Joint Committee (Public)

Tue 06 September 2022, 09:30 - 12:30

Teams

Agenda

09:30 - 09:35
5 min

1. PRELIMINARY MATTERS

0.0 - JC Public Agenda 6 Sept 2022 v2.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Minutes of the Meeting held on 12 July 2022 and Matters Arising

Att. *Chair*

1.4 Unconfirmed JC (Public) Minutes 12 July 2022 v1.pdf (22 pages)

1.5. Action Log

Att. *Chair*

1.5 2022 JC Action Log - JC 06.09.22.pdf (7 pages)

09:35 - 10:55
80 min

2. PRESENTATION

2.1. Major Trauma Presentation

Att. *Director of Planning*

2.1 Major Trauma Presentation - August 22 DG edits - JC 06.09.22.pdf (20 pages)
2.1.1 SWTN Peer Review Final Reports Pack (July 22) - JC 06.09.22.pdf (91 pages)
2.1.2 SWTN Handling of Peer Review Reports and Next Steps FINAL 27thJune2022.pdf (4 pages)
2.1.3 Benefits Realisation Plan (July 22) - JC 06.09.22.pdf (2 pages)

2.2. Specialised Services Strategy Presentation and Report

Att. *Managing Director*

2.2 Specialised Services Strategy Development and Engagement - JC 06.09.22.pdf (6 pages)
2.2.0 Specialised Services Strategy Development and Engagement - Presentation - JC.pdf (8 pages)
2.2.1 Appendix 1 - Engagement and Communication Plan - Specialised Services Strategy Development.pdf (22 pages)
2.2.2 Appendix 2 - Specialised Services Strategy Development - Key Stakeholder Survey.pdf (19 pages)

2.3. Recovery Update Paediatrics – Presentation

Att. *Director of Planning*

2.3 Paediatric services deep dive v0.4 - JC 06.09.22.pdf (28 pages)

10:55 - 11:50
55 min

3. ITEMS FOR CONSIDERATION AND/OR DECISION

3.1. Chair's Report

Att. *Chair*

3.1 Chair's Report - JC 06.09.22.pdf (4 pages)
3.1.1 Letter Joint Committee Chairs action Interim IPFR Chair - 27 July 2022.pdf (3 pages)

3.2. Managing Director's Report

Att. *Managing Director*

3.2 Managing Director's Report - JC 06.09.22.pdf (8 pages)
3.2.1 Appendix 1 - 2022-07-22 Judith Paget to SL IMTP Accountability Letter.pdf (3 pages)
3.2.2 Appendix 2 - Letter to WHSSC Joint Committee regarding secure services review recommendation.pdf (2 pages)
3.2.3 Appendix 3 - 2022-07-28 JP to SL Molecular Radiotherapy.pdf (2 pages)

3.3. Neonatal Transport – Update report from Delivery Assurance Group

Att. *Director of Planning*

3.3 Neonatal Transport Update from the Delivery Assurance Group (DAG) - JC Open.pdf (4 pages)

3.4. Specialised Paediatric Services 5 year Commissioning Strategy

Att. *Director of Planning*

3.4 Paediatric Strategy - post stakeholder feedback JC 06.09.22.pdf (3 pages)
3.4.1 Appendix 1 - Stakeholder feedback Paediatric Strategy.pdf (6 pages)
3.4.2 Appendix 2 Specialised Paediatric Strategy - JC 06.09.22.pdf (89 pages)

3.5. Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement Process

Att. *Director of Planning*

3.5 Cochlear Implant and Bone Conduction Hearing Implant Device Service - En.._.pdf (7 pages)
3.5.1 Appendix 1 MG SW Cochlear Implant and BAHA Report - JC 06.09.22.pdf (26 pages)
3.5.2 Appendix 2 South Wales Cochlear Implant and BAHA Hearing Device service v0.8.pdf (26 pages)
3.5.3 Appendix 3 Draft Cochlear BAHA EQIA v0.2 LK 230822 - JC 06.09.22.pdf (17 pages)

3.6. Designation of Provider Framework

Att. *Director of Planning*

3.6 Designation of Provider Framework Report 0922 - JC 06.09.22.pdf (5 pages)
3.6.1 Appendix 1 Framework for designating specialist services JC 06.09.22.pdf (20 pages)

3.7. Individual Patient Funding Requests (IPFR) Governance Report

Att. *Committee Secretary*

3.7 IPFR Governance Update - JC 06.09.22.pdf (7 pages)
3.7.1 Appendix 1 AE NP ltr to SL re IPFR ToR July 2022 FINAL - JC 06.09.22.pdf (3 pages)
3.7.1a Appendix 1a Letter IPFR Policy Review CEO Powys THB to Dr Sian Lewis.pdf (1 pages)
3.7.2 Appendix 2 IPFR Themes & Suggestions for Engagement Process - JC 06.09.22.pdf (3 pages)

3.8. WHSSC Annual Report 2021-2022

Att. *Committee Secretary*

3.8 WHSSC Annual Report 2021-2022 - JC 06.09.22.pdf (4 pages)

11:50 - 12:25
35 min

4. ROUTINE REPORTS AND ITEMS FOR INFORMATION

4.1. COVID-19 Period Activity Report Month 3 2022-2023

Att. *Director of Finance*

4.2. Financial Performance Report Month 4 2022-2023

Att. *Director of Finance*

4.3. Corporate Governance Matters Report

Att. *Committee Secretary*

4.4. Reports from the Joint Sub-Committees

Att. *Joint Sub- Committee Chairs*

i. Audit and Risk Committee (ARC) Assurance Report
ii. Management Group Briefing
iii. Quality & Patient Safety Committee (QPSC)
iv. Integrated Governance Committee (IGC)
v. Individual Patient Funding Request (IPFR) Panel

12:25 - 12:30
5 min

5. CONCLUDING BUSINESS

5.1. Any Other Business

Oral *Chair*

5.2. Date of Next Meeting (Scheduled)

Oral *Chair*

- 8 November at 13.30hrs

5.3. In Committee Resolution

Oral *Chair*

The Joint Committee is recommended to make the following resolution: “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)”.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WHSSC Joint Committee Meeting held in public
Tuesday 6 Sept 2022 at 09:30 hrs

Microsoft Teams

ITEM		LEAD	PAPER / ORAL	TIME
1.0	**PRELIMINARY MATTERS**			
1.1	Welcome and Introductions	Chair	Oral	09:30 - 09:35
1.2	Apologies for Absence	Chair	Oral	
1.3	Declarations of Interest	Chair	Oral	
1.4	Minutes of the Meeting held on 12 July 2022 and Matters Arising	Chair	Att.	
1.5	Action Log	Chair	Att.	
2.0	**PRESENTATION**			
2.1	Major Trauma Presentation	Director of Planning	Att.	09:35 - 10:05
2.2	Specialised Services Strategy Presentation and Report	Managing Director	Att.	10:05 - 10:25
2.3	Recovery Update Paediatrics – Presentation	Director of Planning	Att.	10:25 – 10:55
3.0	**ITEMS FOR CONSIDERATION AND/OR DECISION**			
3.1	Chair's Report	Chair	Att.	10:55 – 11:00
3.2	Managing Director's Report	Managing Director	Att.	11:00 – 11:05
3.3	Neonatal Transport – Update report from Delivery Assurance Group	Director of Planning	Att.	11:05 – 11:10
	Break 5 minutes			
3.4	Specialised Paediatric Services 5 year Commissioning Strategy	Director of Planning	Att.	11:15 – 11:25
3.5	Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement Process	Director of Planning	Att.	11:25 - 11:35
3.6	Designation of Provider Framework	Director of Planning	Att.	11:35 - 11:40
3.7	Individual Patient Funding Requests (IPFR) Governance Update	Committee Secretary	Att.	11:40 - 11:45

ITEM		LEAD	PAPER / ORAL	TIME
3.8	WHSSC Annual Report 2021-2022	Committee Secretary	Att.	11:45 – 11:50
4.0	**ROUTINE REPORTS AND ITEMS FOR INFORMATION**			
4.1	COVID-19 Period Activity Report Month 3 2022-2023	Director of Finance	Att.	11:50 - 12:00
4.2	Financial Performance Report Month 4 2022-2023	Director of Finance	Att.	12:00 - 12:10
4.3	Corporate Governance Matters Report	Committee Secretary	Att.	12:10 - 12:15
4.4	Reports from the Joint Sub-Committees i. Audit and Risk Committee (ARC) Assurance Report ii. Management Group Briefings iii. Quality & Patient Safety Committee (QPSC) iv. Integrated Governance Committee (IGC) v. Individual Patient Funding Request (IPFR) Panel	Joint Sub-Committee Chairs	Att.	12:15 - 12:25
5.0	**CONCLUDING BUSINESS**			
5.1	Any Other Business	Chair	Oral	
5.2	Date of Next Meeting (Scheduled) - 8 November at 13.30hrs	Chair	Oral	
5.3	In Committee Resolution The Joint Committee is recommended to make the following resolution: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)".	Chair	Oral	12:25 - 12:30

Unconfirmed Minutes of the Meeting of the WHSSC Joint Committee Meeting held In Public on Tuesday 12 July 2022 via MS Teams

Members Present:

Kate Eden	(KE)	Chair
Sian Lewis	(SL)	Managing Director, WHSSC
Carole Bell	(CB)	Director of Nursing & Quality Assurance, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Iolo Doull	(ID)	Medical Director, WHSSC (part)
Mark Hackett	(MH)	Chief Executive Officer, Swansea Bay UHB
Paul Mears	(PM)	Chief Executive Officer, Cwm Taf Morgannwg UHB
Steve Moore	(SM)	Chief Executive Officer, Hywel Dda UHB
Karen Preece	(KP)	Director of Planning, WHSSC
Suzanne Rankin	(SR)	Chief Executive Officer, Cardiff & Vale UHB
Carol Shillabeer	(CS)	Chief Executive Officer, Powys THB
Ian Wells	(IW)	Independent Member, Cwm Taf Morgannwg UHB
Jo Whitehead	(JW)	Chief Executive Officer, Betsi Cadwaladr UHB

Deputies:

Sian Harrop-Griffiths (for Mark Hackett)	(SH-G)	Director of Strategy, Swansea Bay UHB
Rob Holcombe (for Glyn Jones)	(CH)	Interim Director of Finance, Aneurin Bevan UHB
Linda Prosser (for Paul Mears)	(LP)	Executive Director of Strategy and Transformation, Cwm Taf Morgannwg UHB

Apologies:

Mark Hackett	(MH)	Chief Executive Officer, Swansea Bay UHB
Steve Ham	(SH)	Chief Executive Officer, Velindre
Glyn Jones	(GJ)	Interim Chief Executive Officer, Aneurin Bevan UHB
Ceri Phillips	(CP)	Independent Member, Cardiff & Vale UHB

In Attendance:

James Barry	(JB)	Clinical Director for Cardiology, Swansea Bay UHB
Scott Caplin	(SC)	Consultant General Surgery, Swansea Bay UHB
Hannah Evans	(HE)	Programs Delivery Director, Cardiff & Vale UHB
Jacqui Evans	(JE)	Committee Secretary & Head of Corporate Services, WHSSC
Maxine Evans	(ME)	Project Manager, WHSSC
Deb Lewis	(DL)	Deputy Chief Operating Officer, Swansea Bay UHB
Ian Phillips	(IP)	Chair, Welsh Renal Clinical Network (WRCN), Powys THB
Chris Stockport	(CSt)	Executive Director Transformation, Strategic Planning and Commissioning, Betsi Cadwaladr UHB

Minutes:

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Charles Brain (CNB) Interim Corporate Services Manager, WHSSC

The meeting opened at 13:30hrs

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Min Ref	Agenda Item
JC22/076	**1.1 Welcome and Introductions** The Chair welcomed members to the meeting in Welsh and English and reminded everyone that meetings will continue to be held virtually via MS Teams. No objections were raised to the meeting being recorded for administrative purposes. It was noted that a quorum had been achieved. The Chair reminded members that the purpose of the Joint Committee (JC) was to act on behalf of the seven Health Boards (HBs) to ensure equitable access to safe, effective and sustainable specialised services for the people of Wales by working collaboratively on the basis of a shared national approach, where each member worked in the wider interest. The Chair welcomed the following who were in attendance to deliver presentations on Recovery Trajectories across NHS Wales: • Scott Stockport from BCUHB, • James Barry, Scott Caplin and Deb Lewis from SBUHB; and • Hannah Evans from CVUHB.
JC22/077	**1.2 Apologies for Absence** Apologies for absence were noted as above.
JC22/078	**1.3 Declarations of Interest** The JC noted the standing declarations and that there were no additional declarations of interest relating to the items for discussion on the agenda.
JC22/079	**1.4 Minutes of the meeting held on 10 May 2022 and Matters Arising** The minutes of the JC meeting held on 10 May 2022 were received and approved as a true and accurate record of the meeting. There were no matters arising.
JC22/080	**1.5 Action Log** The action log was received and members **noted** the progress on the actions including: • **JC22/004 – 3.5 Major Trauma Update** – Dindi Gill from Major Trauma Network to provide an update at the JC meeting on 6 September 2022.

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	All other actions were confirmed as completed and were closed.
JC22/081	**2.1 Recovery Trajectories across NHS Wales - Workshop** The presentations on the recovery trajectories across Wales from the NHS Wales Delivery Unit (DU), Betsi Cadwaladr UHB (BCUHB), Swansea Bay UHB (SBUHB) and Cardiff & Vale (CVUHB) were received. Karen Preece (KP) introduced the session and advised that the focus was on NHS Wales service providers as the activity of the NHS England (NHSE) providers, which was included in the activity reports presented to the JC, regarding waiting time concerns were not as significant. Members noted the NHS Wales DU update on a cohort analysis against Ministerial targets for NHS Wales including Cardiology, Cardiac Surgery, Neurosurgery and Plastic Surgery. It provided linear trajectories to achieve the Ministerial targets by 30 December 2022 and 31 March 2023 respectively. Carol Shillabeer (CS) queried if data for NHSE could be detailed alongside the NHS Wales data in order to analyse the differences in access times for the Welsh population, to review equity and consider pathway options. KP agreed to provide this information. **ACTION:** KP to create a slide presenting NHS England provider data against NHS Wales provider data to be circulated outside of the meeting. Ian Wells (IW) advised that the Welsh Government (WG) waiting time targets of 52 and 104 weeks in the respective categories were still significant and should not become normalised. IW also enquired how the Welsh providers compared against other UK providers and if there were any lessons learned that could be adopted. Stuart Davies (SD) advised that NHSE's recovery rates were better than the Welsh providers partly due to it receiving strategic investment at an early stage through an incentivisation structure resulting in delays not being embedded. Members noted that financial investment was not the solution at the current time. KP added that NHSE's recovery in specialised services had been greater and quicker than Welsh providers partly because it had experienced fewer pressures and constraints, although issues remained for some NHSE services. Linda Prosser (LP) advised that NHSE had a historic working relationship with private sector providers compared to NHS Wales allowing for increased access.

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Members noted the BCUHB recovery presentation and the significant challenges being encountered and that a structured approach was being taken to address the challenges including:

- Increasing capacity, including the regional treatment centre(s),
- Prioritising diagnostics and outpatients,
- Transformation (pathway redesign) for both planned ambulatory care and complex surgery; and
- Information and communication, including validation.

Chris Stockport (CSt) advised that there was limited outreach capacity within both private sector providers and NHSE for both general and specialised services, which was impacting on BCUHB's ability to achieve the 104 week Ministerial targets. Members noted that BCUHB expected to achieve all of the Ministerial targets for the eight categories of services it provided to WHSSC by 30 October 2022.

CSt highlighted some potential hidden demands relating to cardiology as there was a significant backlog of stage 1 outpatients. Members noted that a locum was being appointed in September which will assist in clearing the backlog.

Members noted an issue concerning cardiac physiology patients due to a backlog waiting list for diagnostics, principally echo (echocardiogram), which impacted on surgical intervention. The demand and waiting times were being minimised through various actions, including the use of BNP (B-type natriuretic peptid).

SD advised that BCUHB's, and other HB echo conversion rates into Percutaneous coronary intervention (PCI) and ultimately surgery was lower than the 8% pre-COVID-19 rate and that this should be investigated.

Suzanne Rankin (SR) suggested that HBs should address capacity issues through collaborative working arrangements within Wales.

Members noted the SBUHB recovery presentation and that SBUHB provided nine WHSSC commissioned services of which five will achieve contracted volumes by the end of the financial year.

Deb Lewis (DL) advised that all of the plastic surgery specialties would be delivered against the 52 week Ministerial targets by 31 December 2022. However, there was an issue in achieving the 104 week target by 31 March 2023 partly due to in-patient bed capacity at Morriston Hospital (MH). Members noted that plans were in place to create capacity at Singleton Hospital (SH) and Neath Port Talbot Hospital (NPTH) to relieve this pressure. DL advised that the plastic surgeons were content to use theatre capacity where it was available

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however; consideration would need to be given to the support team resource, which could either be provided by SBUHB or the local hospital.

Members noted that SBUHB:

- were on target to deliver interventional cardiology and that there were plans to increase capacity,
- had the capacity to deliver cardiac surgery to contracted levels however there were insufficient patients to fulfil the contracted volumes, which was further hampered by COVID-19 surgery restrictions,
- were experiencing lower echo conversion rates than the 8% pre-COVID-19 rates and the reason for this was currently unknown. Consideration was being given to providing cardiac surgery on behalf of other HBs, for both NHS Wales and NHSE in order to fulfil capacity,
- had robust plans in place to achieve contracted bariatric surgery volumes, including resolving the current backlog,
- had a number of long waiters due to HB delivery of cross-sectional imaging of CMR, MRI and CT, a non-WHSSC commissioned regional service,
- a theatre was being refitted which will increase capacity by 25% and capacity may be offered to other HBs to clear backlogs.

KP suggested that insufficient capacity in dermatology services has led to transfers to plastic surgery and a resolution in this area could ease demand on plastic surgery.

ACTION: KP to liaise with James Barry (JB) on dermatology flows after the meeting to investigate opportunities and to convey good practice to other HBs.

Members noted the CVUHB recovery presentation and that 25 out of 35 specialties would be delivered against both the 52 week and 104 week Ministerial targets by 31 December 2022 and 31 March 2023 respectively. Hannah Evans (HE) advised that the five WHSSC commissioned services were included in the 25 specialities referred to. Members noted the scale of the backlog was further impacted by staff availability following the recent spike in COVID-19 cases.

Members noted that CVUHB were unable to continue to achieve contracted paediatric surgery volumes during the pandemic and a focus was placed on the most clinically urgent patients, which had led to longer waiting times. This prioritisation focus continued with the case list, particularly the long waiters, being clinically reviewed on a regular basis.

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Although in-patient capacity was at 99% and outpatient activity was in excess of 100%, there was a theatre capacity issue, particularly regarding the availability of paediatric anaesthetists. There were plans in place to resolve this issue via additional resource with contracted volumes expected to be achieved by March 2023.

Members noted that:

- there were some bed capacity restrictions for neurosurgery following the configuration changes implemented during the pandemic and there were plans in place to resolve the issue,
- there was a high level of confidence in delivering interventional cardiology contracted volumes and stabilising waiting list numbers,
- CVUHB were currently at pre-pandemic volumes for cardiac surgery, although this was below contracted volumes. Waiting list initiatives were being implemented to increase activity with plans to increase theatre capacity but it will be dependent on resource availability; and
- a decision was to be made to repatriate cardiothoracic patients from University Hospital Llandough (UHL) to University Hospital Wales (UHW).

