has also provided the foundation for a scoping exercise to map the full range of services in order to begin to shape what a regional core offer for Carers might look like, and how this could be delivered within the context of local priorities.

An initial priority has been to focus on reviewing respite provision as a model for future joint commissioning across the region. The Refreshing Respite work involved conducting a review in partnership with University of Swansea to examine and understand the current provision and offer across the region and the potential additional services that could be offered. It also gathered examples of good and emerging practice from elsewhere. The review involved engaging with Carers, service providers and stakeholders from across the region in reviewing services and beginning a process of co-production with them. This work will continue through the year; refreshing respite and providing a range of breaks from caring is a priority including respitality schemes and approaches.

4.2 Learning & development opportunities for Carers

The Health Board now includes a focus on Carers and diversity and inclusion within its corporate induction programme for all new employees. As a result, since introducing the new induction programme in October 2018, 1173 new staff employees across a wide range of professional groups and departments have received information about Carers, including how to identify and support Carers whether they are staff members, patients or their Carers. This has been a great opportunity to raise awareness within the Health Board and ensure employees are thinking about Carers rights from day one of their employment. Local Authorities have also committed to including a section to raise awareness about Carers and to promote the new Carer Aware e-learning on corporate induction sessions.

"We were able to share our experiences and coping strategies in a relaxed and confidential atmosphere"

Throughout the year a variety of specific Carer related training courses were delivered across the three counties, for example the Introduction to Looking after me (I2LAM) was delivered four times in Pembrokeshire with 34 Carers attending.

Skills to help me manage in the future. I will try and get out more and time to relax"

Feedback from the participants indicated the positive impact this course has had on the well-being of carers.

The new Carer Aware e-learning was launched in November 2018 by Social Care Wales and the group established an access guide for all organisations across the region which was then cascaded out to staff via a number of different means. Facilitated sessions were held across the region to support individuals with limited ICT access/skills. This was funded using the allocated grant from Social Care Wales to support the roll out of the new programme. To support the new Carer Aware e-learning, the group have also supported the commissioning of a booklet containing the content of the e-learning as an aid memoir.

Uptake of the e-learning will be monitored during 2019/20 and all frontline staff will be encouraged to complete the e-learning in the first instance.

5.0 Identifying and recognising Carers

Identifying and recognising Carers and ensuring they can access the right support is a continuing priority, alongside improving Carers recognition of their role. To support this priority area, a number of activities have been undertaken.

5.1 Improving engagement of Carers in Discharge Planning and Transfer of Care

Welsh Government identified an ongoing need to improve support for Carers when they, or the person they care for, is discharged from hospital. In response to this, the West Wales Carers Development Group established a pilot in January 2019 in two community hospitals within the Hywel Dda University Health Board area. The work continued over the summer and has been used to inform our next steps. The work has been built on during 2019-20 via the development of a Carer Awareness Programme which will be delivered to staff working throughout our four main hospitals and our community hospitals. We are working with key partner organisations from the third sector to look at developing a dedicated resource for each hospital that will provide Carer awareness support that will support improvements for Carers during the discharge / transfer of care process. This will also include development of Carers Information Boards at each hospital and consistent Carers information pack which will include:

- GP surgery carer registration and referral form
- 'Message in a Bottle' (funded by the Lions Group in Carmarthenshire)
- Coming out of hospital fact sheet
- Emergency Card application form

5.2 Young Carers and Young Adult Carers

The Young Carers and Young Adult Carers work stream identified the need to gain a better understanding of the well-being of Young Carers and what gaps exist in the support that they are currently able to access, in order to shape future services. In response to this, the WWCDG allocated resource to support the Young Carers work stream to undertake a consultation with Young Carers and Young Adult Carers across the three counties.

An on-line SNAP survey was developed comprising of a variety of questions focussing on;

- Mental Health
- Physical Health
- Time for self
- Caring role
- School / College experience.

The survey was completed by 142 carers though engagement at open days, support groups, drop-in sessions and on social media, using iPads to encourage participation. Following early analysis of the results from the survey, a number of recommendations and next steps have been identified and will be taken forward during 2019-20. These include but not limited to;

- Ensuring arrangements are in place to provide appropriate support to all Carers, regardless of age will be considered. 21 young people (14.7%) responded that they started caring before they were 8 years old.
- There is evidence that Young Carers feel that they benefit from, youth clubs and day trips, however, these all have funding implications for delivery organisations. Opportunities for innovative ways to deliver these types of services need to be explored.
- Strengthening the involvement of schools in the identification and support to Young Carers. Of the Young Carers that said school are aware of their caring role, only 35% felt that teachers were more understanding and 25% said that nothing came of it.

In addressing some of needs identified Carers Trust Crossroads Sir Gar have secured funding through the National Lottery Community Fund for a Children & Young People's Carers Service that will deliver additional projects from January 2020. The Education Engagement project will work closely with schools to identify young Carers as soon as possible and ensure they get the support they need to balance their caring roles. A Volunteer/Peer Mentor project will provide Carers of all ages the opportunities to volunteer their time and to gain new skills and experience. There will also be in place an Events Coordinator who will arrange and deliver activities.

5.3 Investors in Carers scheme (IiC)

The IiC scheme provides a key link between each setting and county based Carers Information Services. One key aspect is encouraging Carers to identify themselves to GP practices. Up to September, 2019 a total of 7,946 Carers had registered with GP surgeries across the health board area.

We continue to work collaboratively with key stakeholder organisations, Carers and the IiC team to promote the Investors in Carers scheme which has been recognised by Welsh Government as a best practice example. The IiC now identifies 6 themed standards across three levels of bronze, silver and gold using a Progressive Stepped process. A key achievement has been adapting the scheme to enable it to be available for a wide range of health, social care, education or community settings or teams. Identification of Carers at GP practice level has been the foundation of the scheme but wider involvement and accreditation across the whole health and well-being system is reaping benefits by promoting increased Carer recognition and support.

Two GP surgeries in Pembrokeshire have gained their Silver level under the new scheme, including St David's Surgery as shown in the photograph below.

"We are delighted to have achieved our silver award. We have worked hard at looking at ways to help our carers and look for hidden carers and are grateful our work has been recognised."

Carer lead Kim Phillips, St David's Surgery, Pembrokeshire.

Settings are also encouraged to submit their evidence in Welsh and Ysgol y Strade School in Llanelli have been the first setting to do so.

'The welfare of all young people at the school is always at the forefront of our planning. We are committed to providing opportunities for all young pupils, including those facing social difficulties. The Investors in Care Bronze award has helped us identify young people that require extra support and provide them with a voice. The project has also helped us raise awareness of the difficulties young carers face along with ways in which we can further support them both academically and their wider development. I must thank Debbie for her support in preparing the evidence and to Cat for her continued work with our young carers.'

Adam Powell, Assistant Head Teacher, Ysgol Y Strade

A wide range of settings that are now engaged with the scheme including: GP surgeries, some Community Pharmacies, All Mental Health and Older Adult Mental Health teams, secondary schools, libraries, Community Inclusion for Learning Disabilities, 3rd Sector Organisations, Pre-assessment clinics, Patient Advice Liaison Services team and the Job Centre plus in Haverfordwest.

Investors In Carers - 2019/20- Key Indicators

Carer Identification & Referrals	**Via Primary Care**	Carers registered at GP Surgeries (March 2018/June 2019	7528	7882
		Carer referrals from GPs for IAA (March 2018/June 2019	587	165

IiC Accreditation			Achieved	In Progress
Health	**Primary Care**	GPs bronze level	48	1
		GPs silver level	2	5
		Community Pharmacies - (B)	6	3
	Wards & Hospitals	Older Adult and Acute Mental Health Wards - (B)	5	1
		Older Adult and Acute Mental Health Wards - (S)	0	1
		Community Hospitals & Outpatients - (B)	3	2
	Patient Information, Advice & Assistance	Pre-assessment Clinic (Withybush/Bronglais/GGH/PPH) - (B	2	2
		Patient Advice Liaison Service (B)	0	1
		Non-Emergency Patient Transport (WAST) (B)	1	0
		DoLS team (B)	1	0
	Community Teams	S-CAMHS - (B)	3	4
		CMHT (Acute) - (G)	1	0
		CMHT (Acute) - (S)	0	1
		CMHT (Acute) - (B)	2	2
		CMHT (Older Adults) - (B)	4	1
		CMHT (Older Adults) - (S)	1	1
		ECT (B)	1	0
		CRHT - (B)	0	3
		PICU/Cwm seren - (S)	1	0
		Learning Disabiliites - (B)	0	1
		Long term care nursing team (B)	0	1
		Amman Gwendreath Community Nursing team (B)	0	1

			Achieved	In Progress
		Secondary Schools - (B)	9	6
		Secondary Schools - (S)	0	3
		Colleges - (B)	1	2
	Council & Commissioned Services	3rd sector commissioned organisations (B)	2	8
		3rd sector commissioned organisations (S)	0	3
		3rd sector commissioned organisations (G)	0	3
		Learning Disabiliites/Community Inclusion (B)	3	1
		TAF Pembs/Carms (B)	1	1
		Workways+ (Pembs/Cere) (B)	1	1
		Jobcentre plus H'West/Cardigna/Carms (B)	1	2
		Ceredigion Carers Unit (G)	1	0
		PCC Commissioning team	0	1

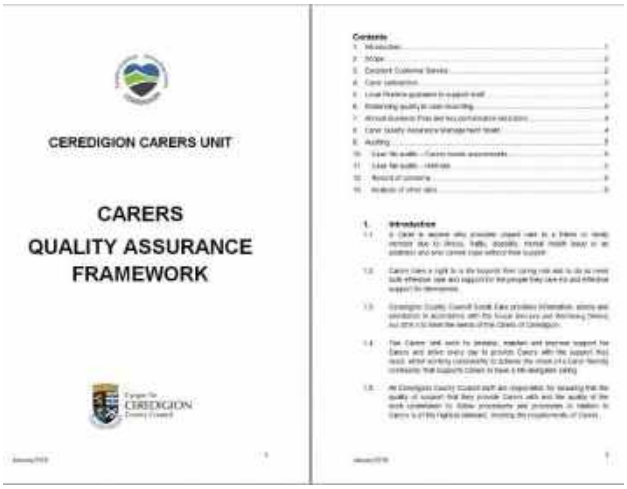
			Achieved	In Progress
Communities & Social		Libraries (B) (Pembs/Carms)	4	6
		Norman Industries (Social Entreprise) (B)	1	0

(B) Bronze Accreditation	105	65
(S) Silver Accreditation	5	6
(G) Gold Accreditation	2	3

5.4 Service improvement and integration

The service improvement and integration work stream has progressed a number of key projects for Carers during the last period. The West Wales Employers for Carers (EfC) Umbrella Membership and Steering Group has been formally established, chaired by Ceredigion County Council with representation from the four statutory organisations. The steering group is being supported by the EfC Wales Hub Manager from Carers Wales to evaluate current policies and practices around how organisations are supporting Carers within their workforce. The steering group have been considering how organisations can best utilise the resources available, for example policy advice, staff networks, staff survey and learning materials for line managers, to improve organisational support for working Carers.

Ceredigion has been the pacesetter for the development of a Carers needs assessment quality assurance framework and audit tool. The framework has been completed and sample testing will take place during 2019-20 before further roll-out to share learning and best practice across the region.


CEREDIGION CARERS UNIT

CARERS
QUALITY ASSURANCE
FRAMEWORK

A member of the WWCDG also participated in the Social Care Wales Task and Finish Group during the engagement and consultation arrangements to develop a national Practitioners Toolkit.

Regional ICF funding was secured during the year for Ceredigion County Council to deliver the third phase of the Carers Resilience & Well-Being programme. Dr Dee Gray was commissioned to pilot the delivery of a Carers Resilience and Wellbeing programme. The programme was delivered to adult Carers in employment within Ceredigion County Council and also to staff and pupils in Penglais Secondary School. In total 11 people completed the Train the Trainer Level 1 accreditation and 6 Facilitators were accredited at Level 1.

"The programme has made me take a step back, look at the bigger picture and be kinder to myself. I feel confident that I can share what I have learned with colleagues, building a resilient community of Carers in work".

The development of wellbeing breakfasts in school, together with design and co-produced resources, course materials, delivery and communication plans have now be completed and further programmes will be delivered during 2019-20. Best practice and learning is to be considered for 2019-20 with the view of rolling the programme out across wider communities and organisations with further ICF Bids submitted.

6.0 Providing information, advice and assistance

The information, advice and assistance work stream group undertook a mapping exercise which identified disparity in the information available to Carers across the region. In response, the group developed a regional approach to the provision of some key information materials and re-prints of key leaflets have been completed and are now available across the region.

One of the Carer information materials which was identified as extremely valuable was the 'Say I'm Fine and Mean it' book; one Carer quoted;

"*I noted from the publication you gave me "Say I'm Fine - and Mean It" there were some interesting books I would like to read. That publication in itself is priceless. How I identified with every single page. From now on that book is going in my handbag. It is a fabulous tool in itself.*"

The work stream have also strengthened links with DEWIS and other information services, ensuring information relating to Carers across the region is relevant, up to date and accessible.

7.0 Priorities for the next 6 months 2019/20

Carers and the Carers' agenda has been established a priority within the Area Plan for West Wales. The Regional Partnership Board has adopted Carers as an integral priority, particularly recognising the cross-cutting impact across all its key initiatives. In support of the prominence of this population group the RPB has appointed Sarah Jennings, the Health Board Director of Partnerships and Corporate Services, as RPB sponsor and lead for this area.

The West Wales Carers' Development Group which includes representatives from partner agencies, including Carers and working closely with third sector organisations will continue to co-ordinate the delivery of partnership actions on behalf of the Regional Partnership Board. The RPB have recently approved the Carers Delivery Plan for 2019/20 which notably;

- Addresses key requirements, gaps and improvements identified through the West Wales Population Assessment
- Responds to Ministerial priorities for supporting carers
- Aligns with other RPB priorities and reflects the strategic objectives with the Area Plan
- Complements and integrates a range of Carers' initiatives across the region
- Incorporates the views and ideas of key stakeholders captured at the regional carers planning event held in January 2019

8.0 Conclusion

This Report provides an overview of the wide range of activity which has been on-going in West Wales to improve outcomes for Carers. The focus of the report has been on the work done in partnership via the West Wales Carers Development Group and how the Welsh Government funding has been utilised to support this work.

Over the next 6 months we will continue to progress our priority actions as set out in the WWCDG Delivery Plan for 2019-2020. A key focus will be improving support for Carers when they, or the person they care for, is discharged from hospital. We will be working collaboratively with our third sector partners to improve discharge arrangements through a dedicated Carer Officer at each of our four acute hospitals. This resource will deliver Carer awareness support and training to all wards so that staff understand and can improve Carers' (of all ages) experience of discharge.

Annex 1 – West Wales Carers Development Group Delivery Plan 2019-2020

wwcp
Partneriaeth Gofal Gorllewin Cymru
West Wales Care Partnership

West Wales Carers Development Group

West Wales Carers Delivery Plan 2019/20

1. Introduction

The 2019/20 Carers Delivery Plan has been developed by the West Wales Carers Development Group (WWCDG) and will form part of the response to the West Wales Area Plan. This Delivery Plan sets out the proposed activity during 2019/20 with planned resources, based on key factors, namely;

a. Addressing Carers' requirements identified by the West Wales Population Needs Assessment (PNA)
b. Responding to the Welsh Government Ministerial priorities for supporting Carers.
c. Aligning with the West Wales Regional Partnership Board (RPB) priorities, working collaboratively to deliver effective services for Carers across the region.
d. Responding to feedback from a regional planning event held by WWCDG in January 2019, involving a wide range of stakeholders including carer representatives and third sector organisations.

2. Background

Under the Carers Strategies (Measure) 2010, a Regional Carers Group was established to develop a regional partnership between Health, Social Care and Third/Voluntary Sector organisations, to deliver the objectives of the Information and Consultation strategy. The progress and achievements of the group have been detailed in the annual reports to Welsh Government and Local Authority Well-being Scrutiny committees.

The introduction of the Social Services and Well-being (Wales) Act 2014 (SSWBA) further strengthened the rights for Carers through legislation. The development of a specific work programme for Carers has enabled a regional, integrated approach to service development. This is co-ordinated by the West Wales Carers Development Group who form part of the governance structures of the West Wales Regional Partnership Board.

There are a number of specific achievements which have resulted from the collaborative working arrangements which have been in place since 2010. These include:

a. Regional co-ordination and joint commissioning between health and social care of Carers Information, Outreach and Carers support services;
b. The development of a suite of regional information leaflets for Carers as well as coordinated communications and events;
c. Commissioning and delivery of Carer Aware training;
d. Establishment of Carers' forums within each local authority area to provide direct input to local and regional issues and service improvement discussions;
e. Establishing a regional focus for Young Carers support services and co-operation across Health, Authorities and Third Sector.

f. Delivery and development of the Investors in Carers quality assurance scheme supported by Council Voluntary Services (CVS) and Third Sector partners across the region, which has been extended as a scheme suitable for a diverse range of settings including: health (primary, community and secondary care), education, community services e.g. libraries, local authority teams and services e.g. and Carer service providers.
g. Contributing to the development of the Regional Population Needs Assessment, Area Plan, Integrated Care Fund and Transformation bids ensuring the needs of Carers are clearly articulated.

3. Priorities for Delivery

Carers have specific and individual needs, distinct from service users. The SSWBA provides a foundation through which the Regional Partnership Board can strengthen service delivery and inclusion of Carers in all aspects of health and social care integration work.

The WWCDG has developed this Delivery Plan, to address both the Welsh Government priorities as well as the gaps highlighted within the PNA. On 25th January 2019 the WWCDG facilitated a regional planning event and invited a wide range of stakeholders including carer representatives, to consider what the priorities should be in 2019/20. In order to take the work forward the local priorities will build on the three Welsh Government priorities for Carers;

- Supporting life alongside caring - providing opportunities for carers to have reasonable breaks from their caring role to enable them to maintain capacity to care, and to have a life beyond caring.
- Identifying and recognising Carers - improving Carers recognition of their role and ensuring they can access the right support.
- Providing information, advice and assistance - providing appropriate advice where and when Carers need it.

The Delivery Plan provides an outline of the priority areas and tasks, how it is intended to fund this work and how it links to the areas identified in the Population Needs Assessment, Area Plan or Welsh Government national priorities.

The WWCDG are committed to ensuring Carer involvement and co-production in initiatives that will improve services for Carers.

4. Funding the Delivery Plan

The work identified within the 2019/20 Delivery Plan will be funded through a number of annual funding streams:

- Welsh Government Carers Grant of £121k. This funding is provided to Hywel Dda University Health Board to support their work with partners to enhance the lives of Carers. Welsh Government have specified two areas of eligible activity:
  1) Supporting carers in general practice to implement a scheme that supports health professionals working in primary care and community care

to develop their carer awareness and understanding of how to identify carers, the issues that carers face and ways of working to better support carers; **and**
2) Discharge from hospital planning - taking steps to support and engage carers in the patient's discharge planning.

- Welsh Government Integrated Care Fund (ICF). The RPB has allocated £488,800 from the overall regional ICF allocation in order to drive forward specific projects for Carers.

The funding streams identified above are all short-term and time-limited and as such the WWCDG have developed plans to ensure that they support transformational change with minimal investment in staff posts. In addition to the specific resources identified above, funding is also made available through the Health Board and Local Authorities who jointly, and separately, commission services for Carers.

5. Governance arrangements

The West Wales Carers Development Group forms part of the governance arrangements of the West Wales Regional Partnership Board. The Carers Representatives of the RPB have a standing invitation to attend meetings of the WWCDG. As governance arrangements evolve during 2019/20 the membership of the WWCDG will be reviewed to ensure continued fitness for purpose.

Theme 1: Supporting life alongside caring All Carers must have reasonable breaks from their caring role to enable them to maintain their capacity to care, and to have a life beyond caring.			
Priority Actions	**Lead Officer**	**Financial**	**Links**
1. Ensure commissioning of carers services supports the regional collaborative models, co-production of service specifications and tender requirements. This will include:	Rhian Bennett Pembrokeshire County Council		
a. Implementation of the recommendations from the review of respite provision across the region undertaken by Swansea University, including new models of delivery e.g. respitality and social tourism.	Rhian Bennett Pembrokeshire County Council	ICF / LA Core Funding	1.11 area plan
b. Identify further opportunities to develop joint commissioning arrangements, in line with the regional approach.	Rhian Bennett Pembrokeshire County Council	Partner Core Funding	
c. Establishment of a Community development fund to support the growth of community led initiatives which tests out new models and ideas which meet regional priorities and recognised within this delivery plan. Co-production with carers will inform the focus of the initiatives.	Rhian Bennett Pembrokeshire County Council	ICF	
2. Rollout of Carers Resilience & Well-Being (CR&WB) across community settings and employers across the region.	Heather West – Ceredigion County Council	ICF	1.13 area plan
3. Support the regional rollout of **Employers for Carers** (EfC) across statutory organisations and SMEs encouraging and supporting employers to in turn support employees who balance their work alongside a caring role. This is also supported by the IiC scheme.	Heather West – Ceredigion County Council	ICF	1.10 area plan
4. Support for carers wishing to return to education, employment or volunteering roles.	Chris Harrison Pembrokeshire & Carmarthenshire County Council	Transformation Fund	1.10 area plan

Theme 2: Providing information, advice, assistance - Ensuring access to information, advice, assistance and training meets local demands including benefits advice, housing & accommodation advice and transport information. This is a through age priority.			
Priority Actions	**Lead Officer**	**Financial**	**Links**
1. Development and expansion of online and digital media and establish roadmaps to guide carers on various paths throughout their caring journey.	Rhian Bennett Pembrokeshire County Council	ICF / Transformation Fund	1.4 area plan and LD/ Dementia pathway development
2. Identify opportunities to align practice, process and roll out good practice across the region based on carer needs – strengthening links with services who can provide specialist advice i.e. legal / benefits.	Alison Watkins Carmarthenshire County Council	Core Funding	
3. Raise awareness across a wide range of organisations, teams and departments to ensure carers receive appropriate information and support when required. This includes promoting the uptake of the new carer aware e-learning, the Investors in Carers scheme and links to statutory and commissioned services.	Pennie Muir Hywel Dda University Health Board	WG (IiC) and Core Funding	1.10 area plan
4. Identify ways of supporting carers to improve their physical, emotional and mental well-being.	Anna Bird Hywel Dda University Health Board	WG grant / Core	1.10 area plan
5. Discharge from hospital planning – taking a whole system approach to support and engage carers in the patient's discharge planning and ensure active provision of IAA to all carers.	Anna Bird Hywel Dda University Health Board	WG grant / Core	1.12 area plan

Theme 3: Identifying and recognition of carers - Fundamental to the success of delivering improved outcomes for carers is the need to improve carer's recognition of their role and to ensure they can access the necessary support. This is a through age priority.			
Priority Actions	**Lead Officer**	**Financial**	**Links**
1. Investors in Carers scheme – continued roll-out of the regional IiC scheme across a broad range of settings, teams and departments (i.e. housing teams) encouraging participants to progress through the three levels and identifying new ways of working such as digital media to promote the scheme and digital portfolio submissions.	Pennie Muir Hywel Dda University Health Board	WG Grant / Core UHB funding	
2. To support practitioners to utilise toolkits and other materials to enable them to be more confident when carrying out Carers assessments. Carers will then feel supported to continue to care as their views and wishes will be considered in the planning of care for their loved one.	Chris Harrison Pembrokeshire & Carmarthenshire County Council	ICF and link to Transformation programme	
3. To develop a through age Carers Passport scheme across the region which can be transferred across numerous settings and supports carers to self-identify and in turn access carer-based support / benefits.	Regional post	ICF	
4. Development of a Regional Carers Strategy to connect local and regional delivery plans.	Regional post	Core funding	

Update on work to support Syrian refugees
Strategic Partnerships, Diversity and Inclusion Team
November, 2019

This is an update on current activity within Hywel Dda University Health Board (Health Board) and across Carmarthenshire, Ceredigion and Pembrokeshire, with regards to the Syrian Vulnerable Person Resettlement Programme (SVPRP).

1. Current legislation and evidence

Since December 2015, the UK Government has responded to the humanitarian crisis in the middle-east with the SVPRP and has agreed to resettle up to 20,000 Syrians in need of protection. The current scheme is due to end on 31st March 2020. Relocation is managed by Local Authorities and task groups/forums have been created for Carmarthenshire, Ceredigion and Pembrokeshire, led by the Local Authorities with partner organisations (including health, education, Police, Department for Work and Pensions and Third Sector).

The table below shows how many individuals/families have been resettled within each of the three counties from 2015/16 to October 2019.

County	Currently residing in HDUHB		Resettled since April 2019 (current financial year)		Due to arrive in HDUHB (Nov 2019-March 2020)	
	Number of groups	Number of individuals	Number of groups	Number of individuals	Number of groups	Number of individuals
Carmarthenshire	t.b.c	132	5	21	1	5
Pembrokeshire	9	46	1	6	2	t.b.c
Ceredigion	13	62	3	17	0	0

The Health Board receives funding of £2,600 from the Home Office for each individual who is resettled during the first 12 months. The initial payment of £2,600 is provided to cover initial registration with primary care providers (£600) and £2,000 to cover the costs of any secondary care required.

2. How the Health Board is supporting homeless and vulnerable groups

The responsibility for overseeing the co-ordination of the SVPRP has recently been transferred to the Strategic Partnership, Diversity and Inclusion Team, working under the leadership of Sarah Jennings, Director of Partnerships and Corporate Services.

In order to take action to promote diversity and inclusion and improve health outcomes for individuals being resettled, an internal Health Board workshop, which included representation from corporate services and operational teams across all three counties was held in June 2019. The workshop provided an opportunity for staff from different parts of the organisation to come together to assess how the Health Board is supporting Syrian families and to identify opportunities for service improvements. Colleagues attending felt that the workshop had been useful to share information and experiences, and further meetings will be arranged periodically.

Two meetings have been held with the lead officers from each of the three local authorities, British Red Cross (BRC) and EYST. This provided an opportunity for the Health Board to share details of a range of work which has been on-going over the past few months:

- A patient story was developed, working with the British Red Cross in Ceredigion, in response to concerns regarding lack of interpretation services. Patients are partners in their health care, and for this to be effective both Health Board staff and the patient need to be able to communicate clearly together. The story has been shared with members of the Executive Board at a Board Development session in June 2019 and shared at the Improving Experience Sub-Committee.
- To alleviate some of the issues with interpretation, the SPD&I team has worked in partnership with the Operational Directorate to streamline the procedures for booking interpretation services so that staff in secondary care can now ring their Switchboard who make all the arrangements for an interpreter.
- Work is on-going with WITS to support a local recruitment campaign to increase the number of interpreters based in the Health Board area. The SPD&I doesn't advocate the use of family members or other Arabic speaking staff as interpreters because of potential safeguarding issues, differences in dialect and taking Health Board staff away from their operational duties. A policy is currently being drafted to formally confirm the Health Board position.
- The SPD&I team deliver a session on person-centred care at the Corporate Induction Programme which includes a case study that highlights the need for interpreters for patients. All new Health Board staff attend this session and the streamlined process for booking interpreter services is explained.
- The Health Board held its first Diversity and Inclusion Conference in partnership with Swansea Bay University Health Board on 4th July 2019. A new recruitment campaign to encourage overseas applications was launched; this was delivered bilingually in English and Arabic. The Chief Executive launched a new Health Board Diversity and Innovation Fund (D&I) which seeks to renew the focus on promoting equality, diversity and inclusion for groups with protected characteristics.

The health issues identified by partner organisations supporting the SVPRP were:

- Access to dental care – those coming to the UK often require extensive dental treatment. While access to Primary Care is usually good, once a patient is discharged from the Community Dental Service, depending on the location, there are a lack of General Dental Services accepting new NHS patients. The Head of Dental Services attended the regional meeting and was able to provide an update on the patient pathway through Community Dental Services to General Dental Services. An information leaflet is under development and will be translated into a number of languages to support increased understanding of the local systems and processes so that patients know what to expect.
- On-going issues with provision of interpretation services – this includes concerns regarding lack of pre-booking of an interpreter for scheduled appointments as well as "no shows" when an interpreter has been pre-booked but then doesn't arrive for the scheduled appointment.
- Reluctance of individuals to disclose mental and emotional health concerns to GPs and other health professionals. The needs of individuals can range from acute issues such as PTSD to needing lower level emotional health and social support and/or talking therapies. There can be a reluctance to access these services due to a cultural stigma around mental health as well as a lack of culturally sensitive services delivered

directly in the language of choice. These issues are often dealt with within the family rather than seeking external support.

Whilst the existing scheme is due to end in March 2020, it should be noted that the Home Office has announced that a new scheme for resettling refugees will be set up next year. The commitment currently is for 12 months, with a target of 5,000 people to be resettled in the UK during that time. The scheme will be widened to resettle refugees from anywhere in the World, so while most refugees will come from a limited number of countries, such as Syria, South Sudan and Somalia, it is important that the Health Board and partners monitor this, to ensure that language support is available.

3. Priorities

As a result of the internal workshop and regional meeting with partners the following actions are being facilitated by the SPD&I Team:

- Support to Primary Care to review their processes for booking interpretation services.
- The development of language cards that include each country's flag so that language of need can be easily identified by staff, even if the individual has limited/no literacy skills. This will support communication with those whose first language is not English.
- Work in partnership with the current interpretation services provider on recruitment of Arabic speakers in areas across Hywel Dda where availability is low and compromising the ability for face to face interpretation.
- Evaluation of the options for improving communication in Primary and Secondary Care settings through online interpretation services. This will include a pilot of the chosen options using Improving Quality Together (IQT) methodology, with the aim of full roll-out.
- Exploration of the issues with assessment of need and access to mental health services including the review of existing mental health screening tools.
- Submission of a bid in collaboration with the Education Programme for Patients for funding to Welsh Government's Self-Management and Well-being Fund, to develop a bespoke, culturally sensitive educational package for families being resettled under the SVPRS, which would be delivered by lay tutors who are Arabic speakers.
- Improving communication issues that still exist for some, when accessing dental services – possibly including the development of communication tools.
- Learning from the experiences of those who have already gone through the process, to identify issues/barriers and make improvements.
- Learning from other partners (Health Boards, Local Authorities and Third Sector) on what has worked well, what has not worked well.

At present there are 240 individuals currently residing in the Hywel Dda area; of these 9 families and 44 individuals have been resettled during the financial year 2019/20 and the Health Board will be drawing down the Home Office funding to support their healthcare needs. A further 3 family groups are expected to arrive later in the year. The potential of reallocating surplus funds i.e. unallocated secondary care funding could be explored in order to fund actions that would address some of the needs identified above.

Update on work to support the Armed Forces Covenant
Strategic Partnerships, Diversity and Inclusion Team
November, 2019

This is an update on current activity within Hywel Dda University Health Board (Health Board) and across Carmarthenshire, Ceredigion and Pembrokeshire, on how the Armed Forces Covenant is being implemented and work to improve access to services for Veterans.

1. Current legislation and evidence

The Armed Forces Covenant is a pledge that together we acknowledge and understand that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives. The Health Board has signed the Armed Forces Covenant and achieved a Silver Award in the Employer Recognition Scheme in 2016.

In 2018 Government published The Strategy for Our Veterans which sets out three key principles:

- Veterans are first and foremost citizens and continue to be of benefit to society;
- Veterans are encouraged and enabled to maximise their potential as citizens; and
- Veterans are able to access support that meets their needs when necessary, through public and voluntary services.

The principles encompass Regular and Reservist Veterans and where appropriate, their families and the bereaved.

Whilst the wider determinants of health and well-being are acknowledged within the Strategy, Health and Well-being features as a specific key theme. The Strategy seeks to focus on ensuring that all Veterans enjoy a state of positive physical and mental health and well-being enabling them to contribute to wider aspects of society.

2. How the Health Board is supporting Veterans

The Strategic Partnership, Diversity and Inclusion team co-ordinates the Health Boards response to the Armed Forces Covenant under the leadership of Sarah Jennings, Director of Partnerships and Corporate Services. This includes work across a range of different areas, working collaboratively within the health board as we as with other public and third sector partners. Some of the key areas of focus over the past six months are summarised below.

Armed Forces Forum and Regional Covenant Group (AFF&RCG)

Councillor Simon Hancock is the Armed Forces Champion on behalf of the Independent Members and jointly chairs the Hywel Dda Armed Forces Forum and Regional Covenant Group. The AFF&RCG meets approximately 3 times per year and includes representation from local authorities, local armed forces services, third sector partners, Welsh Government and a range of services charities.

All Wales Armed Forces Champions Group
The Health Board is represented at the All-Wales Armed Forces Champions Group by the Armed Forces Champions and Lead Officers. This all-Wales group offers the opportunity to share best practice and discuss future initiatives. Cardiff and Vale University Health Board are currently exploring the potential of rolling out the Veteran Friendly GP practice scheme which has been adopted by the Royal College of General Practitioners (RCGP) within England and Scotland. The toolkit to support the scheme has been designed to advise GPs on how best to help veterans who may have been affected by their service careers, and information can be used by all GPs and practice staff. The scheme is similar in format to the Investors in Carers Scheme which Hywel Dda University Health Board co-ordinate to support increased carer awareness.

Health Needs Assessment
Over the past 6 months, the Strategic Partnership, Diversity and Inclusion Team have worked with the local public health team to develop a Veterans needs assessment document. The needs assessment document brings together a wide range of published evidence and information which will help to inform the development of a broader action plan for homeless and vulnerable groups, in line with NHS Delivery Framework requirements.

The needs assessment is being adapted by the national Public Health lead for Veterans, Professor Robert Atenstaedt and will be published bilingually as an all-Wales needs assessment, acknowledging the work which was initially undertaken within Hywel Dda.

Healthcare Priority Treatment for Veterans
The *Armed Forces Covenant – Healthcare Priority for Veterans WHC (2017) 041* refreshed the former guidance WHC (2008) 051. The latest WHC (2017) 041 reaffirms that all Armed Forces veterans are entitled to receive priority access to NHS care within Wales for any conditions which are likely related to, or resulting from their military service. This priority is over patients with a similar level of clinical need and is only for service related conditions. The priority access is for hospital, primary and community care (for conditions which are mental and/or physical) but does not apply to GP appointments.

Actions to support implementation of the Priority Treatment Welsh Health Circular (WHC (2017) 41) are continuing. To coincide with National Armed Forces day Welsh Government launched a new awareness raising campaign which the Health Board supported using social media. In addition all GP practices received emails and copies of the posters to display within their surgeries. Welsh Government are planning to provide an additional supply of printed material which the Health Board will distribute to GP practices, community pharmacies and other locations within the community.

Whilst there are estimates of the number of Veterans residing in the area, there is no way of accurately verifying this and many younger service leavers don't identify with the term "Veteran". Discussions have been on-going with the Primary Care Team in order to review local arrangements for recording Veteran status on GP systems and

for ensuring that all members of the primary care team are aware of the WHC commitments and how to implement these.

Veterans NHS Wales (VNHSW)
VNHSW is a national service providing highly specialist assessment to veterans with military service attributable mental health problems (e.g. PTSD) and with needs that can be appropriately met in primary care. VNHSW use NICE approved evidence based psychological therapy and give signposting advice or onward referrals as appropriate.

VNHSW operates via a 'Hub and Spoke model', the Hub being in Cardiff and Vale University Health Board (CVUHB) and the local Spoke being based in Hywel Dda University Health Board who employ Veterans Therapists. VNHSW has two main aims as below:

- To improve the mental health and wellbeing of veterans residing in Wales with a military service-related mental health injury
- To develop sustainable, accessible and effective services that meet the needs of veterans with mental health and wellbeing difficulties who live in Wales

VNHSW operates an open and direct referral system. Referrals are accepted, with the veterans consent, from any and all statutory and 3rd sector services, veterans families, friends and from veterans themselves. Work has been on-going to raise awareness of how to access VNHSW services which has resulted a significant increase in referrals. For the period April 2017-March 2018 the total referrals were 80. This rose to 106 referrals during 2018-19, and first six months of the current year (April-Sept 2019) 74 referrals have been received.

Whilst partly hosted within the Mental Health and Learning Disabilities Directorate at Hywel Dda University Health Board the service is centrally funded by Welsh Government, with additional funding secured from a time limited grant from Help for Heroes. The additional grant funding will end on 30 September 2020 and work is ongoing within VNHSW to establish alternative sources of sustainable funding. The impact of not securing additional financial resources will be a reduction in local capacity which will have a detrimental impact for Veterans. The number of referrals to VNHSW is growing on an annual basis so the maintaining current capacity is imperative.

Veterans Trauma Network (VTN)
At the national Armed Forces Covenant Conference on 3rd October 2019 details of a newly established Veterans Trauma Network was shared. This is being hosted by Cardiff and Vale University Health Board as part of the NHS Trauma Network. The VTN has been established to support ex-service personnel who suffered physical injury as a result of their service. These patients receive comprehensive care and rehabilitation before being discharged from the Armed Forces; thereafter they are NHS patients. VTN Wales will provide a central service to assist patients, health care professionals and the third sector with advice and assessment. Referrals to the network can be made by GPs where there is unmet need for specialist assessment or treatment for physical conditions relating to serving in the Armed Forces. This is a service commissioned by Welsh Health Specialised Services Committee.

Engagement with veterans and armed forces groups
The Regional Armed Forces Covenant Liaison Officer has joined the membership of the Stakeholder Reference Group (SRG) in order to ensure a voice and perspective of the armed forces. The Strategic Partnership, Diversity and Inclusion Team are also asked to participate and deliver sessions to local groups which provides an important connection to Veterans and their families living within the community.

3. Priorities

The priorities for the next six month reporting period (October 2019-March 2020) are:

- To continue to work in partnership with Primary Care to raise awareness of the Healthcare Priority Treatment for Veterans and establish a mechanism to provide assurance that this is being applied e.g. through appropriate recording of Veteran status in patient registration records.
- Support Veterans NHS Wales to continue to raise awareness of their service and work collaboratively to support them to secure funding to continue with the delivery of their services to Veterans.
- Contribute to the all-Wales discussions regarding the potential of adopting Veteran Friendly GP Practice scheme.
- Develop an action plan to support the Health Board to progress its commitment to Veterans as an employer with a view to implementing actions and collating evidence for achievement of the Gold level Employer Recognition Scheme in 2020/21.

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Public Services Ombudsman for Wales – Annual Letter 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Midwifery and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Louise O'Connor, Assistant Director (Legal Services/Patient Experience)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Public Services Ombudsman for Wales issued the attached Annual Letter for 2018/19 in August 2019. The letter sets out the overview of the complaints received by the Ombudsman during the year and his review of complaint handling performance.

The Board is asked to note the findings and recommended action within the report and the current complaint management position and performance.

Cefndir / Background

The Ombudsman raised concerns that Hywel Dda University Health Board (the Health Board) was one of the four health boards in Wales to receive the highest number of complaints referred to the Ombudsman, 42% of which required investigation by his office. The intervention rate had increased during the financial year 2018/2019 compared with the previous year, this increase was associated with timeliness of responding to complaints and complaint handling. The Ombudsman had cause to also discuss with the Chief Executive the failure to complete an action within the agreed timeframe set by his office.

The Board will be aware that two public interest reports were received during the year. All recommendations for these reports have been completed and will be subject to ongoing monitoring by the directorates involved. A review of the all Wales public interest reports will be undertaken and presented to the new Listening and Learning from Group which will be established in January 2020.

The Annual Letter required the Health Board to undertake the following actions:

- Present the Annual Letter to the Board;
- Reflect upon the findings of the Public interest reports;
- Work to reduce the number of cases which require intervention by the Ombudsman's office;
- Work to improve complaint handling, particularly in the parts of the Health Board which generate the most complaints.

The above actions have been achieved as demonstrated by the performance update below. Throughout the year significant work has been undertaken to strengthen the process, in particular monitoring and escalation procedures. Additional capacity has been provided to the concerns hub which provides the first point of contact for all telephone and written enquiries. The Patient Advice and Liaison Team (PALS) continues to provide face-to-face support in our clinical areas to achieve early resolution for patients and their families. It is recognised that due to capacity this service is not currently available on all hospital and community sites.

A review of the internal Ombudsman case handling process for case management and governance has recently been undertaken by the Board Secretary. An action plan from this review is currently being monitored by the Executive Team and has been shared with the Ombudsman. Regular updates on progress will be provided.

Asesiad / Assessment

In response to the actions undertaken throughout the past 12 months, current performance figures and feedback from the Ombudsman's office is positive.

As at end of September 2019, 83% of closed complaints were responded within 30 working days (WG target of 75%); and 93% of complaints were responded to within 6 months.

Feedback from the Ombudsman's office as at mid-October indicates:

- There has been a reduction in the number of complaints received by his office.
- A 50% reduction in the number of cases received about complaint handling.
- An increase in the number of reports not upheld as well as a decrease in the number of reports upheld.
- A 70% decrease in cases requiring Ombudsman intervention.

There are currently 24 cases open and subject to investigation by the Ombudsman's office.

Whilst this represents a positive mid-year position; challenges remain in maintaining and improving on this performance. Regular liaison with the Ombudsman's office will continue throughout the year.

Current priorities for the team include improvement of the 30 working day performance and achieving the target of 100% of all cases responded to within 6 months; improving the investigation process, particularly focussing on complaints which involve multiple teams and across different sites.

From an Ombudsman perspective, implementation of the action plan will continue and to meet the target of 100% compliance with agreed actions by the set timescale.

Argymhelliad / Recommendation

The Board is asked to receive the Ombudsman's Annual letter for 2018/19 and note the work that is being undertaken to improve performance for complaints management and Ombudsman cases.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	3. Effective Care 6.3 Listening and Learning from Feedback
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NHS (concerns, complaints and redress arrangements) (Wales) 2011 Public Services Ombudsman (Wales) Act 2019
Rhestr Termau: Glossary of Terms:	Included within report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Under the revised regulations the Health Board has a duty to consider Redress as part of the management of concerns. Ombudsman reports which identify recommendations often carry financial penalties. Poor complaint systems can lead to increased costs of litigation.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Information from concerns raised highlights a number of clinical and service risks, which should be reflected in directorate and corporate risk registers. Lessons learnt processes should be robust to ensure the risk of repeated patient safety incidents is minimised.

Gweithlu: **Workforce:**	All staff are required to comply with the above regulations; to participate in reviews and investigations and the learning from events process. The impact on staff involved in adverse incidents can be significant. All managerial staff have a responsibility to ensure staff are appropriately supported and receive appropriate advice throughout the process.
Risg: **Risk:**	Information from concerns raised highlights a number of clinical and service risks, which should be reflected in directorate and corporate risk registers. There are financial and reputational risks associated with complaints that are upheld or not managed in accordance with the regulations.
Cyfreithiol: **Legal:**	The inability to effectively manage concerns can lead to increased litigation and associated costs.
Enw Da: **Reputational:**	Concerns and associated public interest reports can cause loss of public confidence in the Health Board's quality of services and governance systems.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

Our ref: NB

Ask for: Communications

01656 641150

Date: 7 August 2019

communications
@ombudsman-wales.org.uk

Judith Hardisty
Interim Chair of the Board
Hywel Dda University Health Board

By Email Only
judith.hardisty@wales.nhs.uk

Dear Ms Hardisty

Annual Letter 2018/19

I am pleased to provide you with the Annual letter (2018/19) for Hywel Dda University Health Board. This year I am publishing my Annual Letters as part of my Annual Report and Accounts. I hope the Board finds this helpful and I trust this will enable it to review its own complaint handling performance in the context of other public bodies performing similar functions across Wales.

As you will note from my Annual Report, Hywel Dda is one of the four health boards in Wales which has continued to receive the highest number of complaints. I am concerned that 42% of cases which were dealt with involving the Health Board last year required intervention by my office (whether in upholding a complaint or settling a complaint). This intervention rate has risen from an already high 38% during 2017/18. Also, over 17% of the complaints I received about the Health Board involved complaint handling.

You will be aware that I recently raised serious concerns with the Chief Executive about the Health Board's failure to honour a settlement agreed with my office. I highlighted similar concerns in last year's Annual Letter, despite the fact that I had already issued a Special Report for such a failure (the first of its kind involving a Health Board in Wales). I am concerned that deadlines agreed with my staff have not been met. More importantly, the failure to meet agreed timescales will inevitably diminish a complainant's trust in the ability of the Health Board to openly and honestly respond to complaints.

Public Services Ombudsman For Wales | Ombwdsmon Gwasanaethau Cyhoeddus Cymru, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ
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Having discussed my concerns with the Chief Executive I have been reassured that the Health Board is committed to improving the position. I will be monitoring the Health Board's performance closely over the coming year and I and my staff will provide support and guidance if that would be helpful. In particular, I look forward to visiting the Health Board in September to receive an update on the actions the Health Board has agreed to take to prevent this situation happening again.

Of the ten public interest healthcare-related reports I issued last year, two concerned care and treatment delivered by your Health Board. One concerned serious failures to monitor a baby's development during pregnancy and labour. The second report concerned the management of specialist paediatric services which had been commissioned from the Cardiff & Vale University Health Board. I will also be following up on these recommendations to ensure they have been complied with in practice.

The Public Services Ombudsman (Wales) Act 2019 has now been introduced. I am delighted that the Assembly has approved this legislation giving the office new powers aimed at:

- Improving access to my office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing me to undertake own initiative investigations when required in the public interest
- Ensuring that complaints data from across Wales may be used to drive improvement in public services for citizens in Wales.

I am very much looking forward to implementing these new powers over the coming year.

Action for the Health Board to take:

- Present my Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance
- Reflect upon the findings in the Public Interest reports I have issued and positively act upon my recommendations to improve services
- Work to reduce the number of cases which require intervention by my office
- Work with my Improvement Officer to improve complaint handling, particularly in the parts of the Health Board which generate most complaints about complaint handling

- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by **31 October 2019**.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely

Nick Bennett
Public Services Ombudsman for Wales

CC: Steve Moore, Chief Executive
Roger Smith, Contact Officer

Factsheet

A. Complaints Received and Investigated with Health Board average adjusted for population distribution

Health Board	Complaints Received	Average	Complaints Investigated	Average
Hywel Dda University Health Board 2018/19	109	96	20	23
Hywel Dda University Health Board 2017/18	109	92	38	32
Abertawe Bro Morgannwg University Health Board	139	132	35	32
Aneurin Bevan University Health Board	134	146	38	36
Betsi Cadwaladr University Health Board	194	173	44	42
Cardiff and Vale University Health Board	102	123	28	30
Cwm Taf University Health Board	75	74	22	18
Powys Teaching Health Board	26	33	3	8

B. Complaints Received by Subject with Health Board average

Hywel Dda University Health Board	Complaints Received	Average
Health - Complaint Handling	19	12
Health - Appointments/admissions/discharge and transfer procedures	4	4
Health - Clinical treatment in hospital	61	70
Health - Clinical treatment outside hospital	8	8
Health - Confidentiality	1	1
Health - Continuing care	1	4
Health - De-Registration	2	0
Health - Medical records/standards of record-keeping	3	1
Health - Non-medical services - food. cleanliness etc	1	0
Health - Other	5	5
Health - Patient list issues	4	3

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

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution / voluntary settlement	Discontinued	Other Reports - Not Upheld	Other Reports - Upheld in whole or in part	Public Interest Reports	Grand Total
2018/19									
Hywel Dda University Health Board	23	11	27	26	1	5	20	2	115
Health Board average (adjusted)	15	12	25	19	1	8	19	1	100
2017/18									
Hywel Dda University Health Board	24	10	22	23	2	6	16	1	104
Health Board average (adjusted)	14	9	22	14	0	6	13	0	80

D. Number of cases with PSOW intervention

Health Board	No. of complaints with PSOW intervention	Total number of closed complaints	% intervention
Hywel Dda University Health Board 2018/19	48	115	42%
Hywel Dda University Health Board 2017/18	40	104	38%
Abertawe Bro Morgannwg University Health Board	54	139	39%
Aneurin Bevan University Health Board	49	128	38%
Betsi Cadwaladr University Health Board	86	210	41%
Cardiff and Vale University Health Board	37	107	35%
Cwm Taf University Health Board	27	82	33%
Powys Teaching Health Board	10	17	59%
Powys Teaching Health Board – All-Wales Continuing Health Care cases	7	16	44%

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received and investigated by my office during 2018/19, with the Health Board average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2018/19 with the Health Board average for the same period. The figures are broken down into subject categories.

Section C compares the complaint outcomes for the Health Board during 2018/19, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section D provides the numbers and percentages of cases received by my office in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent via email to communications@ombudsman-wales.org.uk

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Funded Nursing Care Fee Increases 2019/20 and 2020/21
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jill Paterson, Director of Primary Care, Community and Long Term Care
SWYDDOG ADRODD: **REPORTING OFFICER:**	Vicki Broad, Head of Long Term Care Heledd Bingham , Performance Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To seek Board approval for:

- Extending the current methodology used to calculate the Funded Nursing Care (FNC) rate for a further two years;
- Confirming the FNC rate for 2019/20 and 2020/21.

Cefndir / Background

Funded Nursing Care (FNC) refers to the NHS funding of Registered Nursing care within care homes, where this has been assessed as necessary. In addition to funding Registered Nursing time the rate also includes a component to fund any continence provisions that may be necessary.

Board members will recall from previous papers, most recently in March and December 2018, the background to this and the work commissioned by Health Boards from Laing & Buisson that was used as the basis for uplifting the FNC rate. Following this, legal challenges culminated in 2017 with a Supreme Court hearing.

The Supreme Court found that, in addition to the services already funded, Health Boards should fund some further services provided by the Registered Nurse. The Judgment also resulted in Local Authorities being responsible for funding some of the Registered Nurse time, where the Registered Nurse is providing a service that is incidental and unconnected to the nursing care requirement. Previous Board papers have set out the Supreme Court judgment in detail and the work underway across Health Boards and with Local Authority representative partners to revise the funding model and address outstanding matters to reflect the Supreme Court's Judgment.

Asesiad / Assessment

The Funding Methodology

In 2014, Health Board Boards approved the adoption of an Inflationary Uplift Mechanism (IUM) to be used when calculating the FNC rate. The IUM methodology linked the labour element of the FNC rate to mid-point Band 5 of the NHS Agenda for Change pay award, with the continence component of the rate uplifted in line with Consumer Price Index (CPI). Uplifts have been made on an annual basis in line with this and, since 2014, have been adjusted to reflect the revised rates post Supreme Court Judgment.

Boards approved the IUM in 2014 to apply for a period of five years, then review. The five years completed with 2018/19 and so Boards now need to consider the approach to apply from 2019/20 onwards.

The Recommended Approach

Health Board professional and finance leads for longer term care have developed and considered a number of options regarding the methodology to apply from 2019/20 onwards and are all in agreement that the recommended approach be that the IUM be extended for a further two year period – to cover 2019/20 and 2020/21. There are a number of reasons why this is viewed to be the most appropriate approach:

- The IUM as a process has operated successfully for the past 5 years;
- An extension of two years would cover the full 3 years of the current NHS Agenda for Change pay award;
- It allows for further time to consider alternative longer term approaches following an anticipated Welsh Government policy review and also work commissioned in England from Laing & Buisson;
- The opportunities/implications of pooled budgets as they further develop.

In addition to the expert advice from HB professional/finance leads the HB Deputy Directors of Finance and Directors of Finance have also considered this matter and agree that the extension of the current methodology for a further two years is the most appropriate option.

Chief Executive Officers (CEOs) have also considered the advice from the professional and finance leads and support the proposal to extend the IUM for a further two years – to cover 2019/20 and 2020/21.

Health Board Boards across Wales are now asked to ratify the proposal.

5. The 2019/20 Rate

Setting the 2019/20 rate using the IUM has been more complex than usual. The three year NHS pay award has included revisions to the actual pay spines, with some incremental points being realigned and different percentage uplifts applied to some points within the Bands. It has emerged, following discussions with provider representatives, that this has an impact on the way the uplift could be calculated.

Two possible options were identified[1] and, following detailed discussions across Health Boards (and with Welsh Government colleagues) there is a majority consensus that the uplift applied should appropriately reflect the changes to the pay scale.

The revised option derives an inflation rate to ensure the resulting uplift is in line with the Midpoint of Band 5, including the effect of both inflation and the pay scale restructure. Adopting this approach ensures that the uplift applied to the nursing pay element of the fee results in the derived salary being in line with the Mid Point of Band 5 over these years and is thus more robust and in line with the way the IUM has been used since 2014. This results in a 3.1% uplift for 2019/20 and a 3.7% uplift for 2020/21. This will have an in year unplanned financial impact of circa £818k across Wales.

This can be demonstrated as follows:

Pay Point	**18/19**	**19/20**	**20/21**
19	24,915	26,220	26,970
20	25,934	26,220	27,416
Average	**25425**	**26220**	**27193**
Actual % uplift	**1.5%**	**3.1%**	**3.7%**

The uplift translates into a weekly Health Board FNC rate as below. The 2018/19 rate is included for comparison.

Year	**% uplift of RN labour component**	**RN component £**	**% uplift of continence component**	**Continence component £**	**Total HB FNC rate* £**
2018/19	1.5%	156.30	2.5%	11.57	167.87
2019/20	3.1%	161.15	2.1%	11.81	172.96
2020/21	3.7%	167.11	**	tbc post February 2020	tbc post February 2020

* Note: In addition the Local Authority is responsible for an additional 0.385 hours of RN time. This is currently paid by the responsible Local Authority utilising a Welsh Government Grant.

** Note: The CPI uplift for 2020/21 will be based on the February 2020 published index for the previous 12 months, ensuring the rate can be calculated and becomes payable directly from the 1st of April 2020.

Engagement

The lead Health Board CEO and the lead Executive Council Member of Assistant Directors of Social Services Cymru (ADSS Cymru) have met with sector representatives on a number of occasions over the past year to ensure appropriate engagement and also as a route to address and ongoing queries/issues. These meetings have been productive and helpful and sector representatives have indicated they are content with the extension of the IUM as the

[1] The other option would have resulted in a 1.1% uplift in year based on the NHS Wales Pay Journey. When applying this the derived salary in 19/20 and 20/21 it would have been lower than the actual average of pay points 19 and 20.

recommended approach along with a need to begin consideration of an appropriate longer term methodology.

Conclusion

Health Board Boards have received a number of updates on FNC linked to the legal proceedings that have taken place over recent years. These updates have provided Boards with detailed information on the work underway following on from the Supreme Court Judgment in 2017.

This paper focuses on the need to consider the extension of the current methodology to calculate the annual FNC rate – the Inflationary Uplift Mechanism – for a further two years to cover 2019/20 and 2020/21. Lead professional and finance officers in each Health Board have considered the options and recommend extending the IUM for a period of two more years. Boards are now asked to ratify this recommendation as the approved approach.

This paper also sets out the FNC rate for 2019/20 and the approach to setting the rate for 2020/21. The 2019/20 rate calculation reflects the revisions to the Agenda for Change Pay Scale that form part of the three year pay award. Two options exist for setting the rate and the majority consensus view of HB finance leads, professional leads and Directors of Finance is to recommend the option that reflects the impacts of the revisions to the pay scale as set out in the tables above. This paper now seeks Board approval for this recommendation.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** that the current Inflationary Uplift Mechanism (IUM) was approved by each Health Board's Board in Wales in 2014 for a period of five years then review;
- **Note** that professional and finance leads from each Health Board in Wales have considered options and recommend that the IUM be extended for a further two year period, to cover 2019/20 and 2020/21, for the reasons set out in section 4 of this paper, and that CEOs support this recommendation;
- **Approve** the proposal that the IUM be extended for a further two year period;
- **Note** and **approve** the FNC rate for 2019/20 and 2020/21;
- **Note** that further work will be undertaken to consider a longer term model following on from a WG review of the FNC policy position and that Boards will be updated on this work as it develops.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	3. Effective Care 4. Dignified Care 6. Individual care

Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 2. Living and working well
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Develop a sustainable skilled workforce Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	CHC CIP/ Turnaround Group All Wales Complex Care Board All Wales LTC Leads

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There is a financial consequence to applying the rate increase. Finance colleagues have fully costed the likely cost pressure. Calculations are available if required.
Ansawdd / Gofal Claf: Quality / Patient Care:	Risk of adverse quality – both in terms of the sustainability of the market and of the quality of care being impacted due to no increases in fees.
Gweithlu: Workforce:	There is a risk around workforce. There are specific issues around the sustainable recruitment of registered nursing staff and also of care staff, ensuring that the homes are funded adequacy mitigates to some degree this potential impact.
Risg: Risk:	Number of risk areas: Financial, workforce, capacity issues and a risk in the event of agencies/ homes ceasing to trade that hospitals admission would be a risk.
Cyfreithiol: Legal:	Significant legal risk of not approving the rate. Background to the Supreme Court Judgement is outlined in the body of the report.
Enw Da: Reputational:	There would be a risk of reputational damage if the Health Board did not apply the All Wales recommendation for FNC fee increases. Failure to approve the recommended rates could also lead to further JR proceedings
Gyfrinachedd: Privacy:	N/A

Cydraddoldeb: **Equality:**	EQIA screening has not been undertaken.

Enw'r Pwyllgor / Name of Committee	Business Planning & Performance Assurance Committee (BPPAC)
Cadeirydd y Pwyllgor/ Chair of Committee:	David Powell
Cyfnod Adrodd/ Reporting Period:	Meeting Held on 29th October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

- **Health & Safety and Emergency Planning Sub-Committee (HSEPSC) Update Report** - the Committee received the H&SEPSC update report from the meeting held on 10th September 2019 and a verbal update following receipt of the report following the recent Health and Safety Executive (HSE) inspection. Eight Improvement Notices and eleven breaches have been identified and a fine of a minimum of £12,500 plus additional fines of lesser value anticipated. The Committee was informed that the next meeting of the H&SEPSC will concentrate on the HSE inspection and areas of concern, focusing on how the Board will manage and support compliance against these improvement notices in accordance with the timescale of May 2020 set by the HSE. A more detailed report and plan will be presented to BPPAC at its December 2019 meeting. The Committee noted that a fire governance/estates control group is being established, chaired by the CEO, outside of the H&SEPSC. The Committee further noted that a Task & Finish Group has been established with the aim of reducing the number of incidences of needle stick injuries to staff, and a dedicated group has been established to review the safety of patients and staff during the conveyance of patients. In addition, a number of departments have developed plans with regard to lockdown and have the capability of being locked down in an emergency situation. Assurance has also been sought from the Fire Safety Team regarding the management of bariatric patients in an emergency situation. The Committee requested that this concern be escalated to the Board.

- **Information Governance Sub-Committee (IGSC) Update Report** - the Committee received the IGSC update report from the meeting held on 20th September 2019 and advised that an advert has been placed for an additional clinical coder to increase capacity. The Committee was also advised that the Standard Operating Procedure pilot scheme for adding an alert risk of child sexual exploitation (CSE) to children's medical electronic records is to continue for a further six months. The Committee noted the significant work that has been undertaken and is continuing to complete the three red actions identified relating to the development of a full Information Asset Register (IAR). Two procedures were approved by the IGSC, namely the All Wales Data Protection Privacy Impact Assessment Procedure and Information Rights Procedure. An algorithm in regard to the National Intelligent Integrated Audit Solution (NIIAS) will be presented to the next IGSC meeting, together with a full Data Protection Privacy Impact Assessment (DPPIA) for the Friends and Family Text (FFT) Service for endorsement.

- **Integrated Performance Assurance Report Month 6 2019/20** - the Committee received the Integrated Performance Assurance Report for Month 6 2019/20. Members noted that in regard to all Wales data, HDdUHB is ranked in the top 3 for 36.1% of indicators, 2.8% higher than the previous month's position. Referral to Treatment Times performance improved from 506 breaches in August to 452 in September and the Committee noted that work is continuing to achieve the required position of zero breaches by year end. The Committee expressed concern regarding the significant drop in stroke admissions to a specialist ward and it was agreed that the situation would continue to be monitored. Members were assured regarding the plans in place to reduce the continuing declining position of delayed transfers of care, and also assured that non-compliance of medical staff with mandatory training is being monitored with a report expected at the next meeting. Concern was expressed regarding the fragility of clinical staff within hospitals and it was agreed for a meeting to take place outside of the Committee to discuss further. Members sought assurance in regard to therapy waits and were assured that additional staff would be recruited in order to recover performance by February 2020.

- **Adoption / Coverage of Key National Clinical Systems in Hywel Dda University Health Board** – the Committee received an update on progress in regard to Hywel Dda's adoption and coverage of key national clinical systems and were pleased to note the progress made in relation to pathology testing compliance. The Committee was advised that 96% of all urgent suspected cancer referrals are received electronically from primary care and of those, 79% are electronically prioritised by secondary care clinicians. Although there has been some reluctance from clinicians in relation to electronic test requesting, clinical leads have been informed of the expectation that the electronic system would be utilised following roll out of training. An update will be provided at the BPPAC meeting in February 2020 to demonstrate the improvements made.

- **Flu Vaccine Supply Issues** – the Committee received an update on Flu Vaccine Supply Issues in Hywel Dda, noting that following Board approval of the HDdUHB Flu Plan on 26th September 2019, news of vaccination shortages was received due to batch testing failures with stock for staff and GP practices put at risk. The Committee was informed that mitigations have been put in place to continue the staff programme, with the 2-3 year old programme prioritised and the school programme put on hold for the next fortnight. More batch testing is due to be carried out on the 5th and 10th November 2019 when it can be established whether or not the catch up campaign in relation to school age children can be achieved. Communications material have been prepared and the Committee requested that this concern be escalated to the Board.

- **Out of Hours –** the Committee received a verbal update regarding the out of hours' peer review and were pleased to note that a positive and well engaged half day meeting had recently taken place with the Out of Hours' team regarding plans for the future. The Committee noted that an overall strategic

plan for Out of Hours would be presented to the February 2020 BPPAC meeting.

- **Planning Sub-Committee –** the Committee received the Planning Sub-Committee update report from the meeting held on 23rd September 2019. The meeting had focused on the planning cycle for the Integrated Medium Term Plan (IMTP) and the recently issued NHS Wales Planning Framework 2020/23, Welsh Health Circular (WHC/2019/30). It was noted that a joint Regional Clinical Plan with Swansea Bay University Health Board had been approved at the recent Joint Regional Planning and Delivery Committee (JRPDC) meeting.

- **Capital, Estates and IM&T Sub-Committee Update Report** - the Committee received the Capital, Estates and IM&T Sub-Committee update report from the meeting held on 24th September 2019, highlighting the key points discussed including the escalation of the Crosshands Health & Wellbeing Centre to red due to the Outline Business Case (OBC) taking longer than anticipated, which should revert to green once the OBC has been approved. The Committee noted that the CEIMTSC approved the proposed capital costs in order to provide a medical grade Wi-Fi network for medical students in residential accommodation and it was agreed for concerns regarding the poor external state of the residential accommodation at Withybush General Hospital (WGH) to be raised with the Estates Team.

- **Report on the Discretionary Capital Programme 2019/20** – the Committee received the Report on the Discretionary Capital Programme (DCP) 2019/20. Members noted the positive news that WG have confirmed funding for Imaging and Pharmacy priorities. Members further noted the available capital funds and the recommended priority expenditure list which will be the subject of reporting and agreement at Executive Team. Discussions will be held with the aim of navigating the capital costs of the Pond St/Penlan scheme into the all Wales capital programme as opposed to being funded from discretionary capital.

- **Health Records Management Report** – the Committee received an update on progress made by the Health Records Modernisation Programme Group and supported the work undertaken. Members also supported the long-term vision of introducing an e-patient record and the requirement to adequately resource this venture.

- **Delivery of Ophthalmology Plans and Long Term Sustainability** – the Committee noted the verbal update on the desire for a sustainable three-year plan for ophthalmology and it was agreed that a longer term plan be presented to the next BPPAC meeting. The Committee also noted that monies provided by WG are being used to commission optometrists to carry out glaucoma and cataract work. It was acknowledged that due to the UHB only having three substantive consultant ophthalmologists with five consultant vacancies, that ophthalmology services would remain a challenging issue.

- **A Regional Collaboration for Health (Arch) Portfolio Update Report** – the Committee received and noted an update on the activities of the ARCH Portfolio for the period August to September 2019. Members were pleased to note that a regional plan can now be re-framed and re-calibrated, with HDdUHB the only Health Board in Wales implementing this and commended the progress made.

- **Any Other Business** - given this represented Mr Teape's final BPPAC meeting, he was thanked for his input and wished well for his new role. Thanks were also extended to Mr David Powell as Chair of the Committee on behalf of the Health Board and the Executive team.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer /
Matters Requiring Board Level Consideration or Approval:

- To consider the concerns raised following the receipt of the report following the HSE inspection.
- To consider the concerns raised regarding the flu vaccine supply issues.

Risgiau Allweddol a Materion Pryder /
Key Risks and Issues/ Matters of Concern:

- **Integrated Performance Assurance Report Month 6 2019/20 -** concerns regarding the significant drop in stroke admissions to a specialist ward and the fragility of clinical staff within hospitals.
- **Delivery of Ophthalmology Plans and Long Term Sustainability** – noting that ophthalmology services will continue to be a challenging issue.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /
Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified above will be undertaken.

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

17th December 2019

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mid-Year Review of the Annual Plan 2019/20
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Karen Miles, Director of Planning, Performance, Informatics & Commissioning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Daniel Warm, Strategic Planning Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report is intended to provide a mid-year update on progress in the delivery of the University Health Board's 2019/20 Annual Plan. In-year, on behalf of the Board, this is reported to the Business Planning and Performance Assurance Committee on a quarterly basis.

It is also based on Welsh Government (WG) Accountability Requirements, required to be reported on a quarterly basis by the University Health Board on:

- Specific issues relating the University Health Board, noted as being areas of risk requiring distinct focus in the short and medium term to meet core expectations of delivery;
- General accountability conditions (applicable to all health boards).

The Board is asked to take an assurance from the current progress in delivering the 2019/20 Annual Plan.

Cefndir / Background

Following several discussions between the University Health Board and Welsh Government, Hywel Dda is operating an Annual Plan for 2019/20. This report updates the Board on progress to date.

The University Health Board's WG Accountability Letter (28th June 2019) has directed that the following requirements must form the basis of the delivery and internal monitoring of our plan, '*The 'Five Ways of Working' and the Well-being of Future Generations Act must be central to the Health Board's approach. It is essential that your organisation continues to build on the progress made to utilise the five ways of working, sustainable development principles, to deliver your integrated plan.'*

Furthermore, specific Accountability Issues for Hywel Dda are:
The following areas of risk require distinct focus in the short and medium term to meet core expectations of delivery (with clear and realistic milestones).

- *Referral to Treatment (RTT) and unscheduled care must be delivered in line with the performance profiles agreed with Welsh Government, and accelerated to deliver sustained performance improvements throughout 2019/20;*

- *Ongoing assurance regarding the implementation of the Transforming Clinical Services and long-term strategies;*
- *Clarity on planning commitments and milestones to deliver priority areas;*
- *Further clarity on the turnaround approach, activities and anticipated outcomes;*
- *Ensure robust plans are in place to deliver improvements in infection control rates within the community and acute sector, including monitoring and addressing variations in infection control performance;*
- *Financial control, including delivery of savings plans, and meeting the agreed control total is essential to underpinning the delivery of your plan. Through sustainable and integrated planning, the Health Board must:*
    - *deliver the control total of a maximum deficit of £25 million in 2019-20, with the expectation for the annual plan to be revised to reflect this and a clear expectation of a step-change in financial improvement in 2019-20, and maintain ongoing dialogue between your Board and Welsh Government officials regarding financial assumptions and modelling; and*
    - *Demonstrate the benefits of any additional investment, in particular any monies received via specific and targeted funding. You will be expected to provide updates on how this investment has yielded benefits at the Joint Executive Team (JET) meetings.*

<u>General accountability conditions (applicable to all Health Boards)</u>
***Quality:** The Health Board must:*
- *ensure well-being objectives for your organisation are consistent with and supported by your planning arrangements;*
- *continue to develop the preventative work seeking opportunities through existing and new opportunities;*
- *ensure that quality standards are maintained and improved across all of your services (primary, secondary and community and social care);*
- *continue to develop plans for the long term that provide sustainable services and improved outcomes for your population.*

***Collaboration**: Supporting the quality and well-being agenda, the Health Board must ensure that:*
- *it continues to extend collaborative working and regional planning with surrounding Health Boards and trusts to develop regional solutions where applicable; -*
- *continue to prioritise, strengthen and realise benefits through your partnership, collaboration and involvement arrangements, agreements and plans; -*
- *Must be clear on planning commitments and milestones to deliver Major Trauma services; and*
- *work with internal and external stakeholders (in relation to the Primary Care Model for Wales, third sector, social care and wider local authority partners) to explore potential solutions for transformation and new models of health and care.*

***Performance**: Developing sustainable service delivery, the Health Board must:*
- *meet the targets and profiles set out in your plan for year 1 in order to achieve the improved position in line with national priorities and targets and the local service change proposals outlined in your Integrated Medium Term Plan (IMTP);*
- *demonstrate progress in working towards sustainable improvements against targets for 2020/21 and beyond;*
- *continue to have robust delivery, monitoring and performance management arrangements in place to assure your Board and Welsh Government that your plan is on track; and*
- *ensure this information is provided to Welsh Government's planning team through quarterly monitoring template updates on delivery of your IMTP.*

These areas must be covered in your quarterly monitoring report by exception. The Accountability Letter also states "Whilst the Health Board has been unable to approve a balanced integrated plan, we intend on monitoring the Health Board's progress against your annual plan in the same way as we will for all organisations to promote consistency and alignment with wider plans.

Details of the specific requirements that must be reported to Welsh Government, on the template provided, and on a quarterly basis, are attached. This will form a reference document as part of future JET meetings and be the basis of ongoing engagement with the Welsh Government Planning team and policy leads. The delivery of your plan will continue to be tracked against the profiles which you have committed to as part of your plan. These will be monitored through the existing Quality and Delivery meetings and any additional mechanisms put in place".

In addition to the WG requirements, the Business Planning and Performance Assurance Committee (BPPAC) receive quarterly RAG rated monitoring reports on all of the actions within the 2019/20 Plan. The monitoring return provides an overview of each action plan with detail included on: Executive Lead, current RAG Status, change in RAG Status from previous quarter, key achievements in this quarter, and key risks to delivery of actions and plans / mitigations to improve RAG status.

Asesiad / Assessment

Accountability Letter

The Quarter 2 Accountability Return was submitted to Welsh Government on 21st October 2019 (An abridged version is provided at Annex 1). Key points to note with regards to performance and finance are:

Performance:

Indicator	Target	Latest data	12 month trend	Non-random variation	Latest all Wales rank
Ambulance red calls	65%	68.5%	↑	No	6th out of 7
Ambulance handovers over 1 hour	0	406	↓	No	2nd out of 6
A&E/MIU 4 hour waits	95%	80.3%	↓	No	2nd out of 6
A&E/MIU 12 hour waits	0	910	↓	No	4th out of 6
Referral to treatment (RTT) <=26 weeks	95%	86.5%	↑	n/a	3rd out of 7
RTT – patients waiting 36 weeks+	0	452	↑	n/a	2nd out of 7

Target delivered
Within 5% of target
Target not delivered

Whilst some recovery has been made through Quarter 2, the UHB is aware that there needs to be full improvement of RTT, in particular, in coming quarters, and there are plans to deliver this.

Finance:

- Month 6 position
  - Month 6 position is £0.7m variance to plan (£3.8m YTD) comprising operational surge, vacancies covered by premium cost staff and drugs in Unscheduled Care impact of £0.3m; Local TB outbreak impact of £0.2m; Medicines Management Primary Care Prescribing £0.2m and unidentified savings profile impact of £0.2m.

- Savings Summary
  - £7.0m delivery to date against £25.2m total savings requirement, with £16.6m of Assured schemes, £2.1m of Marginal Risk schemes, and, therefore risk to delivery is £6.5m

- Key areas of concern: All of our savings plan has not yet been identified; Grip and Control has been highlighted as a key area of concern, especially in workforce management; and significant pressures on drugs are manifesting in both Secondary and Primary Care; and therefore significant risk in relation to the organisation's ability to deliver the required control total.

2019/20 Action Plans

The following table provides the overarching summary RAG status for all of the action plans:

Plan	Executive Lead	Q1 Status	Q2 Status	Performance Last Quarter
A Regional Collaboration for Health	Director of Planning, Performance and Commissioning			Declining
Cancer / Oncology	Deputy Chief Executive / Director of Operations			Declining
Capital	Director of Planning, Performance and Commissioning			No Change
Carmarthenshire Integrated County	Director of Primary Care, Community and Long Term Care			Declining
Ceredigion Integrated County and Bronglais General Hospital	Deputy Chief Executive / Director of Operations and Director of Primary Care, Community and Long Term Care			No Change
Dementia	Director of Therapies and Health Science			Improving
Digital	Director of Planning, Performance and Commissioning			Improving
Drug and Alcohol	Director of Public Health			No Change
Glangwili General Hospital	Deputy Chief Executive / Director of Operations			No Change
Immunisation & Vaccinations	Director of Public Health			No Change
Infection Prevention	Director of Nursing, Quality and Patient Experience			No Change
Joint Regional Planning and Delivery Committee	Director of Planning, Performance and Commissioning			No Change
Mental Health and Learning Disabilities	Deputy Chief Executive / Director of Operations			Declining
Mid Wales Joint Committee for Health	Director of Planning, Performance and Commissioning			No Change
Nursing Digital Healthcare	Director of Nursing, Quality and Patient Experience			Improving
Out of Hours	Deputy Chief Executive / Director of Operations			Declining
Pathology	Deputy Chief Executive / Director of Operations			Declining
Pembrokeshire Integrated County and Withybush General Hospital	Deputy Chief Executive / Director of Operations and Director of Primary Care, Community and Long Term Care			No Change
Pharmacy / Medicines Management	Deputy Chief Executive /Director of Operations			Improving

Pre Nurse Education	Director of Nursing, Quality and Patient Experience			Improving
Primary Care	Director of Primary Care, Community and Long Term Care			No Change
Prince Phillip Hospital	Deputy Chief Executive / Director of Operations			No Change
Quality and Improvement	Director of Nursing, Quality and Patient Experience			Improving
Quality and Safety – patient experience	Director of Nursing, Quality and Patient Experience			Declining
Quality Governance	Director of Nursing, Quality and Patient Experience			Declining
Radiology	Deputy Chief Executive / Director of Operations			Declining
Research, Development and Innovation	Medical Director and Director of Clinical Strategy			Improving
Safeguarding	Director of Nursing, Quality and Patient Experience			Improving
Smoking Cessation	Director of Public Health			Declining
Therapies	Director of Therapies and Health Science			Improving
Unscheduled Care	Deputy Chief Executive / Director of Operations			Declining
Women's & Children's	Deputy Chief Executive / Director of Operations			No Change
Workforce & Nurse staffing levels (Wales) Act	Director of Nursing, Quality and Patient Experience			Improving
Workforce	Director of Workforce and OD			Improving

The current status as at Q2 shows that of the 34 Actions Plans, none are RAG rated as Red; 24 are RAG rated as Amber; and 10 are RAG rated as Green. In previous returns, a Blue rating was also possible (no risk to delivery, 100% certainty to deliver); however in August 2019, BPPAC noted that that the addition of a blue rating is counterintuitive, given that plans rated green include risks, thereby providing a false sense of delivery. It was agreed to remove the blue rating from future reports and to revert back to RAG status.