CS suggested focussing on waiting times for children as their 'lives lived' had been disproportionately affected by the pandemic. Sian Lewis (SL) advised that WHSSC was very concerned about the Royal College of Surgeons (RCS) prioritisation profile. KP suggested that a regional system review should be undertaken to establish if there had been a change in run rate over the last five years in HB referral thresholds as referrals into the Children's Hospital had increased leading to pressure on the service. KP also advised that waiting times at the Alder Hey Children's Hospital (AHCH), a commissioned provider, were lower leading to inequity concerns. Members agreed it would be useful to see performance data for children's services by both provider and HB of residence.

ACTION: KP to take forward a review of the paediatric system.

SD noted that there were anecdotal concerns that patterns of referrals for paediatric services into CVUHB had increased over the last 5 years and this change was having an adverse impact on the ability of the Children's Hospital for Wales (CHfW) to deliver tertiary care.

ACTION: KP to include data on referral patterns into paediatric review.

SD advised that he would follow up inquiries with both CVUHB and SBUHB on the increase in TAVI (Transcatheter aortic valve implantation) to investigate if this was a one-off issue due to backlogs

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	or whether it was a long-term trend which would have a fundamental impact on being able to achieve contracted volumes. **ACTION:** SD to liaise with CVUHB and SBUHB to establish the rationale for the increase in TAVI and the potential long-term impact in achieving contracted volumes. KP thanked the three HBs for providing more clarity on trajectories and advised that conversations will continue at the planned Service Level Agreement (SLA) meetings with each HB. KP advised that there was an opportunity to pool lists and exploit collaborative capacity capabilities as well as considering specialist capacity in England. Rob Holcombe (RH) suggested considering the position from a commissioner service provision rather than by HB. JW advised she supported this approach and that consideration should also be given to providing options to patients should a service be available across boundaries. SR suggested that KP prioritise the various actions discussed and focus on paediatric referrals first. HE advised that some of the DU data gave global figures presented a challenge on perception and comparison and that there was a need to focus on local and national data to ensure messages were clear. SL advised that this approach had already been discussed with WG. **ACTION:** A deep dive session on Paediatric referrals to be arranged for the JC meeting on 6 September 2022. The Chair thanked those that presented and contributed to a most useful session on recovery trajectories and advised that she looked forward to seeing the developments over the coming months, and advised that the slides would be circulated to members after the meeting. The Joint Committee resolved to: • **Note** the presentations and resulting actions.
JC22/082	**3.1 Chair's Report** The Chair's report was received and the Chair gave an update on relevant matters undertaken as Chair since the previous JC meeting. Members **noted**: • That no Chair's actions had been taken since the last meeting, • An update on the letter issued to NHS Chairs requesting support in appointing an interim HB chair for the All Wales Individual Patient Funding Request (IPFR) Panel for a 6 month period from amongst their Independent Members (IMs) to

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	ensure business continuity and that two expressions of interest had been received which were being pursued, • An update on plans for the recruitment process to fill the WHSSC IM vacancy, • Attendance at the Integrated Governance Committee (IGC) meeting on the 7 June 2022; and • Attendance at key meetings. The Joint Committee resolved to: • **Note** the report.
JC22/083	**3.2 Managing Director's Report** The Managing Director's Report was received and the Managing Director gave an update on relevant matters undertaken since the previous JC meeting. Members **noted** updates on: • Discussions with WG concerning the All Wales IPFR Panel, the All Wales IPFR policy, the briefings given to the Board Secretaries on 10 June 2022 and to the All Wales Medical Directors Group (AWMDG) on 1 July 2022 and the letter confirming next steps which was awaited from WG. A productive meeting was held with Welsh Government (WG) on 10 May 2022 and a formal response is due imminently, • Mental Health Specialised Services Strategy for Wales 2022-2028 - the engagement timeline had been extended and the stakeholder circulation list had been broadened as agreed at the last meeting of JC. CS noted that the timeline was better and aligned to the appointment of the new national director for Mental Health. A progress update will be provided to the JC on 6 September and the final strategy is due to be presented to the JC on 14 March 2023, • The funding for cell pathology laboratories to meet the growing demand for commissioned WHSSC cancer genomic testing - the genomics service and cell pathology services had raised concern that not all pathology laboratories had been funded and, as a consequence, there were likely to be delays and/or an inequity of access for patients requiring these tests. Also, cell pathology services had raised concern that the original agreed funding would not be sufficient to deliver the increasing demands on its service. The cell pathology services will be submitting a revised set of proposals for investment via the NHS Wales Chief Executives Group; and • the Management Group (MG) had supported the designation of SBUHB as a provider of Stereotactic Ablative Radiotherapy (SABR). The Joint Committee resolved to: • **Note** the report,

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	• **Note** the ongoing discussions with WG concerning the All Wales Individual Patient Funding Request (IPFR) Panel; and • **Note** that the draft Mental Health Specialised Services Strategy 2022-2028 was issued via email on 30 May 2022, with a request for feedback by 22 July 2022.
JC22/084	**3.3 Neonatal Transport – Update from the Delivery Assurance Group (DAG)** The report providing an update on the Neonatal Transport Delivery Assurance Group (DAG) was received. KP gave an update on the activity for the transport service and progress to implement the Neonatal Transport Operational Delivery Network (ODN). Members noted that the ODN was currently a work-in-progress and that additional narrative on performance will be included in future reports. KP advised that a business case will be presented to the MG on 28 July 2022 and to the JC on 6 September 2022 to agree a funding release for a staffing structure for the ODN with an intention to 'go live' in September 2022. The Joint Committee resolved to: • **Note** the report, • **Receive assurance** that the Neonatal Transport is being scrutinised by the Delivery Assurance Group (DAG), • **Note** that further work is being undertaken by the transport service on the reporting to strengthen the assurance; and • **Note** the update on the implementation of the Neonatal Transport Operational Delivery Network (ODN).
JC22/085	**3.4 Draft Specialised Paediatric Services 5 year Commissioning Strategy** The report presenting the Draft Specialised Paediatric Services 5 year Commissioning Strategy for information and seeking support to share the strategy through a six week engagement process to obtain stakeholder feedback was received. KP advised that the final draft incorporated all of the comments from the Programme Board. It was anticipated that, following the engagement process, the final version would be presented to the JC for approval on 6 September 2022 when the JC will be able to consider the value benefit of the strategy versus the current provision. Ian Wells (IW) requested further clarity to be provided on training and education of the staff operating the service. Steve Moore (SM) requested further detail to be included on workforce requirements in section 7.2. CS asked for the relationship with child and adolescent

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	mental health services (CAMHS) and neurosciences to be referred to within the report. KP agreed to update the strategy and advised that that a resourcing plan would be developed to support the strategy. **ACTION:** KP to update the draft Specialised Paediatric Services 5 year Commissioning Strategy to include reference to staff training and education, workforce requirements and the link between CAMHS and neurosciences. LP queried if the strategy will be available for individual HBs. KP advised that it would be circulated to each HB. **ACTION:** Once approved by the Joint Committee KP is to circulate the Specialised Paediatric Services 5 year Commissioning Strategy to all HB's. The Joint Committee resolved to: • **Note** the contents of the draft Specialised Paediatric Services 5 year Commissioning Strategy; and • **Support** that the Strategy will be issued for a six week engagement process to obtain stakeholder feedback, prior to the final version being presented to the Joint for Committee for approval on 6 September 2022.
JC22/086	**3.5 South Wales Cochlear Implant and BAHA Hearing Implant Device Service** The report presenting the process and outcome of a recent review of tertiary auditory services and the planned next steps for the south Wales Cochlear Implant and BAHA Hearing Implant Device Service was received. Members noted that: • following an external assessment of the five options presented at a clinical options appraisal workshop the only option that met all of the required standards was the option to have a single implantable device hub for Cochlear and BAHA for both children and adults with an outreach support model, • following a financial assessment, none of the options would create a cost pressure, and the proposed option was deemed the most cost effective; and • the proposed option could potentially enable the release of resource back into the service for further developments, including an 'out of hours' service. Sian Harrop-Griffiths (SH-G) raised concerns regarding the option appraisal process leading to the preferred commissioning option. Members discussed this matter and agreed that the report be

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	updated with more detail on the process undertaken, and that the report be presented at the next MG meeting for review prior to being brought back to the JC either virtually or at an extraordinary committee meeting. The Joint Committee resolved to: • **Note** the report, • **Note** and **receive assurance** on the assessment process inclusive of a) clinical options appraisal, b) external review against standards and c) financial option appraisal, • **Note** the outcome of the clinical options appraisal for the south Wales centres, the external hearing implant centre and the financial appraisal, • **Note** the preferred commissioning options as the basis of engagement/consultation; and **agree** to enter into further discussion on this through the Management Group meeting on 28 July 2022 and to reconsider the proposals either virtually or at a future extra-ordinary meeting of the JC; and • **Agree** to receive the required engagement/consultation documentation and process after it has been approved by the Management Group.
JC22/087	**3.6 Hepato-Pancreato-Biliary (HPB) Services for Wales** The report providing a summary on the Hepato-Pancreato-Biliary (HPB) surgery project for south and west Wales, and to seek support for the proposed arrangements to provide assurance to the WHSSC JC as the future commissioners for the service was received. KP advised that following the approval in principle of the model service specification for HPB surgery by the NHS Wales Health Collaborative Executive Group (CEG) in May 2021, CVUHB and SBUHB Regional and Specialised Services Provider Planning Partnership (RSSPPP) had established a project to progress the development of an integrated HPB surgery service model. Members noted that the CEG had also requested that WHSSC take on the delegated commissioning responsibility for HPB surgery, when the service model had been agreed. Members noted that it was accepted practice across the UK for liver and pancreatic surgery to be based together as part of a comprehensive HPB service. However, the service was split into two separate sites in south Wales, namely hepatobiliary surgery at the University Hospital of Wales (UHW), Cardiff and pancreatic surgery at Morriston Hospital (MH), Swansea. WG had requested that the Wales Cancer Network (WCN) develop proposals to integrate the service provision. Members noted that the RSSPPP had established a project to develop recommendations for a service model which complied with the WCN

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	service specification, which would include a two-phase approach. A Project Board has been developed which would provide executive oversight and assurance, as well as providing assurance reports to the JC. The project governance arrangements were set out in detail in the Project Initiation Document (PID). CS advised that the NHS Wales Directors of Planning Group had been reviewing commissioning arrangements and that broader discussion was required on potential commissioner roles. KP advised that for clarity the expectation was that WHSSC assumed the commissioning for all liver and pancreatic surgery in the future. This would be similar to the work undertaken on the major trauma model whereby it came into WHSSC for commissioning, and was delivered by CVUHB and SBUHB. LP advised that there was a need to articulate what was meant by the terms planning and commissioning. SR suggested that given that two of the providers had fragility issues that they work collaboratively to provide a higher quality sustainable service. KP advised that 'touch points' had been built in to the project which would ensure that commissioning HBs could identify any issues early on in the project development and ensure these were resolved before the final service model was presented to WHSSC for approval. SL reminded members of the history relating to the request and that there was clinical agreement that a single centre was required, and that there was clear authority from the CEG, the JC and HBs to progress the work. The Joint Committee resolved to: • **Note** the report, • **Support** the Hepato-Pancreato-Biliary (HPB) surgery Project Initiation Document (PID) and Action Plan Tracker; and • **Support** the proposals to receive assurance that the outputs of the Hepato-Pancreato-Biliary (HPB) project align with the WHSSC strategic objectives and commissioning intentions.
JC22/088	**3.7 Policy for Policies & EQIA Policy** The report to present feedback from the stakeholder consultation on the revised WHSSC 'Policy for Policies' Policy and the new Equality Impact Assessment (EQIA) policy was received. SL advised that the WHSSC Policy Group had agreed to update and merge policies Corp-05 and Corp 054b to create a single stand-alone methodology for all WHSSC policies. The new document outlined the process within WHSSC for the development, review, validation and distribution of various policies.

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	Members noted that: • an Equality Impact Assessment (EQIA) had been developed to provide guidance and advice on conducting an EQIA and the impact of WHSSC activities or policies across all of the nine protected characteristics, and the impact they may have on people living in less favourable social and economic circumstances, • the policy suggested that an EQIA be undertaken when a need for a new policy, service or activity was identified, or when an existing one was reviewed at the scoping stage and then reviewed at all subsequent stages of development, including validation and publication, • following stakeholder consultation WHSSC had updated both policies where appropriate; and • Members of the Corporate Directors Group Board (CDGB) and the WHSSC Policy Group had approved both documents for publication subject to approval by the JC. The Joint Committee resolved to: • **Note** the report, • **Support** the rationale and process that has been applied when updating the WHSSC 'Policy for Policies' Policy and developing the new EQIA policy; and • **Approve** the request to publish the WHSSC 'Policy for Policies' Policy and EQIA Policy following stakeholder consultation.
JC22/089	**3.8 Policy position for the commissioning of drugs and treatments for patients aged between 16 and 18 years of age** The report seeking support on the preferred policy position for the commissioning of drugs and treatments for patients aged between 16 and 18 years of age was received. SL advised that a number of new drugs and treatments had recently been approved by the National Institute for Health and Care Excellence (NICE) and the All Wales Medicines Strategy Group (AWMSG) for both children and adults, which had highlighted an issue affecting young adults aged 16-18 years. Up to the age of 16 years children would normally access these treatments via WHSSC commissioned paediatric services. WHSSC does not commission the adult services that would normally prescribe or deliver these treatments. There is ambiguity regarding the commissioning responsibility for young adults (16-18 years) who would typically be looked after by adult services. WHSSC was therefore seeking to establish a clear position to include within all relevant policy position statements.

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	Members noted that of the three options put forward, option 3 was WHSSC's preferred option whereby it has the commissioning responsibility for the paediatric service which would normally prescribe or deliver the treatment but not for the adult service, WHSSC will fund the drugs or treatment up to the age of 18 years but only as long as the young adult remains within the paediatric service. When the patient transitions to the adult service the drug and/or treatment costs will then transfer to the HB. Members noted that it was suggested that the options presented would be for all new drugs and treatments only, with all historic arrangements remaining in place until the policy that underpins the treatment was due for review. SR queried if additional time was required to review this via the MG. SL advised that following discussion at the MG concerning the Nusinersen drug they had requested that a report on the policy position for the commissioning of drugs and treatments for patients aged between 16 and 18 years of age be brought to JC for consideration. Due to timing of meetings the MG had not received the actual report but had discussed the issues and will be given an update on progress at its July meeting. The Joint Committee resolved to: • **Note** the report; and • **Support** the preferred option identified within the report.
JC22/090	**3.9 Supporting Ukrainian Refugees with Complex Health Needs** The report setting out a proposal for managing the complex health needs of Ukrainian refugees arriving in Wales and seeking approval to manage the excess costs (>£20k per annum) within the current funding baselines in year, offsetting against non-recurrent slippage and reserves was received. SL advised that in June 2022, WHSSC was approached by WG regarding the complex health needs of Ukrainian refugees arriving in Wales. To date, over 3,000 visas had been issued to Ukrainians to resettle in Wales through the approved schemes. Members noted that Ukrainians who had settled in Wales either through an individual Welsh resident sponsor or via the 'super sponsorship' route sponsored by WG were provided with wrap around support, including initial health assessments and screening. Arrivals were eligible for free access to healthcare for the duration of their stay (up to three years). There was the possibility that some individuals who had been granted visas and planned to travel to Wales may have complex health (and broader) needs such that

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assessments were needed prior to their travel to determine the most appropriate package of care.

Members noted that the UK Government did not currently provide any additional funding for health costs, which were being met from within existing HB budgets.

Members noted that based on previous experience of working with WG, Public Health Wales (PHW), the Welsh Strategic Migration Partnership and the Home Office (HO) on a health pathway for Syrian and Afghan Refugees, WHSSC has been asked to support the establishment of a consistent process to assess the health needs of Ukrainian refugees that are flagged as having complex health needs prior to travel.

The proposal for WHSSC was to:

- Support the identification of a HB to undertake the virtual assessment prior to travel. There was no budget for this but given the low number of cases, WG will consider funding a provider on a sessional basis,
- Utilise the WHSSC network of Clinical Gatekeepers to seek advice on complex cases and link Clinicians with the individuals to prepare for their arrival via the government call centre and translation service (case history, potential links with previous Clinicians where possible),
- Advise housing organisations where health needs could be met to inform the Local Authority that they will be resettled in,
- Through financial risk sharing agreement, reimburse HB's where ongoing health needs were likely to exceed an annual limit of £20,000 per annum. This was the agreed limit that was established in the case of Syrian refugees and broadly aligned to the average unit costs seen in specialised services. The excess costs will be managed within the current funding baselines in year, offsetting against non-recurrent slippage and reserves; and
- Take on full commissioning responsibility for any care that is within its current commissioning remit.

LP queried how individuals will be funded should they not have been identified at the screening stage or self-identified when entering the country or become more costly after a period of time once entering the country. It was agreed that further investigation would be undertaken in these areas.

ACTION: WHSSC to investigate a method for identifying refugees who subsequently require high cost health care and a system of reimbursement for the HB of residence.

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	The Joint Committee resolved to: • **Note** the information presented within the report; and • **Approve** the proposal to manage the excess costs within the current funding baselines in year, offsetting against non-recurrent slippage and reserves.
JC22/091	**3.10 Name Change Welsh Renal Clinical Network (WRCN)** The report outlining the outcome of the engagement process to consider a change of the name of the Welsh Renal Clinical Network (WRCN) and to ratify the decision of the WRCN Board to change the name to the Welsh Kidney Network (WKN) was received. SD advised that the although the WRCN logo and name was well known across the network of health care professionals it was less known amongst patients receiving care and people seeking information about chronic kidney disease and the treatment options available to them. Members noted that as the WRCN moves into a more digital arena coupled with the strategic aim of the network to promote the uptake of home dialysis, it was important that the terminology used to describe the care and service was more aligned with language used by patients and carers. Most patients identified with the term 'kidney' rather than 'renal', and the word 'clinical' indicated that it was only hospital based care that was available. Also, most kidney care organisations both within the NHS and externally, such as Professional Bodies and Charity partners, had adopted the term 'kidney' to be the key descriptor of their purpose. SD advised that following an engagement process the preferred option was to rename the WRCN to the WKN. Once ratified all stakeholders will be notified of the change in writing and that the new name will be effective from 1 August 2022. The Joint Committee resolved to: • **Note** the outcome of the engagement process to seek views to change the name of the Welsh Renal Clinical Network (WRCN); and • **Ratify** the decision of the WRCN Board to change the name of the WRCN to the "Welsh Kidney Network".
JC22/092	**3.11 Annual Committee Effectiveness Self-Assessment Results 2021-2022** The report presenting an update on the actions from the annual Committee Effectiveness Self-Assessment undertaken in 2020-2021 and to present the results of the annual committee effectiveness self-assessment 2021-2022 was received.

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	Jacqui Evans (JE) advised that positive progress had been made against each of the agreed actions from the 2020-2021 self-assessment and that the survey for 2021-2022 had received a positive response overall. The findings and feedback will be reviewed with a view to developing an action plan to address any areas that require development, and to create a Joint Committee Development plan to map out a forward plan of development activities for the JC and its sub-committees for 2022-2023. Progress will be monitored by the Integrated Governance Committee (IGC). The Joint Committee resolved to: • **Note** the completed actions made against the Annual Committee Effectiveness Survey 2020-2021 action plan, • **Note** the results from the Annual Committee Effectiveness Survey for 2021-2022, • **Note** that the findings were considered by the Integrated Governance Committee (IGC) on the 7 June 2022, • **Note** that the feedback will contribute to the development of a Joint Committee Development plan to map out a forward plan of development activities for the Joint Committee and its sub committees for 2022-2023; and • **Note** the additional sources of assurance considered to obtain a broad view of the Committee's effectiveness.
JC22/093	**3.12 Corporate Risk Assurance Framework (CRAF)** The report to present the updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers was received. JE advised that as at 31 May 2022, there were 18 risks on the CRAF, including 16 commissioning risks and 2 organisational risks with a risk score of 15 and above. Members noted the summary of changes to the CRAF between February and May 2022. Members noted that the highest commissioning risks related to: • Risk 23 Access to Care Adults with a Learning Disability (LD), • Risk 26 Neuropsychiatry patients waiting times; and • Risk 36 which was a new risk relating to 3D Biotronics-imaging platform and its chances of success/likelihood of failure. The two organisational risks related to: • Risk 29 - IPFR governance; and • Risk 33 - WG priority delivery measures. SM raised concern regarding the number of red risks with scores of 15 or above and the ability to focus on individual risks to reduce exposure. SL advised that WHSSC had established a Risk Scrutiny Group (RSG), which reported to the CDGB to monitor this, and that only the risks scored 20 and above were classed as high risks,

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	however these were commissioning risks and therefore would score differently to risks managed within provider HBs. KP advised that the risks were split between each of the five commissioning groups so that there were relatively few per sub-committee to focus upon, and that work had recently been completed at the request of the IGC to benchmark WHSSC risk scores against HBs' scores and the findings had demonstrated that WHSSC were scoring appropriately in accordance with its risk profile and appetite. Members noted that a risk management workshop was planned for 20 September 2022 to review how the RSG process was working, to consider risk appetite and tolerance levels across the organisation and to discuss developing a Joint Assurance Framework (JAF). A further update on risk scrutiny will be provided after the workshop. The Joint Committee resolved to: • **Note** the updated Corporate Risk Assurance Framework (CRAF) as at 31 May 2022, • **Approve** the Corporate Risk Assurance Framework (CRAF); and • **Note** that a follow up risk management workshop is planned for 20 September 2022 to review how the risk management process is working and to consider risk appetite and tolerance levels across the organisation.
JC22/094	**3.13 All Wales IPFR Panel Sub-Committee Annual Report 2021-2022** The All Wales IPFR Panel Annual Report 2021-2022 was received. The report set out the activities of the Sub-Committee for the reporting period 1 April 2021 to 31 March 2022. The Chair thanked the Corporate Governance Team and the Director of Nursing for compiling the Annual Report. The Joint Committee resolved to: • **Note and receive** the All Wales IPFR Panel Annual Report 2021-2022.
JC22/095	**4.1. Covid-19 Period Activity Report - Month 1 2022-2023** The COVID-19 activity report for month 1 was received and members noted the scale of the decrease in specialist activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in south Wales. The activity decreases were shown in the context of the potential risk regarding patient harms and of the loss of value from nationally agreed financial block contract arrangements. SD advised that performance against contracted levels had been poor

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	in the first two months of the financial year and that waiting lists were continuing to grow. Of particular concern were those over the 52 week and 104 week Ministerial targets. However, following the presentations earlier in the meeting, performance was expected to improve over the next six months. The Joint Committee resolved to: • **Note** the report.
JC22/096	**4.2 Financial Performance Report Month 2 2022-2023** The financial performance reports setting out the financial position for WHSSC for month 2 of 2022-2023 was received. Members noted that the financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan by the JC in February 2022. The financial position reported at Month 2 for WHSSC is a year-end outturn forecast under spend of £515k. The under spend predominantly relates to slippage in new planned developments and the NHSE Service Level Agreement (SLA) position. SD reported that there has been £8m of reserves released in month 3 and further releases were expected in the second half of the year. The Joint Committee resolved to: • **Note** the current financial position and forecast year-end position.
JC22/097	**4.3 Corporate Governance Matters Report** The Corporate Governance Matters report was received and members noted the update on corporate governance matters that had arisen since the last meeting. The Joint Committee resolved to: • **Note** the report, • **Note** the Declarations of Interest Register for 2021-2022, • **Note** the Gifts, Hospitality and Sponsorship register for 2021-2022; and • **Receive assurance** regarding the WHSSC Declarations of Interest (DOI), Gifts, Hospitality and Sponsorship process.
JC22/098	**4.4 Reports from the Joint Sub-Committees** The Joint Committee Sub-Committee reports were received as follows: **i. Audit and Risk Committee (ARC) Assurance Report** The JC noted the assurance report from the CTMUHB Audit and Risk Committee including:

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	• The Extraordinary Meeting to discuss the Annual Accounts and Accountability Report held on 18 May 2022, • The Extraordinary Meeting to approve the Annual Accounts and Accountability Report held on 14 June 2022; and • The Audit & Risk Committee CTM Hosted Bodies – Part 2 meeting held on 23 June 2022. **ii. Management Group Briefings** The JC noted the core briefing documents from the meetings held on 26 May 2022 and 23 June 2022. **iii. Quality & Patient Safety Committee (QPSC)** The JC noted the Chair's report from the meeting held on 7 June 2022. **iv. Integrated Governance Committee (IGC)** The JC noted the Chair's report from the meeting held on 7 June 2022. **v. Individual Patient Funding Request (IPFR) Panel** The JC noted the Chair's report from the meeting held on 16 June 2022. It was noted the meeting scheduled for 5 May 2022 had to be stood down due to the lack of quoracy. **vi. Welsh Renal Clinical Network (WRCN)** The JC noted the Chair's report from the meeting held on 6 June 2022. Ian Phillips (IP) highlighted that a number of risks had been mitigated on the WRCN risk register; and that in September 2022 there will be a significant procurement tender evaluation process for the provision for the 'West Wales Satellite Renal Dialysis Service with the inclusion of Dialysis Equipment' and that an update on progress will be brought to the JC on 8 November 2022. The Joint Committee resolved to: • **Note** the reports.
JC22/099	**5.1 Any Other Business** One item of other business was received in relation to: **WHSSC Specialised Services Strategy** - SL reported that the draft 10 year WHSSC Specialised Services Strategy will be presented to the Management Group on 28 July 2022 and to the JC on 6 September 2022.
JC22/100	**5.2 Date and Time of Next Scheduled Meeting** The JC noted that the next scheduled meeting would be at 09.30 on 6 September 2022.

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	There being no other business other than the above the meeting was closed at 16:25 hrs.
JC22/101	**5.3 In Committee Resolution** The Joint Committee resolved: "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)".

Chair's Signature: .....

Date: .....

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Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

JOINT COMMITTEE MEETING
2022 Action Log – 6th September 2022

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
15 March 2022					
JC22/004	**JC22/041 3.5 Major Trauma Update** **ACTION:** Dindi Gill from the Major Trauma Network (MTN) to be invited to provide an update presentation to the JC meeting in September 2022.	KP	Sep 2022	**24.08.22** – On JC Agenda – Item 2.1.	**OPEN**
10 May 2022					
JC22/006	**JC22/064 Neonatal Transport – Update from the Delivery Assurance Group (DAG)** **ACTION:** An update report on the Neonatal Transport Operational Delivery Network to be presented to the WHSSC Joint Committee at the next meeting.	KP	~~July 2022~~ Sept 2022	**10.05.2022** – Carried forward to September. **24.08.22** – On JC Agenda – Item 3.3.	**OPEN**
JC22/009	**COVID – 19 Period Activity Report Month 11 2021-22** **ACTION:** The July JC meeting will include a workshop to review the recovery trajectories from NHS Wales providers.	KP	July 2022	**24.06.22** - On Agenda – Item 2.1. Action to be closed. **29.07.22** – Presentations provided to JC on 12.07.22. Action completed.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
12 July 2022					
JC22/010	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** Presentations on the recovery trajectories across Wales from the NHS Wales Delivery Unit (DU), Betsi Cadwaladr UHB (BCUHB), Swansea Bay UHB (SBUHB) and Cardiff & Vale (CVUHB) were received. Karen Preece (KP) advised that the focus was on NHS Wales service providers as the activity of the NHS England (NHSE) providers regarding waiting time concerns were not as significant. Carol Shillabeer (CS) queried if data for NHSE could be detailed alongside the NHS Wales data in order to analyse the differences in access times for the Welsh population, to review equity and consider pathway options. **ACTION:** KP to create a slide presenting NHS England provider data against NHS Wales provider data to be circulated outside of the meeting.	KP	Aug 2022	**25.08.22 –** Presentations and this new slide was circulated to JC members on 27 July and 18 August 2022. **Action Completed.**	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/011	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** KP suggested that insufficient capacity in dermatology services has led to transfers to plastic surgery and a resolution in this area could ease demand on plastic surgery. **ACTION:** KP to liaise with James Barry (JB) on dermatology flows after the meeting to investigate opportunities and to convey good practice to other HBs.	KP	Aug 2022	**24.08.22 -** Discussions underway. To be explored further in Management Group Plastic Surgery Workshop on September 22nd	**CLOSED**
JC22/012	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** Sian Lewis (SL) advised that WHSSC was very concerned about the Royal College of Surgeons (RCS) prioritisation profile. KP suggested that a regional system review should be undertaken to establish if there had been a change in run rate over the last five years in HB referral thresholds as referrals into the Children's Hospital had increased leading to pressure on the service. KP also advised that waiting times at the Alder Hey Children's Hospital (AHCH), a commissioned provider, were lower leading to inequity concerns. Members agreed it would be useful to see performance data for children's services by both provider and HB of residence. **ACTION:** KP to take forward a review of the paediatric system.	KP	Aug 2022	**24.08.22** – Paediatric Deep Dive on JC Agenda. Item 2.3.	**OPEN**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/013	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** SD noted that there were anecdotal concerns that patterns of referrals for paediatric services into CVUHB had increased over the last 5 years and this change was having an adverse impact on the ability of the Children's Hospital for Wales (CHfW) to deliver tertiary care. **ACTION**: KP to include data on referral patterns into paediatric review.	KP	Aug 2022	**24.08.22** – Paediatric Deep Dive on JC Agenda. Item 2.3.	**OPEN**
JC22/014	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** Stuart Davies (SD) advised that he would follow up inquiries with both CVUHB and SBUHB on the increase in TAVI (Transcatheter aortic valve implantation) to investigate if this was a one-off issue due to backlogs or whether it was a long-term trend which would have a fundamental impact on being able to achieve contracted volumes. **ACTION:** SD to liaise with CVUHB and SBUHB to establish the rationale for the increase in TAVI and the potential long-term impact in achieving contracted volumes.	SD	Aug 2022	**24.08.22** – Update provided in the MD report.	**OPEN**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/015	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** SR suggested that KP prioritise the various actions discussed and focus on paediatric referrals first. HE advised that some of the DU data gave global figures presented a challenge on perception and comparison and that there was a need to focus on local and national data to ensure messages were clear. **ACTION:** A deep dive session on Paediatric referrals to be arranged for the JC meeting on 6 September 2022.	KP	Sept 2022	**24.08.22** – Paediatric Deep Dive on JC Agenda. Item 2.3.	**OPEN**
JC22/016	**MG22/085 - Draft Specialised Paediatric Services 5 year Commissioning Strategy** The report presenting the Draft Specialised Paediatric Services 5 year Commissioning Strategy for information and seeking support to share the strategy through a six week engagement process to obtain stakeholder feedback had been circulated prior to the meeting. Ian Wells (IW) requested further clarity to be provided on training and education of the staff operating the service. Steve Moore (SM) requested further detail to be included on workforce requirements in section 7.2. CS asked for the relationship with child and adolescent mental health services (CAMHS) and neurosciences to be referred to within the report.	KP	Aug 2022	**24.08.22** – These sections were updated prior to the document being issued for stakeholder feedback. **Action Completed.**	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/016	KP agreed to update the strategy and advised that that a resourcing plan would be developed to support the strategy. **ACTION:** KP to update the draft Specialised Paediatric Services 5 year Commissioning Strategy to include reference to staff training and education, workforce requirements and the link between CAMHS and neurosciences.				
JC22/017	**MG22/085 - Draft Specialised Paediatric Services 5 year Commissioning Strategy** Linda Prosser (LP) queried if the strategy will be available for individual HBs. KP advised that it would be circulated to each HB. **ACTION:** Once approved by the Joint Committee KP is to circulate the Specialised Paediatric Services 5 year Commissioning Strategy to all HB's.	KP	Aug 2022	**24.08.22** – This has been completed, all stakeholder feedback has been collated and is to be presented to members at the September meeting. **Action Completed.**	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/018	**JC22/090 - Supporting Ukrainian Refugees with Complex Health Needs** The report setting out a proposal for managing the complex health needs of Ukrainian refugees arriving in Wales and seeking approval to manage the excess costs (>£20k per annum) within the current funding baselines in year, offsetting against non-recurrent slippage and reserves was discussed. LP queried how individuals will be funded should they not have been identified at the screening stage or self-identified when entering the country or become more costly after a period of time once entering the country. It was agreed that further investigation would be undertaken in these areas. **ACTION:** WHSSC to investigate a method for identifying refugees who subsequently require high cost health care and a system of reimbursement for the HB of residence.	SL	Aug 2022	**24.08.22** - Retrospective reimbursement arrangement in place for patients exceeding £20k pa threshold. **Action Completed**.	**CLOSED**

South Wales Trauma Network

WHSSC Joint Committee

August 2022

GIG CYMRU NHS WALES
Rhwydwaith Trawma De Cymru
South Wales Trauma Network

Achub bywydau
Gwella canlyniadau
Gwneud gwahaniaeth

Saving lives
Improving outcomes
Making a difference

South Wales Trauma Network

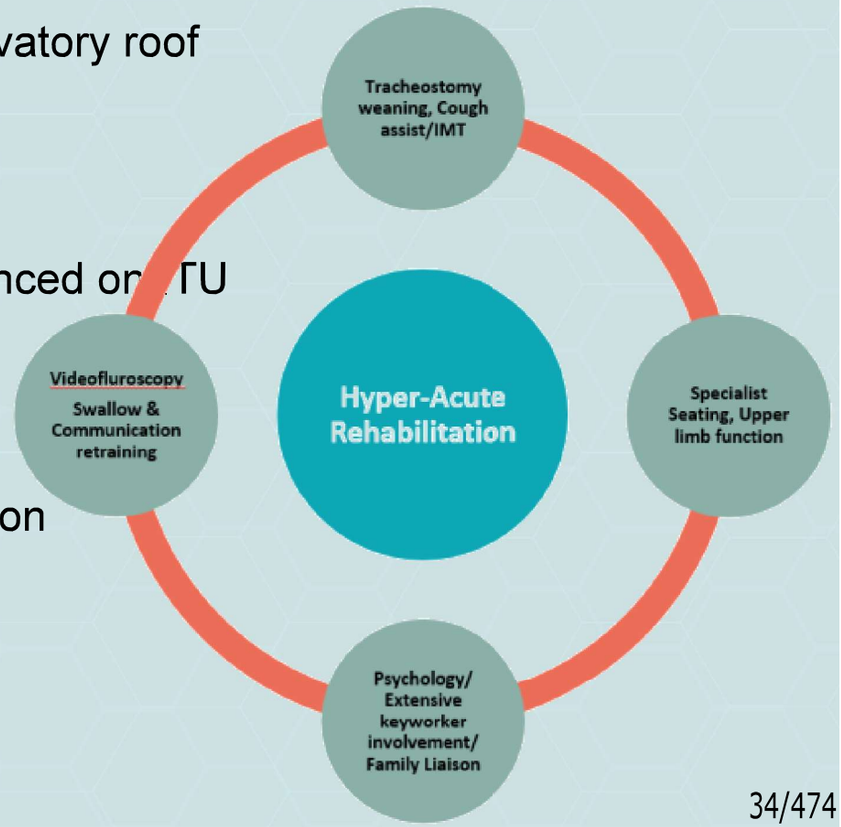
Introduction

- South Wales Trauma Network was launched 14th September 2020;
- Presentation & Experience of the first 18 months of the Major Trauma Network including TARN;
- Comprehensive evaluation process underway comprising of 3 stages focussing on-
  - **Programme implementation**
    - Post Programme Evaluation- published in May 2022;
  - **Programme in use- shortly after becoming operational**
    - **Peer Review-** measures SWTN Performance against a published set of quality indicator standards;
    - **1 Year Evaluation-** measures SWTN performance against the qualitative and quantitative measures where possible in the Benefits Realisation Plan (some benefits will not be realised until further maturity of the SWTN);
    - **Welsh Government Gateway 5 Review**;

South Wales Trauma Network

Patient Case Presentation

- 65 yr old gentleman from CTM UHB
- Admitted to MTC following a fall from his conservatory roof
- Diagnosed with an acute C4/5 spinal cord injury
- Ventilated post Spinal stabilisation surgery
- Tracheostomy formed and rehabilitation commenced on ITU
- Transferred to acute T&O ward
- Tracheostomy Removed
- Transferred to UHL Specialist Spinal Rehabilitation



South Wales Trauma Network

Rehabilitation Model

GIG CYMRU NHS WALES | Rhwydwaith Trawma De Cymru South Wales Trauma Network

Achub bywydau Gwella canlyniadau Gwneud gwahaniaeth | Saving lives Improving outcomes Making a difference

Acute Care
Major Trauma Centre / Critical Care Unit / Neurosurgical

Post-Acute Care
Ward Based

Hyper-acute Rehabilitation
Multidisciplinary team led by a Consultant specialist in Rehabilitation Medicine

Secondary Care
Ward Based

Specialist In-patient Rehabilitation
Multidisciplinary team led by a Consultant specialist in Rehabilitation Medicine

In-patient Rehabilitation
Level 3 inpatient services

Supported Discharge
Early Community Rehabilitation

Specialist Community Rehabilitation
Multidisciplinary rehabilitation.
Mathematical modelling taking place by ODN to determine future resource requirements

Level 1
For highly complex needs, provided in:
University Hospital Llandough
Neath Port Talbot
Supported by SWTN via Sitrep

Level 2
Secondary Services for complex needs, provided in Trauma Units, supported by MTP & RC model

Level 3
Local generic level 3 inpatient services, provided in Trauma Units, LEH, RTF's & DGH's

Specialist Community Rehabilitation

South Wales Trauma Network

TARN Demographics

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Achub bywydau
Gwella canlyniadau
Gwneud gwahaniaeth

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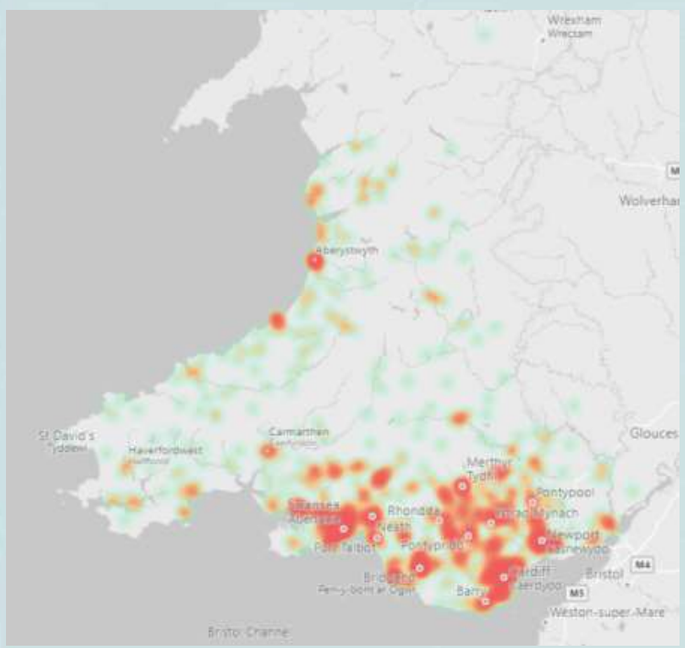
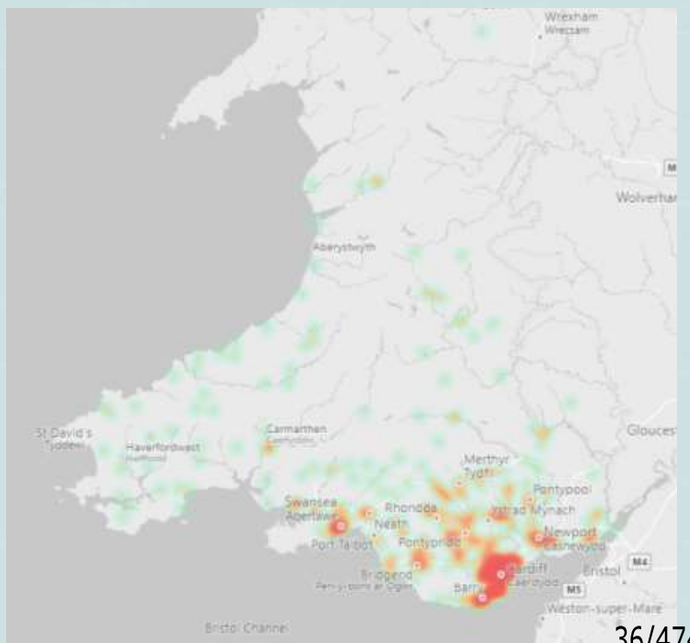
Making a difference