Argymhelliad / Recommendation

The Board is asked to take assurance in the progress in the delivery of the University Health Board's 2019/20 Annual Plan at the mid-year point, with particular reference to:

- Our performance position
- Our financial position
- Progress in the delivery of our actions plans supporting the 2019/20 Annual Plan

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	Not applicable

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included in the report
Rhestr Termau: Glossary of Terms:	Included in the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Business Planning & Performance Assurance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	This is a key component in the delivery of the Annual Plan 2019/20
Ansawdd / Gofal Claf: Quality / Patient Care:	This is a key component in the delivery of the Annual Plan 2019/20
Gweithlu: Workforce:	This is a key component in the delivery of the Annual Plan 2019/20
Risg: Risk:	Risks will be assessed as part of the ongoing process of monitoring the Annual Plan 2019/20
Cyfreithiol: Legal:	As above
Enw Da: Reputational:	The University Health Board needs to meet the targets it has set out in individual plans to maintain its reputation with Welsh Government together with our stakeholders including our staff
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Consideration of equality legislation and impact is a fundamental part of the planning of service delivery changes and improvements

Annex 1 – Abridged Quarter 2 Accountability Return to Welsh Government (21st October 2019)

Specific issues for HDUHB	Quarter 2 evidence
RTT and unscheduled care	See SBAR
Ongoing assurance regarding the implementation of the Transforming Clinical Services and long-term strategies	**Programme establishment:** • Establishment of three programme groups and associated project groups and workstreams with schedule of regular meetings in place • Establishment of Strategic Enabling Group with schedule of regular meetings in place • Development of detailed plans for all programmes • Review and re-design of UHB and regional governance arrangements to ensure alignment with the portfolio of programmes, through a phased approach • Development of a benefits realisation management methodology • Development of a robust process for the management of risks • Establishment of a variety of evaluation methods • Allocation of leadership of each of the fragile service pathways to an individual change programme to lead service re-design across the whole system **Transformation Programme Office Mobilisation:** • Recruitment into Transformation Programme Office. Following roles now in post: o Head of Transformation Programme Office, Project Managers (x3), Project Support Officers (x4), Committee Services Officer, Modelling Analysts (x2) Following roles to commence in October/November: o Therapies & Health Science Lead, Nursing, Quality & Patient Experience Lead, Senior Project managers (x2 to support Turnaround) Following roles being recruited into: o Lead Pharmacist, Continuous QI Advisor & QI Team **2019/20 Work Plan** • Executive led workshop held on 18 September 2019 to prioritise high impact actions to re-focus delivery against the 2019/20 plan, and support in particular delivery of early priorities in line with *A Healthier Mid and West Wales: Our future generations living well* design assumptions e.g. ALOS, day case and Outpatient improvements – see section on Turnaround Activities • Key projects to be continued through corporate support: o Identified Transforming Mental Health and Learning Disabilities projects o Transformation Fund projects o Capital Programme Business Case development o Specific pathway re-design work (e.g. Stroke and Community Pathways)
Clarity on planning commitments and milestones to deliver priority areas	• Aiming to develop an ambitious and deliverable 3 year plan, which: o Eliminates the deficit o Mainstreams the benefits of the Transformation Fund plans o Delivers Tier 1 targets: (Referral to Treatment, Single Cancer Pathway, Unscheduled Care, Public Health and Hospital Care Acquired Infections) o Delivers a modernising Outpatient Plan, including a delayed follow ups improvement programme o Delivers Primary Care priorities: contract reform, dental access and orthodontics waiting times improvement o Delivers Nurse Staffing Act requirements o Delivers a Stroke Services Reconfiguration Plan and a comprehensive Rehabilitation Delivery Plan o Strengthens governance arrangements and Board development o Delivers the next 3 years of our strategy (including capital, digital and workforce) o Develops further our integration with Social Care o Delivers population health focused plans in Early Years and Making Every Contact Count o Delivers 3 programmes linked to our values: Empowering our Clinicians, Empowering our Patients and Empowering our Public o Delivers a plan to significantly improve the experience of our patients

Specific issues for HDUHB	Quarter 2 evidence
	○ Delivers an Organisational Development Programme, including a Learning and Development plan and Financial Skills training plan
Further clarity on the turnaround approach, activities and anticipated outcomes	The Holding To Account process continues to oversee the delivery of Directorate savings plans where managers are held accountable for delivering their agreed plans and for mitigating any issues that arise during the year on at least a monthly basis. At the end of Q2, 8 Directorates had an escalated status to CEO level due to the assessed risk of them delivering their financial plans. **KPMG Review - Outcomes to date include**: • A review of the existing savings plan and further in-year opportunities. • The development of a single tracker including all Green, Amber, Red and Idea schemes. • A review of the delivery assurance framework in order to strengthen operational delivery of schemes locally and to ensure the Holding to Account escalation process continues to add value, with changes planned for implementation by the end of September 2019. **Executive stock-take on In-Year 2019/20 Plan Delivery** The Executive Team recently reviewed delivery progress against this year's plan as a number of areas, including performance and finance, are off-track. A workshop was held on 18th September 2019 with central teams to agree how to better support operational delivery over the remainder of the year. The purpose was to ensure that the Health Board executes the plan set at the start of the year and delivers on the commitments made to the Board and Welsh Government. Following the workshop, the Executive Team has worked through the in-year priority areas and considered the level and type of resource required to progress projects at pace to deliver the annual plan for 2019/20, with project teams identified for each of the priority areas. On behalf of the Executive Team, the Turnaround Director will link with key Senior Managers to oversee and co-ordinate the ongoing resource allocation and management of the priority areas as the work progresses. If new urgent priorities emerge in that time, the Executive Team will consider how they are supported. Project Managers will assist Executive Lead, Lead Officer(s), and other members of the project team to determine which actions provide the greatest opportunity for impact in terms of recovering the off-plan position.
Ensure robust plans are in place to deliver improvements in infection control rates within the community and acute sector, including monitoring and addressing variations in infection control performance	• At the end of quarter 2 the University Health Board reported a 17% reduction in Clostridium difficile Infection CDI compared with the same period the previous year. Changes to the local antibiotic policy were implemented in June 2019. This change together with the achievement of the Antibiotic Targets for 2018/19 in two of our District General Hospitals have had a positive impact on the reported infection rates and demonstrates improved prescribing practice. The University Health Board, however, did report a period of increased incidence (PII) in Pembrokeshire earlier in the year and in collaboration with the Healthcare Associated Infection, Antimicrobial Resistance & Prescribing Programme (HARP team) identified a requirement for further improvements to antimicrobial prescribing. The review of the TOR for the University Health Board Infection Prevention Sub-Committee has strengthened clinical leadership, involvement and ownership. These revised governance arrangements facilitated a deep dive into the PII of CDI at the September Infection Prevention (IP) Sub-Committee with the Clinical Director taking a lead role in developing the action plan. It was noted that initial prescribing often took place in A&E thus it was agreed it would be helpful to have pharmacists involved on post take ward rounds. As a consequence, going forward, the Antimicrobial Pharmacist will be based on the admissions unit to support antibiotic reviews and as a resource for clinical teams. • Since May 2019 we have carried out 3 successful Faecal Microbiota Transplants (FMT) resulting in no further relapses for these patients. • At the end of Q2 we also reported a reduction in S.aureus Blood Stream Infections (BSI) of 8% compared to 2018/19 figures. Over Q1 & Q2 we have had roll out of vascular access trolleys across all acute wards. The work being done to reduce contamination of blood cultures has been supported by data from Public Health Wales Top 10 Bacteraemia data published, Coagulase Negative Staphylococcus aureus (CNS) are no longer in the HB Top 10. This implies that work done with blood culture packs has

Specific issues for HDUHB	Quarter 2 evidence
	had impact and improved practise in taking blood cultures, resulting in improved diagnosis and reduced antibiotic prescriptions for patients. • At the end of quarter 2 the University Health Board also reported a 21% reduction in Pseudomonas aeruginosa Blood Stream Infections (BSI). • However, an increase was reported in the other infection reduction targets 13% increase in E.coli BSI (24 more cases), and 3% increase in Klebsiella BSI (1more case). The rise in E.coli and Klebsiella BSI have been mainly in community and considered to be linked to the warm weather and poor hydration. Education around hydration and management of urinary tract infections is continuing in community and admission areas. **Other key actions include:** • Our improvement plan continues to be monitored and reviewed. • The locality based Infection Prevention teams continue to meet are evolving to promote an integrated approach to Infection Prevention by increasing community senior leadership team representation, the Terms of Reference for these groups have been reviewed to reflect this.. • The Chief Executive Performance meetings are also utilised to identify areas of concern or good practice for quality matters. • In addition the monthly Serious Incident Panel meetings, chaired by the Director of Nursing, Quality & Patient Experience, have been enhanced to provide a wider focus on quality related performance, including IPC related matters. • Face to face visits with microbiologist and antimicrobial pharmacist are taking place with primary care providers to support greater awareness of the impact of prescribing plus provide updates as required. • The work in care and nursing homes continues with a focus on UTI management and admission avoidance, this work has been further extended in to Emergency and admission units across the 4 acute sites.
Financial control, including delivery of savings plans, and meeting the agreed control total	See SBAR

General accountability conditions [by exception]	Quarter 2 evidence
QUALITY: The health board must: o Ensure well-being objectives for your organisation are consistent with and supported by your planning arrangements; o Continue to develop the preventative work seeking opportunities through existing and new opportunities; o Ensure that quality standards are maintained and improved across all of your services (primary, secondary and community and social care); o Continue to develop plans for the long term that provide sustainable services and improved outcomes for your population.	Quality Standards are monitored through a variety of mechanisms including the Fundamentals of Care audits, with increasing number of areas utilising the standards and reporting against them through the audit cycle. A clinical audit plan is in place and findings are monitored through the Clinical Audit Group reporting to the Effective Clinical Practice Sub-Committee. Participation in peer audit and review takes place although it is recognised the calendar of such activity needs to be strengthened. Our prevention and value based work programmes are a key element of our transformation programme

General accountability conditions [by exception]	Quarter 2 evidence
COLLABORATION: Supporting the quality and well-being agenda, the health board must ensure that: o It continues to extend collaborative working and regional planning with surrounding health boards and trusts to develop regional solutions where applicable; o Continue to prioritise, strengthen and realise benefits through your partnership collaboration and involvement arrangements, agreements and plans; o Must be clear on planning commitments and milestones to deliver Major Trauma services; and o Work with internal and external stakeholders (in relation to the Primary Care Model for Wales, third sector, social care and wider local authority partners) to explore potential solutions for transformation and new models of health and care.	<u>Regional Planning</u> The UHB continues to develop its regional work programme through ARCH, the Joint Regional Planning and Delivery Committee, and The Mid Wales Joint Committee For Health And Care <u>Collaboration</u> As noted in our quarter 1 return, the UHB has continued to encourage stronger collaboration between the Regional Partnership Board and Public Services Boards. A regional meeting was held on 7th June to explore areas of work which are common to each partnership and the Health Board will be leading on establishing a regional social and green solutions for health working group, to provide a strategic overview and encourage local innovation. In addition to PSB members, this session was also attended by representatives of the West Wales RPB and Powys PSB/RPB. The meeting provided an opportunity to explore in depth where opportunities exist for the PSBs and RPB in West Wales to work together on shared priorities. The notes of the meeting have been summarised into a paper which will be considered at each of the forthcoming PSB and RPB meetings for endorsement. There are clear links between the PSBs and various proposals within the regional Transformation Bid A Healthier West Wales, namely: • Implementation of an Involvement Summary Record (ISR) to enable sharing of client information across public agencies (part of programme 2 – sharing data for a person centred approach). This links with a project which is being driven forward by the three PSBs who have secured WG funding to commission the development of a digital information system and data sharing platform to support local well-being assessments. This work is being co-ordinated via Ceredigion PSB. • Development of a digital engagement tool to facilitate virtual conversations with different communities (part of programme 5a – continuous citizen engagement). If these bids are successful, opportunities for a single system performing all functions or, as a minimum, full interoperability between separate systems, will be actively explored. • Developing models to support social and green solutions for health. Social prescription to help people manage their own long-term conditions (linked to proposed programme 4 - proactive supported self-management, which has yet to be approved for funding). • Developing services within our communities and enhancing the community connector role and supporting local enterprise through growing the third sector role (linked to programme 7 - creating connections <u>Trauma</u> Wales Trauma Network - The Welsh Health Specialised Services Committee is responsible for commissioning the Network and the Major Trauma Centre, and will work closely with the Emergency Ambulance Services Committee who commission the Welsh Ambulance Services NHS Trust and the Emergency Medical Retrieval and Transfer Service. Health Boards will commission Trauma Units and Local Emergency Hospitals. Locally, the UHB has engaged on a proposal to designate Glangwili General Hospital as the local Trauma Unit for the Hywel Dda area, in the interim to a new

<table>
<tr><th>General accountability conditions [by exception]</th><th>Quarter 2 evidence</th></tr>
<tr><td></td><td>hospital for urgent and planned care being built between Narberth and St Clears. A comprehensive update paper was presented to Public Board in September (included in Supporting Document column)

<u>Primary Care</u>
• The UHB is engaged with the national work being undertaken by Miller Research into the impact of the Primary Care model, and will participate in the workshops to be held locally
  ○ Workshop held and feedback provided as it was not in keeping with the anticipated brief for the session
• The UHB has embedded Pharmacy Technicians into managed practices
  ○ Pharmacy Techs appointed to work across the Managed Practices in conjunction with the Clinical Pharmacists to improve patient care and service efficiency
• A number of Locum GPs have been appointed as salaried GP posts
  ○ Two locum GPs have been appointed as salaried GPs and unfortunately whilst there has been some interest from other locums to take up Health Board employment this has not come to fruition. We continue to have a rolling advert for recruitment on NHS jobs
• Work is continuing to ’buddy-up’ community pharmacists with GP Practices
  ○ Work in relation to the Community Pharmacy contract is ongoing at cluster level
• Cluster Plans
  ○ The University Health Board have completed and submitted 7 cluster IMTPs by 30 September 2019 and these will now be used as the baseline for the cluster IMTPs as part of QAIF moving forward in subsequent years.</td></tr>
<tr><td>PERFORMANCE:</td><td>See October 2019 BPPAC Report for detail, in summary:
<table>
<tr><th>30 key deliverable indicators</th><th>All+ performance indicators</th><th>Position</th></tr>
<tr><td>21 (67.7%)</td><td>66 (47.8%)</td><td>target not delivered</td></tr>
<tr><td>2 (6.5%)</td><td>10 (7.2%)</td><td>within 5% of target</td></tr>
<tr><td>8 (25.8%)</td><td>62 (45.0%)</td><td>target delivered</td></tr>
</table>
The most recent all Wales data shows that the UHB ranked in the top 3 for 36.1% of indicators, which is 2.8% higher than the previous month’s position. In addition, Hywel Dda ranked 1st in Wales for 10 national indicators including sepsis screening in emergency departments, staff appraisals and mental health assessments.</td></tr>
<tr><td>FINANCE:</td><td>As per the response provided in SBAR</td></tr>
<tr><td>OTHER COMMENTS/ISSUES BY EXCEPTION</td><td>Please refer to our 2018/19 Public Health and Strategic Equality Annual Reports</td></tr>
</table>

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Performance update for Hywel Dda University Health Board – Month 7 2019/20
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Karen Miles, Director of Planning, Performance, Informatics and Commissioning In association with all Executive Leads
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Miles, Director of Planning, Performance, Informatics and Commissioning

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This performance update report is being brought to the Board's attention to examine and consider Hywel Dda University Health Board's latest performance data, achievements, challenges and needs. Following a request to make the Board performance report more accessible for the general public and to focus on our key priorities at Board level, the report has been reformatted. Indicators have been added for the single cancer pathway, smoking and childhood obesity. This is a 'starter for ten' and a snapshot of our performance. We expect the report to be enhanced over the coming months as we receive feedback and to be flexible as we respond to our priorities.

This performance update consists of:

- Title page – includes buttons to navigate to the different sections of the report;
- Executive summary – a one page summary of key points;
- Performance overview – a one page summary of the 32 key deliverable indicators;
- Topic summaries – 7 themed pages.

To help provide additional context including trend data, the following accompanying resources are also provided: performance run charts, overview matrix, cancer dashboard, diagnostics & therapies dashboard, delayed follow up dashboard, referral to treatment dashboard, stroke dashboard and unscheduled care dashboard. A new performance web page has been set up on the internet site to enable members of the general public to more easily access our performance report and these supporting resources.

The Integrated Performance Assurance Report (IPAR) will be scrutinised by the Business Planning and Performance Assurance Committee (BPPAC) and continue to include exception reports for all metrics not meeting targets / unstable green.

Cefndir / Background

The NHS Wales Delivery Framework 2019/20 identifies key areas to be monitored and, where relevant, improvements made for this aim to be achieved. The University Health Board is working to make improvements for its resident population, patients and staff and has identified a number of additional local performance indicators to further support the Framework.

Asesiad / Assessment

The latest performance data for our 32 key deliverable indicators shows:

- met target = 22% (7/32)
- within 5% of target = 16% (5/32)
- target not met = 62% (20/32)

All Wales data is available for 30 of the 32 key deliverable measures. Of these, Hywel Dda UHB ranked in the top 3 for 40% of measures which is a 3.3% improvements from the previous month.

Argymhelliad / Recommendation

The Board is asked to discuss the report and raise any issues arising from its content.

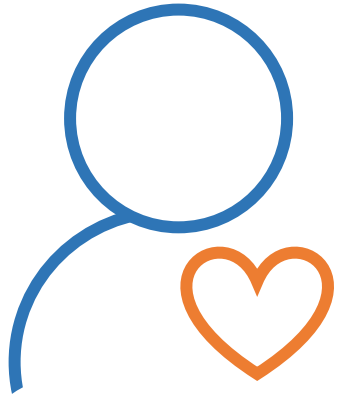
Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	NHS Wales Delivery Framework 2019-20
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Busnes a Sicrhau Perfformiad: Parties / Committees consulted prior to University Health Board:	Finance, Performance, Quality and Safety, Nursing, Information, Workforce, Mental Health, Primary Care Business Planning and Performance Assurance Committee
Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Better use of resources through integration of reporting methodology

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Use of key metrics to triangulate and analyse data to support improvement
Gweithlu: **Workforce:**	Development of staff through pooling of skills and integration of knowledge
Risg: **Risk:**	Better use of resources through integration of reporting methodology
Cyfreithiol: **Legal:**	Better use of resources through integration of reporting methodology
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

Performance update for Hywel Dda Univerity Health Board

as at 31st October 2019

Click one of the boxes below to navigate to that section of the report



Executive summary

This report includes summary information on some of the key areas that we have prioritised to make improvements in 2019/20.

Which targets have we achieved?

- The target has been consistently met since April 2019 for delayed transfers of care of mental health patients;
- In October, all stroke patients were assessed within 24 hours by a specialist stroke consultant;
- The 12 month improvement target was met for speech and language therapy for stroke patients;
- The reduction target was met for operations cancelled for non-clinical reasons within 24 hours of a patient's procedure date;
- Responses to concerns within 30 working days of the complaint being received by us exceeded the 75% target in October;
- Between April and June, 95.1% of babies had the recommended 3 doses of the '6 in 1' vaccine by their 1st birthday;
- We have the lowest staff sickness rate of the 6 largest Health Boards in Wales.

Where have we made improvements?

- Despite early winter pressures, our A&E/MIU waiting times improved slightly in October compared to September;
- The number of patients waiting more than 8 weeks for a diagnostic test reduced from 391 in September to 164 in October;
- The number of patients waiting more than 14 weeks for a specific therapy reduced from 426 in September to 277 in October;
- 51.2% of stroke patients were admitted to a stroke unit within 4 hours in October, compared to 39.0% in September;
- 97% of patients on a non-urgent suspected cancer pathway started treatment within 31 days of it being agreed;
- There were 4,720 fewer patients in October having a delayed planned care specialty follow up outpatient appointment;
- There was a 1.6% improvement in April-June for children having the recommended doses of the MMR vaccine;
- There has been a 12 month improvement in the number of staff completing their core skills training and staff having a performance appraisal development review;
- At the end of October, 9% more consultants and SAS doctors had an up-to-date job plan than the previous month;

Where is improvement needed?

- The 65% target was not met for ambulances arriving within 8 minutes to calls for patients with life threatening conditions;
- 465 ambulance handovers were reported as taking longer than 1 hour which is a deterioration from 406 the previous month;
- The census count day in October 2019 saw high numbers of delayed transfers of care for patients aged 75+ (60 patients);
- During September 2019, 73.9% (68/92) of urgent suspected cancer patients commenced treatment within 62 days of referral;
- The number of patients waiting over 36 weeks from referral to treatment increased from 452 in September to 476 in October;
- Only 58.1% of high risk Ophthalmology patients waited no more than 25% over their clinical target date;
- Performance for serious incidents assured within timescale has been declining away from target since July 2018;
- In September there were 585 children / young people waiting over 26 weeks for a neurodevelopmental assessment and 625 adults waiting over 26 weeks for a psychological therapy;
- We are unlikely to achieve the end of year deficit of no more than £15m that was previously agreed with Welsh Government.

Spotlight on infection control

- Our healthcare acquired infection rates are higher than we would like with mixed results over the past month. We are working hard to address this.
  - C.difficile - number of cases decreased from 13 in September to 12 in October;
  - E.coli - number of cases decreased from 37 in September to 30 in October;
  - S.aureus - number of cases increased from 9 in September to 16 in October.

Our 32 key deliverable measures

Latest data

All Wales rank

All Wales data is available for 30 of the 32 key deliverable measures. Of these, Hywel Dda UHB ranked in the top 3 for 40% of measures:

1. 3 measures
2. 3 measures
3. 6 measures
4. 3 measures
5. 4 measures
6. 6 measures
7. 5 measures

Latest performance overview

		Target	Previous period	Latest data	12m trend	Plan met?	All Wales rank	Notes **
Unscheduled care	Ambulance red calls	65%	68.5%	61.9%	↑	No	3rd out of 7	Poorest performance seen in Carmarthenshire (59.9%)
	Ambulance handovers over 1 hour	0	406	465	↓	No	3rd out of 6	BGH only site to see a decrease in delays (-46) to last month
	A&E/MIU 4 hour waits	95%	80.3%	81.1%	↓	No	2nd out of 6	Compared to Sep '19, all acute sites improved except PPH
	A&E/MIU 12 hour waits	0	910	882	↓	No	3rd out of 6	Compared to Sep '19, all acute sites improved except PPH
	Non-mental health DTOC	12m↓	54	60	↓	No	6th out of 8	27 in Carmarthenshire and 20 in Pembrokeshire in Oct '19
	Mental health delayed transfers of care (DTOC)	12m↓	7	6	↑	No	1st out of 7	Target has been consistently met in 2019/20
Stroke and cancer	Admission to stroke unit <4 hours	55.5%	39.0%	51.2%	↓	No	1st out of 6	Target not met in GGH (30.8%) or PPH (42.9%)
	Assessed by stroke consultant <24 hours	84.0%	96.1%	100%	↑	Yes	3rd out of 6	Best performance since April 2019
	Stroke patients - speech and language therapy	12m↑	38.9%	33.3%	↑	n/a	5th out of 6	Lowest compliance WGH (25.4%) and highest GGH (51.5%)
	Urgent suspected cancer	95%	75.7%	73.9%	↓	No	6th out of 6	24 out of 92 patients breached
	Non urgent suspected cancer	98%	96.4%	97.0%	↓	No	4th out of 6	4 out of 140 patients breached
	Single cancer pathway	12m↑	76.7%	76.7%	n/a	n/a	2nd out of 6	Not enough data to do a 12 month trend
Planned care and therapies	Hospital initiated cancellations	5%↓	100	118	n/a	Yes	2nd out of 7	50 fewer patients cancelled in Sep '19 compared to Sep '18
	Delayed follow-up appointments 5 specialties	12m↓	21,235	16,515	↓	No	3rd out of 5	There was 22% improvement in Oct '19 (4,720 patients) to Sep.
	Ophthalmology patients seen by target date	95%	58.3%	58.1%	n/a	n/a	7th out of 7	This is a new measure with 6 months of reported data
	Diagnostic waiting times	0	391	164	↓	No	5th out of 7	227 fewer breaches in October compared to previous month
	RTT – patients waiting 36 weeks+	0	452	476	↑	No	2nd out of 7	The 2019/20 Annual Plan ambitions were not met and there was a decline in performance for both RTT metrics
	Referral to treatment (RTT) <=26 weeks	95%	86.5%	87.5%	↑	No	3rd out of 7	
	Therapy waiting times	0	426	277	↓	No	7th out of 7	261 Physiotherapy, 13 Occupational Therapy & 3 Dietetics
Quality and safety	C.difficile	<=25	38.38	38.14	↑	n/a	6th out of 6	Number of cases decreased from 13 in Sep to 12 in Oct '19
	E.coli	<=67	109.44	106.89	↓	n/a	6th out of 6	Number of cases decreased from 37 in Sep to 30 in Oct '19
	S.aureus	<=20	29.56	32.38	↑	n/a	5th out of 6	Number of cases increased from 9 in Sep to 16 in Oct'19
	Serious incidents	90%	53.8%	30.8%	↓	No	6th out of 9	Further decline in performance (8 out of 26 met target)
	Concerns and complaints	75%	83.0%	76.5%	↑	Yes	4th out of 10	Performance improved by 8.5% since Oct '18
MH +	Children/young people neurodevelopment waits	80%	36.5%	34.6%	n/a	n/a	7th out of 7	In Sep' 19 there were 585 patients waiting over 26 weeks
	Adult psychological therapy waits	80%	60.0%	57.94%	n/a	n/a	6th out of 7	In Sep' 19 there were 625 adults waiting over 26 weeks
Population Health	'6 in 1' vaccine	95%	92.8%	95.1%	↑	Yes	7th out of 7	Quarter 1 2019/20 (Apr-Jun) saw a 2.3% improvement
	MMR vaccine	95%	90.6%	92.2%	↑	Yes	7th out of 7	Quarter 1 2019/20 (Apr-Jun) saw a 1.6% improvement
	Attempted to quit smoking	5%	3.40%	0.87%	↔	n/a	5th out of 7	486 smokers treated
	Smoking cessation - CO validated as quit	40%	49.70%	47.90%	↓	n/a	3rd out of 7	Target consistently met for over 1 year
	Childhood obesity		13.3%	11.8%	n/a	n/a	4th out of 7	Carms 13.0%, Pembs 10.6% and Cere 10.3%
Workforce & finance	Sickness absence (R12m)	12m↓	4.90%	4.95%	↑	n/a	4th out of 10	Lowest sickness rate of the 6 largest Health Boards in Wales
	Performance appraisals (PADR)	85%	77.0%	76.0%	↑	No	1st out of 10	12 month improvement despite recent 2 months dipping 1%
	Core skills mandatory training	85%	82.6%	82.9%	↑	No	5th out of 10	12 month improvement and 2.1% short of target
	Consultants/SAS doctors - current job plan	90%	52.0%	61.0%	n/a	No	n/a	Current improvement rate must continue to achieve year-end
	Finance	£15.0m	£12.56m	£14.53m	↓	n/a	n/a	Health Board Control Total requirement is £15.0m deficit.

+ Mental Health & neurodevelopment
** BGH: Bronglais General Hospital GGH: Glangwili General Hospital PPH: Prince Philip Hospital WGH: Withybush General Hospital.

Unscheduled care

Executive Lead: Director of Operations

Senior Responsible Officer(s): General Managers / County Directors / MH Director

How did we do in October 2019?

61.9% of ambulances arrived to patients with life threatening conditions within the 8 minute target.

465 ambulances waited more than 1 hour at our hospitals to handover their patient to an Accident and Emergency (A&E) department / Minor Injury Unit (MIU). This is almost two and a half times the handover delays that we reported in October 2018 (185).

13,309 patients attended an A&E/MIU in October as a new attender. Of these patients, **81.1%** were seen and treated within 4 hours of arrival but 2,522 patients waited longer and **882** patients waited over 12 hours; this is an improvement from September but much higher than we want. From April to October there has been a 3.2% increase in attendances for major illness compared to 2018.

In October there were 3,498 emergency admissions to our hospitals of which 2,101 (60%) were admitted via A&E / MIU. On average medical emergency patients stayed in hospital for 9 days (Apr-Sep).

On October census count day there were **60** patients (aged 75 plus) and **6** mental health patients in our hospitals that no longer needed medical support (medically optimised) but their discharge was delayed. These numbers are a small proportion of all patient discharge delays. The average daily number of medically optimised patients in October was 95 which equates to 15% of our adult funded beds. Delayed discharges have a direct impact on patients waiting in A&E.

How did we compare to our all Wales peers in Aug/Sep 2019?

Ambulance reaching patients with life threatening conditions within 8 minutes	3rd out of 7
Ambulances waiting > 1 hour to handover a patient	3rd out of 6
Patients being seen and treated within 4 hours in A&E/MIU	2nd out of 6
Patients waiting more than 12 hours in A&E/MIU	3rd out of 6
Non-mental health patients aged 75+ DTOC	6th out of 8
Mental health patients DTOC	1st out of 7

Risks

- Staff vacancies in our hospitals lead to difficulty filling doctor and nursing shift rotas which impacts on our ability to treat patients in a prompt manner;
- High sickness levels in the Wales Ambulance Service Trust (WAST) have a negative impact on ambulance response times;
- Delays in handing over patients at our hospitals means ambulances are not always immediately available to respond to life threatening calls;
- At times there are not enough GPs to run the Out of Hours service which often results in an increase in A&E / MIU attendances;
- Long inpatient waits for temporary care (reablement) and long term care;
- Depleted nursing home beds and the closure of an elderly mentally ill nursing home during October meant the transfer of care out of hospital was delayed for some patients across the 3 counties;
- Recruitment into the community care sector, medical, therapist and nursing positions is challenging;
- Vacancies in community hospitals are negatively impacting on the efficient transfer of some patients from our main hospitals.

What are we doing?

- A local action plan has been developed to improve ambulance response times. This includes recruitment of additional paramedics;
- Ambulatory care is medical care provided as an outpatient and includes observation, investigations, diagnosis, treatment and rehabilitation. We are focusing efforts on developing our ambulatory care services to avoid unnecessary admissions to hospital;
- Frailty pathways and assessment units are being developed to help avoid hospital admission where appropriate;
- We are appointing advanced practitioners to support more timely patient care and assessment through an alternative workforce;
- We are planning in advance of when patients are medically optimised to reduce the delay of them being able to leave hospital;
- Patients affected by the elderly mentally ill nursing home closure were found alternative placements in Hywel Dda, Swansea or Powys;
- We received £12m from the national transformation fund. This will be used for technology-enabled care for people in their homes, integration of health and care services and to support people to remain independently.
- The Health Board and Local Authorities are actively recruiting into vacant care, medical and nursing positions;
- Planning our services to meet additional pressures during winter.

Stroke and cancer

Executive Lead: Director of Therapies & Health Science / Director of Operations

Senior Responsible Officer(s): Service Delivery Manager / Assistant Director

How did we do in September/October 2019?

51.2% of patients presenting at one of our 4 acute hospitals in October with a stroke were then admitted to a dedicated stroke unit within 4 hours.

All (**100%**) of the 53 patients admitted with a stroke in October were assessed by a specialist stroke consultant within 24 hours.

Only a third (**33.3%**) of stroke patients had the recommended amount of speech and language therapy in hospital during October and the 12 month improvement target was met. However, this is lower than we would like and we are reviewing our stroke services to determine how this can be improved. The business case will be completed by March 2020 for consideration by the Board early in 2020-21

During September 2019, **73.9%** (68/92) of cancer patients who were referred by their GP as urgent with suspected cancer, commenced treatment within 62 days of their referral.

97% (136/140) of patients who were not on an 'urgent suspected cancer' pathway commenced treatment within 31 days of the date the requirement for treatment was agreed with them.

We are working towards implementation of the new single cancer pathway (SCP) to monitor progress of all newly referred cancer patients from the point their cancer is suspected until their treatment starts. The new pathway increases the number of patients who will be monitored during the diagnostic phase of their pathways. In August, **76.7%** of patients covered by the SCP were treated within 62 days of the point of suspicion.

How did we compare to our all Wales peers in Aug 2019?

	Admission to stroke unit within 4 hours	1st out of 6
	Assessed by stroke consultant within 24 hours	3rd out of 6
	Stroke patients - speech and language therapy	5th out of 6
	Urgent suspected cancer	6th out of 6
	Non urgent suspected cancer	4th out of 6
	Single cancer pathway	2nd out of 6

Risks

- Stroke
  - Lack of suitable care packages in the community results in stroke patient discharge delays which impacts admitting patients to a stroke unit within the 4 hour target;
  - High demand for inpatient beds can lead to hospitals not being able to ring fence beds in the stroke units solely for stroke patients.
  - Insufficient therapy resource impacts on our ability to provide the recommended levels of rehabilitation support
- Cancer
  - Complex pathway delays – the nature and complexity of tumours for some patients do not support rapid diagnosis and treatment due to the need for multiple investigations and multi-disciplinary team reviews;
  - Tertiary (specialist) centre capacity pressures at Swansea Bay University Health Board (SBUHB) continue to significantly compromise our performance across a number of cancer pathways;
  - Local diagnostic service capacity pressures within our Radiology service continue to present a risk.
  - The new pathway significantly increases the number of patients who will be monitored during the diagnostic phase of their pathways, placing added pressure on capacity within our diagnostic services.

What are we doing?

- Stroke
  - We are redesigning our stroke services and how we use resources in order to make meaningful improvements for our patients;
  - We are reviewing our stroke data to identify issues, putting plans in place to address and therefore improve the quality of care we provide for our stroke patients.
- Cancer
  - We are continuing to escalate our concerns regarding tertiary centre capacity and associated delays;
  - Funding has been secured to support a 7-day working in our CT pathway and the provision of additional MRI capacity to cover BGH patients;
  - SBUHB has appointed an additional gynaecology cancer surgeon;
  - SBUHB are recruiting oncologists to help address the tertiary centre capacity issue.
  - A group has been established to coordinate planning activities in respect of the SCP. Investment has been secured from Welsh Government to support partial expansion of diagnostic service capacity.

Planned care and therapies

Executive Lead: Director of Operations / Director of Therapies & Health Science

Senior Responsible Officer(s): Service Delivery Managers / Assistant Director

How did we do in September/October 2019?

164 patients waited over 8 weeks for a diagnostic test in October which is a 227 reduction since the previous month.

277 patients waited longer than 14 weeks for a therapy appointment, which is a 149 reduction from September.

118 patients had their procedure cancelled within 24 hours in September and the 5% reduction target was met;

In October, **87.5%** were waiting less than 26 weeks from referral to being treated (RTT) and **476** patients waited beyond 36 weeks.

58.1% of R1 Ophthalmology patients waited no more than 25% over their clinical target date. A patient is classed as R1 if there is risk of irreversible harm or a significant patient adverse outcome if their target date is missed. 7.2% (361) patients are yet to be allocated a risk factor.

In October, 34,989 outpatients waited twice as long as their proposed wait for a follow up appointment. This includes **16,515** patients waiting for a Trauma & Orthopaedics, Ear, Nose & Throat, Urology, Dermatology or Ophthalmology outpatient appointment. In total there are 8,864 less patients delayed since the previous month.

How did we compare to our all Wales peers in Apr-Aug 2019?

Diagnostic waiting times	5th out of 7
Therapy waiting times	7th out of 7
Hospital initiated cancellations	2nd out of 7
Referral to treatment (RTT) <=26 weeks	3rd out of 7
RTT – patients waiting 36 weeks or more	2nd out of 7
Ophthalmology patients seen by target date	7th out of 7
Delayed follow-up appointments 5 specialties	3rd out of 5

Risks

- Capacity pressures and equipment failure can impact the service's ability to meet the 8 week diagnostic target;
- Therapy breaches are mainly due to staff capacity challenges and increasing demand within our physiotherapy service;
- Hospital Initiated Cancellation numbers are affected by staffing (particularly for post-operative care) and bed availability pressures;
- RTT risks arise from capacity being impacted by unexpected issues e.g. fire regulations, vacancies, sickness and unexpected annual leave;
- New Eye Care patients can wait longer due to a shortage of consultant ophthalmologists. Capacity being used to cover the Emergency Eye Care service can also impact on waiting times;
- Historical clinical practice and supporting administrative systems promote the planning of a follow-up outpatient appointment without full consideration of alternatives and/or the clinical necessity.

What are we doing?

- Diagnostic actions include demand and capacity optimisation, outsourcing, clinical validation, recruitment and revising pathways;
- Therapy actions include skill mix / service reviews, signposting, self-management, community musculoskeletal initiatives, recruitment and agency utilisation;
- The service is reducing hospital initiated cancellations (<24 hours) by optimising theatre lists, liaising daily with patient flow teams and realising the benefits from unscheduled care improvement plans;
- RTT delivery plans are in place across all specialties and recovery actions are being progressed;
- Our eye care service is improving cataract referral to enable a direct surgery listing process as well as increasing the number of patients who can be reviewed by a community optometrist;
- Delayed follow up appointment actions include improved reporting/validation and a range of clinical transformation plans to increase the number of reviews which can be undertaken outside of the traditional clinic setting. Examples include Patient Reported Outcome Measures (PROMs) and Patient Know Best (PKB) modules.

Quality and safety

Executive Lead: Director of Nursing, Quality and Patient Experience

Senior Responsible Officer(s): Assistant Directors of Quality

How did we do in September/October 2019?

Clostridium difficile (C.diff) is an infection of the bowel that is generally associated with the use of antibiotics. Hywel Dda diagnosed **12** cases of C.diff in October, a slight reduction from 13 in September.

Escherichia coli (E.coli) is a blood stream infection. The number of diagnosed E.coli infections reduced from 37 in September to **30** in October. The high number of cases seen over the summer months has not been sustained.

Staphylococcus aureus (S. aureus) is also a blood stream infection. The number of cases of S.aureus increased from 9 cases in September to **16** in October. Half of the cases in October were related to skin and bone infections and were unavoidable.

In September there were 1,120 incidents reported of which 12 were reported as serious incidents. Welsh Government ask Health Boards to review and close serious incidents within 60 working days. In September, **30.8%** of our serious incidents were closed in this agreed timescale.

We responded to **76.5%** of concerns within the agreed timescales and achieved the 75% target.

How do we compare to our all Wales peers?

C.difficile infections	6th out of 6
E.coli infections	6th out of 6
S.aureus bacteraemias (MRSA and MSSA) infections	5th out of 6
Serious incidents assured in a timely manner	6th out of 9
Timely responses to concerns and complaints	4th out of 10

Risks

- Antibiotics are often necessary to treat infections in the community and in hospital but broad spectrum antibiotics can disturb the good bacteria in the bowel which can take up to 6 months to recover putting the patient at risk of developing c.diff.
- Management of urine infections in the community remains an issue with one third of E.coli cases being urine related and positive on admission to hospital.
- We are now going in to winter months and seeing an increasing number of infections related to respiratory infections which may then lead to secondary blood stream infections.
- It is essential that a root cause analysis is undertaken promptly for each serious incident for action plans to be prepared and learning identified in a timely manner;
- Reduced capacity in our Patient Advice and Liaison Service (PALS) is affecting the amount or proactive work we are able to do with our clinical staff and in the community.

What are we doing?

- We want to reduce the number of infections in hospitals and the community by educating the public and our health professionals on management of urinary tract infections (UTI), hydration and antibiotic usage.
  - In WGH there has been improved engagement with both pharmacists and consultants on patients' antibiotics management;
  - 'Jabs to Tabs' training has been delivered to our staff across all acute sites as part of World Antibiotic Awareness Week.
  - Education sessions have been delivered to all admission units on management of UTI's 'Do Not Dipstick over 65's'
  - Faecal Microbiota Transplant (FMT) is now available as a service across the health board.
- A review into our serious incident closures has identified a number of factors which we are working very closely with colleagues in Welsh Government to improve. Following each serious incident a full review is undertaken and 'learning from events' meetings are held to support wider learning within the teams. A number of safety posters have been developed to support wider learning.
- Increased staffing levels in our Patient Support Contact Centre has enabled some complaint cases to be dealt with more efficiently.

Mental health and neurodevelopment

Executive Lead: Director of Operations

Senior Responsible Officer(s): Director of Mental Health / Assistant Director

How did we do in September 2019?

34.6% of children and young people (310 out of 895) waited less than 26 weeks to start a neurodevelopmental assessment. This is the combined figure for autistic spectrum disorder (ASD, 42.5%) and attention deficit hyperactivity disorder (ADHD, 17.2%) referrals.

57.9% of adults (861 out of 1,486) waited less than 26 weeks to start a psychological therapy with our Specialist Mental Health Service. Psychological therapies are used for common problems such as stress, anxiety, depression, obsessive compulsive disorder and phobias.

How did we compare to our all Wales peers in Aug 2019?

Children/young people neurodevelopment waits	7th out of 7
Adult psychological therapy waits	6th out of 7

Risks

- Neurodevelopmental assessments:
  - Delays in assessments can impact on the quality of life for patients and their families
  - ASD - growing demand compared to current resources and difficulties in recruitment;
  - ADHD – historical referral backlog and vacancies within the team.
- Psychological therapies
  - Increased demand for psychological therapy from primary and secondary care mental health services;
  - Vacancies and inability to recruit into specialist posts;
  - Service still providing a range of low intensity psychological interventions / therapy due to backlog of referrals;
  - High waiting lists for both individual and group therapy;
  - Lack of a robust IT infrastructure.

What are we doing?

- We are transferring our mental health patient records to a new system called Wales Patient Administration System (WPAS). The launch date is planned for January 2020 and once implemented will allow timelier reporting. At that point we will undertake a review of the indicators available and enhance this briefing accordingly;
- Neurodevelopmental assessments
  - Each mental health service team is working with the all Wales performance Delivery Unit to undertake demand and capacity exercises;
  - Waiting list initiatives have been utilised;
  - Additional hours have been offered to current members of staff to increase capacity;
  - A part-time speech and language therapist has been recruited;
  - An investigation has been undertaken and a report written outlining the additional resources required for a sustainable ASD service;
  - Efficiency and productivity opportunities are being explored;
  - An additional part-time community GP post has been recruited.
- Psychological therapies
  - A team restructure is underway;
  - A new service model is being developed;
  - Referrals from emotional cognitive scale (ECS) are no longer accepted in order for us to concentrate on high intensity therapy;
  - Waiting list initiatives are being utilised;
  - A single point of contact has been created for all referrals to ensure improved coordination and response.

Population health

Executive Lead: Director of Public Health

Senior Responsible Officer(s): Immunisation, smoking and obesity leads

How did we do?

The '6 in 1' vaccine is given as a single injection to protect babies against 6 serious childhood diseases: diphtheria, hepatitis B, Haemophilus influenzae type b (Hib), polio, tetanus and whooping cough. The '6 in 1' vaccine is given at 8, 12 and 16 weeks old. Between April and June 2019, **95%** of children had received 3 doses of the '6 in 1' vaccine by their first birthday, an improvement of 2.3% from the previous quarter.

The MMR vaccine is also given as a single injection and protects against mumps, measles and rubella (German measles). It is given within a month of a baby's first birthday then again when the child is around 3 years 4 months. In Hywel Dda, between April and June 2019, **92%** of children received 2 doses of the MMR vaccine by their 5th birthday. This is an improvement of 1.6% from the previous quarter.

In April to June 2019, **0.87%** (486) of adults attempted to quit smoking using a smoking cessation service.

47.9% of smokers who quit had the carbon monoxide (CO) levels in their blood confirm they has quit in April to June 2019.

Obesity is a risk factor for many life-threatening conditions including diabetes, heart disease, bowel cancer and stroke. The most recent data shows that **11.8%** of 4-5 year olds and **23.0%** of adults aged 16+ living in Hywel Dda are obese.

How do we compare to our all Wales peers?

3 doses of the '6 in 1' vaccine by age 1	7th out of 7
2 doses of the MMR vaccine by age 5	7th out of 7
Smokers who attempted to quit	5th out of 7
Smokers CO validated as quit	3rd out of 7
Children aged 4-5 year who are obese	4th out of 7

Risks

- Both the MMR and '6 in 1' vaccines are safe and effective, however pockets of the population resist childhood vaccination for cultural and ethical reasons;
- Rurality causes difficulty for some families to attend clinics due to a lack of transport and the road network in some parts of Carmarthenshire, Ceredigion and Pembrokeshire.
- Ensuring clear pathways are in place and used to help people quit smoking. This is especially important for inpatients and patients seen in primary care;
- Ensuring that there is sufficient capacity within the weight management services to support adults to manage their weight.
- We need to develop a weight management service/approach for children.

What are we doing?

- We have a pilot scheme in place to improve the uptake of MMR for children living in the Hywel Dda area. Those children identified as having outstanding MMR are offered immunisation in an alternative venue (e.g. a nursery) to give parents more flexibility with venue and time to have their child immunised;
- We have employed 2 community nurse immunisers;
- We are sharing vaccination uptake data with our GPs to allow them to have a greater understanding of the uptake in their practice and how they perform to other GP practices in their area. This will enable to the GPs to more easily identify, plan, and target specific groups of patients where uptake is low.
- Ongoing recruitment of pharmacists and pharmacy technicians into the Pharmacy Level 3 Smoking Cessation Scheme to ensure services are provided across the Health Board area;
- Local Stop Smoking Wales services have integrated into the Hywel Dda;
- Pregnant women are CO validated during their antenatal appointments;
- All pregnant women with a CO reading above 4PPM (parts per million) are offered specialist support to quit smoking;
- We offer weight management services to adults with chronic conditions;
- We are awaiting the publication of a Welsh Government action plan (January 2020) to help implement the priorities in the new *Healthy Weight: Healthy Wales* strategy. We will develop a local response to this plan.

Workforce and finance

Executive Lead: Director of Workforce / Medical Director / Director of Finance

Senior Responsible Officer(s): Assistant Directors / Revalidation & Appraisal Manager

How did we do in September/October 2019?

4.95% of full time equivalent (FTE) staff days were lost due to sickness in the 12 month period October 2018 to September 2019.

76% of our staff have completed their individual performance appraisal and development review (PADR) with their line manager in the previous 12 months.

82.9% of our staff have completed their level 1 core skills training which includes topics such as manual handling, safeguarding and information governance.

61% of our consultants and Specialty and Associate Specialist (SAS) doctors have a current job plan. Further improvement is needed over the coming months to meet the 90% target by March 2020.

The Health Board's financial position at the end of October is **£14.5m deficit** for the financial year to date. In October we delivered £1.6m of savings schemes. The Health Board is working in conjunction with KPMG to identify further savings opportunities.

How did we compare to our all Wales peers in July 2019?

Sickness absence	4th out of 10
Performance appraisal and development review	1st out of 10
Level 1 core skills training framework completed	5th out of 10
Medical staff with a current job plan	Not available
Finance	Not available

Risks

- The current all Wales sickness policy encourages more management discretion than was permitted in our previous policy. This is better for staff and gives managers more autonomy to make suitable adjustments. We did see a temporary increase in sickness when the policy was originally introduced but that has since improved;
- Achieving the PADR target requires managers to overcome conflicting demands on their leadership roles. Additional risks arise from the lack of feasible training options;
- Medical and dental staff have difficulty securing time away from the workplace to attend mandatory level one training;
- The job planning process requires a number of phases to achieve finalisation, this needs to be effectively planned and coordinated around clinical time;
- Given our year to date position, we are unlikely to achieve the end of year deficit of no more than £15m that was previously agreed with Welsh Government.

What are we doing?

- We are continuing to closely monitor and manage sickness. Compliance with the policy is being audited where sickness rates are at their highest and training on the new All Wales policy is ongoing;
- Additional PADR training sessions have been organised and discussions are in place to develop an e-learning package. We are also reviewing our available support mechanisms;
- Same day multi-subject training, face to face sessions, skills guides, telephone support and facilitated e-learning sessions are provided for staff;
- Job planning workshops have been arranged to take place across Hywel Dda between now and the end of March 2020. We have a collaborative approach to sharing best practise with the other Welsh Health Boards;
- The financial "Turnaround / Holding to Account" process provides a high level of scrutiny and challenge to our Directorate Leads in terms of adherence to assigned budget and delivery and identification of robust savings schemes.

Performance run charts for our key deliverable indicators: data as at 31st October 2019

Click a link below to view the run chart and data for that indicator.

- ‘6 in 1’ vaccine
- MMR vaccine
- C.difficile
- E.coli
- S.aureus
- Serious incidents
- Hospital initiated cancellations
- Concerns and complaints
- Mental health delayed transfers of care (DTOC)
- Non-mental health DTOC
- Finance
- Sickness absence
- Performance appraisals (PADR)
- Core Skills Training Framework (CSTF)
- Consultants/SAS doctors - current job plan
- Ambulance red calls
- Ambulance handovers over 1 hour
- A&E/MIU 4 hour waits
- A&E/MIU 12 hour waits
- Admission to stroke unit <4 hours
- Assessed by stroke consultant <24 hours
- Stroke patients - speech and language therapy
- Delayed follow-up appointments 5 specialties
- Ophthalmology patients seen by target date
- Urgent suspected cancer
- Non-urgent suspected cancer
- Diagnostic waiting times
- Therapy waiting times
- Referral to treatment (RTT) <=26 weeks
- RTT patients waiting 36 weeks+
- Children/young people neurodevelopment waits
- Adult psychological therapy waits

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Additional resources (intranet access needed)

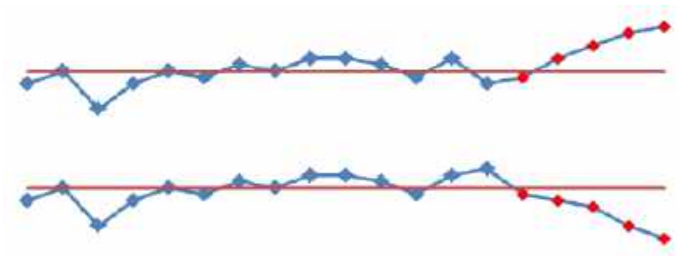
Rules for interpreting run charts

Integrated Performance Assurance Reports (IPAR) and performance overview

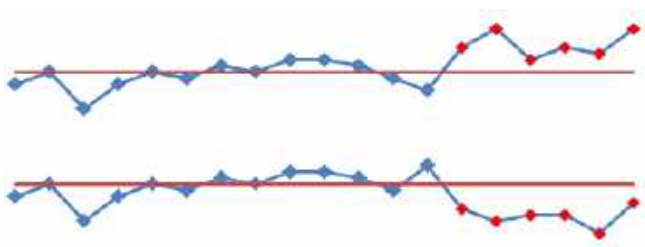
Performance dashboards

Performance run charts – rules* for determining non-random variation

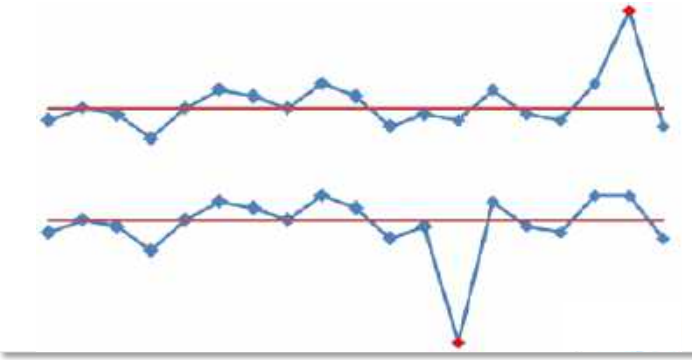
Trend – 5+ points increasing or decreasing



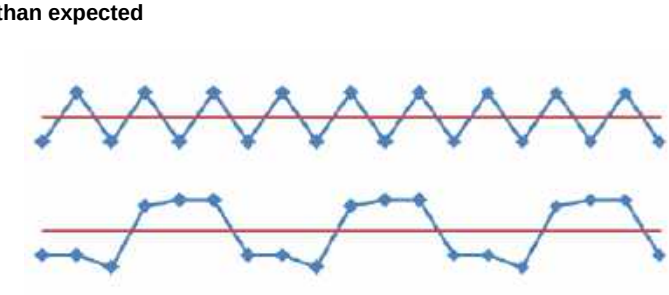
Shift – 6+ points in a row above or below the median



Astronomical – a point very different to the other points

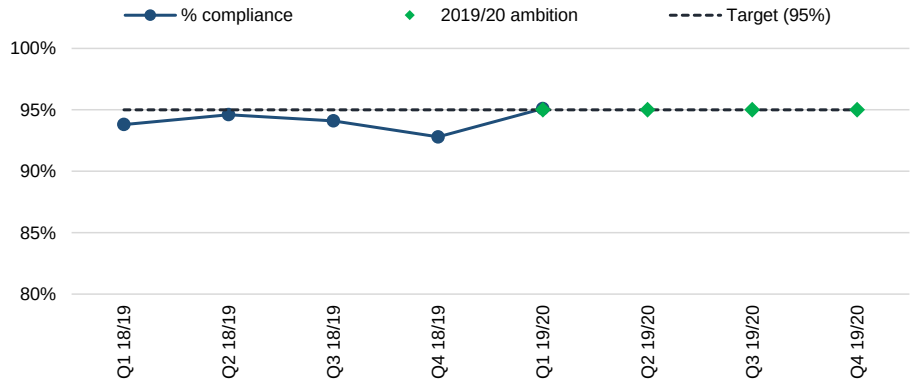


Run – a trend which crosses the median more or less frequently than expected



* Taken from Advancing Quality Alliance (AQuA) and based on the Institute for Healthcare Improvement (IHI) standards

% children receiving 3 doses of '6 in 1' vaccine by age 1

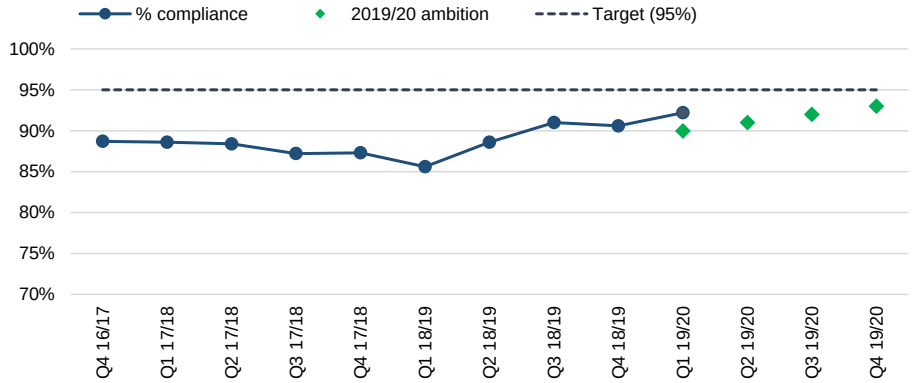


Evidence of non-random variation in recent months?

Need 10+ data points to determine whether or not there is evidence of non-random variation

% children receiving 3 doses of '6 in 1' vaccine by age 1	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
% compliance	93.8%	94.6%	94.1%	92.8%	95.1%			
2019/20 ambition					95%	95%	95%	95%
Target (95%)	95%	95%	95%	95%	95%	95%	95%	95%

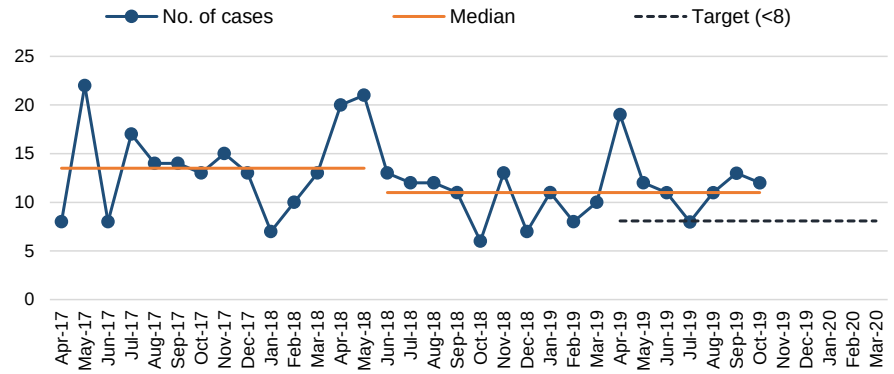
% children receiving 2 doses of MMR vaccine by age 5



Insufficient valid data points to calculate median (fails runs test). Therefore, cannot currently apply non-random variation rules.

% children receiving 2 doses of MMR vaccine by age 5	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
% compliance	88.7%	88.6%	88.4%	87.2%	87.3%	85.6%	88.6%	91.0%	90.6%	92.2%			
2019/20 ambition										90%	91%	92%	93%
Target (95%)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

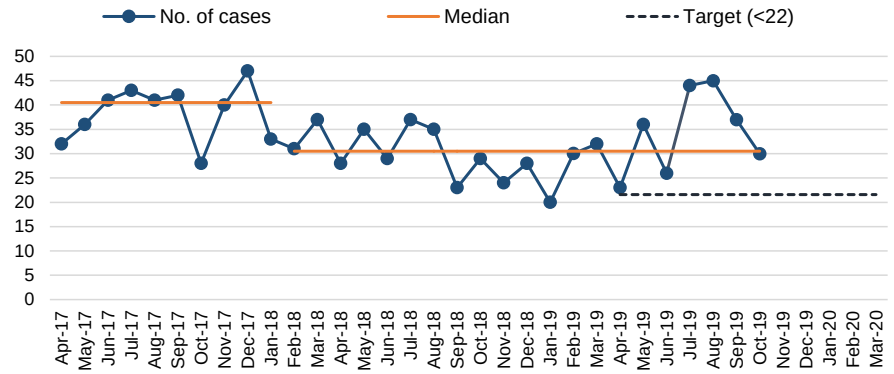
Number of cases of C.diff



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

Number of cases of C.diff	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of cases	8	22	8	17	14	14	13	15	13	7	10	13	20	21	13	12	12	11	6	13	7	11	8	10	19	12	11	8	11	13	12					
Median	14	14	14	14	14	14	14	14	14	14	14	14	14	14	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11					
Target (<8)																									8	8	8	8	8	8	8	8	8	8	8	8

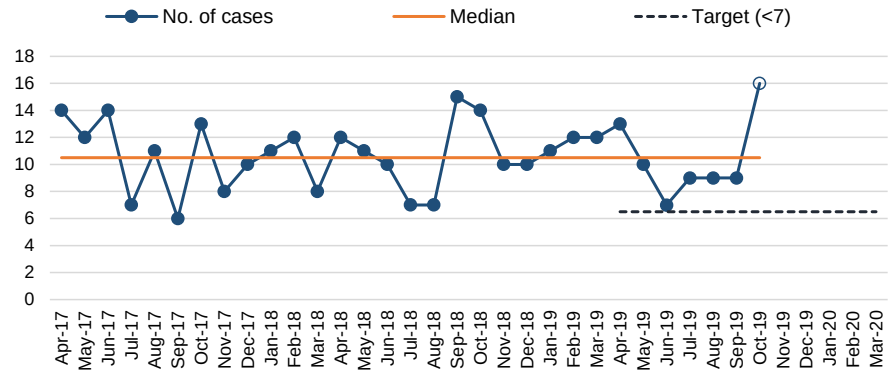
Number of cases of E.coli



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

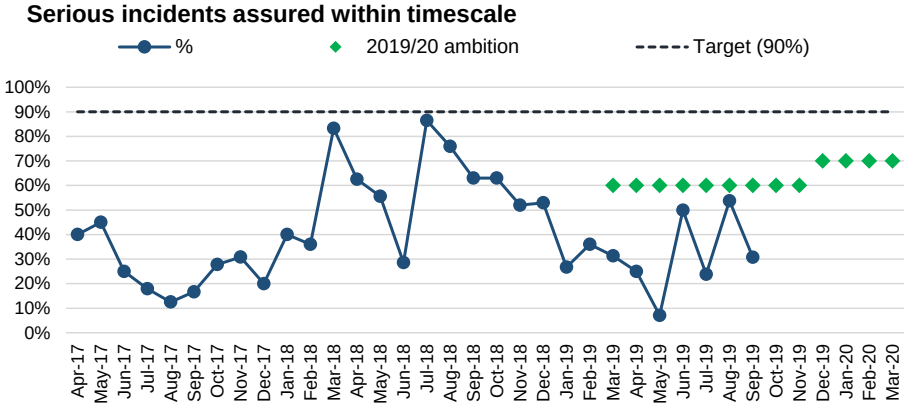
Number of cases of E.coli	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of cases	32	36	41	43	41	42	28	40	47	33	31	37	28	35	29	37	35	23	29	24	28	20	30	32	23	36	26	44	45	37	30					
Median	41	41	41	41	41	41	41	41	41	41	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31					
Target (<22)																									22	22	22	22	22	22	22	22	22	22	22	22

Number of cases of S.aureus



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	Yes
Trend crossing median in an unexpected pattern?	No

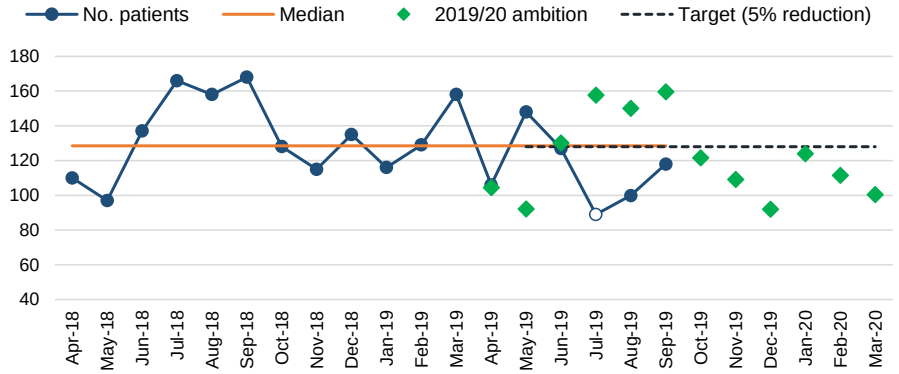
Number of cases of S.aureus	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of cases	14	12	14	7	11	6	13	8	10	11	12	8	12	11	10	7	7	15	14	10	10	11	12	12	13	10	7	9	9	9	16					
Median	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11					
Target (<7)																									7	7	7	7	7	7	7	7	7	7	7	7



It is not appropriate to use a run chart for this indicator due to the wide monthly variation in the denominator (number of serious incidents). Therefore, a trend chart has been provided.

Serious incidents assured within timescale	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%	40%	45%	25%	18%	13%	17%	28%	31%	20%	40%	36%	83%	63%	56%	29%	87%	76%	63%	63%	52%	53%	27%	36%	31%	25%	7%	50%	24%	54%	31%						
2019/20 ambition																								60%	60%	60%	60%	60%	60%	60%	60%	60%	70%	70%	70%	70%
Target (90%)	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

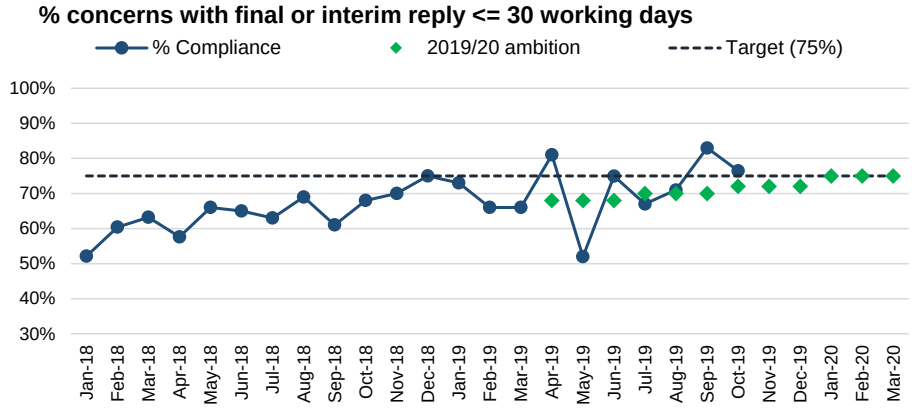
Hospital Initiated Cancellations within 24 hours



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	Yes
Trend crossing median in an unexpected pattern?	No

Note: the median calculation does not include the astronomical point highlighted on the chart.

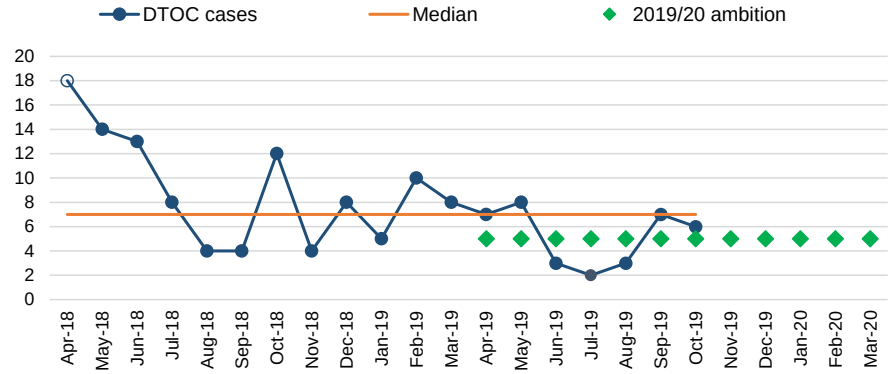
Hospital Initiated Cancellations within 24 hours	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. patients	110	97	137	166	158	168	128	115	135	116	129	158	106	148	127	89	100	118						
Median	129	129	129	129	129	129	129	129	129	129	129	129	129	129	129	129	129	129						
2019/20 ambition													105	92	130	158	150	160	122	109	92	124	112	100
Target (5% reduction)														128	128	128	128	128	128	128	128	128	128	128



This indicator is on an improving trajectory. The target has been met, when this is sustained a median will be added and the rules for non-random variation will be applied.

% concerns with final or interim reply <= 30 working days	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Compliance	52%	60%	63%	58%	66%	65%	63%	69%	61%	68%	70%	75%	73%	66%	66%	81%	52%	75%	67%	71%	83%	77%					
2019/20 ambition																68%	68%	68%	70%	70%	70%	72%	72%	72%	75%	75%	75%
Target (75%)	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

Mental Health DTOC cases (12 mth reduction target)

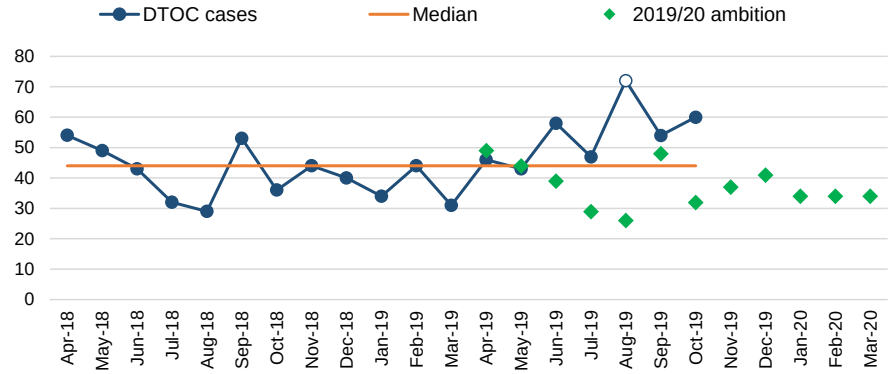


Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

Note: the median calculation does not include the astronomical point highlighted on the chart.

Mental Health DTOC cases (12 mth reduction target)	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
DTOC cases	18	14	13	8	4	4	12	4	8	5	10	8	7	8	3	2	3	7	6					
Median	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7					
2019/20 ambition													5	5	5	5	5	5	5	5	5	5	5	5

Non Mental Health DTOC cases (12 mth reduction target)

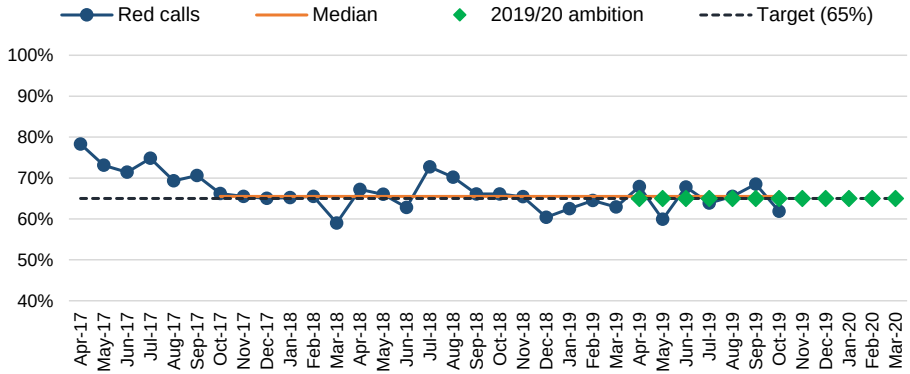


Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

Note: the median calculation does not include the astronomical point highlighted on the chart.

Non Mental Health DTOC cases (12 mth reduction target)	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
DTOC cases	54	49	43	32	29	53	36	44	40	34	44	31	46	43	58	47	72	54	60					
Median	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44					
2019/20 ambition													49	44	39	29	26	48	32	37	41	34	34	34

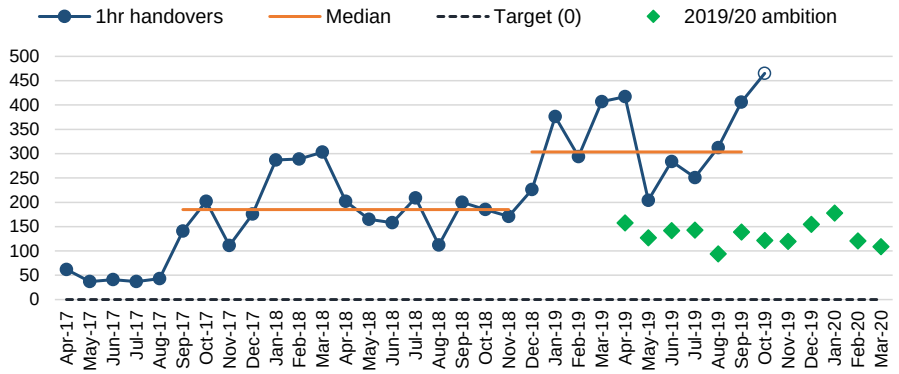
% of responses to ambulance red calls within 8 mins



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

% of responses to ambulance red calls within 8 mins	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Red calls	78.3%	73.1%	71.4%	74.8%	69.3%	70.6%	66.2%	65.5%	65.0%	65.2%	65.5%	59.0%	67.2%	66.0%	62.8%	72.7%	70.2%	66.1%	66.1%	65.4%	60.4%	62.5%	64.5%	62.9%	67.9%	59.9%	67.8%	63.9%	65.5%	68.5%	61.9%					
Median							65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%	65.5%					
2019/20 ambition																									65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Target (65%)	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%

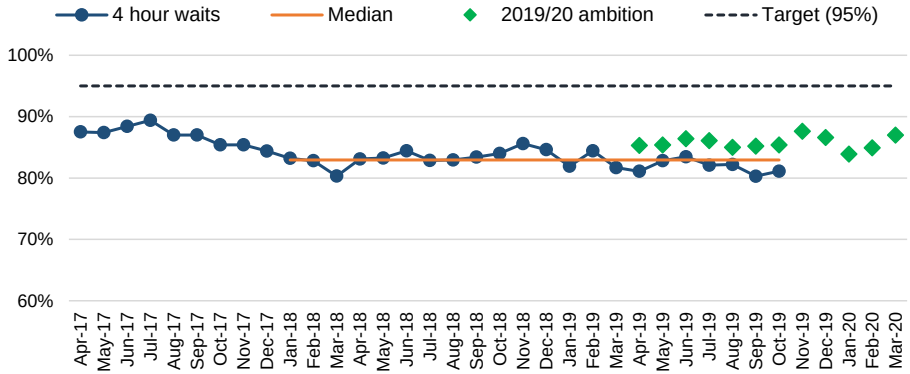
Ambulance handovers taking longer than 1 hour



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	Yes
Trend crossing median in an unexpected pattern?	No

Ambulance handovers taking longer than 1 hour	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
1hr handovers	62	37	41	37	43	141	202	111	176	287	289	303	202	165	158	209	112	200	185	171	226	376	294	407	417	204	284	251	313	406	465					
Median						185	185	185	185	185	185	185	185	185	185	185	185	185	185	185	304	304	304	304	304	304	304	304	304	304	304					
2019/20 ambition																									158	127	142	143	94	139	122	120	155	178	121	109
Target (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

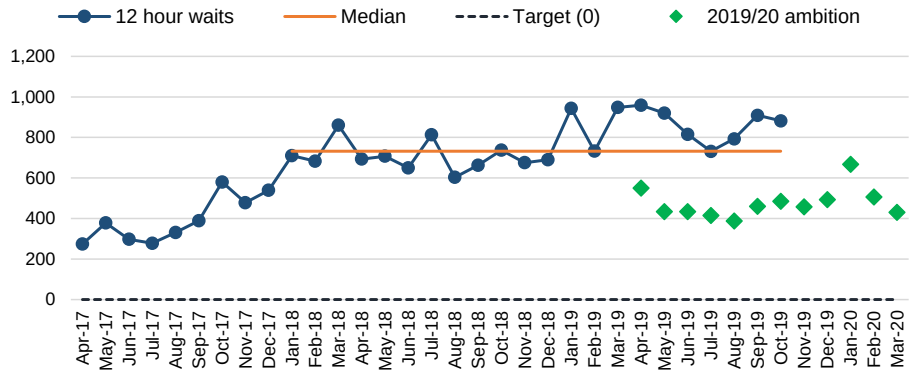
% of patients seen within 4 hours in A&E / MIU



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

% of patients seen within 4 hours in A&E / MIU	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
4 hour waits	87.5%	87.4%	88.4%	89.4%	87.0%	87.0%	85.4%	85.4%	84.4%	83.2%	82.8%	80.3%	83.1%	83.3%	84.4%	82.9%	82.9%	83.4%	84.0%	85.6%	84.6%	81.9%	84.4%	81.7%	81.1%	82.8%	83.5%	82.1%	82.2%	80.3%	81.1%					
Median										82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%					
2019/20 ambition																									85%	85%	86%	86%	85%	85%	85%	88%	87%	84%	85%	87%
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%

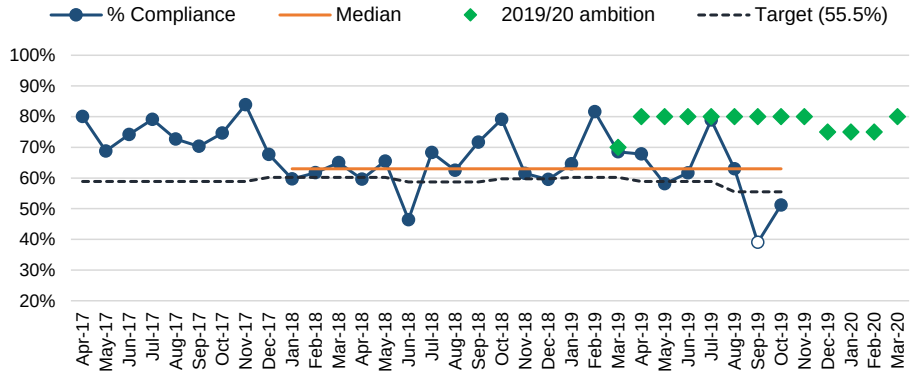
Patients waiting more than 12 hours in A&E / MIU



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

Patients waiting more than 12 hours in A&E / MIU	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
12 hour waits	274	378	297	278	331	389	580	478	539	710	683	860	693	707	650	813	603	663	737	675	690	943	732	948	959	920	816	732	793	910	882					
Median										732	732	732	732	732	732	732	732	732	732	732	732	732	732	732	732	732	732	732	732	732	732					
2019/20 ambition																									551	435	434	415	388	460	485	458	494	668	507	431
Target (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Admission to a stroke unit within 4 hours

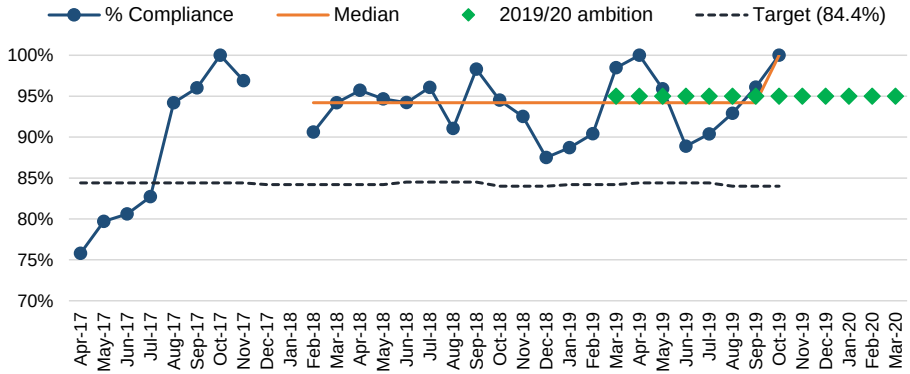


Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	Yes
Trend crossing median in an unexpected pattern?	No

Note: the median calculation does not include the astronomical point highlighted on the chart.

Admission to a stroke unit within 4 hours	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Compliance	80.0%	68.8%	74.2%	79.1%	72.7%	70.3%	74.6%	83.9%	67.7%	59.7%	61.7%	65.0%	59.6%	65.5%	46.4%	68.3%	62.5%	71.7%	79.1%	61.5%	59.5%	64.6%	81.6%	68.5%	67.8%	58.1%	61.7%	78.9%	63.0%	39.0%	51.2%					
Median										63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%	63.0%					
2019/20 ambition																								70%	80%	80%	80%	80%	80%	80%	80%	80%	75%	75%	75%	80%
Target (55.5%)	58.9%	58.9%	58.9%	58.9%	58.9%	58.9%	58.9%	58.9%	60.2%	60.2%	60.2%	60.2%	60.2%	60.2%	58.7%	58.7%	58.7%	58.7%	59.7%	59.7%	59.7%	60.2%	60.2%	60.2%	58.9%	58.9%	58.9%	58.9%	55.5%	55.5%	55.5%					

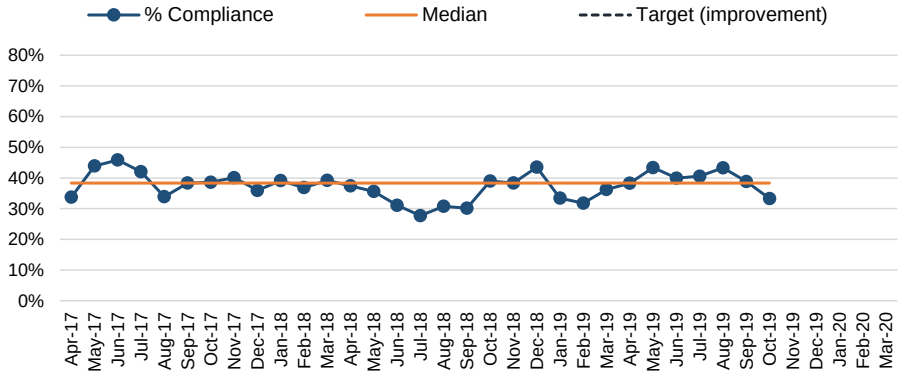
Assessed by stroke consultant within 24hrs



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

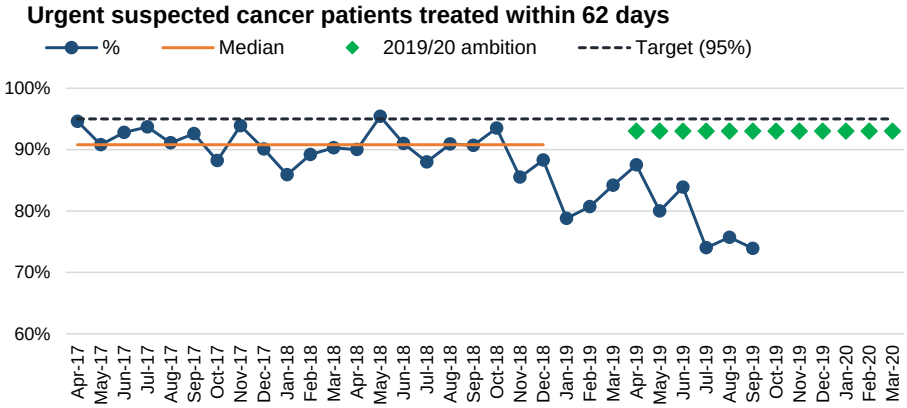
Assessed by stroke consultant within 24hrs	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Compliance	75.8%	79.7%	80.6%	82.7%	94.2%	96.0%	100.0%	96.9%			90.6%	94.2%	95.7%	94.7%	94.2%	96.1%	91.0%	98.3%	94.5%	92.5%	87.5%	88.7%	90.4%	98.5%	100.0%	95.9%	88.9%	90.4%	92.9%	96.1%	100.0%					
Median											94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	100.0%					
2019/20 ambition																								95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Target (84.4%)	84.4%	84.4%	84.4%	84.4%	84.4%	84.4%	84.4%	84.4%	84.2%	84.2%	84.2%	84.2%	84.2%	84.2%	84.5%	84.5%	84.5%	84.5%	84.0%	84.0%	84.0%	84.2%	84.2%	84.2%	84.4%	84.4%	84.4%	84.4%	84.0%	84.0%	84.0%					

Stroke patients receiving required minutes for SALT



Evidence of non-random variation in recent months?	
5+ points increasing / decreasing?	No
6+ points in a row above / below the median?	No
Astronomical data point (very different to the rest)?	No
Trend crossing median in an unexpected pattern?	No

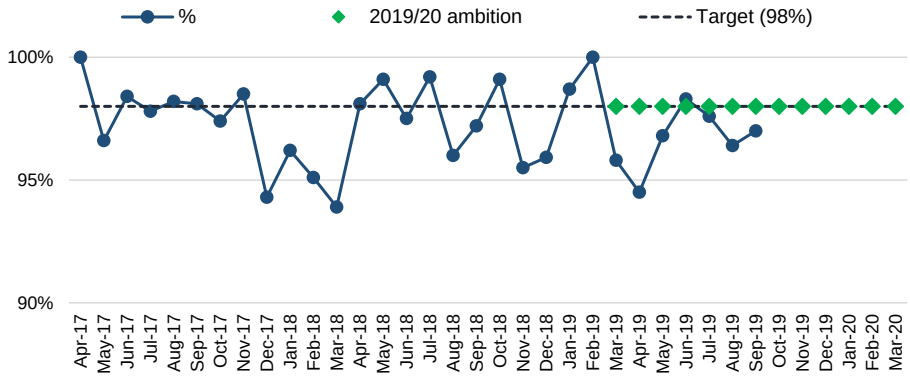
Stroke patients receiving required minutes for SALT	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Compliance	33.7%	43.9%	45.9%	42.0%	33.9%	38.3%	38.6%	40.1%	36.0%	39.1%	36.9%	39.2%	37.4%	35.6%	31.1%	27.7%	30.8%	30.2%	39.0%	38.4%	43.5%	33.4%	31.8%	36.2%	38.3%	43.4%	40.0%	40.6%	43.3%	38.9%	33.3%					
Median	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%	38.3%					
Target (improvement)																																				



A shift (recent decline) in performance requires a new median to be calculated. This will be done when 10 valid data points are available.

Urgent suspected cancer patients treated within 62 days	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%	95%	91%	93%	94%	91%	93%	88%	94%	90%	86%	89%	90%	90%	95%	91%	88%	91%	91%	94%	86%	88%	79%	81%	84%	88%	80%	84%	74%	76%	74%						
Median	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%															
2019/20 ambition																									93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
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%

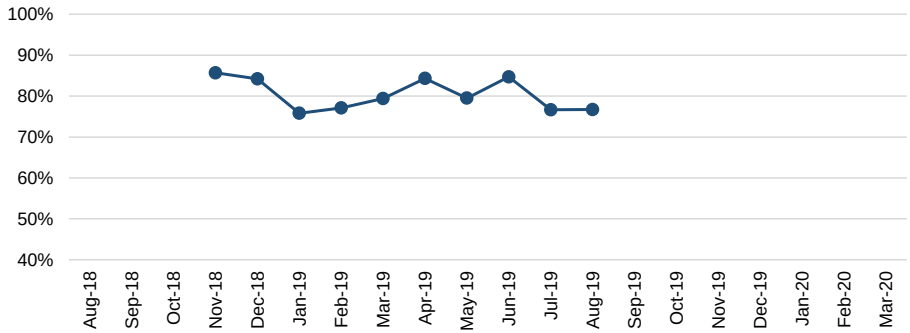
Non-urgent suspected cancer patients treated within 31 days



It is not appropriate to use a run chart for this indicator due to the wide monthly variation in the denominator (number of patients treated). Therefore, a trend chart has been provided.