4702 TARN submissions from 14/09/2020 (go live) to 31/03/2022 across the network

	SWTN	MTC
	All incidents across the Network	Incidents treated at UHW
		
Median age	73	59
Male	50%	63%
days LOS (median)	9	8

South Wales Trauma Network

TARN Injuries

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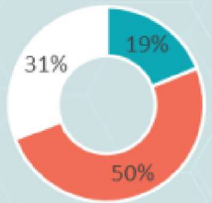
SWTN

MTC

MECHANISM OF INJURY

SWTN		MTC	
67%	Fall<2m	40%	Fall<2m
12%	Fall>2m	20%	Fall>2m
15%	Vehicle incident	30%	Vehicle incident
6%	other	10%	other

INJURY SEVERITY SCORE



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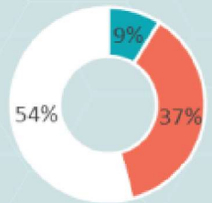

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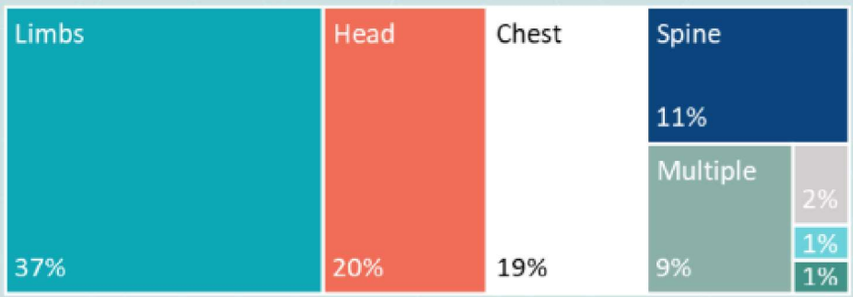
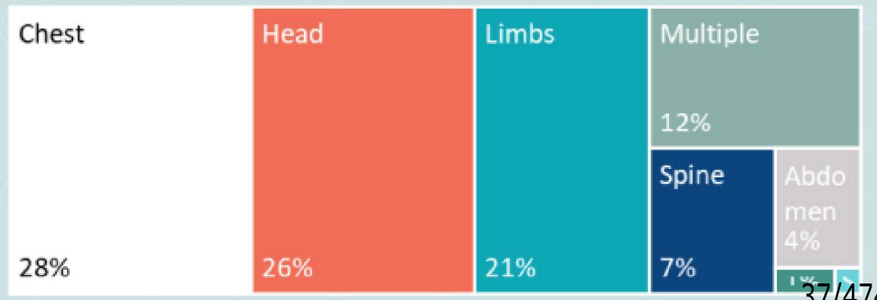
MOST SEVERELY INJURED BODY REGION





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TARN Outcomes

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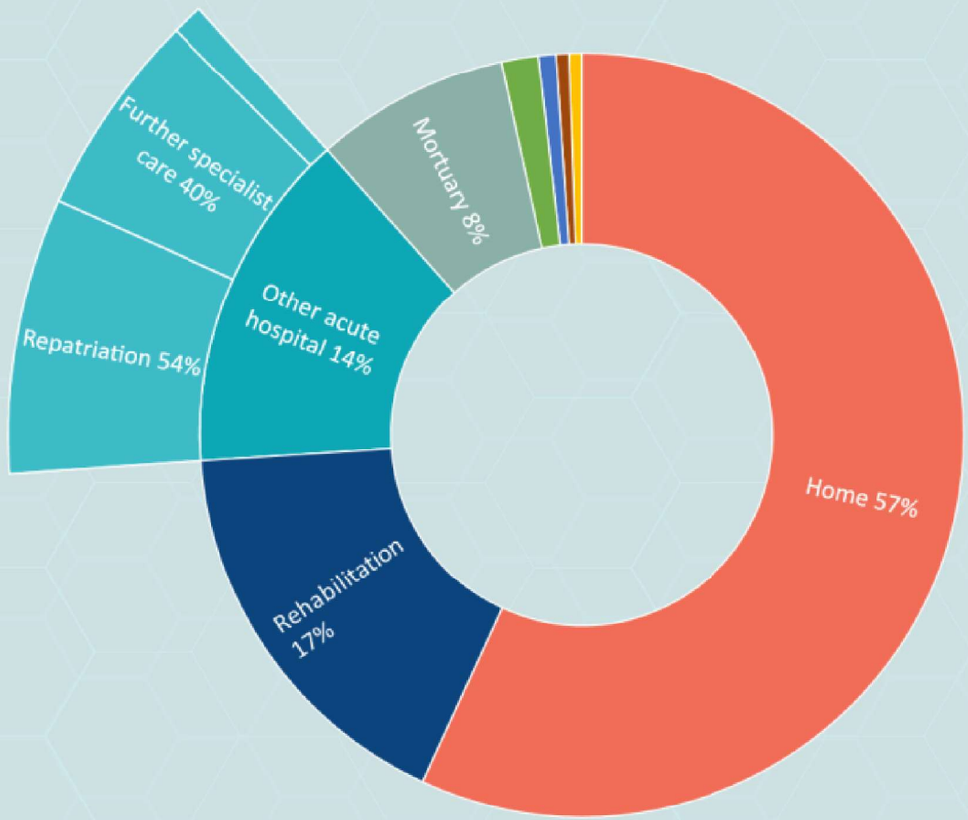
DISCHARGE DESTINATION FROM MTC



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Repatriation

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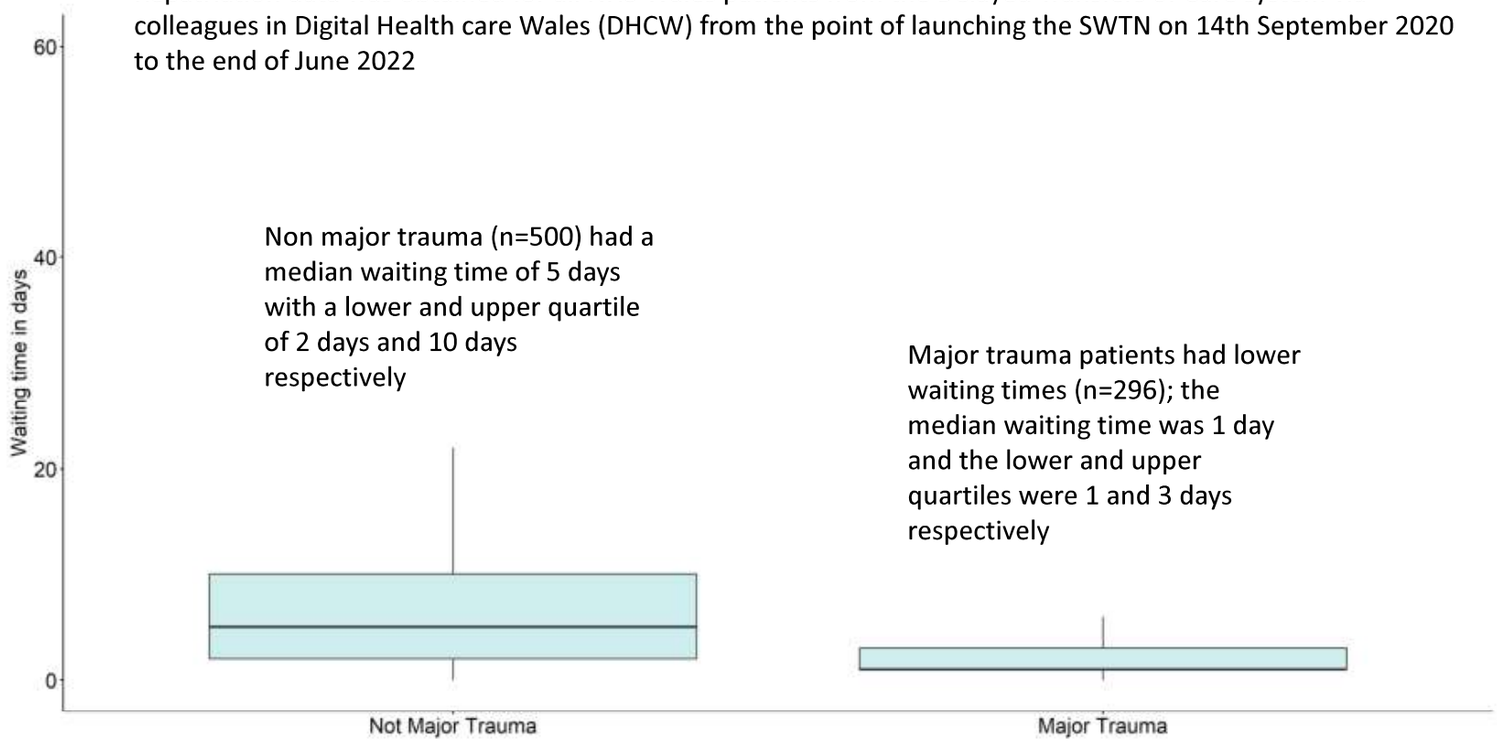
MAJOR TRAUMA Vs NON MAJOR TRAUMA REPATRIATION TIMES

Repatriation data was obtained for all NHS Wales patients from the Delayed Transfers of Care system via colleagues in Digital Health care Wales (DHCW) from the point of launching the SWTN on 14th September 2020 to the end of June 2022

Non major trauma (n=500) had a median waiting time of 5 days with a lower and upper quartile of 2 days and 10 days respectively

Major trauma patients had lower waiting times (n=296); the median waiting time was 1 day and the lower and upper quartiles were 1 and 3 days respectively



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Trauma Desk, WAST & EMRTS

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13 Median number of trauma desk calls connected per day from 14/09/2020 (go live) to 31/03/2022

MAJOR TRAUMA TRIAGE TOOL

917 trauma tool positive incidents

61% taken to UHW

39% taken to TU/LEH/RTF/ out of network

752 silver trauma tool positive incidents

18% taken to UHW

82% taken to TU/LEH/RTF/ out of network

SECONDARY TRANSFERS

52 pathway 1 (Hyperacute) transfers to MTC

83 pathway 2 (Emergency) transfers to MTC

22 pathway 3 transfers to MTC recorded

28 pathway 3 transfers to Morriston recorded

EMRTS

681 primary missions to MTC, **1079** primary missions overall, **56** secondary transfers to MTC (17 were ACCTS) involving EMRTS

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TRID's, GREATIX & Education

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TRIDS

240 TRIDs submitted

88 Delayed repatriation

38 Pathway awareness

<5 999 calls

49 Clinical issues

11 No transport available

8 Trauma desk contact

16 Automatic acceptance

20 Delayed transfer

17 Referral

6 Miss-communication

<5 Inappropriate transfer

8 other

Some TRIDs have more than one issue therefore counts of themes do not add up to 240

GREATIX

38 Nominations for team work, support, leadership and communication

EDUCATION

8384 Views of the guidelines and policies held in induction

SWTN training platform is now available and ready for release.

Review and editing of TTL and pre-hospital scenarios ongoing

REVIEW & EVALUATION

- [x] Peer review
- [x] Post programme Evaluation
- [ ] First Year Evaluation
- [ ] Gateway Review

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Peer Review

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- **South Wales Trauma Network underwent its first formal peer review in March 2022**
  - Facilitated by NHSE Quality Surveillance & Nursing National Specialised Commissioning Team and supported by Major Trauma Network providers from across the UK;
  - Peer Review is a detailed analysis of major trauma service provision, delivery and subsequent performance against the NHSE major trauma quality indicators for each provider; covered all HBs and organisations

- **Peer Review Outcomes**
  - The peer review team acknowledged the success of the South Wales Trauma Network since its launch in September 2020;
  - Several areas of good practice were identified by the peer review team;
  - There were **NO** Immediate Risks raised across the South Wales Trauma Network;
  - The process will help guide improvements to the SWTN pathways and processes in the

South Wales Trauma Network

Peer Review- Areas of Good Practice

- Clear and robust governance processes across the network;
- Provision of a standardised local major trauma team model at each provider;
- CWTCH Policy- providing rehabilitation and repatriation for patients closer to home where possible;
- Successful repatriation model across the network- >80% of patients repatriated within 24hrs;
- Regular and consistent communication demonstrated between clinical major trauma teams across the network, supporting the provision of a collaborative service for patients & families;

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Peer Review- Serious Concerns

- **Serious concerns raised with four Health Board providers:**
  - Cardiff and Vale University Health Board;
  - Aneurin Bevan University Health Board;
  - Cwm Taf Morgannwg University Health Board;
  - Hywel Dda University Health Board;

- **Formal submission of action plans to address serious concerns received from each health board- May 2022;**

- **Support provided to each provider organisation by the Operational Delivery Network via Health Board bi-monthly meetings- August 2022;**
  - Responsibility of delivery against the action plans sits with the organisations supported by the ODN;
  - Assurances will be sought on completion of actions through the Network Governance Group Meeting, Clinical and Operational Board and the Delivery Assurance Group;

- **Delivery against action plans to ensure resolution- October 2022.**

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Cardiff and Vale UHB- Summary of Serious Concerns & Action Plan

Serious Concern	Actions Agreed
Lack of Trauma Team Activation against criteria & secondary transfer acceptance	• Developed a work plan to improve compliance around team activation • Continued education around secondary transfers (position much improved)
Delayed in 5 minute primary survey CT reporting	• Audit & action plan to improve position
Lack of comprehensive adult Pain Service	• Assurance provided regarding the comprehensive service in place
Delay between time of arrival to craniotomy	• Review of TARN data to determine if due to a data quality issue
Lack of bespoke Paediatric Acute Pain Service	• Assurance provided regarding the comprehensive service in place
Lack of dedicated Paediatric Rehabilitation service & reliance on adult service	• Benchmark against other combined centres and action as appropriate • Links to WHSSC specialist paediatric rehab work stream

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Aneurin Bevan UHB- Summary of Serious Concerns & Action Plan

Serious Concern	Actions Agreed
Lack of Trauma Team Activation against criteria	• Action plan to address. • Immediate, medium term and long term strategy's to address the concern.
No rehabilitation strategy pertaining to major trauma for the organisation	• Secured funding for SALT provision. • Work with Clinical Director of Family & Therapies on rehabilitation strategy for OT provision at GUH. • 0.4 sessions of rehabilitation medicine secured

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Cwm Taf Morgannwg UHB- Summary of Serious Concerns & Action Plan

Serious Concern	Actions Agreed
Lack of operational management oversight across organisation	• CTMUHB undergoing large organisational change. • In the interim implement an Operational Board to provide a level of oversight of coordination and service delivery.
The Royal Glamorgan Hospital is recognised as a Local Emergency Hospital (LEH) within the structure of the SWTN, however it appears that they are functioning as a trauma unit (TU) without meeting a number of the quality indicators pertaining to being a TU.	• Gap analysis undertaken against TU quality indicators. • Review of ISS >15 cases for year 1 managed at the LEH (refinement of Silver trauma triage tool underway with WAST pan network) • Subsequent to action plan submission, Exec MD of CTMUHB confirmed at Delivery Assurance Group (2/8/22) that RGH will remain an LEH for the purposes of major trauma. • ODN to work with health board regarding the changes of flow.

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Hywel Dda UHB- Summary of Serious Concerns & Action Plan

Serious Concern	Action Plans
There is no clear definition for the role of the rural trauma facility (RTF), evidence indicates that at times patients are inappropriately directed to these units when a higher level of care is or may be required.	• Amendment to local RTF protocol to ensure greater flow to TU (desktop exercise completed). • Enhance secondary transfer pathways from RTF to TU and identification of major trauma patients in the RTF. • Refinement of Silver trauma triage tool underway with WAST pan network
Senior attendance at trauma calls	• Work plan to address

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Peer Review- Areas for Improvement

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- **Common themes throughout the peer review recommendations (built into organisational work plans):**
  - Trauma team activation;
  - Local training & education for Trauma Team Leader & Emergency Trauma Nurse to meet requirements;
  - Resilience of local major trauma teams;
  - Network wide rehabilitation strategy;
  - Redesign and promoted use of a patient facing rehabilitation prescription;
  - Capture and evaluation of patient experience;
  - Evaluate the provision of major trauma services by non-Trauma Units;
  - Cohorted management of complex major trauma patients managed by Trauma Unit and/or repatriated from MTC

South Wales Trauma Network

One Year Evaluation

- **The South Wales Trauma Network One Year Evaluation considers the deliverables of the network against the Benefits Realisation Plan;**
  - The scope of the benefits realisation plan to be evaluated has already been defined and agreed through the network governance structure;
- **The report is being authored by the SWTN data analyst & research and quality improvement clinical lead;**
- **The One Year evaluation will be validated externally through Swansea University;**
- **The One year Evaluation of the South Wales Trauma Network will be delivered via the following governance processes prior to being formally published:**
  - SWTN Clinical & Operational Board – 20th October 2022;
  - SWTN Delivery Assurance Group – 15th November 2022;
- **Combined with the peer review, this will form the basis of the forthcoming WG**

South Wales Trauma Network

Conclusion & Questions

- **Overall, the establishment of the SWTN has been successful, delivering some early positive outcomes and areas of excellent practice;**

- **The peer review process has been pivotal in identifying core areas for improvement incl. further tightening of pathway and clinical care.**
  - The caveat to this is a requirement for organisations to positively engage in the recommendations from peer review. Request that WHSSC Management Group and Joint Committee organisational members check in with their respective trauma clinical and operational leads to ensure issues are being addressed;

- **A mature trauma network takes 5 years to develop (as benchmarked through NHSE) – therefore it will take time to determine functional outcome benefits and resultant translation into Value for Money;**

- **The SWTN Operational Delivery Network would like to thank all organisations for**

SOUTH WALES
TRAUMA NETWORK

July 2022

PEER REVIEW FINAL REPORTS

CONTENTS

Trust Name: Cardiff and Vale University Health Board	**Date of Review:** 25 March 2022
Service: Major Trauma Centre – Adult	**Type of review:** National

Self-Declaration Compliance	**38/50 76%**	**Peer Review Compliance**	**35/50 70%**

Contextual Information and General Comments:

The major trauma centre (MTC) for adults is based within Cardiff and Vale University Health Board and is part of the South Wales Trauma Network (SWTN). It covers a geographical region extending across South and West Wales and South Powys. The MTC covers the following Health Board areas: Aneurin Bevan University Health Board (ABUHB), Swansea Bay university Health Board (SBUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Hywel Dda University Health Board (HDUHB) and Powys Teaching Health Board (PTHB).