Non-urgent suspected cancer patients treated within 31 days	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%	100%	97%	98%	98%	98%	98%	97%	99%	94%	96%	95%	94%	98%	99%	98%	99%	96%	97%	99%	96%	96%	99%	100%	96%	95%	97%	98%	98%	96%	97%						
2019/20 ambition																								98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Target (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%

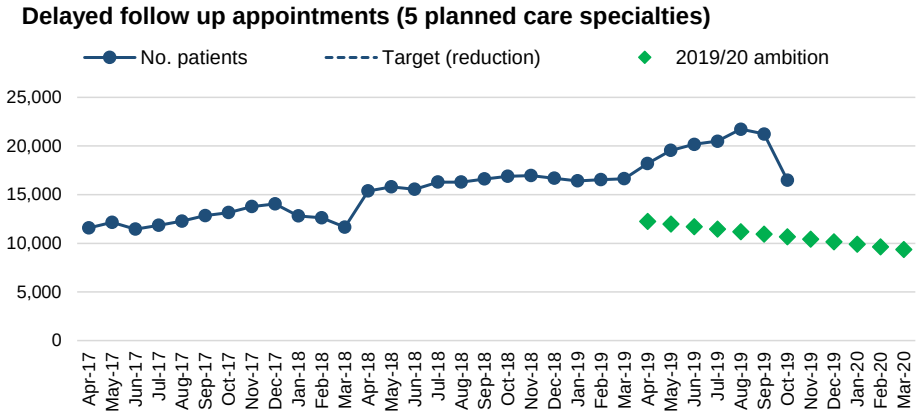
Patients starting first definitive cancer treatment < 62 days (with clinical suspensions)



Evidence of non-random variation in recent months?

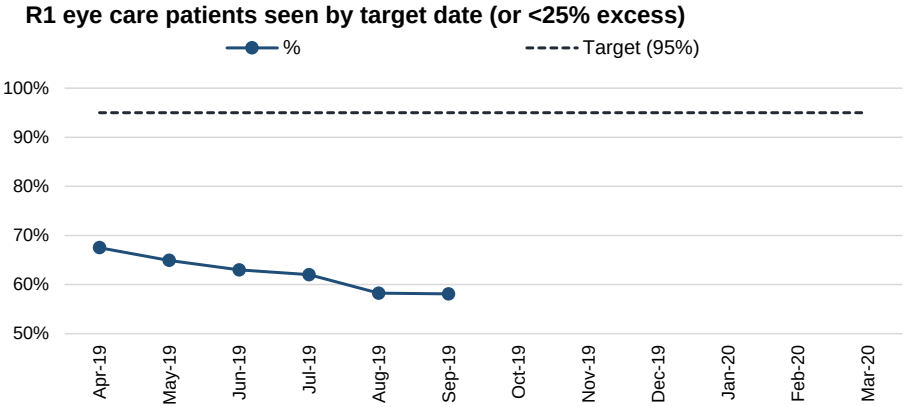
Need 10+ data points to determine whether or not there is evidence of non-random variation

Patients starting first definitive cancer treatment < 62 days (with clinical suspensions)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% with suspensions																				85.7%	84.2%	75.8%	77.1%	79.4%	84.3%	79.5%	84.7%	76.7%	76.7%							
without suspensions																												61.9%	63.7%							



This indicator is on a declining trajectory. When an improved position has been achieved and sustained a median will be added and the rules for non-random variation will be applied.

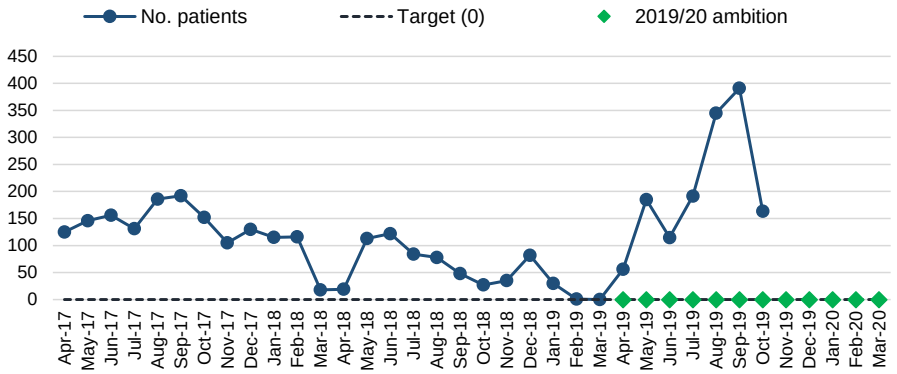
Delayed follow up appointments (5 planned care specialties)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. patients	11579	12155	11449	11844	12281	12847	13148	13770	14046	12808	12624	11662	15376	15800	15550	16285	16285	16605	16887	16956	16680	16409	16540	16629	18199	19551	20189	20492	21736	21235	16515					
Median																																				
2019/20 ambition																									12249	11989	11728	11468	11207	10946	10686	10425	10164	9903.8	9643.1	9382.5



Evidence of non-random variation in recent months?
Need 10+ data points to determine whether or not there is evidence of non-random variation

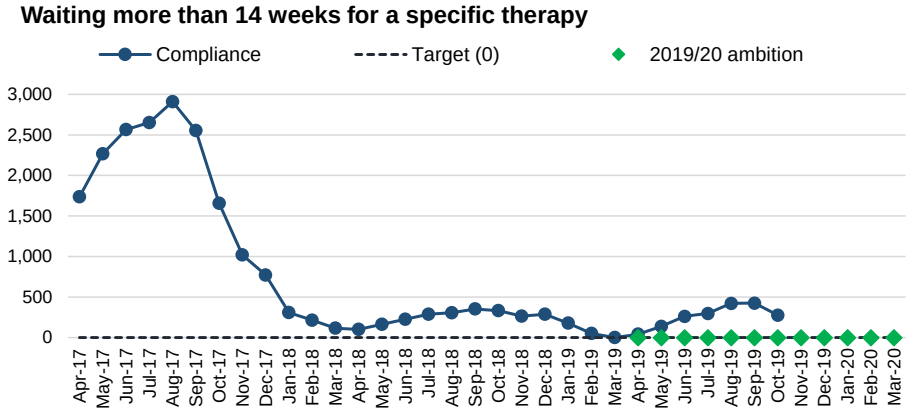
R1 eye care patients seen by target date (or <25% excess)	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%	68%	65%	63%	62%	58%	58%						
Target (95%)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Patients waiting 8 weeks+ for a specified diagnostic



This indicator is unstable. When an improved position has been achieved and a more stable pattern is sustained a median will be added and the rules for non-random variation will be applied. In the interim a trend chart is provided for this indicator.

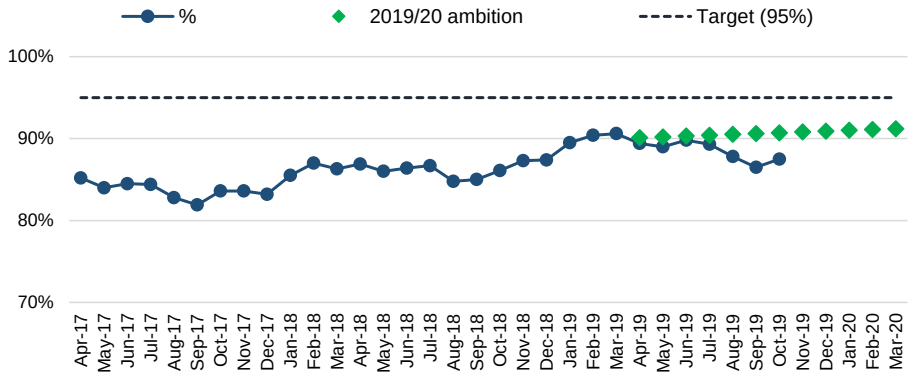
Patients waiting 8 weeks+ for a specified diagnostic	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. patients	125	146	156	131	186	192	152	105	130	115	116	18	19	113	122	84	78	48	27	35	82	30	1	0	56	185	115	192	345	391	164					
2019/20 ambition																									0	0	0	0	0	0	0	0	0	0	0	0
Target (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



It is not approporiate to use a run chart for this indicator because the data are following a non-random pattern. Therefore, a trend chart has been provided.

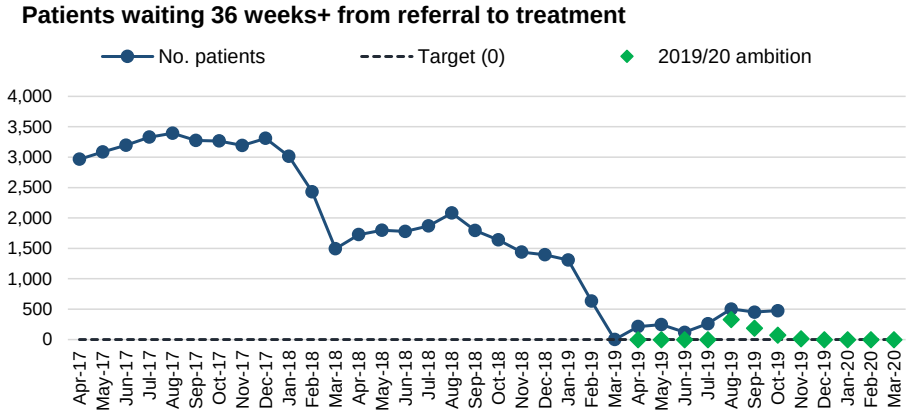
Waiting more than 14 weeks for a specific therapy	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Compliance	1736	2267	2565	2652	2910	2554	1657	1019	772	308	215	115	101	164	226	288	307	352	332	265	287	177	51	0	41	138	262	297	424	426	277					
2019/20 ambition																									0	0	0	0	0	0	0	0	0	0	0	0
Target (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Patients waiting less than 26 weeks from referral to treatment



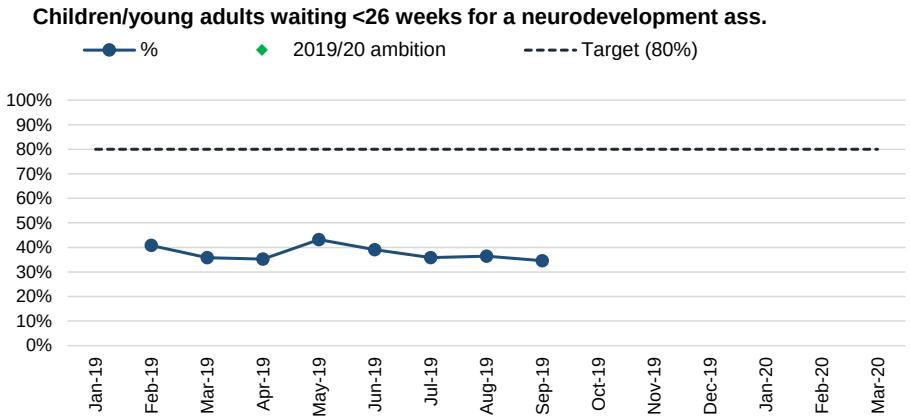
It is not approporiate to use a run chart for this indicator because the data are following a non-random pattern. Therefore, a trend chart has been provided.

Patients waiting less than 26 weeks from referral to treatment	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%	85.2%	84.0%	84.5%	84.4%	82.8%	81.9%	83.6%	83.6%	83.2%	85.5%	87.0%	86.3%	86.9%	86.0%	86.4%	86.7%	84.8%	85.0%	86.1%	87.3%	87.4%	89.5%	90.4%	90.6%	89.4%	89.0%	89.8%	89.3%	87.8%	86.5%	87.5%				
2019/20 ambition																									90.1%	90.2%	90.3%	90.4%	90.5%	90.6%	90.7%	90.8%	90.9%	91.0%	91.1%	91.2%
Target (95%)	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



It is not approporiate to use a run chart for this indicator because the data are following a non-random pattern. Therefore, a trend chart has been provided.

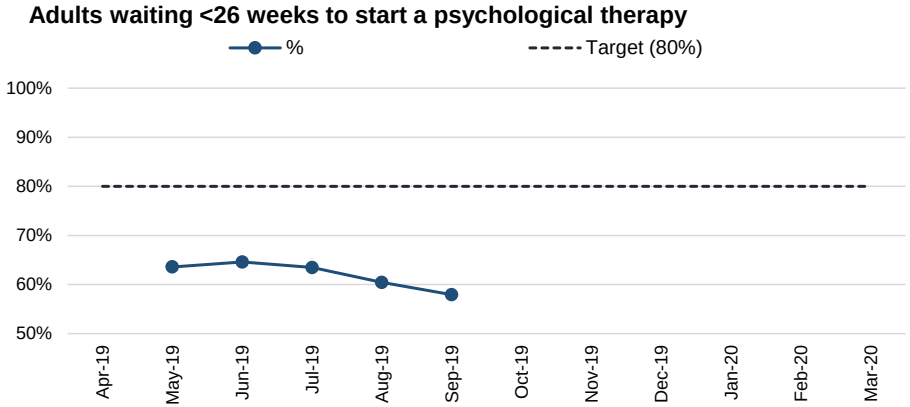
Patients waiting 36 weeks+ from referral to treatment	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. patients	2965	3086	3197	3328	3394	3275	3265	3193	3309	3014	2430	1494	1725	1798	1779	1869	2080	1794	1638	1439	1394	1308	633	0	213	246	122	264	506	452	476					
2019/20 ambition																									0	0	0	0	331	187	75	15	0	0	0	0
Target (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Evidence of non-random variation in recent months?

Need 10+ data points to determine whether or not there is evidence of non-random variation

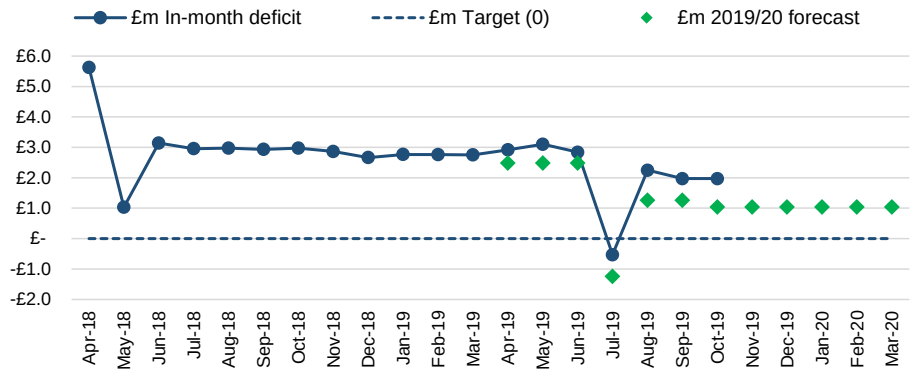
Children/young adults waiting <26 weeks for a neurodevelopment ass.	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%		41%	36%	35%	43%	39%	36%	37%	35%						
2019/20 ambition															
Target (80%)	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



Evidence of non-random variation in recent months?
Need 10+ data points to determine whether or not there is evidence of non-random variation

Adults waiting <26 weeks to start a psychological therapy	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%		63.6%	64.6%	63.5%	60.5%	57.9%						
Target (80%)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

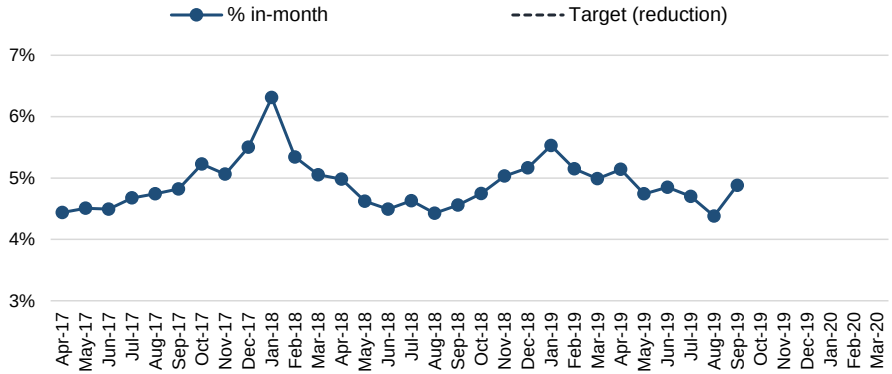
Financial balance



It is not approporiate to use a run chart for this indicator because the process is not consistent (e.g. additional funding in July 2019). Therefore, a trend chart has been provided.

Financial balance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
£m In-month deficit	£ 5.63	£ 1.03	£ 3.14	£ 2.95	£ 2.97	£ 2.93	£ 2.97	£ 2.87	£ 2.66	£ 2.76	£ 2.76	£ 2.75	£ 2.92	£ 3.10	£ 2.85	-£ 0.53	£ 2.25	£ 1.97	£ 1.97					
£m 2019/20 forecast													£ 2.49	£ 2.49	£ 2.49	-£ 1.24	£ 1.26	£ 1.26	£ 1.04	£ 1.04	£ 1.04	£ 1.04	£ 1.04	£ 1.04
£m Target (0)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0

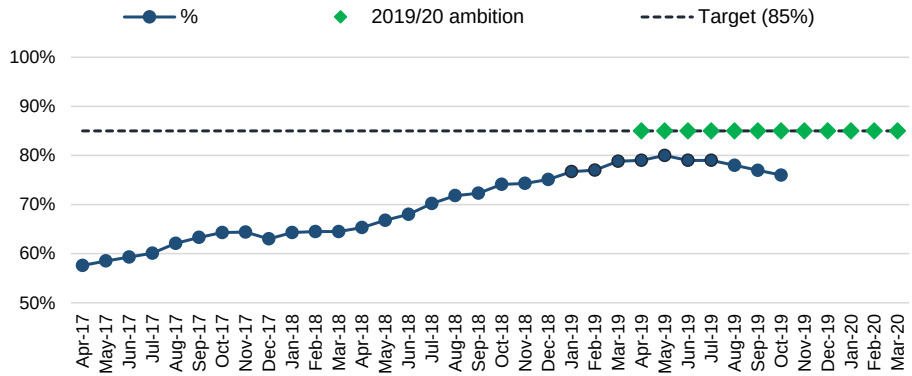
Sickness absence



It is not approporiate to use a run chart for this indicator because the data are following a non-random pattern. Therefore, a trend chart has been provided.

Sickness absence	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% in-month	4.4%	4.5%	4.5%	4.7%	4.7%	4.8%	5.2%	5.1%	5.5%	6.3%	5.3%	5.1%	5.0%	4.6%	4.5%	4.6%	4.4%	4.6%	4.7%	5.0%	5.2%	5.5%	5.1%	5.0%	5.1%	4.7%	4.9%	4.7%	4.4%	4.9%						
2019/20 ambition																																				
Target (reduction)																																				

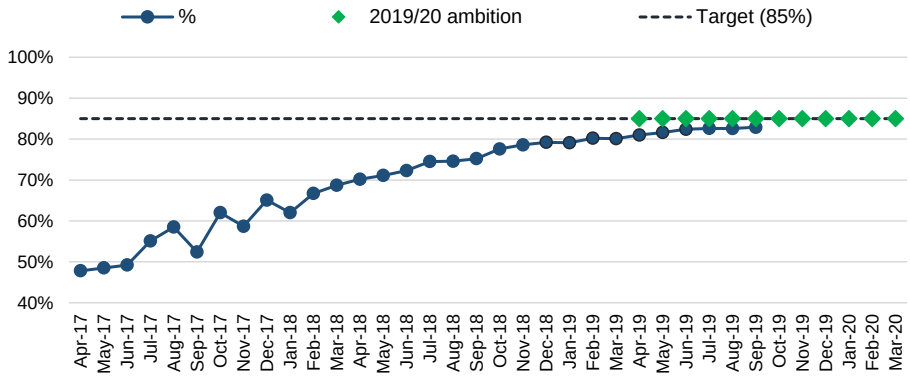
Staff who have had a PADR in the previous 12 months



This indicator is on an improving trajectory. When the target has been met and sustained a median will be added and the rules for non-random variation will be applied.

Staff who have had a PADR in the previous 12 months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%	58%	59%	59%	60%	62%	63%	64%	64%	63%	64%	65%	65%	65%	67%	68%	70%	72%	72%	74%	74%	75%	77%	77%	79%	79%	80%	79%	79%	78%	77%	76%					
Median	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%					
2019/20 ambition																									85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Target (85%)	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

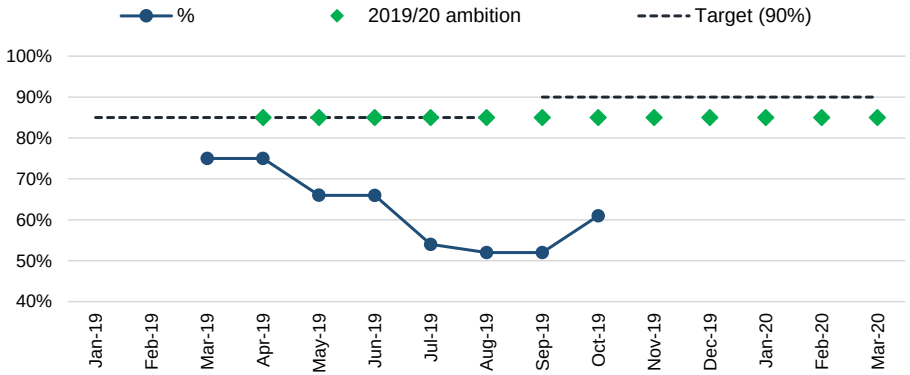
Core Skills Training Framework (CSTF)



This indicator is on an improving trajectory. When the target has been met and sustained a median will be added and the rules for non-random variation will be applied.

Core Skills Training Framework (CSTF)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%		47.8%	48.5%	49.2%	55.1%	58.5%	52.4%	62.0%	58.7%	65.1%	62.0%	66.7%	68.7%	70.2%	71.1%	72.3%	74.5%	74.6%	75.2%	77.6%	78.6%	79.2%	79.1%	80.2%	80.1%	81.0%	81.6%	82.4%	82.6%	82.6%	82.9%					
Median	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%					
2019/20 ambition																									85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Target (85%)	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Consultants/SAS doctors with a current job plan



Evidence of non-random variation in recent months?

Need 10+ data points to determine whether or not there is evidence of non-random variation

Consultants/SAS doctors with a current job plan	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
%			75%	75%	66%	66%	54%	52%	52%	61%					
Median			64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%	64%
2019/20 ambition				85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Target (90%)	85%	85%	85%	85%	85%	85%	85%	85%	90%	90%	90%	90%	90%	90%	90%

* target increased from 85% to 90% from September 2019

Latest Performance against Key Delivery Areas

Target not Delivered
Within 5% of target *
Target Delivered
NA = Not Available

*** For measures where there is a reduction or improvement target, these will be scored red or green, except when Performance remains static. This also applies to measures with a small percentage target (10% and under), e.g. Sickness/absence, smoking cessation. For measures where the target is 0, these will only be scored red or green. Green for 0, red for anything above.**

HDUHB Performance Against Key Delivery Areas

INDICATOR	Target 2019/20	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend	Latest all Wales comparison			
		Q3 2018/19			Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20		Time period	All Wales	Hywel Dda	Rank in Wales
The percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual target (cumulative)	2.50%			3.40%			0.87%							↔	Q1-Q4 19/20	0.95%	0.87%	5th out of 7
The percentage of those smokers who are Carbon Monoxide (CO) validated as quit at 4 weeks	40% annual target	45.60%			49.70%			47.90%							↓	Q1-Q4 19/20	42.90%	47.90%	3rd out of 7
Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	94.1%			92.8%			95.10%							↑	Q4 18/19	95.3%	92.8%	7th out of 7
Percentage of children who received 2 doses of the MMR vaccine by age 5	95%	91.0%			90.6%			92.20%							↑	Q4 18/19	92.4%	90.6%	7th out of 7
Percentage of children who are 10 days old within the reporting period who have accessed the 10-14 days health visitor contact component of the Healthy Child Wales Programme	4 quarter improvement trend	91.1%			93.0%										↑	Q4 18/19	92.3%	93.0%	6th out of 7
European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales	4 quarter reduction trend	NA						406							NA	Q1 19/20	417.2	406.0	2nd out of 7
% uptake of Influenza vaccination - 65 year olds and over	75% - Annual Improvement (as at 13/06/2019)	62.9%													↓	2018/19	68.3%	62.9%	7th out of 7
% uptake of Influenza vaccination - Under 65's in risk groups	55% - Annual Improvement (as at 13/06/2019)	38.1%													↓	2018/19	44.1%	38.1%	7th out of 7
% uptake of Influenza vaccination - Pregnant women (PHW Point of Delivery survey)	75% - Annual Improvement (as at 13/06/2019)	49.0%													↓	2018/19	74.2%	49.0%	7th out of 7
% uptake of Influenza vaccination in pregnant women (locally verified data source)	75% - Annual Improvement	NA													NA	Not Available			
% uptake of Influenza vaccination - Healthcare workers with direct patient contact	60% - Annual Improvement (as at 13/06/2019)	47.9%													↑	2018/19	55.5%	47.8%	9th out of 10
Of those women who had their initial assessment and gave birth within the same health board, the percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks of pregnancy)	Annual improvement	23.3%													↑	2018/19	17.4%	21.7%	3rd out of 7
The percentage of people with learning disabilities who have an annual health check	75% - Annual Improvement	27.4%													NA	Not Available			
Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	12 month improvement trend	100.0%	92.6%	84.6%	96.2%	93.1%	86.4%	92.3%	90.6%	94.1%	91.2%	88.6%	92.6%	97.0%	↑	Aug-19	71.4%	88.6%	2nd out of 6
Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	12 month improvement trend	95.0%	90.6%	94.2%	93.5%	87.9%	88.2%	90.7%	82.0%	89.2%	87.5%	88.1%	84.3%	89.8%	↓	Aug-19	65.0%	88.1%	1st out of 6
Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population	<= 67 cases / 100,000 pop.	95.57	93.17	92.57	89.41	90.44	91.09	72.77	91.8	88.66	100.36	107.94	109.44	106.89	↓	Apr 19 - Sep 19	84.05	109.44	6th out of 6
Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	<= 25 cases / 100,000 pop.	42.23	42.10	39.72	39.11	38.11	37.48	60.11	48.23	43.81	38.90	37.84	38.38	38.14	↑	Apr 19 - Sep 19	26.95	38.38	6th out of 6
Cumulative rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population	<= 20 cases / 100,000 pop.	33.78	33.53	33.16	33.22	33.84	34.09	41.13	35.79	31.29	30.34	29.78	29.56	32.38	↑	Apr 19 - Sep 19	26.19	29.56	5th out of 6
Cumulative number of cases of Pseudomonas aeruginosa bacteraemia	10% reduction on 2017/18 baseline	11.56	11.31	11.74	11.18	10.52	10.41	0	1	5	14	14	19	20	↓	Apr 19 - Sep 19	98.00	19	Joint 4th out of 6
Cumulative number of cases of Klebsiella bacteraemia	10% reduction on 2017/18 baseline	21.78	22.22	22.45	21.11	20.19	19.78	3	10	15	24	32	41	49	↓	Apr 19 - Sep 19	333.00	41	1st out of 6
Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	90%	63.0%	52.0%	52.9%	26.7%	36.0%	31.3%	25.0%	7.1%	50.0%	23.8%	53.8%	30.8%	NA	NA	Sep-19	39.7%	30.8%	6th out of 9
Number of new never events	0	1	0	0	0	0	0	0	0	0	0	0	0	NA	NA	Sep-19	2	0	Joint 1st out of 10
The number of healthcare acquired pressure sores in a hospital setting	Reduction	16	19	28	38	18	23	31	13	19	22	20	45	46	↓	Not Available			
The number of healthcare acquired pressure sores in a Community setting	Reduction	53	45	51	55	52	48	52	57	57	56	56	33	52	↑				
Number of reports made within the timeframe set by RIDDOR	60%	NA	NA	NA	49.0%	55.6%	62.5%	68.4%	65.0%	63.0%	63.3%	62.5%	65.8%	65.0%	NA				
The number of potentially preventable hospital acquired thrombosis	4 quarter reduction trend	8			7										↓	Q4 18/19	15	7	8th out of 8
Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)	A quarterly reduction of 5% against a baseline of April 2017 – March 2018	314.0			312.2			273.8							NA	Q4 18/19	305.6	312.2	5th out of 7
Fluoroquinolones, Cephalosporins, Clindamycin and Co-amoxiclav items per 1,000 patients	A quarterly reduction of 10% against a baseline of April 2017 – March 2018	16.8			15.7			14.3							↑	Q4 18/19	7.6%	8.5%	6th out of 7
Opioid average daily quantities per 1,000 patients	4 quarter reduction trend	5,168.4			4,964.4			4,991.2							↑	Not Available			
Number of patients aged 65 years or over prescribed an antipsychotic	4 quarter reduction trend	Data not available						1.27%							↑				
Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale	0	1			2			2							NA	Q1 19/20	3	2	Joint 5th out of 10
Percentage of compliance for staff appointed to new roles where a child barred list check is required	6 month improvement														NA	Not Available			
Percentage of compliance for staff appointed to new roles where an adult barred list check is required	6 month improvement														NA				
Number of hospital admissions with any mention of intentional self-harm for children and young people (aged 10-24 years) per 1,000 population	Annual reduction														NA	Not Available			
Rate of hospital admissions with any mention of intentional self harm for children and young people (aged 10-24 years) per 1,000 population	Annual reduction														NA				
Amenable mortality per 100,000 of the European standardised population	Annual reduction														NA	2017	131.40	124.10	3rd out of 7

INDICATOR	Target 2019/20	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend	Latest all Wales comparison			
		Q3 2018/19			Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20		Time period	All Wales	Hywel Dda	Rank in Wales
Number of health board mental health delayed transfer of care	12 month reduction trend	12	4	8	5	10	8	7	8	3	2	3	7	6	↑	Aug-19	71	3	Joint 1st out of 7
Number of health board non mental health delayed transfer of care	12 month reduction trend	36	44	40	34	44	31	46	43	58	47	72	54	60	↓	Aug-19	418	72	Joint 6th out of 8
Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	95%	84.1%	90.8%	84.7%	90.1%	86.4%	87.1%	82.7%	83.1%	85.1%	81.9%	87.0%	91.4%	NA	NA	Aug-19	70.3%	87.0%	2nd out of 7
Crude hospital mortality rate (74 years of age or less)	12 month reduction trend	0.72%	0.72%	0.72%	0.71%	0.70%	0.70%	0.70%	0.69%	0.69%	0.69%	0.70%	0.70%	NA	NA	Aug-19	0.72%	0.70%	3rd out of 7
Percentage of episodes clinically coded within one reporting month post episode discharge end date	95%	84.9%	80.4%	84.1%	83.1%	85.6%	80.9%	65.7%	72.6%	74.7%	75.7%	82.0%	NA	NA	NA	Jul-19	85.6%	75.7%	6th out of 8
Percentage compliance of the completed level 1 Information Governance (Wales) training element of the Core Skills and Training Framework	85%	NA	NA	NA	NA	NA	NA	79.0%	NA	79.8%	81.3%	NA	80.6%	80.8%	NA	Jul-19	75.8%	81.3%	Joint 5th out of 10
All new medicines recommended by AWMSG and NICE, including interim recommendations for cancer medicines, must be made available where clinically appropriate, no later than two months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation	100%	99.4%			100.0%			100.0%							↑	Q4 18/19	97.9%	99.4%	Joint 1st out of 7
Number of Health and Care Research Wales clinical research portfolio studies	10% annual improvement (Cumulative - as at 31/04/2019)	58													↓	2018/19	417	58	6th out of 10
Number of Health and Care Research Wales commercially sponsored studies	5% annual improvement (Cumulative - as at 31/04/2019)	5													↓	2018/19	118	5	7th out of 10
Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	10% annual improvement (Cumulative - as at 31/04/2019)	1,085													↓	2018/19	19,918	1,085	7th out of 10
Number of patients recruited in Health and Care Research Wales commercially sponsored studies	5% annual improvement (Cumulative - as at 31/04/2019)	43													↑	2018/19	961	43	5th out of 10
Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Annual improvement	89.7%													↑	2018/19	92.3%	89.7%	7th out of 8
The percentage of patients who had their procedures postponed on more than one occasion for non clinical reasons with less than 8 days notice and are subsequently carried out within 14 calendar days or at the patient's earliest convenience	12 month improvement trend	75.0%	63.0%	25.0%	28.5%	55.0%	24.1%	13.0%	NA	NA	20.0%	36%	0	NA	NA	Mar-18	25.9%	24.1%	4th out of 6
Number of procedures postponed either on the day or the day before for specified non-clinical reasons	A reduction of no less than 5% of the total number of the health board's postponements for the previous financial year	128	115	135	116	129	158	106	148	127	89	100	118	NA	NA	Sep 18 - Aug 19	14,605	1,516	2nd out of 7
% compliance with Hand hygiene (World Health Organisation (WHO) 5 moments)	95%	90.0%	86.0%	85.0%	89.0%	87.0%	91.0%	90.0%	90.0%	90.0%	89.0%	91.0%	92.0%	NA	NA	Not Available			
Percentage of Nutrition Score Completed and Appropriate Action Taken within 24 hours of admission	85%	90.4%	88.3%	88.7%	88.1%	84.8%	89.1%	88.4%	91.3%	92.1%	90%	87%	88%	NA	NA				
The percentage of concerns that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the concern was first received by the organisation.	75%	68.0%	70.0%	75.0%	73.0%	66.0%	66.0%	81.0%	52.0%	75.0%	67.0%	71.0%	83.0%	76.5%	↑	Q1 19/20	68.8%	75.5%	4th out of 10
Percentage of employed NHS staff completing dementia training at an informed level	85% - Annual Improvement	Not Available						83.3%	84.2%	85.1%	86.0%	86.8%	86.9%	86.9%	NA	Oct 18 - Mar 19	0.0%	82.4%	2nd out of 8
Percentage of people in Wales registered at a GP practice (age 65 years or over) who are diagnosed with dementia	Annual improvement	47.90%													↑	2018/19	54.7%	47.9%	6th out of 7
Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that is provided by their GP/family doctor	Annual Improvement	90.4%													↓	2018/19	92.5%	90.4%	7th out of 7
Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital	Annual Improvement	91.9%													↓	2018/19	93.3%	91.9%	6th out of 7
Percentage of GP practice teams that have completed mental health training in dementia care or other training as outlined under the Directed Enhanced Services for mental illness	Annual improvement	NA													↑	2017/18	16.7%	20.8%	2nd out of 7
Percentage of adults (aged 16+) who had a hospital appointment in the last 12 months, who felt they were treated with dignity and respect	Annual improvement	95.3%													NA	2018/19	96.3%	95.3%	6th out of 7
The average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	Annual Improvement	6.25													↑	2018/19	6.31	6.25	4th out of 7
The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	66.1%	65.4%	60.4%	62.5%	64.5%	62.9%	67.9%	59.9%	67.8%	63.9%	65.5%	68.5%	61.9%	↑	Sep-19	68.4%	68.5%	3rd out of 7
The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes - Carmarthenshire	65%	66.7%	71.1%	56.3%	61.2%	69.8%	64.0%	71.1%	61.1%	69.9%	66.2%	66.1%	67.9%	59.9%	↑	As Above			
The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes - Ceredigion	65%	67.6%	62.5%	64.3%	67.4%	59.5%	65.9%	69.7%	60.5%	65.0%	51.2%	63.2%	58.0%	64.7%	↓				
The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes - Pembrokeshire	65%	64.6%	55.4%	64.8%	61.8%	57.4%	59.7%	61.8%	58.1%	65.2%	67.4%	66.0%	75.3%	63.8%	↑				
% of Amber Calls responded to within 20 minutes	NA	47.6%	51.2%	54.2%	53.5%	52.6%	52.6%	48.2%	54.7%	42.5%	54.7%	46.7%	42.9%	45.3%	NA				
Number of ambulance handovers over one hour	0	185	171	226	376	294	407	417	204	284	251	313	406	465	↓	Sep-19	3741	406	3rd out of 6
Number of ambulance handovers over one hour - Bronglais GH	0	65	12	24	60	87	49	97	52	54	31	84	116	70	↓	As Above			
Number of ambulance handovers over one hour - Glangwili GH	0	49	59	67	122	76	152	190	56	135	156	99	182	236	↓				
Number of ambulance handovers over one hour - Prince Philip H	0	6	0	9	19	9	10	10	1	5	4	5	16	35	↓				
Number of ambulance handovers over one hour - Withybush GH	0	65	100	126	175	122	196	120	95	90	57	125	92	124	↑				

INDICATOR	Target 2019/20	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend	Latest all Wales comparison			
		Q3 2018/19			Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20		Time period	All Wales	Hywel Dda	Rank in Wales
The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95%	84.0%	85.6%	84.6%	81.9%	84.4%	81.7%	81.1%	82.8%	83.5%	82.1%	82.2%	80.3%	81.1%	↓	Sep-19	75.0%	80.3%	2nd out of 6
The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge - Bronglais GH	95%	84.5%	90.4%	86.6%	82.2%	82.9%	86.4%	81.5%	84.7%	84.6%	86.7%	85.9%	81.9%	82.3%	↓	As Above			
The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge - Glangwili GH	95%	81.1%	81.6%	79.9%	78.7%	81.7%	77.8%	76.4%	77.2%	79.7%	75.3%	75.8%	70.5%	73.2%	↓				
The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge - Prince Philip GH	95%	91.3%	94.2%	94.4%	91.7%	94.0%	92.5%	92.3%	91.9%	93.4%	91.4%	94.2%	92.6%	91.9%	↓				
The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge - Withybush GH	95%	77.6%	77.0%	79.4%	74.9%	78.6%	71.0%	74.7%	77.1%	76.0%	75.0%	73.6%	76.3%	77.1%	↓				
The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	737	675	690	943	732	948	959	920	816	732	793	910	882	↓	Sep-19	5,708	910	3rd out of 6
The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge - Bronglais GH	0	108	42	52	104	105	95	138	99	80	37	69	135	117	↓	As Above			
The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge - Glangwili GH	0	308	295	301	390	260	379	370	364	316	345	273	354	342	↓				
The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge - Prince Philip H	0	5	3	9	21	13	17	12	16	21	16	8	8	27	↓				
The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge - Withybush GH	0	316	335	328	428	354	457	439	441	399	334	443	400	396	↓				
% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time - HDUHB	55.5% Jan 19-Mar 19 (SSNAP UK National quarterly average)	79.1%	61.5%	59.5%	64.6%	81.6%	68.5%	67.8%	58.1%	61.7%	78.9%	63.0%	39.0%	51.2%	↓	Aug-19	48.3%	63.0%	1st out of 6
% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time - Bronglais GH	55.5% Jan 19-Mar 19 (SSNAP UK National quarterly average)	88.9%	80.0%	80.0%	61.5%	100.0%	100.0%	66.7%	92.3%	75.0%	91.7%	91.7%	62.5%	66.7%	↓	As Above			
% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time - Glangwili GH	55.5% Jan 19-Mar 19 (SSNAP UK National quarterly average)	87.5%	30.8%	25.0%	88.9%	76.9%	60.0%	59.3%	52.9%	52.9%	71.4%	76.5%	40.0%	30.8%	↓				
% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time - Prince Philip H	55.5% Jan 19-Mar 19 (SSNAP UK National quarterly average)	72.7%	100.0%	87.5%	58.3%	100.0%	70.6%	100.0%	72.7%	69.2%	72.7%	88.9%	57.1%	42.9%	↓				
% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time - Withybush GH	55.5% Jan 19-Mar 19 (SSNAP UK National quarterly average)	77.8%	71.4%	60.0%	53.8%	66.7%	66.7%	54.5%	37.5%	55.6%	100.0%	12.5%	18.8%	66.7%	↓				
% assessed by Stroke Consultant <24 hours of the patient's clock start time - HDUHB	84% Jan 19-Mar 19 (SSNAP UK National quarterly average)	94.5%	92.5%	87.5%	88.7%	90.4%	98.5%	100.0%	95.9%	88.9%	90.4%	92.9%	96.1%	100.0%	↑	Aug-19	84.6%	92.9%	3rd out of 6
% assessed by Stroke Consultant <24 hours of the patient's clock start time - Bronglais GH	84% Jan 19-Mar 19 (SSNAP UK National quarterly average)	100.0%	90.0%	72.7%	84.6%	75.0%	100.0%	100.0%	94.1%	90.0%	76.9%	84.6%	90.0%	100.0%	↑	As Above			
% assessed by Stroke Consultant <24 hours of the patient's clock start time - Glangwili GH	84% Jan 19-Mar 19 (SSNAP UK National quarterly average)	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	70.6%	100.0%	90.5%	100.0%	100.0%	↓				
% assessed by Stroke Consultant <24 hours of the patient's clock start time - Prince Philip H	84% Jan 19-Mar 19 (SSNAP UK National quarterly average)	82.4%	60.0%	71.4%	75.0%	75.0%	95.0%	100.0%	92.9%	94.7%	87.5%	90.9%	100.0%	100.0%	↑				
% assessed by Stroke Consultant <24 hours of the patient's clock start time - Withybush GH	84% Jan 19-Mar 19 (SSNAP UK National quarterly average)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	95.0%	100.0%	↓				
% of stroke patients receiving the required minutes for speech and language therapy - HDUHB	12 month improvement trend	39.0%	38.4%	43.5%	33.4%	31.8%	36.2%	38.3%	43.1%	40.0%	40.6%	43.3%	38.9%	33.3%	↑	Aug-19	48.7%	44.6%	5th out of 6
% of stroke patients receiving the required minutes for speech and language therapy - Bronglais GH	12 month improvement trend	61.4%	39.6%	46.0%	27.9%	32.5%	37.5%	59.6%	51.7%	54.4%	54.7%	52.4%	40.7%	37.8%	↑	As Above			
% of stroke patients receiving the required minutes for speech and language therapy - Glangwili GH	12 month improvement trend	36.6%	34.4%	39.5%	30.5%	35.2%	48.4%	51.3%	46.4%	38.7%	37.8%	38.6%	71.1%	51.5%	↑				
% of stroke patients receiving the required minutes for speech and language therapy - Prince Philip H	12 month improvement trend	31.5%	41.2%	56.4%	56.3%	32.6%	20.8%	13.1%	20.1%	28.5%	24.4%	41.8%	20.4%	31.6%	↓				
% of stroke patients receiving the required minutes for speech and language therapy - Withybush GH	12 month improvement trend	31.5%	30.6%	34.7%	37.4%	39.0%	40.3%	44.1%	40.5%	53.2%	38.6%	39.8%	13.9%	25.4%	↓				
The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to & including) 62 days of receipt of referral	95%	93.5%	85.5%	88.3%	78.8%	80.7%	84.2%	87.5%	80.0%	83.9%	74.0%	75.7%	73.9%	NA	NA	Aug-19	81.7%	75.7%	6th out of 6
The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days of diagnosis (regardless of referral route)	98%	99.1%	95.5%	95.9%	98.7%	100.0%	95.8%	94.5%	96.8%	98.3%	97.6%	96.4%	97.0%	NA	NA	Aug-19	96.6%	96.4%	4th out of 6
% of patients starting first definitive cancer treatment within 62 days from point of suspicion	12 month improvement trend	Not available					79.4%	84.3%	79.5%	84.7%	76.7%	76.7%	NA	NA	NA	Aug-19	75.5%	76.7%	2nd out of 6
% of Out of Hours (OoH)/111 patients prioritised as P1CH that started their definitive clinical assessment within 1 hour of their initial call being answered	90%	Not available													NA	Not Available			
% of Out of Hours (OOH)/111 patients prioritised as P1F2F requiring a Primary Care Centre (PCC) based appointment seen within 1 hour following completion of their definitive clinical assessment	90%														NA				
For health boards with 111 services, the percentage of P1 calls that were logged and patients started their definitive assessment within 20 minutes of the initial calls being answered (Carmarthen)	12 month improvement trend	NA	71.8%	70.8%	73.8%	65.4%	62.6%	65.0%	74.4%	68.7%	66.8%	67.9%	65.5%	NA	NA	Mar-19	NA	62.6%	1st out of 1
For health boards with 111 services, the percentage of patients prioritised as P1 and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage (Carmarthen)	12 month improvement trend	Not available	40.0%	0.0%	100.0%	0.0%	50.0%	40.0%	33.0%	100.0%	100.0%	0.0%	0.0%	NA	NA	Mar-19	NA	50.0%	1st out of 1
The percentage of patients waiting less than 26 weeks for treatment	95%	86.1%	87.3%	87.4%	89.5%	90.4%	90.6%	89.4%	89.0%	89.8%	89.3%	87.8%	86.5%	87.5%	↓	Aug-19	85.7%	87.8%	3rd out of 7
The number of patients waiting more than 36 weeks for treatment	0	1,638	1,439	1,394	1,308	633	0	213	246	122	264	506	452	476	↑	Aug-19	19,100	506	2nd out of 7

INDICATOR	Target 2019/20	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend	Latest all Wales comparison			
		Q3 2018/19			Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20		Time period	All Wales	Hywel Dda	Rank in Wales
The number of patients waiting more than 8 weeks for a specified diagnostic	0	27	35	82	30	1	0	56	185	115	192	345	391	164	↓	Aug-19	5,091	345	5th out of 7
The number of patients waiting 8 weeks and over for a specified diagnostic - Cardiology	0	27	17	43	20	1	0	4	74	71	34	NA	NA	NA	NA	Not Available			
The number of patients waiting 8 weeks and over for a specified diagnostic - Endoscopy	0	0	18	37	10	0	0	9	24	0	0	NA	NA	NA	NA				
The number of patients waiting 8 weeks and over for a specified diagnostic - Imaging	0	0	0	0	0	0	0	0	0	0	0	NA	NA	NA	NA				
The number of patients waiting 8 weeks and over for a specified diagnostic - Neurophysiology	0	0	0	0	0	0	0	0	0	0	0	NA	NA	NA	NA				
The number of patients waiting 8 weeks and over for a specified diagnostic - Physiological Measurement	0	0	0	0	0	0	0	0	0	0	0	NA	NA	NA	NA				
The number of patients waiting 8 weeks and over for a specified diagnostic - Radiology – consultant referral	0	0	0	1	0	0	0	26	35	28	85	NA	NA	NA	NA				
The number of patients waiting 8 weeks and over for a specified diagnostic - Radiology GP Referral	0	0	0	1	0	0	0	17	52	15	73	NA	NA	NA	NA				
The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (2017/18)	15% reduction against baseline of March 2019 by March 2020	34,410	34,400	34,227	33,613	34,140	34,324	37,403	39,425	40,627	41,742	43,405	43,853	34,989	↓				
The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care sub specialties	12 month reduction trend	16,887	16,956	16,680	16,409	16,540	16,629	18,199	19,551	20,189	20,492	21,736	21,235	16,515	↓	Apr-19	NA	18,199	3rd out of 5
The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care sub specialties - Trauma and Orthopaedics	12 month reduction trend	2,350	2,385	2,395	2,327	2,378	2,440	NA	NA	NA	NA	NA	NA	NA	NA	No available			
The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care sub specialties - Ear, Nose and Throat	12 month reduction trend	408	333	319	324	354	372	NA	NA	NA	NA	NA	NA	NA	NA				
The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care sub specialties - Urology	12 month reduction trend	4,348	4,264	4,358	4,396	4,347	4,429	NA	NA	NA	NA	NA	NA	NA	NA				
The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care sub specialties - Dermatology	12 month reduction trend	2,188	2,263	2,321	2,384	2,386	2,319	NA	NA	NA	NA	NA	NA	NA	NA				
The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care sub specialties - Ophthalmology	12 month reduction trend	7,593	7,711	7,287	6,978	7,075	7,069	NA	NA	NA	NA	NA	NA	NA	NA				
Percentage of survival within 30 days of emergency admission for a hip fracture	12 month improvement trend	81.8%	86.1%	80.0%	89.7%	73.9%	65.2%	73.9%	79.5%	NA	76.9%	NA	NA	NA	NA	Jul-19	77.0%	76.9%	4th out of 6
The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	96.6%	93.0%	93.5%	92.5%	96.5%	91.9%	93.4%	87.3%	94.3%	85.8%	82.3%	91.3%	NA	↓	Aug-19	73.7%	82.3%	3rd out of 7
The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Services (LPMHSS)	80%	92.5%	95.6%	93.8%	87.2%	85.5%	81.5%	89.9%	86.3%	88.0%	90.6%	87.0%	83.6%	NA	↓	Aug-19	73.9%	87.0%	3rd out of 7
% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	NA	NA	NA	NA	NA	NA	NA	63.6%	64.6%	63%	60.5%	57.9%	NA	NA	Aug-19	70.2%	60.5%	6th out of 7
% of children and young people waiting less than 26 weeks to start a neurodevelopment assessment	80%	NA	NA	NA	NA	40.8%	35.83%	35.26%	43.20%	39.10%	35.90%	36.54%	34.64%	NA	NA	Aug-19	46.4%	36.5%	7th out of 7
Perinatal - Longest Waiting times for First Assessment Appointment	NA	NA	NA	NA	NA	NA	NA	51	50	51	NA	NA	NA	NA	NA	Not available			
RTT - Hywel Dda residents waiting over 36 weeks for treatment by other providers	0	274	250	230	225	231	198	231	261	268	320	506	348	353	↓	Not available			
Number of patients waiting more than 14 weeks for specific therapy	0	332	265	287	177	51	0	41	138	262	297	424	426	277	↓	Aug-19	460	424	7th out of 7
Number of patients waiting 14 weeks plus for Art Therapy	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	NA	Not available			
Number of patients waiting 14 weeks plus for Audiology	0	91	109	107	58	10	0	0	0	0	0	0	1	0	↑				
Number of patients waiting 14 weeks plus for Dietetics	0	41	38	69	71	11	0	3	1	0	0	0	2	3	↑				
Number of patients waiting 14 weeks plus for Occupational Therapy (excludes MHLD)	0	86	74	53	18	7	0	5	29	2	0	0	2	13	↑				
Number of patients waiting 14 weeks plus for Physiotherapy	0	1	0	3	1	4	0	29	108	258	297	424	420	261	↓				
Number of patients waiting 14 weeks plus for Podiatry	0	113	44	51	29	19	0	4	0	0	0	0	0	0	↑				
Number of patients waiting 14 weeks plus for Speech and Language Therapy	0	0	0	4	0	0	0	0	0	0	0	0	0	0	↑				
Number of patients waiting 6 weeks plus for Clinical Musculoskeletal Assessment and Treatment	0	1	1	0	0	0	0	0	0	0	0	0	0	0	↑				
Number of patients waiting 14 weeks plus for Lymphoedema	0	3	1	2	0	0	0	0	0	0	0	0	0	0	↑				
Number of patients waiting 14 weeks plus for Pulmonary Rehab	0	176	187	182	170	192	183	166	174	183	149	164	129	193	↑				
% of ophthalmology R1 patients to be seen by their clinical target date or within 25% in excess of their clinical target date for their care or treatments	95%	Not available					NA	67.5%	65%	63%	62.0%	58.3%	58.1%	NA	NA	Aug-19	63.0%	58.3%	7th out of 7

INDICATOR	Target 2019/20	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend	Latest all Wales comparison			
		Q3 2018/19			Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20		Time period	All Wales	Hywel Dda	Rank in Wales
The number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	15% reduction against baseline of March 2019 by March 2020	Not available											NA	NA	NA	Not Available			
Individual Patient Funding Request (IPFR) - Total number received	N/A	10			13			8			10				NA				
Individual Patient Funding Request (IPFR) - Total number approved	N/A	7			<5			6			9				NA				
Individual Patient Funding Request (IPFR) - Total number declined	N/A	<5			<5			<5			<5				NA				
Number of CHC packages delivered	N/A	487			458			459			479				NA	Not Available			
Total Health board CHC spend	N/A	£20.9m			£21.5m			£20.03m			£20.35m				NA				
Access Times for Re-Accessing Audiology Services - Total number of patients waiting 14 weeks and over	0	2,828			2,710			3,314			3,103				↓				
Access Times for Re-Accessing Audiology Services - Longest wait in weeks	14 weeks	98 weeks			98 weeks			98 weeks			101 weeks				↓				
Percentage of qualifying patients (compulsory & informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA	100%	99.3%			100.0%			100.0%							↓	Q1 19/20	100.0%	100.0%	Joint 1st out of 7
Percentage of the health board population regularly accessing NHS primary dental care	4 quarter improvement trend	45.5%			45.8%			45.8%			45.9%				↑	Mar-19	55.0%	45.6%	7th out of 7
% of stroke patients who receive a 6 month follow up assessment	Quarterly improvement trend	Data not available until Q1 19/20													NA	Not Available			
Percentage of GP practices offering daily appointments between 17:00 and 18:30 hours	Annual improvement	90.0%													↑	2018	86.2%	90.2%	4th out of 7
% of practices with one half day closure per week	6% - Annual														↑	Not available			
% of practices with extended opening hours and offering appointments after 18:30 at least one week day	7% - Annual														↑				
Percentage of people (aged 16+) who found it difficult to make a convenient GP appointment	Annual reduction	36.1%													NA	2018/19	39.9%	36.1%	1st out of 7
The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	90%	91.1%	92.1%	92.5%	91.3%	91.6%	91.1%	90.9%	91.0%	91.6%	92.0%	94.5%	92.7%	NA	NA	Aug-19	88.7%	94.5%	2nd out of 7
All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place (Mental Health Wales Measures 2010 Data Collection - Part 3)	100%	100.0%	100.0%	No Patients	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	Aug-19	98.0%	100.0%	Joint 1st out of 6
Percentage of qualifying compulsory/voluntary patients have been offered advocacy services in the Mental Health Services	100%	97.6%	95.7%	94.4%	97.7%	98.5%	100.0%	97.2%	94.0%	100.0%	100.0%	100.0%	100.0%	NA	NA				
95% of service users admitted to a psychiatric hospital between 0900 and 2100 will have received a gate-keeping assessment by the Crisis Resolution Home Treatment (CRHT) service prior to admission	95%	96.7%	100.0%	100.0%	100.0%	100.0%	98.0%	98.0%	97.6%	100.0%	100.0%	100.0%	100.0%	NA	NA				
100% of service users admitted to a psychiatric hospital, who have not received a gate keeping assessment by the Crisis Resolution Home Treatment (CRHT), will receive a follow-up assessment by the CRHTS within 24 hours of admission	100%	50.0%	No Patients	No Patients	No Patients	No Patients	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	N/A	NA	NA				
To maintain a maximum waiting time for first appointment with specified therapies of 14 weeks	0%	2	0	4	0	0	0	0	0	0	0	0	1	NA	NA				
To maintain a maximum waiting time for first outpatient appointments of 10 weeks	0%	7	4	5	5	4	4	13	4	9	11	10	11	NA	NA				
Increase the number of clients who engage with services between assessment and planned ending of treatment, by reducing the incidences of clients who do not attend (DNA) or respond to follow up contact post assessment date - Carmarthenshire	Welsh Government Baseline 20% Decrease in DNAs [Rating; Red >=30%, Amber 20.1 - 29.9% and Green <=20%]	5.66%	5.33%	3.51%	6.17%	3.80%	3.70%	4.26%	2.08%	1.9%	2.9%	3.3%	NA	NA	NA	Not Available			
Increase the number of clients who engage with services between assessment and planned ending of treatment, by reducing the incidences of clients who do not attend (DNA) or respond to follow up contact post assessment date - Ceredigion	Welsh Government Baseline 20% Decrease in DNAs [Rating; Red >=30%, Amber 20.1 - 29.9% and Green <=20%]	11.59%	13.33%	3.45%	6.67%	3.85%	3.85%	6.38%	3.28%	0.0%	9.1%	7.7%	NA	NA	↑				
Increase the number of clients who engage with services between assessment and planned ending of treatment, by reducing the incidences of clients who do not attend (DNA) or respond to follow up contact post assessment date - Pembrokeshire	Welsh Government Baseline 20% Decrease in DNAs [Rating; Red >=30%, Amber 20.1 - 29.9% and Green <=20%]	10.61%	5.77%	2.27%	3.28%	5.56%	1.16%	6.56%	5.97%	4.6%	7.5%	9.8%	NA	NA	↑				
Achieve a waiting time of less than 20 working days between referral and treatment - Carmarthenshire	Welsh Government baseline 80% [Rating; Red <=70%, Amber 70.1 - 79.9% and Green >=80%]	94.74%	91.89%	96.61%	88.89%	92.31%	94.25%	88.30%	84.51%	85.4%	90.2%	92.4%	NA	NA	NA				
Achieve a waiting time of less than 20 working days between referral and treatment - Pembrokeshire	Welsh Government baseline 80% [Rating; Red <=70%, Amber 70.1 - 79.9% and Green >=80%]	96.72%	96.77%	97.14%	89.47%	90.32%	95.00%	92.06%	92.06%	94.0%	90.3%	96.2%	NA	NA	↓				
Achieve a waiting time of less than 20 working days between referral and treatment - Ceredigion	Welsh Government baseline 80% [Rating; Red <=70%, Amber 70.1 - 79.9% and Green >=80%]	94.44%	93.88%	100.00%	89.80%	92.68%	98.33%	96.23%	97.73%	93.5%	96.9%	88.9%	NA	NA	↓				
Substance misuse is reduced for problematic substance between start and most recent review/exit - Carmarthenshire	Welsh Government Baseline 76.94% [Rating; Red <=Baseline, and Green >=Baseline] Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	88.60%	88.37%	83.17%	88.77%	89.50%	90.29%	83.26%	90.54%	89.0%	88.2%	80.9%	NA	NA	NA				
Substance misuse is reduced for problematic substance between start and most recent review/exit - Ceredigion	Welsh Government Baseline 76.94% [Rating; Red <=Baseline, and Green >=Baseline] Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	84.68%	93.75%	89.74%	87.79%	90.12%	83.65%	82.28%	86.51%	89.6%	89.6%	86.0%	NA	NA	↑				
Substance misuse is reduced for problematic substance between start and most recent review/exit - Pembrokeshire	Welsh Government Baseline 76.94% [Rating; Red <=Baseline, and Green >=Baseline] Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	88.42%	88.51%	87.82%	88.10%	87.67%	92.90%	91.92%	90.91%	88.2%	88.2%	85.7%	NA	NA	↓				
Quality of life is improved between start and most recent review/ exit Treatment Outcome Profile (TOP) - Carmarthenshire	Welsh Government Baseline 63.74%, Increase [Rating; Red <=Baseline, and Green >=Baseline]. Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	82.80%	80.91%	88.68%	95.60%	82.19%	92.59%	82.86%	85.54%	87.6%	76.9%	71.4%	NA	NA	NA				

INDICATOR	Target 2019/20	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend	Latest all Wales comparison			
		Q3 2018/19			Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20		Time period	All Wales	Hywel Dda	Rank in Wales
Quality of life is improved between start and most recent review/ exit Treatment Outcome Profile (TOP) - Ceredigion	Welsh Government Baseline 63.74%, Increase [Rating; Red <=Baseline, and Green >=Baseline]. Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	74.51%	83.33%	100.00%	74.63%	84.09%	82.35%	88.37%	92.31%	75.9%	75.0%	83.7%	NA	NA	↑				
Quality of life is improved between start and most recent review/ exit Treatment Outcome Profile (TOP) - Pembrokeshire	Welsh Government Baseline 63.74%, Increase [Rating; Red <=Baseline, and Green >=Baseline]. Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	80.23%	80.00%	72.86%	87.23%	89.55%	87.01%	85.39%	82.98%	94.4%	79.4%	76.2%	NA	NA	↑				
Number/percentage of cases closed (with a treatment date) as treatment completed - Carmarthenshire	Welsh Government Baseline 75.09%, Increase, [Rating; Red <=Baseline, and Green >=Baseline], Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	87.78%	93.75%	95.65%	94.03%	98.46%	94.29%	93.83%	96.34%	97.7%	95.4%	96.3%	NA	NA	NA				
Number/percentage of cases closed (with a treatment date) as treatment completed - Ceredigion	Welsh Government Baseline 75.09%, Increase, [Rating; Red <=Baseline, and Green >=Baseline], Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	87.50%	80.49%	95.45%	93.02%	97.83%	95.74%	87.50%	96.15%	95.5%	91.2%	94.1%	NA	NA	↑				
Number/percentage of cases closed (with a treatment date) as treatment completed - Pembrokeshire	Welsh Government Baseline 75.09%, Increase, [Rating; Red <=Baseline, and Green >=Baseline], Achievement to show continual improvement against own baseline & adherence to the Welsh benchmark figure.	86.89%	92.00%	97.56%	95.00%	90.63%	98.18%	87.72%	89.23%	92.5%	92.2%	82.9%	NA	NA	↓				
Number of calls to the mental health helpline CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population	4 quarter improvement trend	158.0			133.0			134.6							↓	Q1 19/20	183.5	134.6	5th out of 7
Number of calls to the Wales dementia helpline by Welsh residents per 100,000 of the population (age 40+)	4 quarter improvement trend	10.1			13.7			3.6							↓	Q1 19/20	5.2	3.6	5th out of 7
Number of calls to the DAN 24/7 helpline (drugs and alcohol) by Welsh residents per 100,000 of the population	4 quarter improvement trend	20.6			25.8			34.0							↑	Q1 19/20	41.7	34.0	7th out of 7
Financial balance: Expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years (as agreed by the Planned Care Board; cumulative year to date)	Agreed balance	£21.634m deficit	£24.499m deficit	£27.161m deficit	£29.925m deficit	£32.687m deficit	£35.438m deficit	£2.917m deficit	£6.018m deficit	£8.864m deficit	£8.338m deficit	£10.587m deficit	£12.560m deficit	£14.533m deficit	↓				
Financial balance: Stay Within Capital Resource Limit (cumulative year to date position)	<=0	0	0	0	0	0	0	0	0	0	0	0	0	0	↔				
Cash Expenditure is less than the Cash Limit	Year end forecast	£38.442m shortfall	£42.592m shortfall	£42.092m shortfall	£29.899m shortfall	£1.074m surplus	£1.460m surplus	Not reported in M1	£25.000m shortfall	£25.000m shortfall	£15.000m shortfall	£15.000m shortfall	£15.000m shortfall	£30.368m shortfall	↓	Not Available			
The Savings Plan is on target (cumulative year to date position)	100%	90.10%	85.70%	82.25%	81.64%	80.55%	80.95%	100.00%	96.20%	93.18%	84.98%	90.01%	98.91%	91.82%	↓				
Variable pay (Agency, Locum, Bank & Overtime; monthly position)	Reduction on 2016/17	£3.904m	£4.344m	£4.218m	£4.218m	£3.949m	£3.950m	£4.878m	£4.220m	£4.860m	£4.388m	£4.431m	£4.431m	£4.497m	↑				
Percentage of sickness absence rate of staff	12 month reduction trend	4.98%	4.98%	4.94%	4.88%	4.87%	4.86%	4.87%	4.88%	4.92%	4.92%	4.90%	4.95%	NA	↑	Jul-19	5.42%	4.93%	4th out of 10
Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	85%	74.1%	74.3%	75.1%	76.7%	77.0%	78.8%	79.0%	80.0%	79.0%	79.0%	78.0%	77.0%	76.0%	↑	Jul-19	70.0%	79.7%	1st out of 10
The percentage of completed Planned Preventative Maintenance (PPM) - high risk	95%	90.0%	92.0%	88.0%	90.0%	82.0%	88.0%	88.0%	85.0%	88.0%	86.0%	86.0%	NA	NA	NA				
The percentage of completed Planned Preventative Maintenance (PPM) - general	70%	63.0%	66.0%	51.0%	56.0%	49.0%	59.0%	53.0%	59.0%	54.0%	53.0%	54.0%	NA	NA	NA				
Catering Patient Satisfaction - % of audits to achieve good/very good/excellent scores	95%	100.0%	98.0%	90.0%	100.0%	97.0%	99.0%	99.0%	99.0%	96.0%	98.0%	97.0%	96.0%	NA	NA				
Number of overdue fire risk assessments by Hywel Dda University Health Board (HB)	0%	122	98	111	113	110	83	40	31	38	26	29	37	36	↑				
Facilities Standards of Cleanliness (C4C) - % (VHR) Very High Risk Audits - Soft FM	98%	95.60%	95.70%	95.30%	95.9%	96.0%	94.8%	94.9%	94.9%	94.9%	94.7%	95.1%	95.6%	94.9%	↓				
Facilities Standards of Cleanliness (C4C) - % (VHR) Very High Risk Audits - Hard FM	98%	71.37%	71.90%	72.80%	68.2%	68.8%	68.6%	64.9%	64.6%	64.9%	68.3%	65.4%	67.1%	66.5%	↓				
Facilities Standards of Cleanliness (C4C) - % (HR) High Risk Audits - Soft FM	95%	93.67%	92.80%	92.40%	92.5%	92.5%	93.9%	92.7%	93.0%	93.1%	92.4%	91.6%	92.4%	91.4%	↓				
Facilities Standards of Cleanliness (C4C) - % (HR) High Risk Audits - Hard FM	95%	61.57%	57.50%	59.20%	62.5%	62.5%	61.4%	62.3%	60.7%	59.2%	60.3%	60.9%	58.5%	60.2%	↓				
Clinical Engineering - Acute % completed HIGH Planned Preventative Maintenance (PPM)	100% [Rating; Red =<90%, Amber <100% & >90% and Green =100%]	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	NA	100.0%	NA	100.0%	100.0%	100.0%	100.0%	NA	Not Available			
Clinical Engineering - Acute % completed MEDIUM Planned Preventative Maintenance (PPM)	75% [Rating; Red =<50%, Amber <75% & >50% and Green >=75%]	83.1%	76.9%	55.0%	69.4%	62.6%	62.0%	62.0%	56.0%	53.0%	44.0%	42.0%	52.0%	44.0%	↓				
Clinical Engineering - Acute % completed LOW Planned Preventative Maintenance (PPM)	40% [Rating; Red =<20%, Amber <40% & >20% and Green >=40%]	94.1%	79.1%	63.0%	66.0%	37.5%	74.0%	65.0%	43.0%	51.0%	47.0%	45.0%	56.0%	28.0%	↓				
Clinical Engineering - Community % completed HIGH Planned Preventative Maintenance (PPM)	100% [Rating; Red =<90%, Amber <100% & >90% and Green =100%]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	NA	100.0%	0.0%	NA	NA	NA				
Clinical Engineering - Community % completed MEDIUM Planned Preventative Maintenance (PPM)	75% [Rating; Red =<50%, Amber <75% & >50% and Green >=75%]	75.0%	81.7%	67.0%	89.0%	56.0%	86.0%	65.0%	42.0%	38.0%	51.0%	34.0%	28.0%	20.0%	↓				
Clinical Engineering - Community % completed LOW Planned Preventative Maintenance (PPM)	40% [Rating; Red =<20%, Amber <40% & >20% and Green >=40%]	78.8%	88.4%	92.0%	75.1%	75.0%	26.0%	47.0%	34.0%	27.0%	79.0%	77.0%	81.0%	33.0%	↓				
Consultants/SAS Doctors with a job plan	90%	76.0%	77.0%	69.0%	70.0%	79.0%	92.0%	92.0%	94.0%	94.0%	90.0%	86.0%	86.0%	89.0%	↑				
Consultants/SAS Doctors with an up to date job plan (reviewed with the last 12 months)	90%	NA	NA	NA	NA	NA	75.0%	75.0%	66.0%	66.0%	54.0%	52.0%	52.0%	61.0%	NA				
Number of National Intelligent Integrated Audit Solution (NIIAS) notifications for Own Record	8	14	11	12	7	11	12	9	14	11	6	8	6	10	↑				
Number of National Intelligent Integrated Audit Solution (NIIAS) notifications for Family Record	13	22	17	15	15	13	11	9	8	8	9	4	7	12	↑				
% of Server infrastructure patched with the latest updates	90%	17%	18%	18%	19%	24%	43%	52%	78%	81%	83%	81%	72%	63%	↑	Not Available			
% of Desktop infrastructure patch with the latest updates	90%	26%	90%	91%	75%	81%	35%	73%	98%	85%	89%	93%	92%	91%	↑				
Non NHS Invoices by Number are Paid within 30 Days (cumulative year to date position)	95%	97.0%			96.1%			95.4%			95.4%			NA	↓	Not Available			

INDICATOR	Target 2019/20	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend	Latest all Wales comparison			
		Q3 2018/19			Q4 2018/19			Q1 2019/20			Q2 2019/20			Q3 2019/20		Time period	All Wales	Hywel Dda	Rank in Wales
Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product including biosimilar (for a selected basket of biosimilar medicines)	Quarter on quarter improvement target	73.5%			70.0%			77.0%							↑	Q4 18/19	63.1%	68.7%	2nd out of 6
% of critical care bed days lost to delayed transfer of care (ICNARC definition)	Quarter on quarter improvement towards the target of no more than 5%	Not Available			22.3%										NA	Q1 19/20	22.5%	22.3%	4th out of 6
% of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	4 quarter reduction trend	Not Available						35.3%			34.7%				NA	Q2 19/20	32.8%	34.7%	4th out of 7
Percentage compliance for all completed Level 1 competencies within the Core Skills and Training Framework by organisation	85%	75.2%	77.6%	78.6%	79.2%	79.1%	80.2%	80.1%	81.0%	81.6%	82.4%	82.6%	82.6%	82.9%	↑	Jul-19	79.9%	83.0%	5th out of 10
Percentage of staff who have had a performance appraisal who agree it helps them improve how they do their job	Annual Improvement														↑	2018	54%	53%	Joint 5th out of 10
Overall staff engagement score – scale score method	Annual Improvement														NA	2018	3.82	3.85	5th out of 10
Percentage of staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	Annual Improvement														NA	2018	73%	71%	Joint 8th out of 10

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	HDdUHB Well-being Objectives Annual Report 2018/19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sarah Jennings, Director of Partnerships and Corporate Services
SWYDDOG ADRODD: **REPORTING OFFICER:**	Anna Bird, Head of Strategic Partnerships, Diversity and Inclusion Clare Hale, Strategic Partnership and Inclusion Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Well-being of Future Generations (Wales) Act 2015 (the Act) came into effect on 1 April 2016 and aims to improve the social, economic, environmental and cultural well-being of Wales. The Act requires NHS bodies to report on the progress they have made in meeting their well-being objectives in each financial year.

The Board is invited to:

- Approve for publication the Health Board's Well-being Objectives Annual Report for the period 1 April 2018 - 31 March 2019 in order to fulfil the UHBs statutory obligations outlined above.
- Agree the refreshed Health Board's Well-being Objectives for 2019-2020 and beyond.

Cefndir / Background

The Well-being of Future Generations (Wales) Act 2015 sets out a number of requirements for individual Public Bodies, including Hywel Dda University Health Board (the Health Board). These include that the Health Board must:

- Set and publish well-being objectives (s.3(2)(a)) and take all reasonable steps to meet those objectives (s.3(2)(b)); and
- Publish a statement about well-being objectives (s.7(1)); and
- Each year publish an Annual Report showing the progress they have made in meeting their objectives (s.13 (1) and Sch.1).

Where possible, NHS bodies should seek to integrate such reporting with their requirement to publish annual reports and accounts. Whilst there is a Well-being of Future Generations Act section within the annual report of the Health Board, the detailed reporting on progress in meeting well-being objectives and the steps taken to contribute to the wider well-being goals of Wales are set out in this specific Well-being Objectives Annual Report 2018/19.

Asesiad / Assessment

When approving the Health Boards well-being objectives in March 2017, the Board agreed that there was strong alignment to the UHBs strategic objectives and ambition to become a population health organisation. It was acknowledged that the Health Boards contribution was aligned to the national goal "A healthier Wales" and the Task and Finish Group have since been working to identify how in delivering our core business we have also contributed to the other six well-being goals for Wales.

The Well-being Objectives Annual Report 2018/19 therefore provides:

- Evidence of how work delivered through the Health Board has supported the achievement of the well-being objectives;
- An overview of how in delivering our core business we have contributed to the 7 well-being goals;
- Information on our work with Public Service Boards; and
- A refreshed set of updated Well-being Objectives for 2019/20 and beyond which reflects our strategy, a Healthier Mid and West Wales.

There is significant evidence that the five Ways of Working required under the Act are being considered in the development and delivery of services, and they are particularly evident in the significant programme of work which we undertook during the year to establish our health and care strategy. This was also acknowledged in a recent audit completed by the Auditor General for Wales which was presented to the Audit, Risk and Assurance Committee in October 2019. We involved a wide range of stakeholders during our formal public consultation on our future model of services analysing feedback from both a public consultation survey as well as individual conversations with staff, patients and the public. This gives us confidence that our vision for services that are safe, sustainable, accessible and kind will be contributing to the achievement of our duties under the Well-being of Future Generations (Wales) Act 2015.

During 2018-19 we have undertaken two self-evaluations co-ordinated by the Future Generations Commissioner. The first was a self-reflection of our progress with implementing our well-being goals and the second was a response to the Commissioner's "Art of the Possible" programme where we self-assessed our progress against the 80 simple changes published by the Commissioner in Autumn 2018. This has given us a fresh insight into our progress towards meeting our well-being objectives.

Reflecting on our self-evaluation and feedback, we have refreshed and updated our Well-being Objectives for 2019-2020 and beyond. These now link our corporate objectives, reflect clearly our contributions to the 7 national well-being goals and the actions we are taking forward through our three Public Services Boards.

The refreshed and updated Health Boards Well-being Objectives for 2019-2020 and beyond are:

1. Plan and deliver services to increase our contribution to low carbon
2. Develop a skilled and flexible workforce to meet the changing needs of the NHS
3. Promote the natural environment and capacity to adapt to climate change
4. Improve population health through prevention and early intervention, supporting people to live happy and health lives
5. Offer a diverse range of employment opportunities which support people to fulfil their potential

6. Contribute to global well-being through developing international networks and sharing of expertise
7. Plan and deliver services to enable people to participate in social and green solutions for health
8. Transform our communities through collaboration with people communities and partners.

Argymhelliad / Recommendation

The Board is invited to:

- Approve for publication the Health Board's Well-being Objectives Annual Report for the period 1 April 2018 - 31 March 2019 in order to fulfil the UHB's statutory obligations; and
- Agree the refreshed Health Board's Well-being Objectives for 2019-2020 and beyond.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgor Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Support people to live active, happy and healthy lives Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Well-being of Future Generations (Wales) Act 2015
Rhestr Termau: Glossary of Terms:	Included within report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Well-being of Future Generations Task and Finish Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	HDdUHB staff time to support engagement activities and plan development form part of their existing duties and responsibilities. There are additional project and delivery group meetings being established to drive forward implementation of the Well-being Plans which will require input from senior officers of the UHB.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Improving the well-being of the population is at the forefront of this legislation.
Gweithlu: **Workforce:**	Implementing the five ways of working required under the Well-being of Future Generations (Wales) Act 2015 should lead to evidence of increased collaboration and integration between services, professionals and communities.
Risg: **Risk:**	The UHB has a duty to work collaboratively to address the 7 Well-being Goals for Wales. There is a risk that the need to demonstrate our progress is considered an "add on" responsibility by UHB staff. Embedding the principles of the act into everyday business is therefore paramount and contributing to the project and delivery groups of PSBs needs to demonstrate the synergy with achieving the UHBs goals.
Cyfreithiol: **Legal:**	*The Well-being of Future Generations (Wales) Act 2015* (the Act) provides that the UHB (as a designated public body) must publish a Well-being Statement, Well-being Objectives and provide an Annual Report on progress towards meeting these objectives. An aim of the Act is to place communities at the heart of decision making. The public can use the Act to ensure that public bodies are taking the approach to decision making that utilises the 5 ways of working in line with the sustainable development principle when developing or making changes to services that impact upon them and their community. The UHB will need to ensure that all transformation and service change projects, including capital developments, take account of the new statutory requirements.
Enw Da: **Reputational:**	There is a statutory requirement for the UHB to contribute to the work of the PSBs.
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	The focus of equality runs throughout the work of the PSBs aligned to the Well-being goal: A More Equal Wales.

Well-being Objectives: Annual Report for the period 1 April 2018 – 31 March 2019

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"Thinking differently to improve the well-being of current and future generations"

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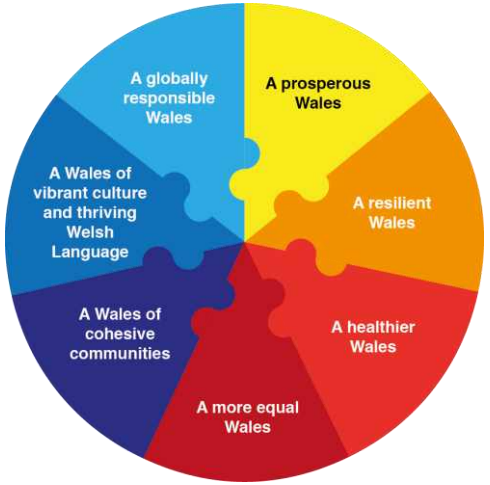
Introduction

Hywel Dda University Health Board (The UHB), are publishing this Annual Report to demonstrate our progress during 2018/19 towards meeting the Well-being Objectives we set out in our Well-being Statement published on 30th March 2017.

The Well-being of Future Generations (Wales) Act 2015 establishes both individual and collective duties for forty four public bodies, including Health Boards. The UHB is a member of three Public Services Boards (PSBs) one in each of our local authority areas of Carmarthenshire, Ceredigion and Pembrokeshire. Through our membership, we work with a variety of local and regional partners and aim, through our collaboration and partnership working, to improve well-being for our population. The Act sets out seven national well-being goals and five ways of working that public bodies are required to work collaboratively to address. The seven well-being goals are:

A prosperous Wales – where resources are used efficiently and proportionately (including acting on climate change) and everyone has jobs and there is no poverty.



A resilient Wales – where we are prepared for things like floods and are adapting to climate change.

A healthier Wales – where physical and mental health are maximized.

A more equal Wales – where everyone has an equal chance whatever their background.

A Wales of cohesive Communities – where Communities are safe and well-connected.

Continued

A Wales of vibrant culture and thriving Welsh language – where we have lots of opportunities to do different things that promote culture, heritage and Welsh language.

A globally responsible Wales – where we think about global well-being of other people around the world.

The seven Well-being Goals for Wales and Five Ways of Working provided by the Act are designed to support and deliver a public service that meets the needs of the present generation, without compromising the ability of future generations to meet their own needs. This is called the sustainable development principle. There are five things that public bodies need to think about to demonstrate that they have applied the sustainable development principle, these are called the Five Ways of Working and are shown below:

Five Ways of Working:

Long Term **Prevention** **Integration** **Collaboration** **Involvement**

Continued

In this Act, any reference to a public body doing something "in accordance with the sustainable development principle" means that the body must act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.

Well-being of Future Generations (Wales) Act 2015, Part 2 'Improved well-being, section 5 'the sustainable development principle, paragraph (1)'.

Appendix 1 provides a summary of how the national Well-being Goals and Five Ways of Working are defined by Welsh Government, as some of the words have a slightly different meaning to that which we might generally use.

Implementing the Act's requirements will support other legislative commitments such as the Social Services and Well-being (Wales) Act 2014, the Environment (Wales) Act 2016, Welsh Language Act 1993, Equality Act 2010, and the United Nations Convention on the Rights of the Child.

Our Well-being Statement & Objectives

In order to develop our Well-being Objectives, the UHB established a Task and Finish Group drawing membership from across the organisation. We also sought input from the office of the Future Generations Commissioner for Wales. The role of the internal multi-professional Task and Finish Group has been to steer the implementation of the Act's requirements and act as champions to support embedding this important legislation into everyday working practice.

The UHB's Well-being Objectives were agreed in 2017 and their contribution to each of the national well-being goals are shown below:

1. Improve population health through prevention and early intervention.	
2. Support people to live active, happy and healthy lives.	

Continued

3. Improve efficiency and quality of services through collaboration with people, communities and partners.	
4. **Ensure a sustainable, skilled and flexible workforce to meet the changing needs of the modern NHS**.	

This year has seen the UHB committing to long-term outcomes for our population through continuous engagement with our key stakeholders, namely our patients, our staff, our clinicians and our partners' including social care and the third sector. Our Health and Care Strategy A Healthier Mid & West Wales: Our Future Generations Living Well sets out for the first time a strategic vision for services that are safe, sustainable, accessible and kind both for current and future generations across the UHB area. The strategy is based on the implementation of an integrated social model of health. It signals a shift from our current focus on hospital-based care and treatment toward a focus on prevention and building the resilience of people and communities, as described above. It also establishes a parity of esteem between physical health, mental health and learning disabilities across the age span.

Continued

Our Future Generations Living Well: A Health and Well-being Framework for Hywel Dda helps us create the movement for change we are going to need to achieve our long term ambitions. Our three strategic goals – starting and developing well, living and working well, and growing older well - are framed around three life phases and replace the previous eight health related strategic objectives. The three pro-active strategic goals emphasise a joint whole system approach to health and well-being with our partners and communities. While we recognise that these life phases overlap and that none is more important than the other, we also wish to support the provision of services and actions taken to improve health and well-being that may be focused on the delivery of specific goals. Whilst we can make a positive contribution to influence these strategic goals, we recognise that we cannot deliver them alone.