As the single MTC for the region, co-ordination and collaboration is required with the regional pre-hospital and transfer services including the Welsh Ambulance Service NHS Trust (WAST), the Emergency Medical Retrieval and Transfer Service (EMRTS) and Wales and West Acute Transfers for Children (WATCh). Furthermore, there are six adult and paediatric trauma units (TUs) in the SWTN; Grange University Hospital, Cwmbran (ABUHB); University Hospital Wales (UHW) (CVUHB); Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend (CTMUHB); Glangwili Hospital, Carmarthen (HDUHB). The MTC also serves the Local Emergency Hospital at the Royal Glamorgan Hospital (CTMUHB) and Rural Trauma Facilities at Bronglais General Hospital and Withybush General Hospital (HDUHB). In addition, there is an adult and paediatric TU with designated specialist services in Morriston Hospital (SBUHB), which provides specific specialist support to the MTC in burns and plastics, thoracic and spinal surgery for patients who do not have multi-system injuries requiring transfer.

Reception and Resuscitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2B-101	**Trauma Team Leader**	**Y**	**Y**
Comments	There is a 24/7 trauma team leader (TTL) rota in place and a copy from October to December 2021 was shared with the reviewers. There is a list of responsibilities listed within the operational policy. There is an identified TTL solely for major trauma between the hours of 08:00 and midnight. Out of these hours the TTL role is undertaken by the emergency department (ED) consultant on call between midnight and 08:00 hours although this is not a supernumerary position that would ensure full capability during times of ED activity surges. There are honorary contracts in place for nine consultants from the SWTN to allow the MTC to support colleagues from the regional TUs and pre-hospital services across the region in undertaking shifts on the MTC rota and support in maintaining and developing skills. There is		

	however, a reluctance in carrying out TTL shifts due to the pressures on workload and travel. Trauma Audit Research Network (TARN) clinical reports indicated 70% of ISS >15 patients were seen within five minutes of arrival, which is positive against a national average of 64%. However, the overall number of TARN eligible trauma team activations is only 341/600 (56.8%) for the year which is worryingly low compared to a mature MTC that might achieve nearer 80% of the TARN cohort. In line with the standards, attendance times to trauma calls by a speciality trainee (ST) three and above within five minutes were poor at 10.9%, whilst this was mitigated by consultant attendance within 5 minutes at 88%, which is just below the national average of 91%. Attendance by a consultant within 30 minutes was also just below the national average at 88.9%, indicating >50% of the country are outperforming the unit in this area currently.		
T16-2B-102	**Trauma Team Leader Training**	**Y**	**Y**
Comments	Reviewers were informed that all TTLs have completed TTL training. There was no evidence provided to reviewers to gain an understanding of the course attended or when they attended to ensure all are in date and that there is a robust plan to continue attendance at this training. Trauma team leader training should also include regular updates on pathway awareness for new TTLs and ongoing updates and reminders for existing TTLs.		
T16-2B-103	**Emergency Trauma Nurse AHP**	**Y**	**Y**
Comments	There is 100% rota cover from a nurse or allied health profession (AHP) of band 7 or above available for major trauma 24/7 who has successfully attained the adult competency and educational standard of level two as described in the National Major Trauma Nursing Group guidance. For trained nurses in emergency and acute medicine there is 76% trained at level one and 59% at level two. 23% have level two training that has expired due to lack of course availability during the Covid-19 pandemic. There is a plan for these nurses to renew their training by September 2022. Specifically, for band 7 nurses there is 100% compliance with level two training which covers both adult and paediatrics who can cross cover for the paediatric nurse, as there is only one band seven in post. The use of the South Wales Trauma Network (SWTN) online training package for level one nurse training followed by a competency checklist has supported the training of staff alongside in-house training. For new nurses into the unit the level one course is built within their induction with competencies not signed off for the first 12 months.		
T16-2B-104	**Trauma Team Activation Protocol**	**Y**	**Y**
Comments	There is a network trauma team activation protocol which includes a list of roles and responsibilities. It was noted within the triage tool that it designates a fall from six meters or more, this was considered to be a generous target and should be reviewed and reduced. Additionally, the trauma call activation criteria consist of Glasgow coma score (GCS) of less than four with most other MTC major trauma calls being activated with GCS less than 13/14. Additionally, spinal injury is evidenced by neurological deficits however this is just selecting spinal cord injury patients and ignoring potential three column fracture patients. This should also be reviewed within the trauma call criteria. Furthermore, There is a trauma team activation poster which is a visual aid that is displayed in the clinical areas to support assessment of trauma.		

	If a patient meets the trauma activation criteria, the adult trauma team should be activated by the TTL calling switchboard on 2222 and stating, 'adult trauma team to emergency unit resus please'. Once a trauma call is activated, all team members must attend the resuscitation room in the emergency unit immediately and report to the scribe to document their name, position, and grade. Team members should wear appropriate personal protective equipment (PPE) and role/name stickers. The TTL will brief the team and allocate roles. The TTL should use the SWTN pre-arrival checklist to ensure all necessary personnel, drugs and equipment are prepared. Reviewers were informed that there are some trauma patients that are missed that get picked up the next morning by the major trauma practitioners (MTP). Following an audit of missed patients, it was noted that these are patients in the higher age group, who self-present, with low impact injury. To support addressing these missed patients, funding has been secured for eight sessions of a geriatrician, including supporting professional activities (SPA) time, to work up pathways for this group of patients. There needs to be ongoing audit to monitor if there is a continued lack of silver trauma call activations for self-presenting cases that needs to be addressed. The reviewers are concerned that there is a lack of adherence to the criteria, as activation calls appear to be lower than expected for the number of major trauma patients attending the MTC. The MTC should work with the network to address this issue. Additionally, there are some concerns about automatic acceptance from secondary transfers expressed by other organisations, although this has improved of late which was discussed with reviewers during the walk through of the patient pathway and raised to reviewers within TU peer reviews. The MTC should focus on continuing to ensure all TTLs and specialties have a good understanding of the secondary transfer pathways and importantly an appreciation of the principles of automatic acceptance and what this means in practice.		
T16-2B-105	**24 7 Surgical and Resus Thoracotomy Capability**	**Y**	**Y**
Comments	In South Wales, chest trauma is predominantly blunt trauma with a smaller amount of penetrating trauma, predominantly knife injury, with gunshot injury rare. Penetrating injury requiring resuscitative thoracotomy is sufficiently frequent (approximately one every one to two months) that there needs to be an established working pathway, but not high enough to give regular experience for individual members of staff. Reviewers were informed that there is anxiety and fear regarding performance of surgical and resuscitative thoracotomy amongst some staff due to the lack of opportunity to undertake these skills. Additionally, reviewers were informed that cardiac or thoracic surgeons attending the resuscitation department may also have limited experience/training/understanding of resuscitative thoracotomy due to limited on site cardiac and thoracic services. A training course based on definitive surgical trauma skills (DSTS) course principles is run in house to train staff however, trainers are from specialities other than cardiothoracic surgery. Reviewers would recommend it would be appropriate if some of these courses have a faculty member teaching who has a cardiac or thoracic surgical background with an interest in chest trauma and resuscitative thoracotomy. Cardiothoracic surgery is a speciality on the General Medical Council (GMC) specialist register however, in practice, practitioners are either cardiac or thoracic surgeons. Cardiothoracic consultant surgeons are no longer being appointed in the United Kingdom. Increasingly, cardiac surgeons may be uncomfortable dealing with thoracic injuries and thoracic surgeons may be uncomfortable dealing with cardiac injuries. Staff reported that in Cardiff the cardiac surgeons do not want to deal with chest trauma and thoracic surgery provide support. Reviewers recommend it is important that the attending trauma team should easily be able to request and obtain appropriate support of either cardiac or thoracic surgeons as needed, and the pathways and contact routes must be clear and simple to progress. Additionally, reviewers were informed that immediate major intervention; an example is resuscitative thoracotomy, is normally provided by non-cardiac/thoracic surgeons who have limited experience and training usually amounting to one day's tissue simulation training. This at best		

	allows damage control surgical management and rarely definitive treatment. Currently, attendance of senior staff to the MTC within 30 minutes of call cannot be guaranteed. It was noted that this is due to cardiac and thoracic surgery in UHW has been moved off-site to Llandough Hospital. Thoracic surgery is also provided at Morriston Hospital, SBUHB. Reviewers would recommend that experienced cardiac/thoracic surgical support must be available in a timely manner to provide ongoing treatment and care. There was a lack of clarity regarding if the thoracic surgical units potentially will consolidate, whether cardiac and thoracic surgery will be co-located and whether services will be located at the MTC, offsite in Cardiff or at SUHB. Reviewers would suggest that both cardiac and thoracic surgery should be located such that cardiac and thoracic attendance and support to the MTC can be achieved within 30 mins.		
T16-2B-106	**24 7 CT Scanner Facilities and on-site Radiographer**	**Y**	**Y**
Comments	There are three computer tomography (CT) scanners based on UHW site. There is a CT scanner based in the emergency department which provides a 24/7 cover with a full complement of staff, and the facilities to scan three patients simultaneously during the working day. Emergency radiology reception has a reporting radiology hub which is manned 24/7 with the minimum of a registrar. Not all trauma patients have reports written straight away, this is assessed against risk by the radiologist. There is a direct to CT policy for patients transferred to the MTC by EMRTS who are accompanied by a pre-hospital consultant and critical care practitioner. Only patients that have isolated head trauma and those that are haemodynamically stable are considered for transfer directly to the CT scanner. These patients remain the clinical responsibility of the pre-hospital team until formal handover of care to the TTL. Currently, this policy is on hold due to Covid-19 and infection prevention measures that were introduced by UHCV as pre-hospital staff were not allowed into the scanning rooms due to PPE requirements. Reviewers were informed that this policy was planned to be reactivated however, no timescales were provided for the reimplementation and this should now be clarified. The TARN data for quarter two 2021/2022 identified that the proportion of patients with injury severity score (ISS) greater than eight with trauma scan less than 30 minutes as 34.9%, which is greater than the national average of 26.5%. The proportion of patients with ISS greater than fifteen with trauma scan less than 30 minutes is reported at 47.1%, which is greater than the national average of 35.9%.		
T16-2B-107	**CT Reporting**	**Y**	**Y**
Comments	Reviewers were informed that currently, providing a hot report within five minutes of the scan commencing is not always met. The impact of this could cause potential delays and impact upon patient care. Whilst it was suggested that this may reflect a data capture issue, an audit should be undertaken to ensure the availability of reports within the required timescale. The TARN data for quarter two 2020/2021 identifies the median time to provisional report is 52 minutes (34 – 76 minutes), which is slightly below the national average of 54 minutes. The median time to final report is 362 minutes (143 – 685), which is above the national average of 260 minutes. All reports completed by a radiology registrar are reviewed within a maximum of 24 hours by a consultant radiologist who will verify and add addendums to reports, as appropriate. Out of hours, the radiologist has additional responsibilities across the hospital and therefore clinical prioritisation needs to be considered.		

T16-2B-108	**24 7 MRI Scanning Facilities**	**Y**	**Y**
Comments	There is 24/7 access to magnetic resonance imaging (MRI) with no reported issues or delays to access or reporting.		
T16-2B-109	**24 7 Interventional Radiology**	**N**	**Y**
Comments	The interventional radiology (IR) service is in operation providing a 24/7 consultant led service within 30 minutes for major trauma. There are three IR rooms in the main department and all three have daytime sessional lists of a mix of interventional and diagnostic examinations in vascular and neurological. The IR rooms are on a different level and a different block of the hospital to the emergency department. The approach for each case is guided by the radiologist and surgeon as to which approach is taken. Belmont transfusion and full body scan is available, if required. There is a vascular surgeon on call, available within 30 minutes. There is a business case presented within CVUHB for a hybrid theatre which would mean patients could be taken to the IR room and converted to an open theatre, if needed. There were no timescales for the progress of this business case provided to reviewers however, reviewers would encourage the progress of this to ensure safe environment when a patient requires an open procedure.		
T16-2B-110	**24 7 Access to Emergency Theatre and Surgery**	**Y**	**Y**
Comments	There are two dedicated confidential enquiries into perioperative deaths (CEPOD) theatres available 24/7. These are in theatres eight and nine in UHW main theatre suite. The CEPOD theatre operation policy and example of rota was shared with reviewers. There was no audit of access to these theatres and reviewers would recommend completion of an audit to ensure timely access is available to all patients 24/7.		
T16-2B-111	**Damage Control Training for Emergency Trauma Cons**	**Y**	**Y**
Comments	There are five consultants fully trained in damage control surgery with the aim for a further two to be trained by December 2022.		
T16-2B-112	**24 7 Access to On-site Surgical Staff**	**Y**	**Y**
Comments	There is access to a general surgeon, trauma and orthopaedic surgeon and an anaesthetist ST four or above and a neurosurgeon ST two or above onsite 24/7 to support the MTC. Additionally, there is access to consultant specialists within 30 minutes for all main specialties. All on-call rotas are available via the CVUHB intranet and examples of rotas were shared with reviewers.		
T16-2B-113	**24 7 Access to Consultant Specialists**	**Y**	N
	Reviewers were informed that there is access to all consultant specialities within 30 minutes. However, there is a lack of out of hours and weekend cover for plastics. There are four plastic surgeons covering only Monday to Friday, 08:00 to 20:00 hours, specifically designed to		

	provide site cross cover for open fractures. There are plans to increase this to 24/7 cover however, no timescales were provided as to when this would be implemented. There are 27 plastic surgeons based in SBUHB. Additionally, there is the lack of on-site cardiothoracic cover as described above and this needs to be urgently addressed.		
T16-2B-114	**Dedicated Orthopaedic Trauma Operating Theatre**	**Y**	N
Comments	There are two CEPOD theatres and a third theatre that is dedicated to major trauma, but when not in use becomes a third CEPOD theatre. The hours of availability were unclear to reviewers however, there was a gap for weekends and the team do have a detailed theatre recovery plan for Saturdays, which is currently being worked up and will be implemented by June 2022. Additionally, there is a dedicated orthopaedic theatre which is separate to the other three theatres and runs from 08:00 to 19:00 hours seven days a week. It was unclear to reviewers if this theatre was dedicated to orthopaedic trauma lists or included daily orthopaedic elective lists. Reviewers would suggest having clear theatre schedules to evidence the dedicated use for orthopaedic trauma lists. The major trauma theatre is primarily used for major trauma cases and damage control surgery. When fitting in extra cases the team try not to fill in these spaces with cases that may over run. There is a standard operating procedure (SOP) in place for this which only allows for specific cases under 45 minutes. Reviewers were informed that weekends can be more of a problem due to no dedicated list however, major trauma will take priority. In order to accept transfers, there is a need to be flexibility with orthopaedic colleagues, although the polytrauma unit is not deemed as an ideal transfer destination. This has been flexed to meet the 48-hour time frame to transfer a patient in. Ambulatory patients can be waiting up to a week at home to gain access to an orthopaedic waiting list in Llandough Hospital. Craniotomy TARN data shows only 11 craniotomy cases in 2020/21. Timings show that patients are getting to CT scan within 39 minutes however, craniotomy waiting time is 209 minutes. The median time from incident to craniotomy is 471 minutes, this is above the MTC average of 370 minutes. It was unclear to reviewers the reasons for this delayed time to craniotomy. The impact of this delay may cause deterioration of the patient and the patient's outcomes could be impacted. The data needs to be reviewed to identify if this is an accurate reflection on practice as reviewers were informed that there are no noted issues of trauma patients getting into the operating theatres. If the data is accurate there needs to be an understanding of where there are potential delays, whether the problem relates to availability of operating space, availability of on-site trauma-dedicated neurosurgical on-call or that there is not a timely activation call or other potential factors with interventions are put in place to reduce potential delays.		
T16-2B-115	**Provision of Surgeons and Facilities for Fixation**	**Y**	**N**
Comments	There are two separate thoracic units with differing provision of services between them in relation to pathways for blunt trauma, including the provision of rib fixation. In view of the number of patients who may require rib fixation, both in polytrauma patients and isolated chest trauma, rib fixation services should be a co-ordinated single service covering the needs of South Wales meeting BOAST - The Management of Blunt Chest Wall Trauma standards (https://www.boa.ac.uk/resources/boast-15-pdf.html). The sustainability of having two separate independent thoracic units rather than a single thoracic service should be strongly considered. A single thoracic trauma service will help ensure consistency and equitable provision of care to trauma patients.		

T16-2B-116	**Trauma Management Guidelines**	**Y**	**Y**
Comments	All clinical guidelines are available electronically via the induction application and on the CVUHB SharePoint site. On induction, staff are orientated to how to access the clinical guidelines. All guidelines follow a governance process to ensure they are current and up to date. An extensive selection of guidelines were shared with the reviewers.		
T16-2B-117	**Critical Care Provision**	**Y**	**Y**
Comments	There are seven intensive care and four high dependency beds within the paediatric critical care unit (PCCU) in the Children's Hospital for Wales and there is an automatic acceptance for paediatric major trauma patients across the SWTN. For exceptional circumstances, if children are cared for on an adult intensive care unit (ITU) prior to transfer to a PCCU, there is a guidance for when resources are constrained including guidelines for the temporary management of children that comply with the minimum standards of the paediatric intensive care society, safe transfer / retrieval pathways. The unit is part of a paediatric intensive care network.		
T16-2B-118	**247 Specialist Acute Pain Service**	**N**	**N**
Comments	The acute pain service is nurse led with a team of clinical nurse specialists (CNS) combining clinical, educational and governance responsibilities. The team is comprised of 8.44 whole time equivalent (WTE) CNSs; 6.44 WTE band sevens and 2.0 WTE Band sixes. Many of the nurses are non-medical independent prescribers and all have a MSc in pain management. Service provision in UHW is seven days a week Monday to Friday, 08.00 to 20:00 hours and Saturday and Sunday 08.00 to 18:00 hours. This team also provides a service in UHL 08.00 to 15:30 hours, Monday to Friday, with a workload that is generally elective theatre activity and therefore more predictable. Several CNSs also manage their own caseload through either face to face chronic pain clinics in outpatients or by virtual clinics and provide interventional treatment clinics. Medically there is no dedicated sessional time however, the service is supported when required, and able to, 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 specialist acute pain service available to the MTC should allow patients early access to regional or epidural analgesia should they require it within six hours. At the time of the review reviewers were informed that the average wait times for a regional technique is 23.2 hours, far exceeding the required 6-hour standard. No patient since March 2021 has received a block within this six-hour timeframe. Reviewers were informed that the principle reason for this delay is the lack of funded resources required to expedite this treatment modality. There has been agreement for funding for an additional band seven nurse, however, no timescales have been identified for commencement of the role. The adult pain services are over-reliant on duty anaesthetic teams out of hours and lacks dedicated personnel to deliver a comprehensive service. Data should be reviewed to determine how this might be presenting an issue and steps taken to ensure the issue is resolved.		
T16-2B-119	**Administering Tranexamic Acid**	**Y**	**Y**
Comments	The TARN data identifies that from September 2020 to August 2021 there were 53 patients that received tranexamic acid. Of these patients 47 (88.7%) received within three hours of incident. This is slightly lower than the national average for MTCs which is 90.4%.		

Definitive Care			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2C-101	**Major Trauma Centre Lead Clinician**	**Y**	**Y**
Comments	There is a named clinical lead for the major trauma centre with a job description listing roles and responsibilities and one PA per week to undertake this role.		
T16-2C-102	**Major Trauma Service**	**Y**	**Y**
Comments	The major trauma service is led by consultants who take responsibility for the holistic care and co-ordination of management for every individual major trauma patient daily. Each patient has a named speciality consultant and a MTC consultant who coordinates the complex interdisciplinary management of all aspects of their care. Major trauma patients are admitted according to clinical needs under the care of a named parent speciality consultant, with daily coordination of care provided by a MTC consultant. If the patient is admitted to critical care they would be admitted under the on-call critical care consultant and speciality ward under the care of the named parent speciality consultant. The MTC consultant is responsible for ensuring that each patient has a thorough tertiary survey and will coordinate management of all aspects of care. There is one morning ward round on PTU, and one afternoon board round. The outliers are seen daily by the MT service through a combination of MTC consultant, MTPs, RC, rehabilitation medicine consultant/ registrar, PTU Surgical registrar, MTC trauma and orthopaedic consultant or MTC geriatric consultant, however not all outliers are seen every day by the MTC consultant. It was unclear to reviewers that if the patient is admitted under a speciality consultant with the MTC consultant overseeing if this was a robust process to ensure that patients with polytrauma have the priority of care from all specialities required to support the patient, especially if they were placed in a bed outside of the polytrauma unit.		
T16-2C-103	**Major Trauma Coordinator Service**	**Y**	**Y**
Comments	There are five major trauma practitioners (MTP) which equates to 4.2 WTE posts from nursing and AHPs who cover the service from 07:30 to 18:00 hours seven days a week. Monday to Friday there are two MTPs rostered on duty and on weekends there is one MTP. All MTPs have completed level three safeguarding training. The MTPs cover both adult and paediatric trauma however, there are no MTPs with paediatric specific training. There is a weekly paediatric safeguarding meeting which is attended by the MTP, paediatric lead AHP and members of the paediatric therapy team. Reviewers would suggest the consideration of a specific paediatric major trauma practitioner, who sits within this team, where cross cover can be provided with ownership of the paediatric aspects of the role and continuity with safeguarding issues that are raised.		
T16-2C-104	**Major Trauma MDT Meeting**	**N**	**Y**

Comments	There is a daily multi-disciplinary team (MDT) meeting that commences at 08:30 hours, with a signed register of those who attend. The MTC consultant will chair the major trauma MDT and undertake a review of all admissions over the previous 24 hours. Attendees include clinical staff from the major trauma service, orthopaedics, general surgery, thoracics, critical care, the MTP and a physiotherapist. Radiology are available but do not attend the MDT daily. The discussions within the meeting includes all relevant specialities to ensure that all appropriate investigations have been undertaken and all relevant specialities are involved in the care of the patient. Attendance lists and a recording of an MDT meeting were shared with reviewers which evidenced good attendance which are beneficial to support individual learning and ensuring holistic care for the patient. This was recognised as a good practice. The meeting could be strengthened further by involvement of other tertiary surgical services incl. neurosurgery.		
T16-2C-105	**Dedicated Major Trauma Ward or Clinical Area**	**Y**	**Y**
Comments	There is a 14 bedded polytrauma unit as the identified area for co-location of admission for all major trauma cases, including for cases with neurological, pelvic injuries and tracheotomies. However, a maximum of two tracheostomies can be cared for together. Additionally, patients with patient-controlled analgesia (PCA) regional blocks can be cared for on the unit. Patients with external lumbar drains and intercranial pressure (ICP) are not cared for on the unit. Out of the 14 beds, six are classed as higher acuity with a 1:3 nursing ratio for level 1 patients. There is a significant challenge surrounding access to the two cubicles, for various reasons however mental health and adolescent patients are prioritised. Infection prevention and control constrains for patients moving across networks also add pressure on use of the side rooms. The poly trauma unit demonstrated an area of good practice and one of the key investments for a MTC, although TARN length of stay (LOS) data from the clinical reports indicated there would on average be circa 10.7 beds of outlying patients on average for the year, of which 1.3 beds would contain patients with an ISS greater than 15. It was not clear how outlying patients beyond the polytrauma unit were coordinated or cared for by outreach teams from the specialist polytrauma unit area. There are plans to develop the other side of the unit to enable more capacity reducing the number of outliers however, there were no timelines for this. Reviewers would recommend pursuing the development of additional beds.		
T16-2C-106	**Formal Tertiary Survey**	**N**	**N**
Comments	The MTC consultants are responsible for ensuring that each patient has a thorough tertiary survey and co-ordinate management of all aspects of care, in collaboration with the rehabilitation medicine consultant who oversees the rehabilitation needs of all major trauma patients. There is also collaboration with TARN, auditing and measuring compliance. As a wider service, one of the polytrauma practitioners is carrying out an audit of trauma booklet which contains a detailed tertiary survey checklist. The team acknowledge they need to expand the portfolio of audits undertaken.		
T16-2C-107	**Management of Neurosurgical Trauma**	**Y**	**Y**
Comments	There is on-site neuroradiology and neurocritical care. There is a neurosurgical consultant and a senior neurosurgical trainee, ST4 or above available for advice to the trauma network 24/7. All neurosurgical patient referrals are discussed with a consultant, as are all decisions to perform emergency neurosurgery. There are facilities to allow neurosurgical intervention within one hour of arrival at the MTC. The TARN data for September 2020 to August 2021 identifies there were 16 patients requiring a head and brain operation with the median minutes to		

	operation 232 (120 – 582) which is slightly below the national average of 235 (131 – 466) minutes.		
T16-2C-108	**Management of Craniofacial Trauma**	**Y**	**Y**
Comments	There is an agreed pathway for patients with craniofacial trauma, which includes joint management with maxillofacial and neurosurgery. Patients can be referred for craniofacial injury either from a maxillofacial surgery referral pathway or from a neurosurgery referral pathway for management. Collaborative management of the patient with both the specialties occurs once they are in the pathway. Neurosurgery and maxillofacial are collocated at UHW and there is an on site maxillofacial surgeon on call to assist with such cases.		
T16-2C-109	**Management of Spinal Injuries**	**Y**	**Y**
Comments	There is a MTC agreed SWTN clinical guideline for protecting and assessing the whole spine in adults and children with major trauma. The neuro and spinal specialised rehabilitation unit is based in the University Hospital Llandough (CVUHB) as well as the spinal cord injury centre (SCIC) for adults. Patients with spinal injuries are seen by MTC spinal rehabilitation within five days through the coordination of the outreach team and specialist consultants, therapists, and surgeons. It was unclear to reviewers whether outreach support is provided to patients following discharge to a local hospital closer to home. If this is a service gap, it should be reviewed and addressed.		
T16-2C-110	**Management of Musculoskeletal Trauma**	**N**	**N**
Comments	There is a SWTN SOP for orthoplastic management 2022 and plastic surgery within the MTC. There is a collaboration between CVUHB and SBUHB to provide an orthoplastic service. The trauma and orthopaedic departments in both health boards have complex trauma specialists that work collaboratively to provide expertise in major and orthoplastic trauma, supported by trauma and orthopaedic departmental colleagues for a full on-call service. All patients that require orthoplastic care for complex limb trauma will be under joint care by trauma and orthopaedics and plastic surgery at the MTC. The plastic Surgery SOP defines plastic surgery provisions in the MTC, ensuring comprehensive assessment and treatment to adult and paediatric trauma patients referred as inpatients or outpatients for plastic surgery following trauma. There isn't an out of hours and weekend consultant plastic surgeon which compromises the care of complex musculoskeletal injuries. The lack of a comprehensive orthopaedic / plastic service is a significant problem. The benefit of combined care is having senior decision making from the initial surgery, not just to conduct the definitive soft tissue cover.		
T16-2C-113	**Management of Maxillofacial Trauma**	**Y**	**Y**
Comments	There is on site maxillofacial surgeons with access to theatre for the reconstruction of maxillofacial trauma. There is a three-tier service, which includes five oral and maxillofacial consultants and one oral surgery consultant. There are seven middle grade doctors involved with the on-call team, including three maxillofacial registrars, three staff grades and one locum middle grade. The rota consists of eight first on-call, 12 hour shifts with split nights. There is also a junior doctor covering the wards on weekends and covering the emergency department.		
T16-2C-114	**Vascular and Endovascular Surgery**	**Y**	**Y**

Comments	There are facilities for open vascular and endovascular surgery, including endovascular repair (EVAR), available 24/7 with dedicated theatre and interventional radiology (IR) sessions. There are five vascular surgeons and four IR surgeons based at UHW with a regional vascular surgeon on call rota for South East Wales. Since the centralisation of vascular services from RGH, there are an additional two vascular surgeons based at UHW. The availability of a hybrid theatre would support the provision of vascular and endovascular surgery.		
T16-2C-115	**Designated Specialist Burns Care**	**Y**	**Y**
Comments	There is the SWTN guideline for burns. The MTC and SWTN sit within the South West UK Burns Network. Adult patients who require specialist burns care will be transferred for management to the regional centre for burns and plastics at MH (SBUHB).		
T16-2C-116	**Patient Transfer**	**Y**	**N**
Comments	A number of TU reviews within the SWTN indicated recurrent problems and inconsistences with the 'automatic acceptance' process for transfer and threshold of patients accepted by the MTC TTL. Further to this, it was indicated by consultants that recurrently, subsequent direct calls to specialties would then override the initial MTC TTL rejection and accept direct transfers to wards. This was further evidenced by a low number of TARN transfers in to the MTC at only 111 cases for the year, near half what would be expected for a unit of this size. This has been highlighted as a serious concern and needs to be further addressed.		
T16-2C-117	**Network Patient Repatriation Policy**	**Y**	**Y**
Comments	There is a regional repatriation policy for major trauma, to which all Health Boards in the SWTN have signed up. There is a good repatriation rate of above 80% repatriation within 48 hours from ready to transfer. This is supported with the well-attended weekly rehabilitation MDT meetings with the TUs allowing the preparation for readiness to accept a patient once fit for transfer.		
T16-2C-118	**Specialist Dietetic Support**	**Y**	**Y**
Comments	There is a band seven specialist dietitian available daily as part of the major trauma multi-disciplinary therapies team. Main areas are generally centred upon polytrauma unit and specialist services however, all major trauma patients requiring input are covered by the service.		
T16-2C-119	**24 7 Access to Psychiatric Advice**	**Y**	**Y**
Comments	There is access to 24/7 psychiatric liaison services for all adult patients through liaison psychiatry or liaison psychiatry for older persons (LPOP). The service provides support to those following a suicide attempt, intentional self-harm, or where pre-existing mental health issues have been identified, where there is a need for a psychiatric medication review, displaying significant risk to self or others or is currently detained under a section of the mental health act (MHA). There is a dedicated clinical psychologist for adult MTC patients, who provides a visible model of psychological care. This includes direct psychological assessment, specialist neuropsychological assessment, and psychological interventions for patients and relatives. This is		

	provided to inpatients on the polytrauma unit, and to outpatients where other pathways do not already exist. The clinical psychologist provides advice and consultation to staff, staff training and reflective practice, service improvement, and research. A member of the clinical psychology service attends the weekly MTC therapies rehabilitation meeting.		
T16-2C-120	**Patient Information**	**Y**	**Y**
Comments	There is a patient information leaflet available in English and Welsh. The content is well laid out and provides information about trauma, the departments within the trauma service and contact numbers to the hospital switch board in addition to telephone and email contact details for the MTPs.		
T16-2C-121	**Patient Experience**	**N**	**N**
Comments	Before the MTC was established, a project was started to implement patient reported outcome measures (PROMs). This progressed well however, was disrupted with Covid-19. The team did try to re-establish the project in September 2020, but it has been challenging due to continued pressures of Covid-19 and recovery. Currently, PROMS is delivered to all patients on the polytrauma unit, and the team recognise this needs to be improved to cover the whole patient cohort. There is a key worker project underway at the moment with the aim that the key workers (major trauma coordinators, rehab coordinators and the therapy unit) will have the responsibility to ensure all patients receive a PROMs questionnaire after completion of treatment. The TARN major trauma PROMs report for October 2020 to September 2021 identifies, 636 TARN submissions with 67 PROMs quarter one responses and a PROMs ascertainment of 10.5%. Additionally, six families were approached to participate in collection of a patient story. Patients provided consent for the story to be collected and shared across the network. Questions were asked in an informal interview setting using open ended questions to derive the biography of the patient and/or families' experiences. Two stories were shared with reviewers however, it was unclear if there had been any changes made to the service following the feedback or how this information was shared with the wider network. Reviewers would suggest setting a formal feedback session to include TU and pre-hospital staff to allow the opportunity to gain an understanding of the full patient journey and where improvements can be made, as well as celebrating good practices.		
T16-2C-122	**Discharge Summary**	**Y**	**N**
Comments	Reviewers were provided with a MTC emergency department discharge check list and a critical care discharge form. It was unclear to reviewers if these documents were provided to the patient as both were very medical focused with no detail for the patient, including a lack of contact details. Additionally, there was no examples of discharge summaries provided for discharge from the polytrauma unit or other ward environment.		
T16-2C-123	**Rate of Survival**	**Y**	**Y**

Comments	The Ws score for 1 September 2019 to 31 August 2021 is -0.98 with a 95% confidence interval of –2.11 to 0.15. All TARN data including the Ws score is discussed within the TQuIC meetings. While this score is not an outlier, it must be remembered that some of this data relates to the period prior to the inception of the MTC.		
T16-2D-101	**Clinical Lead for Acute Trauma Rehabilitation Service**	**Y**	**Y**
Comments	There is a named clinical lead with an agreed list of responsibilities who has one PA per week to undertake the role. Additionally, there is a band 8a lead therapist for major trauma for adult and paediatric to support the clinical lead. The therapy lead role, with the support from rehabilitation coordinator and rehabilitation medicine consultants, lead the coordination and management of therapy and delivery of the rehabilitation prescription across all major trauma patients. They work closely with the consultant in rehabilitation medicine, trauma psychologist and the MTPs to support major trauma patients in accessing timely rehabilitation. They also support onward referral to rehabilitation services once patients have left the MTC.		
T16-2D-102	**Specialist Rehabilitation Team**	**Y**	**Y**
Comments	The rehabilitation MDT consists of a consultant in rehabilitation medicine, rehabilitation coordinator, MTPs, physiotherapy, occupational therapy, speech and language therapy, clinical psychology, dietetics, and nursing staff. Discussions include the cognitive and physical needs of the patients, and consideration of any legal aspects such as best interest decisions, advanced directives etc. Rehabilitation requirements will be captured within the rehabilitation prescription and the team will agree how the patient and their family is supported. Formal goal planning meetings will be required for the most complex patients and a key worker will be allocated from the MDT. The team will establish early links with the specialist rehabilitation services and the TUs to ensure that the parent health board is aware of the rehabilitation requirements of the patient. The weekly rehabilitation meeting is held collaboratively with TUs and supports the planning of repatriation of patients. This is seen as a good practice. This is supported by the 80% and above repatriation within the required 48 hours.		
T16-2D-103	**Rehabilitation Coordinator Post**	**N**	**N**
Comments	There is one WTE rehabilitation coordinator, with a lead AHP with 0.5 WTE dedicated to rehab coordination. The service is only delivered Monday to Friday, 08:00 to 16:00 hours. There is cross cover from the MTPs of a weekend if there is any support required. There is the weekly adult MDT meeting which is attended by the rehabilitation coordinator and the AHP lead attends the critical care and the neuro weekly MDTs. The rehabilitation coordinator also covers paediatrics where there is no dedicated rehabilitation coordinator.		
T16-2D-104	**Specialist Rehabilitation Pathways**	**N**	**N**
Comments	There are clear rehabilitation pathways except for a musculoskeletal pathway. There is an extensive rehabilitation directory.		
T16-2D-105	**Key worker**	**N**	**N**
Comments	The AHPs act as the patient's key worker and meet with the patient within 24 hours of admission. Their contact details are also on the major trauma information leaflet given to patients and family. This is also flexible, and the key worker may be extended to one of the		

	practitioners from the polytrauma unit.		
T16-2D-106	**Rehabilitation Assessment and Prescriptions**	**N**	**N**
Comments	There are rehabilitation prescriptions which are currently very medically focused. The team have had feedback from patients to say that it is difficult to understand due to the terminology that is used within the prescription. The MTC are currently working to improve the content of the rehabilitation prescription to ensure it is more patient friendly however, there were no timescales for the implementation of the improved style. The key worker will go through the rehabilitation prescription with the patient and the therapists on the polytrauma unit will undertake the rehabilitation prescribed. It was unclear if the rehabilitation prescription was sent with the patient when repatriated closer to home. The TARN data for 1 September 2020 to 31 August 2021 identified that rehabilitation prescriptions were completed for 52% of patients with ISS greater than eight, this is above the MTC average of 50%.		
T16-2D-107	**Rehabilitation for Traumatic Amputation**	**Y**	**Y**
Comments	The rehabilitation medicine consultant, rehabilitation coordinator and the wider MTC MDT will link with the in-reach amputation team based at Rookwood hospital to assess the patient and identify individual rehabilitation needs and complete the rehabilitation prescription. This team currently in-reach to review amputees as required within UHW and on a case-by-case basis across the region. There are two clinics per week at in Rookwood hospital which are covered by rehabilitation medicine clinicians, orthotics and prosthetics and psychology. In addition, there is a combined clinic with plastic surgery colleagues from Morriston hospital every three months focusing on complex stump problems. Patients repatriated to the TUs will be followed up by their local amputee medicine team. Ongoing amputation rehabilitation treatment will continue as the current outpatient provision.		
T16-2D-108	**Referral Guidelines to Rehabilitation Services**	**Y**	**Y**
Comments	There are comprehensive referral guidelines to rehabilitation services.		
T16-2D-109	**Clinical Psychologist for Trauma Rehabilitation**	**Y**	**Y**
Comments	The team has an 8b psychologist who has a mental health background. Additionally, there are adult intensive care psychologists who provide support and the amputee service has a separate psychologist. Development of a liaison role is required to support patients accessing the service. Screening assessment is carried out if there are some complexities post trauma.		
T16-2D-110	**RCSET Dataset**	**N**	**N**
Comments	Data is not currently submitted. The team plan to commence contributing to these datasets however, there are no timescales or clear plan for when this will commence.		

15 Steps observations	
Comments - Positive	The polytrauma unit has a welcoming feel, friendly staff and good views from each of the bed spaces. Clear signs with dual language. Newer areas of the hospital are bright and clean. Excellent area for rehabilitation on polytrauma unit. Laminated major trauma guidelines readily available in bay.
Comments – Areas to improve	The polytrauma unit does not have time and date easily seen for all patients to assist with orientation from day and night. Bins on corridors are overflowing with rubbish. Old areas of the hospital have marked floors so looks dirty no matter how clean the floor actually is.

Good Practice / Significant Achievements (List key points covering good practice)
Well attended daily major trauma MDT meeting Development of the poly trauma unit Good access to psychological support Rehabilitation MDT meetings with TUs in the network Repatriation of patients within 48 hours at above 80%

Specify Immediate Risks An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action
CEO/Board Representative risk handed over to at feedback session:

Specify Serious Concerns

A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve
CEO/Board Representative risk handed over to at feedback session:
1. The SWTN has an agreed set of trauma team activation criteria. There are concerns that there is a lack of adherence to this criteria, as activation calls appear to be lower than expected for the number of the candidate major trauma patients attending the MTC. The MTC should work with the network to address this issue. Additionally, there are some concerns around automatic acceptance around secondary transfers although this has improved of late. The reasons for the above are to be determined and remedial actions provided. 2. There was evidence that there are times when there are delays in the production of a rapid primary survey CT report within 5 minutes of the scan commencing. The impact of this could cause potential delays and impact upon patient care. Whilst it was suggested that this may reflect a data capture issue, an audit should be undertaken to ensure the availability of reports is available within the required timescale. 3. The adult pain services appears to be over-reliant on duty anaesthetic teams and lacks dedicated personnel to deliver a comprehensive service. Data should be reviewed to determine how this might be presenting an issue and steps taken to ensure the issue is resolved. 4. TARN data shows significant delays between arrival at the MTC and craniotomy for patients requiring emergent neurosurgical intervention. The impact of this delay may cause deterioration of the patient and the patient's outcomes could be impacted. The data needs to be reviewed to identify where there are potential delays if so, interventions put in place to reduce potential delays.