Delivering Our Health and Care Strategy A Healthier Mid & West Wales: Our Future Generations Living Well in partnership will realise our commitment to achieving the seven goals as set out in the Well-being of Future Generations (Wales) Act, 2015 in the following ways:

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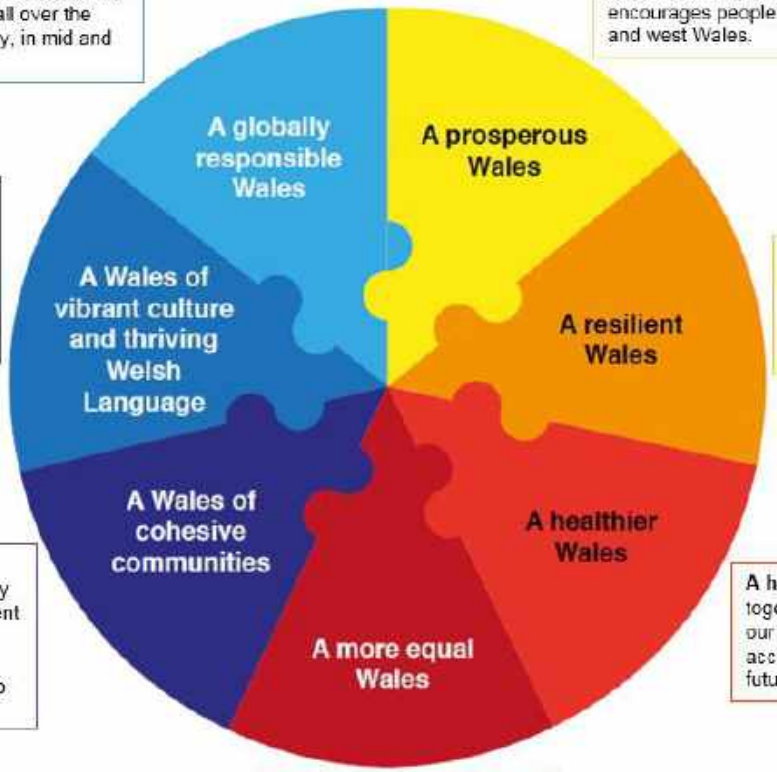

A globally responsible Wales – Supporting global well-being by working with other countries and cultures to share best practice, and encouraging people from all over the world to come to work, and stay, in mid and west Wales.

A prosperous Wales – Opportunities for volunteering, the development of new career pathways and employment that encourages people to live and work in mid and west Wales.

A Wales of vibrant culture and thriving Welsh Language – A social model for health that involves people in creating better lives, promotes community assets and promote Welsh Language.

A resilient Wales – Modernising our health facilities, and providing them in the most appropriate locations to support social, economic and ecological resilience.

A Wales of cohesive communities – A community model which develops resilient communities, with people supporting each other, and providing more care closer to home.

A healthier Wales – Working together to consider how we ensure our services are safe, sustainable, accessible and kind for ours and future generations.

A more equal Wales – More equitable care and opportunity that reduces variation, and better meets the needs of vulnerable groups.

Embedding the principles of the Well-being of Future Generations (Wales) Act 2015

A key priority has been to embed core approaches to sustainable development in all that we do. The five ways of working are being introduced as considerations within all aspects of planning at an operational level through to strategic planning. Thus, over time, the principles of the Act will become embedded within organisational culture. The Board and Committees receive regular updates on our internal work, as well as our work with PSB partners.

The five ways of working are particularly evident in our vision within our Healthier Mid & West Wales: Our Future Generations Living Well Strategy. We involved a wide range of stakeholders during our formal public consultation on our future model of services analysing feedback from both a public consultation survey as well as individual conversations with staff, patients and the public. This gives us confidence that our vision for services that are safe, sustainable, accessible and kind will be contributing to the achievement of our duties under the Well-being of Future Generations (Wales) Act 2015.

To provide a catalyst for change we developed two “Check and Challenge” tools; one for the whole system and the other for individual services and teams. Both tools are designed to help us put on a pair of glasses with health and well-being lenses and encourage a different conversation, shifting it from illness towards individual and community well-being.

All new staff attend a corporate induction programme which includes training and awareness raising about the Act. Regardless of employee job roles the induction session highlights how the areas of work being reported to our Board and Committees contribute to the achievement of the UHB’s Well-being Objectives. In the spring of 2019 our Well-being of Future Generations Task and Finish Group supported the self-assessment process led by the Future Generations Commissioner. The feedback we received will enable the organisation to reflect on our current approaches and stimulate further work.

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Delivering our Well-being objectives during 2018-2019

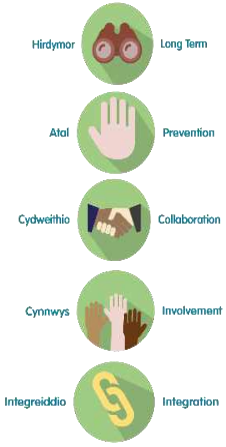
We published our first Well-being Objectives Annual Report on 31 May 2018 outlining our progress made during 2017-2018 to meet our well-being objectives and evidence of our contribution to achieving the national well-being goals.

The UHB did not made any changes to its own Well-being Objectives for 2018-2019 as they continued to have strategic relevance to our vision and mission to become a population health focused organisation. We are committed to combined partnership actions addressing the wider determinants of health, to achieve longer term sustainable outcomes, and in particular improvements in health and well-being; the goal of achieving "A Healthier Wales".

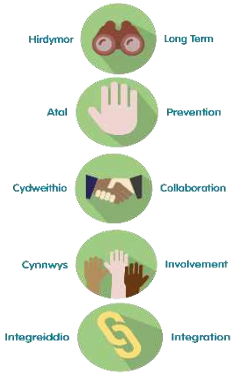
This is our second Annual Report setting out our progress in delivering our Well-being Objectives and we are continuing to learn how best to evidence our wider contributions to all seven Well-being goals. We have given examples overleaf on progress with actions to deliver our Well-being objectives during 2018/19 and how these contribute to the seven well-being goals and five ways of working.

We recognise that there is more we can do in contributing to 'a prosperous Wales', 'a resilient Wales' and a 'globally responsive Wales' in the context of our contribution to a low carbon economy, reducing waste and plastic and tackling climate change. During 2019/20 this work will also be focused on the seven corporate areas of change of risk, performance management, corporate planning, financial planning, workforce planning, assets and procurement. Further information about our Well-being Statement and Objectives, the PSB Well-being Plans and our Well-being Objectives Annual Report can be found at the following link: http://www.wales.nhs.uk/sitesplus/862/page/85517

UHB Well-being Objective 1: Improve population health through prevention and early intervention



The UHB approved A Healthier Mid & West Wales: Our Future Generations Living Well in November 2018 and Our Future Generations Living Well: A Health and Well-being Framework for Hywel Dda at its meeting on 31 January 2019. This document sets out our future direction of travel and embeds prevention and early intervention as key commitments for the organisation.
Outcomes: Since board approval, we have moved with pace to plan the delivery of the strategy. This has included: scoping a portfolio of programmes and enabling groups.



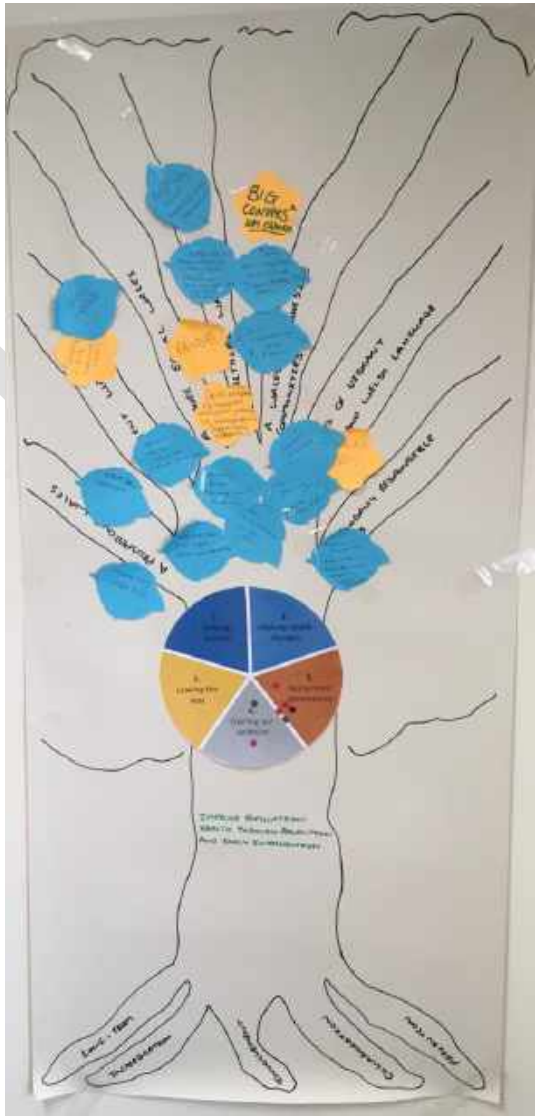
Our Education Programme for Patients is working with a number of clinical areas such as cancer, podiatry and continence to ensure we include robust patient education to empower the patient to make subtle changes that may result in fewer medical interventions. Contributing to achievement of significantly better health and well-being outcomes in the short and long term.
Outcomes: During last year nearly 150 courses were held with 1365 individuals completing a health education programme with a 91% completion rate.

Continued

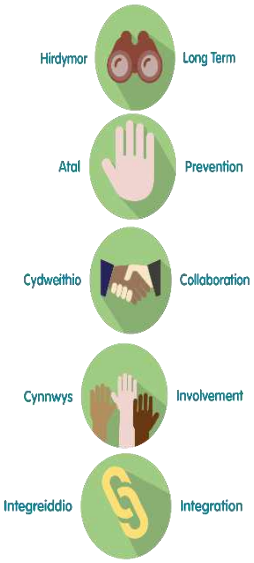
Other examples include of our work to improve population health:

- ✓ We are working with Police, Public Health and other partners to respond to Adverse Childhood Experiences (ACES). ACE awareness training has been delivered to key groups of staff, mainly in Children's Public Health reflecting our commitment to early years support.

- ✓ The UHB has signed up to the **Mindful Employer Charter**. All staff are able to self-refer to the Occupational Health Service (OHS) for support. Any staff referred to OHS for other reasons when absent due to sickness are screened for depression. We also launched the "lawn" website to provide early access to emotional health resources.



UHB Well-being Objective 2: Supporting People to live active, happy and healthy lives



Pharmacy Walk-in Centres. A number of community pharmacies across Carmarthenshire, Ceredigion and Pembrokeshire became known as Pharmacy Walk-in Centres on 1 March 2019. This service is provided by 93 community pharmacies in the UHB area. Centres will also offer emergency hormonal contraception, emergency supply of medication, smoking cessation, patient sharps return service, flu vaccinations, and medicine reviews.
Outcomes: The centres have reduced the need for GP appointments and provides a more accessible service for all in a community setting.

A pilot e-STI testing service was launched in late 2018 as a collaborative project between Public Health Wales, the Health Board and Signum Health, funded by Welsh Government.
Outcomes: The results after the first six months have shown 931 questionnaires have been completed. Of the kits returned, 8% of those tested positive for Chlamydia and 0% positive for Gonorrhoea. The pilot service has also generated a 100% positive response and is being considered for a further period of time by Welsh Government.

Continued

Other examples of our work to support people to live active, happy, healthy lives include:

- ✓ **111 was rolled out across the Health Board** region on 31 October 2018. The free-to-call phone number provides access to the GP Out of Hours service and NHS Direct Wales - making it easy to get advice, support or treatment that is right, all in one place.

- ✓ We adopted the **#EndPJparalysis campaign** which encouraged patients to get dressed and mobile to help maintain their dignity and to help them recover quicker.

UHB Well-being Objective 3: Improve efficiency and quality of services through collaboration with people, communities and partners

We set up a Withybush Green Health Group that has been developing and coordinating the implementation of a programme to improve green spaces across the Withybush hospital site, for the benefit of staff, patients, visitors, the wider community and the environment.
Outcomes: The group has secured funding from Natural Resources Wales and have established partnership working with a number of community and voluntary groups.

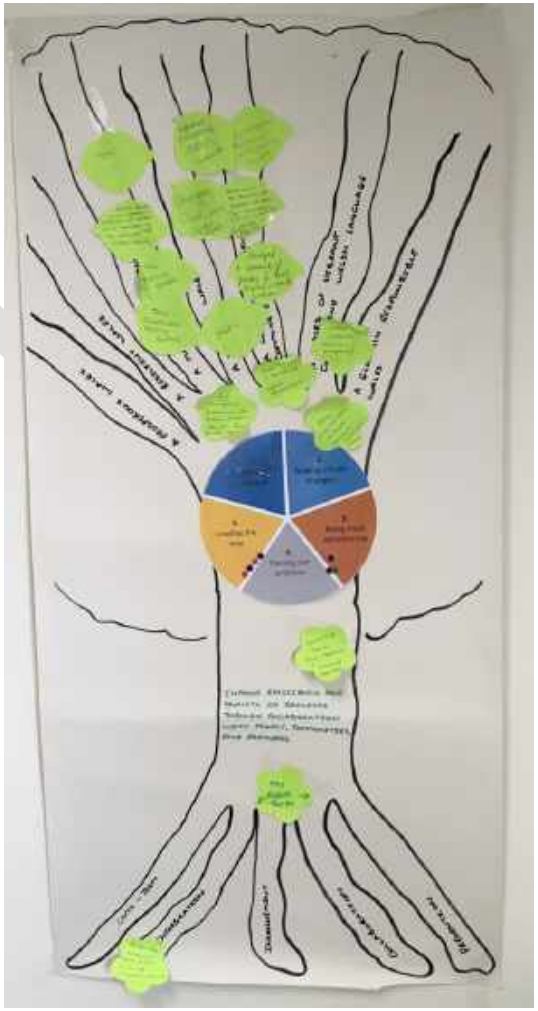
Our innovative project, VIPAR (Virtual Pulmonary Rehabilitation) won the 'Improving Health and Well-being and Reducing Inequalities' award at the NHS Wales Awards 2018. Pulmonary rehabilitation is a multi-disciplinary programme of exercise and education for COPD (Chronic Obstructive Pulmonary Disease) patients which traditionally takes place twice a week over a six-week period. While the programme offers proven health benefits for those living with long-term lung disease, no service currently exists in rural parts of West Wales. The VIPAR (Virtual Pulmonary Rehabilitation) initiative tackled this issue by using video conferencing, in partnership with technology partners Comcen and Polycom, so that patients in rural Tregaron could participate in real-time in the rehab session led from Glangwlli General Hospital.
Outcomes: The VIPAR initiative has saved its patients 9 days of driving and 7,579 miles contributing to lowering carbon, as well as providing improved health outcomes.

Continued

Other examples of our work to improve efficiency and quality of services through collaboration include:

- ✓ **Hywel Dda's Big NHS Change** - We undertook a period of public consultation during the summer of 2018 for 12 weeks. During this time there was an unprecedented level of activity, including 17 public drop-in events reaching over 1,400 people; 44 staff events involving over 1,100 staff members; and 77 meetings with community groups with over 1,300 attendees. Our activity was successful in generating a very positive response rate, with 5,395 formal consultation responses. We focused significant resource around seldom heard groups, working on the principle that if services take into account the needs of the most vulnerable, they are of a better standard for all.

- ✓ The Strategic Partnerships, Diversity and Inclusion team has worked collaboratively with procurement colleagues to streamline the booking system for Interpretation and Translation Services through WITS and Language Line in order to make it easier for staff to book services in advance of appointment as required.



UHB Well-being Objective 4: Ensure a sustainable, skilled and flexible workforce to meet the changing needs of the modern NHS

Volunteering for Health – The UHB's volunteer service has seen Volunteer Forums get up and running in Pembrokeshire and Carmarthenshire with Ceredigion in the pipeline. This enables volunteers to meet other volunteers and feed their views, concerns and ideas into the UHB.
Outcomes: 10 volunteers have gained paid employment, 4 with HDUHB. 23 volunteers went onto further education in University and 13 of these went into nursing or medicine after their volunteering experience.

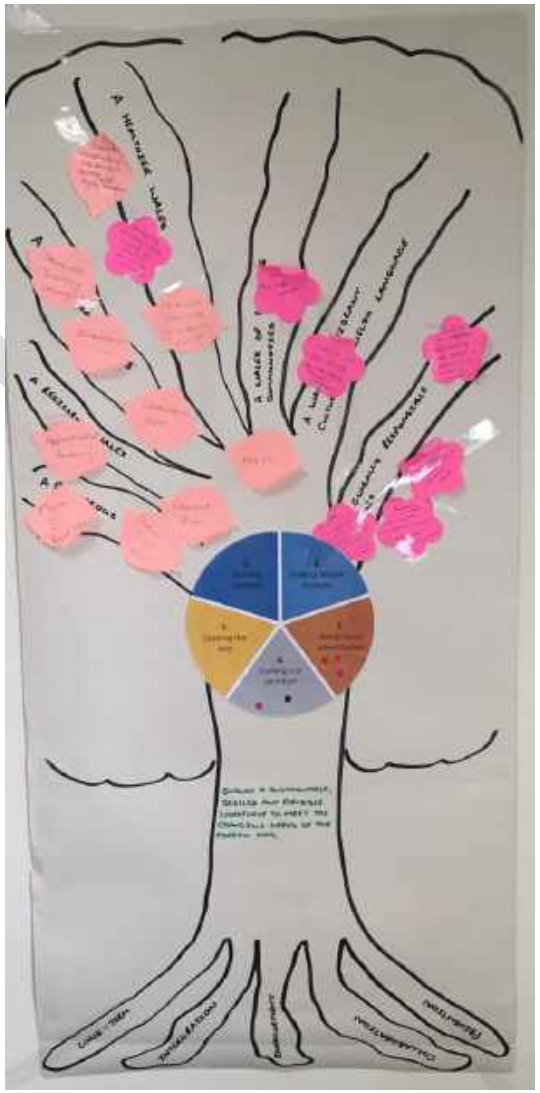
The UHB has developed **'Destination NHS'** in partnership with Swansea University and Pembrokeshire College. This is aimed at local students aged 16-18, with the aim to support their ambition to follow a future career in health.
Outcomes: 44 students participated in the programme to date; of those students we are aware, 2 are now bank Health Care Support Workers, 6 are attending University to study health related courses (plus another 3 studying science related courses).

Continued

Other examples of our work to develop our workforce include:

- ✓ During 2018 we have continued to develop and are currently implementing our **'Grow Your Own' programme**. This programme is a combination of existing, new and innovative schemes, aimed at increasing our registered nurses**.** We have also established the **Apprentice Academy**, through which we are building the apprentice model for the UHB.

- ✓ We have been working with our partners regionally particularly through the West Wales Regional Partnership Board to develop greater integration between public, private, third sector and voluntary sectors, and also the private sector. We are alert to the changing concept of what we mean by "workforce" in health and social care and the "contingent workforce" i.e. service user, carers, commissioned and non-commissioned services across social care, third sector (& development of social enterprise) and independent sector.



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Measuring our progress

During 2018-2019 we have undertaken two self-evaluations co-ordinated by the Future Generations Commissioner. The first was a self-reflection of our progress towards implementing our well-being goals. The second was a response to the Commissioner's "Art of the Possible" programme where we self-assessed our progress towards the 80 simple changes published by the Commissioner in Autumn 2018. This has given us a fresh insight into our progress towards meeting our well-being objectives. It has reinforced our belief that a small number of specific well-being objectives provide a helpful focus for action in order to maximise our contribution towards the well-being goals for Wales.

We have also worked with the Wales Audit Office in examining our work in relation to the Education Programme for Patients and the contribution it makes to improved population health and well-being. The audit commenced in Spring 2019 and will be completed by autumn 2019.

The National Well-being Indicators help us to measure whether our collective efforts are having an impact on outcomes for the Welsh population. However, it is recognised that the measures are unlikely to change dramatically in the short term – these are long-term population outcomes that we are working to address.

The table in appendix 2 demonstrates the link between our Well-being Objectives and the National Indicators for Wales. It establishes a line of sight between our local organisation actions and the contribution this will make towards national outcomes for the Welsh population.

Continued

Progress across the Seven corporate areas of change:

The guidance for the Act also sets out where change needs to happen within seven corporate functions of an organisation - risk, performance management, corporate planning, financial planning, workforce planning, assets and procurement. These are the parts of the organisation that should be seeking to do things differently since the introduction of the Act because they affect the rest of the organisation's services.

We believe we are embedding the Act into our strategic planning for the delivery of future health and well-being services. Our new strategy A Healthier Mid and West Wales: Our Future Generations Living Well together with Our Future Generations Living Well: A Framework for Health and Well-being is our way of demonstrating how the seven corporate areas of change are contributing to our longer term outcomes.

The UHB will be working through a programme approach to move our health care strategy into reality through a set of enabling and change projects. The scale of this strategy covers the whole-system and includes:

- Prevention and early intervention at scale;
- Developing integrated community services and working in an integrated way to deliver services across a whole system;
- Helping those who need the most specialist health and care support through a network of hospitals across mid and west Wales;
- Building key partnerships with local authorities, university partners, third sector, and other organisations to deliver and commission services and support.

We will plan in three-year cycles, with the level of detail being different for each:

- Year 1 plans – will clearly describe actions, milestones and resourcing for the coming year
- Year 2 plans – will indicate priorities, actions and risks for the second year, and include performance projections and will identify major challenges and opportunities
- Year 3 plans – will show how we propose to make continued progress towards our strategic vision.

Continued

Using existing resources to support our Well-being objectives

The Act requires that we publish a statement detailing how as a public body we will ensure that resources are allocated annually to meet our Well-being Objectives. As our Well-being Objectives are aligned with, and integral to, the UHB's Annual Plan we have not identified or allocated specific financial resources. Our priority has been to embed the principles of the Act so that alignment to the five ways of working and delivery of the Well-being Objectives are integral to our daily way of working.

The UHB has nominated an existing Executive and Officer to maintain oversight of, and act as Future Generations "Champions". Our Future Generations "Champions" are long-standing staff members and partnership work associated with implementing the Act, has become embedded into their existing roles and responsibilities.

The UHB is committed to using the Act in its decision making to contribute to improving the social, economic, environmental and cultural well-being of Wales. We have worked with our corporate colleagues to raise awareness of the Act including Reporting Officers/Executive Directors so that they can explicitly highlight these in reports to our Board, Committees, Sub-Committees and Groups.

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Working with our Public Service Boards

In this section of our Annual Report we highlight the work which has been undertaken collectively through our three Public Services Boards (PSBs).

Public Services Boards (PSBs) were established in Carmarthenshire, Ceredigion and Pembrokeshire as part of the Well-being of Future Generations (Wales) Act 2015 with the aim of sustainably improving economic, cultural, social and environmental well-being for local people.

The Well-being Plans of the Public Services Boards (PSBs) represent the additional value that can be delivered through working innovatively and collaboratively as partners. Their development has created a significant opportunity to reframe the focus and understanding of health and well-being not just on the absence of disease or the treatment of illness; the PSB Well-being Plans will help to re-orientate the focus on the wider determinants of health. Each PSB has established a governance structure to drive forward the delivery of the PSB Well-being Plans and a number of new sub-groups have been established in order to progress this work.

This is a new way of working and the UHB acknowledges that there will need to be synergy between the Well-being Plans of each PSB and the well-being objectives of each individual organisation. The actions that the PSB identify to take forward will enable each individual partner to utilise their expertise, but work collectively to create the momentum for actions (and changes) which will also contribute to the achievement of all seven Well-being Goals.

Continued

There have been significant developments in working regionally with our PSB partners during the last year as outlined below:

Prevention - Over the past 18 months, Carmarthenshire PSB, along with the PSBs in Ceredigion and Pembrokeshire, have been engaged in the development of the UHB's 'Healthier Mid and West Wales Strategy' and accompanying Health and Well-being Framework. Through this engagement, PSB partners have signalled their commitment to take a preventative approach in all that they do.

Work is ongoing to implement Dewis information and awareness sessions across the workforce and is being driven through Community Health and Social Care services within the Council and the UHB.

A successful bid was made for Welsh Government 'Enabling Natural Resources and Well-being' funding for a pilot project in 2019/2020. The 'Green Health and Access West Wales' project aims to improve health and well-being by being active outdoors and engaging with nature. It brings together partners across the three counties and will investigate current greenspace provision for local communities, support providers of green health initiatives to promote best practice and work directly with the health sector, raise the profile of social prescribing to 'nature-based health care' and build strong partnerships between the healthcare and environmental sectors.

A regional Climate Change group was convened as the requirement to produce a Climate Change risk assessment is common to Carmarthenshire, Pembrokeshire and Ceredigion Public Services Boards. Leads from the working groups for the three counties have met regularly over the last year to work collaboratively, share information and to progress this work in a co-ordinated way.

Continued

Integration and Collaboration – There have been a series of discussions to identify possible areas of integration and regional collaboration between PSB's and the West Wales Regional Partnership Board based on commonality of aims and objectives identified in local plans. These include technology enabled care; continuous engagement; social and green solutions for health and connecting people, kind communities.

Involvement and Long Term planning - Involving local communities is very much at the heart of the work by the PSB Delivery Groups. It is recognised that more needs to be done to further develop approaches to involvement and engagement and as noted above the UHB and PSBs are working with the Regional Partnership Board to look at developing a public sector approach to citizen engagement.

Continued

Other examples at County level:

In **Pembrokeshire** each PSB partner has identified a Work Experience Champion and we have established an operational group involving all key stakeholders which has designed a framework for the provision of work placements across PSB members. The group has also developed and agreed some key promotional literature which we can aim at those who potentially will be interested in work placements. This includes an 'Employer Guide to Work Experience in Pembrokeshire'. Link to Pembrokeshire Public Service Board Website.

In **Carmarthenshire** our 'Making Every Contact Count' pilot project has resulted in the decision to roll this programme out to additional cohorts of key staff. The project uses the daily interactions front line staff have with the public to promote a range of messages from partners to support them to make positive changes to their well-being. Multi-agency training was provided to staff from PSB partners to give them the skills to talk to members of the public about additional important messages from other organisations which may be of use to them, such as cyber crime and fire safety messages. Link to Carmarthenshire Public Service Board Website.

In **Ceredigion** the Health Board have chaired the Social and Green Solutions Project. We have agreed on a definition that social prescribing is a way to assist a person's health and well-being – whether physical, psychological or social – by referring or signposting to non-medical sources of support, interaction or activities. As well as creating a definition to focus our work we have been hearing of examples of Social and Green prescribing within the county and beyond. Link to Ceredigion Public Service Board Website.

Our Priorities for 2019/2020 onwards

We have refreshed our well-being objectives for 2019 – 2020 onwards and shown how they contribute to the seven national wellbeing goals. Our Well-being objectives are not confined to a single national outcome and align to more than one of the national goals but for ease of reference we have linked our objective to the goal where there is likely to be the greatest impact.

The priority for the year ahead will be to ensure that the Well-being of Future Generations Wales Act is integrated more fully with the development of the UHBs wider planning agenda both through A Healthier Mid and West Wales, and the development of our Integrated Medium Term Plan.

UHB Well-being objectives 2019/20 onwards	Wales' National Well-being Goals	Working with our Public Service Board and other partners
1. Plan and deliver services to increase our contribution to low carbon. **2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS.**		• To maximise opportunities for people and places in both urban and rural parts of our county (Carmarthenshire PSB) • Enable people to create and grasp opportunities and meet challenges throughout their lives through improving vocational and life skills, build confidence and enable people to respond positively to change (Ceredigion PSB) • Work towards a Carbon Neutral and environmentally balanced County with a long term aim to become carbon positive (Pembrokeshire PSB) • A cross-PSB commitment to developing a Recruitment and Employment Transformation Framework to support people to work in Pembrokeshire (Pembrokeshire PSB)

Continued

UHB Well-being objectives 2019/20 onwards	Wales' National Well-being Goals	Working with our Public Service Board and other partners
3. Promote the natural environment and capacity to adapt to climate change.		• People have a good quality of life, and make healthy choices about their lives and environment (Carmarthenshire PSB) • Create environmentally responsible and safe communities that can adapt and respond to the effects of climate change (Ceredigion PSB) • Celebrate the Great Outdoors and using this key asset to support all elements of individual and community well-being (Pembrokeshire PSB) • Produce an Environmental and Climate Change Risk Assessment and develop appropriate measures in response (Pembrokeshire PSB) • Work towards a Carbon Neutral and environmentally balanced County with a long term aim to become carbon positive (Pembrokeshire PSB)
4. Improve population health through prevention and early intervention, supporting people to live happy and healthy lives.		• To make sure that people have the right help at the right time; as and when they need it (Carmarthenshire PSB) • Enable people to live active, happy and healthy lives supporting physical and mental health and improve well-being through promoting healthy behaviors (Ceredigion PSB) • Enable every child to have the best start in life supporting parental preparedness through early intervention, overcome inequalities and promote holistic learning (Ceredigion PSB) • Celebrate the Great Outdoors and using this key asset to support all elements of individual and community well-being (Pembrokeshire PSB)

Continued

UHB Well-being objectives 2019/20 onwards	Wales' National Well-being Goals	Working with our Public Service Board and other partners
5. Offer a diverse range of employment opportunities which support people to fulfil their potential.		• To maximise opportunities for people and places in both urban and rural parts of our county (Carmarthenshire PSB) • Enable people to create and grasp opportunities and meet challenges throughout their lives through improving vocational and life skills, build confidence and enable people to respond positively to change (Ceredigion PSB) • A cross-PSB commitment to developing a Recruitment and Employment Transformation Framework to support people to work in Pembrokeshire (Pembrokeshire PSB)
6. Contribute to global well-being through developing international networks and sharing of expertise.		• Work towards a Carbon Neutral and environmentally balanced County with a long term aim to become carbon positive (Pembrokeshire PSB)
7. Plan and deliver services to enable people to participate in social and green solutions for health.		• People have a good quality of life, and make healthy choices about their lives and environment (Carmarthenshire PSB) • Celebrate the Great Outdoors and using this key asset to support all elements of individual and community well-being (Pembrokeshire PSB)

Continued

UHB Well-being objectives 2019/20 onwards	Wales' National Well-being Goals	Working with our Public Service Board and other partners
8. Transform our communities through collaboration with people, communities and parthers.		• Strongly connected people, places and organisations that are able to adapt to change (Carmarthenshire PSB) • Create conditions for communities to support individuals from all backgrounds to live fulfilling, independent lives (Ceredigion PSB) • Enable communities to become prosperous, sustainable and connected by supporting the transformation of economic prospects (Ceredigion PSB) • Transform traditional models of service delivery and access through use of innovative solutions and technology, creating connectivity and improved coverage (Pembrokeshire PSB) • Enable community participation through active citizens and community initiatives (Pembrokeshire PSB) • Undertake a mapping exercise of our communities, to include the physical, natural, cultural assets and infrastructure, and the formal and informal social networks within them (Pembrokeshire PSB) • A coordinated PSB approach to meaningful community engagement, consultation and sharing of knowledge (Pembrokeshire PSB)

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Closing Comments

The Health Board recognises that the four Well-being Objectives published in March 2017 were a starting point as we commenced our journey of responding to the Act. At that point, our objectives were aligned to our previous strategic objectives.

With the publication of our new Health and Care Strategy we have reviewed and refreshed our Well-being Objectives and established 8 new Well-being Objectives for 2019/20 and beyond.

Our Well-being Objectives provide a high level direction of travel and this enables us to deliver activities and actions at a local level, whether these be consistently for all, or responding to differences in local need.

We recognise that we're on a collective journey to implement the vision of the Act which provides an opportunity to embed cultural change in the Health Board. We are committed to thinking about the long term, working with people and communities, looking to prevent problems and take a joined up approach in everything that we do.

Appendix 1

Wales' National Well-being Goals	Official Definition used by Welsh Government
	An innovative, productive and low carbon society which recognises the limits of the global environment and therefore uses resources efficiently and proportionately (including acting on climate change), and which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work.
	A nation which maintains and enhances a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience and the capacity to adapt to change (for example climate change).
	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.
	A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio economic background and circumstances).

Continued

	A nation which, when doing anything to improve the economic, social, environmental and cultural well-being of Wales, takes account of whether doing such a thing makes a positive contribution to global well-being.
	A society that promotes and protects culture, heritage and the Welsh language, and which encourages people to participate in the arts, and sports and recreation.
	Attractive, viable, safe and well-connected communities.

Continued

There are five (5) things that public bodies need to think about to show that they have applied the sustainable development principle. These are set out in the table below.

Five Ways of Working	
	Looking at the **long term** so that we do not compromise the ability of future generations to meet their own needs.
	Understanding the root causes of the issues to **prevent** them happening in the first place.
	Working with others in a **collaborative** way to find shared sustainable solutions.
	**Involvement** of a people in decisions that affect them, and ensuring that those people reflect the diversity of our area.
	Taking an **integrated** approach so that we consider how our well-being objectives may impact upon each of the well-being goals, and on the objectives of other public bodies.

Appendix 2

Hywel Dda University Health Board Well-being Objective	Contribution to National Indicators
Improve population health through prevention and early intervention	**1, 2, 3, 4, 5, 6, 24**
Support people to live active, happy and healthy lives	**1, 2, 3, 5, 6, 24, 29, 30, 35, 38**
Improve efficiency and quality of services through collaboration with people, communities and partners	**23, 24, 26, 27**
Ensure a sustainable, skilled and flexible workforce to meet the changing needs of the modern NHS	**16, 28**

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Enw'r Pwyllgor / Name of Committee	Finance Committee
Cadeirydd y Pwyllgor/ Chair of Committee:	Michael Hearty, Associate Member
Cyfnod Adrodd/ Reporting Period:	Meeting held on 24th September 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

The Finance Committee has been established to advise the Board on all aspects of finance and the revenue implications of investment decisions. Hywel Dda University Health Board's (HDdUHB's) Finance Committee's primary role is, as such, to provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation.

This report summarises the work of the Finance Committee at its meeting held on 24th September 2019, with the following highlighted:

- **Finance Report Month 5** – the Month 5 Finance Report was presented to Committee. The Committee was advised that the Health Board's Control Total requirement is a deficit of £15m, following receipt of £10m Welsh Government (WG) funding in Month 4, subject to achieving this control total by the end of the financial year. The Committee was further advised that the Health Board's financial position at the end of Month 5 represented an adverse variance against plan of £1m, which brings the cumulative Year to Date (YTD) variance to £3.1m. The Month 5 YTD variance to breakeven is £10.6m. The Committee was informed that the total savings requirement is £25.2m, which has been reduced by £3.5m due to funds released from the NHS Wales Performance Fund to support the cost of delivery of Referral to Treatment Time (RTT). £15.5m of these savings are associated with green schemes, £3.7m are for amber schemes, and therefore risk to delivery is £6m. Operational Directorate projections are at a variance to plan of £5.5m. Therefore, the total impact on the underlying deficit is £26.5m.

- **Turnaround Report Month 5** – the Turnaround Report Month 5 was presented to Committee. The Committee was advised that that there are two significant challenges to delivery of savings schemes, one being the delivery of plans already in place, including green, amber and converting red schemes; the other is how to address the £4m savings gap. With regard to the £4m savings gap, the Committee was assured that Executive Team discussions with the Corporate teams to support delivery include how best to deploy resources, skills and expertise centrally to deliver the plan. The Committee requested assurance be provided in the Month 6 report that existing budget holders are not overspending on their budgets

- **Referral to Treatment Time (RTT) Month 5 Report –** the Month 5 Referral to Treatment Time (RTT) Report was presented to Committee. The Committee was advised that the forecast cost of the RTT, Diagnostics and Therapy services delivery proposals for 2019/20 is £5.5m, with a savings target of £1.4m applied

to Ophthalmology, Orthopaedics and other specialities. Allowing for non-delivery of the Orthopaedic savings target, due to the risks with Orthopaedic theatres in Withybush General Hospital, the total forecast cost of delivery stands at £4.6m. Members were informed of the £5.8m allocation from the NHS Wales Performance Fund to support the cost of delivery of RTT, with £3.5m to be released from this fund to reduce the overall savings plan. Of the remaining £2.3m Performance Fund allocation, £0.5m will be allocated for delayed follow ups, £0.3m will address the achievement of a 32 week maximum waiting time target for Stage 1 outpatients, and the remainder will be used to develop more sustainable solutions for Ophthalmology and Dermatology and to account for new/emerging delivery risks for Orthopaedics, General Surgery and Urology. The Committee was informed of a potential opportunity arising from the bid to WG to secure the £5.8m, which included provision for £0.9m towards the delayed cost of lost work which may require consideration of recovery for up to 50 Orthopaedic job sessions; work on this is scheduled to be completed by mid-October 2019

- **Grip and Control** – the Grip and Control report was presented to Committee, advising that KPMG had been asked to assess the control environment operating within HDdUHB to identify areas for improvement. The draft findings indicate a reasonable level of assurance around Non-Pay controls and make a number of recommendations in respect of Pay controls. Action plans have been developed to address the weaknesses identified in KPMG's assessment which focus upon medical workforce controls, nursing agency controls, nursing rostering controls, and general workforce controls.

- **Capital Financial Management –** the Capital Financial Management report was presented to Committee. The Committee was advised that a draft Full Business Case (FBC) is being progressed for submission to WG and a bid for Integrated Care Fund (ICF) monies has been submitted to the Minister for approval.

- **Long Term Agreement Governance** – the Long Term Agreement (LTA) Governance report was presented to Committee, highlighting the steps currently being undertaken to align the contracts/Long Term Agreements (LTAs) across HDdUHB. The Committee approved the inclusion of a LTA/Contracts Update to feature as a standing item on the Committee's agenda, and to ensure the Committee is sighted on any contracts over £0.5m to enable any concerns to be reported to Board.

- **Winter Plan Model 2019/20** – a verbal update on the Winter Plan Model 2019/20 was presented to Committee, where it was noted that the funding process would be similar to 2018/19. A comprehensive Winter Plan report will be submitted to the October 2019 Finance Committee meeting.

- **External Finance Review** – the Committee received a verbal update on KPMG's work, and noted that a refresh of the 2020 plan, which will include an assessment of cost improvement plans and cost pressures forecast to land in year, has now been completed and will be submitted to the Finance Delivery Unit (FDU). This will provide information on the extent to which the forecast outturn is mitigated, and the opportunities to impact on the control total. It will also provide mitigating actions for

Directorates as well as considering transformational work. The refresh plan will be submitted to the October 2019 Finance Committee meeting.

- **Deep Dive into Ring-fenced Allocation within Mental Health and Learning Disabilities -** the Committee received a presentation and report on a Deep Dive into Ring-fenced Allocation within Mental Health and Learning Disabilities (MH&LD). The Committee was presented with a snapshot of the ring-fenced funding and spend for 2017/18 for Mental Health and Learning Disabilities, which reported expenditure as £83.5m on Mental Health services and approximately £10m on Learning Disabilities. The Committee was advised that £107m was spent against the £94m allocation, due to the Continuing Health Care (CHC) element totalling £13m. The Committee was informed of next steps and opportunities, which included potential efficiencies across HDdUHB such as working better with Primary Care, avoidance of duplication of service provisions, assisting with the future planning of services in line with service transformation, and assisting in cross directorate working.

- **Financial Procedures** – the Committee approved the Patient Property and Monies procedure, subject to addressing a query in relation to the repayment of patient monies in the form of a cheque.

- **International Financial Reporting Standard (IFRS) 16 Update** – the International Financial Reporting Standard (IFRS) 16 Update report was presented to Committee for information, highlighting the progress made in regard to the steps being taken to prepare for the implementation of the International Financial Reporting Standard (IFRS) 16 Leases accounting standard. The main area of work undertaken to date has been to identify leases that are in existence within HDdUHB. The finance team is working through the nuances and assessing the implications of adding any additional assets to the balance sheet.

- **Workshop Session: Development and Implementation of Value Based Health Care** – the Committee received a presentation and report on the Development and Implementation of Value Based Health Care (VBHC), noting that the Intelligence and Value Strategy is designed to outline the journey and key components toward developing the necessary skills in research and application of Business Intelligence and VBHC within the finance team to more widely support VBHC across HDdUHB. In order to implement the Strategy, an education programme will operate from October 2019 to April 2020 to ensure the core finance team is skilled up to support the organisation. A further update will be provided to the December 2019 Finance Committee meeting

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:

No matters requiring Board level consideration or approval.

Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:

- The significant risk in relation to the organisation's ability to deliver the required £15m control total
- Delivery of 2019/20 Savings Plan

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:
Adrodd yn y Dyfodol / Future Reporting:
In addition to the standing agenda items, the next Finance Committee meeting will include reports relating to Financial Plan Development and Draft Financial Plan, KMPG's Refresh Plan to the FDU, Winter Planning Model 2019/20 and Opportunities Identified by the FDU. The Committee will also receive financial procedures for review and approval.
Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:
21st October 2019

Enw'r Pwyllgor / Name of Committee	Finance Committee
Cadeirydd y Pwyllgor/ Chair of Committee:	Michael Hearty, Associate Member
Cyfnod Adrodd/ Reporting Period:	Meeting held on 21st October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

The Finance Committee has been established to advise the Board on all aspects of finance and the revenue implications of investment decisions. Hywel Dda University Health Board's (HDdUHB's) Finance Committee's primary role is, as such, to provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, giving early warning on potential performance issues and making recommendations for action to continuously improve the financial position of the organisation.

This report summarises the work of the Finance Committee at its meeting held on 21st October 2019, with the following highlighted:

- **Finance Report Month 6** – the Month 6 Finance Report was presented to Committee. The Committee was advised that the Health Board's Control Total requirement is a deficit of £15m, following receipt of £10m Welsh Government (WG) funding in Month 4, subject to achieving this control total by the end of the financial year. The Committee was further advised that the Health Board's financial position at the end of Month 6 represented an adverse variance against plan of £0.7m, which brings the cumulative Year to Date (YTD) variance to £3.8m. The Month 6 YTD variance to breakeven is £12.6m. Operational Directorate projections are at a variance to plan of £7.4m. Projection, including savings risk, including projected slippage on identified savings schemes, is an adverse variance to plan of £13.9m; this would equate to a year end deficit position of £28.9m. The Committee was advised of the risks relating to £2.6m core team funding and £1.4m Welsh Risk Pool. If these do not materialise there will be an additional £4m pressure. The Committee was advised that all opportunities to achieve the £15m control total are being explored with an audit trail to be presented to the next Committee meeting for assurance. It was agreed to hold a structured discussion at the next meeting to receive the assurance that all avenues have been explored prior to advising the Board on the forecast position.

- **Turnaround Report Month 6** – the Turnaround Report Month 6 was presented to Committee. The Committee was advised that Executive Leads have been appointed to each of the priority areas to deliver the annual plan for 2019/20, with project teams identified to progress projects at pace.

- **Referral to Treatment Time (RTT) Month 6 Report –** the Month 6 Referral to Treatment Time (RTT) Report was presented to Committee. The Committee was advised that the total funding provision for 2019/20 stands at £7m. Activity to Month 6 demonstrates targeted expenditure, above core budgeted levels, of

£2.4m plus contractual commitments of £0.2m to support additional validation capacity. Based on current and future projected expenditure patterns, the total projected expenditure for 2019/20 has been revised to £6.5m.

- **Workforce Pay Controls – KPMG Grip And Control Action Plan Update And Establishment Control Project Update** – the Workforce Pay Controls – KPMG Grip And Control Action Plan Update and Establishment Control Project Update was presented to Committee, advising that KPMG's assessment of the control environment operating in HDdUHB to identify areas of improvement has resulted in the development of recommendations and an action plan, which is being led by the Workforce Delivery Group. The Establishment Control Project (ECP) tool is produced and distributed monthly and has been updated in September 2019 to include the reasons for booking bank/agency. Development of a tool to monitor compliance against the Nurse Staffing Act (Wales) 2016 and to assist Senior Nurses monitoring the rostering of staff substantive/bank/agency has been completed. Work is ongoing to review the vacancy figures held within TRAC and the Establishment Control tool.

- **Capital Financial Management –** the Capital Financial Management report was presented to Committee. The Committee was advised that the £1.3m total balance available for allocation is being discussed at the Business, Planning and Performance Assurance Committee (BPPAC).

- **Contracts Update** – the Contracts Update report was presented to Committee, providing the Month 6 and forecast position in relation to Long Term Agreements (LTA).

- **Draft Indicative Financial Plan 2020/21 -** the Draft Indicative Financial Plan 2020/21 was presented to Committee, advising that the opening underlying deficit for 2020/21 has been calculated at £43.2m. The Committee was advised of the £10.4m additional cost of Welsh Health Specialised Services Committee (WHSSC) contracts and Long Term Agreements (LTA). Based upon the current identification of cost pressures and allocation increase assumptions, the financial challenge facing HDdUHB for 2020/21 is £63.2m.

- **External Finance Review/KPMG Refresh Plan to Financial Delivery Unit** – the Committee received a verbal update on KPMG's work to date, advising that the review will be completed by 8th November 2019.

- **Winter Planning Model 2019/20** – the Winter Planning Model 2019/20 was presented to Committee, providing costed winter planning 2019/20 additionality actions that can be put in place to ensure safe navigation through winter. The final plan will be submitted to Board in November 2019.

- **Efficiency Opportunities: Financial Delivery Unit (FDU) Efficiency Framework Report** – the Efficiency Opportunities: Financial Delivery Unit (FDU) Efficiency Framework report was presented to Committee, setting out the key areas of potential improvement of financial performance identified by the FDU and their likelihood of delivery.

- **Financial Procedures** – the Committee approved FP11 Financial Management System (FMS) – System Access & General Ledger Security Procedure.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer /
Matters Requiring Board Level Consideration or Approval:

Discussion on the 2019/20 forecast position.

Risgiau Allweddol a Materion Pryder /
Key Risks and Issues/ Matters of Concern:

- The significant risk in relation to the organisation's ability to deliver the required £15m control total
- Delivery of 2019/20 Savings Plan
- Significant pressures on drugs manifesting in both Secondary and Primary Care; particularly following a price increase in August 2019 in Category M drugs
- Grip and Control highlighted as an area of concern, particularly in Workforce Management
- Risks relating to £2.6m core team funding and £1.4m Welsh Risk Pool. If these do not materialise there will be an additional £4m pressure.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /
Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

In addition to the standing agenda items, the next Finance Committee meeting will include discussion of the Strategic Financial Planning Group Update Report to Strategic Enabling Group (SEG), and reports relating to Corporate Risks and Finance Operational Risks. The Committee will also receive financial procedures for review and approval. An In-Committee meeting will be held to review the financial forecast 2019/20.

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

26th November 2019

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance and Turnaround – Month 7 2019/20
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance Andrew Carruthers, Turnaround Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mark Bowling, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to outline the Health Board's financial position to date against our Annual Plan and Control Total requirement; and assess the key financial projections and risks for the financial year.

Asesiad / Assessment

The Health Board's confirmed control total is £15m. Interim Forecast position now £25m given on-going operational pressures, subject to further discussion at this Board meeting.

It is proposed, given the cumulative financial position and on-going operational pressures, that the Health Board formally changes the forecast outturn from a £15m deficit to £25m deficit. This places a significant risk to the £10m additional Welsh Government (WG) funding received in year, as this was predicated on delivery of the required £15m control total.

A discussion at Finance Committee on 26th November 2019 is expected to result in a recommendation to the Board in respect of the proposed change to the Forecast position. Due to the timing in the publication of Papers for both Finance Committee and Board being seven days prior to the date of the respective meeting, the recommendation from Finance Committee cannot be documented in this Paper, and a verbal update will be provided during this meeting.

Month 7 position

- Month 7 position is £0.9m (Month 6, £0.7m) operational variance to plan (£4.7m YTD).
- Month 7 YTD variance to breakeven is £14.5m.
- Significant adverse variances against plan, in month, partly offset by YTD TB funding of £0.4m and favourable gains elsewhere:
    - Medicines Management Primary Care Prescribing £1.1m;
    - Operational surge, vacancies covered by premium cost staff and drugs in Unscheduled Care impact of £0.4m;

    - Unidentified savings profile impact of £0.4m.
- Recovery and management within available resources critical in future months.

Directorate Projections

- Operational forecasts in excess of budget of £7.9m, plus recognition of £1.0m share of Welsh Risk Pool.
- Projection including savings risk is an adverse variance to plan of £14.8m; this would equate to a year end deficit position of £29.8m.

Savings Summary

- £8.6m delivery to date against £25.2m total savings requirement. The pace of savings delivery requires acceleration in future months.
- £17.5m of Assured schemes.
- £1.8m of Marginal Risk schemes.
- Risk to delivery is therefore £5.9m; includes projected slippage on identified schemes of £1.5m.

Conclusions

Key areas of concern:

- Savings requirement plan has not yet been fully identified;
- Grip and Control has been highlighted as a key area of concern, especially in workforce management;
- Significant pressures on drugs are manifesting in both Secondary and Primary Care;
- Significant risk to £10m additional WG funding as this was predicated on delivery of the required £15m control total. Change in forecast is interim pending completion of normal governance process through Finance Committee and Board.

Summary of key financial targets

The Health Board's key targets are as follows:

- Revenue: to contain the overspend within the Health Board's planned deficit
- Savings: to deliver savings plans to enable the revenue budget to be achieved
- Capital: to contain expenditure within the agreed limit
- PSPP: to pay 95% of Non-NHS invoices within 30 days of receipt of a valid invoice
- Cash: While there is no prescribed limit for cash held at the end of the month, WG encourages this to be minimised and a rule of thumb of 5% of monthly expenditure is used. For the Health Board, this is broadly £4.0m.

Key target		Annual limit	YTD limit	Actual delivery	Forecast Risk
Revenue	**£'m**	15.0	9.8	14.5	**High**
Savings	**£'m**	25.2	9.4	8.6	**High**
Capital	**£'m**	37.2	17.5	17.5	**Medium**
Non-NHS PSPP	**%**	95.0	95.0	95.4	**Low**
Period end cash	**£'m**	4.0	4.0	3.2	**Medium***

*Assumes Welsh Government strategic repayable support for the planned deficit position.

Argymhelliad / Recommendation

The Board is asked to:

- Discuss the financial position for Month 7;
- Note the key drivers to the increased deficit, notably Primary Care Prescribing (£4.4m), Unscheduled Care pressures (£4.1m), Core Team and KPMG (£2.5m), Welsh Risk Pool (£1.0m), and the expected gap in savings delivery for the year (£5.9m). The full effect of these items has been partly mitigated by underspends on other budgets, notably Primary Care and Mental Health, alongside the expected benefit arising from the implementation of Control Totals; and
- Approve the change in the forecast deficit position from £15m to £25m, having considered the advice of the Finance Committee on 26th November and discussed at In Committee Board meeting on 27th November 2019.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	BAF S09-PR20 BAF SO10-PR33
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	5. Timely Care 7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system.
Rhestr Termau: Glossary of Terms:	BGH – Bronglais General Hospital CHC – Continuing Healthcare FYE – Full Year Effect GGH – Glangwili General Hospital GMS – General Medical Services MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence NOAC - Novel Oral Anti-Coagulant

	OOH – Out of Hours PPH – Prince Philip Hospital PSPP– Public Sector Payment Policy RTT – Referral to Treatment Time TB – Tuberculosis WG – Welsh Government WGH – Withybush General Hospital WRP – Welsh Risk Pool WHSSC – Welsh Health Specialised Services Committee YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y pwyllgor cyllid: Parties / Committees consulted prior to University Health Board:	Finance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial impacts and considerations are inherent in the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	These are assessed as part of our savings planning.
Gweithlu: Workforce:	The report discusses the impact of both variable pay and substantive pay.
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	The Health Board has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against the Health Board's financial plan will affect our reputation with Welsh Government, the Wales Audit Office, and with external stakeholders.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Executive Summary

	Health Board's confirmed control total is £15m. Interim forecast position now £25m given on-going operational pressures.
Revenue	• Month 7 YTD variance to breakeven is £14.5m. • Month 7 position is £0.9m (Month 6, £0.7m) operational variance to plan (£4.7m YTD). • Significant adverse variances against plan, in month, partly offset by YTD TB funding of £0.4m and favourable gains elsewhere: o Medicines Management Primary Care Prescribing £1.1m; o Operational surge, vacancies covered by premium cost staff and drugs in Unscheduled Care impact of £0.4m; o Unidentified savings profile impact of £0.4m.
Projection	• Operational forecasts in excess of budget of £7.9m plus recognition of £1.0m share of Welsh Risk Pool; the deterioration from Month 6 is primarily due to Primary Care Prescribing after projecting a further price increase from August; combined with continued pressures relating to NOACs, this is an adverse £4.4m. The projected cost of the investment in the Core Team, including KPMG fees, has also been included this month, totalling £2.5m. • Projection including savings risk is an adverse variance to plan of £14.8m; this would equate to a year end deficit position of £29.8m. • After delivering pipeline schemes there are discussions on-going with WG around the further costs associated with the TB outbreak beyond the confirmed funding of £0.8m.
Savings	• £8.6m delivery to date against £25.2m total savings requirement. The pace of savings delivery requires acceleration in future months. • £17.5m of Assured schemes. • £1.8m of Marginal Risk schemes. • Risk to delivery is therefore £5.9m; includes projected slippage on identified schemes of £1.5m.
Conclusions	Key areas of concern: • Savings requirement plan has not yet been fully identified; • Grip and Control has been highlighted as a key area of concern, especially in workforce management; • Significant pressures on drugs are manifesting in both Secondary and Primary Care;

Executive Summary

- Significant risk to £10m additional WG funding as this was predicated on delivery of the required £15m control total.

  Change in forecast is interim pending completion of normal governance process through Finance Committee and Board.

Summary of key financial targets

The Health Board's key targets are as follows:

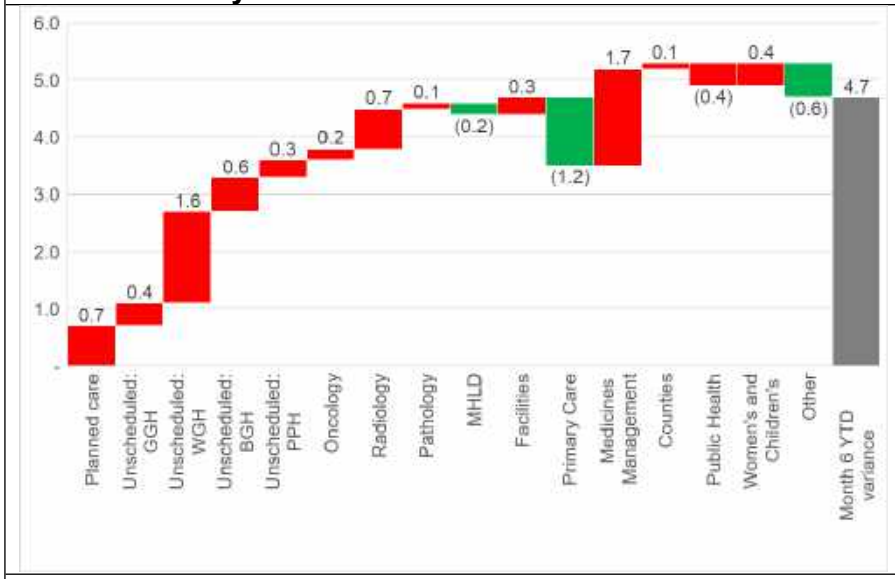
- Revenue: to contain the overspend within the Health Board's planned deficit
- Savings: to deliver savings plans to enable the revenue budget to be achieved
- Capital: to contain expenditure within the agreed limit
- PSPP: to pay 95% of Non-NHS invoices within 30 days of receipt of a valid invoice
- Cash: While there is no prescribed limit for cash held at the end of the month, WG encourages this to be minimised and a rule of thumb of 5% of monthly expenditure is used. For the Health Board, this is broadly £4.0m.

Key target		Annual limit	YTD limit	Actual delivery	Forecast Risk
Revenue	**£'m**	15.0	9.8	14.5	**High**
Savings	**£'m**	25.2	9.4	8.6	**High**
Capital	**£'m**	37.2	17.5	17.5	**Medium**
Non-NHS PSPP	**%**	95.0	95.0	95.4	**Low**
Period end cash	**£'m**	4.0	4.0	3.2	**Medium***

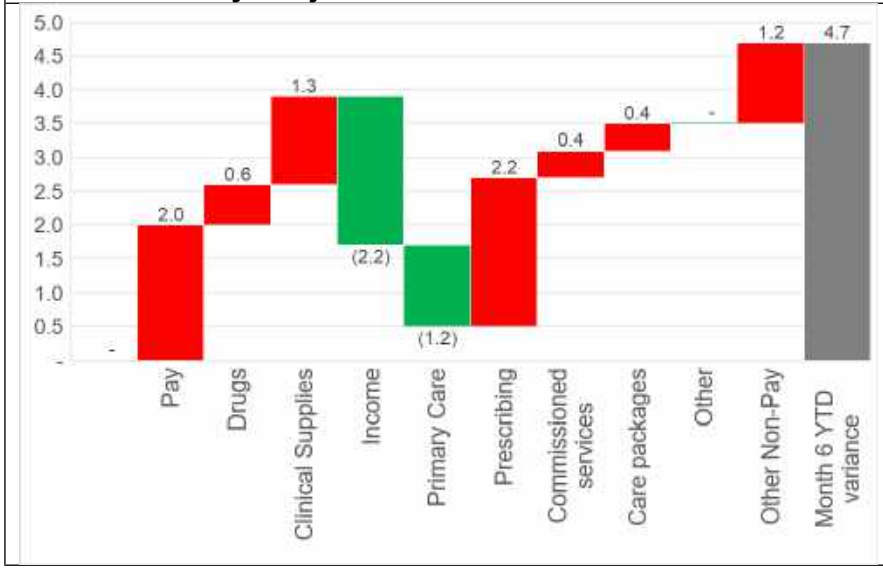
* Assumes Welsh Government strategic repayable support for the planned deficit position.

Revenue Summary

YTD variance by Directorate



YTD variance by Subjective



Assurance

- The Turnaround and Holding to Account (HTA) process provides a high level of scrutiny and challenge to Directorates in terms of adherence to assigned budget and delivery and identification of robust savings schemes.

Concerns

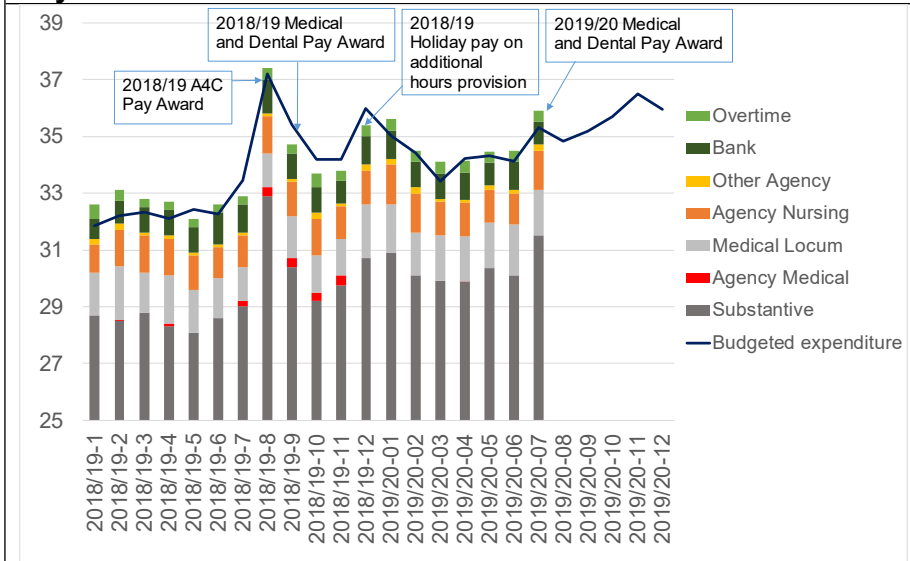
- Of the YTD deficit against plan:
  - £2.9m Unscheduled Care;
  - £1.7m Medicines Management;
  - £0.7m Planned Care;
  - £0.7m Radiology.

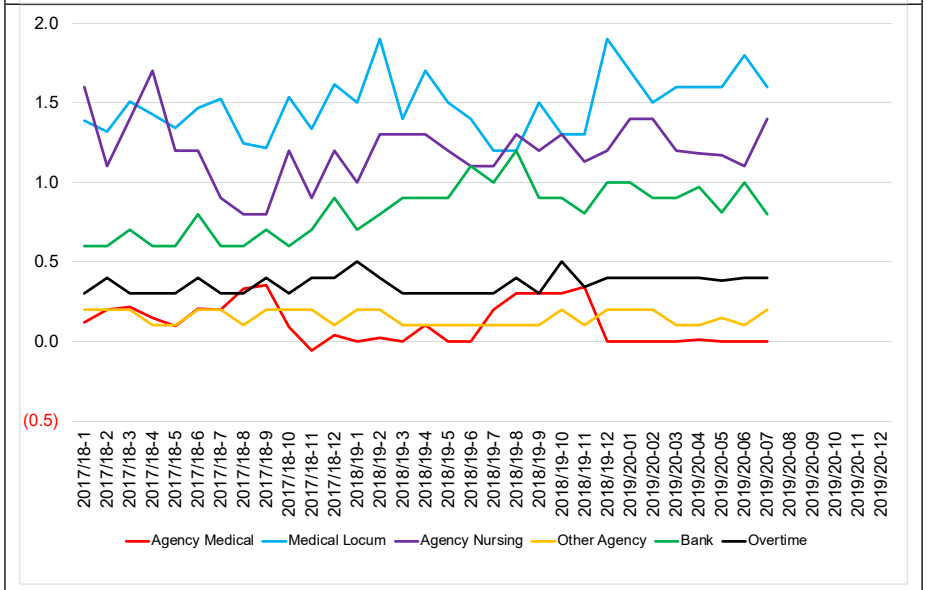
Next Steps

- Core team support to key proposals.
- Embedding output from KPMG Grip and Control Workshops.
- Embed Nursing Establishment Control triangulation of WTEs between financial ledger, ESR/payroll and rostering. Further work to be completed on medical staffing.
- Further work to identify and convert opportunities, with support from KPMG.
- Re-assessment of budget manager responsibilities.
- KPMG proposals drafted to discuss with Executive Team regarding weekly drum beat on control governance, supported by suitable metrics.
- Pursue opportunities on key subjectives on following pages.

Key Subjective Summary

Pay





The Month 7 expenditure is high, predominately due to the impact of the Medical and Dental Pay Award, for which the 2.5% uplift was paid in Month 7 for Months 1-7. Additional substantive newly qualified Nursing resource commenced in-month, however 'dual running' was required for training purposes.

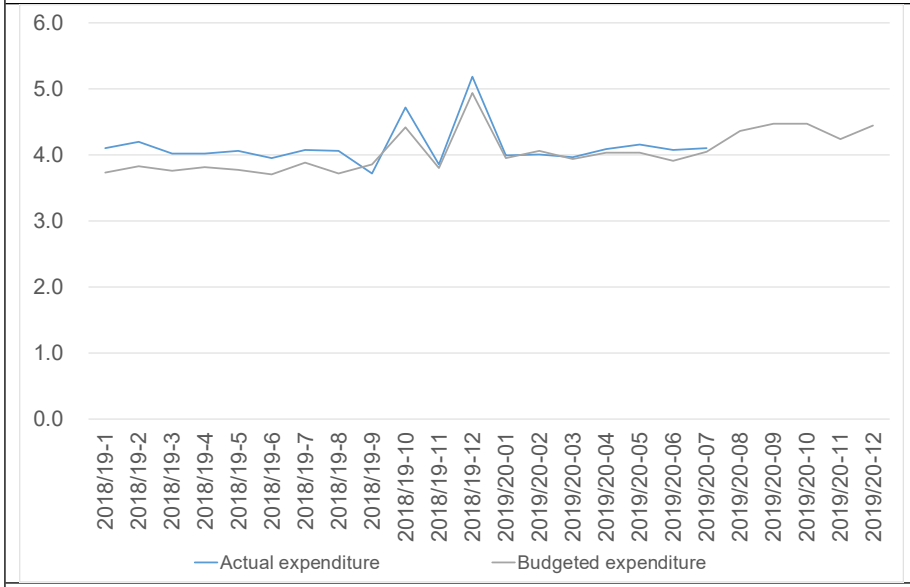
Month 7 variable pay is in line with Month 6, however Nursing Agency has increased due to a significant number of surge beds in Critical Care.

Opportunities:

- Workforce Grip and Control Action Plan developed focusing on:
  - Medical workforce controls
  - Nursing agency controls
  - Nursing rostering controls
  - General workforce controls
- Nursing Task and Finish Group set up to implement Actions for:
  - Agency booking process
  - Targeted reduction in Thornbury use
  - Use of agency HCSWs
  - Review overtime
- Medical Task and Finish Group set up to implement Actions to:
  - Assess impact/control of Consultants 'Acting Down'
  - Address inconsistencies in job plans
  - Cohesive approach to rota management
  - Accuracy of time recording, targeting paid breaks
- Potential areas of over-establishment identified – plan to validate and address areas of concern to be developed.
- Reduce sickness rates through review of sickness policy and non-ward sickness levels.
- Maximise use of bank workforce.

Key Subjective Summary

CHC



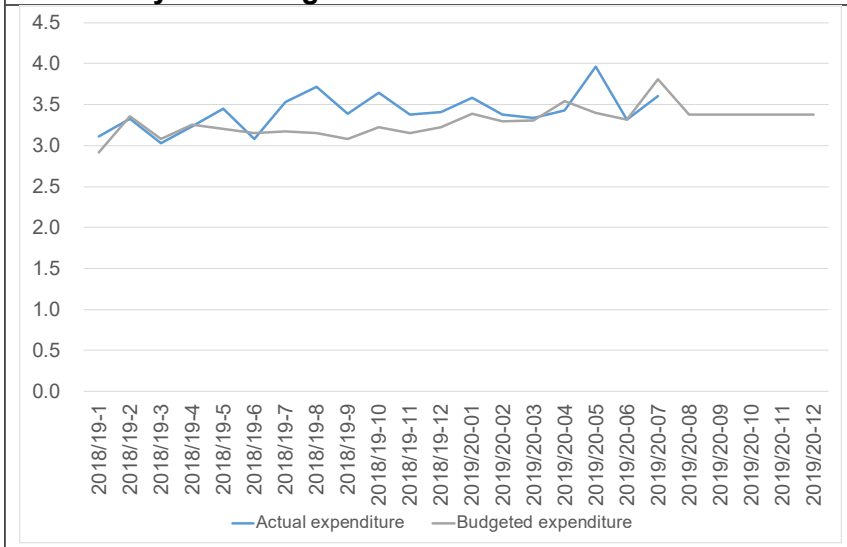
The total number of cases decreased in month. The increase in budget from Month 8 relates to the recognition of expected FNC rate changes and CHC inflation. Full confirmation is awaited, and remains a risk to the position. The complexity of cases remains a key cost driver.

£'m	Spend	Over/(under) spend
FNC/CHC	13.2	(0.2)
LD	8.2	0.6
MH	5.6	0.1
Children	0.7	(0.1)
Total	**27.7**	**0.4**

Opportunities:

- Transfer of placement contracts to national framework.
- Scrutiny of existing and new packages, moving to less restrictive and community based cost effective options.
- Joint working with Local Authority to reduce reliance on residential care and increase use of supported community living.

Secondary Care Drugs



Secondary Care Drugs pressures continue with the Aseptics unit closure and the higher than expected activity treating Wet AMD. The reported position is showing an underspend of £0.2m due to a budget virement in Medicines Management.

Continued support will be needed from the Pharmacy team to address this growth and a number of initiatives are in place to do this.

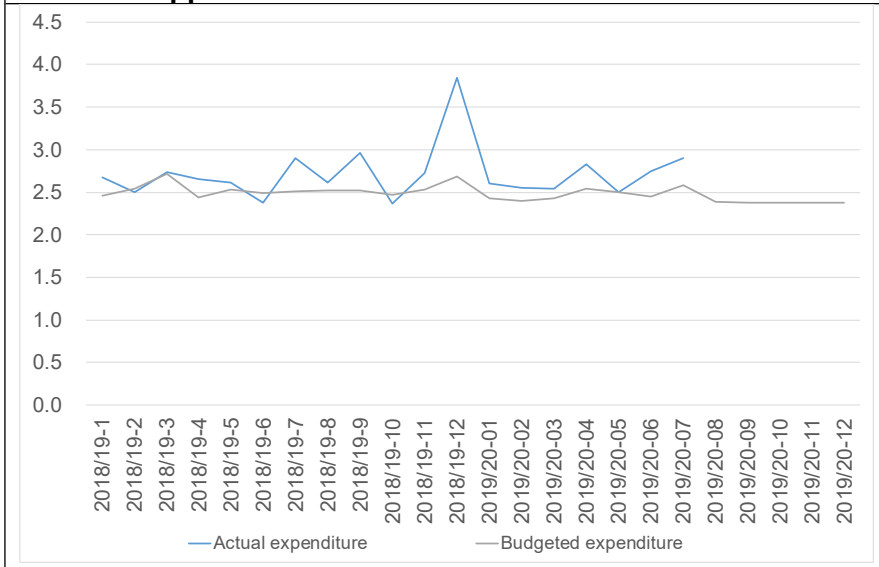
Whilst specific savings schemes are delivering in-month, pressures are being seen in other areas, particularly Dermatology, Rheumatology and Ophthalmology.

Opportunities:

- A benchmarking exercise is underway to identify focus areas.

Key Subjective Summary

Clinical Supplies and Services



The YTD position includes signficant over-spends in relation to diabetic pumps and associated consumables due to a supplier ceasing to trade resulting in the need to replace existing pumps with available alternatives which are more costly. This is primarily manifesting within GGH, Children's Services and WGH Directorates.

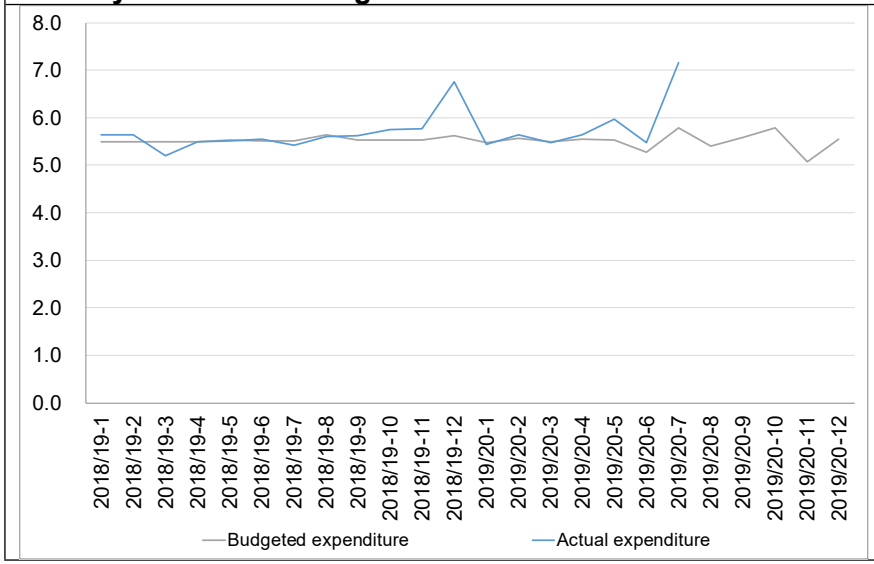
Radiology are outsourcing reporting at a premium cost due to the level of vacancies caused by recruitment challenges.

Planned Care Theatres also had higher than average expenditure in Month 7 in relation to prosthetics and surgical equipment.

Opportunities:

- Non-Pay and Procurement Turnaround Assurance group are assessing the opportunities and identifying a Health Board relationship lead with key suppliers in an effort to improve terms and drive a reduction in costs.

Primary Care Prescribing

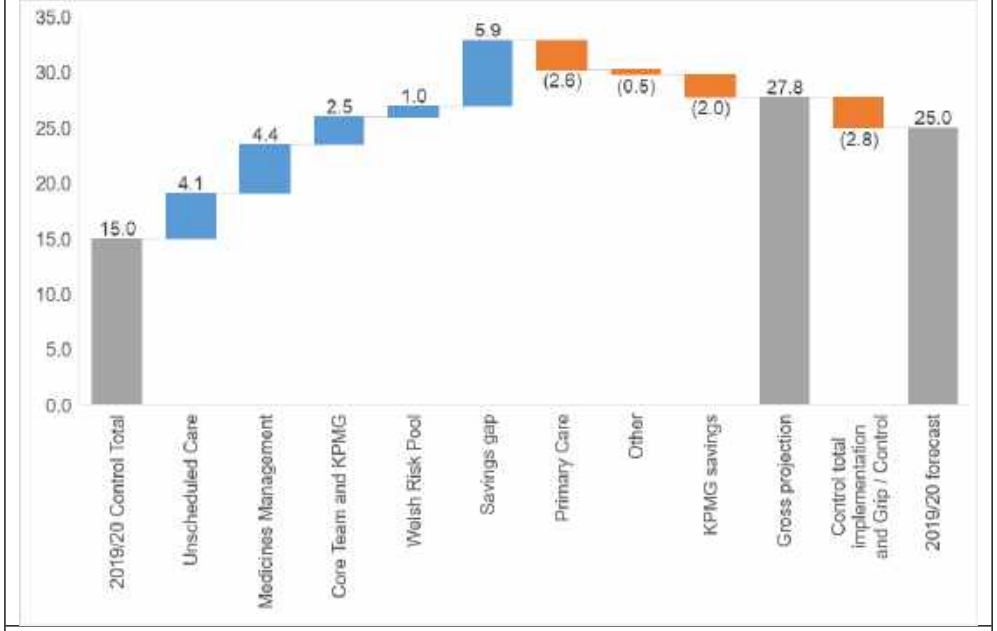


The Directorate reported a significant adverse variance to budget of £1.1m in-month. The projection is an adverse £4.4m to the end of the financial year based on modelling the Category M outturn following the price increase from August 2019. This is a worsening of £1m on the Month 6 model following further price increases. The Health Board has also seen a significant increase in the use of NOACs as a result of the operation of the new NOAC Enhanced Service in GMS.

Opportunities:

- A benchmarking exercise is underway to identify focus areas.

Directorate Projections



Assurance

- The Turnaround and Holding to Account process provides a high level of scrutiny and challenge to Directorates in terms of adherence to assigned budget and delivery and identification of robust savings schemes.

Concerns

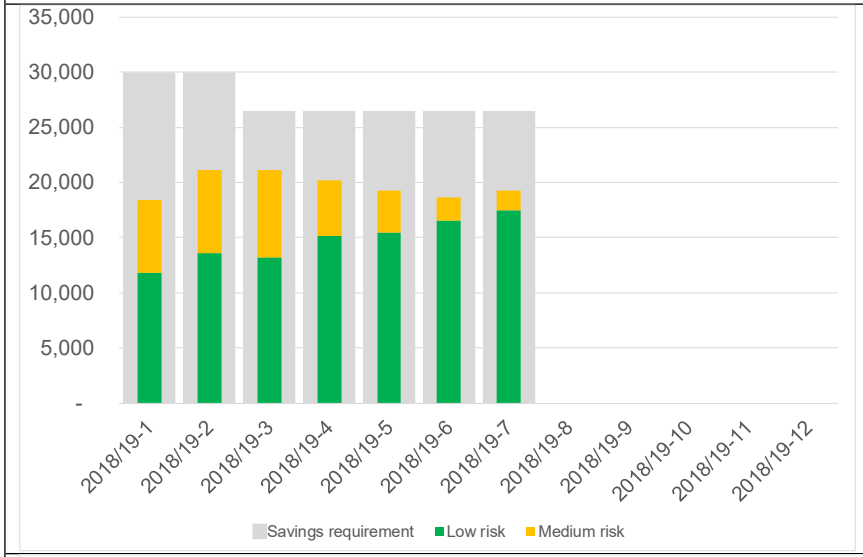
- Current projections indicate: 1) a gap of £4.4m in fully identified savings schemes; 2) operational forecasts in excess of budget of £7.9m, plus recognition of £1.0m share of Welsh Risk Pool, plus projected slippage on identified schemes of £1.5m, giving a projection of £14.8m adverse variance to plan. This would equate to a year end deficit position of £29.8m. After delivery of the KPMG savings, the forecast is £27.8m.
- The financial position is under severe pressure and, as a result of the cumulative position and trajectory, the reported forecast is now £25.0m. This change in forecast is interim, pending completion of the Health Board's normal governance process through Finance Committee and Board.
- There is a risk to the additional WG funding of £10.0m as this was dependent on the Health Board achieving the required Control Total of £15.0m.

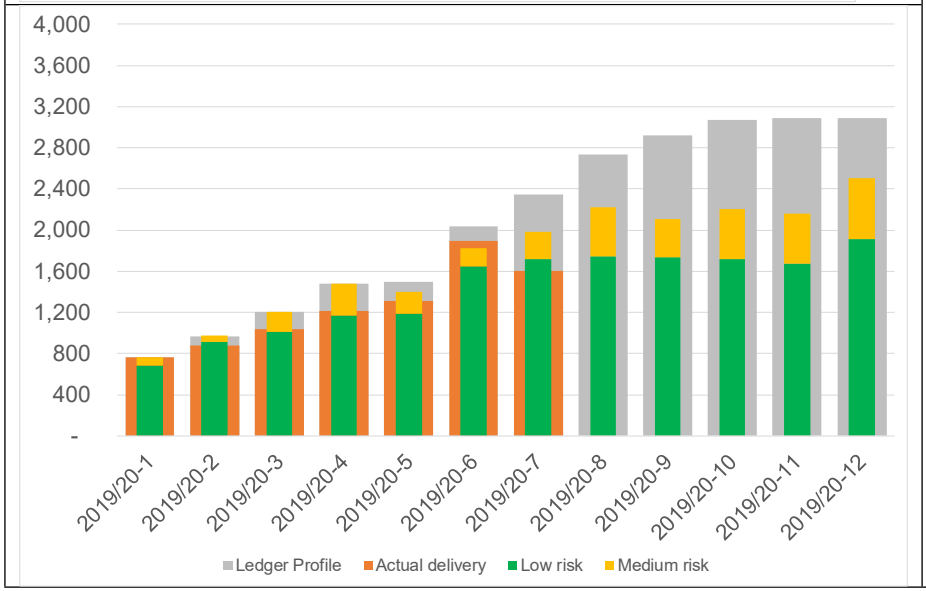
Next Steps

- Grip and Control workshops:
  - Workforce conducted in September, now being translated into Action Plans with pace;
  - Pharmacy scheduled to include all Lead Pharmacists;
  - Further workshops to be scheduled to cover other material opportunity categories.
- KPMG opportunities to be developed into Pipeline schemes, with further assessment of potential in-year benefit and patient quality outcomes to allow prioritisation.

Savings and turnaround actions

Risk-assessed directorate savings profile, delivery and forecast





Assurance

- Green and Amber forecast delivery of £19.3m identified to Month 7, of which £17.5m are Assured (Green).
- In-month delivery of £1.6m, which is broadly in line with Month 6, however £0.4m below plan.

Concerns

- The full identification of savings and the delivery of those plans is also an area of concern, and one which remains subject to our accountability process.
- The gap between identified plans and the ledger profile of the savings requirement has led to an adverse variance of £0.4m in Month 7. The pace of savings delivery requires acceleration in future months.
- Cumulative slippage in delivery of Green and Amber schemes is £0.8m; total slippage projected in delivery of savings £1.5m.

Next Steps

- Working with KPMG, there are certain areas where we are seeking to increase the level of focus to address the weekly metrics we have available as the lead indicators of delivery in order to better focus our efforts.
- The KPMG draft opportunities identified to date, prior to any risk adjustments are:
    - Lever 0: Grip and Control £1.7m
    - Lever 1: Efficiency and Productivity £2.1m
    - Lever 2: Shift Left £0.1m
    - Lever 3: Duplication £0.9m

  Expected delivery after risk adjustments is £2.0m.

Appendix 1: Turnaround Update

Turnaround update

Section 1 – Summarises 19/20 Directorate savings plans against required savings target of 3.7% for Directorates that are escalated to the Chief Executive Holding to Account meetings. The figures included in this section are based on the known Month 7 position as at 6th November 2019 and will be subject to change with the identification of further savings opportunities. Figures in square brackets represent the position in the previous month, where different to current month.

Facilities	**19/20 target saving £'000s**	**1,385**	**Total of saving plans £'000s**		917	450	0	**1,367**	**Variance £'000s**	**18**	**Idea in-year potential**	**125**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(521)	(489)	32	Water management scheme under delivering partly due to an improvement in Health Board processes (£14k to month 7, expected year-end variance of £40k.) Carbon credit settlement was £8k less than anticipated. On-call reduction has delivered £7k less than planned at Month 7.							
	Amber schemes	(58)	(0)	6	Re-introduction of Borehole in WGH has not delivered savings to date (£8k). Non-domestic rates due to start delivering from Oct 19 (£50k) has not delivered.							
	Red schemes	0	0	0	Facilities management savings and further benchmarking savings have not been identified. These schemes have both been closed.							
	Total	(579)	(451)	76	Other actions agreed • A formal risk assessment on all held vacancies to be undertaken. • A paper on electronic advertising opportunities to come back to the next CEO HTA. • Review current specification of sheets and agree tendering process/availability from the Procurement Framework • Develop the Business Case/ Invest to Save documents for future energy plans • A robust Delivery Plan to be presented at next CEO HTA meeting that provides confidence in meeting the 2019/20 savings target. • A robust Delivery Plan to be produced for 20/21							

Appendix 1: Turnaround Update

Pathology	**19/20 target £'000s**	**741**	**Total plans £'000s**		289	140	321	**750**	**Variance £'000s**	**(9)**	**Idea in-year potential**	**63**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(133)	(142)	(9)	N/A							
	Amber schemes	(20)	(20)	0	Secondary Care Demand Optimisation savings starting to come through. Total of £100k planned for 19/20 – on track for delivery.							
	Red schemes	0	0	0	£321k demand optimisation scheme. This scheme has been closed.							
	Total	**(153)**	**(162)**	**(9)**	Other actions agreed PID to be developed for the reconfiguration of the Blood Sciences out of hours service in Carmarthenshire. • Demand optimisation work being progressed with Project Management support – see update in Section 3 of this report.							

Scheduled Care	**19/20 target £'000s**	**3,682**	**Total plans £'000s**		2,531 [2,031]	50 [575]	671 [646]	**3,252**	**Variance £'000s**	**430**	**Idea in-year potential**	**1,325**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(1,186)	(972)	214	Delivery of reduced outsourcing of cataract activity and review of on-call arrangements continue to be delayed due to the current medical workforce position. Reorganisation of elective orthopaedic activity has also slipped and has under-delivered by £104k as at Month 7. Transactions against loss of patent schemes in September and October 19 have mitigated some of the impact of the above schemes.							
	Amber schemes	(25)	(10)	15	This relates to the Urology Medical Staffing (PSA monitoring) scheme.							
	Red schemes	(313)	0	313	Referral Management opportunities and reduction in inefficient procedures schemes will not deliver in 19/20 and have been closed.							
	All schemes	**(1,524)**	**(982)**	**542**	Other actions agreed Reassess risks and opportunities and bring re-forecast to the Nov 19 CEO HTA meeting.							

Appendix 1: Turnaround Update

BGH USC	19/20 target £'000s	786	Total plans £'000s		851 [801]	68 [0]	44 [162]	963	Variance £'000s	(177)	Idea in-year potential	0
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(540)	(538)	2	Roster efficiency scheme is under-delivering although this has been offset by an over-delivery against the Nurse Agency scheme.							
	Amber schemes	0	0	0	Collaborative MH Shared Care Model Enlli/Y Banwy (amber elements) due to deliver from January 2020.							
	Red schemes	0	0	0	Collaborative MH Shared Care Model (red elements) and printer review scheme will not deliver in 19/20 and have been closed.							
	Total	**(540)**	**(538)**	**2**	Other actions agreed • Collaborative MH Shared Care Model - identify what success will look like and the level of confidence in delivery. • Develop a PID to scope out a 5-day short-stay surgical model by next CEO HTA meeting. • Frailty assessment implementation plan to be produced by next CEO HTA meeting. • Discussion about expanding Community service to free-up hospital beds- would mean higher acuity patients in hospitals and length of stay would increase but there would be fewer patients. • Review opportunities for BGH and Community to work together more closely.							

GGH USC	19/20 target £'000s	1,557	Total plans £'000s		732	373	339	1,444	Variance £'000s	113	Idea in-year potential	0
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(426)	(460)	(34)	Cumulative under-delivery of roster efficiency savings (£48k) at Month 7. Transactions against the loss of patent scheme in September and October 19 contributed to the year to date position.							
	Amber schemes	(36)	0	36	• Length of Stay – recurrent planned savings from Oct 19 have not delivered. This scheme has been closed. However, non-recurrent savings are forecast to deliver from January 2020. • Thornbury reduction – planned savings from Nov 19.							
	Red schemes	(185)	0	185	This relates to the Nurse on-boarding scheme which will not deliver and has been closed.							
	Total	**(647)**	**(460)**	**187**	Other actions agreed • Implementation plans for Frailty and for Ambulatory Care to be developed							

Appendix 1: Turnaround Update

PPH USC	**19/20 target £'000s**	**931**	**Total plans £'000s**		639 [263]	150 [526]	0	**789**	**Variance £'000s**	**142**	**Idea in-year potential**	**0**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(148)	(322)	(174)	The Community Intermediate Beds scheme (amber elements) has not delivered the expected £87k saving in October 19. Transactions totalling £260k have been transacted in September and October 19 against the loss of patent scheme.							
	Amber schemes	(0)	(0)	0	The Community Intermediate Beds scheme (red elements) will not deliver in 19/20 and has been closed.							
	Total	**(148)**	**(322)**	**(174)**	Other actions agreed Reassess opportunities for 6 beds by the next CEO HTA meeting.							

WGH USC	**19/20 target £'000s**	**1,125**	**Total plans £'000s**		986 [1,125]	139	0	**1,125**	**Variance £'000s**	**0**	**Idea in-year potential**	**125**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(588)	(541)	47	The Ambulatory Care scheme has under-delivered by £53k as at Month 7. This work continues to be progressed through the wider Improvement Collaborative work. The Ward 10 refurbishment scheme has also under-delivered by £28k as at Month 7. Transactions against the loss of patent scheme in September and October 19 have mitigated some of the impact of the above schemes.							
	Amber schemes	(77)	(5)	72	This relates to the Middle Grade vacancy position in Medicine.							
	Total	**(665)**	**(546)**	**119**	Other actions agreed Strategic overview of the key issues in accessing Packages of Care and potential solutions to be presented at the next CEO HTA meeting.							

Oncology & Cancer	**19/20 target £'000s**	**438**	**Total plans £'000s**		284	0	0	**284**	**Variance £'000s**	**154**	**Idea in-year potential**	**15**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(170)	(157)	13	• Homecare opportunities scheme is not being fully realised (£40k delivered against a planned saving of £96k at Month 7). • Trastuzumab Invest to Save scheme has delivered £47k more than planned as at Month 7.							
	Total	**(170)**	**(157)**	**13**	Other actions agreed • Explore opportunities to support in-sourced activity.							

Appendix 1: Turnaround Update

Section 2 – Summarises 19/20 Directorate savings plans against required savings target of 3.7% for Directorates that are monitored through the Turnaround Director Holding to Account meetings. The figures included in this section are based on the known Month 7 position as at 6th November 2019 and will be subject to change with the identification of further savings opportunities.

Carmarthenshire County	**19/20 target £'000s**	**884**	**Total plans £'000s**		683	121	0	**804**	**Variance £'000s**	**80**	**Idea in-year potential**	**0**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(340)	(276)	64	Slippage against a number of schemes, including nurse recruitment, Chronic Disease Management and Amman Valley Hospital ambulatory care, has been partly offset by delivery against the CHC and Palliative Care schemes.							
	Amber schemes	(60)	(4)	56	A number of amber schemes have not delivered as planned. Approval has been granted to invest capital to deliver the Medicine Locker scheme.							
	Total	**(400)**	**(280)**	**120**	Other agreed actions • Start to implement Bridging Service							

Ceredigion County	**19/20 target £'000s**	**415**	**Total plans £'000s**		355	60	200 [0]	**615**	**Variance £'000s**	**0**	**Idea in-year potential**	**None**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(191)	(191)	0	N/A							
	Amber schemes	0	0	0	N/A							
	Red schemes	0	0	0	N/A							
	Total	**(191)**	**(191)**	**0**								

Appendix 1: Turnaround Update

Pembrokeshire County	19/20 target £'000s	729	Total plans £'000s	351	53	388	792	Variance £'000s	(63)	Idea in-year potential	None
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**						
	Green schemes	(241)	(231)	10	CHC scheme slippage of £10k to Month 7 due to delays in reviewing a number of cases. Assurance has been given that robust processes are in place locally to ensure reviews are being undertaken in a timely way, and that new cases are being assessed in line with Health Board policy.						
	Amber schemes	(24)	0	24	This variance represents slippage on the Enhanced Recovery service scheme.						
	Red schemes	0	0	0	Both red schemes have not delivered and have been closed.						
	Total	**(265)**	**(231)**	**34**	Other agreed actions To address their savings gap, the Directorate have been tasked with Identifying slippage on new monies due to be received in 19/20, reviewing areas where spend had not been incurred so far this year with a view to holding the position for the remainder of this financial year only and reviewing any new spend planned over the second half of the year with a view to whether it could be stopped, delayed or held for the remainder of the financial year.						

Women & Children	19/20 target £'000s	1,359	Total plans £'000s	421	0	108	529	Variance £'000s	830	Idea in-year potential	70
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**						
	Green schemes	(130)	(111)	19	£15k relates to the review of the visiting Anti-natal Clinic – this was due to start delivering £15k per month from October 19.						
	Red schemes	(48)	(0)	48	C sections – improvements in performance scheme has not delivered and has been closed.						
	Total	**(178)**	**(111)**	**67**							

Appendix 1: Turnaround Update

Primary Care	**19/20 target £'000s**	**790**	**Total plans £'000s**		1,058	227	400	**1,685**	**Variance £'000s**	**(895)**	**Idea in-year potential**	**0**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(403)	(377)	26	Locum cost scheme has under-delivered by £26k as at month 7. Total planned 19/20 savings are £670k.							
	Amber schemes	(81)	(9)	72	• GP Hub likely to deliver only £51k - saving to be re-profiled. • The savings from the Salaried GPs have yet to be identified or transacted.							
	Red schemes	(61)	0	61	Steps are being taken to return one managed practice to independent contractor status by December 19. This may deliver £36k in quarter 4. There has been no interest in the other two managed practices. Work to continue on an alternative model to reduce costs by a further £50k over the second half of the year.							
	Total	**(545)**	**(386)**	**159**								

Radiology	**19/20 target £'000s**	**584**	**Total plans £'000s**		390	405	0	**795**	**Variance £'000s**	**(211)**	**Idea in-year potential**	**0**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(165)	(85)	80	Reduction in outsourcing costs not delivered in Month 3, 4 or 6.							
	Amber schemes	(152)	0	152	24 hour provision of Radiology services – proposed rota changes currently out to consultation. Savings re-profiled for revised delivery date of January.							
	Total	**(317)**	**(85)**	**232**								

Mental Health	**19/20 target £'000s**	**2,691**	**Total plans £'000s**		2,521	124 [56]	44 [112]	**2,689**	**Variance £'000s**	**2**	**Idea in-year potential**	**0**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Mitigating actions**							
	Green schemes	(1,045)	(1,081)	(36)	The under-delivery of a number of schemes has been mitigated through slippage transacted in Months 5, 6 & 7.							
	Amber schemes	(45)	(0)	45	Non-recurrent element of the roster review and nursing KPIs scheme did not deliver the planned £36k saving by Month 2. No further savings are planned in relation to this scheme and it has therefore been closed.							
	Red schemes	0	0	0	Collaborative Care Scheme – due to the delayed delivery of this scheme to January 20 this scheme has been closed.							
	Total	**(1,090)**	**(1,081)**	**9**	<u>Other actions agreed</u> To develop a plan for the delivery of 19/20 schemes recurrently along with maintaining current performance. Recurrent plan to include plans to cover the £1.5m of 19/20 non-recurrent actions.							

Appendix 1: Turnaround Update

Section 3 – Executive Team priority areas

3.1 The table below provides an update against each of the Executive Team priority areas with associated savings plans for 19/20, as at Month 7.

Workforce	**19/20 target £'000s**	5,900 [7,389]	797 [1,005]	339 [851]	**Total**	**7,036 [9,245]**	**Idea in-year potential**	**1,863**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**			
	Objectives: • Support schemes developed by other Directorates which have a workforce element to their delivery; • Monitor expenditure on variable pay across all staff groups; and • Identify Health Board wide/corporately driven schemes which may deliver results in workforce efficiency and effectiveness.							
	Green schemes	(3,448)	(2,960)	488	Progress last month: • First meeting of Workforce Delivery Group held on 16th October 2019. Terms of Reference considered and objectives agreed. • Liaison with Finance to determine the delivery status of Directorate workforce related schemes, including any risk to delivery of 'green' schemes. • Identifications of Corporate schemes and a number of opportunities scoped. Actions for November: • Agree the 19/20 priorities at the next meeting on 18th November for both Directorate and Corporate schemes. • Allocate Project Leads to the priority schemes. • Produce PIDs/plans for agree priority schemes.			
	Amber schemes	(294)	(9)	285				
	Red schemes	(185)	0	185				
	Total	**(3,927)**	**(2,969)**	**958**				

Appendix 1: Turnaround Update

<table>
<tr><td rowspan="6">Patient Flow – Unscheduled Care</td><td>19/20 target £'000s</td><td>991</td><td>369</td><td>0</td><td>Total</td><td>1,360</td><td>Idea in-year potential</td><td>525</td></tr>
<tr><td>Schemes</td><td>YTD planned</td><td>YTD actual</td><td>YTD variance</td><td colspan="4">Progress</td></tr>
<tr><td colspan="8"><u>Objectives:</u>
• Undertake review of current activity underway/ planned and agree actions to be carried out within USC with aim to improve overall LOS
• Agree and undertake short term changes to service(s)/ site(s) that will bring demonstrable improvements within 2019/20
• Acknowledge and plan (if appropriate) the required longer term changes</td></tr>
<tr><td>Green schemes</td><td>(463)</td><td>(257)</td><td>206</td><td colspan="4" rowspan="3">Progress last month:
• USC improvement work-stream/ group established (with fortnightly meetings in place)
• PIDs for each site General Hospital site completed and being reviewed/ updated – key areas for activity broadly noted as 1. Ambulatory care; 2. Frailty
• Scoping activity planned/ underway at each site in line with acute flow bed reduction across whole system
• Discussions underway regarding data requirements to ensure suggested changes are appropriate.
Actions for November:
• Complete scoping discussions/ activity
• Begin support to key project areas to show demonstrable improvements with 2019/20
• Confirm data requirements to ensure suggested changes are appropriate</td></tr>
<tr><td>Amber schemes</td><td>(36)</td><td>0</td><td>36</td></tr>
<tr><td>Total</td><td>(499)</td><td>(257)</td><td>242</td></tr>
</table>

Appendix 1: Turnaround Update

Patient Flow – Critical Care	**19/20 target £'000s**	338	0	0	**Total**	**338**	**Idea in-year potential**	**0**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**			
	Objectives: • Undertake review of current Critical care service noting overall baseline/ flagging areas of concern and/ or areas for improvement • Plan required longer term changes • Agree and undertake short term changes to service that will bring demonstrable improvements within 2019/20							
	Green schemes	(176)	(165)	11	Progress last month: • Critical care work-stream/ group established (with fortnightly meetings in place) • Draft PID completed noting overall project outputs/ activity (currently aimed at longer term service changes/ redesign) Actions for November: • Agree with service short term improvements/ changes that can be carried out during financial year 2019/20 • Plan & undertake wider engagement with critical care (and linked services) to agree overall way forward regarding service redesign for the longer term			
	Total	**(176)**	**(165)**	**11**				

Patient Flow – Out of Hours	**19/20 target £'000s**	380	120	0	**Total**	**500**	**Idea in-year potential**	**375**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**			
	Objectives: • To overcome multi-faceted issues affecting the current Out of Hours service in Hywel Dda and agree a vision for a future service model. • Address the current service fragility affecting Out of Hours sites caused through workforce pressures. • Develop a future workforce plan taking into account recruitment opportunities, flexible working and the growing concept of multi-disciplinary teams. • Measure and analyse identified weaknesses of the current service in relation to the patient flow through 111 call centre and clinical support hub. • Assess opportunities to re-brand the service in light of the need to readdress patient expectations and behaviours in relation to urgent primary care. • In noting links to other projects, develop an integrated 24/7 approach to urgent primary care.							
	Green schemes	(155)	(155)	0	Progress last month: • Successful future service model workshop held on 24th October, attended by GP out of hours staff and other key stakeholders • Winter plans and deliverables approved by exec. team and change plan commenced Actions for November: • Feedback to workshop attendees on what they contributed and to engage on next steps • Deliver the associated actions for December within the winter change and communications plans.			
	Amber schemes	(380	(38)	0				
	Total	**(193)**	**(193)**	**0**				

Appendix 1: Turnaround Update

Patient Flow – Primary Care	**19/20 target £'000s**	1,058	227	400	**Total**	**1,685**	**Idea in-year potential**	**0**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**			
	Objectives: • Explore all factors that currently influence patient flow in Primary Care as part of a wider context of improving performance in unscheduled care • Take a demand management focused approach, to explore the different components of demand that impact on Primary Care • Use the Primary Care model for Wales and the National Strategic Programme for Primary Care to act as a key "lens" for the project. • Act and build on the Primary Care access guidance issued by the Health Minister. • Consider urgent primary care in the round and to note cause and effect from different components of the urgent primary care system • Examine local innovation at a locality level and explore standardisation of good practice where possible i.e. control room approach to triage. • Develop a communications plan for Primary Care building on successful examples elsewhere • Develop quick wins as an early output for the project where there is a known requirement. i.e. communications support for patient education, improving health literacy etc. • Develop further projects with community pharmacy to reduce demand on clinicians' time in Primary Care. • Quickly note the numerous links and dependencies in other projects to avoid duplication.							
	Green schemes	(403)	(377)	26	Progress last month: • Early days in project initiation – introductory meeting between PM & Asst Director of Primary Care to explore relevant discussion points • First draft of PID completed Actions for November: • Identify project team • Present PID to initial group meeting • Push forward quick wins for the project and develop a change plan			
	Amber schemes	(81)	(9)	72				
	Red schemes	(61)	0	61				
	Total	**(545)**	**(386)**	**159**				

Appendix 1: Turnaround Update

Outpatients

19/20 target £'000s	198 [75]	50 [575]	325 [146]	**Total**	**573 {796}**	**Idea in-year potential**	**425**

Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**
Objectives: To oversee an Efficiency and Productivity plan that could release core capacity in to the system, including; • Improve new to follow-up ratios • Improve outcome form compliance • Reduce new and follow-up DNA rates • Improve patient pathways • Reduce follow-ups and follow-ups not booked; • Establish a process for managing Seen on Symptoms (SOS) patients • Increase uptake of electronic referrals • Improve referral management processes				
Green schemes	(55)	(53)	2	Progress last month: • Work continues to streamline referral pathways for each specialty, to implement Skype clinics and to improve compliance with follow-up criteria. Actions for November: • Agree the scope of the Outpatients programme of work • Consider links to the Chronic Conditions group to ensure a whole pathway approach is taken.
Amber schemes	(25)	(10)	15	
Red schemes	(233)	0	233	
Total	**(313)**	**(63)**	**250**	

Appendix 1: Turnaround Update

Mental Health & Learning Disabilities

19/20 target £'000s	596	136	88	**Total**	**820**	**Idea in-year potential**	**0**

Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**
Objectives: • Shared Care project for Older Adults Mental Health • Developing plan for Transformation of Learning Disability Services • Moving forward TMH programme deliverables				
Green schemes	(333)	(324)	9	Progress last month: • Draft Standard Operating Procedure developed for shared care model, estates work has commenced, staff workshops have taken place and 1:1 sessions planned. An evaluation framework has been agreed based on other areas where similar models are in place. • LD programme – resettlement of long-stay patients within the community is underway, the Intensive Support Team has launched and the Primary Liaison Service has been approved. The scope of the programme around the future model for specialist LD care has been defined. • Third sector commissioning has been brought forward to reflect the development of the Gorwelion pilot in Aberystwyth. Agreement in principle to carry out the review work jointly. Actions for November: • SOP and medical model for shared care model to be signed off by project board, complete OCP and submit to Executive Team for approval and develop a communications plan for wider communications and engagement. • LD programme – resettlement of long-stay patients within the community to continue, determine engagement and consultation requirements for designing the future model for specialist LD care, draft a specification which outlines how the Health Board and third sector organisations can formally support engagement and consultation. • Development of the Single Point of Contact design, liaising with local authority partners. The Programme Business Case for Transforming Mental Health is due to be submitted next month. The HIW review of Gorwelion resulted in additional estates work being required, resulting in delay to work while costings are agreed. This impacts on the development of the place of safety, and reduced testing time for the model.
Amber schemes	0	0	0	
Red schemes	0	0	0	
Total	**(333)**	**(324)**	**9**	

Appendix 1: Turnaround Update

Demand Optimisation – Pathology								
	19/20 target £'000s	79	120	321	**Total**	**520**	**Idea in-year potential**	**125**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**			
	Objectives: • Develop a data tool to enable assessment of pathology test request activity and costs. • Use the data tool (and other data sources and evidence) to investigate potential areas of demand optimisation focussed on reducing unwarranted variation and/or optimising overall care through better use of pathology. • Work with clinicians and clinical teams to develop, agree and implement demand optimisation interventions.							
	Green schemes	(39)	(39)	0	Progress last month: • Data tool developed and in use (note that continuous development required over lifetime of this priority area work). • Eight potential pathology demand optimisation interventions identified and in various states of development (one already initiated). • Two of the eight developed to the point of initiation in November (Limiting Tumour Marker requests from Primary Care & Anaemia Test Profile Pilot in Primary Care). Actions for November: • Initiate two demand optimisation interventions (Limiting Tumour Marker requests from Primary Care & Anaemia Test Profile Pilot in Primary Care). • Complete scoping of other five potential demand optimisation interventions. • Develop overall programme and savings plan for all viable demand optimisations. Considerable time and consultation is required to work up and agree demand optimisation interventions, therefore the savings target unlikely to be met in short term.			
	Amber schemes	(10)	(10)	0				
	Red schemes	0	0	0				
	Total	**(49)**	**(49)**	**0**				

Appendix 1: Turnaround Update

Commissioning & Contracting

19/20 target £'000s	676 [534]	225 [133]	0 [150]	**Total**	**809 [817]**	**Idea in-year potential**	**0**

Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**
Objectives: • Cardiology service model and pathway with Swansea Bay • Reclaiming costs of section 117 after care from external health boards • PPH theatre utilisation				
Green schemes	(384)	(403)	(19)	Progress last month: • Project scoping has taken place to identify priority areas. Actions for November: • Link with project leads to determine nature of project support required, current milestones met to date, etc. • Gather developed business cases to determine scope of existing projects and governance in place.
Amber schemes	(32)	0	32	
Total	**(416)**	**(403)**	**13**	

Medicines Management

19/20 target £'000s	2,786 [2,810]	258	792	**Total**	**3,836**	**Idea in-year potential**	**0**

Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**
Objectives: • Consideration of priority areas identified by KPMG. • Excess medicine stock – reduction in stock days to average to reduce obsolescence and disposal costs (£225k). • To scope opportunities in for benefits realisation in relation to Biosimilar insulin (£74k), Lio-thryonine (£15K), repeat prescribing process (£650K), PODs (£150K cost avoidance if 75% use of Patient's own drugs), Aspirin in VTE (£38k).				
Green schemes	(1,277)	(1,880)	(603)	Progress last month: • Key opportunity areas have been identified and individual business cases developed. • Stakeholder identification, mapping and assessment undertaken and communications and engagement plan developed • Relationship management plan developed • Stakeholder cost benefits and benefits realisation plan developed Actions for November: • Partner executive work stream groups to champion medicines management opportunities • Partner service delivery leads, managerial leads and clinical leads to champion medicines management opportunities • Develop monitoring, evaluation and reporting mechanisms and Quality Assurance Plan.
Amber schemes	(41)	(41)	0	
Red schemes	(103)	0	103	
Total	**(1,421)**	**(1,921)**	**(500)**	

Appendix 1: Turnaround Update

Non-Pay	**19/20 target £'000s**	3,564 [3,441]	508	0	**Total**	**4,072 [3,949]**	**Idea in-year potential**	**395**
	Schemes	**YTD planned**	**YTD actual**	**YTD variance**	**Progress**			
	Objectives: • Seek assurance that managers are effectively managing non-pay claims • Identify opportunities for positive communication with staff to raise awareness of, and support a reduction in, non-pay expenditure • Identify and promote alternative options to individual private travel • Monitor the delivery of all non-pay saving schemes							
	Green schemes	(1,479)	(1,294)	185	Progress last month: • A number of potential savings opportunities identified and scoping commenced. • Opportunities to implement an electronic pool car booking system, electronic key cabinets and a travel hierarchy are being explored. • Review of contracts with suppliers continued – 40 interviewed to date. • Options to standardise knee prostheses are being progressed. Actions for November: • Agree action plan for 19/20 priorities • Commence work to conduct a feasibility study on Community Nurse scheduling software. • Continue with review of top 100 contracts • Complete review of Endoscopy consumables			
	Amber schemes	(88)	0	88				
	Total	**(1,567)**	**(1,294)**	**273**				

Appendix 1: Turnaround Update

Section 4 – Executive Team priority areas – new workstreams

4.1 The table below provides an update against each of the Executive Team priority areas which do not yet have any identified savings as at Month 7.

Demand Optimisation - Radiology	Objectives: • Develop a data tool to enable assessment of radiology test request activity and costs. • Use the data tool (and other data sources and evidence) to investigate potential areas of demand optimisation focussed on reducing unwarranted variation and/or optimising overall care through better use of radiology. • Work with clinicians and clinical teams to develop, agree and implement demand optimisation interventions
	Progress last month: • Data tool development commenced (note that continuous development required over lifetime of this priority area work). • Initial focus on out of hours radiology demand optimisation interventions, for which scoping and development is underway. Actions for November: • Complete initial data tool development. • Complete scoping and development of out of hours demand optimisation interventions. • Develop long list of other potential radiology demand optimisations.

Patient Empowerment	Objectives: To develop and deliver a programme of work to modernise the way we communicate with our patients, allowing patients to have a choice on how the UHB communicates with them and to provide a future proofed platform, based around the following; • Attendance Optimisation (i.e. patient reminder, on-line booking, text reminder services) • Patient Feedback • A full communications platform, including a hybrid mail approach, allowing patient choice on how they wish to be communicated with. • A full citizen / patient portal to allow patients to access their results, letters, appointment details and any other applications or messaging that the Health Board wishes to adopt, and providing the ability to provide health education messages, medication alerts, and service improvements.
	Progress last month: • Ongoing discussions with Welsh Government in respect of the introduction of a citizen portal. • Draft Digital Plan in development Actions for November: • Explore opportunities to extend the Text Reminder Service to appointments made outside the Contact Centre. • Analyse postage data to identify reasons for fluctuations in postage costs and volumes.

Appendix 1: Turnaround Update

Chronic Conditions & Community	Objectives: • Completion of a 'whole system' review of current practice and resources associated with the management of chronic conditions in Hywel Dda. Specifically, the review will focus on diabetes, respiratory disease and heart failure. • Produce a 'current state' baseline. • Develop and agree a 'whole system integrated pathway framework. • Test the 'whole system' integrated pathway framework as an organising and planning tool to redesign clinical and preventative care pathways to improve outcomes in the 'future state' in the identified • Propose transformational care pathways that align to our 'Healthier Mid and West Wales' strategy for consideration by the Executive Team • Preparation for roll-out of framework in other disease areas
	Progress last month: • First meeting of the assigned project task & finish group • Agreed initial scope of the "baselining" and initial "service assessment" • Template for data gathering reviewed by project lead and project management teams Actions for November: • Collate findings of the service assessment / data gathering • Identify any potential quick wins from the above exercise • Agree project measures • Review early progress of the project against plan • Scope 1st stakeholder workshop

Stroke Pathway	Objective: To redesign the stroke pathway for Hywel Dda University Health Board (HDdUHB) to align with the Health Board's Health and Care Strategy "A Healthier Mid and West Wales", National guidance, best practice and regional planning for Hyper Acute Stroke Unit (HASU) at Morriston Hospital.
	Progress last month: • Workshops held to discuss the long-term and medium-term options • Discussion with stroke survivors and carers to seek their views on current and future services. Actions for November: • Collate scoring for long term scenarios • Collate SWOT for medium term scenarios • Workshop for scoring of medium term scenarios against set criteria (which may need revision) • Agree preferred option(s) for medium and long-term service configurations. • Work on the Business Case for staffing the future model/configurations with data analyst input.

Appendix 1: Turnaround Update

Efficiency Opportunities	Objective: Undertake a review of efficiency opportunities as identified by KPMG review and provide support where appropriate.
	Progress last month: • Various efficiency opportunities (time limited projects) work-stream/ group established and meetings held • Initial filtering/ review of master list of 'various efficiency opportunities' undertaken to flag those projects that are more appropriate to sit within an alternative work-stream. Said opportunities have in turn been accepted by other Executive Priority work-stream areas. • Review of recycling scheme to note improvements/ possible additional savings Actions for November: • Further filtering of master list of 'various efficiency opportunities' and agree final list of projects to be supported within the work-stream Investigate appropriateness for an Invest to Save application for recycling scheme

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Update Reports
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Clare Moorcroft, Committee Services Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Board with a level of assurance in respect of recent Board level Committee meetings that have been held since the previous Board report and are not reported separately on the Board agenda, as follows:

- Mental Health Legislation Assurance Committee (MHLAC) held on 17th September 2019;
- Charitable Funds Committee (CFC) held on 20th September 2019;
- Primary Care Applications Committee (PCAC) held on 8th October 2019;
- Health & Care Strategy Delivery Group (HCSDG) held on 16th October 2019;
- University Partnership Board (UPB) held on 7th November 2019.

Additionally, in respect of the In-Committee Board meeting held on 26th September 2019.

This report also provides an update to the Board in respect of recent Advisory Group meetings held including the following:

- Healthcare Professionals Forum held on 16th September 2019;
- Staff Partnership Forum held on 7th October 2019;
- Stakeholder Reference Group held on 22nd October 2019.

Cefndir / Background

The Hywel Dda University Health Board (UHB) Standing Orders, approved in line with Welsh Government guidance, require that a number of Board Committees are established.

In line with this guidance, the following Committees have been established:

- Audit & Risk Assurance Committee
- Charitable Funds Committee
- Quality, Safety and Experience Assurance Committee
- Mental Health Legislation Assurance Committee
- Remuneration and Terms of Service Committee

The Board has established the following additional Committees:

- Business Planning & Performance Assurance Committee
- Primary Care Applications Committee
- University Partnership Board
- Health & Care Strategy Delivery Group

Attached to this report are individual summaries of the key decisions and matters considered by each of the Committees held since the previous Board report, where these are not separately reported to the Board.

Approved minutes from each of the Committees meetings are available on the UHB's website via the link below:
http://www.wales.nhs.uk/sitesplus/862/page/72048

The UHB has approved Standing Orders, in line with Welsh Government guidance, in relation to the establishment of Advisory Groups. In line with this guidance, the following Advisory Groups have been established:

- Stakeholder Reference Group
- Staff Partnership Forum
- Healthcare Professionals Forum

Asesiad / Assessment

Matters Requiring Board Level Consideration or Approval:

The Health & Care Strategy Delivery Group requested that the following items be raised at Board level:

- Approval of the Bronglais General Hospital strategy, presented at agenda item 4.2.

The University Partnership Board requested that the following items be raised at Board level:

- To support the amended governance arrangements for the University Partnership Group (UPG).

There were no matters raised by the Charitable Funds Committee, the Mental Health Legislation Assurance Committee or the Primary Care Applications Committee which require Board level consideration or approval.

There were no matters raised by the In-Committee Board which require Board level consideration or approval.

The Healthcare Professionals Forum requested that the following items be raised at Board level:

- The need for the Health Board to engage with key clinical leaders and GP leads at an early opportunity, during the infancy of development of proposals for funding, in order for clinicians to have effective influence with any future large scale funding.
- The need for the Health Board to engage with the Healthcare Professionals Forum, as the clinical and professional advisory group to Board, at the earliest opportunity in developing proposals for large scale funding.

There were no matters raised by the Staff Partnership Forum or Stakeholder Reference Group which require Board level consideration or approval.

Key Risks and Issues/Matters of Concern:

The Health & Care Strategy Delivery Group raised the following key risks and issues/matters of concern:

- HCSDG recognise that delivery of the health and care strategy requires significant investment in organisational development, continuous engagement and digital resources, which without investment would represent key risks to the portfolio of programmes. This is reflected in the portfolio risk register.

There were no key risks and issues or matters of concern raised by the Charitable Funds Committee, Mental Health Legislation Assurance Committee, Primary Care Applications Committee or University Partnership Board.

There were no key risks and issues or matters of concern raised by the In-Committee Board.

The Healthcare Professionals Forum raised the following key risks and issues/matters of concern:

- The Forum appreciated the tightness of the timescales with submission for funding proposals for the Transformation Fund, and the fact that agreement of proposals was with all partners and not solely based with Health. However, the Forum expressed concern about the level of engagement with clinicians, in the infancy of the development of the proposals, in order for clinicians to make significant influence.
- The Forum expressed concern that professional groups experienced difficulties with knowing who was involved and how to influence and add value to process.

The Stakeholder Reference Group raised the following key risks and issues/matters of concern:

- Education Programme for Patients (EPP Cymru) would be a vital link into some of the transformation work. EPP Cymru empower individuals to make a difference to improving lives. This is a low cost initiative but very effective. SRG would like to see EPP Cymru provided with funding to strengthen their team and embed their courses into health and social care services. In addition, the SRG would like to see the development of new programmes with young carers and mental health EPP programmes to help young people and young carers.
- Members were advised that Welsh Government may reduce funding for the next financial year to support work with unpaid carers. Members noted that it is imperative that funding is sustainable. Concerns were raised that partners are consistently chasing funding e.g. lottery funding, and around what happens when the funding streams end.

There were no key risks and issues or matters of concern raised by the Staff Partnership Forum.

Argymhelliad / Recommendation

The Board is asked to:

- Endorse the updates, recognising any matters requiring Board level consideration or approval and the key risks and issues/matters of concern identified, in respect of work undertaken on behalf of the Board at recent Committee meetings;
- Receive the update report in respect of the In-Committee Board meeting;
- Receive the update reports in respect of recent Advisory Group meetings.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Standing Orders External Governance Review
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Committee and Advisory Group Chairs

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Explicit within the individual Update Reports where appropriate.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Explicit within the individual Update Reports where appropriate.
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable

Cyfreithiol: **Legal:**	The Board has approved Standing Orders in relation to the establishment of Board level Committees. In line with its model Standing Orders, the Health Board has established Board level Committees, the activities of which require reporting to the Board. In line with its model Standing Orders, the Health Board has established a Stakeholder Reference Group, a Healthcare Professionals Forum and a Partnership Forum, the activities of which require reporting to the Board.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Enw'r Pwyllgor/Name of Committee:	Mental Health Legislation Assurance Committee (MHLAC)
Cadeirydd y Pwyllgor/ Chair of Committee:	Mrs Judith Hardisty (Vice Chair)
Cyfnod Adrodd/ Reporting Period:	Date of Meeting: 17th September 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor/Key Decisions and Matters Considered by the Committee:

This report summarises the work of the Mental Health Legislation Assurance Committee (MHLAC) at its meeting held on 17th September 2019, with the following highlighted:

- **MHLAC Terms of Refence and Connectivity of Committees**
  Mr Paul Newman informed he had met with Mrs Judith Hardisty, Mr Joe Teape and Mrs Joanne Wilson, Board Secretary to discuss shared concerns. Governance arrangements and sub-committee structures are being reviewed, as well as assurance. There is a commitment to ensuring the right level of assurance and engagement is undertaken. Terms of Reference from other committees across Wales are being examined, and the intention is to be able to streamline the amount of meetings people are having to attend. Miss Maria Battle, the new Chair of Hywel Dda University Health Board, is examining the agendas for Board sub-committees. It is hoped that more clarity will be available by the next MHLAC meeting in December 2019.

- **MH&LD Performance Data**
  Part 3 of the Mental Health Measure, self-referral to secondary care for former service users: The report indicates 100% compliance for individuals re-assessed in a timely manner; with a copy of a report to that individual being provided no later than 10 working days, indicating the total number of requests for re-assessment received.

  Mr Clive Smith queried the detail behind this percentage. Members agreed to recommend to undertake a drill-down into mental health advocacy and reasons this may or may not be done, and move on to Care and Treatment Plans (CTP's). Mr Teape will speak separately to Independent Members outside of the meeting to establish any other areas upon which they would like a drill-down, then request that the Scrutiny Group considers this.

- **Mental Health Scrutiny Group Update**
  The Committee received a progress update from the Scrutiny Group Chair via an SBAR. It was suggested and agreed that a work plan should be developed for the Scrutiny Group, with this to be provided at the December meeting. Following a recent Care and Treatment Plan audit, Members asked for further information on emerging themes. This information to be brought back to the December meeting.

- **Hospital Managers Power of Discharge Sub-Committee Terms of Reference**
  The Committee noted and approved the Terms of Reference.

Risgiau Allweddol a Materion Pryder/Key Risks and Issues/Matters of Concern:

- None

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd ar eu cyfer/Matters Requiring Board Level Consideration or Approval:

- None

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf/Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol/Future Reporting:

- Scrutiny Group annual work plan – December meeting
- Specialist Child & Adolescent Mental Health to provide a report on admissions and patient pathway – December meeting
- Head of Older Adults & Learning Disabilities to provide an update report on learning disability services – December meeting
- CTP audit emerging themes – December meeting

Dyddiad y Cyfarfod Nesaf/Date of Next Meeting:

Tuesday 17th December 2019

Enw'r Pwyllgor / Name of Committee	Charitable Funds Committee
Cadeirydd y Pwyllgor/ Chair of Committee:	Simon Hancock, Independent Member
Cyfnod Adrodd/ Reporting Period:	Meeting held on 20th September 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

- **Charitable Funds Story – Marketing & Promotion - Our New Approach** – Members were updated on the charity's approach to marketing and promotion and plans for modernisation and future development of the charity's image and printed materials. Development work is being undertaken in conjunction with the UHB's communications team and members were presented with sample imagery which is in the process of being developed.

- **Chair's Actions & Decisions taken outside of CFC meetings** – There were no Chair's Actions or decisions taken outside of Charitable Funds Committee meetings.

- **Charitable Funds Operations Sub-Committee Update Report** – Members received an update on the work of the Charitable Funds Operations Sub-Committee for the period 19th June to 19th September 2019. Members were updated on charitable items approved for purchase, items rejected and items pending decision as well as those approved by Chair's Actions, with the following highlighted:
  - Attendance at the following three meetings: 2nd July, 6th August and 3rd September 2019 was quorate.
  - 14 requests valued at £73,562 have been approved.
  - No requests were approved through Sub-Committee Chair's Action.
  - 5 requests are presently on hold whilst further information is obtained.
  - 2 requests were rejected.
  - 1 request valued at £32,915 was recommended for Executive Director approval.

  The Committee was presented with 2 items for consideration, those being:

  1) A proposal from the Executive Director of Operations on the principle of using charitable monies as a gesture to support staff working beyond expectations during the winter months. All members endorsed the charity's role in supporting staff wellbeing, however members felt that it was not possible to approve a proposal without additional information on the scale and nature of charitable expenditure. A further update would follow.
  2) Internal design fees for charitable funded projects – the matter was being highlighted by the Sub-Committee following recent approval of a garden development for dementia patients at Prince Philip Hospital. The Sub-Committee had agreed that a review of the situation would be undertaken.

- **Charitable Funds Committee Risk Register** – A brief update was provided on an ongoing risk in relation to reputational damage by default due to association with

external charities. Escalating the tolerance level was discussed and it was agreed that a target risk of 8 would be given. An assurance update will be provided at the March 2020 meeting. It was noted that the Standards of Behaviour policy had now gone through consultation, had been agreed and will be communicated widely.

- **Integrated Hywel Dda Health Charities Performance Report –** An update report was provided on the charity's financial performance and position as of 31st July 2019. Key messages from the report included:

  - A 12% decline was noted in Carmarthenshire – an analysis will be brought to the December workshop.
  - A new fundraising database is now online – Finance colleagues will help people access funds.
  - The Charity has exceeded its fundraising target during this quarter.
  - Staff lottery scheme to be considered in December 2019.

  The Committee approved the content of the report and received assurance on the charity's performance.

- **Hywel Dda Health Charities Annual Accounts & Report 2018-19 –** An update was given by our Welsh Audit Office colleague, Mr Jeremy Saunders, and it was noted that the Accounts & Report had been completed a quarter earlier than the previous year. The report was warmly welcomed by the Committee, and the Chair added that it provides a high level of assurance in terms of accounting. A brief discussion was had on charitable funded items and those that the NHS typically funds. The charity is regulated by the Charity Commission and the WAO audits our accounts and Annual Report based on the Charity SORP (Statements of Recommended Practice) and as part of charity reporting arrangements when we are also required to report on the charity's public benefit. It was noted that the CFC has previously approved eligibility criteria for charitable expenditure which is used to determine the eligibility of items of expenditure.

- **Expenditure & Commitments Requiring Approval -**

  - **Pembrokeshire Cancer Services –** A paper was submitted to request the approval of charitable funds held by the University Health Board to support enhancements to the ward 10 refurbishment scheme at Withybush General Hospital to improve the patient experience, above and beyond that which the NHS can provide. Thanks to donations received under the umbrella of Elly's Ward 10 Flag Appeal and from other generous supporters, there has been an opportunity to identify items to offer additional patient comforts, to improve the ward environment, purchase specialist equipment and technology as well as to enhance staff training. The Committee approved the request to contribute £259,214 of charitable funds to support an enhanced scheme which will improve the experience for patients using Ward 10.

  - **Ceredigion Property Options –** The options and recommendations of the Ceredigion property were discussed and it was agreed that the item would be taken to the December 2019 workshop for further discussion with a final paper being brought back to the March 2020 meeting. Further research is needed on

why the property was purchased initially and it was agreed that a more detailed costing was needed.

- **Fundraising appeal for the development of a new Chemotherapy Day Unit at Bronglais General Hospital –** Members were presented with a summary of areas for consideration relating to the development of a fundraising appeal for a new CDU at Bronglais General Hospital. The business case confirms that the project would need to meet an estimated £0.594m funding shortfall. The Committee approved the development of a fundraising appeal under the umbrella of Hywel Dda Health Charities for a new Chemotherapy Day Unit at Bronglais Hospital, subject to confirmation of the availability of the proposed location for the development (following the pilot of the shared care model with Y Banwy and Enlli Ward).

- **Any Other Business :**

  - **Wales for Africa –** Members were informed that following the 2018 Internal Audit Report it was recommended that the funded projects associated with the T607 fund are considered to be completed and can now be formally closed.

  - **Reflective Summary –** A brief reflective summary of the meeting was provided by Ms Sarah Jennings.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd ar eu cyfer /Matters Requiring Board Level Consideration or Approval:

- None to report.

Risgiau Allweddol a Materion Pryder /
Key Risks and Issues/ Matters of Concern:

- No risks or issues/matters of concern identified to escalate to the Board.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /
Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress of the various actions identified at the previous Committee meeting will be undertaken.

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

16th December 2019

Enw'r Pwyllgor/Name of Committee:	Primary Care Applications Committee (PCAC)
Cadeirydd y Pwyllgor/ Chair of Committee:	Mrs Judith Hardisty, HDdUHB Vice Chair
Cyfnod Adrodd/ Reporting Period:	Meeting held on 8th October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor/Key Decisions and Matters Considered by the Committee:

- **Chair's Action:** Mrs Hardisty reported that Committee Members had agreed two Pharmacy Contracts Applications via Chair's Action, as the 6th August 2019 PCAC meeting had been stood down:
  - Application to vary core opening hours, Margaret Street Pharmacy, Ammanford (agreed via Chair's Action on 24th July 2019).
  - Application for a minor relocation by Sach Chemists Ltd., t/a Caerleon Pharmacy, Cardigan (agreed via Chair's Action on 31st July 2019).

- **Managed Practices Update:** the Committee received a report on the four Managed Practices which are delivering General Medical Services (GMS) to over 27,000 patients. The Committee was informed that, following a formal procurement exercise, an Expression of Interest had been received for Tenby Surgery and that a tender scoring exercise would be taking place on 11th October 2019. Members were assured that Hywel Dda University Health Board (HDdUHB) will continue to run a formal procurement exercise for Meddygfa Minafon, Kidwelly and Meddygfa Sarn, Pontyates despite no Expressions of Interest having been received, because it will give HDdUHB a mandate for reviewing how to continue to deliver services to the population if no tenders are received. For the remaining Managed Practice, Ash Grove Medical Centre, the Committee was informed that it was not included in the procurement exercise and that this would be revisited in early 2020.

  Discussions took place about the need to explore further the data in the paper relating to lists sizes, which has been requested by the Committee, to understand the reasons behind the changes and why becoming a Managed Practice has an impact on patient numbers. It was noted that the net gain and loss may not be representative of the actual patient movements. The Committee agreed that it would be an important exercise and asked for a paper to be presented at the next PCAC meeting on 7th January 2020.

- **Application to vary opening hours of Q Dental, Carmarthen:** the Committee received a report on the request by Q Dental to align its opening hours for the remainder of its Waiting List Initiative contract, which ends on 31st March 2021, with its other Orthodontic contracts by reducing its opening hours by two hours on Fridays (from 3:00pm to 1:00pm). The Committee was assured that Q Dental had completed its main work on the Waiting List Initiative contract and that urgent access for patients on Friday afternoons

would be provided through Q Dental's Swansea branch. The Committee agreed the application to vary the opening hours of Q Dental for the remaining duration of its Waiting List Initiative contract.

- **Applications for changes of ownership – Cross Hands Pharmacy, Gravells Pharmacy (Llangennech) and Kidwelly Pharmacy:** the Committee received a report on the applications received for changes of ownership. The Committee was assured that the applications met all regulatory criteria and the Committee noted the changes of ownership of the NHS Pharmacy contracts for Cross Hands Pharmacy, Gravells Pharmacy (Llangennch) and Kidwelly Pharmacy.

- **Application for a Minor Relocation by Lloyds Pharmacy, Pembroke:** the Committee was informed that the consultation had ended on 5th October 2019 and that only one response had been received from another Pharmacy, which confirmed that it did not have any comments. The Committee was assured that the application met the regulatory criteria and the Committee approved the Minor Relocation Application.

- **Community Pharmacy – Cardigan Integrated Care Centre tender process update:** the Committee was reminded that two Minor Relocation applications had been agreed via Chair's Action in July 2019 for the relocation of Well Pharmacy, Cardigan and Caerleon Pharmacy, Cardigan to lease a unit in the new Cardigan Integrated Care Centre (CICC), and that the next stage of the process was to run a tender exercise to determine which of the two Pharmacy contractors would be offered the agreement to lease the unit. Following the tender exercise, the Committee was informed that Well Pharmacy had been offered an agreement to lease the unit in the new CICC. The Committee noted the conclusion of the tender process and the subsequent selection of Well Pharmacy as the Community Pharmacy contractor for Cardigan Integrated Care Centre. The Committee requested that a paper be presented at the next PCAC meeting on 7th January 2020 regarding Pharmacy Enhanced Services and Pharmacy Walk-in Centres and the services that they provide.

- **PCAC Work Programme.** The Committee noted the PCAC Work Programme for 2019/2020 and asked that it is reviewed to ensure it accurately reflects the Committee's work to the end of March 2020.

- **PCAC Update Report to the Board meeting held on 25th July 2019:** The Committee noted the update report to the 25th July 2019 Board meeting.

Risgiau Allweddol a Materion Pryder/Key Risks and Issues/Matters of Concern:

None.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd ar eu cyfer/Matters Requiring Board Level Consideration or Approval:
None.
Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf/Planned Committee Business for the Next Reporting Period:
Adrodd yn y Dyfodol/Future Reporting:
In addition to the items scheduled to be reviewed as part of the Committee's work programme, following up progress on actions identified above will be undertaken.
Dyddiad y Cyfarfod Nesaf/Date of Next Meeting:
7th January 2020 (re-scheduled from 5th December 2019).

Enw'r Pwyllgor/Name of Committee:	Health and Care Strategy Delivery Group
Cadeirydd y Pwyllgor/ Chair of Committee:	Mr Steve Moore, Chief Executive Officer
Cyfnod Adrodd/ Reporting Period:	Meeting held on 16th October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor/Key Decisions and Matters Considered by the Committee:

Portfolio Milestones
HCSDG were informed of initial challenges with some of the portfolio milestones due to slippage whilst recruiting into the additional posts within the Transformation Programme Office (TPO). During this time focus has remained on establishing groups in order to get them up and running. In response to the re-prioritisation of projects for each of the three transformation programmes, a review has suggested that a number of the high level portfolio milestones are pushed to the end of the financial year while resources are reprioritised. It was suggested that the implementation plans, currently in draft form, would dovetail into the three year planning position at the end of October 2019, however will need to be revisited in line with changes in the projects for this year and the need to reflect the in-year actions for the programmes also included in the report. It was agreed that a detailed report be submitted to the November 2019 Board to outline the re-prioritisation exercise undertaken by the Executive Team for 2019/20 projects, the associated corporate resource allocation process and subsequent impact on strategic portfolio milestones. The importance of continued communication with Welsh Government in terms of timescales and deliverables was confirmed.

Managing Successful Programmes Training (MSP)
HCSDG received an update on MSP training with the first cohort having been completed. Agreement was requested to progress the next phase of training in order to move towards a standard methodology for project and programme management in line with the developing "Hywel Dda Way". Members of HCSDG committed to pick up general conversation about MSP/project management training going forward, including revisiting the list of proposed training delegates. Discussion ensued on the importance of ensuring that correct staff undertake the relevant level of training to equip them to deliver their roles. It was agreed that this needed to form a key part of the PADR process for those staff involved in project management, and be identified as a core training need. HCSDG were informed that opportunities for joint training with Local Authority colleagues and other agencies are being explored, and a committment was made to maximise this across health, social care and the third sector.

Strategic Enabling Group
HCSDG received confirmation that Mrs Karen Miles, Director of Planning, Performance and Commissioning would replace Mr Huw Thomas, Director of Finance, as the Chair of the Strategic Enabling Group (SEG) with Mr Thomas

agreeing to be Vice Chair. Inclusion of improvement science / quality improvement as a key enabler was also agreed.

Check and Challenge Process
HCSDG received an update on the check and challenge approach and Version 13 was shared as the updated version which is now being used from the outset of initiation of projects. This includes some additions and amendments to the approach following feedback from colleagues, particularly in relation to the workforce and legislative domain. It was agreed that Green Health is to be considered as part of the check and challenge process, particularly around estates and capital schemes moving forward. As a number of the check and challenge processes have been completed, it was suggested comparisons of these case studies be undertaken in order to evaluate the difference the check and challenge process has made. Confirmatin was received that the project initiation document (PID) developed for Turnaround and Quality Improvement projects has been refined and adopted to be consistent with the Teulu Jones design, with further work required to incorporate the check and challenge approach from the outset. The initial Hywel Dda Way product developed by Capita has been further refined to ensure consistency of approach and recognisable terminology for sharing more widely. Building on the essential principles agreed by the Executive Team, the approach commences from project initiation, to project development, through to managing and reporting and evaluating and will provide a robust approach in line with MSP training. This work is being undertaken with the PMO, Service Improvement Team and the Transformation Programme Office (TPO) to ensure a consistent approach and methodology, including the use of a standard IT system for project management. As Swansea Bay UHB are currently working on a 'Swansea Bay Way', the TPO are working collaboratively with the Strategy Team to explore opportunities to align processes to support regional working.

Bronglais Check and Challenge
HCSDG received a summary of the Bronglais Strategy Check and Challenge process. Assurance was provided that this had been a very detailed process and that support would continue to be provided around key actions up to submission of the November 2019 Board paper to ensure all work has been undertaken. Subject to Board approval, the implementation plan development and delivery will be progressed through the Transforming our Hospitals and Transforming our Communities programmes.

Portfolio Risk Register
HCSDG were informed that the TPO and the SEG have developed a portfolio risk register, with the assistance of the Head of Risk and Assurance. This is a developing document that, in response to the current reprioritisation, needs to reflect the impact of resulting portfolio milestone slippage. Conversations are to be held with programme group chairs, and governance and risk leads, to ensure there are risk registers for each transformation programme and SEG and to provide clarity on the governance process of risk management. An update was requested for the next HCSDG in December 2019.

Delivery Plans, Management and Leadership

HCSDG received the Delivery Plans, Management and Leadership report for discussion and agreement on the proposed approach to defining the oversight and governance for the delivery plans going forward aligned to the Health and Care Strategy's three strategic programmes. HCSDG also received the initial draft organisation of the Together for Health (T4H) delivery plan actions in the portfolio mapping and establishment document, noting that the Planning Team and the TPO will be working together to further refine and propose the ongoing oversight and leadership of the delivery plans, subject to the outcome of the Welsh Government review.

Evaluation Approaches
HCSDG received an update on a report prepared on evaluation approaches and informed that several highly interrelated and complementary change programmes have been launched within Hywel Dda under the Health and Care Strategy Delivery portfolio, with each describing strong relationships with key partner organisations as prerequisite for securing delivery. It was acknowleged that there may be scope to reduce the duplication of work being undertaken regionally and nationally and linkages with the Welsh Government evaluation approach around A Healthier Wales have been made. It was further acknowledged that there may be opportunity to use the same principles and approach as the evaluation linked to the University Partnership Board and work on-going with Swansea University. Members noted the core requirement of the Transformation Fund programmes to commission an external evaluation framework, which has been progressed through a tendering process, with the successful provider commencing in November 2019. An evaluation steering group will be convened and an initial evaluation produced in December 2019 with a final report expected at the end of the financial year. It was agreed that the approach taken in relation to the Transformation Fund programmes will extend to include Integrated Care Fund (ICF) programmes, and adapted as required for the Health and Care Strategy evaluation.

Alignment of Capital Planning and Strategic Portfolio Timelines
HCSDG received a report on the alignment of the development of the detailed clinical model and the business case timeline.The high level complexity and detail of clinical model information required to include at each stage of development of a successful Business Case was highlighted. It was suggested that this be taken via Transforming our Hospitals Group, SEG and any other relevant groups. Alignment of Capital Planning and Strategic Portfolio Timelines would be reported back to HCSDG in December 2019.

Transformation Fund – Updates and Benefits
The HCSDG received an update on the Transformation Fund with confirmation received from the Minister that money is available to spend for the next 18 months, up until March 2021. HCSDG were also presented with a slideshow embedding the principles of the quadruple aim, looking at an objective based approach focussing on a different model of workforce and models of care. The approach focussed on the following four principles - Helping Strong Communities; Help to help yourself; Help when you need it; and Ongoing help. Governance around staff training was discussed with a workforce group reporting to the Regional Partnership Board to oversee staff training. It was noted that the professional leads around these programmes

have the responsibility to check governance is being followed in terms of delivery of staff training. It was further noted that an outcomes framework is being developed to enable reporting to Welsh Government with a clearly defined baseline position. This will be reported back to HCSDG in December 2019.

External Advice / Advisors for Portfolio Programme
The need for external advisory capacity / advisory group to help ensure delivery of the strategy and the right approach was discussed. The HCSDG reflected on the skills and expertise required to undertake this.

Stroke Pathway Workshop
HCSDG received an overview of the stroke pathway workshop. The stroke redesign group is establishing a long term plan for when the new hospital is operational, a medium term plan before completion of the new hospital and what can be provided now. The group have undertaken SWOT analysis of 30 scenarios and 6 remain which are currently being scored. Next steps include scoring on the 6 scenarios; development of workforce implications on preferred scenario(s); aligning the long-term scenarios with the medium term and regional HASU planning; developing a community based rehabilitation team model to address the rural challenges; aligning stroke redesign with the wider rehabilitation work e.g. trauma; and activity and financial modelling. Once the preferred models have been established the check and challenge process will be applied with a deadline for business case development of March 2020.

Risgiau Allweddol a Materion Pryder/Key Risks and Issues/Matters of Concern:

HCSDG recognise that delivery of the health and care strategy requires significant investment in organisational development, continuous engagement and digital resources, which without investment would represent key risks to the portfolio of programmes. This is reflected in the portfolio risk register.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd ar eu cyfer/Matters Requiring Board Level Consideration or Approval:

Approval of the Bronglais Hospital strategy.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf/Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol/Future Reporting:

- Programme Group updates
- Strategic Enabling Group update
- Transformation Fund update
- Programme Risk Register workshop
- Alignment of Capital Planning and Strategic Portfolio Timelines

Dyddiad y Cyfarfod Nesaf/Date of Next Meeting:

4th December 2019

Enw'r Pwyllgor / Name of Committee	University Partnership Board (UPB)
Cadeirydd y Pwyllgor/ Chair of Committee:	Professor John Gammon
Cyfnod Adrodd/Reporting Period:	Meeting Held on 7th November 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

- **University Partnership Board Revised Governance Arrangements & Terms of Reference** – The UPB agreed to the revised governance arrangements proposed that under the auspices of a University Partnership Group (UPG), the UPG Chair and Lead Director, supported and facilitated by HDdUHB's Strategic Partnerships & Inclusion Manager, would meet on a bi-annual basis with each University and Pembrokeshire College to scope areas of mutually beneficial activities, building on their unique strengths to improve services to the population of HDdUHB. These areas of work would culminate in an annual meeting or workshop event bringing together the products of the joint work that had taken place throughout the year, with an annual report to be presented to the Board to discharge the UPG's responsibilities within its revised terms of reference.

- **University Partnership Board Strategy – Year 3 and Plans for the Future** The UPB supported the Aberystwyth University, Swansea University and University of Wales Trinity Saint David individual workplans used as a basis for identifying in terms of their respective strengths, their proposed engagement with the Health Board's strategic direction and plan over the next 3 years.

- **Rural Health and Care Wales (RHCW) Update** – The UPB was informed that the RHCW Conference held on the 5th and 6th November 2019 opened by Mr Mark Drakeford, First Minister for Wales, had been particularly informative, propounding a range of presentations which would be available from the RHCW website (https://ruralhealthandcare.wales) at the end of November.

- **Widening Access to Training** – The UPB received a presentation on the Cardiff Medical School programme "Community and Rural Education Route (CARER)", which is currently in its second year. The UPB was pleased to note that positive feedback has been received from both the students involved and the public. A presentation was also received from Professor Hawthorne in respect of Swansea University's equivalent programme "Primary Care Academy", where it was acknowledged that support would be needed from HDdUHB in terms of building resilience and planning for providing opportunities in hospital and primary care placements in order for the Academy to be a success.

- **Apprenticeships within the University Health Board** – The UPB received an update in respect of the 50 apprentices employed by HDdUHB and welcomed the Invest to Save bid that has been submitted with a view to creating a cross sector apprenticeship scheme for 2020/21.

- **Evaluation Approaches** – The UPB received a report on evaluation approaches for the Health and Care Strategy Delivery Portfolio, noting that all

University partners are considering how best to align their considerable knowledge, expertise and analytical resources to support HDdUHB in advancing the Health and Care Strategy and related portfolio. Further meetings will be scheduled between the Deputy Director for Research & Innovation and representatives of the three Universities to progress this work.

- **Academic Centre (Hub) Update** – The UPB received an update on the activities of the West Wales Academic Health Collaborative (WWAHC) and was pleased to note that 11 applications to the Bevan Exemplar Programme had been supported, 9 of which have gone on to become Exemplars. The Director of Partnerships and Corporate Services was requested to ensure that conversations continue between HDdUHB and University partners regarding funding to extend the programme.

- **Support Plan for Active Research Clinicians** – The UPB received a presentation emphasising the need for additional research-active departments within HDdUHB. Members were pleased to note that the Research & Development Department is pro-active in promoting the importance of research to other health care professionals and that grant funding sources are being pursued to resolve this.

- **Action from Effective Clinical Practice Sub Committee & Academic Advisors Template** – The UPB welcomed the review that has been undertaken of the Effective Clinical Practice Sub-Committee and its underpinning reporting structure, with the findings indicating that access to University partners' expertise around literature reviews and new interventional procedures would be most beneficial. A template will be developed for sharing with University partners.

- **University Partnership Board Workplan 2019/20** – A new workplan will be developed in light of the amended governance arrangements and revised terms of reference for the UPG.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer /Matters Requiring Board Level Consideration or Approval:

To support the amended governance arrangements for the University Partnership Group (UPG).

Risgiau Allweddol a Materion Pryder/Key Risks and Issues/Matters of Concern:

None.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

Going forward, the UPG will meet on a bi-annual basis with each University culminating in an annual meeting or workshop event, with an annual report capturing the work undertaken to be presented to the Board.

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

To be confirmed.

Enw'r Pwyllgor / Name of Committee	In-Committee Board
Cadeirydd y Pwyllgor/ Chair of Committee:	Miss Maria Battle
Cyfnod Adrodd/ Reporting Period:	Meeting held on 26th September 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

At its meeting on 26th September 2019:

- **Tuberculosis (TB) Outbreak** – the In-Committee Board received an update on the Tuberculosis (TB) Outbreak, Llwynhendy.
- **Research Governance** – the In-Committee Board received an update on research governance.
- **Suspensions Report** – the In-Committee Board received the suspensions report.
- **In-Committee Audit & Risk Assurance Committee (ARAC)** – the In-Committee Board received an update report from the In-Committee ARAC meeting held on 27th August 2019.
- **In-Committee Quality, Safety & Experience Assurance Committee (QSEAC)** – the In-Committee Board received an update report from the In-Committee QSEAC meeting held on 1st August 2019.
- **In-Committee Welsh Health Specialised Services Committee (WHSSC)** – the In-Committee Board received an update report from the In-Committee WHSSC meeting held on 23rd July 2019.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:

None.

Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:

None.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

To be confirmed.

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

28th November 2019.

Enw'r Pwyllgor / Name of Committee	Health Care Professionals Forum
Cadeirydd y Pwyllgor/ Chair of Committee:	Dr Kerry Donovan
Cyfnod Adrodd/ Reporting Period:	Meeting of 16th September 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

The Forum received two presentations: An update on the Transformation Fund and an update on the Paediatric Task & Finish Group

1. Update on the Transformation Fund-

A presentation on the Transformation Fund with an overview of the programmes that have received funding from the Welsh Government was provided. Reference to the Future Generations, Healthier Wales and Social Services Wellbeing Act which encourages all partners working together for seamless locally delivered services that meet population health and social need was made. The work of the Regional Partnership Board and this 'dove tailing' with Health Board Strategy, with a combined vision, and informed the forum that a number of Health Board staff and commissioners had been involved in developing some of the proposals was described. The total bid was £80m noting there were four themes involving 8 programmes that interacted and supported one another. Programmes1, 3 and 7 were approved. The other programmes are awaiting ministerial approval.

The Forum received details on the following programmes:

- Programme 1 – Proactive Enabled Technology Care - (£6 million - which carries the majority of the agreed funding that enables agencies to keep in touch with the most vulnerable people, leading to a reduction in formalised care. Dialogue is in process with the technology suppliers working in partnership with Delta Wellbeing and the implementation plan will recognise local differences between counties. The Forum was advised that the debate will be how to upscale the project, as the funding is only guaranteed for two years, and that this is a discussion for all partners.

- Programme 3 Fast Track Consistent Integration - the Forum was advised that this provides a consistent crisis response, across all 3 counties, in the shape of a 'virtual ward,' providing the appropriate medical, nursing and multi-disciplinary response at a locality level where, within 6 hours, members of teams can be deployed to provide intensive support for up to 10 days, in an attempt to enhance outcomes and avoid unnecessary hospital admission or long term care.

- Programme 7 - Connections for all - the Forum was informed that this was a digital support plan, where older people would have an electronic tablet, with the aim to link people up in virtual networks, based around their interests, reducing isolation. The initiative will enable people to be involved in their

communities so that communities become more functional. Community Connector Plus teams will have a key role in promoting these community initiatives.

It was noted that other programmes were awaiting approval by Welsh Government. These included programmes associated with : IT systems; A focus on Self-Management, (around complex conditions and how to work with social prescription to improve it), Engagement (facilitating ongoing conversations with people about their needs and what care and support are needed) and ; Providing support for the growth of social enterprise and micro enterprise,

The Forum recognised the benefits of all of the above programmes. However, Members of the Forum expressed concern relating to the amount of engagement with clinicians and the difficulties professional groups experienced with knowing who was involved and how to influence and add value to process. It was noted that there were strict timeframes (i.e. a few months) that were not ideal for such processes to take place for full, detailed engagement. Representation had come from the appropriate strands that formulated the bids.

It was noted that the plans developed required agreement with multiple public sector agencies, so decisions were not therefore solely with the Health Board. Proposals in the Transformation Fund bids were in line with the Health & Care Strategy (which was developed from public, staff and stakeholder consultation). Proposals submitted were ones which could facilitate and act as a catalyst for delivery of elements of the strategy. The role of the Integrated Executive Group, which included the Health Board Executive Directors, social services directors and third sector representation was described. This group meets on a weekly basis to discuss partnership and integrated working. Whilst the Forum appreciated the tightness of the timescales and the scrutiny of the Integrated Executive Group with refinement of proposals, it questioned the extent of engagement and availability of the detail to clinicians, clinical leads and service managers. It was also the view of the Healthcare Professionals Forum that, as a clinical advisory forum to the Board, it should have been engaged at the very earliest opportunity.

Concern was expressed by the GP representative, who described current challenges in General Practice, and questioned the level of engagement with GPs and also what difference the programmes will make to GPs, their workload, their capacity and their recruitment difficulties. It was emphasised that the majority of GP patient contacts are people who require health care, not the people described in most of the programmes and disappointment expressed that the monies are not being used to transform the way that GP is being delivered. The validity of this point was acknowledged. However, it was indicated that, in terms of aspiration, both programmes 1 & 3, and also programme 7, should have an impact on reducing pressure for GPs as, for example, a virtual ward will ensure appropriate professionals are directed to patients, instead of people needing to access a GP in person. The Forum was advised that there had been engagement with a GP representative in the development of proposals. Whilst Forum members acknowledged that relevant individuals may have been consulted prior to plans being submitted, it was felt that this engagement was not early enough to influence significantly and that there was a period of time where clinicians were trying to enquire about plans in process. It was

resolved that although engagement had occurred with the proposals for the Transformation Fund that this was not during the infancy of development of the proposals. It was also resolved that the Head of the Regional Collaboration Unit would feed back the concerns raised, that there should be clear primary care (GP) representation and that effective and early engagement would be welcomed.

The Forum acknowledged that the programmes reflect the thinking that came out of the Health Board's Health & Care Strategy and the extensive involvement of clinicians in the Development Phase of the Health & Care Strategy.

2. <u>Presentation on Paediatric Task & Finish Group</u>

David Morrissey Service Delivery Manager, Paediatrics and Neonates, delivered a presentation updating on the work of the Paediatric Task & Finish Group. He gave the context of changes proposed to acute paediatric and neonate services in 2014 which created public and media interest. The increased challenges around medical staffing in Withybush in 2016 and the resultant decision that it was not possible to sustain a paediatric consultant on-call nor maintain paediatric ambulatory care unit 12 hour service, led to the temporary reduction in opening hours and of the overnight consultant. The Paediatric Task & Finish Group was set up discuss potential models of paediatric care, and to ensure this will be sustainable, clinically safe and appropriate for patients, to move forward in the longer term. An update of the work of the task and finish group was provided, with the Forum recognising with the Forum recognising the work that is being undertaken in this area.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer /
Matters Requiring Board Level Consideration or Approval:

- The need for the Health Board to engage with key clinical leaders and GP leads at an early opportunity, during the infancy of development of proposals for funding, in order for clinicians to have effective influence with any future large scale funding.

- The need for the Health Board to engage with the Health Care Professionals Forum, as the clinical and professional advisory group to Board, at the earliest opportunity in developing proposals for large scale funding.

Risgiau Allweddol a Materion Pryder /
Key Risks and Issues/ Matters of Concern:

The Forum appreciated the tightness of the timescales with submission for funding proposals for the Transformation Fund, and the fact that agreement of proposals was with all partners and not solely based with Health. However, the Forum expressed concern about the level of engagement with clinicians, in the infancy of the development of the proposals, in order for clinicians to make significant influence. The Forum expressed concern that professional groups experienced difficulties with knowing who was involved and how to influence and add value to process.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf /
Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

Update on Regional Partnership Board – November 2019

Update on Public Services Boards – November 2019 Empowering Clinicians – January 2020 Value Based Health Care – January 2020
Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:
8th November 2019 20th January 2020

Enw'r Pwyllgor / Name of Committee	Staff Partnership Forum
Cadeirydd y Pwyllgor/ Chair of Committee:	Lisa Gostling, Director of Workforce & Organisational Development (Joint Chair of Staff Partnership Forum) Ann Taylor-Griffiths (Royal College of Nursing Representative/Joint Chair of Staff Partnership Forum and Chair of Ceredigion County Partnership Forum)
Cyfnod Adrodd/ Reporting Period:	Meeting held on 7th October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

This report summarises the work of the Staff Partnership Forum at its meeting held on 7th October 2019, with the following highlighted:

- **Finance Update** – the Finance Update was presented to Forum. The Forum was advised that HDdUHB's financial position at the end of Month 5 represented an adverse variance against plan of £3.1m, with an adverse variance of £10.6m to breakeven. This position was driven by bed pressures, vacancies covered by premium cost staff, drug costs in both Scheduled and Unscheduled Care, slippage on a referral management savings scheme, Medicines Management Prescribing, and the continued local Tuberculosis (TB) outbreak. KPMG have been appointed to support HDdUHB with the identification and delivery of savings, with a number of opportunities proposed to date. However, there is still a gap in identifying the full savings required to reach the £15m control total. The Forum was advised of the Waste Action Reuse Programme (WarpIT) page on the intranet, which has already avoided approximately £0.25m in procurement costs.

- **Turnaround Update** – the Turnaround Update was presented to Forum, highlighting the key areas and themes of the Turnaround Programme. The Forum was advised of the focus on delivery of the savings gap and that, although there is no shortage of ideas, the challenge is in converting these ideas into deliverable savings plans.

- **Managing Attendance at Work** – the Managing Attendance at Work report was presented to Forum, providing information relating to sickness absence within HDdUHB for the period ending 30th June 2019. The Forum was advised that the monthly absence rate of June 2019 was 4.85 % and the 12 month rolling rate was 4.92%. The latest figures for August 2019 show a monthly rate of 4.38% and a 12 month rolling rate of 4.9%. It was agreed to circulate recent correspondence from the Welsh Partnership Forum in relation to changes to Enhanced Pay during sickness absence from 1st October 2019, to Members following the meeting.

- **No Deal Brexit Preparations** – a verbal update on No Deal Brexit Preparations was presented to Forum. The Forum was advised that work on contingencies, particularity around supply chains, continues and that the Brexit Steering Group is seeking further assurance around the supply of Non Stock items. There will

be arrangements in place for local Clinical Forums to look at the distribution of stocks should they start to deplete. However, the Forum acknowledged that there are some stock issues with particular drugs, regardless of Brexit arrangements. The risk associated with the stockpiling of drugs, notably expiration dates, was discussed and the Forum was advised of particular issues with the shelf life of radioisotopes, which is being reviewed.

- **Health & Safety and Emergency Planning Sub-Committee Update Report -** the Health & Safety and Emergency Planning Sub-Committee Update report presented to the Business, Planning and Performance Assurance Committee (BPPAC) on 29th August 2019 was presented to Forum. The Forum was advised that the Health and Safety Executive (HSE) Inspection report has been issued, which will be a focus for the H&SEPSC to ascertain the issues and recommended actions required.

- **Employment Policy Update** - The following policies were presented to Forum and agreed, prior to onward submission to the Workforce & Organisational Development Sub-Committee for formal approval:
    - Guidance on Referral of Employees to the Occupational Health Service
    - Staff Immunisation and Screening Policy
    - Preceptorship Policy

  The Supporting Transgender Staff Policy was discussed and is to be resubmitted to the December 2019 Forum meeting for approval. The Trade Union Congress (TUC) Dying to Work Charter paper was presented to Forum for information and the proposal for the Health Board to sign up the Charter was supported.

- **Revised Rostering Policy –** the revised Rostering policy was presented to Forum advising that the original Rostering policy would be reviewed and updated and form an overarching rostering policy for all staff groups within HDdUHB. The Forum was presented with Guidelines to support effective rostering, specifically for Nursing and Midwifery staff, which are to be added as an appendix to the current Rostering policy and approved whilst the work to review the overarching policy is completed. The Forum agreed the Interim Guidelines to Support Effective Rostering for Nurses and Midwifes, prior to onward submission to the Workforce & OD Sub-Committee for formal approval, subject to comments received from Forum Members.

- **Payrolling of Benefits –** the Payrolling of Benefits report was presented to Forum, proposing commencement of the payrolling of benefits from 6th April 2020, which is the ability to include all taxable benefits in an employee's payroll. The Forum supported the proposal to commence the payrolling of benefits from 6th April 2020, subject to approval by Executive Team/Board.

- **Smoke Free Sites Policy Update –** the Smoke Free Sites Policy Update report was presented to Forum advising that draft Regulations coming into force in early 2020 will make it illegal to smoke on hospital sites. The current policy therefore needs to be updated to reflect this change. The Forum approved the appointment of a representative from each county to attend the pan-Hywel Dda Smoke Free Sites Working Group to feedback on any developments.

- **County Partnership Fora –** Update reports from the Carmarthenshire and Pembrokeshire County Partnership Fora were presented to Forum for information. The Ceredigion County Partnership Forum update report was unavailable due to the previous meeting, scheduled for 17th October 2019, being cancelled. The Forum was advised that risks raised by the Carmarthenshire County Partnership Forum report in relation to manual handling/health and safety issues on particular sites are being addressed as part of the recent Health and Safety Executive (HSE) Inspection Report.

- **County Partnership Fora and Staff Partnership Forum Terms of Reference** – the County Partnership Fora Terms of Reference and Staff Partnership Forum Terms of Reference were deferred to the Forum meeting on 9th December 2019.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:

There were no matters requiring Board level consideration or approval.

Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:

No risks or matters of concern were raised.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

In addition to the standing agenda items, the next Staff Partnership Forum meeting will include an update on the Wellbeing Work Programme, a review of the Staff Partnership Forum Terms of Reference and a review of the County Partnership Fora Terms of Reference.

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

9th December 2019.

Enw'r Pwyllgor / Name of Committee	Stakeholder Reference Group (SRG)
Cadeirydd y Pwyllgor/ Chair of Committee:	Hilary Jones
Cyfnod Adrodd/ Reporting Period:	Meeting held on 22nd October 2019

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

Vice Chair

The SRG would like to inform the Board that Hazel Lloyd Lubran, Chief Executive, Ceredigion Association of Voluntary Organisations (CAVO) has been nominated Vice Chair of the SRG.

West Wales Care Partnership

SRG members were advised that the Regional Partnership Board is currently in discussion with Health and Social Care regarding winter plans. Members recognise that there will be unprecedented pressure this winter on both Health and Social Care and were pleased to hear that a single regional approach would be agreed.

Transformation Programme Update

Members were provided with an update on how the transformation programme is progressing. Members are very supportive of this work and raised the following:

- SRG members would like to be kept informed of developments regarding the three transformation programmes, including having sight of the outcomes framework;
- Concerns were raised that Community Connectors were not engaging with some Town and Community Councils in Pembrokeshire. Hazel Lloyd Lubran will be invited to the next SRG meeting to update on transformation programme 7 'Creating connections for all';
- Members raised concern regarding how Health and Social Care will fund the projects into the future, once the funding stream ends in 2021;
- Developing new types of services can make a difference for the future. Education Programme for Patients (EPP Cymru) is a low cost initiative. The programme is leading the way in enabling individuals to make choices for themselves, improving lives and building community resilience. SRG would like to see the development of new programmes with young carers and mental health programmes to help young people and young carers.

Engaging with Children and Young People

SRG members were informed that the Engagement Team has met with Youth Forums in Carmarthenshire, Ceredigion and Pembrokeshire to establish how they would like to be engaged with. The three groups had different views:

- Carmarthenshire and Ceredigion would prefer to circulate information on behalf of the SRG to their networks, and when required, to meet with the groups.
- Pembrokeshire would be interested in representatives attending SRG meetings, although it was recognised that this may be difficult due to timings of the meetings. The Youth Council would welcome SRG representatives to meet with them to engage in conversations

Development of a Children's Board
SRG members were advised that the University Health Board (UHB) is looking to establish an approach to a Children's Board which would assist in embedding the Rights of the Child within the organisation.

A scoping exercise is being undertaken to see how Children's Boards have been set up in other areas e.g. Swansea Bay and Cardiff. The Consultation Institute also advised of a Children's Board in Scotland, which includes a digital network where children are asked to make video diaries. This work is at a very early stage, with the intention being to work with partners to explore how best to establish a Children's Board for the Hywel Dda UHB area.

Update on Engagement Tools
SRG members were advised that a Regional Engagement Partnership Group was set up in January 2019, with one aim being to explore digital platforms which will support continuous engagement. Whilst undertaking a scoping exercise it was discovered that not one digital platform could provide both an engagement tool and a stakeholder management system.

Over the summer, the UHB arranged a series of demonstrations with providers of digital platforms, which included IT and Information Governance representatives from within the UHB and invited partners from other organisations. The software platforms included: Stakeholder Management Tools called Darzin and Tractivity. The Engagement Tools were called Commonplace, Engagement HQ and VocalEyes.

Attendees were asked to provide a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis of each system on each software platform, and subsequently the Engagement Team met to collate this feedback. The feedback will be shared at a Regional Engagement Partnership Group meeting in November 2019 to consider the way forward. It is intended that the systems will be commissioned by the end of the financial year. There was also a demonstration of Made Open organised by Public Health Wales under Transformation funding which will manage time-banking. It was noted that any software will be in addition to current engagement methods, with the aim being to reach additional audiences.

Supporting Unpaid Carers in Hywel Dda
SRG members were provided with assurance that the UHB recognises the value of unpaid carers and is passionate about driving forward the agenda in this area.

The SRG were delighted to hear the following updates:

- Carers Trust Crossroads Sir Gar have successfully secured lottery funding for three years to commission work with young carers in schools. As part of the work, four posts are being advertised: two Engagement Officers working in schools with Investors in Carers, an Event Co-ordinator and a Volunteer Co-ordinator. There are also services commissioned in Ceredigion and Pembrokeshire to support carers;
- Ceredigion Carers Unit is the first team in the Hywel Dda UHB area to obtain the Gold Level in Investors for Carers accreditation;
- Work is being undertaken to improve carers' experience of discharge from hospital/ transfer of care;
- The UHB is taking part in Carers UK's 'Employers for Carers' scheme, and has established a task and finish group, with the Vice Chair, as Carers Champion.

The SRG members are very supportive of the work undertaken by the UHB and its partners to strengthen services and initiatives for unpaid carers within the area. SRG notes the following:

- Raising awareness is key, providing information at the right time can make a difference;
- Early intervention is critical, reaching individuals before a crisis happens;
- Housing Associations have a significant part to play in identifying carers. An approach will be taken forward by the Strategic Partnership, Inclusion and Diversity team;
- The positive direction taken by the UHB in how they can support their workers whilst juggling working and caring responsibilities.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:

- None

Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:

- Education Programme for Patients (EPP Cymru) would be a vital link into some of the transformation work. EPP Cymru empower individuals to make a difference to improving lives. This is a low cost initiative but very effective. SRG would like to see EPP Cymru provided with funding to strengthen their team and embed their courses into health and social care services. In addition, the SRG would like to see the development of new programmes with young carers and mental health EPP programmes to help young people and young carers.
- Members were advised that Welsh Government may reduce funding for the next financial year to support work with unpaid carers. Members noted that it is imperative that funding is sustainable. Concerns were raised that partners are consistently chasing funding e.g. lottery funding, and around what happens when the funding streams end.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol / Future Reporting:

- Patient Experience Charter
- Supporting Vulnerable Groups
- Transformation Fund Update
- Transformation Programme 7: Creating connections for all
- Winter Plan
- Learning Disability Charter

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

Friday 10th January 2020

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Hywel Dda University Health Board (HDdUHB) Joint Committees and Collaboratives Update Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Steve Moore, Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rosie Frewin, Partnership Governance Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of recent Joint Committee and Collaborative meetings to include the following:

- Welsh Health Specialised Services Committee (WHSSC)
- Emergency Ambulance Services Committee (EASC)
- NHS Wales Shared Services Partnership (NWSSP) Committee
- Mid Wales Joint Committee for Health and Social Care (MWJC)
- NHS Wales Collaborative Leadership Forum (CLF)
- Joint Regional Planning & Delivery Committee (JRPDC)

Cefndir / Background

The Hywel Dda University Health Board (HDdUHB) has approved Standing Orders in line with Welsh Government guidance, in relation to the establishment of the Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and NHS Wales Shared Services Partnership (NWSSP) Committee. In line with its Standing Orders, these have been established as Joint Committees of HDdUHB, the activities of which require reporting to the Board.