Areas of Improvement (List areas of improvement)
• Supernumerary TTL between the hours of midnight and 08:00 hours and improve support from network TTL working at the MTC. • In house thoracotomy training courses have a faculty member teaching who has a cardiac or thoracic surgical background with an interest in chest trauma and resuscitative thoracotomy. • The trauma team should be easily able to request and obtain appropriate support of either cardiac or thoracic surgeons as needed, and the pathways and contact routes must be clear and simple • Experienced cardiac/thoracic surgical support must be available in a timely manner to provide ongoing treatment and care. • Hybrid theatre within interventional radiology • Audit access to emergency theatres • Weekend access to trauma and orthopaedic theatre, including monitoring of ambulatory waiting times • Ensure all polytrauma patients receive the care for all injuries in a timely manner including outliers from the polytrauma unit. • Development of a paediatric focused MTP • Development of additional beds within the poly trauma unit • Formal sharing of patient stories and feedback with the wider network • Development of a robust rehabilitation coordinator service covering a seven day week

- Development of patient focussed rehabilitation prescriptions that are taken with the patient when repatriated
- Evidence the availability of daily orthopaedic trauma lists

Trust Name: Cardiff and Vale University Health Board	**Date of Review:** 25 March 2022
Service: Major Trauma Centre – Paediatric	**Type of review:** National

Self-Declaration Compliance	**31/46 67%**	**Peer Review Compliance**	**24/46 52%**

Contextual Information and General Comments:

The major trauma centre (MTC) for paediatrics is based within Cardiff and Vale University Health Board (CVUHB) and is part of the South Wales Trauma Network (SWTN). It covers a geographical region extending across South and West Wales and South Powys. The MTC covers the following Health Board areas: Aneurin Bevan University Health Board (ABUHB), Swansea Bay University Health Board (SBUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Hywel Dda University Health Board (HDUHB) and Powys Teaching Health Board (PTHB).

As the single MTC for the region, co-ordination and collaboration is required with the regional pre-hospital services including the Welsh Ambulance Service NHS Trust (WAST), the Emergency Medical Retrieval and Transfer Service (EMRTS) and Wales and West Acute Transfers for Children (WATCh). Furthermore, there are six adult and paediatric trauma units (TUs) in the SWTN; Grange University Hospital, Cwmbran (ABUHB); University Hospital Wales (UHW)(CVUHB); Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend (CTMUHB); Glangwili Hospital, Carmarthen(HDUHB). There are Rural Trauma Facilities at Bronglais General Hospital and Withybush General Hospital and a Local Emergency Hospital at the Royal Glamorgan Hospital. In addition, there is an adult and paediatric TU with designated specialist services in Morriston Hospital (SBUHB), which provides specific specialist support to the MTC in burns and plastics, thoracic and spinal surgery for patients who do not have multi-system injuries requiring transfer.

Reception and Resuscitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2B-201	**Trauma Team Leader**	**Y**	**N**
Comments	There is a trauma team leader (TTL) list of responsibilities included within the operational policy. Paediatric emergency doctors cover the TTL role from 08:00 to 22:00 hours seven days a week. Outside of these hours the adult TTL takes the joint role of paediatric and adult TTL. Between 22:00 and 00:00 hours a mixed shift will operate with the resus/TTL consultant present in the adult resuscitation area until midnight. After this time, they will become resident-on-call for major trauma and can retire to an on-call room near the emergency department. They are also available by telephone to answer queries and receive transfer requests from TUs in the SWTN. Paediatric trauma is not as frequent as adult trauma. To ensure maintenance of skills, paediatric emergency department consultants assist with adult trauma to gain greater exposure and upkeep of skills.		

	The trauma audit research network (TARN) data for CVUHB collates both paediatric and adult data. The TARN data identifies that there were 36 under 16s who were admitted with trauma, which equates to 4.9% of activity across the health board, between 1 September 2020 to 31 August 2021. The TARN clinical reports indicated 70% of ISS >15 patients were seen within five minutes of arrival, which is good against a national average of 64%. However, the overall number of TARN eligible trauma team activations is only 341/600 (56.8%) for the year which is worryingly low, compared to a mature MTC who might achieve nearer 80% of the TARN cohort. In line with the standards, attendance times to trauma calls by a speciality trainee (ST) three and above within five minutes were poor at 10.9%. Whilst this was mitigated by consultant attendance within 5 minutes at 88% is still below the national average of 91%. Attendance by a consultant within 30 minutes was also just below the national average at 88.9%, indicating >50% of the country are outperforming the unit in this area currently.		
T16-2B-202	**Trauma Team Leader Training**	**Y**	**N**
Comments	There are three TTLs who have not completed the training. One is on long term leave and two have previously completed though are now out of date. There are TTL training sessions every three to six months and there are plans for those not compliant to attend training by September 2022. The TTL training is completed as part of study leave or as part of rostered hours in direct clinical care (DCC) or supporting professional activity (SPA) time. A training compliance sheet was shared with reviewers however, it was difficult to understand the split between paediatric and adult TTLs.		
T16-2B-203	**Emergency Trauma Nurse AHP**	**Y**	**N**
Comments	There is only one whole time equivalent (WTE) band seven paediatric nurse. They have achieved level two compliance however, only having one nurse means there is only 21% coverage of shifts and no paediatric cover during periods of leave. There are four band seven adult nurses who have completed the level two combined training for adults and paediatrics who can support paediatric cover. It was unclear to the reviewers how this was identified on the staffing rota to ensure that there is always a band seven level two competent nurse with paediatric skills on duty 24/7. There are plans to ensure all band six paediatric nurses are level two trained to support the non-paediatric band seven however, there were no timescales as to when this would be completed. For all paediatric nursing staff in the department there is 41% compliance with level one and 14% have level two training. There are 57% of nursing staff who have completed the advanced paediatric life support (APLS).		
T16-2B-204	**Trauma Team Activation Protocol**	**Y**	**Y**
Comments	There is a network trauma team activation protocol which includes a list of roles and responsibilities. For patients 15 years and under who have sustained a traumatic injury there are separate criteria for activation of a trauma call. If any of the criteria are met, the paediatric trauma team should be activated by calling switchboard using 2222 and stating, 'paediatric trauma team to emergency department resus'. Once a trauma call is activated, all team members must attend the paediatric resuscitation bay immediately and report to the scribe to document their name and position. The paediatric resuscitation bay is within the adult department. It is a large cubicle that is well stocked. When a paediatric patient is admitted into the resuscitation bay within the adult department, the paediatric trauma call attendees attend. To backfill for this, staff from		

	the adult department are then sent to backfill in the paediatric emergency department. Reviewers identified that treating the paediatric patient in an area where there is more expertise was good practice however, it was unclear how the staffing would work when the adult resuscitation/emergency department were working at full capacity.		
T16-2B-205	**24 7 Surgical and Resus Thoracotomy Capability**	**Y**	**Y**
Comments	There is a resuscitative thoracotomy guideline within the SWTN paediatric major trauma guidelines. It was noted that the numbers are very low. The team identified cover for surgical and resuscitative thoracotomy are consultant paediatric surgeon, paediatric anaesthetist and paediatric intensive care (PICU). There are 26 specialist registrars trained on resuscitative thoracotomy (RT) and damage control laparotomy (DCL): 22 adult general and vascular surgeons and four paediatric surgeons. The course is run annually and is a practical course using porcine tissue and synthetic models. This course has been supported by six consultants, two adult general/vascular surgeons, one paediatric surgeon, one orthopaedic surgeon and two plastics surgeons from SBUHB. It was unclear to reviewers where the support from cardiac and/or thoracic surgeons is included within this guideline.		
T16-2B-206	**24 7 CT Scanner Facilities and on-site Radiographer**	**Y**	**N**
Comments	There are three computer tomography (CT) scanners based on UHW site. There is a CT scanner based in the adult emergency department which provides a 24/7 cover with a full complement of staff, and the facilities to scan three patients simultaneously during the working day. The paediatric resus bed is within the adult resus area and therefore is co-located. Emergency radiology reception has a reporting radiology hub which is manned 24/7 with the minimum of a registrar. Not all trauma patients have reports written straight away, this is assessed against risk with only a verbal report instantly and followed up with a written report. There is a direct to CT policy for patients transferred to the MTC by EMRTS who are accompanied by a pre-hospital consultant and critical care practitioner. Only patients that have isolated head trauma and those that are haemodynamically stable are considered for transfer directly to the CT scanner. These patients remain the clinical responsibility of the pre-hospital team until formal handover of care to the TTL. Currently, this policy is on hold due to Covid-19 and infection prevention measures that were introduced by UHCV as prehospital staff were not allowed into the scanning rooms due to personal protective equipment (PPE) requirements. Reviewers were informed that this policy was planned to be reactivated however, no timescales were provided for the reimplementation. This should be undertaken as soon as possible, given the benefits of timely access to CT. The TARN data for quarter two 2021/2022 identified that the proportion of patients with injury severity score (ISS) greater than eight with trauma scan less than 30 minutes was 34.9%, which is greater than the national average of 26.5%. The proportion of patients with ISS greater than fifteen with trauma scan less than 30 minutes was 47.1%, which is greater than the national average of 35.9%.		
T16-2B-207	**CT Reporting**	**N**	**N**
Comments	Reviewers were informed that currently providing a hot report within five minutes of the scan commencing is not always met. The impact of this could cause potential delays and impact upon patient care. Whilst it was suggested that this may reflect a data capture issue, an audit should be undertaken to ensure the availability of reports within the required timescale. The TARN data for quarter two 2020/2021		

	identifies the median time to provisional report is 52 minutes (34 – 76 minutes), which is slightly below the national average of 54 minutes. The median time to final report is 362 minutes (143 – 685), which is above the national average of 260 minutes. All reports completed by a radiology registrar are reviewed within a maximum of 24 hours by a consultant radiologist who will verify and add addendums to reports, as appropriate. Out of hours, the radiologist has additional responsibilities across the hospital and therefore clinical prioritisation needs to be considered.		
T16-2B-208	**24 7 MRI Scanning Facilities**	**Y**	**Y**
Comments	There is 24/7 access to magnetic resonance imaging (MRI) with no reported issues or delays to access or reporting.		
T16-2B-209	**24 7 Interventional Radiology**	**N**	**N**
Comments	There is a regional interventional radiology (IR) service in operation providing a 24/7 consultant led service for major trauma. Paediatric patients who may benefit from IR are discussed on an individual case-by- case basis.		
T16-2B-210	**24 7 Access to Emergency Theatre and Surgery**	**Y**	**Y**
Comments	There are two dedicated confidential enquiries into perioperative deaths (CEPOD) theatres available 24/7 and reviewers were informed that there are no issues in accessing these theatres. There are paediatric staff including general surgeons, orthopaedics and anaesthetists ST four and above onsite with consultants able to attend from home within 30 minutes. The trauma theatres are located a distance away from the dedicated paediatric surgical ward and paediatric critical care unit.		
T16-2B-211	**Damage Control Training for Emergency Trauma Consultant Surgeons**	**N**	**N**
Comments	There is a plan for all consultants on the on-call rota to be trained in the techniques of damage control surgery (DCS) via the Royal College of Surgeons Definitive Surgical Trauma Skills Course (DSTS) or the Ministry of Defences Military Operational Surgical Skills Course (MOST) or equivalent and a record of training to ensure skills are up to date will be maintained. The timescale for this to be completed is December 2022.		
T16-2B-212	**24/7 Access to Consultant Specialists**	**Y**	**Y**
Comments	There is the availability of a general paediatric surgeon; a paediatric anaesthetist; a paediatric intensivist and a paediatric neurosurgeon to attend an emergency within 30 minutes. However, there was a concern that orthopaedic/plastic cooperation could be impacted by the off-site plastic surgery service. On site plastics covering only Monday to Friday, 08:00 to 20:00 hours		
T16-2B-213	**Provision of Surgeons and Facilities for Fixation of Pelvic Ring Injuries**	**Y**	**Y**
	There are three major trauma consultants with a specialist interest in pelvic fractures. There is access to a 7-day trauma list running 08:00 to 20:00 hours. Reviewers were informed that there have been no delays in accessing theatre within 24 hours.		

T16-2B-214	**Trauma Management Guidelines**	**Y**	**Y**
Comments	All clinical guidelines are available electronically via the induction application and on the CVUHB SharePoint site. On induction, staff are orientated to how to access the clinical guidelines. All guidelines follow a governance process to ensure they are current and up to date. An extensive selection of guidelines was shared with the reviewers.		
T16-2B-215	**Critical Care Provision**	**Y**	**Y**
Comments	There are seven intensive care and four high dependency beds within the paediatric critical care unit (PCCU). The reviewers were informed that despite the low number there were no issues in accessing a bed. There is an automatic acceptance policy for major trauma patients. Maintenance of competencies are supported by collaborative working with WATCh and when possible, PCCU nurses will attend trauma calls to offer support and paediatric experience. Reviewers would recommendation a strong network, benchmarking and training with other PICU teams to allow sharing of best practice and development of the service.		
T16-2B-216	**24/7 Specialist Acute Pain Service**	**N**	**N**
Comments	There is a severe lack of a bespoke paediatric focussed acute pain service to assess and treat children with the most severe injuries in the region. The impact of this is that children could be experiencing more severe pain, which can affect the child's mental health and participation in other aspects of their care.		
T16-2B-217	**Administering Tranexamic Acid**	**Y**	**Y**
Comments	There is a paediatric major haemorrhage policy.		
T16-2C-201	**Major Trauma Centre Lead Clinician**	**Y**	**Y**
Comments	There is a named clinical lead with a list of responsibilities and one programmed activity (PA) per week. The clinical lead attends two weekly paediatric trauma multi-disciplinary team (MDT) meetings, the trauma quality improvement committee (TQuIC) and other meetings related to the running of the service. It was unclear to reviewers the support that was provided to the clinical lead through a deputy or other to provide cover during times of leave and therefore lacks resilience.		
T16-2C-202	**Major Trauma Coordinator Service**	**Y**	**N**
Comments	There are five adult major trauma practitioners (MTP) which equates to 4.2 WTE posts from nursing and allied health professionals (AHPs) who cover the service from 07:30 to 18:00 hours seven days a week. Monday to Friday there are two MTPs rostered on duty and on weekends there is one MTP. All MTPs have completed level three safeguarding training. The MTPs cover both adult and paediatric trauma however, there are no MTPs with paediatric specific training or dedicated time allocated to coordinate the care and service for paediatric patients. Reviewers would suggest the consideration of a specific paediatric major trauma practitioner, who sits within this team,		

	where cross cover can be provided with ownership of the paediatric aspects of the role including enable consistent tracking, service delivery, coordination, discharge planning, engagement in national meetings and continuity with safeguarding issues that are raised.		
T16-2C-203	**Major Trauma MDT Meeting**	**N**	**N**
Comments	The paediatric MDT meets twice a week however, not with all MDT members listed for the meeting to be quorate attend. There is no input from a youth worker, safeguarding or a psychologist. In addition, there are several specialities where attendance is difficult due to the lack of dedicated time in their job plans. This is mitigated by the inclusion and attendance of specialist nurses. Reviewers had sight of attendance lists from the MDT meetings which identifies quoracy is not met. Reviewers would suggest that job plans are reviewed to ensure that all key members of the team are in attendance to allow involvement in the discussions around treatment plans and safeguarding, where necessary.		
T16-2C-204	**Identification of Social and Welfare Needs**	**N**	**N**
Comments	There are no identified members of the team who are trained to assess the social and welfare needs of the child, family and/or carers following a major trauma event whilst they are resident in the MTC and are experts in dealing with complex discharges and be able to identify and support child protection investigations. The identified members should include rehabilitation co-ordinator, safeguarding team, family support services and paediatrician who all attend the MDT meetings. There is no dedicated paediatric rehabilitation co-ordinator, family support services or dedicated paediatrician time. There is a paediatrician who attends on goodwill for complex cases. Co-ordination is undertaken within the paediatric therapy MTC team. This links to the serious concern regards the lack of rehabilitation coordinator however, there needs to be clear time allocated in individuals job plans to recognise the importance of safeguarding and social and welfare needs within paediatric major trauma. There is a weekly paediatric safeguarding meeting which is attended by the MTP, paediatric lead AHP and members of the paediatric therapy team. Reviewers would suggest the attendance of a safeguarding specialist nurse to the paediatric major trauma meetings to screen and advise on major trauma cases. This would provide a more robust safeguarding net and education to the wider clinical team.		
T16-2C-205	**Formal Tertiary Survey**	**N**	**N**
Comments	This is not an embedded process and needs further development. The TARN data for quarter two 2021/2022 identifies only 13 out of 140 equating 9.3% received a tertiary survey. This is below the national average of 40.7%.		
T16-2C-206	**Management of Neurosurgical Trauma**	**Y**	**Y**
Comments	There is neurosurgical availability to undertake surgery within one hour of arrival at the MTC. A 24/7 paediatric surgeon rota was shared with reviewers.		
T16-2C-207	**Management of Craniofacial Trauma**	**Y**	**Y**
Comments	There is an agreed craniofacial pathway.		

T16-2C-208	**Management of Spinal Injuries**	**Y**	**Y**
Comments	There is a MTC agreed SWTN clinical guideline for protecting and assessing the whole spine in adults and children with major trauma.		
T16-2C-209	**Management of Musculoskeletal Trauma**	**Y**	**N**
Comments	At present in UHW the spinal injury pathway for paediatrics is in development. Spinal rehabilitation beds are commissioned in Stoke Mandeville, Buckinghamshire Healthcare NHS trust. Complex musculoskeletal injury rehabilitation is not funded via WHSSC so no specialist pathway exists. Rehabilitation is supplied by existing non-specialist services in CHfW. in-patient school teacher for bilingual education is available to all in-patients.		
T16-2C-210	**Management of Hand Trauma**	**N**	**N**
Comments	A rota was present for hand surgery which incorporated four consultant specialists. There are facilities for microsurgery delivered by MTC plastic surgeons, a dedicated hand therapy team and three hand clinics delivered per week. Plastics is only available on-site Monday to Friday, 08:00 to 20:00 hours.		
T16-2C-211	**Management of Complex Peripheral Nerve Injuries**	**Y**	**Y**
Comments	Patients requiring the management of complex peripheral nerve injuries, including brachial plexus, are referred to specialists at the Regional Centre for Burns and Plastics in Morriston Hospital (SBUHB).		
T16-2C-212	**Management of Maxillofacial Trauma**	**Y**	**Y**
Comments	There is 24/7 cover for maxillofacial trauma with a 24/7 paediatric surgeon on call rota.		
T16-2C-213	**Designated Specialist Burns Care**	**Y**	**Y**
Comments	Paediatric patients who require specialist burns care to be transferred to the SBUHB. Children with severe burns who require paediatric intensive care will be transferred to Bristol Children's Hospital as per SWTN CG 15 and National Burn Care Referral Guidance.		
T16-2C-214	**Patient transfer**	**Y**	**Y**
Comments	There is a SWTN agreed transfer policy however, it was unclear to reviewers how decisions about paediatric primary and secondary transfers from mid-wales and the east border areas are made as transit times to Birmingham will be equal or shorter.		
T16-2C-215	**Specialist Dietetic Support**	**Y**	**Y**
	There is a band seven paediatric dietitian who supports MTC patients however, it was unclear the amount of protected time in the role is for		

Comments	MTC patients.		
T16-2C-216	**24/7 Access to Psychiatric Advice**	**Y**	**Y**
Comments	There is 24/7 access to children and adolescent mental health services, in addition to liaison psychiatry. This was identified as a good practice by the reviewers.		
T16-2C-217	**Patient Information**	**N**	**N**
Comments	Reviewers were provided with a selection of leaflets. This included a leaflet about the paediatric major trauma service which is regularly updated to reflect changes within the service. Additionally, there is resource pack to provide parents with additional information about the child's onward care. There is a leaflet for the TUs to disseminate to families awaiting transfer to paediatric MTC in development however, there were no timescales to when this would be completed. The team also identified that there were injury information leaflets they would like to develop however, currently there is no time in the work plan to complete these. There was not a robust system of the identification of paediatric major trauma patients as it relied all nursing and therapy teams to identify patients, dissolved responsibility can result in gaps and inconsistency. Patients that are identified did have a systematic approach to prioritisation and delivering the correct key worker leaflets.		
T16-2C-218	**Patient Experience**	**N**	**N**
Comments	Children under 16 years receive a PEDsQL health related quality of life measurement tool which is specific to children. There are different questionnaires based on age ranges: Ages 1 to12 months, 13 to 24 months, 2 to 4 years, 5 to 7 years, 8 to 12 years and 13 to 18 years. Detailed qualitative feedback is collected locally through routine follow-up phone calls by the adult MTPs which will be audited in July 2022 and a new survey developed to be sent out with leaflets. Feedback and learning are discussed in the monthly steering group meeting. The lack of a dedicated paediatric major trauma service hinders the opportunity for direct patient feedback, education liaison, service review and engagement in national patient development initiatives. Psychological, social and educational needs do not always become apparent until post discharge therefore a robust paediatric rehabilitation service is required.		
T16-2C-219	**Discharge Summary**	**Y**	**Y**
Comments	An example discharge summary was shared with reviewers which included details of patient history, injuries, operations, consultant notes, medications, and blood results.		
T16-2C-220	**Network Patient Repatriation Policy**	**Y**	**Y**
Comments	There is a patient repatriation policy that applies to all major trauma cases admitted to the MTC under the age of 16 years of age. It is usual that most children will return directly home from the MTC. Where consideration is being given to repatriating a child to the nearest TU, there is the need for a MDT meeting involving the referring and receiving clinical team, MTC and TU major trauma practitioner, rehabilitation coordinator and a consultant in rehabilitation medicine, before the decision is taken for this to happen. The MDT involve the child, families, and carers, where possible.		