The confirmed and unconfirmed minutes, agendas and additional reports from WHSSC, EASC and NWSSP Committee meetings are available from each Committee's websites via the following links:
Welsh Health Specialised Services Committee Website
Emergency Ambulance Services Committee Website
NHS Wales Shared Services Partnership Website

The Mid Wales Healthcare Collaborative was established in March 2015 following a study of healthcare in Mid Wales commissioned by Welsh Government and undertaken by the Welsh Institute for Health and Social Care (WIHSC) (*ref: Mid Wales Healthcare Study, Report for Welsh Government, WIHSC – University of South Wales, September 2014*). In March 2018, the Mid Wales Healthcare Collaborative transitioned to the Mid Wales Joint Committee for Health and Social Care whose role will have a strengthened approach to planning and delivery

of health and care services across Mid Wales and will support organisations in embedding collaborative working within their planning and implementation arrangements.

The NHS Wales Collaborative Leadership Forum was constituted in December 2016. As the responsible governance group for the NHS Wales Health Collaborative it has been established to agree areas of service delivery where cross-boundary planning and joint solutions are likely to generate system improvement. The forum also considers the best way to take forward any work directly commissioned by Welsh Government from Health Boards and Trusts as a collective; and provides a vehicle for oversight and assurance back to Welsh Government as required. Assurance is given to individual Boards by providing full scrutiny of proposals.

The Joint Regional Planning & Delivery Committee (JRPDC) has been established as a Joint Committee of Swansea Bay (formally Abertawe Bro Morgannwg) and Hywel Dda University Health Boards and constituted from 24th May 2017. It provides joint leadership for the regional planning, commissioning and delivery of services for Swansea Bay and Hywel Dda University Health Boards.

Asesiad / Assessment

The following Joint Committee minutes are attached for the Board's consideration:

Welsh Health Specialised Services Committee (WHSSC)

- Summary of key matters considered by WHSSC and any related decisions made at its meeting held on 16th September and 12th November 2019.

Emergency Ambulance Services Committee (EASC)

- Confirmed minutes of the meeting held on 23rd July 2019 and confirmed minutes of the meeting held on 10th September 2019.

NHS Wales Shared Services Partnership (NWSSP) Committee

- Summary of key matters considered by NWSSP and any related decisions made at its meeting held on 18th September 2019.

Joint Regional Planning and Delivery Committee (JRPDC)

- Update Report following the meeting held on 18th October 2019

NHS Wales Collaborative Leadership Forum (CLF)

- Confirmed minutes of the meeting held on 13th May 2019

There are no further Joint Committee minutes or Collaborative updates to include for the following reasons:

Mid Wales Joint Committee for Health and Social Care (MWJC)

- No Update Report is available due to the next meeting taking place on Thursday 21st November 2019.

Argymhelliad / Recommendation

The Board is asked to receive for information the minutes and updates in respect of recent WHSSC, EASC, NWSSP, JRPDC, and CLF meetings.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Link to WHSSC Website Link to EASC Website Link to NWSSP Website Link to MWJC Website
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Welsh Health Specialised Services Committee Emergency Ambulance Services Committee NHS Wales Shared Services Partnership Committee NHS Wales Collaborative Leadership Forum Mid Wales Joint Committee for Health and Social Care Joint Regional Planning and Delivery Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Explicit within the individual Joint Committee and Collaborative reports where appropriate.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Not Applicable
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	The Board has approved Standing Orders in relation to the establishment of WHSSC, EASC and NWSSP Joint Committees, and Terms of Reference for the CLF, MWJC and JRPDC.
Cyfreithiol: **Legal:**	In line with its Standing Orders, the Health Board has established WHSSC, EASC and NWSSP Joint

	Committees, the activities of which require reporting to the Board.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – SEPTEMBER 2019

The Welsh Health Specialised Services Committee held its latest public meeting on 16 September 2019. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

http://www.whssc.wales.nhs.uk/2019-20-whssc-joint-committee

Action log & matters arising
Members noted the action log.

Managing Director's Report
The Joint Committee noted the content of the Managing Director's report and, in particular, updates on:

- ***Soft Tissue Sarcoma in South Wales***: There had been positive progress in addressing the previously reported issues.
- ***Perinatal Mental Health – Mother and Baby Unit***: Management Group (MG) had reviewed the business case for the south Wales MBU and significant progress had been made in addressing the remaining issues.
- ***CAR-T***: The business case had been signed off, enabling CVUHB to proceed with the service.
- ***Veterans' Trauma Network (VTN)***: Approval was given for WHSSC to directly commission the VTN from CVUHB until it could be hosted by the MTN. The service was expected to be cost neutral or better.
- ***WHSSC Office relocation***: The impending move to Treforest Industrial Estate, Pontypridd was noted.

Chair's Report
The Joint Committee received an oral report from the Chair. The Chair explained that Charles (Jan) Janczewski has stepped down as an Independent Member of the Joint Committee and as chair of the WHSSC Quality & Patient Safety Committee following his appointment as Interim

Chair of CVUHB and that a replacement was being sought. The Chair recorded her thanks to CJ for his contribution.

Major Trauma Network for South Wales – Tranche 2 Recruitment
Members received a paper that had been circulated prior to receipt of key items, including CVUHB Business Case and output from the latest Gateway Review. The paper identified Tranche 2 Recruitment items (1) that were in accord with recommendations derived as a result of the Peer Review (2) that didn't accord with recommendations from Peer Review. Tranche 1 Recruitment had been agreed by JC on 30 August.

A Professional Peer Review had been undertaken during August. An Executive Steering Group (ESG) Report included recommendations from the ESG derived as a result of the Peer Review. CVUHB did not agree with all of the recommendations in the Report. The Report had been approved by the ESG earlier in the day, subject to comments received back within 48 hours. Peer Reviewers had also seen and confirmed support for the ESG Report and recommendations.

The result of the latest Gateway Review was now known to be Amber/Red with good progress on many issues but four significant outstanding issues.

The SBUHB ODN Business Case had been reviewed on 11 September. The CVUHB Business Case had now received preliminary review and it was noted that there were three main areas of discord (1) 24/7 consultant rota, (2) proposal for 14 (rather than 10) beds in Poly Trauma Unit, and (3) additional (fourth) plastic surgery consultant. It had been agreed at the ESG meeting earlier in the day that WHSSC would review these issues with CVUHB and take them to the MG meeting on 26 September for scrutiny.

Welsh Government was optimistic about funding start-up costs incurred during 2019-20 with some recognition that further top-up funding might be required for future years. The overall financial picture was noted as being around £15m p.a.

The Finance Working Group is waiting for (1) finance and manpower baselines, (2) activity and income flows for non-elective cases, and (3) the business case for the CVUHB Trauma Unit (distinct from MTC).

The key requirements for an April 2020 go live are (1) physical and staff infrastructure, (2) governance structure for ODN, and (3) Welsh Government capital approval. EMERTS was scheduled for an April 2020 'go live' but needed to be asked to confirm that protocols can be varied and/or patient risks managed for a later go live of the MTC and ODN if necessary.

The WHSS Team will develop commissioning advice to JC.

The Project Business Case (PBC) would be available in October 2019. A PBC briefing for all parties being was being arranged for 23 October. The 12 Nov JC meeting will receive feedback on the PBC. Health boards will formally consider the PBC at their late November board meetings. It was agreed that health boards would hold short meetings at end of October 2019 to ascertain likely level of support from boards prior to formal consideration of the PBC at their boards in November, this will inform the 'go live' date and potentially provide cover for incurring Tranche 2 costs. It was agreed that the Tranche 2 recruitment process can begin ahead of late October support from boards (subject to MG scrutiny on 26 September) with interviews scheduled for late October but without confirming appointments until November. This reflects the need to manage the risks associated with moving too quickly or not quickly enough.

Major Trauma – Commissioner's Risk Register
The Joint Committee received the first draft of the Commissioner's Risk Register for the Major Trauma Centre and Operational Delivery Network. It was noted that the Register would now, and continuously, be updated for the latest developments.

Integrated Commissioning Plan – Revised Timeline
Members received a paper explaining that Welsh Government has relaxed the submission date for IMTPs to 31 January 2020. It was noted that the WHSSC ICP needs to include MTC and ODN on approval of the Project Business Case. It was agreed that the WHSS Team would continue to work toward submitting the ICP to JC on 12 November 2019.

Radio Frequency Ablation for Barrett's Oesophagus
Members received a paper that (1) provided an update on the work led by WHSSC to develop the commissioning framework for a south Wales based Radiofrequency Ablation service for patients with Barrett's Oesophagus, and (2) confirmed the future commissioning arrangements for Radiofrequency Ablation for patients with Barrett's Oesophagus. Approval of the proposal was delegated to MG.

Other reports
The Joint Committee received the Integrated Performance Report and the Financial Performance Report.

The Joint Committee also noted the update reports from the following joint sub committees and advisory groups:

- Management Group; and
- Quality & Patient Safety Committee.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – NOVEMBER 2019

The Welsh Health Specialised Services Committee held its latest public meeting on 12 November 2019. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

http://www.whssc.wales.nhs.uk/2019-20-whssc-joint-committee

Action log & matters arising
Members noted the action log.

Chair's Report
The Chair reported that Mr Emrys Elias, Vice-Chair of ABUHB, had been nominated as an Independent Member of the Joint Committee and Chair of the WHSSC Quality & Patient Safety Sub-committee, and had signified his willingness to act. He would be appointed shortly by Chair's Action.

Managing Director's Report
The Joint Committee noted the content of the Managing Director's report and, in particular, updates on:

- ***Perinatal Mental Health – Mother and Baby Unit***: Discussions have commenced regarding options for an interim solution and the business case for the substantive model has been progressed. A paper will go to Management Group on 28 November for consideration.
- ***Vulnerable Groups Portfolio***: Welsh Government has formally requested that WHSSC take forward the commissioning of an All Wales Traumatic Stress Service and supports the further development of the Gender Service, Forensic Adolescent Consultation and Treatment Service as well as refugee resettlement. To facilitate this they have agreed two years' funding for a Senior Planner and Associate Medical Director.

Risk Register for Thoracic Surgery Implementation
Members received a paper that shared the south Wales thoracic surgery services centre risk register. Members noted the information provided and asked for the nature of the risks to be clarified. It was further noted that good progress was being made on the project.

WHSSC Governance and Accountability Framework
Members received a paper that explained proposed changes to be made to the WHSSC Governance and Accountability Framework, including the WHSSC Standing Orders and Associated Documents.

Members:

- Noted the content of the paper;
- Approved the amended WHSSC Standing Orders and Associated Documents; and
- Supported the amended WHSSC Standing Orders being taken forward for approval by the seven Welsh Local Health Boards.

Integrated Governance Committee Terms of Reference
Members received a paper that presented revised Terms of Reference for the Integrated Governance Committee for approval.

Members approved the revised Integrated Governance Committee Terms of Reference.

Other reports
The Joint Committee received the Integrated Performance Report for August 2019 and the Financial Performance Report for Month 6 of 2019-20.

The Joint Committee also received the update reports from the following joint sub committees and advisory groups:

- Management Group;
- Integrated Governance Committee;
- Quality & Patient Safety Committee;
- All Wales Individual Patient Funding Request Panel;
- Welsh Renal Clinical Network; and
- NHS Wales Gender Identity Partnership Group.

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 23 JULY 2019 AT THE EDUCATION CENTRE LLANDOUGH HOSPITAL CARDIFF

PRESENT

Members	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Gary Doherty	Chief Executive, Betsi Cadwaladr UHB
Len Richards	Chief Executive, Cardiff & Vale UHB
Sian Harrop-Griffiths	Swansea Bay UHB
Karen Miles	Hywel Dda UHB (Via VC)
Carol Shillabeer	Chief Executive, Powys THB
Glyn Jones	Director of Finance/Deputy CEO, Aneurin Bevan UHB
In Attendance:	
Jason Killens	Chief Executive Welsh Ambulance Services NHS Trust
Anthony Hayward	Corporate Director, National Collaborative Commissioning Unit
James Rodaway	Head of Commissioning, EASC
Jamie Kaijaks	Finance Graduate Trainee, Swansea Bay UHB
Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Shane Mills	Director Quality and Patient Experience, National Collaborative Commissioning Unit
Stuart Davies	Director of Finance, WHSSC and EASC Joint Committees
Chris Polden	Managing Director ORH (for one item)
Gwenan Roberts	Head of Corporate Services, Cwm Taf Morgannwg UHB (Secretariat)

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 19/48	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. The Chair advised that the main business would be followed by a development session involving a presentation from James Rodaway on Risk Management.	

EASC 19/49	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Judith Paget, Len Richards, Steve Moore, Tracy Myhill, Sharon Hopkins, Julian Baker, Steve Webster and Robert Williams.	
EASC 19/50	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	
EASC 19/51	**MINUTES OF THE MEETING HELD ON 14 MAY 2019** The minutes were **confirmed** as an accurate record of the meeting held on 14 May 2019.	
EASC 19/52	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** progress as follows: **EASC17/44 & 17/73 & 19/21** **Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review** Members **NOTED** that a further update would be provided at the next meeting. **EASC 18/06 & 18/65 & 19/21** **Integrated Performance Dashboard** Members **NOTED** that work was continuing on the development of the Dashboard which was linking data across the system. A further update would be provided at the next meeting. **EASC 18/107 & 19/21** **Expansion of EMRTS (Emergency Medical Retrieval and Transfer Service)** Members **NOTED** that an update would be provided in the Chief Ambulance Service Commissioner's report. **EASC 19/08 & 19/21** **Mental Health Staff Clinical Desk** Members **NOTED** that work was continuing with the Welsh Government in terms of developing a national approach. A further update would be provided to the Committee in November (**Added to the Forward Look**).	CASC CASC CASC Director of Quality and Experience

	EASC 19/08 & EASC 19/21 & EASC 19/23 **Emergency Medical Retrieval and Transfer Service (EMRTS)** Members **NOTED** that information was awaited in relation to the Gateway Review, a meeting was scheduled to take place in early August and an update would be provided at the November meeting. **Ambulance Quality Indicators (AQI)** Members **NOTED** the work to link the AQIs with the performance dashboard. Members **RESOLVED** to: • **NOTE** the action log.	CASC
EASC 19/53	**MATTERS ARISING** There was none.	CASC
EASC 19/54	**CHAIR'S REPORT** The Chairs report was **received** by Members. In presenting the report Chris Turner highlighted his key meetings which had taken place since the last meeting of the Committee. Members **NOTED** that during the appraisal with the Minister, the emphasis had been on driving change across the system and ensuring that the EAS Committee was operating corporately. Other issues discussed included Amber implementation and the Red performance. Members also **NOTED** that a request has been received from the Deputy Chief Executive at NHS Wales for a discussion to take place at EASC on the regional escalation processes. Members **RESOLVED** to: • **NOTE** the Chair's Report.	Chair
EASC 19/55	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** The Chief Ambulance Services Commissioners (CASC) report was **received** by the Committee. • **Update on Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway Review** Members **NOTED** that the CASC was due to meet with colleagues from Swansea University at the beginning of August to receive the first draft of the Gateway Review.	CASC

	The document would be shared with Committee Members when received and discussion would take place at the next available Management Group meeting and a summary of the discussions would be provided to the Committee.	CASC
	• **Update on Management Group** Members **NOTED** that the first meeting of the Management Group took place on 12 July was well attended. The meeting concentrated on the use of the 1% 'A Healthier Wales' allocation which allowed time to discuss in detail. The CASC explained that a good and positive start had been made at the first Management Group meeting. Sian Harrop-Griffiths asked about the Terms of Reference and membership for the Management Group; Stephen Harrhy explained that it was similar to the approach to the Welsh Health Specialised Services Committee (WHSSC) management group and the terms of reference would be shared with the Committee at the next meeting. The aim was to ensure that the right representatives attend management group. Stephen Harrhy agreed to ensure that the meetings were scheduled and planned in advance to ensure the right staff were available to represent the health boards (**Added to the Action Log**).	CASC
	• **RED performance** Members **NOTED** that the performance in June was over 65% and was an improvement on the previous 2 months. Red performance across Wales was in excess of 70% and although was 61.9% in Hywel Dda this was slowly increasing. Members **NOTED** that the Powys and Hywel Dda areas were regularly reporting lower than 65%.	
	• **Mental Health** Members **NOTED** that South Wales Police requested continuation of the funding for Mental Health clinicians in the control room. Shane Mills explained that discussions were taking place with the Police Federation lead which included Carol Shillabeer as the lead Chief Executive. Although the report is yet to be published, the South Wales Police have shared that early findings from a review are that there has been a reduction in persons with 'MH issues' requiring a Police response. Members **NOTED** that further discussion and analysis would need to take place in order that Members understood how this all fits together with 111 and the WAST clinical desk.	

	Members **NOTED** that the Mental Health Access review was due to report in the new year which would give a better understanding of demand from people with mental health distress for urgent care services. Carol Shillabeer explained that the term 'mental health' was being used in its widest form. Jason Killens also supported that there was a need for a better service but suggested a 'Once for Wales' approach was needed. Shane Mills and Carol Shillabeer agreed to develop further information for Committee Members to capture all of the work to date (**Added to the Action Log**). Members **RESOLVED** to: • **NOTE** the update and the actions agreed.	Carol Shillabeer /Shane Mills
EASC 19/56	**DEMAND AND CAPACITY REVIEW** Jason Killens provided an overview of the work on the Demand and Capacity Review at the Welsh Ambulance Services NHS Trust (WAST) to date and invited Chris Polden from ORH to give a short presentation. Members **NOTED** the intention to provide a final report to the Committee at the November meeting. Chris Polden gave an overview of the work of the ORH Management Consultancy set up in 1986 who were working globally with emergency services. Members **NOTED** the work across the UK with ambulance services who were identifying similar themes to those identified by WAST. Other issues such as the ageing population, long waits for patients in Amber category and seasonal variation were also considered as part of the review. The Review aims were clarified as: • Forecast incident demand over the next 5 years • Agree the required level of quality and time performance for each type of patient • Model the resources needed to achieve these levels of time and quality assuming current operations • Identify WAST efficiencies and the impact these will have on the staffing required • Identify unscheduled care system efficiencies and the impact these will have on the staffing required • Model the impact of planned service changes and their impact on patient flows • Model the resources required for call handling clinical staff and dispatch in the clinical contact centres.	Jason Killens

	The Review would ensure comprehensive data collection to identify issues across Wales and would also model the incident life cycle. Members discussed the impact of the work and the potential to widen across the pathway. Chris Polden confirmed that work was underway to also benchmark both within and outside of Wales and the UK. Members **NOTED** that a steering group would be developed to oversee the work. It was felt that clinical service plan leads could provide the right links to get the best information for the Review and although the review would not include aspirational ideas although they would be captured as issues. Directors of Planning had also been involved in the work which included the changes planned for the major trauma service although the steering group would clarify what could be included in the work. Members discussed the information shared and suggested that the work on population segmentation may also be helpful for the Review team. Members **NOTED** that schemes which have been evaluated were included, such as the clinical desk and advanced paramedic practitioners. Members felt that the role of the steering group would be important to test the model and analyse the choices to be made about the future provision. Steve Moore would provide the leadership for the group and the reports and minutes of meetings would be shared with Members (**Added to Action Log**). The Chair thanked Chris Polden for the helpful presentation on the overview of the work and it was agreed to receive further information on the work, if available, at the next meeting (**Added to the Action Log).** Members **RESOLVED** to • **NOTE** the presentation.	Steve Moore Steve Moore
EASC 19/57	**PROVIDER ISSUES BY EXCEPTION** The Welsh Ambulance Services NHS Trust Provider Update was received by the Committee. In presenting the report, Jason Killens highlighted some key issues: • **Serious Adverse Incidents (SAIs)** Members **NOTED** the increasing trends for SAIs in the Aneurin Bevan and Swansea Bay University Health Board areas. The Directors of Nursing were discussing the Joint Investigation Framework in July to identify the best practice on investigating incidents going forward.	Jason Killens

	• **RED Performance** Members **NOTED** that in the main Hywel Dda and Powys health board areas were dipping below the 65% target; recovery plans were in place and further actions had been added although it was recognised that there was more work to do to improve response times. Members **NOTED** the current improvement focus areas had been identified and were being actioned including: • Continuing to develop and utilise information on demand, capacity and efficiency to inform action planning. This includes the use of sophisticated performance analysis and modelling software (Qliksense and Optima Predict) to support Operations • Overproducing on RRV unit hours at times when red performance is poor (twilight shifts) • Increasing the number of Community First Responders • Working with Trade Union Partners to understand post production hours lost and to identify actions to reduce them • Continuing work to reduce abstraction rates, with sickness levels now on a downward trend • Reviewing deployment points, moving them where possible to reduce response times. The expansion of the Advanced Paramedic Practitioner (APP) was discussed and Members **NOTED** the plans for the condensed APP MSc programme. Members **NOTED** that WAST had also been working to reduce hours lost from handover to clear. As part of this work to cleanse and refine the data, a dual pin system for handover was being rolled out in each Emergency Department and the work would be completed by the end of August. Jason Killens explained that the service changes and the Major Trauma Network work would have an impact and WAST felt that a co-ordinating desk would be required for 16 hours. Members **NOTED** that the WAST bid covered training and how much in the current allocation or getting the ambulance teams for the major trauma centre, call handling requirements would also need to be considered. Members **RESOLVED** to • **NOTE** the report.	

EASC 19/58	**UPDATE ON AMBER REVIEW** Members **received** the report on the Amber Review which was presented by Shane Mills. Members **NOTED** that additional work was required and an action plan had been developed; a group was in place to oversee the work working with the team at WAST to ensure progress was being made. The aim was to have a comprehensive action plan which included all health board to reduce the numbers of ambulances waiting. Members **NOTED** that patients are being informed when the service is at escalation and a script has been developed for the staff. Shane Mills explained that the aim was to link the data across the whole system and to use the NHS Wales Informatics Service (NWIS) data set. The work to complete the Amber Review should be completed by the end of the year and Members may need to consider the commissioning intentions for the service. A further update would be provided at the next meeting (Added to the Action Log). Members **RESOLVED** to: • **NOTE** the report	Shane Mills Shane Mills
EASC 19/59	**INTEGRATED MEDIUM TERM PLAN (IMTP) UPDATE** Members received the IMTP Update Report which was presented by Anthony Hayward. Members **NOTED** the clarity of information relating to the accountability conditions as part of the reporting proforma for 2019-2020. The EASC IMTP Quarter 4 for 2018/19 and the Quarter 1 for 2019/20 progress was discussed and **NOTED**. Areas identified which had slipped from the target timescale included: • Quality assurance and improvement findings reporting for EMRTS • Quality assurance and improvement findings reporting for NEPT • EMS commissioning Intentions • NEPTS commissioning Intentions Members were assured that plans were in place to recover the position. Members **RESOLVED** to: • **NOTE** the report.	Anthony Hayward

EASC 19/60	**REGIONAL ESCALATION** Members **AGREED** to discuss further in the development session.	Chair
EASC 19/61	**FINANCE REPORT** Members r**eceived** the Finance Report which was presented by Stuart Davies. Members **NOTED** that the identified risks were being managed. Members **RESOLVED** to: • **NOTE** the report.	Stuart Davies
EASC 19/62	**1% 'A HEALTHIER WALES' ALLOCATION** Members received the report on the allocation of the 1% 'A Healthier Wales' funding. The Chief Ambulance Services Commissioner gave a short overview of the work to date and James Rodaway presented the report which highlighted the important principles being adopted. Members **NOTED** that a long list would be developed for further discussion and no information would be sifted before the meeting of the Management Group to finalise the allocation, this would take place on 26 July 2019. Following discussion, Members requested that the Management Group undertake an evaluation of all the Schemes which should be shared with the Committee (**Added to Action Log**). Members **NOTED** that all of the information was being captured to ensure the principles were upheld. The evaluation panel would take place on Friday and the recommendations would be sent to Members. Stephen Harrhy explained that if there were any specific issues to be resolved a special meeting of the Committee would be convened. Following discussion Members **RESOLVED** to: • **NOTE** the report • **APPROVE** that the Management Board evaluate the bids and report back to the Committee.	James Rodaway CASC
EASC 19/63	**EASC GOVERNANCE UPDATE** The governance update report was **received** by the Committee and presented by Gwenan Roberts.	Gwenan Roberts

	Members **NOTED** that the Annual Governance Statement had been finalised and received at the Audit Committee on 30 May 2019. Members **RECEIVED** and **NOTED** the Internal Audit Report on Handover of Care at Emergency Departments Follow-up Health Board Related Recommendations which was received by the Host Body's Audit Committee on 9 July 2019. Members **NOTED** that the report received a 'Reasonable' assurance rating and four medium priority recommendations had been made. The actions required would be factored into the forward work plan for the Committee with the majority to be delivered by the next meeting. Members **RESOLVED** to: • **ENDORSE** the Annual Governance Statement • **NOTE** the report.	
EASC 19/64	**CLINICAL RISK REVIEW – CLOSURE REPORT** The closure report for the Clinical Risk Review was **received**. In presenting the report, Ross Whitehead confirmed that 24 actions had been identified and most had now been completed or now informed the work of the Management Group. Member **NOTED** the importance of the clinical records within the Ambulance service; additional clinical audits would also be carried out and access to policies and guidelines would take place. Members **RESOLVED** to: • **NOTE** the report • **ENDORSE** the closure report.	Ross Whitehead
EASC 19/65	**FORWARD PLAN OF BUSINESS** Members **received** the forward plan of business. Members **RESOLVED** to: • **NOTE** the Forward Plan • **AGREE** that the Chair and the Chief Ambulance Services Commissioner review the Forward Plan for future	*ALL*

ANY OTHER BUSINESS		
EASC 19/66	There was none.	
DATE AND TIME OF NEXT MEETING		
EASC 19/67	A meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 10 September 2019 at the National Collaborative Commissioning Unit, Treforest Industrial Estate.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date:……

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 10 SEPTEMBER 2019 AT THE NATIONAL COLLABORATIVE COMMISSIONING UNIT, TREFOREST INDUSTRIAL ESTATE

PRESENT

Members	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Gary Doherty (Via VC)	Chief Executive, Betsi Cadwaladr BCUHB
Len Richards	Chief Executive, Cardiff & Vale CVUHB
Tracy Myhill	Chief Executive, Swansea Bay SBUHB
Steve Moore (Via VC)	Chief Executive, Hywel Dda HDdUHB
Carol Shillabeer	Chief Executive, Powys PTHB
Sharon Hopkins	Chief Executive, Cwm Taf Morgannwg CTMUHB
In Attendance:	
Simon Dean (in part)	Deputy Chief Executive NHS Wales
Nicola Prygodzicz	Director of Planning, Aneurin Bevan ABUHB
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust
James Rodaway	Head of Commissioning & Performance Management, EASC
Julian Baker	Director, Collaborative Commissioning
Ross Whitehead	Assistant Director of Quality and Patient Experience
Jo Mower	Clinical Director National Programme Unscheduled Care
Rachel Marsh	Interim Director of Planning, Welsh Ambulance Services NHS Trust
Lee Brooks (in part)	Director of Operations, Welsh Ambulance Services NHS Trust
Stuart Davies	Director of Finance, WHSSC and EASC Joint Committees
Gwenan Roberts	Head of Corporate Services, Cwm Taf Morgannwg UHB (Secretariat)
Maxine Power (in part)	Executive Director of Quality, Innovation and Improvement, North West Ambulance Service

Part 1. PRELIMINARY MATTERS		ACTION
EASC 19/68	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves.	
EASC 19/69	**PRESENTATION** Maxine Power, Executive Director of Quality, Innovation and Improvement from the North West Ambulance Service was welcomed to the meeting and gave a presentation entitled 'Tackling the Challenge of Handover Delays'. Members **NOTED**: • Population 7.9m; 31 hospital sites, large numbers of Clinical Commissioning Groups to work with; large population health footprint; 4 strategic transformation partnerships which provided an area of great challenges but great opportunities • Winter of 2017-8 particularly challenging including increase of serious incidents from 2-3 per month to 20; key issue crews waiting at A&E • The overview of the 10 years of initiatives in NHS England • Worked with the 'super six' organisations as the most willing • Chief Executives asked to take a personal interest in the lost hours • Used patient stories to help understanding • Used 15 different actions to get different responses – the exchange visits to different organisations most powerful as well as having executive and board sponsorship • Locally on the ground things felt 'chaotic' • Sites chose what actions they felt were appropriate • A strong set of diagnostics and measures were identified • Tracker on an hourly basis and worked closely with the regulator. Members discussed the implications and ideas for NHS Wales and identified that other agencies would also be willing to assist such as 1,000 Lives Plus. The notion of having a competitive element was also recognised as a useful driver. In terms of patient safety the use of a safety checklist was known and Members felt it was helpful to learn from the experience of others although a lot of the actions identified were already available in NHS Wales.	Jo Mower

	The value of front line staff working together and learning between sites was felt to be key. Both Jo Mower and Julian Baker shared the specific initiatives being led or co-ordinated by the National Programme for Unscheduled Care in Wales and Members felt that actions were already been taken. Members felt it would be helpful to have an update in the future on the actions taken which impacted specifically on handover delays. It was agreed that the Clinical Director for the National Programme for Unscheduled Care (Dr Jo Mower) should present the Emergency Department Quality and Delivery Framework to the next EASC meeting ensure that that the pace of progress was being maintained (**Added to Action Log**).	
EASC 19/70	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Judith Paget, Glyn Jones, Georgina Galletly, Steve Ham, Anthony Hayward, Shane Mills and Tracey Cooper.	
EASC 19/71	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	
EASC 19/72	**MINUTES OF THE MEETING HELD ON 23 JULY 2019** The minutes were **confirmed** as an accurate record of the meeting held on 23 July 2019.	
EASC 19/73	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** progress as follows: **EASC 18/06 & 18/65 & 19/21** **Integrated Performance Dashboard** Members **NOTED** that work was continuing on the development of the Dashboard which was linking data across the system. A further update would be provided at the next meeting. **EASC 19/08 & 19/21** **Mental Health Staff Clinical Desk** Members **NOTED** that work was continuing with the Welsh Government in terms of developing a national approach. A further update would be provided to the Committee in November (**Added to the Forward Look**).	CASC Director of Quality and Experience

	Members **NOTED** that Carol Shillabeer had discussed with the lead Chief Constable (Dyfed Powys Police) and the work would inform the 'Once for Wales' option. It was anticipated that the work would be completed early in 2020. **EASC 19/08 & EASC 19/21 & EASC 19/23** **Emergency Medical Retrieval and Transfer Service (EMRTS)** Members **NOTED** that information was awaited in relation to the Gateway Review, a meeting was scheduled to take place in early August; an update would be provided at the November meeting. Members **RESOLVED** to: **NOTE** the action log.	CASC
EASC 19/74	**MATTERS ARISING** There was none.	CASC
EASC 19/75	**CHAIR'S REPORT** The Chairs report was **received** by Members. In presenting the report, Chris Turner highlighted his key meetings which had taken place since the last meeting of the Committee. Members **NOTED** the: • Feedback on the Annual Appraisal from the Minister and the importance of maintaining momentum of the Amber Review • Chair's involvement in Chairing the Evaluation Panel for the allocation of the 'A Healthier Wales' funding • Impact on EASC of the NHS Executive and that further discussion would be required when more information was available • Intention of the Chair and the Chief Ambulance Services Committee (CASC) to visit all health boards to update Boards on the work of the Joint Committee and asked for the support of Members to arrange as soon as possible (**Added to Action Log**). Members **RESOLVED** to: • **NOTE** the Chair's Report.	Chair Members
EASC 19/76	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** The Chief Ambulance Services Commissioners (CASC) report was **received** by the Committee.	CASC

	• **Amber Review Implementation Programme** Members **NOTED** the work to date and that the Minister was planning to make a statement in November. Progress was being made against the 9 recommendations as a detailed report would be provided for the Committee at the November meeting (**Added to Forward Look**).	CASC
	Members also **NOTED** that there were no specific risks to be reported although all were aware of the continuing challenges to ambulance responsiveness and lost hours in relation to handover delays.	CASC
	• **Update on Management Group** Members **NOTED** that the representation from all areas was good and subject to reviewing the membership, including adding WAST to the Group, **APPROVED** the terms of reference. It was **AGREED** that a forward work plan would be produced by the Management Group and shared at the next meeting (**Added to the Forward Look**).	CASC
	• **Risk Register** Members **NOTED** that further discussion would need to be held at the next meeting including agreement how the risk management framework would be used (**Added to the Forward Look**).	CASC
	• **Stroke Services** Members **NOTED** the Minister's expectations and new measure for ambulance services. Further information would be provided in due course (**Added to the Forward Look**).	CASC
	• **Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review** Members **NOTED** that the Delivery and Assurance Group was due to meet in September and an update would be provided at the November meeting (**Added to the Action Log**).	
	• **Non-Emergency Patient Transport Service (NEPTS**) Members **NOTED** that good progress was being made. The Chief Ambulance Services Commissioner thanked the health boards for their support and thanked the Welsh Ambulance Services NHS Trust for their work to date. Further updates would be provided at the meeting in January (**Added to the Forward Look**).	

	• **RED performance** Members **NOTED** that this would be discussed in detail in the provider update report. • **Handover position** Members **NOTED** that during the last weekend, performance was not at the level expected with 650 hours lost across Wales. **Members NOTED** ongoing work in the following areas: • Aneurin Bevan, Cardiff & Vale and Betsi Cadwaladr as pilot sites for the EDQDF • The Swansea Bay improvement plan was considered good but needed pace to implement • The Delivery Unit were planning to work at the Princess of Wales Hospital site to assist with the drifting performance • Aneurin Bevan had visited Preston to view progress being made. Members discussed what additional actions should be taken, how they could learn from others and how they could work more closely together at times of heightened escalation. It was felt that it was important to build on work already underway and to concentrate on a small number of initiatives that would have the greatest impact. Members discussed the need to do further work and to address the current position which was much worse than last year. Members **NOTED** that at the National EDQDF Summit held in July 2019, a significant amount of good initiatives which were showing signs of success had been identified. Members specifically discussed the use of the checklist and having the emergency department consultant at the front door in terms of triage but this did not have the anticipated impact due to the whole system issue of patient flow throughout the hospital sites. Members **NOTED** the good progress that was being made with the EDQDF programme. A discussion took place on the current escalation plans and processes. It was agreed that the plans needed to be reviewed and the daily conference calls should be hosted by WAST. A national event would be organised as a matter of urgency to finalise this.	

	A discussion took place on the use of alternative pathways and the important role that they can play in managing demand into Emergency departments and reducing the number of ambulance conveyances. It was agreed that each Health Board would make available to WAST an additional three pathways in time for this winter. Simon Dean challenged the leadership and ownership of the Members and felt that it was important to make more progress on the journey which was a clear Ministerial priority. The Deputy Chief Executive of NHS Wales asked about priorities of organisations and the role of the whole executive in ensuring the pace. Simon Dean also challenged the Members regarding whether the local systems were completely understood and the impact on the lack of consistency across Wales; he felt that there were areas that organisations could just make the changes required. The challenge was to ensure that changes could be made at pace - these changes needed to be clarified organisation by organisation. The importance of the work required by WAST was also discussed including the importance of increasing the staffing levels as well as clarifying how community risks are captured and managed effectively. Members discussed resetting thresholds such as for corridor waits which are normalised thresholds in some organisations. Members agreed that the goal zero tolerance although this would depend on the starting point for each health board (HB). Discussion took place in relation to the immediate release arrangements for RED category requirements and agreed the need to comply with the current policy to avoid what was seen as a potentially growing risk to patients waiting longer for an ambulance response in the community. Members also agreed to use the next Management Group to identify areas for further pace and for in-depth discussion prior to any Committee meeting. Following discussion Members **RESOLVED** to: • **NOTE** the report and the agreed actions • **APPROVE** the Terms of Reference for the Management Group (subject to the review of the membership).	CASC

EASC 19/77	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) PROVIDER UPDATE** The Provider Update report provided by the Welsh Ambulance Services NHS Trust was received. In presenting the report, Jason Killens highlighted some key areas including: • The number of patients more than 12 hours following a 999 call • The increase in immediate release requests • RED performance – which had been particularly challenging, particularly in Powys; Members NOTED that the demand was increasing at a rate of 7% year on year • The increasing reliance on overtime currently over 20% • The high levels of sickness • The early indications within the demand and capacity review including a potential relief rate of 42.2% giving a staffing gap of 262 whole time equivalent • Newly qualified pipeline continued although natural turnover – identified a significant number of re-sits which Members asked if it was considered excessive and Jason Killens agreed to discuss with the provider (**Added to the Action Log**). **Winter Resilience** Members held a wide ranging discussion on the additional schemes that could be introduced to ensure greater resilience over this winter. The following were agreed for inclusion in winter plans and for implementation: • The use of 3rd sector support for transfers and discharges and to support the unscheduled care workforce • The provision of extra support by extending the hours of clinical staff already employed in the CCC's • Support to cohort patients in safe spaces in specific district general hospitals • Provision of additional emergency medical services staff. **RED Performance** Members received the presentation outlining RED performance which was presented by Lee Brooks. The key issues only were highlighted and Members **NOTED**: • RED improvement plan to be produced and shared (**Added to Action Log**) • Resource requirements and the identification of potential sources of funding • The WAST risks including being unable to get additional staff • The WAST implementation plan and monitoring mechanisms.	Jason Killens Jason Killens Jason Killens

	Following discussion, Members agreed to prioritise the hand over delays and RED performance and expressed their urgency to get changes made quickly into the system. Jason Killens also asked Members for support in their organisations with GoodSAM which integrates with the computer aided dispatch. Jason Killens agreed to send additional information following the meeting to Members (**Added to the Action Log**). Members also received the ORH slide deck for information. The steering group was meeting regularly to track progress and it was anticipated would finish in September and the final report would be received at the November meeting (**Added to the Forward Look**). Following discussion Members **RESOLVED** to: • **NOTE** the work being undertaken and the priorities agreed for winter resilience. • **Receive** the RED Improvement plan.	Jason Killens Jason Killens
EASC 19/78	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) RELIEF GAP EMERGENCY AMBULANCE SERVICES REFERENCE DOCUMENT** Members received the Reference Document, Stephen Harrhy presented the document. Members **NOTED** that following the WAST Joint Executive Team meeting with Welsh Government officials Members **NOTED** that the Reference Document had been developed as a response to the information directly provided to the Welsh Government from WAST on the stated relief gap within the provision for emergency ambulance services. Members **NOTED**: • The timescales for the information • IMTP and commissioning intentions • CASC Review of WAST spend on front line staff compared to the overall increased allocation since 2013-2014 Jason Killens informed the Committee that discussions had taken place with the Chair of WAST in relation to the proportion of spend on frontline staff and confirmed the commitment to return to 2013/14 levels; he also explained that the organisation was 'paramedic rich' although in the report to the Welsh Government had identifying a requirement for an additional 40 paramedics.	

	Members felt it would be helpful to have confirmation in terms of where resources had been allocated to better understand the current position, generally Members felt that spending on frontline staff was not as they expected. Following discussion Members **RESOLVED** to: **AGREE** to the following: • Receive a plan from WAST outlining how they would return to 2013/14% levels of spending on frontline staff recurrently • Use WAST contingency and 1% 'A Healthier Wales' funding slippage as non–recurrent allocation for use by EASC; money to be allocated on spend and with agreement on impact on performance • Receive a review what has happened to the funding provided to date since 2013/14 (CASC to undertake on behalf of EASC) • Tapering funding to be discussed as part of the IMTP process and linked to outcome of Demand and Capacity Review • Handover improvement plan to be agreed by EASC • Detailed discussion to take place at the Management Group meeting on 23 September 2019 • No delay in any immediate actions to be undertaken.	 Jason Killens CASC CASC EASC WAST CASC WAST
EASC 19/79	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) SERVICE TRANSFORMATION** Members received the WAST Service Transformation Report. In providing an overview of the background to the report, Jason Killens gave a summary of the work to date. Rachel Marsh provided the detail in relation to the schemes that WAST were asking for support. • Falls Service – strong evidence of the positive impact of the service • Advanced paramedic practitioners: funding received during the last winter; further 25 undertaking training starting in September; working in primary care; rapid response vehicle and the clinical control centre. • GPs and others closely aligned with control centres to work with the categories of green and amber 2 calls for alternative pathways. Stephen Harrhy supported the report in terms of explaining that the patients who would be mostly dealt with would be seen in a more timely way. Julian Baker asked about the net impact of the appointments and the need for a strong evaluation process. Members **NOTED** that the evaluation for the falls bid showed clearly the positive impact on the patient experience.	

	Members also **NOTED** that there was a lot of work required to ensure the right information was available for inclusion in the IMTP for the next year. Chris Turner supported the report reiterating the need to sharpen the impact and capture the outcome. Following discussion Members **NOTED** that there were around 94 pathways in use within WAST. Clinical colleagues had met and developed a proposal to work internally to develop standardised pathways and particularly high volume codes to ensure consistency in the services across Wales would be developed. It was agreed that each Health Board would make available to WAST access to three pathways in time for this winter Members **RESOLVED** to: • **AGREE** make available to WAST access to three pathways in time for this winter • Support the development of Level 1 Falls Response across Wales • Support the expansion of Advanced Paramedic Practitioners using a rotational model (subject to the Demand and Capacity review) • **AGREE** to support WAST as the handler of choice subject to pilot schemes being developed into a viable pan Wales model.	
EASC 19/80	**FINANCE REPORT** Members r**eceived** the Finance Report which was presented by Stuart Davies. Members **NOTED** the current financial position and the ongoing work to allocate the 1% 'A Healthier Wales' allocation. Members **RESOLVED** to: **NOTE** the report.	Stuart Davies
EASC 19/81	**AMBULANCE QUALITY INDICATORS** The Committee received the report on Ambulance Quality Indicators (AQIs). In presenting the report, Stephen Harrhy gave an overview of the key issues which had also been discussed earlier in the meeting including handover delays. Members **RESOLVED** to: • **NOTE** the overview of the last quarter's AQIs.	Ross Whitehead

EASC 19/82	**REGIONAL ESCALATION** Members received the report on Regional Escalation. In presenting the report, Stephen Harrhy explained that the purpose was to improve the arrangements for regional and national escalation and to manage the system risk across NHS Wales. Members welcomed WAST's proposal to chair the conference calls as the system leader (rather than rotating chair) to improve continuity. Members discussed the following: • Terms of reference for the conference call – more proactive than reactive for the next 24-48 hours plan • Development of a more integrated dashboard • Using a set agenda for meeting (around escalation plans) • Use up to date escalation plans – all organisations to submit by 20 September • The need to be realistic for timescales – staff need to be aware of the plans and empowered to enact the plans • Health Board would need to own the plans and the work • Need to consider unintended consequences such as ambulances diverted to other areas – this could create more difficulties and would need to be kept to a minimum, particularly for the patient experience too • Developing an ongoing evaluation criteria and outcomes for patients • The need for more detail on the design and implementation to have a better chance of success • Need to work closely with the Welsh Government and have an indication of numbers • Organisations helping others should not be judged negatively. Following discussion Members **RESOLVED** to: • **APPROVE** the next steps for implementation of this work subject to an ongoing review of arrangements process and • Ensure all organisations provide their escalation plans by 20 September 2019 - Individual site escalation plans - Individual site full capacity plans - The list of individuals that will undertake the national escalation calls this winter on behalf of each organisation.	Stephen Harrhy ALL ALL ALL CASC

	• Establish of task and finish group (aimed at assistant Chief Operating Officers) to provide a peer review process for the above plans, and finalise the proposals for enhancing the national escalation calls. • Develop a bespoke training course for representatives on the call based on the Exercise Wales Gold course, with a specific focus on managing health services during periods of escalation. • Agree that the revised process to be live by the 1 December 2019.	WAST ALL
EASC 19/83	**1% 'A HEALTHIER WALES' COMMISSIONING ALLOCATION 2019/2020** Members received the report which provided the Committee with an update on progress on the proposals agreed through the Healthier Wales Awarding & Evaluation Panel (HWAEP) on the EASC 1% 'A Healthier Wales' Commissioning Allocation 2019/20 and ongoing evaluation. Following discussion Members **RESOLVED** to: • **ENDORSE:** the Chairs action on the advice of the Healthier Wales Awarding Evaluation Panel (HWAEP) for the Green and rejected submissions. • **NOTE** the next steps of the Amber + & - submissions to progress the potential Chair's actions contained within Appendix 1 & 2 in light of the emerging financial and service delivery risks around Emergency Ambulance Services. (WAST Relief Gap Paper & EASC: Reference Document circulated to EASC Members in August 19.)	Julian Baker
EASC 19/84	**ESTABLISHMENT OF THE SOUTH, MID AND WEST WALES TRAUMA NETWORK – WELSH AMBULANCE SERVICES NHS TRUST BUSINESS CASE** The Report to Establish the South, Mid and West Wales Trauma Network and the WAST business case was received by the Committee. In presenting the Report, Stephen Harrhy gave an overview of the content and development process of the WAST element of the Major Trauma Network (MTN) business case. This included the development of the options, the process of peer review and the commissioner oversight of the review and refinement of the costings.	

	It was recognised that the costs had fluctuated through this process due to the options and the decisions that had been made. EASC had supported the WAST business case being put forward to the South Wales MTN board. EASC were asked to agree to support the non-recurrent in year costs (£57k) to develop the trauma desk, IT and staff training. EASC supported funding this proposal. Following discussion on the funding arrangements for implementation Members **RESOLVED** to: • **ENDORSE** the Welsh Ambulance Service NHS Trust element of the Major Trauma Programme Business Case.	
EASC 19/85	**FORWARD PLAN OF BUSINESS** Members **received** the forward plan of business. Members **RESOLVED** to: • **NOTE** the Forward Plan • **AGREE** that the Chair and the Chief Ambulance Services Commissioner review the Forward Plan for future meeting.	*ALL*

ANY OTHER BUSINESS		
EASC 19/86	There was none.	
DATE AND TIME OF NEXT MEETING		
EASC 19/87	A meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 12 November 2019 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL.	Committee Secretary

Signed ……

Christopher Turner (Chair)

Date ……

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	18 September 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The full agenda and accompanying reports can be accessed on our website.

1. GP Indemnity Scheme Deep Dive

Heather Grimbaldeston, Solicitor, Legal & Risk Services provided an update on the progress with the GP Indemnity scheme that came into effect on 1 April 2019 for all future liabilities arising after that date. The scheme is run by Legal & Risk Services on behalf of Welsh Government and covers claims for compensation arising from care, diagnosis and treatment of a patient by GPs and their employed staff. Discussions are currently taking place on whether past liabilities (i.e. incurred before 1 April 2019) will also transfer across to the scheme. The Committee acknowledged the significant contribution made by the Legal & Risk team in implementing the new system within very tight timescales.

2. Managing Director's Report

The Managing Director updated the Committee on:

IMTP - A horizon scanning day for the 2020-23 IMTP was held at IP5 on 12 September. The day was attended by a wide range of senior staff, customers and partners and included excellent presentations from Samia Saeed-Edmonds and Alan Brace from Welsh Government. Time was taken to review, refresh and re-focus the strategy map and ensure that the performance framework was appropriately aligned with the NWSSP vision, mission, values and strategic objectives. This is an integral element of the IMTP process, providing a rich source of information to be incorporated into the planning process. The SSPC will be provided with an opportunity to review the output in more detail at the November meeting.

Lead Employer – NWSSP has been working with HEIW in respect of scoping possible Lead Employer Scheme arrangements for Dentists and Pharmacists. There has also been recent discussion with HEIW and the wider stakeholder group

on the potential for NWSSP to expand on the positive arrangements for the GPSTRs to take on the Lead Employer role for Junior Doctors. A workshop was held by HEIW in early September but concerns were raised that there needed to be more clarity on the process and greater engagement from Health Boards in planning the arrangements for this and it was agreed that this could be done through the NWSSP Committee governance arrangements. It was **AGREED** that a more detailed paper would be brought back to the November SSPC for consideration and endorsement.

Brexit - Supply chain resilience has been strengthened for a no-deal Brexit during the last financial year with the acquisition of the warehouse facility (IP5) in Newport. Work has been undertaken to ensure that it is fully operational and the transfer of the Cwmbran stores into IP5 has recently been completed. The facility gives NHS Wales a number of strategic benefits that will require ongoing financial support through 2020-21 as plans are developed and implemented. NWSSP is working with clinical colleagues to provide a specific focus on the supply of non-stock items over and above those held by manufacturers. Systems testing also continues to ensure that NWSSP is in the best possible position in the event of a no-deal Brexit on 31 October.

111 Project - A challenge to the contract award to for the new 111 system has been received. Our legal advice is very positive and as a result defence papers have been submitted to the High Court. Further updates will be provided as necessary.

Medical Examiner – The Lead Medical Examiner Officer has been appointed and has significant relevant experience having previously led the pilot scheme in England. The service model has been developed and demand and capacity analysis undertaken to establish the resource requirements for each anticipated site and the service as a whole. Recruitment for identified Medical Examiner and Medical Examiner Officer posts will begin over the next few months with the intention to begin the service roll out for deaths occurring in acute hospitals from December. Office accommodation requirements have been identified, reflecting the current 19 major hospital sites, and discussions are underway with individual health boards to agree how these can be accommodated. Service roll out will begin in the areas where the required staff and accommodation are available. Draft operational processes and flows have been designed and are currently being sense checked. When finalised, Standard Operating Procedures will be developed to ensure a consistency of service delivery across Wales. These will be linked to those in other services, such as Bereavement, Registration and Coroner Services, to ensure a seamless delivery across the system.

Staffing – The new Director of Procurement, Jonathan Irvine, starts in post on 23 September.

3. NHAIS Business Case – the draft business case for the replacement of the NHAIS system, used to generate payments to GPs, was brought to the Committee for endorsement. The change to the system is a forced one as the current system which Wales is linked into is being changed by NHS England as part of a reform programme. Further work is needed to refine further elements of the business case. The final business case will be presented to Welsh Government for the additional funding needed to procure an alternative system. The Committee were

happy to note and endorse the work and approach taken to date.

4. Items for Approval

Laundry Services Programme Business Case – The Committee approved a paper setting out the costs of appointing Capita to help further develop the programme business case for Laundry Services. Meetings with staff directly affected by the proposals have been arranged with each Health Board and a programme of engagement / consultation will begin.

Welsh Risk Pool Committee Terms of Reference – The Committee approved changes to the terms of reference for this Committee arising from the implementation of the GP Indemnity Scheme.

5. Items for Noting

- **PMO Highlight Report -** The Committee noted the updates on projects and that there were no major concerns with any at the current time.
- **IP5 Options Paper -** The acquisition of the facility at IP5 offers the potential to provide significant ongoing benefits for NHS Wales. The development of strategic options for the facility's ongoing use is therefore underway in which various NHS and non-NHS organisations have been consulted as part of the process of identifying potential projects that could be located in IP5. The options can be broadly categorised into the following: Warehouse/Logistics, Support Services and Equipment. A Programme Board has been established to manage the process including NWSSP directors and senior staff, staff side representation and WG officials. The Programme Board has engaged consultants to facilitate and help develop strategic options for IP5.
- **Clinical Waste** – The Committee received a presentation on an urgent UK wide issue developing with Clinical Waste. Services across the UK were previously contracted to three suppliers, but following the enforced withdrawal of one contractor, capacity issues for the two main suppliers are now a major concern. The contractor for NHS Wales is Stericycle, and significant backlogs with services are now building up. The Stericycle facilities are almost at permitted maximum limits and there is a warning that the situation will become critical by the end of September. The issue is being managed at both a UK and Welsh government level, and NWSSP is investigating options for additional storage facilities, but this is an issue that needs to be considered by Health Boards at a very senior level.
- **Finance & Workforce Report -** The Committee noted that NWSSP is currently reporting an underspend but that a number of financial challenges remain. KPIs were generally noted as also being on track. Welsh Risk Pool expenditure is higher than for the same period last year and the forecast outturn is in a range from £99m to £117m, against a likely reduced allowance from Welsh Government. It is therefore possible that the risk-sharing agreement may need to be invoked this year, but discussions are to be held with Welsh Government on this issue.
- **Staff Awards** – The Awards ceremony will take place on 3 December with the closing date for nominations 25 October. Nominations of NWSSP staff

can be made by anyone across NHS Wales.

- **Corporate Risk Register –** There are three red risks on the register. One relates to the replacement of the NHAIS system which was discussed earlier on the agenda. The second, relating to Brexit preparations, was also covered in the Managing Director's update. The third relates to the need to replace the Ophthalmic Payments system by May 2020 – work is on-going to source an alternative system but contingency arrangements are in place to cover any delays.

6. Items for Information

The following papers were provided for information:

- PTR Redress Scheme;
- Counter Fraud Annual Report 2018/19;
- Monthly Monitoring Returns;
- Health & Safety Annual Report 2018/19; and
- Welsh Language Annual Report 2018/19.

Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.	
Matters referred to other Committees	
N/A	
Date of next meeting	27 November 2019

JOINT REGIONAL PLANING AND DELIVERY COMMITTEE UPDATE

1. INTRODUCTION

The purpose of this report is to provide the Hywel Dda University Health Board with an update of ongoing Joint Regional Planning and Delivery Committee (JRPDC) projects. The group last met on 18th October 2019 and are due to meet next on 4th December 2019.

2. BACKGROUND

The Joint Regional Planning & Delivery Committee (JRPDC) has a key role in driving forward, at pace, a range of projects that have been identified by both Hywel Dda University Health Board (HDdUHB) and Swansea Bay University Health Board (SBUHB) as priorities for joint working on a regional basis; to deliver Ministerial objectives, especially those relating to the NHS Outcomes Framework, as well as alignment to the more strategic 'A Regional Collaboration for Health' (ARCH) Programme Board and that of the Service Transformation Programme.

Key points to note in this report are:

- The Regional Clinical Service Plan was approved by the Joint Regional Planning Committee for inclusion in both Health Boards IMTPs;
- Opportunities to streamline the governance arrangements for ARCH and Joint Regional Planning were supported and a proposal to dis-establish the Joint Regional Planning Committee and replace with a Joint Regional Executive Group (JREG) is set out in this report for approval by the Health Board;
- A Regional Dermatology workshop was held 3rd October and a formal project group has now been established under ARCH.

3. ASSESSMENT

The minutes for the JRPDC meeting held on the 18th October 2019 are not yet ratified, therefore a high level summary of project progress updates received at the JRPDC in October are as follows:

- **Regional Clinical Services Plan (RCSP)** – the second iteration of the RCSP was presented to the JRPDC. It was approved by the Committee for inclusion in both Health Boards' IMTPs, subject to deliverables for years 2 and 3, as well as 1 year detail being determined and this needs to be included in the updated RCSP.

- **Regional Planning Arrangements –** At the JRPDC in August the Director General and Chief Executive of NHS Wales welcomed the RCSP and noted that it set the South West Wales region out as being distinctive in terms of our approach and commitment to partnership working. He indicated that there was an option to stand down the JRPDC as a formal sub-committee of the Boards as a result significant progress made. Opportunities to streamline the governance arrangements for ARCH and Joint Regional Planning were presented and the Committee supported proposals to dis-establish the Joint Regional Planning Committee and replace with a Joint Regional Executive Group (JREG).These arrangements will come to the January 2020 Board meeting and the two Chairs will meet to discuss the approach and the confirmed detail can be provided in January.

It is suggested that the Chief Executive of NHS Wales is invited to at least one of these meetings a year, to ensure there is an opportunity for discussion on progress and to stimulate new thinking. Updated Terms of Reference and membership for the JRET will be presented at a future meeting.

- **Endoscopy** –a National Endoscopy Implementation Group has been established and as a consequence, the regional work is now overlapping with the national programme. The Committee agreed that a single work plan is developed, setting out the national, local and regional requirements, for review at JRPDC meeting in December 2019.

  HDdUHB are continuing to scope the development of a capital brief to support endoscopy services in Prince Phillip Hospital, which will need to consider the regional implications.

- **Pathology** – An update on the development of the Strategic Outline Case (SOC) for a Mid-South West Wales Regional Centre of Excellence Cellular Pathology Laboratory, Regional Diagnostic Immunology Laboratory Medical Microbiology facility at Morriston hospital was presented. An independent Project Gateway Review 1 was undertaken in September and an amber rating was received. The committee asked for an update to the next JRPDC on the SRO leadership and project management arrangements the Outline Business Case (OBC) stage and the action taken in response to the Welsh Government Gateway Review 1.

- **Dermatology** – A Regional Workshop held on 3rd October 2019, led by Chief Operations Officers (COOs). It was very beneficial in aligning Health Board priorities, bringing teams together and outlining the benefits of both organisations to work together. A formal regional project is now being established under ARCH and an update will be received at a future meeting.

- **Breast Radiology** – The committee noted that a regional position will be required and there is a need to understand what this means locally and scope out issues, constraints and next steps for an update to JRPDC in December

4. RECOMMENDATIONS

Members are asked to:

- **NOTE** the update on the JRPDC regional joint working that is being progressed.
- **APPROVE** the proposal to dis-establish the Joint Regional Planning Committee and replace with a Joint Regional Executive Group (JREG).

NHS Wales Collaborative Leadership Forum

Minutes of Meeting held on 13 May 2019

Author: Mark Dickinson	**Version:** 1 (Approved)

Members present	Ann Lloyd (Chair), Chair, Aneurin Bevan UHB (AL) Maria Battle, Chair, Cardiff & Vale UHB (MB) Tracey Cooper, Chief Executive, Public Health Wales (TC) Andrew Davies, Chair, Swansea Bay UHB (AD) Vivienne Harpwood, Chair, Powys tHB (VH) Alex Howells, Chief Executive, Health Education & Improvement Wales (AH) Chris Jones, Chair, Health Education and Improvement Wales (CJ) Brendan Lloyd, Medical Director, Welsh Ambulance Service NHS Trust (BL) (for Jason Killens) Marcus Longley, Chair, Cwm Taf UHB (ML) Donna Mead, Chair, Velindre NHS Trust (DM) Tracy Myhill, Chief Executive, Swansea Bay UHB (TM) Judith Paget, Chief Executive, Aneurin Bevan UHB (JP) Mark Polin, Chair, Betsi Cadwaladr UHB (MP) Judith Hardisty, Vice Chair, Hywel Dda UHB (JH) (for Bernadine Rees) Carol Shillabeer, Chief Executive, Powys tHB (CS)
In attendance	Mark Dickinson, NHS Wales Health Collaborative (MD) Rosemary Fletcher, Director, NHS Wales Health Collaborative (RF)
Apologies	Gary Doherty, Chief Executive, Betsi Cadwaladr UHB Steve Ham, Chief Executive, Velindre NSH Trust Jason Killens, Chief Executive, Welsh Ambulance Service NHS Trust Steve Moore, Chief Executive, Hywel Dda UHB

	Bernadine Rees, Chair, Hywel Dda UHB Len Richards, Chief Executive, Cardiff & Vale UHB Allison Williams, Chief Executive, Cwm Taf Morgannwg UHB Jan Williams, Chair, Public Health Wales Martin Woodford, Chair, Welsh Ambulance Service NHS Trust

Welcome and introduction	**Action**
AL welcomed colleagues to the meeting and noted apologies for absence.	

Minutes of previous meeting	**Action**
The minutes of the meeting held on 6 December 2018 were **approved** as a correct record. The minutes will be forwarded to board secretaries for noting at health board and trust board meetings.	**MD**

Action log and matters arising	**Action**
The action log was reviewed. It was noted that the majority of actions had been closed as completed. Those actions that remain open all relate to the development of an NHS Wales National Executive function. It was noted that RF and MD are meeting Jo Jordan and Samia Saeed-Edmunds in Welsh Government on 14 May to discuss this. It is anticipated that this will be primarily focused on WG gathering information about the Collaborative. It was noted that detail was awaited in respect of progress with plans for the NHS Executive. *(DM joined the meeting at this point)*	

Year End Report against 2018/19 Collaborative Work Plan	**Action**
RF introduced the report against last year's work plan, noting that it had already been received by the Collaborative Executive Group. Some outstanding actions have been carried forward into the plan for 2019/20. Concerns were noted around delays to the critical care clinical information system and MD provided an update, reporting that it was hoped that procurement documentation would be signed off during May.	

The heightened emphasis on maternity services was noted in the context of the need to establish the new Wales Maternity and Neonatal Network. It was noted that the planned appointment of a National Mental Health Director had been delayed pending progress with the NHS Executive. CS reported that it was approximately a year since the previous director had retired, but was optimistic that progress could soon be made. *(AD joined the meeting at this point)* AL queried why the Eating Disorders dashboard was being delayed until 2022. CS responded that this was due to the timing of the implementation of the WCCIS system, but that some aspects of the dashboard would be operational before full WCCIS roll out. AL thanked RF for the report and noted that, given the context, the Collaborative team has done very well to get through so much work and to complete many important actions.	
Collaborative Annual Report 2018/19	**Action**
RF introduced the Annual Report, noting that this is the first time a narrative annual report has been produced by the Collaborative team. The report is intended to respond to the need for more information for key stakeholders and also the desire of team members to promote the work done. The target audience is primarily stakeholders in NHS Wales, Welsh Government and CHCs and the content has been shaped to reflect this. The report covers both core business for NHS Wales and additional work in support of WG. Content had been provided by staff in individual teams and programmes. RF drew attention to the new areas of work covered in the report, including support to the Women's Health Implementation Group and to the nationally directed programme for endoscopy. RF also noted Collaborative-wide activities, including peer review. RF referred to the fact that the Collaborative team has grown in size and emphasised the efforts being made to engage with staff and to act on their feedback, including via a newly established staff forum.	

(TC joined the meeting at this point) AL noted that the report was very clear and helpful. JP referred to the section on the lymphoedema network, suggesting that, as staff are involved in direct care delivery, there was a need to review the governance and respective roles and responsibilities of the Collaborative and health boards. **RF undertook to review the governance arrangements for the lymphoedema network.**	**RF**
AD suggested that lessons need to be learned about how work is led and about lines of accountability, particularly for work undertaken for WG. DM referred to the reference in the report to Save a Life Cymru, noting that WG had not agreed for CPR training to go into schools, although this was the case in other parts of the UK. BL added that it had been suggested that CPR could have been added to the content of the Welsh Baccalaureate qualification. AD noted the potential role of further education. ML noted that approximately half of resource of the Collaborative is invested in the Wales Cancer Network and queried the rationale for this. RF responded that this is purely a legacy issue reflecting the history of investment decisions over many years. RF added that the Collaborative is increasingly taking opportunities to work across networks and programmes, citing work to develop a Collaborative-wide analytical function as an example. AL stated that there is a need to move towards a more balanced deployment of resources. TC noted the context for the year ahead, anticipating plans for the NHS Executive. There is a need to ensure that resources are aligned behind strategic priorities, including those specified in whatever national delivery plans exist post 2020. **RF undertook to consider the issues raised in the further development of the report.**	**RF**
AL thanked RF and the Collaborative team for producing a helpful and informative report.	

Collaborative Work Plan 2019/20	**Action**
RF introduced the high level work plan, noting that the individual sections will be the subject of 'deep dives' at forthcoming meetings of the Collaborative Executive Group, with the first one being on the work of the Wales Cardiac Network in May. AL asked about the work of the new Maternity and Neonatal Network and how its work will interface with the recently announced action by a number of agencies. RF responded that discussions are ongoing to clarify this. AL queried whether the key deliverables are clearly enough articulated and are both measurable and achievable. TC suggested that the 'big ticket' items should be more clearly identified in the introduction. CJ suggested the need for greater clarity as to where is assurance held and the mechanisms for assurance. MP raised a specific issue of accountability in relation to the LINC programme, which had recently been subject to formal reporting to boards. RF responded to these issues, noting that the Collaborative team had produced a paper last year to clarify the governance and accountability of each of networks back through network boards to the Collaborative Executive Group and the Collaborative Leadership Forum (and, in some contexts to WG). RF added that this was the first she had heard about the concerns in relation to LINC and noted that update reports on LINC had been brought to the last three meetings of the Forum. JP added that the last update had included specific consideration of the process for taking the LINC business case to boards. CJ reported that he still has outstanding concerns about the governance arrangements for work commissioned directly from the Collaborative team by WG. AL responded that these concerns have previously been raised with WG, including directly with Andrew Goodall and it is known that these problems are recognised. AD stressed the need for the work of the Perinatal Mental Health Network (and other parts of the Collaborative) to align with the wider work on health improvement and the early years being led by Public Health Wales. DM referred to the work of the Wales Cancer Network on the single cancer pathway and also the wider work on	

diagnostics, stressing the importance of analytical work to gain a greater understanding of the growth in demand for cancer diagnosis and treatment services. TC noted that, in their respective lead roles for cancer, pathology and imaging, she, Steve Moore and Len Richards are working increasingly closely on these issues. It is planned to submit a three year plan for cancer diagnostics to WG for investment. AH noted that the wider context is shifting with the development of a national NHS Wales clinical plan. AL responded that chairs are not currently sighted on this work. CJ noted the references in the plan to peer review, stressing the need for a more holistic approach. MD reported that peer review was being introduced across the Collaborative's networks, in line with the NHS Wales Peer Review Framework (previously agreed by the Forum) and that learning and experience was being shared across networks. **It was agreed that an updated three year peer review programme will be brought to the next meeting in September**. **RF undertook to consider the issues raised in the implementation of the work plan.**	**MD/RF** **RF**
Collaborative update	**Action**
RF introduced a written update report, containing briefings on a number of areas of work and other issues. *Major trauma network* RF referred to the report and provided additional information. A very productive workshop had been held, which had benefited from patient input. The aspiration remains for the network to be operational from April 2020, but this remains challenging. Engagement is taking place in Hywel Dda in relation to interim trauma unit designation, which may raise issues for other health boards. It was noted that consideration of workforce requirements for thoracics will be taken forward through the WHSSC Joint Committee. TM emphasised both the importance and benefits of having patients 'in the room' participating in the planning and development of services. The precedent set through the workshop needs to be maintained through the ongoing work of the network board. TM also noted the new appointment in	

Cardiff and Vale UHB to the role of Programme Director for the Major Trauma Centre.

CJ emphasised the need for clarity about the OD requirements for the new network, and networks more generally, because they traverse normal boundaries. Participants need support to transition into the required new ways of working.

Single cancer pathway (SCP)
RF introduced the report, referring to £3m WG investment and the fact that the Wales Cancer Network was running a process that had sought, and would be evaluating, applications from health boards and trusts. RF noted the increasing alignment across the SCP work, diagnostics networks and the new endoscopy programme, each of which has associated funding streams.

The processes for allocating the various funding streams were discussed. It was noted that £1m would be deployed under the auspices of the Endoscopy Programme Board, but there was not yet clarity over how the £1.4m for diagnostics and healthcare sciences would be allocated. It was noted that multi-organisation bids had been encouraged in the SCP process and that these should be treated positively, without detriment to Betsi Cadwaladr as, effectively, a 'region' in its own right.

JH expressed concern that there were too many individual funding streams, being allocated separately. This was noted as a recurring theme.

Major conditions implementation groups
The transfer to the Collaborative of responsibility for supporting major conditions implementation groups, together with the TUPE transfer of relevant staff was noted.

AL noted that funding directed via such groups was time limited, but had, in many cases been allocated to ongoing services. Evaluation of the effectiveness of such investment is variable. AL had written to the Deputy Chief Medical Officer on this issue in January and had received a holding response.

RF reported that the Collaborative has worked on mapping the spend of the £1m allocations and will be working with

implementation groups to develop appropriate exit strategies for when the funding ends or is altered. *Wales Maternity and Neonatal Network* The content of the report was noted, as was the need to be clear about purpose of network. The need for close working between the new network and the Perinatal Mental Health Network was stressed. *National endoscopy programme* The content of the report was noted, as was the challenging timescale. *LINC* It was noted that, notwithstanding the issues referred to above, the outline business case has now been approved by health boards and trusts and that the WG scrutiny process had recommended approval. A gateway review has also been undertaken. A substantive paper is to be reported to the May meeting of the Collaborative Executive Group. *Accommodation* The content of the report was noted. *Hosting agreement* The recently agreed extension to the hosting agreement, under which Public Health Wales hosts the Collaborative team on behalf of NHS Wales was noted.	**RF/MD**
Other Business	**Action**
It was noted that it was AD's last meeting of the Collaborative Leadership Forum. AL thanked AD for his contribution, noting specifically his wisdom. CJ, as the previous chair of the Forum, added his thanks and noted that he expected that AD would continue to find ways of collaborating. CJ added that AD demonstrated the value of public service friendship and support and wished him well for the future.	
Date of next meeting	
Post meeting note: the next meeting will be held at 9am on 17 September 2019 at the NHS Wales Confederation, Phoenix House, Cathedral Road, Cardiff.	

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28th November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Statutory Partnerships Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sarah Jennings, Director of Partnerships and Corporate Services
SWYDDOG ADRODD: **REPORTING OFFICER:**	Anna Bird, Head of Strategic Partnerships, Diversity and Inclusion Martyn Palfreman, Head of Regional Collaboration

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Hywel Dda University Health Board (HDdUHB) is a statutory member of Public Services Boards (PSBs) in Carmarthenshire, Ceredigion and Pembrokeshire and the West Wales Regional Partnership Board (RPB).

The purpose of this report is to provide an update to the Board in respect of the recent work of the three Public Services Boards and Regional Partnership Board.

Cefndir / Background

PSBs were established under the Well-being of Future Generations (Wales) Act 2015 (the Act) and their purpose is to improve the economic, social, environmental and cultural well-being in its area by strengthening joint working across all public services in Wales.

The effective working of Public Services Boards is subject to overview and scrutiny by the Well-being of Future Generations Commissioner, Wales Audit Office as well as designated local authority overview and scrutiny committees.

Regional Partnership Boards, based on LHB footprints, became a legislative requirement under Part 9 of the Social Services and Wellbeing (Wales) Act 2014 (SSWBWA). Their core remit is to promote and drive the transformation and integration of health and social care within their areas.

Asesiad / Assessment

Carmarthenshire Public Services Board (PSB)
The PSB met on 12th September 2019 and was hosted by University of Wales Trinity St David. During the meeting members received a presentation from Cllr Kevin Campbell on “Moving Rural Carmarthenshire Forward” and the PSB members agreed to write to Welsh Government to support the need for funding for the Swansea Bay City Deal’s Skills and Talent initiative.

Updates were also received on the work of the project groups. The Carmarthenshire PSB's Healthy Environment Delivery Group is currently undertaking a Climate Change and Environmental Risk Assessment for Carmarthenshire in order to develop clear and defined actions that can be taken by individuals, communities and organisations.
Alongside this work, the PSB agreed to hold a workshop to outline current and planned activity within their organisations and to identify any opportunities for collaboration across PSB partners.

The PSB Team have developed a funding bid to the Foundational Economy Challenge Fund which seeks to take forward the Carmarthenshire Public Sector Food Procurement project work. The bid has been successful and the project was formally launched on 7th November 2019 by Lee Walters AM. As part of this work there will be an officer dedicated to drive forward actions which would include a new procurement methodology focused on supporting local/community wealth from public sector spend.

A link to the Carmarthenshire PSB website is provided below, where copies of agenda and meeting papers are available to review.
http://www.thecarmarthenshirewewant.wales/meetings/

Ceredigion Public Services Board (PSB)
Ceredigion PSB last met on 9th September 2019 and was hosted by Coleg Ceredigion. In addition to updates from the project groups, members received a presentation from The Dream Team and signed the Learning Disabilities Charter.

A presentation was also made jointly by the Local Authority Chief Executive and the Director of Partnerships and Corporate Services on the visit to Bromley by Bow and this stimulated discussion and interest in how a similar approach could be implemented locally and how this supported the direction of travel that the Council was taking to the organisation of its services.

The PSB continues to seek to strengthen links with Town and Community Councils and the work they are doing to implement the Act. The Well-being Plan and Annual Report 2018-19 of Aberystwyth Town Council was presented for discussion.

Members also considered an update paper on the work to support the Syrian Vulnerable Person's Resettlement Programme and noted that Government has given its commitment to a Global Resettlement Scheme which will see the continued commitment to identify and resettle the most vulnerable refugees from a broader geographical focus.

A link to the agenda and papers of Ceredigion PSB is provided below:
https://www.ceredigion.gov.uk/your-council/partnerships/ceredigion-public-services-board/public-services-board-meetings/

Pembrokeshire Public Services Board (PSB)
The PSB met on 24th September 2019 and was hosted at Pembrokeshire Coast National Park Authority. Unfortunately due to unforeseen circumstances the meeting was not fully quorate; Pembrokeshire County Council was not fully represented during the whole meeting by the Chief Executive (or their designated representative) and Council Leader or designated Cabinet Member. PSB members agreed to continue with the meeting as there were no significant items requesting recommendation/agreement.

During the meeting members received an update on the Bromley by Bow visit in order to stimulate discussion and consideration of how a similar approach could be developed locally

where there is already a strong history of community engagement work.

One of the specific projects which has been led by the Health Board addresses the priority area of “Doing things Differently”. Elaine Lorton, County Director (Pembrokeshire) provided a report on the work which has been undertaken to develop new models of service delivery, and the engagement activity to scope five integrated community networks to address the challenges of delivering accessible services in rural communities.

It was acknowledged that focus to date has largely been on responding to the needs of the older population and there is a need to shift to a whole life course focus, including younger people. This included finding ways for all organisations to involve and engage with younger people, especially those not involved in local youth fora and those of working age. The Welsh Government representative agreed to discuss the PSBs enthusiasm with the First Minister to explore how Pembrokeshire could be involved in piloting work on their behalf.

Discussion took place regarding local wealth building and each organisation agreed to gather procurement information to evidence how local social value is being supported in order to inform future discussion and action.

Carbon neutral approaches were also discussed and it was noted that Welsh Government have been looking at approaches in the public sector and are due to report on this work in Spring 2020. Natural Resources Wales offered to facilitate a regional workshop to share experiences of the carbon positive project, as a first phase to looking at this in more detail on a collaborative basis.

A link to the agenda and papers of Pembrokeshire PSB is provided below:
https://www.pembrokeshire.gov.uk/public-services-board/psb-agendas-and-minutes

Collaborative working between PSBs
A small regional grant has been made available to the PSBs across Carmarthenshire, Ceredigion and Pembrokeshire and Welsh Government have approved a bid for the development of a regional digital information sharing platform. This would enable the sharing of high level data to better inform future planning and assessments of local wellbeing.

There are clear links between this work and various proposals within the regional Transformation Bid *A Healthier West Wales*, namely (1) implementation of an Involvement Summary Record (ISR) to enable sharing of client information across public agencies (part of programme 2 – *sharing data for a person-centred approach*) and (2) development of a digital engagement tool to facilitate virtual conversations with different communities (part of programme 5a – *continuous citizen engagement).* If these bids are successful, opportunities for a single system performing all functions or, as a minimum, full interoperability between separate systems, will be actively explored.

Each of the PSBs and the RPB received a report and proposals on potential areas of joint working following a joint regional meeting held earlier in the year. The identified areas for collaboration are:

- Tech Enabled Care (TEC) Continuous engagement
- Social and green solutions for health
- Connecting people, kind communities

Each Board agreed these areas in principle and coordinators of the respective Boards will work

together to develop the proposals further. The work on social and green solutions for health, led by the Director of Public Health, has been identified as a priority and will be taken forward during the autumn, starting with a regional stakeholder workshop to finalise a regional approach and plan for delivery.

Regional Partnership Board update

The Regional Partnership Board (RPB) met on 19 September 2019 in Carmarthen and received updates on the West Wales Learning Disability Charter, regional workforce activity, A Healthier West Wales and the Integrated Care Fund. RPB minutes are available via the following link:
https://www.wwcp.org.uk/west-wales-regional-partnership-board-agendas-and-minutes/

Further information on key areas of the RPB's work is provided below.

Progress has been made in relation to each of the **Healthier West Wales** programmes funded through the Welsh Government's Transformation Fund. Summary details are as follows:

Programme 1 – Proactive, technology-enabled care

- Regional Service Level Agreement (SLA) in place with provider partner Delta Wellbeing
- Strategic partnership arrangements agreed with Tunstall as supplier of the supporting technology
- Finalisation of assessment, support and review tool which will now be hosted on the data platform
- Required upgrades to infrastructure completed
- Commissioned community based pathways in place in Carmarthenshire and Ceredigion
- Recruitment for additional capacity to support programme in train for all counties, with new posts filled in Carmarthenshire

Programme 3 – Fast-tracked, consistent integration

- Governance arrangements established at county level
- Full business cases completed (Carmarthenshire and Pembrokeshire)
- Financial sustainability modelling completed (Carmarthenshire)
- Recruitment in train across the region, and full establishment in place in Carmarthenshire for operational commencement on 11 November 2019
- Staff training commissioned and being implemented
- Engagement and consultation events are taking place

Programme 7 – Creating connections for all

- West Wales is Kind Campaign: Specification for programme delivery under development; Regional investment fund supporting inter-generational projects launched 1 October 2019
- Options for Digital Skills Platform being pursued
- Community Connector Plus: Local and regional posts being filled (regional post via Hywel Dda UHB) and specification for regional review of function under development
- Volunteering Officers being appointed by the three County Voluntary Councils

Following a full tendering exercise conducted through Sell2Wales, FutureGov have been appointed to undertake external evaluation of the Healthier West Wales programme. With a team bringing extensive experience of service redesign and evaluations on an international scale, the approach will be formative and action learning-orientated i.e. involving engagement with staff delivering the programmes and supporting adaptation and redirection of activity and

resources as required during the evaluation cycle, thereby maximising their impact. Key deliverables from the evaluation include:

- Participation in a national community of practice, facilitated by Welsh Government and bringing evaluators from each region together to share learning and support consistency in approach to the evaluation
- Review and refinement of the shared outcomes and benefits framework adopted by the partnership and reporting against this framework on a quarterly basis
- Production of an interim evaluation report by the end of December 2019, a draft final evaluation report by 30 November 2020 and a final evaluation report by 31 January 2021 (later dates may be subject to change in view of the extension to the funding period)

An inception meeting took place with FutureGov on 4 November 2019, at which key milestones and initial activity were agreed. The evaluation will be overseen on behalf of the RPB by a cross-agency steering group.

With confirmation of additional funding through the Transformation Fund, work will commence on establishing a Regional Research, Innovation and Improvement Coordination Hub which will consolidate the functions currently provided by the Hywel Dda UHB's *Hwyl* Organisational Development Hub. Staff will be recruited in the coming months and an early priority will be commissioning a comprehensive review of current research and innovation activity within the region.

An initial grant claim in respect of 2019-20 Quarters 1 and 2 and totalling £358,370 was submitted to Welsh Government on 31 October 2019. A detailed expenditure profile has been produced which projects full spend against the allocation by March 2021, although this will be subject to monthly review, allowing accurate reporting regionally and to Welsh Government and early identification of potential slippage. In the event of significant slippage consideration will be given to possible reallocation of any surplus, subject to Welsh Government agreement, to remaining Healthier West Wales programmes for which funding has not yet been awarded.

Welsh Government is running series of roadshows across Wales aimed at sharing learning and raising awareness among managers and front-line staff of the Transformation Fund and the programmes it supports. Two events have been held in West Wales to date, both well attended and chaired by the RPB Chair Councillor Jane Tremlett. The first, in Carmarthen on 9 September 2019, was attended by the Minister for Health and Social Services and the second, in Haverfordwest on 8 October 2019 by the Welsh Government's Director of Technology, Digital and Transformation. A third roadshow took place in Aberystwyth on 25 October 2019.

Regular updates on delivery of the RPB programmes are provided to the Health and Care Strategy Delivery Group and the Transforming Our Communities Programme Group.

Alongside the Transformation Fund programmes, delivery of a range of schemes funded through the **Integrated Care Fund (ICF)** continues across the region. The revenue programme totals just over £11m and supports a range of initiatives aimed at older people, children with complex needs, children on the edge of care, learning disabilities, dementia and carers. This sits alongside a Main Capital programme which has a three year span to March 2021 and a value of £12m. This is being deployed on a range of schemes addressing identified priorities of reablement, children and families (complex needs and parent and baby support) and learning disabilities/ mental health and will result in local and regional centres supporting a consistent regional service model for each client group. A number of Capital schemes have reached delivery phase and others will come on stream shortly. Progress was reported to the Capital, Estates and Information Management & Technology Sub-Committee on 24 September 2019.

Welsh Government is currently engaging with regions on plans for a proposed joint inspection framework for RPBs and integrated working, which was a commitment within A Healthier Wales. Proposals have been developed by a multi-agency stakeholder group and include a self-assessment framework which would be core to the assessment of performance and outcomes of regional partnerships. Representatives from West Wales attended a national workshop on 2 October 2019 to discuss the proposals and these will be refined further before being piloted in one or more regions across Wales.

On 5 December 2019, a number of colleagues from the West Wales partnership will attend a national meeting for RPB representatives in Cardiff, hosted by the Minister for Health and Social Services, which will provide an opportunity for regions to share learning in relation to the Transformation Fund and arrangements for mainstreaming successful programmes. There will also be discussion with Welsh Government officials around possible successor funding to the ICF and Transformation Fund post March 2021.

On 10 October 2019 the West Wales Care Partnership held its third annual conference in Parc Y Scarlets, Llanelli which was attended by over 100 delegates from across sectors and showcased the work being taken forward across the region. The Deputy Minister for Health and Social Services attended and provided a keynote address.

Argymhelliad / Recommendation

The Board is asked to:

- Note the progress updates for each PSB and the RPB, and the key areas of discussion highlighted in the report.
- Note the links to the PSB and RPB websites where the agenda, papers and minutes of recent meetings can be accessed.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Well-being of Future Generations (Wales) Act 2015 Social Services and Well-being (Wales) Act 2014
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	HDdUHB staff time to support progression of PSB project and delivery group meetings being established to drive forward implementation of the Well-being Plans. The Regional Partnership Board is working collaboratively to deliver "A Healthier West Wales: Transformation proposal by the West Wales Regional Partnership Board". The proposal totalling £18.2m was submitted in November 2018 and Welsh Government has already approved £12m of the proposal, and work is on-going to re-submit some elements of the bid.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Improving the well-being of the population is at the forefront of the two key pieces of legislation that provide a focus for PSBs and RPBs. "A Healthier West Wales: Transformation proposal by the West Wales Regional Partnership Board" embraces a "through-age" model which will support people in Starting and Developing Well; Living and Working Well; and Growing Older Well.
Gweithlu: **Workforce:**	Implementing the five ways of working required under the Well-being of Future Generations (Wales) Act 2015 should lead to increased collaboration and integration between services, professionals and communities. "A Healthier West Wales: Transformation proposal by the West Wales Regional Partnership Board" includes a key programme of work focused on "an asset-based workforce".
Risg: **Risk:**	Whilst each PSB Well-being Plan is different, there are consistent themes of activity. There is a risk that whilst addressing local need, there may be some inconsistency in approach between counties for our wider population. We have a duty as PSB members to encourage consistency of approach where appropriate in order to minimise inequity. Resourcing the project and delivery groups of PSBs could be considered an "add on" responsibility by staff and the synergy with achieving HDdUHB's goals need to be understood.
Cyfreithiol: **Legal:**	It is a statutory duty for each PSB to produce a Well-being Plan and Area Plan and for the UHB as named statutory

	partners to work with the PSBs and RPB to support the development and delivery of the actions within the Plan.
Enw Da: **Reputational:**	There is a statutory requirement for HDdUHB to contribute to the work of the PSBs and RPB. There is a statutory duty for the UHB to work in partnership with its three partner local authorities to transform health and social care delivery. The RPB Governance arrangements for an essential framework to support operational action.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	The focus of equality runs throughout the work of the PSBs aligns to a number of the Well-being goals: A More Equal Wales, A Healthier Wales, A More Prosperous Wales, A Wales of Cohesive Communities. This is an update paper therefore no EqIA screening has been undertaken.

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Presentation of Nurse Staffing Levels for Wards Covered under Section 25B of the Nurse Staffing Levels (Wales) Act 2016
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani Executive Director of Nursing, Quality, and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Chris Hayes, Nurse Staffing Programme Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Nurse Staffing Levels (Wales) Act (NSLWA) 2016 (hereafter referred to as 'the Act') became law in March 2016. Regular updates have been provided to the Board and its Committees since July 2016 on the steps being taken to enable Hywel Dda University Health Board (HDdUHB) to meet the requirements of the Act.

This paper provides the Board with:

- The statutorily required annual presentation to the Board of the nurse staffing levels for all adult medical and surgical wards covered under Section 25B of the Act.
- A brief update on the progress with the 'phased implementation' (previously agreed at the Board meeting in May 2018) of the actions required to achieve full compliance with the Act
- The work being undertaken to prepare the Health Board for the extension to the Act (to cover paediatric in-patient wards) which is anticipated in April 2021.

The Board is asked to note the content of this report for information.

Cefndir / Background

The Nurse Staffing Levels (Wales) Act 2016 was fully commenced in April 2018.

Since the full commencement of the Act, the Board (or a delegated committee of the board) has received regular updates on progress with the implementation of the Nurse Staffing levels (Wales) Act:

April 2018	A detailed briefing at a Board seminar on the outcome of the extensive nurse staffing level reviews which had been undertaken by the Director of Nursing.
May 2018	Board paper received and decision taken to support a phased implementation, with key early priorities identified (listed above) in terms of meeting the financial and workforce impact of the Act.

July 2018	Update provided to Workforce and Organisational Development (W and OD) Sub-Committee to discuss the implications of the Act for the Board's workforce
July 2018	Paper received by Board providing an update on progress in taking forward the priority actions agreed at May 2018 meeting.
August 2018	Paper received at the Quality, Safety and Experience Assurance Committee (QSEAC) noting the progress in moving towards further compliance with the requirements detailed within the statutory guidance; and also the progress against the further actions set out in the detailed Implementation Plan
September 2018	Update provided to the Workforce Control Panel
November 2018	Paper received by Board noting the outcome of the Autumn 2018 nurse staffing levels calculation cycle and the further progress against the Implementation Plan
February 2019	Paper presented to QSEAC providing an update of the Spring 2019 calculation of the nurse staffing level for each ward where section 25B applies
May 2019	The first Nurse Staffing levels (Wales) Act annual report was received at the May 2019 Board meeting.
October 2019	Assurance report provided to QSEAC outlining a revised approach (agreed with operational and finance teams) being taken to the calculation of the WTE staff / budgets required to achieve the nurse staffing levels agreed for each ward where section 25B applies

Asesiad / Assessment:

Calculating and Implementing the Nurse Staffing Levels

1. **Section 25B Wards :**
   As of 1st November 2019, Section 25B applies to 30 wards across HDdUHB. It must be noted that there has been some change in the wards included in this report compared to those included in the November 2018 report to Board and the annual report presented to the Board in May 2019. The Board is asked to note that:

   - Bronglais Hospital: (BGH)
     Y Banwy was included as a Section 25B ward for the Autumn 2018 and Spring 2019 calculation cycles but following an audit and discussions about the nature of the patients cared for within the ward as at Autumn 2019, it has been judged to no longer meet the inclusion criteria for Section 25B wards specified within the statutory guidance.
   - Glangwili Hospital: (GGH)
     The former Dewi ward - now known as Ceri ward: Rehabilitation and Reablement Unit – was included as a Section 25B ward for the Spring 2018 calculation cycle but, due to the subsequent change in function of the ward, the ward no longer meets the inclusion criteria set out in the statutory guidance
   - Withybush Hospital: (WGH)
     Ward 4 was included as a Section 25B ward for the Spring 2018 calculation cycle but again, due to the change in function of the ward, the ward no longer meets the Section 25B inclusion criteria set out in the statutory guidance.

2. **Progress with 'Phased Implementation' Plan:**
In May 2018, the Board committed to fully funding the circa £5.2 million investment required to achieve the nurse staffing levels for all Section 25B wards, as calculated and presented to it by the for Director of Nursing, Quality and Patient Experience. However, because of the scale of the investment (and subsequent workforce recruitment) required, the Board agreed to a phased implementation of the uplifts to establishments and budgets that this would require. At that time it was anticipated that the phasing would take until the end of 2020/21 to fully achieve, with the Board agreeing to an initial £2m investment in 2018/19. This has been followed by a further £1m investment agreed from reserves during 2019/20.

   During the 20 months since the full commencement of the Act, the approach to calculating the costs of the nurse staffing levels have been refined to reflect the changing working patterns of the Board's nursing workforce. Over this period there have been increasing numbers of nursing staff requesting to work a 'long day' (11.5 - 12 paid hours) shift pattern wherever possible rather than the more traditional 'early' and 'late' (7.5 paid hours) shifts. The consequence of these significant shift pattern changes, whilst in line with the national picture, is that the 'care hours' available to the patient case load on any given ward each day - but which were formerly 'hidden' within the traditional shift 'overlap' times - is reduced. It should be noted that there are (potentially negative) consequences to the loss of this shift 'overlap' period; and the evidence relating to the long term consequences of working long (11.5 - 12 hour) shifts on staff well-being is equivocal, there is no doubt that there has been a significant change in recent years in terms of the expectation amongst the nursing workforce to be able to be able to work the standard full time working hours in 3-4 working days, rather than the more traditional five days.

   However, both from a finance and workforce calculation perspective, this change has reduced the 'gap' between the 'current' and the 'required' workforce by around 20%. Thus the £5.2 million financial gap calculated in May 2018 has reduced to circa £4m. In light of this reduction in required funding, a plan to complete the phased implementation of the budget uplifts required by January 2020, has been agreed with the Director of Finance. This enables the Health Board to be compliant with the nurse staffing level calculation duties within the Act within 20 months, as opposed to the original estimated time frame of up to 36 months.

   This will require careful monitoring of the shift patterns actually being worked by nursing staff in line with the 6-monthly staffing levels review cycle.

3. **Evidence of use of triangulated approach – acuity tool (Welsh Levels of Care), quality indictors and professional judgement**: The triangulated methodology prescribed in the Act as the required approach to calculating the nurse staffing levels for each ward is now embedded as a routine, 6-monthly cycle that is undertaken with nursing staff responsible for each Section 25B ward.

   Access to the data required within this methodology has been significantly improved for the Autumn 2019 cycle through the development achieved with the support of the Informatics team in establishing a ward performance report which is now available via the IRIS reporting system

4. **Evidence of professional opinions from those professional involved in the process:**
The Autumn 2019 calculation cycle has, for the first time, included direct discussion with Senior Sisters/Charge Nurses, Senior Nurse Managers and the Heads of Nursing simultaneously. This approach has proved to be beneficial in ensuring that all parties are

understanding the data being used to inform the decision making around the staffing levels to be proposed.

5. Evidence of Supernumerary Status of Ward Sisters/Charge Nurses:

Clinical Leadership: A key priority identified in May 2018 was to invest in the nurse leadership within the ward nursing teams. This was progressed during 2018/19, with all wards with 18 or more beds having two sister/charge nurse posts within their structures and, from September 2019, all Senior Sister/Charge Nurse posts in the wards have been funded to enable them to be fully supernumerary to the planned roster.

The direct discussions with the Senior Sisters/Charge Nurses, Senior Nurse Managers and the Heads of Nursing as part of the Autumn 2019 calculation cycle has provided repeated anecdotal evidence of the benefits of this strengthening of the clinical leadership for the ward. The Nurse Staffing Levels Implementation Group together with the corporate nursing leadership team, are currently finalising the arrangements for monitoring key performance indicators through which to monitor the effectiveness of the investment into the clinical leadership on the Section 25B wards. The Key Performance Indicators will be agreed and the monitoring processes will be in place, by January 2020.

STAR Programme: The statutory guidance states that 'supernumerary persons, such as the Senior Sister/Charge Nurse, should not be included within the planned roster'. It was recognised that any investment in achieving this requirements must result in improvements in the effectiveness of the leadership available to the ward teams. The 'STAR' programme aims to help to develop nurse leaders who are capable of taking services forward, both now and into the future. The first cohort of this programme started on 12th November 2019.

6. Evidence of 26.9% 'uplift':

In line with the requirements of the Act, the financial planning formulas used within this Health Board ensure that all Section 25B wards have a 26.9 % uplift within their calculated Whole Time Equivalent establishments to allow for annual, sick and study leave amongst their staff.

7. Nurse Staffing Level following bi-annual calculation:

The Autumn 2019 calculation of the Nurse Staffing Levels has been concluded. The summarised picture following this cycle are listed below. It is important to note that a much smaller number of changes have been identified in this cycle than in previous cycles, demonstrating that the process is beginning to 'level out'. Where changes have been proposed, this is as a result of changes in ward function, the patient acuity and the quality indicator data.

- BGH: There have been no changes to the planned rosters required for four of the wards in BGH following the Autumn 2019 cycle. One ward has moved staff from evening to morning shifts in line with work pressure intensity requirements.
  Of note, the discussions held have identified the need to closely monitor the nurse staffing levels for two of the wards over the next 3 months and then review the position in January 2020.
- GGH: Of the 12 wards, revised nurse staffing levels are being proposed for one ward (Towy Ward).
- PPH: of the seven wards, revised nurse staffing levels have been agreed for one ward (Ward 4) whilst the nurse staffing levels for another ward (Ward 1) will be monitored over the next 3 months and reviewed in January 2020.

- WGH: of the eight wards, revised nurse staffing levels are being proposed for one ward due to a reduction in bed numbers on this ward (Ward 10).

8. Resource implications including financial costings

As stated above, the budget adjustments to enable the nurse staffing levels to be fully funded for all Section 25B wards will be made in January 2020, significantly ahead of initial timetable projections. Careful monitoring of the impact of the long day shift working practices will be required to ensure that the budget continues to be appropriate for the staffing levels required / shift patterns worked

Maintaining the Nurse Staffing Level:

9. Vacancy position:

The vacancy position for those wards where Section 25B wards apply are set out in Table 2 below (accurate as at 30/09/19).

Table 2

	BGH	GGH	PPH	WGH	Total
RN	29 WTE	22.67 WTE	14.01 WTE	31.15WTE	96.83 WTE
HCSW	5 WTE	10.9 WTE	0.6WTE	0.6 WTE	17.1 WTE

10. Evidence of actions taken to mitigate the vacancy position and maintain nurse staffing levels:

The key actions to ensure an adequate workforce is available to work within the registered nurse and Health Care Support Worker posts on the Section 25B wards include**:**

- A number of HDdUHB policies have been/are being reviewed as part of the NSLWA implementation preparedness work, to ensure they are fully aligned and compliant with the Act. These include procedure for Flexible Deployment of Staff; Enhanced Patient Support Policy; Rostering Policy; and Nurse Staffing Levels and Escalation Plan: Adult Acute Services Policy.
- The corporate and operational nursing teams working closely with Workforce Directorate colleagues who have led on the development and implementation of innovative recruitment schemes along with schemes to develop the local population into a registered nursing workforce.
- Partnership Arrangement with Swansea and Aberystwyth University to seek to establish pre-registration nurse education programme in Aberystwyth with a project group established and chaired jointly by leads from Swansea and Aberystwyth University.
- Recruitment of Newly Qualified nurses through the student nurse auto-allocation scheme.
- Exploring rotational opportunities between acute and community settings.
- Establishing a bespoke partnership arrangement with high volume on-contract agency providers for Bronglais.
- Reconfiguration and remodelling of inpatient wards to better reflect patient needs.
- Changes to patient pathways e.g. cardiac pathway beds in Prince Phillip Hospital.

11. "All Reasonable Steps":

As a result of work initiated and led by this Health Board, the All Wales Directors of Nursing have agreed, and through the All Wales Nurse Staffing programme group have issued,

further clarification of what would be seen to constitute the **'all** reasonable steps' which are required to be taken in order to exercise the duty to maintain the nurse staffing levels at the calculated levels. Each of the 'steps' listed within this additional guidance are currently being reviewed to confirm if they are appropriate 'steps' for this Health Board to include within its standard operating framework for the implementation of the Act. Once confirmed, all the 'steps' agreed as appropriate will then be included in this Health Board's standard operating framework which is contained within Clinical Policy 409: Nurse Staffing Levels and Escalation Plan: Adult Acute Services Policy, which is currently under review with a planned completion date of March 2020.

12. System to 'Review and Record':

The NSLWA statutory guidance requires that ''*LHB's and Trusts should put into place systems that allow them to review and record every occasion when the number of nurses deployed varies from the planned roster*" (paragraph 15).
Enhancements to the nurse staffing module of the national Health & Care Monitoring System, which came into effect in June 2019, enables the daily capture of information which will form part of the mechanism by which we can monitor compliance/variation from the planned roster. It is anticipated that the first accurate report to be produced in respect of this requirement of the statutory guidance will cover the period Quarter 1 2020/21.

13. Informing Patients (paragraph 20-25 of the statutory guidance):

The statutory guidance states that "*LHBs and Trusts must make arrangements to inform patients of the nurse staffing level*" (paragraph 20). To this end, the Health Board is currently complying with the requirements of the Act by:

- Displaying the nurse staffing level calculated for each adult acute medical and surgical ward at the entrance of the Section 25B wards (in accordance with paragraph 22); and
- Providing each of the wards with a patient leaflet (English and Welsh versions) with 'frequently asked questions' (FAQ) on the nurse staffing level which have been developed as part of the operational guidance work (paragraph 23 & 25). The FAQ leaflet has been reviewed as part of the all Wales review of the Operational Guidance and the updated leaflets (standard and easy-read versions, in English and Welsh) will be made available to each of the relevant wards.

Anticipated extension of the Act by April 2021

The Welsh Government is committed to extending the more detailed requirements of the Nurse Staffing Levels (Wales) Act – described in Section 25B and currently applied only to the adult medical and surgical wards - into clinical settings beyond these wards. The extension of these detailed requirements of the Act is dependent on the development and validation of an evidence-based workforce planning tool that is agreed for use within the NHS Wales' services.

In June 2019, the Chief Nursing Officer (CNO) for Wales published a set of interim guiding principles to support the planning of nurse staffing levels in paediatric inpatient services in readiness and anticipation of an extension of the Act to cover these services by April 2021.

An impact assessment has been undertaken within the two paediatric wards of HDdUHB (Cilgerran & Angharad) in order to identify the resource implications of achieving full compliance with the Act. This assessment has identified funding deficits of circa £190k for Cilgerran ward and £81k for Angharad ward (total £271k). It is likely that this investment will be required by April 2021 at latest to ensure compliance by the commencement of the extension of the Act.

In addition to this financial impact assessment, a detailed assessment of compliance against each of the individual nurse staffing principles is being undertaken by the Chief Nursing Officer on a 6-monthly basis, commencing November 2019.

Within the Health Board, a detailed implementation plan has been developed with the Paediatric directorate, with the aim of significant work being undertaken from Quarter 4 2019/20 to ensure organisational readiness if the Act is, as is expected, extended to include paediatric in-patient areas in April 2021. This plan will be monitored through the Nurse Staffing Levels (Wales) Act Implementation Group, which reports ultimately through the Workforce and Organisational Development Sub-Committee.

Argymhelliad / Recommendation

The Board is asked to:

- Receive this report as assurance that the statutory requirements relating to the Act have been complied with.
- Note that the implementation plan agreed at its meeting in May 2018 is achieved ahead of schedule and within the initially identified costs.
- Note that further work is being progressed to prepare for extension of the Act in 2020/21.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Risk Register Reference:	Corporate risk register 647
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 4. Dignified Care 7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives:	9. To improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 10. To deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The evidence underpinning the effectiveness of the maintenance of nurse staffing levels in ensuring the delivery of safe care has been articulated through the working papers of the all Wales Nurse Staffing Group over the past two years
Rhestr Termau: Glossary of Terms:	QSEAC – Quality Safety and Experience Assurance Committee WGH - Withybush General Hospital

	BGH - Bronglais General Hospital GGH - Glangwili General Hospital PPH - Prince Phillip Hospital IMTP – Integrated medium term Plan WTE – whole time equivalent
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Nurse Staffing Levels (Wales) Act Implementation Group Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The financial impact of this paper is significant and is outlined in detail within the paper.
Ansawdd / Gofal Claf: Quality / Patient Care:	The intention underpinning the Act is to ensure safe, effective and quality patient care. One of the key requirements of the Act is to monitor the impact of nurse staffing levels on care quality and so this metric will be carefully monitored as part of the work to implement the Act.
Gweithlu: Workforce:	This paper relates to the additional permanent staffing required within the Health Board's workforce in order to implement Section 25B and C of the Act. It is anticipated the Act will have a positive impact on the sense of well-being of the workforce. The nursing workforce in acute adult ward areas will require an uplift of permanent nursing staff (Registered nurses and Health Care Support Workers) as a result of the implementation of the Act. The Health Care Support Worker recruitment will require a targeted approach but is likely to be achievable in the short term. The additional registered nurses required will further compound the vacancy issues the Health Board is currently working with and interim solutions to consider alternative ways of working (e.g. development of interim Band 4 posts within the team skill mix) may be required
Risg: Risk:	Risk of non-compliance with the Nurse Staffing Levels (Wales) Act 2016 if the work streams do not achieve the planned outcomes
Cyfreithiol: Legal:	Risk of non-compliance with the Nurse Staffing Levels (Wales) Act 2016 if the work streams do not achieve the planned outcomes
Enw Da: Reputational:	The reputation of the nursing services of the Health Board is enhanced through the level of engagement and contribution that staff of the Board are currently making to the All Wales work streams. This would be countered by the negative reputational risk if the Health Board were perceived to be not acting in the spirit of the Act.
Gyfrinachedd: Privacy:	Currently no impact in relation to privacy identifiable within this work
Cydraddoldeb: Equality:	No negative EqIA impacts identified.

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	28 November 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	NHSBT Organ Donation: Review of Actual and Potential Deceased Organ Donation 01/04/2018 – 31/03/2019
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Director of Operations/Deputy Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kathy Rumbelow, Specialist Requester (SR) and Rea John, Specialist Nurse Organ Donation (SNOD)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This SBAR will provide an overview of Hywel Dda University Health Board (HDdUHB) performance against the priorities we set ourselves for 2018/19 regarding organ donation. The detailed report is attached with an action plan.

The Board is asked to note the performance against these for 2018/19 and the Action Plan for 2019/20.

Cefndir / Background

In January 2014, Welsh Government published 'Taking Organ Transplantation to 2020 – Wales Action Plan', which specified the actions necessary to improve donation by 2020 and the timescales for each action. Every Health Board has developed its own local plan to implement these actions. Our priorities for organ donation for 2018/19 were:

- Continue to educate and promote best practice to refer all patients that meet the minimum notification criteria for donation.
- Promote simulation training/education and communication courses to all staff.
- To look at all missed opportunities and explore to ensure actions identified are implemented to prevent further occurrences.
- Maintain a 100% referral rate for potential DBD (Donation after brain death) and DCD (Donation after circulatory death) with Specialist Requester (SR) and Specialist Nurse Organ Donation (SNOD) involvement for collaborative approaches.
- Maintain a 100% testing for death using neurological criteria (previously referred to as Brain Stem Death testing (BSDT)) rate.
- Maintain a 100% consent rate for DBD (Donation after Brain Death) and continue to raise the consent rates for DCD.
- Continue to work closely with link staff and plan for further study day to ensure that they are up to date with organ donation.
- Continue working with the focus group set up to look at current practice with regards to withdrawing life sustaining treatment (WLST) in the theatre environment for all DCD donors. WLST in a theatre setting improves organ transplantation outcomes. Best

practice must be adhered to, so education of Critical Care and theatre staff will be required.
- SNOD to promote organ donation across four sites using organ donation week as a platform to promote deemed consent and encourage ODR (Organ Donor Register) registrations.
- Continue to support and foster good working relationships to promote organ donation and aid education in the wider community.
- Explore linking with local faith groups.

Asesiad / Assessment

The report attached identifies our performance against the priorities set for 2018/19:

- Continue to educate and promote best practice to refer all patients that meet the minimum notification criteria for donation.
  Critical care and ED staff continue to receive teaching sessions regarding organ donation. Teaching sessions have also been delivered to doctors throughout the Health Board and organ donation has been presented and discussed at audit meetings in the past year. The Health Board had a total of 7 donors (6 previous year) resulting in 9 patients receiving lifesaving transplants.

- Promote simulation training/education and communication courses to all staff.
  Families of potential donors will only be approached by someone who is both specifically trained and competent in the role; training packages and accreditation will be provided to those who wish to develop this competence and the potential to deliver these locally within the UHB is being explored.

- To look at all missed opportunities and explore to ensure actions identified are implemented to prevent further occurrences.
  NHSBT have an ambition to have no missed opportunities to make a transplant happen and that opportunities are maximised at every stage. It is excellent to report that there have not been any missed opportunities identified in HDdUHB (page 7).

- Maintain a 100% referral rate for potential DBD (Donation after brain death) and DCD (Donation after circulatory death) with Specialist Requester (SR) and Specialist Nurse Organ Donation (SNOD) involvement for collaborative approaches.
  Measures on page 7 demonstrate that HDdUHB's referral rate for patients with suspected neurological death and DCD have been maintained at 100%. The gold standard is that there should be a SNOD present during the formal family approach as per NICE CG135 and NHSBT best practice guidelines. SNOD involvement for these approaches is 100% (Page 9).

- Maintain a 100% testing for death using neurological criteria (previously referred to as Brain Stem Death testing (BSDT)) rate.
  Measures on page 5 show that a 100% testing of neurological death is maintained in all patients who are suspected to be neurologically dead.

- Maintain a 100% consent rate for DBD and continue to raise the consent rates for DCD.
  The priority of achieving a 100% consent rate for DBD donors has been achieved this year (page 10) an improvement from 75% the previous year. The DCD consent rate has also improved to 80% this year compared to 75% the previous year. Consent was not obtained on one occasion as the family did were not sure whether the patient would have agreed to donation (page 10).

There were 27 potential DCD patients referred. 3 patients had registered an opt out decision on the Organ Donor Register (ODR) and 19 were screened out as non-potential donors using the NHSBT DCD screening tool. This left 5 patients where the families were approached about organ donation with 4 families consenting to organ donation. This is an excellent achievement.

- Continue to work closely with link staff and plan for further study day to ensure that they are up to date with organ donation.
  SR and SNOD continue to work closely with link staff who can disseminate training within their department to ensure staff are up to date.

- Continue working with the focus group set up to look at current practice with regards to withdrawing life sustaining treatment (WLST) in the theatre environment for all DCD donors.
  WLST in a theatre setting improves organ transplantation outcomes. Best practice must be adhered to, so education of Critical Care and theatre staff will be required. Once completed, the process can be added to the policy.

- SNOD to promote organ donation across four sites using organ donation week as a platform to promote deemed consent and encourage ODR (Organ Donor Register) registrations.
  The UHB now has an embedded SNOD who has very recently completed the intense induction training and a Specialist Requester. Organ donation was promoted with a stand in Glangwili hospital during organ donation week.

- Continue to support and foster good working relationships to promote organ donation and aid education in the wider community.
  Glangwili hospital was the first hospital in Wales to have lift wraps installed promoting organ donation. The SNOD has also attended other community events such as the Pembrokeshire Show and the Eisteddfod promoting organ donation.

Argymhelliad / Recommendation

The Board is asked to discuss and note the Health Board's performance against the priorities set for 2018/19 and the action plan for 2019/20.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	2. Safe Care 3. Effective Care 4. Dignified Care 5. Timely Care
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Taking Organ Transplantation to 2020 – Wales Action Plan, Welsh Government
Rhestr Termau: Glossary of Terms:	BSDT – brain stem death testing DBD – donation after neurological death DCD – donation after circulatory death HDdUHB – Hywel Dda University Health Board ODR – Organ Donor Register SNOD – Specialist Nurse Organ Donation. SR – Specialist Requester.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Organ Donation Committee.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A.
Ansawdd / Gofal Claf: Quality / Patient Care:	No implications.
Gweithlu: Workforce:	No impact.
Risg: Risk:	None.
Cyfreithiol: Legal:	There are no legal implications contained within the report.
Enw Da: Reputational:	Media interest in view of ongoing organ donation advertising campaigns.
Gyfrinachedd: Privacy:	None identified.
Cydraddoldeb: Equality:	There are no equality and diversity implications contained within the report.

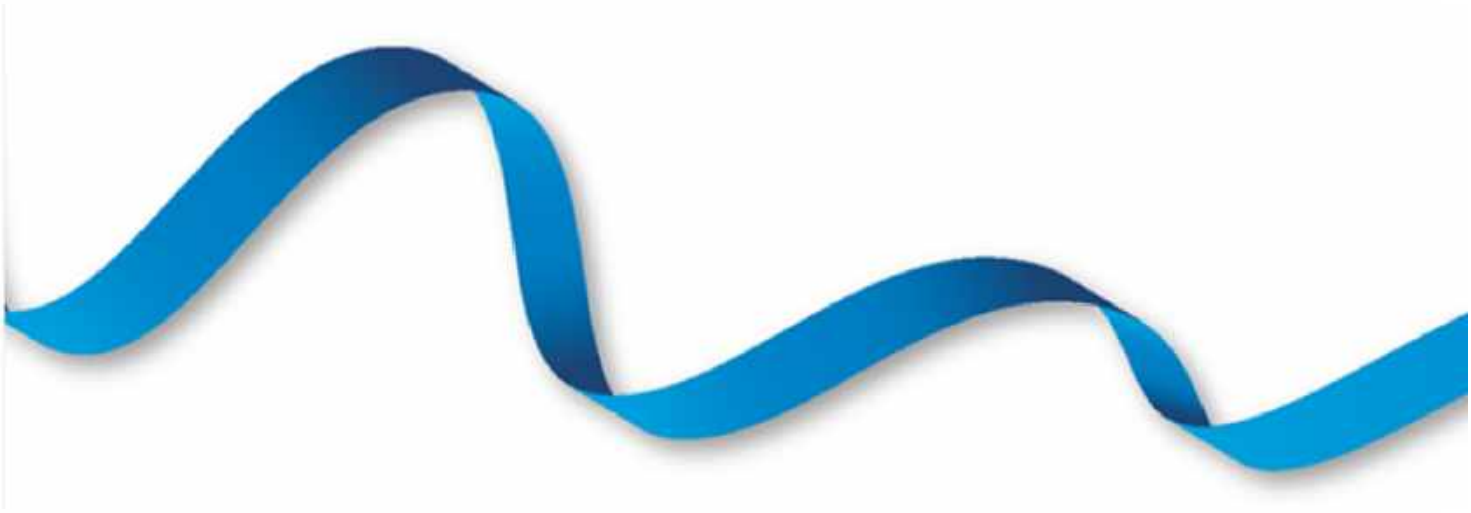
NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2018 - 31 March 2019

Hywel Dda University Health Board



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Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2019 based on data meeting PDA criteria reported at 9 May 2019.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2018 and 31 March 2019, Hywel Dda University Health Board had 7 deceased solid organ donors, resulting in 9 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2017/18. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2018 - 31 March 2019 (1 April 2017 - 31 March 2018 for comparison)

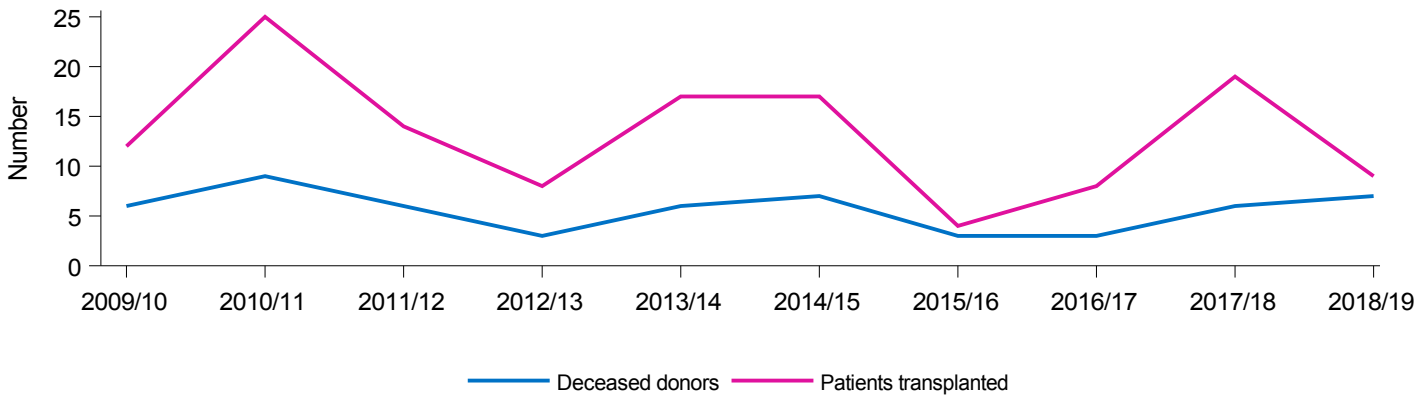
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Health Board		UK	
DBD	4	(3)	6	(12)	2.3	(5.3)	3.5	(3.7)
DCD	3	(3)	3	(7)	2.7	(3.0)	2.7	(2.7)
DBD and DCD	7	(6)	9	(19)	2.4	(4.2)	3.2	(3.3)

In addition to the 7 proceeding donors there was one additional consented donor that did not proceed, where DBD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2018 - 31 March 2019 (1 April 2017 - 31 March 2018 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	3	(5)	0	(1)	3	(3)	0	(2)	0	(4)	0	(0)
DCD	3	(5)	0	(0)	0	(2)	0	(0)	0	(0)	0	(0)
DBD and DCD	6	(10)	0	(1)	3	(5)	0	(2)	0	(4)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2009 - 31 March 2019



2. Key Numbers in Potential for Organ Donation

A summary of the key numbers on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents key numbers in potential donation activity for Hywel Dda University Health Board. This data is presented in Table 2.1 along with UK comparison data. Your Health Board has been categorised as a level 3 Health Board and therefore percentages in this section are only presented on a national level. A comparison between different level Health Boards is available in the Additional Data and Figures section.

It is acknowledged that the PDA does not capture all activity. In total there were 5 patients referred in 2018/19 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Table 2.1 Key numbers comparison with national rates, 1 April 2018 - 31 March 2019

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	5	2004	27	5974	32	7728
Referred to Organ Donation Service	5	1982	27	5539	32	7287
Referral rate %		*99%*		*93%*		*94%*
Neurological death tested	5	1715				
Testing rate %		*86%*				
Eligible donors[2]	5	1635	24	4180	29	5815
Family approached	5	1493	5	1752	10	3245
Family approached and SNOD present	5	1423	5	1527	10	2950
% of approaches where SNOD present		*95%*		*87%*		*91%*
Consent ascertained	5	1082	4	1099	9	2181
Consent rate %		*72%*		*63%*		*67%*
Actual donors (PDA data)	4	970	3	612	7	1582
% of consented donors that became actual donors		*90%*		*56%*		*73%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Health Board at the key stages of organ donation. The ambition is that your Health Board misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2014 - 31 March 2019

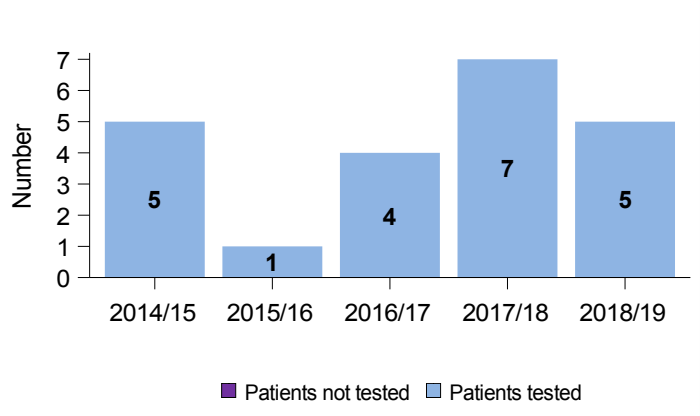


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2018 - 31 March 2019

	Health Board	UK
Biochemical/endocrine abnormality	-	20
Clinical reason/Clinicians decision	-	48
Continuing effects of sedatives	-	14
Family declined donation	-	22
Family pressure not to test	-	35
Inability to test all reflexes	-	13
Medical contraindication to donation	-	10
Other	-	18
Patient had previously expressed a wish not to donate	-	5
Patient haemodynamically unstable	-	80
Pressure on ICU beds	-	1
SN-OD advised that donor not suitable	-	7
Treatment withdrawn	-	11

If 'other', please contact your local SNOD or CLOD for more information, if required.

Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2018 - 31 March 2019

	Health Board	UK
Unknown	-	5
Total	**-**	**289**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2014 - 31 March 2019

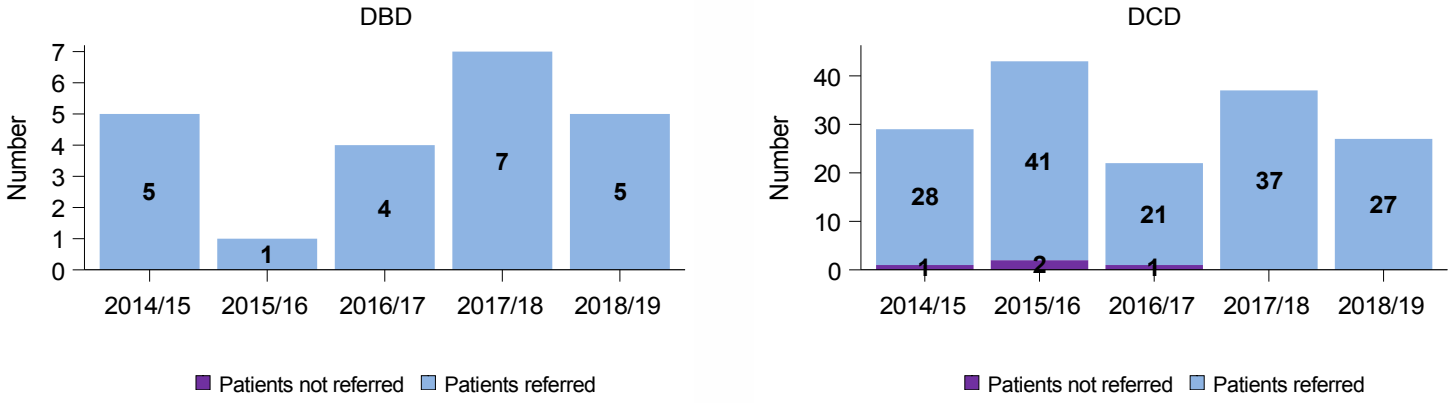


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner/Procurator Fiscal Reason	-	1	-	2
Family declined donation following decision to withdraw treatment	-	2	-	15
Family declined donation prior to neurological testing	-	2	-	2
Medical contraindications	-	-	-	56
Not identified as a potential donor/organ donation not considered	-	11	-	215
Other	-	4	-	56
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	2	-	78
Thought to be outside age criteria	-	-	-	2
Total	**-**	**22**	**-**	**435**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

Table 3.3 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Health Board.

Table 3.3 Primary absolute medical contraindications to solid organ donation, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Health Board	UK	Health Board	UK
Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)	-	14	-	201
All secondary intracerebral tumours	-	2	-	8
Any active cancer with evidence of spread outside affected organ within 3 years of donation	-	46	3	630
HIV disease (but not HIV infection)	-	5	-	12
Human TSE, CJD or vCJD; blood relatives with CJD; other infectious neurodegenerative diseases	-	1	-	8
Melanoma (except completely excised Stage 1 cancers)	-	1	-	3
No transplantable organ in accordance with organ specific contraindications	-	7	-	234
Primary intra-cerebral lymphoma	-	-	-	5
TB: active and untreated	-	2	-	13
West Nile Virus (WNV) infection	-	-	-	1
Total	**-**	**78**	**3**	**1115**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.4 SNOD presence

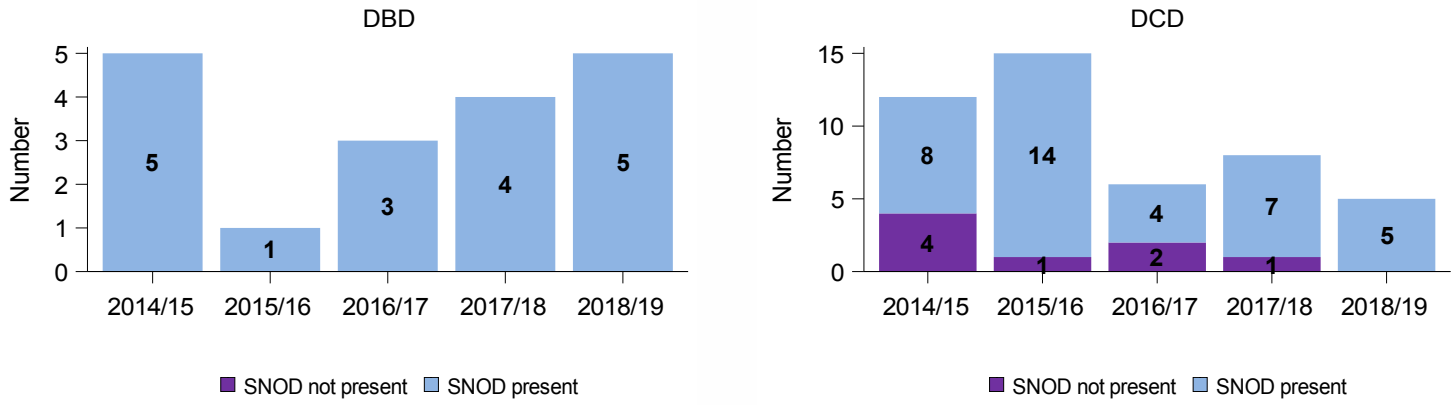
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2018/19, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 53% and 23%, respectively, compared with DBD and DCD consent/authorisation rates of 73% and 69%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2014 - 31 March 2019



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2019]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2019]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2019]

3.5 Consent

Goal: The agreed 2018/19 national targets for DBD and DCD consent/authorisation rates are 78% and 72%, respectively.

In 2018/19 less than 10 families of eligible donors were approached to discuss organ donation in your Health Board therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2014 - 31 March 2019

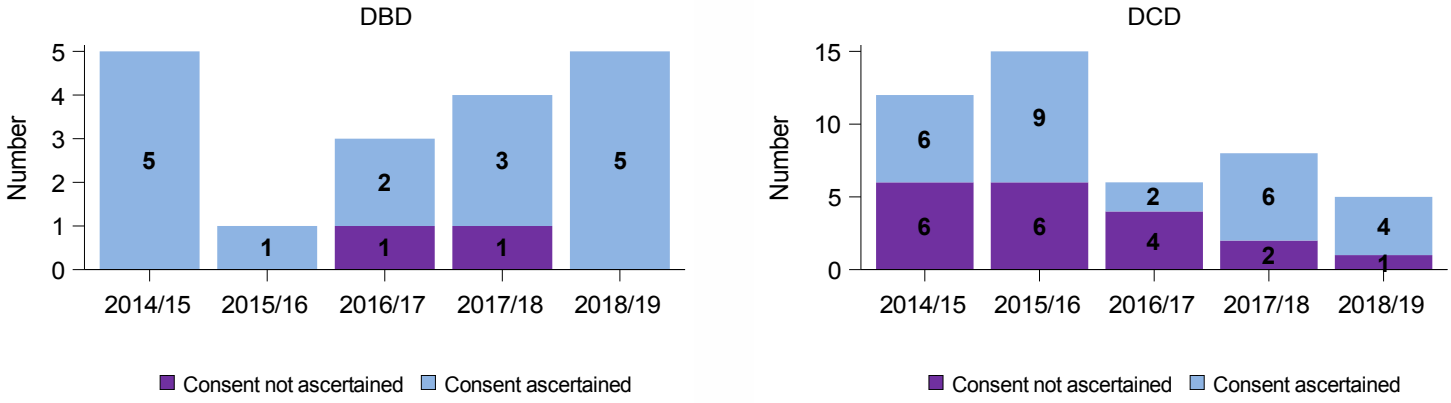


Table 3.4 Reasons given why consent was not ascertained, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Health Board	UK	Health Board	UK
Families concerned about organ allocation	-	4	-	-
Family concerned donation may delay the funeral	-	1	-	-
Family concerned that organs may not be transplanted	-	3	-	8
Family concerned that other people may disapprove/be offended	-	3	-	1
Family did not believe in donation	-	22	-	25
Family did not want surgery to the body	-	42	-	51
Family felt it was against their religious/cultural beliefs	-	44	-	21
Family felt the body needs to be buried whole (unrelated to religious or cultural reasons)	-	24	-	19
Family felt the length of time for donation process was too long	-	22	-	88
Family felt the patient had suffered enough	-	30	-	50
Family had difficulty understanding/accepting neurological testing	-	1	-	-
Family wanted to stay with the patient after death	-	5	-	11
Family were divided over the decision	-	25	-	31
Family were not sure whether the patient would have agreed to donation	-	78	1	123
Other	-	18	-	55
Patient previously expressed a wish not to donate	-	82	-	147
Patients treatment may be or has been limited to facilitate organ donation	-	-	-	1
Strong refusal - probing not appropriate	-	7	-	22
Total	**-**	**411**	**1**	**653**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted. The strategy for achieving this, including steps to minimising warm ischaemic injury in proceeding DCD donors, is set out in NHSBT Taking Organ Utilisation to 2020 [4].

Table 3.5 Reasons why solid organ donation did not occur, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Health Board	UK	Health Board	UK
Cardiac Arrest	-	8	-	5
Coroner/Procurator Fiscal refusal	-	16	-	23
Family changed mind	-	8	-	18
Family placed conditions on donation	-	-	-	1
General instability	-	9	-	32
Logistic reasons	-	-	-	3
Organs deemed medically unsuitable by recipient centres	1	42	1	136
Organs deemed medically unsuitable on surgical inspection	-	5	-	10
Other	-	10	-	33
Positive virology	-	14	-	7
Prolonged time to asystole	-	-	-	219
Total	**1**	**112**	**1**	**487**

If 'other', please contact your local SNOD or CLOD for more information, if required.

[4] NHS Blood and Transplant, 2017.
Taking Organ Utilisation to 2020
[accessed 9 May 2019]

4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 4.1 and 4.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 4.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2018 - 31 March 2019

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Aberystwyth, Bronglais Hospital													
A&E	0	0	-	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	0	0	-	0	-	0	0	0	0	-	0	-	0
Carmarthen, Glangwili General Hospital													
A&E	0	0	-	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	4	4	-	4	-	4	4	4	4	-	4	-	3
Haverford West, Withybush General Hospital													
A&E	0	0	-	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	0	0	-	0	-	0	0	0	0	-	0	-	0
Llanelli, Prince Philips Hospital													
Gen. ICU/HDU	1	1	-	1	-	1	1	1	1	-	1	-	1

Table 4.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2018 - 31 March 2019

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Aberystwyth, Bronglais Hospital											
A&E	0	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	1	1	-	1	0	0	0	-	0	-	0
Carmarthen, Glangwili General Hospital											
A&E	1	1	-	1	1	1	1	-	1	-	1
Gen. ICU/HDU	10	10	100	10	9	2	2	-	1	-	1
Haverford West, Withybush General Hospital											
A&E	2	2	-	2	2	0	0	-	0	-	0
Gen. ICU/HDU	11	11	100	11	10	2	2	-	2	-	1
Llanelli, Prince Philips Hospital											
Gen. ICU/HDU	2	2	-	2	2	0	0	-	0	-	0

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Hywel Dda University Health Board in 2018/19 there were 1 such patients. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

A summary of key numbers for Emergency Departments

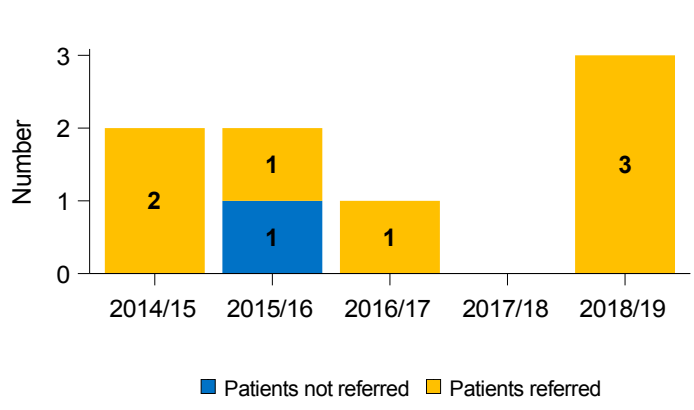
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [5] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

5.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

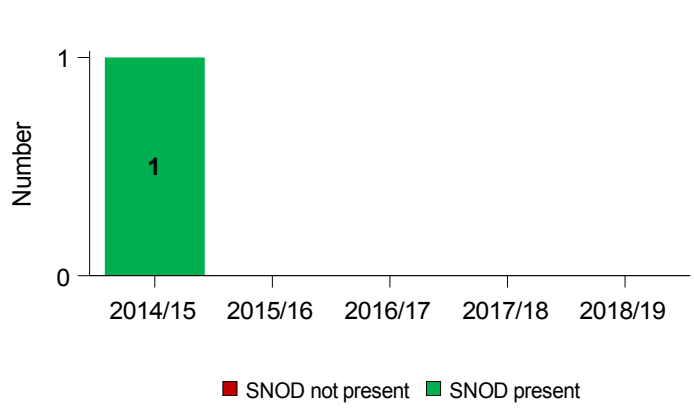
Figure 5.1 Number of patients meeting referral criteria that died in the ED, 1 April 2014 - 31 March 2019



5.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 5.2 Number of families approached in ED by SNOD presence, 1 April 2014 - 31 March 2019



[5] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2019]

6. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

6.1 Supplementary Regional data

Table 6.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2018 - 31 March 2019		
Deceased donors	87	1,600
Transplants from deceased donors	171	3,943
Deaths on the transplant list	25	403
As at 31 March 2019		
Active transplant list	223	6,083
Number of NHS ODR opt-in registrations (% registered)**	1,298,651 (42%)	26,496,220 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 3.1 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

6.2 Trust/Board Level Benchmarking

Hywel Dda University Health Board has been categorised as a level 3 Health Board. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 6.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 6.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 6.3 and 6.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 6.3 National DBD key numbers and rate by Trust/Board level, 1 April 2018 - 31 March 2019

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	5	5	-	5	-	5	5	5	5	-	5	-	4
Level 1	1153	995	86	1144	99	987	951	875	826	94	626	72	563
Level 2	435	361	83	431	99	355	344	313	302	96	221	71	200
Level 3	279	244	87	274	98	237	228	203	197	97	155	76	136
Level 4	137	115	84	133	97	115	112	102	98	96	80	78	71

Table 6.4 National DCD key numbers and rate by Trust/Board level, 1 April 2018 - 31 March 2019

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Your Trust	27	27	100	27	24	5	5	-	4	-	3
Level 1	2570	2413	94	2336	1882	950	816	86	576	61	326
Level 2	1748	1609	92	1541	1235	446	396	89	283	63	156
Level 3	1146	1065	93	979	723	233	210	90	159	68	84
Level 4	510	452	89	441	340	123	105	85	81	66	46

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key numbers in potential for organ donation	
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Appendix A.1 gives a fuller explanation of terms used.

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 PDA data by hospital and unit

Table 4.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 4.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

5 Emergency department data

Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 5.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

6 Additional data and figures

Table 6.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 6.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 6.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 6.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.

Health Board : Hywel Dda University Health Board.

Key Achievements 2018 - 2019	
1	Exploring the implementation of withrawing life sustaining treatment in theatre (DCD).
2	Forged links with key stakeholders (theatres, chaplaincy, St Davids school of health science).
3	Implementation of the Specialist Requester role.
4	
5	

Missed Opportunities and Opportunities to Develop Practice 2018 - 2019	
1	Donor management/optimisation resulting in potential loss of organ utilisation.
2	Teaching sessions being postponed or cancelled due to availability of staff and increased donor activity.
3	Reduced representation in meetings due to donor activity and availability of staff.
4	Reduced embedded SNOD presence throughout Hywel Dda hopitals due to donor activity and staff availibility.
5	

Key Strategic and Performance Priorities 2019 - 2020	
1	WLST in theatre.
2	Reducing the length of process.
3	Prioritising donor optimisation amongst critical care staff.
4	
5	

Please submit with NHS Blood and Transplant Actual and Potential Deceased Organ Donation Summary Report :
April - Sept
April - March

Taking Organ Transplantation to 2020 Theme	Key Action Plan – 2019/20	Responsible Individual	Measurable Outcome	Target Date	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Organ Donation Promotion, Public Engagement & Education							
Action by society and individuals will mean that the UK's organ donation record is amongst the best in the world and people donate when and if they can	To raise awareness of organ donation during organ donation week (September 2019). Engage with Hywel Dda comms team, Welsh Govrnent/Comms and NHSBT media department.	NHSBT, ODC, SNOD,CLOD	Media reports. Promotional activity	Sep-19	Outstanding			
	Promote organ donation at as many publis events as possibe eg local county shows, sporting events.	SNOD, CLOD, ODC.	Media reports. Promotional activity	Sep-19	Outstanding			
	Continue to deliver teaching to Hywel Dda critical care nursing staff and Doctors.	SNOD, CLOD, ODC.	Evaluation/Feedback	May-19	Complete			
	Engage with schools/colleges to raise awareness of organ donation.	SNOD.	Evaluation/Feedback	Sep-19	Outstanding			
	Hospital Engagement							
Action by NHS hospitals and staff will mean that the NHS routinely provides excellent care in support of organ donation and every effort is made to ensure that each donor can give as many organs as possible	Continue to deliver teaching to Hywel Dda critical care nursing staff and Doctors. Also deliver teaching on the RRAMCI course for nurses and 3rd year student nurses at the ST David's school of Health Science.	SNOD, ClLOD.	Evaluation/Feedback	May-19	Complete			
	Plan a study day (whole day event) for the link nurses in Hywel Dda.	SNOD, CLOD, ODC.	Evaluation/Feedback	Sep-19	Outstanding			
	Promote SIM days for Hywel Dda nurses and Doctors to attend	SNOD, CLOD	Evaluation/Feedback	Sep-19	Inprogress			
	Maintain 100% referral rate and early referrals.	SNOD, CLOD.	PDA	Mar-20	Inprogress			
	Donation Process							
Action by NHS hospitals and staff will mean that more organs are usable and surgeons are better supported to transplant organs safely into the most appropriate recipient	Make the process of withdrawing life sustraining treatment in theatres routine practice.	SNOD, CLOD, ODC, NHSBT.	Evaluation/Feedback,. NHSBT stats???	Mar-20	Inprogress			
	Prioritising donor optimisation amongst all critcal care staff.	SNOD, CLOD.	Teaching, debriefing.	Mar-20	Inprogress			
	Reduce the length of the donation process.	SNOD, CLOD.	DonorPath database.	Mar-20	Inprogress			
	Supporting NHSBT and Transplant Activity within Wales							
Action by NHSBT and Commissioners means that better support systems and processes will be in place to enable more donations and transplant operations to happen	Attending/Supporting Transplant games in Newport	SNOD, COD	Media updates	Jul-19	Inprogress			
	Supporting Dying Matters Week - delivering talks in the community	SNOD	Evaluation/feedback	Mar-20	Inprogress			
	Continue close engagement with chaplaincy services	SNOD, CLOD	Media updates, evaluation/feedback	Mar-20	Inprogress			

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
HYWEL DDA

Annual Report

Hywel Dda
Community Health Council

2018/2019

Annual Report

Hywel Dda

Community Health Council

2018 - 2019

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Message from our Chair

I start off the April 2019 year as the new Chairman for Hywel Dda Community Health Council and I am pleased to present the Annual Report for our organisation.

It has, once again been a busy year for the Community Health Council and we have tried to reflect as many of our activities in this document to show what we are doing on behalf of the 384,000 people across our 3 counties within Hywel Dda.

My first important task as I take on the role of Chairman is to thank our members for their commitment during 2018/2019. Without our unpaid volunteers, it would not be possible to undertake so many visits and engagement events, to talk to people within our 3 counties and to scrutinise the work of organisations such as Hywel Dda University Health Board.

It is heartening to be part of an organisation where so many people want to make a difference, using their own time on such a regular basis. As part of this our members have travelled across counties, attended innumerable meetings, scrutinised vast numbers of formal documents and spoken to hundreds of people to make sure that views of people in Carmarthenshire, Ceredigion and Pembrokeshire can all be represented.

I would also like to thank the staff of the Community Health Council for their hard work during the year.

2018-2019 has been an on-going time of challenge for CHCs across Wales. Within Hywel Dda, we are looking ahead at one of the largest changes in local NHS services for generations with the Health Board's plan to transform clinical services.

Change is also planned for Community Health Councils across Wales. Whilst there is much to be decided in terms of how CHCs will evolve over the next few years, the message for the public is that during all these changes, it will be very much 'business as usual'.

Our annual plan for the year ahead is ambitious but shows how we are making every effort to be involved in things that matter to the people of Hywel Dda, wherever they may live.

Last, but not least as we move into a new era for the Health Service and CHCs, I would like to thank our out-going Chairman Dr John Morgan for his unwavering focus on the needs of the residents of the whole of Hywel Dda.

Mansell Bennett MSc
Chair of Hywel Dda
Community Health Council

Our year at a glance

Engagement

We spoke with people across over 100 different events,

- gathering their individual experiences of the NHS and also those of families and carers
- working hard to capture views in a major public consultation run by the Health Board
- listening to people in Health Board public events to discuss changes or closures to pressured GP practices

Patient experience

We heard from many people about their NHS care by:

- visiting a range of NHS services to hear from people in hospital wards, outpatient areas and GP practices
- using online surveys, face to face meetings and stands in community settings to hear from a broad range of people

Advocacy

Our advocacy service:

- Gave advice and information to over 400 people, signposting to others or supporting people to resolve issues informally
- Opened 128 new cases to support people raise concerns through the NHS concerns process
- Closed 143 cases once the concern had been resolved or the process finished
- Supported 39 people to take their concern to the Ombudsman

National themes

We heard from local people about issues that are common across Wales and used this to drive national policy.

About us

Our vision

People in the Hywel Dda area know that they can share their views of the NHS easily and recognise that doing so can have a real influence on the shape of healthcare services.

People understand and value the role played by CHCs in supporting them to be heard and in representing the collective interests of patients and the public.

What we do

Independent watchdog of NHS services	Hywel Dda CHC is the independent watchdog of NHS services in Carmarthen, Ceredigion and Pembrokeshire. We encourage and support people to have a voice in the design and delivery of NHS services.
Provide an important link	Hywel Dda CHC seeks to work with the NHS and inspection and regulatory bodies. We provide an important link between those who plan and deliver NHS service, those who inspect and regulate it, and those who use it.
Engage with the public	Hywel Dda CHC hears from the public in many different ways. We visit NHS services to talk to patients and carers. We talk to people at events, and through community groups. We use surveys, apps and social media.
Our advocacy service helps people	Our advocacy service helps people who want to raise a concern about NHS care or treatment.

Our four main functions can be described as:

1. **Systematically visiting and scrutinising local health services.**

2. **Continuously engaging with the communities we represent and the health service providers serving those communities.**

3. **Representing the interests of patients and the public in the planning and agreement of NHS service developments and changes.**

4. **Enabling users of the NHS to raise concerns about the services they receive through an independent Complaints Advocacy Service.**

Membership

Our volunteer membership

Hywel Dda CHC is made up of up of 36 full members:

- **18 appointed through a public appointments process**
- **9 nominated by the 3rd sector**
- **9 nominated by local authorities.**

Our members are all local people who give their time for free.

We also have co-opted members who we recruit directly from local communities.

If you are interested in becoming a member contact us by using the details at the back of our report.

Our governance

The way in which we organise ourselves to carry out our activities is set out in regulations passed by the National Assembly for Wales.

The activities we carry out are co-ordinated and overseen by 3 local committees; Carmarthenshire, Ceredigion and Pembrokeshire. These committees make up our Full Council. We also have an Executive Committee which is ultimately responsible for what we do and how we do it.

Our national standards

1. CHCs act in the interests of the public and patients in Wales
2. CHCs work effectively with others to safeguard and promote the welfare of people who use NHS services
3. CHC activities and services meet the needs of and are accessible to all
4. CHC activities are open, transparent and inclusive
5. CHC activities are properly led, resourced and supported
6. CHCs plan and carry out their activities in a way that maintains their independence and demonstrates their accountability to the communities they serve
7. CHCs strengthen the voice of patients and the public by working together and with others
8. CHCs reflect the views and experiences of patients and the public about NHS services
9. CHCs share the results of their activities in a balanced and timely way
10. CHCs evaluate the impact of their actions and apply the learning to future activities

About our communities

Hywel Dda Community Health Council represents 384,000 people across Carmarthenshire, Ceredigion and Pembrokeshire. These 3 counties have a mixture of urban and rural communities and cover a quarter of the land mass of Wales.

We know that accessing NHS care particularly with long distances to travel is something that many people say is difficult for them. With very distinct communities across a large area people sometimes tell us they feel at a disadvantage to other communities.

Some areas have higher levels of need than others although in general, the health of people in Hywel Dda is better than average in Wales. It is likely that more people will need to access NHS care in the future because the population is predicted to grow from around 384,000 residents to approximately 425,000 in 2033. The Hywel Dda area also has more older people than other areas of Wales, so health services are busier supporting those people who need additional help as they age.

Hywel Dda Health Board tells us that often people are living with mental health issues and long term conditions such as diabetes, heart disease, chronic obstructive pulmonary disease and dementia.

When people have more than one health condition, it can make care complicated.

Like most of Wales, Hywel Dda has areas where people are less healthy than others. Statistics from Public Health Wales show that there is a difference between the health experience of the best off and the worst off in society[1].

[1] http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/3653c00e7bb6259d80256f27004900db/eace59365015b70380257ff8002b1966/$FILE/MeasuringInequalities2016_HywelDdaUHB_v1.docx

Continuous engagement

Patient and public engagement: working with CHCs across Wales

CHCs have a responsibility to represent the interests of patients and the public within the geographical areas they serve.

Often, the priorities identified by patients and the public will be local to a particular CHC area or even to a specific hospital or service. There will, however, always be themes and priorities that are common to CHCs across Wales.

When this happens, CHCs work together to ensure that the views and experience of patients and the public are reflected both locally and nationally; providing a strong patient voice to influence the development of national policy and local delivery.

Our national reports are available on our website

wwwcommunityhealthcouncils.org.uk/

How we have made a difference: Working locally

Scrutiny and engagement: local priorities

During 2018/2019 we set local priorities. We looked at the issues that people told us were most important to them and responded to concerns raised through our activities and those of others. We focused our scrutiny and engagement activities on:

- people's access to and experience of GP appointments, particularly using telephone triage systems
- care for people living with diabetes
- people's access to and experience of services in the community, e.g., wound care
- diagnosing and supporting people living with dementia
- people's access to and experience of ophthalmology services
- children and young people's experience of their NHS services in Carmarthenshire, Ceredigion and Pembrokeshire, including orthodontic services
- people's access to and experience of specialist care and NHS treatment outside Carmarthenshire, Ceredigion and Pembrokeshire (in particular cardiac and cancer services)
- planning to leave hospital, and the support available to people when they leave (including access to therapy services)
- improving the way NHS services seek and respond to feedback from patients on their NHS experience (including complaints and incidents).

Our staff and members attended a wide range of meetings with NHS providers to hear what was being discussed and to ensure that the views of patients and their families were always being considered. We reviewed and scrutinised agendas, papers and documents to understand what was happening in the area and to identify what impact this would have on people using NHS services. We asked questions and raised challenges when we felt that it was important to get more detail.

Engaging with you

In 2018/19 our members and staff attended over 100 different events and meetings with the public or local groups. We spoke with many different people

raising awareness of the CHC's role and capturing a range of experiences and views from those we heard from.

Given the size and importance of the Health Board's "Transforming Clinical Services" public consultation, much of our engagement with the public focused on this issue. A summary of what we did in response to this consultation can be seen on the following page including a link to our commentary document.

Trinity St David University (Carmarthen) Students Engagement

Building on the work we did at Aberystwyth University last year, we asked students at Trinity St David University about how they would seek to access urgent care if they needed it.

The results were encouraging. Students considered and chose pharmacy and self- care for minor injuries in the first instance.

They recognised that often there may be opportunities to manage something themselves or with the help of a health professional before needing to consider ambulance involvement or hospital care.

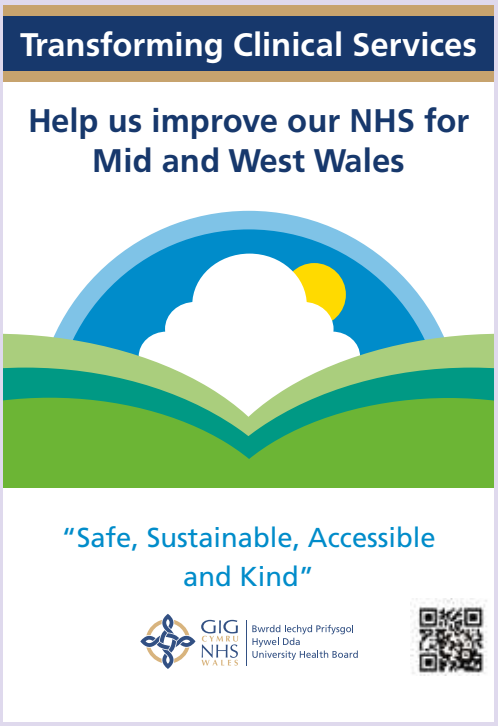
In a similar survey in 2017, far more students chose 999 or A&E as their first option when this might not always have been the wisest course of action.

We still feel that there is more to be done to raise awareness of different options available to people when they need help and when they may be having to make health care decisions on their own, for the first time.

Social media

We have continued to reach out to the public through social media in 2018-19. In two years we have gained over a thousand followers on our busy Twitter account and have been listening to what the public are saying through Facebook. We're pleased to note that our communication on social media is produced bilingually.

Changes to your local NHS; "Transforming Clinical Services"



Through the summer of 2018 the Health Board ran a public consultation to discuss changes that it believes need to be made to make NHS services better for the population. Hywel Dda CHC listened to what people had said during this time and responded to the Health Board in autumn.

We put forward 18 recommendations in our commentary document which can be seen on our website here:

http://www.wales.nhs.uk/sitesplus/documents/904/TCS%20Commentary%20CHC.pdf

What did we say? A summary

We said that change was important, because we know people are not always getting a good experience when they access NHS care.

There were a wide range of views from different areas. We heard that many people were worried about the changes, particularly worried that they could be too far away from help if they needed it urgently.

We felt that whilst the Health Board should continue to make plans, it needed to ensure certain foundations (such as more stable GP practices and stronger community care) were in place before changes happened. We also said that the Health Board must talk to the public again and develop more detail before they seek to make any big changes (such as changing A&E units.) The Health Board agreed to all of our recommendations in its September 2018 Board meeting and we will continue to scrutinise these changes closely.

Visiting

One of our important statutory roles is to enter NHS settings and talk to patients who are accessing care (and the relatives who are with them) about their experiences. The good news is that most people are positive, but sometimes we hear about things that could be better or problems that need addressing with the Health Board.

With a major public consultation in the summer of 2018 we carried out fewer visits than in previous years because our volunteer members and staff were so busy engaging with the public on the big changes proposed by the Health Board. However we still went to 12 different settings and reported on each.

What did we find and what was the outcome?

Communication is a theme that regularly stands out when we talk to people about their experiences. It was an issue that we looked at on a national basis but one that we needed to raise regularly when we visited local settings. For example;

- We visited phlebotomy/anti coagulation clinics in Llanelli and found that patients on warfarin (a blood thinning drug) didn't always know enough about their dosage. We also found that people were unclear on clinic opening times. The Health Board has agreed actions to remedy this.

- When we visited Cadog ward at Glangwili hospital and Ward 7 in Withybush hospital we found that some patients didn't know when they might be leaving hospital or weren't always involved in early discussions about planning to leave. The Health Board has committed to review ward rounds to keep patients better informed and involved and is seeking to use the "SAFER" patient tool to support this.

Women and Children's services

We continue to monitor the experiences of people using women and children's services (for example, maternity or paediatric care) since changes to services at Withybush and Glangwili hospitals that happened in 2014.

Whilst many happy new mums told us of good experiences, we still heard some concerns.

- A small number of first-time mums in labour felt worried and didn't feel assured that their birth was going smoothly if midwives were busy. The Health Board has reviewed its approach and fed this back to staff forums.

- We heard that planning for transport across large geographical distances wasn't always as good as it could be when labour started. The Health Board has agreed to ensure that community midwives discuss transport and contingency plans so that families are clear on what to do and the options they have.

Primary Care

With GP practices under pressure we visited two this year to talk to patients about their experiences. Like many practices, Argyle St Surgery in Pembroke Dock has struggled with recruiting GPs and with a very large patient list size, has high demand for appointments. We spoke with patients and found that:

- People were concerned and frustrated at how difficult it could be to get an appointment. Responding to our report, the Practice has committed to make emergency appointments easier to access within its limited capacity. It reports that following the closure of its branch surgery at St Clements and a redistribution of GP capacity, access has improved.

How we have made a difference:
Responding to local issues

It is important that when we hear about problems in NHS services that we do what we can to improve the situation for patients and the public.

Lupus Support Group Pembrokeshire

We were contacted this year by a group of people who have the disease Lupus. Lupus is an incurable immune system illness, thought to be genetic in origin and mainly suffered by women. It can produce many symptoms and can be difficult to diagnose. It can affect any part of the body and a number of major organs can be damaged in an irreversible way.

We attended a meeting of the support group and heard a range of concerns and stories. One of the main worries people had was accessing the specialist care they needed, especially as the Health Board had been struggling to recruit rheumatologists. We contacted the Health Board on this issue and senior managers agreed to attend the group. After hearing people's concerns they organised extra clinics to reassess care and look at treatment needs.

This has been helpful to many and whilst a number of the group still have concerns about how accessible expert care is for people with Lupus, we were pleased to assist and will continue to do so. If other groups with worries about their NHS care or similar concerns would like to contact us, we'd be pleased to hear from them, (see our contact details at the end of this report).

GP surgeries

Like many other areas of the UK, 2018-19 has been another year where pressured GP practices have needed to make changes, in some cases closing branches or shutting completely. This has created a great deal of concern in the communities they serve.

As a CHC we have worked with the Health Board to ensure that all decisions have been made carefully and with patients at the forefront. After the closure of a practice in Cardigan and another in Llandysul over 10,000 people have had to move to another GP. We reviewed communication with the public to ensure it was clear and asked the Health Board to hold well-attended public events to

discuss the changes and to hear from those affected.

We feel that GP practices across Hywel Dda need to be stable and sustainable as the Health Board seeks to put more NHS care into community settings. We will continue to look at what care is like for individual people who access their GP as well as looking at the strategic picture as the Health Board makes and implements its plans.

How we have made a difference:

Working nationally

Working together, the Board and CHCs highlight issues that do or will impact on people's experiences across Wales. We draw on our local knowledge to shape the national agenda and challenge policy makers and those who deliver our services to do better.

We do more than offer responses on issues raised by others; we set out the case for change on those issues that matter most for patients and the public; describing where improvements are needed and holding the NHS in Wales to account on its performance.

Working through the Board of Community Health Councils in Wales, in 2017-2018 the 7 CHCs in Wales worked on 4 national projects. We wanted to hear what people had to say across Wales about the NHS in some key areas:

- Communication in the NHS in Wales
- GP out of hours services
- The impact of delays in leaving hospital
- Autism services

CHCs also kept a close eye on the progress being made in response to the projects carried out in the previous year.

One simple thing: communication in the NHS in Wales

Throughout the summer CHCs asked people across Wales to tell us about their experience of NHS communication good and bad and to give us their suggestions for how it might improve.

We received over 1,300 responses. Whilst everyone's experience was different we found that there were a number of common themes.

People told us that good communication made difficult times bearable, helped to build trust in NHS care and made people feel safe.

On the other hand, we also heard about how poor or no communication left people feeling frustrated and scared. People didn't always feel that they had any say or control over their health and care and were not able to voice their concerns easily.

There were many examples where people tried and failed to find the information they needed to access NHS services or look after themselves.

We said that improving communication must be at the heart of the changes the NHS needs to make. We challenged the Welsh Government and the NHS in Wales to improve communication quicker and better than it has done up to now.

The Welsh Government told us about the developments underway and planned in the NHS to deliver better care. It set out its expectations that the people leading these developments take on board the feedback from our report in introducing new and improved approaches to communication across health and social care.

In Hywel Dda the Health Board has recognised that various kinds of communication need to improve. It has said that it will develop a patient's charter in 2019-20 and good communication will be focused on. It will also be seeking to commission a "friends and family test" across all of its services to ensure that patient views and experiences are captured more consistently.

Autism

During 2018 we attended 2 Welsh Autism shows in North and South Wales. We also encouraged people to share their views and experiences through social media and via an 'app'. We asked people if the NHS meets the needs of people with autism. We asked people to tell us what was good and what could be better.

We heard that when the NHS works well it provides much needed support for people and families living with autism. We also heard about many of the difficulties people face. People told us that although they valued highly the hard working staff involved in providing NHS care, all too often they felt the "system" let them down. This led to people feeling anxious, frustrated and vulnerable.

The NHS in Wales needs to make real and sustainable progress in tackling the key issues raised by people and families living with autism. So we used the information people shared with us to respond to the Welsh Government's consultation on a code of practice on the delivery of autism services[1].

We will be attending the shows again in 2019 to find out if things have improved over the past year.

GP out of hours (OOH)

In 2017-2018, the Welsh Government told us about the work that was going on to improve the fragility of GP out of hours services in Wales. This was in response to our report that said the NHS needed to work together to make things better quickly.

So during 2019 we asked people to share their views and recent experiences of using GP out of hours services so we could see if things were getting better. We will report on what people told us later this year.

In Hywel Dda the Health Board responded and said it would:

- Work with the CHC to understand what people thought about out of hours patient satisfaction survey
- Advertise for Advanced Paramedic Practitioners within the service
- Put the 111 service in place across Ceredigion and Pembrokeshire after the pilot service in Carmarthenshire

Time to go home?

During 2017-2018 CHCs increasingly heard about the challenges in social care provision and its impact on people being able to leave hospital when they are well enough.

So in early 2019 CHCs asked people who had experience of being in hospital longer than needed to share with us how this had affected them or those they cared about. CHCs did this by asking people at events, on-line and social media, and by visiting hospital wards to hear directly from people.

We will report on what people told us later this year.

Advocacy and enquiries

Hywel Dda CHC provided independent complaints advocacy support and advice for anyone living in their area who wanted help to raise a concern about NHS services wherever they were delivered.

We assisted over 400 people to resolve concerns by offering initial advice, signposting or supporting people to resolve issues informally as sometimes people do not want to make formal complaints.

We also offered support and advice throughout the NHS Concerns Procedure known as Putting Things Right (PTR). We opened 128 new cases offering this support.

Every concern is different and people wanted and needed different levels of support to take their concern forward. Complaints can also take different lengths of time to address and some can be more complex, particularly if several organisations or departments may be involved.

We helped by explaining the concerns process and helping people to think about what they wanted and expected to happen as a result of raising their concern.

We provided practical support to those who wanted it, including helping people write letters, going with them to meetings, helping people understand the information and response provided by NHS organisations.

Advocacy is an integral part of the CHC's core functions. Our case work provided important information about NHS services and issues and we used this to inform our other activities. Where several complaints identified similar locations or issues, these could be used to inform our visiting activities so we hear from others in similar situations.

As a result of concerns raised by clients, changes are often made which have a wider benefit. Some examples from the year include:

- In one case, it was identified that a person undergoing surgery had experienced an inappropriate delay in receiving medication needed for his

mental health condition. The Health Board recognised this in its investigation and arranged for ward staff to attend additional Mental Health training so that this would not happen again.

- As part of another complaint, it was identified that an elderly patient had fallen on a ward and no falls risk assessment had been done on admission or re-assessed afterwards. Further training has been arranged and a falls improvement programme has been introduced with work also being done in relation to introducing a delirium pathway.

- A complaint involving a GP surgery triggered an in depth investigation. This resulted in a change in the appointments system so that patients unable to get an appointment or a house call can still have timely contact with an appropriate health care professional. This has also allowed more urgent appointments to be made available on the day as well as a call back system.

- In another GP surgery, a complaint highlighted the fact that people diagnosed with cancer did not feel supported and did not know who they should turn to. As a result of the complaint, the surgery has identified a better way of helping people when they have to deal with a cancer diagnosis so that information and support is available.

Working with others

During the year we undertook some of our activities with others;

Healthcare Inspectorate Wales

We communicated with HIW on a regular basis to inform our work programme. We referred any clinical concerns to HIW as necessary. We shared information from our visit reports with them to ensure that what people told us was widely heard.

Public Services Ombudsman for Wales

We communicated regularly with Ombudsman staff to discuss how concerns were being handled by the NHS and offered suggestions on how improvements could be made.

Wales Audit Office (WAO)

In carrying out its regular assessment of the Health Board we met with a WAO representative to give our view as a patient voice body of how the Health Board was performing.

Town and Community Councils

We were pleased to attend several meetings with Town and Community Councils this year. We appreciate that Councillors know their communities and the people within them well. With a particular focus on the Health Board's proposals to change services we wanted to raise awareness of the public consultation and our role in representing the public.

Assembly Members and Members of Parliament

Similarly, we wanted to meet with AMs and MPs to discuss the public consultation whilst sharing any issues and concerns that they were hearing through contact with the people they represent. We aim to continue regular meetings with AMs and MPs in the coming year.

Our plans for next year

We will be responding to local priorities identified by patients and the public and drawn from our own activities. This will include:

Communication and information

- About NHS services
- With patients, carers and families
- Across care pathways
- Within communities and with particular groups

Service developments and changes

- A Healthier Mid and West Wales
- Women's and Children
- Transforming mental health services
- Primary care services
- Regional Services (to include Major trauma)

Timely access to health & care services

- Access to GP services
- Delayed transfers of care (DTOC)
- Access to Audiology including Primary care
- Orthodontics to include access

Listening and engaging with local people

- Raising awareness of our role
- Gathering views and experiences in a variety of ways and in partnership with others
- Using what we hear to inform and influence NHS decision making
- Demonstrating our impact

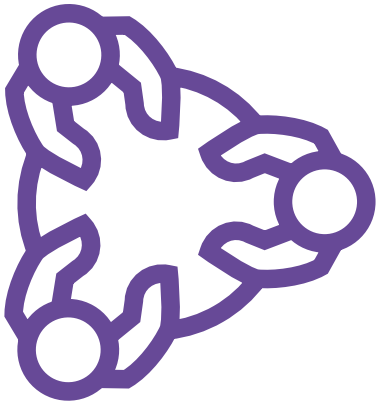
During 2019/2020 we will be working with CHCs across Wales to look at issues impacting on people wherever in Wales they live including:

- GP sustainability
- Cancer pathways
- Ophthalmology
- Mental Health
- Orthodontics

NHS Service Change

As noted in our summary of plans, we will be working hard to ensure that the voice of patients and the public is heard as the Health Board seeks to implement plans or engage further around its clinical strategy "A Healthier Mid and West Wales". With potentially many changes we will continue to be very busy talking and listening to the public across the 3 counties, covering a range of local NHS issues.

Link to Operational Plan http://www.wales.nhs.uk/sitesplus/documents/904/Hywel%20Dda%20CHC%20FINAL%20operational%20plan%202019-20201.pdf



We are listening to you

Your experiences

You can help us by telling us about your experiences of the NHS, we want to hear your views on the services in your area.

You can share your views and experiences with us in any of the following ways:

- By telephoning our office
- By writing to us
- By e-mail
- By visiting our website
- Via twitter
- Via Facebook

We often seek views on particular aspects of health services through on-line surveys accessed through our website.

Keeping you informed

We hold our committee meetings in public, and you can find out when we are next meeting in your area on our website.

Our website also contains more information about our activities. If you would like to come and see us to discuss our activities or to share your views and experiences please let us know.

Becoming a CHC member

If you are interested in becoming a member of the CHC, please get in touch with us.

Our contact details can be found later in this report.

Appendices

Appendix 1 - Financial Statement

Fixed Costs

	Annual Budget	Expenditure to 31st March	Variation
Staff salaries	349,687.00	343,035.87	6,651.13
Office expenses	6,349.00	6,414.83	-65.83
Accommodation costs	37,851.00	39,566.25	-1715.25
Total (Fixed)	393,887.00	389,016.95	4,870.05

Variable Costs

	Annual Budget	Expenditure to 31st March	Variation
Travel and associated expenses	19,000.00	20,440.50	-1,440.50
Office expenses	11,626.00	19,100.49	-7,474.79
Accommodation Costs	4,700.00	4,550.63	149.37
Total (Variable)	35,326.00	44,091.62	-8,765.62
Total (Fixed & Variable)	429,213.00	433,108.57	-3,895.57
Budget adjustment agreed by the CHC Board	3,900.00	-	3,900.00
Total (fixed and variable)	433,113.00	433,108.57	4.43

Appendix 2 - Executive members' declarations of interest

Executive Committee members' directorships of companies or positions in other organisations likely, or possibly, seeking to do business with the NHS are published in the Council's Annual Report to Welsh Ministers required under Regulation 25 of the CHC Regulations 2015.

Name	Position Held in CHC	Directorships	Other Positions of Authority
Alun Williams	Vice Chair Ceredigion Locality		Cabinet Member – Adult Social Services – Ceredigion County Council
Dr John Morgan	Chair Ceredigion Locality		Chair of Board of Trustees – Newlink Wales Chair of Hafan Cymru Housing Association Trustee & Treasurer Seren Charity Member & General Secretary – Wales Green Party
Ken Jones	Vice-Chair Carmarthenshire Locality	None	Member of Care Council Wales; Stakeholder Reference Group, HDUHB; SRG member of Business Planning Performance Assurance Committee, HDUHB; Vice Chair Carmarthen Care forum

Appendix 3 - Members of Hywel Dda CHC 2018/2019

Name (*member left)	Position Held in CHC	Locality
Cllr Rob Evans	Local Authority Member	Carmarthenshire
Cllr Ann Davies	Local Authority Member	Carmarthenshire
Cllr Ken Lloyd	Local Authority Member	Carmarthenshire
Ken Jones	3rd Sector Member	**Carmarthenshire**
Barry Williams	3rd Sector Member	Carmarthenshire
Maureen Webley	3rd Sector Member	Carmarthenshire
Mansell Bennett	Welsh Government Appointee	Carmarthenshire
Dr Pauline Griffiths	Welsh Government Appointee	Carmarthenshire
Patricia Neil	Welsh Government Appointee	Carmarthenshire
Paul Mason	Welsh Government Appointee	Carmarthenshire
Ian Phillips	Welsh Government Appointee	Carmarthenshire
Frederick Burton	Co-opted Member	**Carmarthenshire**
Andrew Davies	Co-opted Member	Carmarthenshire
Iris John	Co-Opted Member	Carmarthenshire

Christine Clark	Co-Opted Member	Carmarthenshire
Cllr Alun Williams	Local Authority Member	Ceredigion
Cllr Lyndon Lloyd	Local Authority member	Ceredigion
Cllr Elizabeth Evans	Local Authority Member	Ceredigion
Maria Emptage	Co-opted Member	Ceredigion
Dr Gabrielle Heathcote	Co-opted Member	Ceredigion
Dylan Lewis	Co-opted Member	Ceredigion
David Thomson	Co-opted Member	Ceredigion
Dr John Morgan	3rd Sector Member (Resigned)	Ceredigion
Pat Bates	3rd Sector Member	Ceredigion
Marjorie Fogg	3rd Sector Member	Ceredigion
Gwenda Williams	Welsh Government Appointee	Ceredigion
Jarrod Thomas	Welsh Government Appointee	Ceredigion
Carol Bainbridge	Welsh Government Appointee	Ceredigion
Diane Richards	Welsh Government Appointee	Ceredigion
Cllr Steve Yelland	Local Authority Appointee	Pembrokeshire
Cllr David Bryan	Local Authority Appointee	Pembrokeshire
Cllr Ken Rowlands	Local Authority Appointee	Pembrokeshire
Raymond Hine	3rd Sector Member	Pembrokeshire

Christopher Jones	Welsh Government Appointee	Pembrokeshire
Lindsay Moran	Welsh Government Appointee	Pembrokeshire
Pamela Parsons	Welsh Government Appointee	Pembrokeshire
Abi Thomas	Welsh Government Appointee (Resigned 30 April 2018)	Pembrokeshire
John Harvey	Welsh Government Appointee	Pembrokeshire
Wynne Evans	Co-opted Member (Retired 24 April 2019)	Pembrokeshire

Appendix 4 - External Representation 2018/19

Committee/group	CHC representative
Board of HDUHB	Chair & Chief Officer
Board of CHCs	Chair
Aberaeron Integrated Care Centre	David Thomson
Business Planning and Performance Assurance Committee	Deputy Chief Officer
Cardigan Integrated Care Communication and engagement committee	Pamela Parsons
Cardigan Integrated Care stakeholder Committee	Maureen Webley Pamela Parsons
CDU/ Ward 10 project Board	Deputy Chief Officer
Cross Hands Health Centre	Pat Neil
Cylch Caron	PPE Officer
Dementia Steering Group	Maureen Webley
Improving Experience Sub Committee	Deputy Chief Officer
Kidwelly PPG	Pat Neil
Kidwelly Project Board	Deputy Chief Officer
Llanelli Hydrotherapy Pool Development	Christine Clarke Andrew Davies
Llanelli Well Being	Ken Jones

Mental Health Act Monitoring Group	Ken Jones
Mental Health Implementation Group	Carol Bainbridge
Mental Health Partnership Group	Chief Officer/ Deputy Chief Officer
Mid Wales Healthcare Collaborative	Gabrielle Heathcote
Paediatrics Task & Finish Group	Deputy Chief Officer
Phase 2 Maternity	Mansell Bennett
Primary Care Applications Committee	Deputy Chief Officer
Primary Care Sub committee	Deputy Chief Officer
Quality & Safety	Mansell Bennett & Chief Officer
RCPCH monitoring group	**Deputy Chief Officer**
Tenby Walk-In Centre	**Wynne Evans**
Unscheduled Care Collaborative Meeting	**Pat Neil Deputy Chief Officer**
Ward 10 / CDU stakeholder Group	**Ray Hine**

Appendix 5 - CHC Staff and Contact Details

CHC members are supported in their work by a team of loyal CHC staff, who are based at the CHC Offices in Carmarthen, Ceredigion and Pembrokeshire:

Name	Job Title	Hours worked per week
Gwen Clements	Visiting & Engagement (PPE) Officer	22.5
Sam Dentten	Interim Chief Officer / Deputy Chief Officer	18.75 18.75
Donna Coleman	Deputy Chief Officer / Complaints Advocate	37.5
Sadie Davies	Administrative Officer	37.5
Sarah Knight	Administrative Officer / Advocacy Support Officer	30
Pauline Marr	Complaints Advocate	37.5
Kerry Pearson	Administrative Officer / Advocacy Support Officer	26
Tracey Setterfield	Administrative Officer / Advocacy Support Officer/Business Manager	37.5
John Stretton	Complaints Advocate	18.75
Alyson Thomas	Chief Officer (Until 30th October 2018)	18.75
Helen Williams	Deputy Chief Officer / Business Manager	37.5

Aberystwyth Office contact details

Post: **Welsh Government Building**
Rhodfa Padarn
Llanbadarn Fawr
Aberystwyth
Ceredigion
SY23 3UR
Telephone: **01646 697610**

Milford Haven Office contact details

Post: **Suite 18 Cedar Court**
Havens Head Business Park
Milford Haven
Pembrokeshire
SA73 3LS
Telephone: **01646 697610**

Camarthen Office contact details

Post: **Suite 5, Ty Myrddin**
Old Station Road
Carmarthen
SA31 1BT
Telephone: **01646 697610**

E-mail: **hyweldda@waleschc.org.uk**

Website: **www.communityhealthcouncils.org.uk/hyweldda**

Accessible formats

If you would like this publication in an alternative format and/or language, please contact us. You can download it from our website or order a copy by contacting our office (contact details above).

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
HYWEL DDA

Adroddiad Blynyddol

Cyngor Iechyd Cymuned
Hywel Dda

2018/2019

Adroddiad Blynyddol

Cyngor Iechyd Cymuned

Hywel Dda

2018/2019

Cysylltu â ni

Post: **Adeilad Llywodraeth Cymru**
Rhodfa Padarn
Llanbadarn Fawr
Aberystwyth
Ceredigion
SY23 3UR
Ffôn: **01646 697610**

Post: **Swyddfa Aberdaugleddau**
Ystafell 18 Cedar Court
Parc Busnes Havens Head Aberdaugleddau
Sir Benfro
SA73 3LS
Ffôn: **01646 697610**

Post: **Swyddfa Caerfyrddin**
Ystafell 5, Tŷ Myrddin
Heol yr Hen Orsaf
Caerfyrddin
SA31 1BT
Ffôn: **01646 697610**

E-bost: **hyweldda@waleschc.org.uk**
Gwefan: **www.communityhealthcouncils.org.uk/hyweldda**
Twitter: **@CICHywelDda**

Fformatau hygyrch

Os hoffech y cyhoeddiad hwn mewn fformat ac/neu iaith amgen, cysylltwch gyda ni os gwelwch yn dda. Gallwch ei lawr lwytho o'n gwefan neu archebu copi drwy gysylltu gyda'n swydda (manylion cyswllt uchod)

Neges gan y Cadeirydd

Rwyf yn cychwyn blwyddyn Ebrill 2019 fel cadeirydd newydd Cyngor Iechyd Cymuned Hywel Dda ac mae'n bleser gennyf gyflwyno Adroddiad Blynyddol ein corff.

Unwaith eto bu'n flwyddyn brysur i'r Cyngor Iechyd Cymuned ac rydym wedi ceisio adlewyrchu cymaint o'n gweithgareddau yn y ddogfen i ddangos beth rydym yn ei wneud ar ran y 384,000 o bobl ar draws y tair sir sydd oddi mewn i Hywel Dda.

Fy nhasg gyntaf bwysig wrth imi gychwyn ar fy ngwaith fel Cadeirydd ydy diolch i'n haelodau am eu hymrwymiad yn ystod 2018/2019. Heb ein gwirfoddolwyr di-dâl, ni fyddai'n bosibl cyflawni cymaint o ymweliadau a digwyddiadau ymgysylltu, sgwrsio gyda phobl yn ein tair sir a chraffu ar waith cyrff fel Bwrdd Iechyd Prifysgol Hywel Dda.

Mae'n galonogol bod yn rhan o gorff lle mae cymaint o bobl eisiau gwneud gwahaniaeth, yn defnyddio eu hamser eu hunain ar sail mor rheolaidd. Fel rhan o hyn mae ein haelodau wedi teithio ar draws y siroedd, wedi mynychu nifer o gyfarfodydd, craffu ar nifer fawr o ddogfennau ffurfiol ac wedi siarad gyda channoedd o bobl i sicrhau bod barn pobl yn Sir Gaerfyrddin, Ceredigion a Sir Benfro yn cael eu cynrychioli.

Hoffwn ddiolch hefyd i staff y Cyngor Iechyd Cymuned am eu gwaith caled yn ystod y flwyddyn.

Bu 2018-2019 yn gyfnod parhaus o her i'r CICau ledled Cymru. Yn Hywel Dda, rydym yn edrych ar y newidiadau mwyaf i wasanaethau GIG ers cenedlaethau, gyda chynllun y Bwrdd Iechyd i drawsnewid gwasanaethau clinigol.

Mae newid hefyd ar y gweill i Gynghorau Iechyd Cymuned

ar draws Cymru. Er bod cryn dipyn i'w benderfynu o ran sut y bydd CICau yn esblygu dros y blynyddoedd nesaf, y neges i'r cyhoedd ydy y bydd 'busnes fel arfer' yn ystod y newidiadau hyn. Mae ein cynllun blynyddol am y flwyddyn i ddod yn uchelgeisiol ond mae'n dangos sut rydym yn gwneud pob ymdrech i fod yn rhan o bethau sydd yn cyfrif i bobl Hywel Dda, lle bynnag maen nhw'n byw.

Yn olaf, ond nid y lleiaf, wrth inni symud i gyfnod newydd i'r Gwasanaeth Iechyd a CICau, hoffwn ddiolch i'n cyn gadeirydd Dr John Morgan am y ffordd y mae wedi canolbwyntio'n gyson ar anghenion holl breswylwyr Hywel Dda.

Mansell Bennett MSc
Cadeirydd Cyngor Iechyd Cymuned Hywel Dda

Golwg sydyn ar ein blwyddyn

Ymgysylltu

Fe wnaethom siarad gyda phobl mewn dros 100 o wahanol ddigwyddiadau,

- casglu eu profiadau unigol o'r GIG a phrofiadau teuluoedd a gofalwyr
- gweithio'n galed i ddal barn mewn ymgynghoriad cyhoeddus mawr a gynhaliwyd gan y Bwrdd Iechyd
- gwrando ar bobl mewn digwyddiadau cyhoeddus y Bwrdd Iechyd i drafod newidiadau neu gau meddygfeydd dan bwysau

Profiad cleifion

Fe wnaethom glywed oddi wrth nifer o bobl am eu gofal GIG drwy:

- ymweld ag amrediad o wasanaethau GIG i glywed gan bobl mewn wardiau ysbyty, ardaloedd cleifion allanol a meddygfeydd
- defnyddio arolygon ar-lein, cyfarfodydd wyneb yn wyneb a stondinau mewn lleoliadau yn y gymuned i glywed gan amrediad eang o bobl

Eiriolaeth

Fe wnaeth ein gwasanaeth eiriolaeth:

- Rhoi cyngor a gwybodaeth i dros 400 o bobl, cyfeirio at eraill neu gefnogi pobl i ddatrys materion yn anffurfiol
- Agor 128 o achosion newydd i gefnogi pobl i godi pryderon drwy broses pryderon y GIG
- Cau 143 o achosion unwaith roedd y pryder wedi'i ddatrys neu ar ôl i'r broses ddirwyn i ben
- Cefnogi 39 o bobl i fynd â'u pryderon i'r Ombwdsmon

Themâu cenedlaethol

Fe wnaethom glywed oddi wrth bobl leol am faterion sydd yn gyffredin ar draws Cymru a defnyddiwyd hyn i sbarduno polisi cenedlaethol ar drafnidiaeth i gleifion ac amseroedd aros.

Amdanom ni

Ein gweldigaeth

Mae pobl yn ardal Hywel Dda yn gwybod bod modd iddyn nhw rannu eu barn am y GIG yn hawdd ac maen nhw'n cydnabod eu bod nhw'n cael dylanwad gwirioneddol ar ffurf eu gwasanaethau iechyd wrth wneud hynny.
Mae pobl yn deall ac yn gwerthfawrogi'r rôl a chwaraeir gan CICau wrth eu cefnogi i gael eu clywed ac wrth gynrychioli buddiannau cleifion a'r cyhoedd.

Beth rydym yn ei wneud

Corff gwarchod annibynnol gwasanaethau'r GIG

CIC Hywel Dda ydy corff gwarchod annibynnol gwasanaethau GIG yn Sir Gaerfyrddin, Ceredigion a Sir Benfro.

Darparu cyswllt pwysig

Rydym yn annog ac yn cefnogi pobl i gael llais yn nyluniad a darpariaeth gwasanaethau GIG.

Ymgysylltu â'r cyhoedd

Mae CIC Hywel Dda yn ceisio gweithio gyda'r GIG a chyrff arolygu a rheoleiddiol. Rydym yn darparu dolen bwysig rhwng y rhai sydd yn cynllunio ac yn darparu gwasanaeth GIG, y rhai sydd yn ei arolygu ac yn ei reoleiddio a'r rhai sydd yn ei ddefnyddio.

Mae ein gwasanaeth eiriolaeth yn helpu pobl

Mae CIC Hywel Dda yn clywed oddi wrth y cyhoedd mewn nifer o ffyrdd gwahanol. Rydym yn ymweld gyda gwasanaethau GIG i siarad gyda chleifion a gofalwyr. Rydym yn siarad gyda phobl mewn digwyddiadau a thrwy grwpiau cymunedol. Rydym yn defnyddio arolygon, apiau a chyfryngau cymdeithasol. Mae ein gwasanaeth eiriolaeth cwynion annibynnol yn helpu pobl sydd eisiau codi pryderon am ofal neu driniaeth GIG.

Gellir disgrifio ein 4 prif swyddogaeth fel:

1. **Ymweld a chraffu yn systematig ar wasanaethau iechyd lleol;**

2. **Ymgysylltu'n barhaus gyda'r cymunedau a gynrychiolwn a'r darparwyr gwasanaethau iechyd sydd yn gwasanaethu'r cymunedau hynny;**

3. **Cynrychioli buddiannau cleifion a'r cyhoedd yn y gwaith o gynllunio a chytuno ar ddatblygiadau a newidiadau i wasanaethau GIG;**

4. **Galluogi defnyddwyr GIG i godi pryderon am y gwasanaeth y maen nhw'n ei dderbyn drwy wasanaeth eiriolaeth cwynion annibynnol.**

Aelodaeth

Ein haelodaeth

Mae CIC Hywel Dda yn cynnwys 36 o aelodau llawn:

- **18 wedi'u penodi drwy broses penodiadau cyhoeddus**
- **6 wedi'u henwebu gan y 3ydd sector**
- **6 wedi'u henwebu gan awdurdodau lleol.**

Mae ein haelodau yn bobl leol sydd yn rhoi o'u hamser am ddim.

Mae gennym aelodau cyfetholedig hefyd sydd yn cael eu recriwtio yn uniongyrchol o gymunedau lleol.

Os oes gennych ddiddordeb mewn dod yn aelod cysylltwch â ni drwy ddefnyddio'r manylion ar ddiwedd yr adroddiad yma (Atodiad 5).

Ein llywodraethiant

Mae'r ffordd yr ydym yn trefnu ein hunain i gyflawni ein gweithgareddau wedi'i nodi yn y rheoliadau a luniwyd gan Gynulliad Cenedlaethol, Cymru. Caiff y gweithgareddau a gyflawnwn eu cydgysylltu a'u goruchwylio gan 3 pwyllgor lleol: Sir Gaerfyrddin, Ceredigion a Sir Benfro. Mae'r pwyllgorau hyn yn llunio ein Cyngor llawn. Mae gennym Bwyllgor Gwaith hefyd sydd yn gyfrifol yn y pendraw am yr hyn a wnawn a sut yr ydym ei wneud.

Ein safonau cenedlaethol

1. **Mae CICau yn gweithio er budd y cyhoedd a chleifion yng Nghymru**

2. **Mae CICau yn gweithio yn effeithiol gydag erall i ddiogelu a hyrwyddo llesiant pobl sydd yn defnyddio gwasanaethau GIG**

3. **Mae gweithgareddau a gwasanaethau CICau yn ateb anghenion pawb, ac maen nhw'n hygyrch i bawb**

4. **Mae gweithgareddau CICau yn agored, yn dryloyw ac yn gynhwysol**

5. **Mae gweithgareddau CICau yn cael eu harwain, eu cefnogi yn gywir, gydag adnoddau cywir**

6. **Mae CICau yn cynllunio ac yn cyflawni eu gweithgaredau mewn ffordd sydd yn cynnal eu hannibyniaeth ac yn dangos eu hatebolrwydd i'r cymunedau y maen nhw'n eu gwasanaethu**

7. **Mae CICau yn cryfhau llais cleifion a'r cyhoedd drwy weithio gyda'i gilydd ac eraill**

8. **Mae CICau yn adlewyrchu barn a phrofiadau cleifion a'r cyhoedd am wasanaethau GIG**

9. **Mae CICau yn rhannu ac yn adrodd ar ganlyniadau eu gweithgareddau mewn dull cytbwys ac amserol**

10. **Mae CICau yn gwerthuso effaith eu gweithrediadau ac yn defnyddio'r hyn a ddysgir ar gyfer gweithgareddau yn y dyfodol**

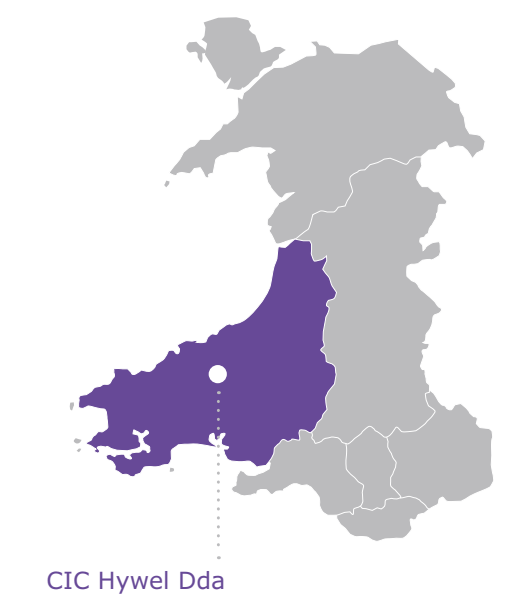
Ein cymunedau

Mae Cyngor Iechyd Cymuned Hywel Dda yn cynrychioli 384,000 o bobl ar draws Sir Gaerfyrddin, Ceredigion a Sir Benfro. Mae cymysgedd o gymunedau trefol a gwledig yn y 3 sir yma ac mae'n cynnwys chwarter y tir yng Nghymru.

Rydym yn gwybod bod cael mynediad i ofal GIG yn enwedig gyda phellter i'w deithio yn rhywbeth y mae llawer o bobl yn ddweud sydd yn anodd iddyn nhw. Gyda chymunedau gwahanol iawn ar draws ardal fawr mae pobl weithiau yn dweud wrthym eu bod yn teimlo dan anfantais o'i gymharu â chymunedau eraill.

Mae gan rai ardaloedd lefelau uwch o angen nag eraill er yn gyffredinol mae iechyd pobl yn Hywel Dda yn well na'r cyfartaledd yng Nghymru. Mae'n debygol y bydd rhagor o bobl angen defnyddio gofal GIG yn y dyfodol oherwydd rhagwelir y bydd y boblogaeth yn tyfu o tua 384,000 o breswylwyr i tua 425,000 yn 2033. Mae gan ardal Hywel Dda hefyd ragor o bobl hŷn nag ardaloedd eraill yng Nghymru, ac felly mae gwasanaethau iechyd yn brysurach yn cefnogi'r bobl hynny sydd angen help ychwanegol wrth iddyn nhw heneiddio.

Dywed Bwrdd Iechyd Hywel Dda wrthym bod pobl yn aml yn byw gyda phroblemau iechyd meddwl a chyflyrau hir dymor fel diabetes, clefyd y galon, clefyd rhwystrol cronig yr ysgyfaint a dementia. Pan fo gan bobl fwy nag un cyflwr iechyd, gall wneud gofal yn gymhleth.



Fel y rhan fwyaf o Gymru, mae gan Hywel Dda ardaloedd lle mae pobl yn llai iach nag eraill. Dengys ystadegau gan Iechyd Cyhoeddus Cymru bod gwahaniaeth rhwng profiad iechyd y rhai gorau eu byd a'r rhai gwaethaf eu byd mewn cymdeithas[1].

[1] http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/3653c00e7bb6259d80256f27004900db/eace59365015b70380257ff8002b1966/$FILE/MeasuringInequalities2016_HywelDdaUHB_v1.docx

Ymgysylltu parhaus

Ymgysylltu gyda chleifion a'r cyhoedd: gweithio gyda CICau ar draws Cymru

Mae'n gyfrifoldeb ar CICau i gynrychioli buddiannau'r cleifion a'r cyhoedd yn yr ardaloedd daearyddol y maen nhw'n eu gwasanaethu.

Yn aml, fe fydd y blaenoriaethau a nodir gan gleifion a'r cyhoedd yn rhai lleol i ardal CIC neilltuol neu hyd yn oed i ysbyty neu wasanaeth penodol. Ond fe fydd themâu a blaenoriaethau sydd yn gyffredin i'r CICau ar draws Cymru.

Pan fo hynny'n digwydd, mae CICau yn cydweithio i sicrhau bod barn a phrofiadau cleifion a'r cyhoedd yn cael eu hadlewyrchu yn lleol ac yn genedlaethol; gan ddarparu llais y claf cryf i ddylanwadu ar ddatblygiad polisi cenedlaethol a darpariaeth lleol.

Mae ein hadroddiadau lleol ar gael ar ein gwefan

www.communityhealthcouncils.org.uk/hyweldda

Sut rydym wedi gwneud gwahaniaeth:
Gweithio yn lleol

Craffu ac ymgysylltu: blaenoriaethau lleol

Yn ystod 2018/2019 fe wnaethom osod blaenoriaethau lleol. Fe fuom yn edrych ar y materion oedd bwysicaf i bobl ac ymateb i bryderon a godwyd drwy ein gweithgareddau a gweithgareddau cyrff eraill. Fe wnaethom ganolbwyntio ein gweithgareddau craffu ac ymgysylltu ar:

- gallu pobl i gael apwyntiadau gyda'u meddyg teulu a'u profiad o hynny, yn enwedig defnyddio systemau brysbennu ffôn gallu pobl i gael apwyntiadau
- gofal i bobl sydd yn byw gyda diabetes
- gallu pobl i gael apwyntiadau gallu pobl i ddefnyddio gwasanaethau yn y gymuned a'u profiadau o hynny e.e. gofal briwiau
- gallu pobl i gael apwyntiadau diagnosio a chefnogi pobl sydd yn byw gyda dementia
- gallu pobl i gael apwyntiadau mynediad pobl i wasanaethau ophthalmoleg a'u profiadau o hynny
- gallu pobl i gael apwyntiadau profiadau plant a phobl ifanc o'u gwasanaethau GIG yn Sir Gaerfyrddin, Ceredigion a Sir Benfro, yn cynnwys gwasanaethau orthodonteg
- gallu pobl i gael apwyntiadau mynediad pobl i ofal arbenigol a'u profiadau o hynny a thriniaeth GIG y tu allan i Sir Gaerfyrddin, Ceredigion a Sir Benfro (yn enwedig gwasanaethau cardiaidd a chanser)
- gallu pobl i gael apwyntiadau cynllunio i adael ysbyty, a'r gefnogaeth sydd ar gael i bobl pan maen nhw'n gadael (yn cynnwys mynediad i wasanaethau therapi)
- gallu pobl i gael apwyntiadau gwella'r ffordd y mae gwasanaethau GIG yn gofyn am adborth gan gleifion ar eu profiad o'r GIG (yn cynnwys cwynion a digwyddiadau) ac yn ymateb i hynny.

Mynychodd ein staff a'n haelodau amrediad eang o gyfarfodydd gyda darparwyr GIG i glywed beth oedd yn cael ei drafod a sicrhau bod barn cleifion a'u teuluoedd bob amser yn cael eu hystyried. Fe wnaethom adolygu a chraffu ar agendâu, papurau a dogfennau i ddeall beth oedd yn digwydd yn yr ardal ac i nodi pa effaith fyddai hyn yn ei gael ar bobl sydd yn defnyddio gwasanaethau GIG. Fe wnaethom ofyn cwestiynau a chodi heriau pan oeddem yn teimlo ei bod yn bwysig cael rhagor o fanylion.

Ymgysylltu gyda chi
Yn 2018/19 mynychodd ein staff a'n haelodau dros 100 o wahanol ddigwyddiadau a chyfarfodydd

gyda'r cyhoedd neu grwpiau lleol. Fe wnaethom siarad gyda nifer o wahanol bobl gan godi ymwybyddiaeth am rôl CICau a dal amrediad o brofiadau a barn gan y rhai y buom yn siarad gyda nhw.
O dderbyn maint a phwysigrwydd ymgynghoriad cyhoeddus 'Trawsnewid Gwasanaethau Clinigol' y Bwrdd Iechyd, roedd cryn dipyn o'n hymgysylltiad gyda'r cyhoedd yn canolbwyntio ar y pwnc yma. Mae crynodeb o'r hyn a wnaethom mewn ymateb i'r ymgynghoriad yma i'w weld ar y dudalen nesaf yn cynnwys dolen i'n dogfen sylwebaeth.

Ymgysylltu gyda myfyrwyr Prifysgol y Drindod Dewi Sant (Caerfyrddin)

Gan adeiladu ar y gwaith a wnaethom ym Mhrifysgol Aberystwyth y llynedd, fe wnaethom holi myfyrwyr ym Mhrifysgol y Drindod Dewi Sant sut y bydden nhw'n mynd ati i chwilio am ofal brys pe bai ei angen.

Roedd y canlyniadau yn galonogol. Roedd y myfyrwyr yn ystyried ac yn dewis fferyllfa a hunanofal am fân anafiadau yn y lle cyntaf. Roedden nhw'n cydnabod y gall fod cyfleoedd yn aml i reoli rhywbeth eu hunain neu gyda chymorth gweithiwr iechyd proffesiynol cyn ystyried galw ambiwlans neu'r angen am ofal ysbyty.

Mewn arolwg tebyg yn 2017, roedd llawer mwy o fyfyrwyr wedi dewis 999 neu adran damweiniau ac achosion brys fel eu dewis cyntaf pan nad oedd hyn efallai bob amser yn ddewis doeth.

Rydym yn parhau i feddwl bod angen gwneud rhagor i godi ymwybyddiaeth am y gwahanol ddewisiadau sydd ar gael i bobl pan maen nhw angen help neu pan maen nhw efallai yn gorfod gwneud penderfyniadau gofal iechyd eu hunain, am y tro cyntaf.

Cyfryngau cymdeithasol

Rydym wedi parhau i ymestyn allan i'r cyhoedd drwy'r cyfryngau cymdeithasol yn 2018-19. Mewn dwy flynedd mae gennym dros fil o ddilynwyr ar ein cyfrif Twitter prysur ac rydym wedi bod yn gwrando ar yr hyn mae'r cyhoedd yn ei ddweud ar Facebook. Rydym yn falch o nodi bod ein cyfathrebu ar y cyfryngau cymdeithasol yn ddwyieithog.

Newidiadau i'ch GIG lleol; "Trawsnewid Gwasanaethau Clinigol"

Drwy gydol haf 2018 cynhaliodd y Bwrdd Iechyd ymgynghoriad cyhoeddus i drafod y newidiadau y mae'n gredu sydd angen eu gwneud i wella gwasanaethau GIG i'r boblogaeth. Gwrandawodd CIC Hywel Dda ar beth ddywedodd pobl yn ystod y cyfnod yma ac ymateb i'r Bwrdd Iechyd yn yr hydref.

Fe wnaethom gyflwyno 18 o argymhellion yn ein dogfen sylwebaeth a gellir eu gweld ar ein gwefan yma:

http://www.wales.nhs.uk/sitesplus/documents/904/TCS%20Commentary%20CHC.pdf

Beth wnaethom ei ddweud? Crynodeb

Fe wnaethom ddweud bod newid yn bwysig, oherwydd ein bod yn gwybod nad ydy pobl bob amser yn cael profiad da wrth ddefnyddio gofal GIG.

Cafwyd amrediad eang o farn o ardaloedd gwahanol.
Fe wnaethom glywed bod nifer o bobl yn bryderus am y newidiadau, yn enwedig pryderon y gallent fod yn rhy bell i ffwrdd oddi wrth help os oedd ei angen ar frys.

Roeddem yn teimlo, tra dylai'r Bwrdd Iechyd barhau i wneud cynlluniau, roedd angen sicrhau bod sylfeini neilltuol yn bodoli (fel meddygfeydd mwy sefydlog a gofal yn y gymuned cryfach) cyn i newidiadau ddigwydd. Fe wnaethom hefyd ddweud bod rhaid i'r Bwrdd Iechyd siarad gyda'r cyhoedd unwaith eto a datblygu rhagor o fanylion cyn ceisio gwneud unrhyw newidiadau mawr (fel newid unedau achosion brys). Cytunodd y Bwrdd Iechyd gyda'n holl argymhellion yn ei gyfarfod Bwrdd ym Medi 2018 ac fe fyddwn yn parhau i graffu'n agos ar y newidiadau yma.

Ymweld

Un o'n rolau statudol pwysicaf ydy mynychu lleoliadau GIG a sgwrsio gyda chleifion sydd yn derbyn gofal (a'u perthnasau) ynghylch eu profiadau. Y newydd da ydy bod y rhan fwyaf o bobl yn gadarnhaol, ond ar adegau rydym yn clywed am bethau allai fod yn well neu am broblemau sydd angen eu trafod gyda'r Bwrdd Iechyd.

Gydag ymgynghoriad cyhoeddus mawr yn haf 2018 fe fu llai o ymweliadau nag yn y blynyddoedd blaenorol oherwydd bod ein gwirfoddolwyr a'n staff mor brysur yn ymgysylltu gyda'r cyhoedd ar y newidiadau mawr oedd yn cael eu cynnig gan y Bwrdd Iechyd. Er hynny, fe aethom i 12 lleoliad ac adrodd ar bob un.

Beth wnaethom ni ei ddarganfod a beth oedd y canlyniad?

Mae cyfathrebu yn thema sydd yn rheolaidd amlwg wrth inni siarad gyda phobl am eu profiadau. Roedd yn fater y buom yn edrych arno yn genedlaethol ond hefyd yn un roedd angen inni ei godi yn rheolaidd wrth ymweld â lleoliadau lleol. Er enghraifft:

- Aethom i glinigau phlebotomi/ gwrth geulo yn Llanelli a darganfod nad oedd cleifion ar warfarin (cyffur teneuo'r gwaed) bob amser yn gwybod digon am eu dogniad. Doedd pobl ddim chwaith yn sicr ynghylch amseroedd agor clinigau. Cytunodd y Bwrdd Iechyd i gymryd camau i wella hyn.

- Pan aethom i ward Cadog yn ysbyty Glangwili a Ward 7 yn Ysbyty Llwynhelyg gwelsom nad oedd rhai cleifion yn gwybod pryd yr oedden nhw'n debygol o adael yr ysbyty neu doedden nhw ddim bob amser yn rhan o drafodaethau cynnar am gynllunio i adael. Mae'r Bwrdd Iechyd wedi ymrwymo i adolygu rowndiau ward i roi mwy o wybodaeth i gleifion ac i'w cynnwys ac mae'n mynd i geisio defnyddio'r offeryn cleifion 'SAFER' i gefnogi hyn.

Gwasanaethau menywod a phlant

Rydym yn parhau i fonitro profiadau pobl sydd yn defnyddio gwasanaethau menywod a phlant (er enghraifft, gofal mamolaeth neu bediatrig) ers y newidiadau i wasanaethau yn ysbytai Llwynhelyg a Glangwili yn 2014.
Tra bod nifer o famau newydd

hapus yn dweud wrthym am brofiadau da, clywsom am rai pryderon.

- Roedd nifer fechan o famau am y tro cyntaf mewn gwewyr esgor yn teimlo'n bryderus a doedden nhw ddim yn teimlo'n sicr bod eu genedigaeth yn mynd yn llyfn os oedd y bydwragedd yn brysur. Mae'r Bwrdd Iechyd wedi adolygu ei ddull gweithredu ac wedi adrodd hyn yn ôl i fforymau staff.

- Fe wnaethom glywed nad oedd cynllunio ar gyfer trafnidiaeth ar draws pellteroedd daearyddol mawr ddim bob amser cystal ag y dylai fod pan oedd y gwewyr esgor yn dechrau. Cytunodd y Bwrdd Iechyd i sicrhau bod bydwragedd cymunedol yn trafod trafnidiaeth a chynlluniau wrth gefn fel bod teuluoedd yn gwybod beth i'w wneud a'r dewisiadau sydd ganddyn nhw.

Gofal Sylfaenol
Gyda meddygfeydd dan bwysau fe aethom ar ymweliad gyda dwy feddygfa eleni i sgwrsio gyda chleifion am eu profiadau. Fel sawl meddygfa, mae Grŵp Meddygol Argyle yn Noc Penro wedi cael trafferth i recriwtio meddygon teulu a gyda rhestr fawr iawn o gleifion, mae'r galw am apwyntiadau yn uchel yno. Fe wnaethom siarad gyda chleifion a darganfod:

- Roedd pobl yn bryderus ac yn rhwystredig ynghylch pa mor anodd mae'n gallu bod i gael apwyntiad. Gan ymateb i'n hadroddiad mae'r Practis wedi ymrwymo i wneud apwyntiadau brys yn haws i'w cael oddi mewn i'w allu cyfyngedig. Mae'n adrodd bod mynediad wedi gwella yn dilyn cau cangen y feddygfa yn St Clements ac ailddosbarthu capasiti meddygon teulu.

Sut rydym wedi gwneud gwahaniaeth:

Ymateb i faterion lleol

Mae'n bwysig pan rydym yn clywed am broblemau mewn gwasanaethau GIG ein bod yn gwneud yr hyn a allwn i wella'r sefyllfa i gleifion a'r cyhoedd.

Grŵp Cefnogi Lwpws Sir Benfro

Cysylltodd grŵp o bobl sydd â'r clefyd Lwpws gyda ni eleni. Mae Lwpws yn salwch system imiwnedd nad oes modd ei wella, a chredir ei fod yn enetaidd ei darddiad gyda menywod yn bennaf yn ei ddioddef. Gall gynhyrchu sawl symptom a gall fod yn anodd ei ddiagnosio. Gall effeithio ar unrhyw ran o'r corff a gall niweidio nifer o'r organau mawr mewn modd di-droi'n-ôl.

Fe aethom i gyfarfod a'r grŵp cefnogi a chlywed amrediad o bryderon a straeon. Un o brif bryderon pobl oedd cael gafael ar y gofal arbenigol angenrheidiol, yn enwedig gan fod y Bwrdd Iechyd wedi bod yn cael trafferth i recriwtio rhewmatolegyddion. Fe wnaethom gysylltu gyda'r Bwrdd Iechyd a chytunodd yr uwch reolwyr i fynychu cyfarfod y grŵp. Ar ôl gwrando ar bryderon pobl cytunwyd i gynnal clinigau ychwanegol i ailasesu gofal ac edrych ar anghenion triniaeth. Bu hyn o gymorth i nifer ac er bod gan nifer yn y grŵp bryderon ynghylch pa mor hygyrch ydy gofal arbenigol i bobl gyda Lwpws, roeddem yn falch o gynorthwyo a byddwn yn parhau i wneud hynny. Os hoffai grwpiau eraill gyda phryderon am eu gofal GIG neu bryderon tebyg gysylltu gyda ni, fe fyddem yn falch o glywed oddi wrthyn nhw (gweler ein manylion cyswllt ar ddiwedd yr adroddiad yma).

Meddygfeydd

Fel sawl ardal arall yn y DU, bu 2018-19 yn flwyddyn arall lle mae meddygfeydd dan bwysau wedi gorfod gwneud newidiadau, mewn rhai achosion cau canghennau neu gau yn gyfan gwbl. Mae hyn wedi creu cryn dipyn o bryder yn y cymunedau a wasanaethir ganddyn nhw. Fel CIC rydym wedi gweithio gyda'r Bwrdd Iechyd i sicrhau bod pob penderfyniad wedi'i wneud yn ofalus a gyda'r cleifion ar y blaen. Yn dilyn cau meddygfa yn Aberteifi ac un arall yn Llandysul, mae dros 10,000 o bobl wedi gorfod symud at feddyg teulu arall. Fe wnaethom adolygu cyfathrebu gyda'r cyhoedd i sicrhau ei fod yn eglur a gofyn i'r Bwrdd Iechyd gynnal digwyddiadau cyhoeddus i drafod y newidiadau ac

i glywed gan y rhai oedd yn cael "ei" heffeithio. Roedd nifer dda yn y cyfarfodydd hynny.
Rydym yn teimlo bod angen i feddygfeydd ar draws Hywel Dda fod yn sefydlog ac yn gynaliadwy wrth i'r Bwrdd Iechyd geisio rhoi rhagor o ofal GIG mewn lleoliadau cymunedol. Fe fyddwn yn parhau i edrych ar y gofal sydd ar gael i bobl unigol sydd yn defnyddio eu meddygon teulu yn ogystal ag edrych ar y darlun strategol wrth i'r Bwrdd Iechyd wneud a gweithredu ei gynlluniau.

Sut rydym wedi gwneud gwahaniaeth:

Gweithio yn genedlaethol

Gan gydweithio, mae CICau yn amlygu materion sydd, neu a fydd yn effeithio ar brofiadau pobl ar draws Cymru. Rydym yn tynnu oddi ar ein gwybodaeth leol i lunio'r agenda cenedlaethol ac i herio llunwyr polisi a'r rhai sydd yn darparu ein gwasanaethau i wneud yn well.

Rydym yn gwneud mwy na chynnig ymatebion ar faterion sydd yn cael eu codi gan eraill; rydym yn gosod yr achos dros newid ar y materion hynny sydd yn cyfrif fwyaf i gleifion a'r cyhoedd; yn disgrifio lle mae angen gwelliannau a dal y GIG yng Nghymru i gyfrif ar ei berfformiad.

Gan gydweithio, mae CICau yn amlygu materion sydd, neu a fydd yn effeithio ar brofiadau pobl ar draws Cymru. Rydym yn tynnu oddi ar ein gwybodaeth leol i lunio'r agenda cenedlaethol ac i herio llunwyr polisi a'r rhai sydd yn darparu ein gwasanaethau i wneud yn well.
Rydym yn gwneud mwy na chynnig ymatebion ar faterion sydd yn cael eu codi gan eraill; rydym yn gosod yr achos dros newid ar y materion hynny sydd yn cyfrif fwyaf i gleifion a'r cyhoedd; yn disgrifio lle mae angen gwelliannau a dal y GIG yng Nghymru i gyfrif ar ei berfformiad.
Gan weithio drwy Fwrdd Cynghorau Iechyd Cymuned yng Nghymru, yn 2017-2018 fe fu'r 7 CIC yng Nghymru yn gweithio ar 4 prosiect cenedlaethol. Roeddem eisiau clywed beth oedd gan bobl ar draws Cymru i'w ddweud am y GIG mewn rhai meysydd allweddol:

- Cyfathrebu yn y GIG yng Nghymru
- Gwasanaethau meddygon teulu allan o oriau
- Effaith oedi wrth adael ysbyty
- Gwasanaethau awtistiaeth

Cadwodd y CICau lygad manwl hefyd ar y cynnydd a wnaethwyd mewn ymateb i'r prosiectau a gyflawnwyd y flwyddyn flaenorol.

Un peth syml: cyfathrebu yn y GIG yng Nghymru

Drwy gydol yr haf holodd CICau bobl ar draws Cymru am eu profiadau o gyfathrebu GIG, y da a'r drwg, ac i roi eu hawgrymiadau inni ar sut y gellid ei gwella.

Derbyniwyd dros 1,300 o ymatebion. Tra bod profiad pawb yn wahanol, gwelwyd bod sawl thema gyffredin.

Dywedodd pobl wrthym bod cyfathrebu da yn gwneud amseroedd anodd yn ddioddefiadwy, yn helpu i adeiladu

ymddiriedaeth yn y GIG ac yn gwneud i bobl deimlo'n ddiogel. Ar y llaw arall, fe wnaethom hefyd glywed am sut y mae cyfathrebu gwael neu ddiffyg cyfathrebu yn gwneud i bobl deimlo'n rhwystredig ac yn ofnus. Doedd pobl ddim bob amser yn teimlo bod ganddyn nhw unrhyw lais na rheolaeth dros eu iechyd a'u gofal ac nad oedd hi'n hawdd lleisio eu pryderon.

Cafwyd sawl enghraifft lle roedd pobl wedi ceisio ac wedi methu darganfod yr wybodaeth roedden nhw ei hangen i gael mynediad i wasanaethau GIG neu i ofalu amdanyn nhw eu hunain.

Fe wnaethom ddweud bod rhaid i wella cyfathrebu fod wrth galon y newidiadau y mae angen i'r GIG eu gwneud. Fe wnaethom herio Llywodraeth Cymru a'r GIG i wella cyfathrebu yn gyflymach ac yn well na'r hyn sdd wedi cael ei wneud hyd yn hyn.

Dywedodd Llywodraeth Cymru wrthym am y datblygiadau sydd ar y gweill ac sydd wrthi'n cael eu cynllunio yn y GIG i ddarparu gofal gwell. Nododd ei disgwyliadau bod y bobl sydd yn arwain y datblygiadau yma yn cymryd sylw o'r adborth o'n hadroddiad ac yn cyflwyno gwasanaethau newydd a gwell dulliau o gyfathrebu ar draws iechyd a gofal cymdeithasol.

Awtistiaeth

Yn ystod 2018, fe wnaethom fynychu 2 sioe Awtistiaeth yng ngogledd a de Cymru. Fe wnaethom hefyd annog pobl i rannu eu barn a'u profiadau drwy'r cyfryngau cymdeithasol a thrwy 'ap'.

Fe wnaethom ofyn i bobl a oedd y GIG yn ateb anghenion pobl gydag awtistiaeth. Fe wnaethom ofyn i bobl ddweud wrthym beth oedd yn dda a beth allai fod yn well.

Fe wnaethom glywed bod y GIG, pan mae'n gweithio'n dda, yn darparu chefnogaeth mawr ei angen i bobl a theuluoedd sydd yn byw gydag awtistiaeth.

Fe wnaethom hefyd glywed am y nifer o anawsterau mae pobl yn eu wynebu. Dywedodd pobl wrthym, er eu bod yn gwerthfawrogi gwaith caled y staff sydd yn darparu gofal GIG, eu bod yn teimlo bod y 'system' yn eu siomi. Roedd hyn yn gwneud i bobl deimlon bryderus, yn rhwystredig ac yn fregus.

Mae angen i'r GIG yng Nghymru wneud cynnydd real a chynaliadwy o ran delio gyda'r materion allweddol a godwyd gan bobl a theuluoedd sydd yn byw gydag awtistiaeth. Felly fe wnaethom ddefnyddio'r wybodaeth yr oedd pobl wedi'i rhannu gyda ni i ymateb i ymgynghoriad Llywodraeth Cymru ar god ymarfer ar ddarparu gwasanaethau [1].

Gwasanaeth allan o oriau meddygon teulu

Icynyddodd yr heriau mewn darpariaeth allan o oriau. Fe wnaethom ymateb i'r problemau oedd yn cael effaith ar draws Cymru drwy gynnal adolygiad pen desg byr. Fe wnaethom gyhoeddi ein hadroddiad ym Mai 2018.
Fe wnaethom ddarganfod bod pob bwrdd iechyd wedi nodi natur fregus gwasanaethau allan o oriau ac wedi creu amrediad o gamau lliniaru oedd wedi gwneud fawr o wahaniaeth ac mewn rhai achosion gyda'r potensial i effeithio'n negyddol ar wasanaethau eraill.
Fe wnaethom ofyn i'r byrddau iechyd gydweithio i sicrhau dull o weithredu Cymru gyfan i ddatblygu gwasanaethau er mwyn sicrhau nad ydy'r camau a gymerir i wella cynaliadwyedd allan o oriau meddygon teulu yn cael effaith negyddol ar feysydd neu wasanaethau eraill.
Yn Hywel Dda ymatebodd y Bwrdd Iechyd a dweud y byddai yn:

- Gweithio gyda'r CIC i ddeall beth oedd pobl yn ei feddwl am arolwg boddhad cleifion allan o oriau
- Hysbysebu am Uwch Ymarferwyr Parameddygol yn y gwasanaeth
- Lledaenu'r gwasanaeth 111 ar draws Ceredigion a Sir Benfro ar ôl y gwasanaeth peilot yn Sir Gaerfyrddin

Amser mynd adref?

Yn ystod 2017-2018 fe wnaeth CICau glywed fwyfwy am yr heriau mewn darpariaeth gofal cymdeithasol ac effaith hynny ar allu pobl i adael ysbyty pan mae'n nhw'n ddigon da.
Felly yn gynnar yn 2019 fe wnaeth CICau ofyn i bobl oedd wedi cael profiad o fod mewn ysbyty yn hirach nag angen i rannu gyda ni sut roedd hyn wedi effeithio arnyn nhw neu ar y rhai roedden nhw'n gofalu amdanyn nhw. Fe wnaeth CICau hyn drwy holi pobl mewn digwyddiadau, ar-lein ac ar y cyfryngau cymdeithasol, a thrwy ymweld â wardiau ysbyty i glywed yn uniongyrchol oddi wrth bobl.
Fe fyddwn yn adrodd ar yr hyn ddywedodd pobl wrthym yn nes ymlaen eleni.

Eiriolaeth ac ymholiadau

Darparodd CIC Hywel Dda gefnogaeth a chyngor eiriolaeth cwynion annibynnol i unrhyw un oedd yn byw yn eu hardal oedd angen help i godi pryder am wasanaethau GIG lle bynnag roedden nhw'n cael eu darparu.

Fe wnaethom gynorthwyo dros 400 o bobl i ddatrys pryderon drwy gynnig cyngor cychwynnol, cyfeirio neu gefnogi pobl i ddatrys materion yn anffurfiol gan nad ydy pobl eisiau gwneud cwynion ffurfiol weithiau.

Fe wnaethom hefyd gynnig cefnogaeth a chyngor drwy Weithdrefn Pryderon y GIG o'r enw Gweithio i Wella. Fe wnaethom agor 128 o achosion newydd yn cynnig y gefnogaeth yma.

Mae pob pryder yn wahanol ac roedd pobl eisiau ac angen gwahanol lefelau o gefnogaeth i fynd ymlaen gyda'u pryder. Gall pryderon hefyd gymryd gwahanol hyd o amser i ddelio gyda nhw a gall rhai fod yn fwy cymhleth, yn enwedig os oes sawl corff neu adran yn rhan o'r broses.

Fe wnaethom helpu drwy esbonio'r broses pryderon a helpu pobl i feddwl am beth roedden nhw eisiau a beth roedden nhw'n ddisgwyl fyddai'n digwydd o ganlyniad i godi eu pryder.

Fe wnaethom ddarparu cefnogaeth ymarferol i'r rhai oedd ei eisiau, yn cynnwys helpu pobl i ysgrifennu llythyrau, mynd gyda nhw i gyfarfodydd, helpu pobl i ddeall yr wybodaeth a'r ymateb a ddarparwyd gan gyrff GIG.

Mae eiriolaeth yn rhan annatod o swyddogaethau craidd CICau. Darparodd ein gwaith achos wybodaeth bwysig am wasanaethau a materion GIG ac fe wnaethom ddefnyddio hyn i lywio ein gweithgareddau eraill. Lle roedd sawl cwyn yn nodi lleoliadau neu faterion tebyg, gellid defnyddio'r rhain i lywio ein gweithgareddau ymweld er mwyn inni allu clywed gan eraill mewn sefyllfaoedd tebyg.

O ganlyniad i bryderon a godwyd gan gleientiaid, caiff newidiadau yn aml eu gwneud sydd â budd ehangach. Mae rhai enghreifftiau o'r flwyddyn yn cynnwys:

- Mewn un achos, nodwyd bod person oedd yn derbyn llawdriniaeth wedi profi oedi amhriodol mewn derbyn y

meddyginiaeth angenrheidiol ar gyfer ei gyflwr iechyd meddwl. Roedd y Bwrdd Iechyd yn cydnabod hyn yn ei ymchwiliad a threfnwyd bod staff y ward yn mynychu hyfforddiant Iechyd Meddwl ychwanegol fel na fyddai hyn yn digwydd eto.

- Fel rhan o gwyn arall, nodwyd bod claf oedrannus wedi syrthio ar ward ac na wnaethwyd unrhyw asesiad risg cwympiadau pan gafodd ei dderbyn nac unrhyw ailasesiad wedi hynny. Mae hyfforddiant pellach wedi'i drefnu ac mae rhaglen gwelliant cwympiadau wedi'i chyflwyno ac mae gwaith ar y gweill hefyd mewn perthynas â chyflwyno llwybr deliriwm.

- Sbardunodd cwyn yn ymwneud â meddygfa ymchwiliad manwl. Esgorodd hyn ar newid yn y system apwyntiadau fel cleifion oedd yn methu cael apwyntiad neu alwad i'r cartref yn parhau i allu cael cysylltiad amserol gyda gweithiwr iechyd proffesiynol priodol. Mae hyn wedi'i gwneud yn bosibl hefyd i sicrhau bod rhagor o apwyntiadau brys ar gael ar y diwrnod yn ogystal â system galw'n ôl.

- Mewn meddygfa arall, amlygodd cwyn y ffaith nad oedd pobl oedd wedi derbyn diagnosis o ganser yn teimlo eu bod yn derbyn cefnogaeth ac nad oedden nhw'n gwybod at bwy i droi. O ganlyniad i'r gwyn, mae'r feddygfa wedi nodi gwell ffordd o helpu pobl pan maen nhw'n gorfod delio gyda diagnosis o ganser fel bod gwybodaeth a chefnogaeth ar gael.

Gweithio gydag eraill

Yn ystod y flwyddyn fe wnaethom gynnal rhai o'n gweithgareddau gydag eraill;

Arolygiaeth Gofal Iechyd Cymru (AGIC)

Fe wnaethom gyfathrebu gyda AGIC yn rheolaidd i lywio ein rhaglen waith. Fe wnaethom gyfeirio unrhyw bryderon clinigol at AGIC fel bo angen. Fe wnaethom rannu gwybodeth o'n hadroddiadau ymweliadau gyda nhw i sicrhau bod yr hyn roedd pobl wedi'i ddweud wrthym yn cael ei glywed yn eang.

Ombwdsmon Gwasanaethau Cyhoeddus Cymru

Fe wnaethom gyfathrebu'n rheolaidd gyda staff yr Ombwdsmon i drafod sut roedd pryderon yn cael eu trafod gan y GIG a chynnig awgrymiadau ar sut y gellid gwneud gwelliannau.

Swyddfa Archwilio Cymru

Wrth iddo gynnal ei asesiad rheolaidd o'r Bwrdd Iechyd fe wnaethom gyfarfod cynrychiolydd o Swyddfa Archwilio Cymru i roi ein barn fel corff llais y claf ynglŷn â sut roedd y Bwrdd Iechyd yn perfformio.

Cymunedau Tref a Chymuned

Roeddem yn falch o gael mynychu sawl cyfarfod o Gynghorau Tref a Chymuned eleni. Rydym yn gwerthfawrogi bod cynghorwyr yn adnabod eu cymunedau a'r bobl sydd yn byw ynddyn nhw yn dda. Gan ganolbwyntio'n arbennig ar gynigion y Bwrdd Iechyd i newid gwasanaethau, roeddem eisiau codi ymwybyddiaeth o'r ymgynghoriad cyhoeddus a'n rôl mewn cynrychioli'r cyhoedd.

Aelodau Cynulliad ac Aelodau Seneddol

Yn yr un modd, roeddem eisiau cyfarfod ACau ac ASau i drafod yr ymgynghoriad cyhoeddus tra'n rhannu unrhyw faterion a phryderon roedden nhw'n eu clywed drwy gysylltiad gyda'r bobl maen nhw'n eu cynrychioli. Ein nod ydy parhau i gynnal cyfarfodydd yn rheolaidd gydag ACau ac ASau yn y flwyddyn sydd i ddod.

Ein cynlluniau ar gyfer y flwyddyn nesaf

Fe fyddwn yn ymateb i flaenoriaethau lleol a nodir gan gleifion a'r cyhoedd ac a dynnir o'n gweithgareddau ein hunain. Fe fydd hyn yn cynnwys:

Cyfathrebu a gwybodaeth

- Am wasanaethau GIG
- Gyda chleifion, gofalwyr a theuluoedd
- Ar draws llwybrau gofal
- Mewn cymunedau a gyda grwpiau neilltuol

Datblygiadau a newidiadau i wasanaethau

- Canolbarth a Gorllewin Cymru iachach
- Menywod a Phlant

Trawsnewid gwasanaethau Iechyd Meddwl

Gwasanaethau gofal sylfaenol

Gwasanaethau rhanbarthol (i gynnwys trawma mawr)

Mynediad amserol i wasanaethau iechyd a gofal

- Mynediad i wasanaethau meddygon teulu,
- Oedi Wrth drosglwyddo gofal
- Mynediad i Awdioleg yn cynnwys gofal sylfaenol
- Orthodonteg i gynnwys mynediad

Gwrando ac ymgysylltu gyda phobl leol

- Codi ymwybyddiaeth o'n rôl
- Casglu barn a phrofiadau mewn amrywiol ffyrdd ac mewn partneriaeth gydag eraill
- Defnyddio'r hyn rydym yn ei glywed i lywio a dylanwadu ar brosesau gwneud penderfyniadau'r GIG
- Arddangos ein heffaith

Yn ystod 2019/2020 fe fyddwn

yn gweithio gyda CICau ar draws Cymru i edrych ar y materion sydd yn effeithio ar bobl lle bynnag yng Nghymru maen nhw'n byw, yn cynnwys:

- Cynaliadwyedd meddygon teulu
- Llwybrau canser
- Ophthalmoleg
- Iechyd Meddwl
- Orthodonteg

Newid i wasanaethau GIG

Fel y nodwyd yn ein crynodeb o gynlluniau, fe fyddwn yn gweithio'n galed i sicrhau bod llais cleifion a'r cyhoedd yn cael ei glywed wrth i'r Bwrdd Iechyd geisio gweithredu cynlluniau neu ymgysylltu ymhellach ar ei strategaeth clinigol "Canolbarth a Gorllewin Cymru Iachach". Gyda nifer o newidiadau potensial fe fyddwn yn parhau i fod yn brysur iawn yn siarad ac yn gwrando ar y cyhoedd ar draws y 3 sir, yn cynnwys amrediad o faterion GIG lleol.

Dolen i'r Cynllun Gweithrediadol

http://www.wales.nhs.uk/sitesplus/documents/904/Hywel%20Dda%20CHC%20FINAL%20operational%20plan%202019-20201.pdf

Rydym yn gwrando arnoch chi

Eich profiadau

Gallwch ein helpu drwy ddweud wrthym am eich profiadau o'r GIG, rydym eisiau clywed eich barn ar y gwasanaethau yn eich ardal.

Gallwch rannu eich barn a'ch profiadau gyda ni drwy unrhyw un o'r dulliau canlynol:

- Drwy ffonio ein swyddfa
- Drwy ysgrifennu atom
- Drwy e-bost
- Drwy fynd i'n gwefan
- Twitter
- Facebook

Rydym yn aml yn gofyn am farn ar agweddau neilltuol o'r gwasanaethau iechyd drwy arolygon ar-lein y gellir eu gweld ar ein gwefan.

Rhoi gwybodaeth i chi

Rydym yn cynnal ein cyfarfodydd pwyllgor yn gyhoeddus a gallwch ddarganfod pryd rydym yn cyfarfod nesaf yn eich ardal ar ein gwefan.

Mae llawer rhagor o wybodaeth am ein gweithgareddau ar ein gwefan hefyd.

Os hoffech ddod i'n gweld i drafod ein gweithgareddau neu i rannu eich barn a'ch profiadau rhowch wybod inni os gwelwch yn dda.

Dod yn aelod o CIC

Os oes gennych ddiddordeb mewn dod yn aelod o CIC, cysylltwch gyda ni os gwelwch yn dda.

Mae ein manylion cyswllt ar gael ar ddiwedd yr adroddiad.

Atodiadau

Atodiad 1 – datganiad ariannol

Costau sefydlog

	Cyllideb Flynyddol	Gwariant i 31 Mawrth	Amrywiad
Cyflogau staff	349,687.00	343,035.87	6,651.13
Costau swyddfa	6,349.00	6,414.83	-65.83
Costau llety	37,851.00	39,566.25	-1715.25
Cyfanswm (sefydlog)	393,887.00	389,016.95	4,870.05

Costau amrywiol

	Cyllideb Flynyddol	Gwariant i 31 Mawrth	Amrywiad
Costau teithio a chostau cysylltiedig	19,000.00	20,440.50	-1,440.50
Costau swyddfa	11,626.00	19,100.49	-7,474.79
Costau llety	4,700.00	4,550.63	149.37
Cyfanswm (amrywiol)	35,326.00	44,091.62	-8,765.62
Cyfanswm (sefydlog ac amrywiol)	429,213.00	433,108.57	-3,895.57
Addasiad i'r gyllideb y cytunwyd arno gan Fwrdd CICau	3,900.00	-	3,900.00
Cyfanswm (sefydlog ac amrywiol)	433,113.00	433,108.57	4.43

Atodiad 2 – datganiad buddiannau'r aelodau gweithredol

Cyhoeddir cyfarwyddiaethau cwmnïau neu safleoedd mewn cyrff eraill aelodau'r pwyllgor gwaith sydd yn debygol, neu o bosibl yn ceisio gwneud busnes gyda'r GIG yn Adroddiad Blynyddol y Cyngor i Weinidogion Cymru, fel ag sydd yn ofynnol dan Reoliad 25 o Reoliadau CIC 2015.

Enw	Safle yn CIC	Cyfarwydd-iaethau	Safleoedd eraill o awdurdod
Alun Williams	Is Gadeirydd lleoliad Ceredigion		Aelod Cabinet – Gwasanaethau Cymdeithasol Oedolion – Cyngor Sir Ceredigion
Dr John Morgan	Cadeirydd lleoliad Ceredigion		Cadeirydd Bwrdd Ymddiriedolwyr – Newlink Cymru Cadeirydd Cymdeithas Tai Hafan Cymru, Ymddiriedolwr a Thrysorydd Elusen Seren Aelod ac Ysgrifennydd Cyffredinol – Plaid Werdd Cymru
Ken Jones	Is Gadeirydd Lleoliad Sir Gaerfyrddin	Dim	Aelod o Gyngor Gofal Cymru; Grŵp Cyfeirio Rhanddeiliaid, BIPHD; Aelod SRG o Bwyllgor Sicrwydd Perfformiad Cynllunio Busnes, BIPHD; Is Gadeirydd Fforwm Gofal Caerfyrddin

Atodiad 3 – aelodau cic hywel dda 2018/2019

Enw	Safle yn CIC	Lleoliad
Cyng Ann Davies	Aelod Awdurdod Lleol	Sir Gaerfyrddin
Cyng Ken Lloyd	Aelod Awdurdod Lleol	Sir Gaerfyrddin
Ken Jones	Aelod 3ydd sector	**Sir Gaerfyrddin**
Barry Williams	Aelod 3ydd sector	Sir Gaerfyrddin
Maureen Webley	Aelod 3ydd sector	Sir Gaerfyrddin
Mansell Bennett	Penodai Llywodraeth Cymru	Sir Gaerfyrddin
Dr Pauline Griffiths	Penodai Llywodraeth Cymru	Sir Gaerfyrddin
Patricia Neil	Penodai Llywodraeth Cymru	Sir Gaerfyrddin
Paul Mason	Penodai Llywodraeth Cymru	Sir Gaerfyrddin
Ian Phillips	Penodai Llywodraeth Cymru	Sir Gaerfyrddin
Frederick Burton	Aelod cyfetholedig	**Sir Gaerfyrddin**
Andrew Davies	Aelod cyfetholedig	Sir Gaerfyrddin
Iris John	Aelod cyfetholedig	Sir Gaerfyrddin
Christine Clark	Aelod cyfetholedig	Sir Gaerfyrddin

Cyng Alun Williams	Aelod Awdurdod Lleol	Ceredigion
Cyng Lyndon Lloyd	Aelod Awdurdod Lleol	Ceredigion
Cyng Elizabeth Evans	Aelod Awdurdod Lleol	Ceredigion
Maria Emptage	Aelod cyfetholedig	Ceredigion
Dr Gabrielle Heathcote	Aelod cyfetholedig	Ceredigion
Dylan Lewis	Aelod cyfetholedig	Ceredigion
David Thomson	Aelod cyfetholedig	Ceredigion
Dr John Morgan	Aelod 3ydd sector (wedi ymddiswyddo)	Ceredigion
Pat Bates	Aelod 3ydd sector	Ceredigion
Marjorie Fogg	Aelod 3ydd sector	Ceredigion
Gwenda Williams	Penodai Llywodraeth Cymru	Ceredigion
Jarrod Thomas	Penodai Llywodraeth Cymru	Ceredigion
Carol Bainbridge	Penodai Llywodraeth Cymru	Ceredigion
Diane Richards	Penodai Llywodraeth Cymru	Ceredigion
Cyng Steve Yelland	Aelod Awdurdod Lleol	Sir Benfro
Cyng David Bryan	Aelod Awdurdod Lleol	Sir Benfro
Cyng Ken Rowlands	Aelod Awdurdod Lleol	Sir Benfro
Raymond Hine	Aelod Awdurdod Lleol	Sir Benfro
Christopher Jones	Penodai Llywodraeth Cymru	Sir Benfro

Lindsay Moran	Penodai Llywodraeth Cymru	Sir Benfro
Pamela Parsons	Penodai Llywodraeth Cymru	Sir Benfro
Abi Thomas	Penodai Llywodraeth Cymru (wedi ymddiswyddo 30 Ebrill 2018)	Sir Benfro
John Harvey	Penodai Llywodraeth Cymru	Sir Benfro
Wynne Evans	Aelod Cyfetholedig (Ymddeol 24 Ebrill 2019)	Sir Benfro

Atodiad 4 – cynrychiolaeth allanol 2018/19

Enw'r Pwyllgor/Grŵp	Cynrychiolydd
Bwrdd Iechyd Prifysgol Hywel Dda	Cadeirydd & Prif Swyddog
Bwrdd CICau	Cadeirydd
Canolfan Gofal Integredig Aberaeron	David Thomson
Pwyllgor Sicrwydd Perfformiad a Chynllunio Busnes	Dirprwy Brif Swyddog
Pwyllgor Cyfathrebu ac Ymgysylltu Gofal Integredig Aberteifi	Pamela Parsons
Pwyllgor Rhanddeiliaid Gofal Integredig Aberteifi	Maureen Webley Pamela Parsons
Bwrdd prosiect CDU/ Ward 10	Dirprwy Brif Swyddog
Canolfan Iechyd Cross Hands	Pat Neil
Cylch Caron	Swyddog YCC
Grŵp Llywio Dementia	Maureen Webley
Is bwyllgor Gwella Profiad	Dirprwy Brif Swyddog
PPG Cydweli	Pat Neil
Bwrdd Prosiect Cydweli	Dirprwy Brif Swyddog
Datblygiad Pwll Hydrotherapi Llanelli	Christine Clarke Andrew Davies
Llesiant Llanelli	Ken Jones

Grŵp Monitro'r Deddf Iechyd Meddwl	Ken Jones
Grŵp Gweithredu Iechyd Meddwl	Carol Bainbridge
Grŵp Partneriaeth Iechyd Meddwl	Prif Swyddog/Dirprwy Brif Swyddog
Cydweithrediaeth Gofal Iechyd Canolbarth Cymru	Gabrielle Heathcote
Grŵp Gorchwyl a Gorffen Pediatrig	Dirprwy Brif Swyddog
Mamolaeth Cam 2	Mansell Bennett
Pwyllgor Ceisiadau Gofal Sylfaenol	Dirprwy Brif Swyddog
Is bwyllgor gofal sylfaenol	Dirprwy Brif Swyddog
Ansawdd a Diogelwch	Mansell Bennett & Prif Swyddog
Grŵp monitro RCPCH	Dirprwy Brif Swyddog
Canolfan Galw Heibio Dinbych y Pysgod	Wynne Evans
Cyfarfod Cydweithredol Gofal heb ei Drefnu	Pat Neil Dirprwy Brif Swyddog
Grŵp Rhanddeiliaid Ward 10 / CDU	Ray Hine

Atodiad 5 – staff cic a manylion cyswllt

Cefnogir aelodau CIC yn eu gwaith gan dîm o staff ffyddlon, sydd wedi'u lleoli yn swyddfeydd CIC yng Nghaerfyrddn, Ceredigion a Sir Benfro:

Enw	Rôl	Oriau yr wythnos
Gwen Clements	Swyddog ymweld ac ymgysylltu (YCC)	22.5
Sam Dentten	Prif Swyddog Dros Dro / Dirprwy Brif Swyddog	18.75 18.75
Donna Coleman	Dirprwy Brif Swyddog / Eiriolydd Cwynion	37.5
Sadie Davies	Swyddog Gweinyddol	37.5
Sarah Knight	Swyddog Gweinyddol / Swyddog Cefnogi Eiriolaeth	30
Pauline Marr	Swyddog Gweinyddol / Swyddog Cefnogi Eiriolaeth	37.5
Kerry Pearson	Swyddog Gweinyddol / Swyddog Cefnogi Eiriolaeth	26
Tracey Setterfield	Swyddog Gweinyddol / Swyddog Cefnogi Eiriolaeth/Rheolwraig Busnes	37.5
John Stretton	Eiriolydd Cwynion	18.75
Alyson Thomas	Prif Swyddog (tan 30 Hydref 2018)	18.75
Helen Williams	Dirprwy Brif Swyddog / Rheolwraig Busnes	37.5

Cysylltu â ni

Post:	**Adeilad Llywodraeth Cymru** **Rhodfa Padarn** **Llanbadarn Fawr** **Aberystwyth** **Ceredigion** **SY23 3UR**
Ffôn:	**01646 697610**
Post:	**Swyddfa Aberdaugleddau** **Ystafell 18 Cedar Court** **Parc Busnes Havens Head Aberdaugleddau** **Sir Benfro** **SA73 3LS**
Ffôn:	**01646 697610**
Post:	**Swyddfa Caerfyrddin** **Ystafell 5, Ty Myrddin** **Heol yr Hen Orsaf** **Caerfyrddin** **SA31 1BT**
Ffôn:	**01646 697610**
E-bost:	**hyweldda@waleschc.org.uk**
Gwefan:	**www.communityhealthcouncils.org.uk/hyweldda**
Trydar:	**@CICHywelDda**

Fformatau hygyrch

Os hoffech y cyhoeddiad hwn mewn fformat ac/neu iaith amgen, cysylltwch gyda ni os gwelwch yn dda. Gallwch ei lawrlwytho o'n gwefan neu archebu copi drwy gysylltu gyda'n swydda (manylion cyswllt uchod).

HYWEL DDA UNIVERSITY HEALTH BOARD – WORK PLAN MARCH 2019 – MARCH 2020

The Board meets in public bi-monthly. The following table sets out the Board's business for 2019/20, including standing agenda items (denoted by *); items denoted by ** are those that are reported to the Board as and when required.

AGENDA ITEM/ ISSUE	LEAD	OFFICER	28 Mar 2019	29 May 2019	30 May 2019	25 Jul 2019	26 Sep 2019	28 Nov 2019	30 Jan 2020	26 Mar 2020
GOVERNANCE										
Public Forum Questions*	**Chair**	**JW**	✓		✓	✓	✓	✓	✓	✓
Patient/Staff Story *	**MR**	**LO'C**	✓		✓	✓	✓	✓	✓	✓
Apologies*	**Chair**	**CM**	✓	✓	✓	✓	✓	✓	✓	✓
Declaration of Interests*	**Chair**	**All**	✓	✓	✓	✓	✓	✓	✓	✓
Minutes from previous meeting*	**Chair**	**CM**	✓		✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions*	**Chair**	**CM**	✓		✓	✓	✓	✓	✓	✓
Report of the Chair* • Thoracic Surgery • Chair's Action	**Chair**	**JW**	✓		✓	✓	✓ ✓	✓	✓	✓
Report of the Chief Executive* • Register of Sealings • Consultations Update • Brexit • Apprenticeship Update • Thoracic Surgery • Major Trauma • Health & Care Strategy • Llanelli Wellness Village • QI Framework • Paediatric Care Task & Finish Group – Progress Update	**SM**	**SMJ**	✓ ✓ ✓ ✓		✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓	✓

AGENDA ITEM/ ISSUE	LEAD	OFFICER	28 Mar 2019	29 May 2019	30 May 2019	25 Jul 2019	26 Sep 2019	28 Nov 2019	30 Jan 2020	26 Mar 2020
Committee Annual Reports • Audit & Risk Assurance Committee • Business Planning & Performance Assurance Committee • Charitable Funds Committee • Finance Committee • Mental Health Legislation Assurance Committee • Primary Care Applications Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	**Chairs**	**Lead Execs JW**		✓		✓ MHLAC				
Governance, Leadership & Accountability Standard	**SM**	**JW**		✓						
Annual Governance Statement	**SM**	**JW**		✓						
Accountability Report	**SM**	**JW**		✓						
Final Accounts for 2018/19	**HT**	**HT**		✓						
Letter of Representation	**HT**	**HT**		✓						
Wales Audit Office ISA 260	**WAO**	**HT**		✓						
Approval of Charitable Funds Annual Report & Accounts	**SJ**	**NLI**		✓						
HDdUHB Annual Quality Statement	**MR**	**SM**		✓						
HDdUHB Annual Report 2018/19	**Chair**	**SJ**				✓				
Minutes from Annual General Meeting	**Chair**	**CM**					✓			
WAO Annual Audit Report	**WAO**	**JW**							✓	
WAO Structured Assessment	**WAO**	**JW**							✓	
Standing Orders/Standing Financial Instructions	**SM**	**JW**			✓		✓	✓		

AGENDA ITEM/ ISSUE	LEAD	OFFICER	28 Mar 2019	29 May 2019	30 May 2019	25 Jul 2019	26 Sep 2019	28 Nov 2019	30 Jan 2020	26 Mar 2020
International Health Partnerships Governance Framework	**RJ**	**RF**							✓	
Committee Terms of Reference	**SM**	**JW**	✓ ARAC BPPAC QSEAC SRG		✓ CFC Fin C PCAC HPF	✓ RTSC HCSDG	✓ SRG		✓ UPB MHLAC SPF	
STRATEGIC ISSUES/FOR DECISION										
Ceredigion Community Equipment Services: Section 33 Agreement	**SJ**	**SMJ**			✓					
Annual & Financial Plan 2019/20	**KM/HT**		✓							✓
Transforming Clinical Services/ Future Health & Care Strategy: A Healthier Mid and West Wales	**PK/RJ**	**PK/RJ**	✓		✓	✓	✓	✓	✓	✓
Bronglais General Hospital (BGH) Strategy	**PK**					✓		✓		
Strengthening Regional Partnership Board Governance	**SJ**		✓							
Pathology Strategic Outline Case	**KM**		✓							
Implementing the Welsh Language Standards	**SJ**		✓							
Thoracic Surgery Consultation	**SM**				✓					
Pooled Budgets/Funding Arrangements	**JP/SJ**				✓					
Major Trauma Network	**SM/KM**				✓		✓	✓		
Sexual Assault Referral Centre (SARC)	**SM**						✓			
Bronglais Chemotherapy Day Unit Capital Scheme	**JT**	**PS**					✓			
Inpatient Malnutrition Business Care	**AS**						✓			
HDdUHB Major Incident Plan 2019/20	**RJ**	**SH**					✓			

AGENDA ITEM/ ISSUE	LEAD	OFFICER	28 Mar 2019	29 May 2019	30 May 2019	25 Jul 2019	26 Sep 2019	28 Nov 2019	30 Jan 2020	26 Mar 2020
HDdUHB Seasonal Influenza Plan 2019/20	**RJ**						✓			
Strategic Equality Plan Annual Report 2018/19	**SJ**	**JH**					✓			
Winter Planning 2019/20	**JT**							✓		
Carmarthenshire Section 33 Agreement	**SJ**	**SMJ**							✓	
Performance Management Assurance Framework	**KM**									✓
Strategic Equality Plan and Objectives 2020-2024	**SJ**	**JH**								✓
QUALITY, SAFETY & PERFORMANCE/DELIVERING THE HERE AND NOW										
Focus on Hospital & Community Services*	**JT**	**County Director**	✓ Cere		✓ Carms	✓ Pembs	✓ Cere	✓ Carms	✓ Pembs	✓ Cere
Integrated Performance Assurance Report (to include)* • Performance • Finance • Workforce & OD (including AAC) • Concerns • Six Monthly Individual Patient Funding Request (IPFR) Data • CHC Quarterly Performance	**SM**	**KM**	✓		✓	✓	✓	✓	✓	✓
Board Assurance Framework	**SM**	**JW**			✓				✓	
Corporate Risk Register	**SM**	**JW**			✓				✓	
Finance and Turnaround Update	**HT/AC**		✓		✓	✓	✓	✓	✓	✓
Dental Plan Progress Update	**JP**		✓			✓				
Update on Nurse Staffing Levels (Wales) Act	**MR**				✓			✓		
Winter Planning 2018/19 – Evaluation	**JT**				✓					

AGENDA ITEM/ ISSUE	LEAD	OFFICER	28 Mar 2019	29 May 2019	30 May 2019	25 Jul 2019	26 Sep 2019	28 Nov 2019	30 Jan 2020	26 Mar 2020
Health & Care Standards Fundamentals of Care Audit 2018	**MR**	**CH**			✓					
Presentation of Learning Disabilities Charter	**JT**					✓				
Transforming Learning Disabilities Project	**JT**					✓				
Internal Assurance Review of Quality and Safety of Maternity Services following Recent Independent Review of Maternity Services at the former Cwm Taf UHB	**JT**					✓				
Bi-Annual Improving Experience Report	**MR**	**LO'C**				✓			✓	
Fragility of Mental Health Services	**JT**	**LC**					✓			
HDdUHB Director of Public Health Annual Report	**RJ**						✓			
NHS Delivery Unit (DU) Audit on Primary Mental Health Services for Children and Adolescent Mental Health Services (SCAMHS)	**JT**	**LC**						✓		
Mid Year Review of Annual Plan	**KM**	**PW**						✓		
Working to improve the Health of Vulnerable Groups	**SJ**							✓		
Ombudsman Annual Letter	**MR**	**LO'C**						✓		
Funded Nursing Care	**JP**							✓		
Well-being Objectives Annual Report 2018/19	**SJ**	**AB**						✓		
Patient Charter	**MR**	**LO'C**							✓	
Ombudsman Reports**	**MR**	**LO'C**								

AGENDA ITEM/ ISSUE	LEAD	OFFICER	28 Mar 2019	29 May 2019	30 May 2019	25 Jul 2019	26 Sep 2019	28 Nov 2019	30 Jan 2020	26 Mar 2020
COMMITTEE UPDATE REPORTS										
HDdUHB Board Level Committees Update Report (to include)* • Audit & Risk Assurance Committee • Business, Planning & Performance Assurance Committee • Charitable Funds Committee • Finance Committee • Mental Health Legislation Assurance Committee • Primary Care Applications Committee • Quality, Safety & Experience Assurance Committee • University Partnership Board	**Chairs**	**JW**	✓		✓	✓	✓	✓	✓	✓
In-Committee Board Update Report	**Chair**	**JW**	✓		✓	✓	✓	✓	✓	✓
HDdUHB Advisory Groups Update Reports (to include)* • Stakeholder Reference Group • Healthcare Professionals Forum • Local Partnership Forum	**Chairs**	**JW**	✓		✓	✓	✓	✓	✓	✓
HDdUHB Joint Committees & Collaboratives Update Report (to include)* • EASC • NWSSP • WHSSC • JRPDC • MWJC	**Chairs**	**RF**	✓		✓	✓	✓	✓	✓	✓

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• Collaborative Leadership Forum										
Update Report from Public Services Boards	**SJ**	**AB**	✓							
Statutory Partnerships Update (incl Public Services Boards)	**SJ**	**AB**			✓	✓	✓	✓	✓	✓
FOR INFORMATION										
Board Annual Workplan	**JW**	**CM**	✓		✓	✓	✓	✓	✓	✓
Head of Internal Audit Opinion	**JW**			✓						
Healthcare Inspectorate Wales (HIW) Annual Report 2018/19						✓	✓			
HDdUHB Primary Care Annual Report 2018/19	**JP**					✓				
Medical Revalidation and Appraisal Annual Report 2018/19	**PK**	**HW**				✓				
NHS Wales Fighting Fraud Strategy						✓				
Organ Donation Annual Report	**JT**							✓		
Community Health Council (CHC) Annual Report	**CHC**							✓		

Initials

AB – Anna Bird	**JH – Jackie Hooper**	**NLl – Nicola Llewellyn**
AC – Andrew Carruthers	**JP – Jill Paterson**	**PS – Peter Skitt**
AG – Alison Gittins	**JPJ – Jenny Pugh-Jones**	**PW – Paul Williams**
AS – Alison Shakeshaft	**JT – Joe Teape**	**RE – Rob Elliott**
CH – Chris Hayes	**JW – Joanne Wilson**	**RF – Rosie Frewin**
CHC – Community Health Council	**KJ – Keith Jones**	**RJ – Ros Jervis**
CM – Clare Moorcroft	**KM – Karen Miles**	**SH – Sam Hussell**
ED's – Executive Directors	**LC – Liz Carroll**	**SJ – Sarah Jennings**
EL – Elaine Lorton	**LO'C – Louise O'Connor**	**SM – Steve Moore**
GM – Gareth Morgan	**LG – Lisa Gostling**	**SMJ – Sian-Marie James**
HT – Huw Thomas	**LRD – Libby Ryan-Davies**	**SP – Sian Passey**
HW – Helen Williams	**MR – Mandy Rayani**	**WAO – Wales Audit Office**
PK – Philip Kloer		