T16-2D-201	**Clinical Lead for Acute Trauma Rehabilitation Services**	**N**	**N**
Comments	There is no paediatric rehabilitation lead clinician with no timescales to appointing into this role. This gap is more prominent due to the lack of paediatric rehabilitation coordinators however, there is a band 8a principle therapist who undertakes some of this role. Reviewers would recommend that this post is appointed to as soon as possible to ensure children have a coordinated rehabilitation pathway with a high-quality service and no delays.		
T16-2D-202	**Specialist Rehabilitation Team**	**N**	**N**
Comments	There is not a full specialist rehabilitation team. There is a weekly rehabilitation MDT meeting and an enthusiastic paediatric therapies team. However, there is no paediatric rehabilitation lead clinician. There is no psychology input to the MDT meetings. The team described that a psychologist is not needed for every trauma case however, the reviewers believe that this is not the case and the expert opinion of a psychologist should be given for all trauma cases. The role of the psychologist is to advise the team on overall mental health issues and to identify those few cases where early intervention is indicated. There is no dedicated acute pain team for children. It was noted that the main physiotherapy gym has been commandeered for Covid-19 reasons and had not been returned at time of the peer review visit, with no timescales for this to be returned to a gym. Reviewers would recommend that this is remedied as soon as possible. Additionally, it was not clear how much therapy resource was dedicated to trauma care or whether it was combined with elective paediatric surgery and orthopaedics. There is a specialist neuro rehabilitation team for children covering brain and spinal injuries.		
T16-2D-203	**Rehabilitation Coordinator Post**	**Y**	**N**
Comments	There is no dedicated paediatric rehabilitation coordinator. There is one adult WTE rehabilitation coordinator, with a lead AHP with 0.5 WTE dedicated to rehab coordination. The service is only delivered Monday to Friday, 08:00 to 16:00 hours to adult with cover into paediatrics as required and does not provide seven day cover. There is cross cover from the adult MTPs over a weekend if there is any support required. There is the weekly adult and bi weekly paediatric MDT meeting which is attended by the adult rehabilitation coordinator and the AHP lead attends the critical care and the neuro weekly MDTs. The impact of no dedicated paediatric major trauma coordination service is a lack to promote the optimal care for the child and family affected by major trauma. Therefore, there is a lack of continuity in delivering and supporting the transfer of information between acute and rehabilitation services, with the risk of inconsistent links into the child safeguarding team who do not attend the weekly paediatric MDT meeting. Reviewers would suggest urgently reviewing this role and identify a nurse or allied health professional with paediatric experience to have dedicated time within their job plan to undertake this role. It was noted that there are times when there are no paediatric trauma patients however these times are less frequent than the times when there are paediatric trauma patients.		
T16-2D-204	**Specialist Rehabilitation Pathways**	**N**	**N**
Comments	There are clear rehabilitation pathways except for a musculoskeletal pathway. There is an extensive rehabilitation directory.		

T16-2D-205	**Key worker**	**N**	**N**
Comments	The key worker is flexible with someone from the MDT being identified as the key worker, but reviewers were informed that there is limited members of the team who takes on this role. The key worker is Identified in the rehabilitation prescription in the notes and at the weekly major trauma MDT meeting. There is plans to include a school liaison role, however details of this role and timescales were not provided to reviewers. An agreed systematic approach to the identification and role of the paediatric patient key worker is suggested.		
T16-2D-206	**Rehabilitation Assessment and Prescriptions**	**Y**	**Y**
Comments	The rehabilitation prescription is not patient friendly, and the team also identified this from previous feedback from patients to say they didn't find the prescriptions user friendly. The team are working with the SWTN to develop rehabilitation prescriptions to become more patient friendly.		
T16-2D-207	**Rehabilitation for Traumatic Amputation**	**Y**	**Y**
Comments	The paediatric amputation clinic is linked with plastic and orthopaedic surgeons from Morriston hospital with rehabilitation clinics in Rookwood Hospital.		
T16-2D-208	**Referral Guidelines to Rehabilitation Services**	**Y**	**Y**
Comments	There are comprehensive referral guidelines to rehabilitation services.		
T16-2D-209	**Clinical Psychologist for Trauma Rehabilitation**	**N**	**N**
Comments	The team has an 8b psychologist who has a mental health background. However, there is a lack of provision and structure for paediatrics. While there is an amputee specific psychologist for adults there is no provision for paediatrics. The psychologist in major trauma would pick up this support for amputees. The psychologist will provide paediatrics with a two week follow up phone call post discharge. The psychologist works closely with the EMRTs liaison nurse, who does a psychological screening during a home visit if they were admitted through EMRTs. There is a lack of paediatric specific psychology with no information leaflets available about access to this service or specialist screening delivered on the follow up phone call.		

15 Steps observations

Comments - Positive	• Paediatric resus. bay is large and well equipped. • Laminated major trauma guidelines readily available in trauma bay • Clear guidelines on personnel and on imaging protocols • Large inpatient gym adjacent to paediatric ward • Large attractive play garden in central quad area • Ward area light and open • Friendly welcoming enthusiastic staff
Comments – Areas to improve	• Front entrance to children's hospital area is unattractive and not welcoming including feature of original architecture which is appreciated not easily addressed • Flooring and walls of entrance area would look better if refurbished / repainted more cheerfully

Good Practice / Significant Achievements
(List key points covering good practice)

- Access to CAMHS and liaison psychiatry
- Large inpatient gym adjacent to paediatric ward
- Large well equipped paediatric resuscitation room
- Regular 2 x week paediatric MT MDT – even if the team is not complete, this is a great start
- Weekly rehabilitation MDT meeting

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:

None Identified

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve

CEO/Board Representative risk handed over to at feedback session:

1. There is a lack of a bespoke paediatric focussed acute pain service to assess and treat children with a reliance on the adult anaesthetic team. This could lead to a delay in the provision of an effective pain control strategy in this group.

2. There is no access to dedicated paediatric rehabilitation coordinators (7 days a week), available in the children's MTC. The service is reliant on the adult MDT for rehabilitation input into the optimal care of children and support to their families. Furthermore, this may lead to some discontinuity of transfer of information between acute and rehabilitation services.

Areas of Improvement
(List areas of improvement)

- There is incomplete plastic surgery cover
- Lack of Safeguarding attendance to a weekly paediatric MDT
- Lack of dedicated Paediatric Clinical Psychology attendance to MDT and availability for assessment of patients and ongoing support advice to staff.
- Lack of Clinical Lead for Acute Trauma Rehabilitation Services- this post is currently vacant
- Paediatric Patient leaflet needs development outlining major trauma services, facilities, and a Key worker /central point of contact
- There is a lack of paediatric trained TTLs covering 24/7
- There is a lack of paediatric band seven level two trained nurses on duty 24/7.
- Need to identify paediatric trained individuals with time to provide social and welfare support
- Requirement for dedicated paediatric rehabilitation coordinator
- Development of capturing paediatric patient experience
- Timely access to CT scanner with timely reporting
- Consultant surgeons to be compliant with damage control training
- PICU to ensure networking and benchmarking with other paediatric major trauma centres

Trust Name: Aneurin Bevan University Health Board	**Date of Review:** 24 March 2022
Service: Major Trauma TU	**Type of review:** National

Self-Declaration Compliance		**Peer Review Compliance**	

Contextual Information and General Comments:
Aneurin Bevan University Health Board (ABUHB) covers a geographically large area and serves a population of 600,000 in South Wales. The population served is diverse with a socio and ethical mix. The ABUHB consists of Grange University Hospital (GUH) which has the trauma unit (TU) and three district general hospitals, which all have a minor injuries department. The GUH is a new purpose built hospital which was opened in November 2020 which brought together two previous hospital sites from the ABUHB being combined to become one. This was especially challenging during the Covid-19 pandemic. The major trauma centre (MTC) within the network is in Cardiff and Vale University Health Board (CVUHB).

Reception and Resuscitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2B-301	**Trauma Team Leader**	**Y**	**N**
Comments	There is 24/7 availability of a trauma team leader (TTL) who has a list of agreed responsibilities. There is always a specialist training ST4 doctor or above resident in the unit 24 hours a day and additionally there is consultant cover on site from 08:00 to 00:00 hours seven days a week, to take the role of TTL. All TTLs are advanced trauma life support (ATLS) trained however, there are some who are out of date due to a lack of training courses available during Covid-19. There is a clinician trained in Advanced Paediatric Life Support (APLS) available 24/7 for children's major trauma, with the aim to also have APLS trained senior sister cover. TARN data from quarter two 2020/2021 to quarter one 2021/2022 evidenced that there was between 6.8% and 13.6% with ST3 plus on arrival.		
T16-2B-302	**Emergency Trauma Nurse AHP**	**N**	**N**
Comments	There is not a nurse or allied health professional (AHP) on shift 24/7 who has attained the level two competency, as described in the national major trauma nursing group guidance. There are 12 senior nursing staff who are working towards this standard which is due to be achieved by the end of December 2022. Due to the merger of the two acute district general hospitals into the one purpose built critical care centre, there has been a high turnover of staff as some chose not to relocate and therefore, this was a loss to the experienced nursing workforce. Since April 2021, there has been a recruitment programme with the purpose of increasing the emergency department (ED)		

	nursing establishment to deliver safe-staffing levels within the department and across all urgent care clinical environments. There are approximately 50% of the band five nursing establishment within the ED are of junior or novice level. These staff will be provided with relevant training and development to support their trauma knowledge, skills and confidence. In October 2021 four practice educators were recruited to support with planning and delivering of education. The practice educator team are operational between the hours of 08.00 and 17.00 hours. For level one training the use of the network training application has been utilised alongside an aggressive roll out of internal training, providing one or two study days a month with all staff having a copy of the workbook. There is a plan to be 80% compliant with level one training by December 2022. Level two training is reliant on external training with limited availability of courses being ran due to Covid-19. There is funding available for the training and staff are being booked onto a course as a place becomes available. However, reviewers were informed it was difficult to make decisions regarding funding for courses due to agreement though multiple divisional structures.		
T16-2B-303	**Trauma Team Activation Protocol**	**Y**	**Y**
Comments	There is a network trauma team activation protocol which includes a list of roles and responsibilities. It was noted within the triage tool it designates a fall from six meters or more, this was considered to be a generous target and should be reviewed and reduced. Additionally, there is a trauma team activation poster which is a visual aid that is displayed in the clinical areas to support assessment of trauma. Reviewers were informed that not all patients receive a trauma call and is only used in emergencies. There is a serious concern that for cases where a trauma call has not been activated there is a risk of not receiving appropriate trauma team attendance, senior management, ongoing coordination, and management of care. Additionally, there is the concern that if the trauma team are not attending all trauma calls then their skills are not being utilised on a regular basis. Documentation of the team attending the trauma call is poor, a sign in process is used however, the documentation is not regularly completed therefore audit of trauma call compliance is not achievable.		
T16-2B-304	**Agreement to Network Transfer Protocol from TUs to MTC**	**Y**	**Y**
Comments	There is a network agreed transfer protocol in place. There is a single point of contact via the trauma desk with the TTL at the MTC. The call is recorded and if transfer is required, the trauma desk arrange transport.		
T16-2B-305	**24 7 CT Scanner Facilities**	**Y**	**Y**
Comments	There are two computer tomography (CT) scanners which are in a good location one is a short walk 20 yards from the emergency department. Demands on GUH CT are immense which can cause delays for some clinically stable patients. Trauma Audit and Research Network (TARN) data identifies time to CT as 49 minutes average which is below the National average.		
T16-2B-306	**CT Reporting**	**Y**	**Y**
Comments	A documented hot report is provided within 30 minutes and a detailed radiological report documented within one hour from the start of the scan, with a report checked by a consultant within 24 hours.		

	There is a radiology registrar onsite from 08:00 until 22:00 hours who carry out hot reports. Out of hours there is the use of external reporting. Reviewers were informed that there are no problems with reporting. November 2021 TARN data shows good times for reporting with times for final within 60 mins ranging from 156 – 170 minutes which is above national average.		
T16-2B-307	**Teleradiology Facilities**	**Y**	**Y**
Comments	There is a Welsh teleradiology system which allows easy transfer of images between different health boards. There are no issues with the use of this system. It is the responsibility of the on-duty CT radiographer to arrange transfer of images to the MTC or other health boards.		
T16-2B-308	**24 7 Access to Surgical Staff**	**Y**	**Y**
Comments	There is good 24/7 access to surgical support. An example of a surgical and anaesthetic rota was shared with reviewers that did not identify any gaps. Reviewers were informed that due to the merger of two hospitals recently this has allowed for a full establishment in GUH.		
T16-2B-309	**Dedicated Orthopaedic Trauma Operating Theatre**	**Y**	**Y**
Comments	There is a dedicated orthopaedic trauma list with appropriate staffing seven days per week at GUH. There is a dedicated trauma and orthopaedic theatre available 218 hours a week across the health board. Outside of these hours, orthopaedic trauma is prioritised on the emergency theatre list.		
T16-2B-310	**24 7 access to Emergency Theatre and Surgery**	**Y**	**Y**
Comments	There are emergency theatres available with trauma lists seven days a week at GUH. The trauma team link closely with theatre coordinators when capacity is becoming challenging. When required, there is the ability to have back up staff from Gwent Hospital, which is one of the district general hospitals within the ABUHB when there is a requirement to open a second theatre.		
T16-2B-311	**Trauma Management Guidelines**	**Y**	**Y**
Comments	The South Wales trauma network clinical guidelines are available on the health board intranet, with copies also available in resus. Updates to clinical guidelines are cascaded via the trauma quality improvement committee (TQuIC) circulation list and added as an agenda item and raised at the next meeting.		
T16-2B-312	**Transfusion Protocol**	**Y**	**Y**
Comments	A local transfusion protocol is used that follows National standards. No issues were raised to the reviewers. It is available via the health board intranet.		

T16-2B-313	**Administration of Tranexamic Acid**	**Y**	**Y**
	The November 2021 TARN data identified that there was only one patient who required tranexamic acid, and this was administered within three hours. Patients are usually administered tranexamic acid prior to arrival at the TU, if it is required. The numbers within the TU are low for major haemorrhage trauma and the team recognise they need to provide staff with ongoing training due to the lack of patients for them to practice and familiarise themselves with the network protocol for haemorrhage and traumatic brain injury		

Definitive Care			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2C-301	**Major Trauma Lead Clinician**	**Y**	**Y**
Comments	There is a named major trauma lead clinician with an agreed list of responsibilities and one programmed activity (PA) to undertake the role. It was noted that the one PA was not sufficient time for the clinical lead to undertake all the agreed responsibilities and therefore utilised other supporting professional activities (SPAs) to undertake the role. A copy of the major trauma lead clinicians job description was shared with reviewers.		
T16-2C-302	**Trauma Group**	**Y**	**Y**
	There are quarterly TQuIC meetings with the correct required membership. Reviewers were informed that attendance at these meetings are variable and previously there has been little engagement from orthopaedics. This has been rectified by naming an individual who has the responsibility to attend and send a deputy, if not able to attend. Minutes from the November 2021 TQuIC meeting were shared with the reviewers. There is a plan to rearrange the timings of the TQuIC meetings to align with the quarterly TARN reporting to allow a timely analysis of the TARN data through the meeting. There is a smaller number of key individuals who meet between the TQuIC meetings in what is referred to as a pre-TQuIC meeting. This is to raise anything that may be important prior to the meeting and to agree the agenda for the main meeting. There are mortality and morbidity (M and M) meetings that are held every four to six weeks. There is a pre-M and M meeting that goes through all cases including silver trauma and picks out the cases that require detailed discussion. Prior to the M and M meeting a summary is sent to all attendees approximately one week prior to the main meeting to allow all attendees awareness of the cases to be discussed. There are four to six cases discussed in each meeting with good attendance including representation from the ambulance service.		
T16-2C-303	**Trauma Coordinator Service**	**Y**	**Y**
	There is a trauma coordinator service provided Monday to Friday 08:00 to 20:00 consisting of two whole time equivalent (WTE) trauma coordinators. There is cross cover from this role to the rehabilitation coordinator. For patients who are admitted outside of the trauma		

	coordinator hours, there are robust pathways to identify these patients. This includes searching admission and ward lists and having good communication with wards to ensure nobody is missed. Despite the number of trauma patients, there are no plans to extend this service to a seven-day service. In November 2021 the number of trauma admissions was noted as 429 patients. It was unclear if this number also included repatriations to the hospital in addition to admissions. Both admissions and repatriations should be considered within the numbers to plan workload. Reviewers would suggest that this is added to the health board work plan to ensure that all patients have equitable access to the rehabilitation coordinator and meet the updated quality indicators in the future. The trauma coordinators act as the patient's key worker to major trauma patients, working as an advocate for the patients and families, communicate with other professionals and refer as appropriate. The key worker completes the patients discharge summary, which is provided to the patient when they have a follow up phone call after discharge. The post discharge phone call was recognised as a good practice.		
T16-2C-304	**Management of Spinal Injuries**	**Y**	**Y**
	There is the South Wales trauma network clinical guideline for protecting and assessing the whole spine (Spinal Cord Injury Care Pathway) in adults and children with major trauma. Patients with polytrauma or a neuro deficit are taken directly to the MTC in Cardiff and Vale University Health Board (CVUHB). Other spinal injuries are managed through the TU. Within GUH the patient is admitted under a named orthopaedic consultant. A joint management plan is formulated with the spinal cord injury centre (SCIC) consultant, who is contacted within four hours of admission. The plan is written in the patients' medical records. All patients with spinal cord injury will be entered onto the National Spinal Cord Injury Database. There is a team of four consultant spinal surgeons based within ABUHB, to provide care and treatment for spinal patients. There is a weekly spinal MDT every Friday whereby spinal injury patients are discussed. If they are not the patients named consultant, they are available to give their opinion. Unstable pelvic fractures would always be transferred to the MTC. There is access to a spinal physiotherapy rehabilitation team to support spinal patients however, equipment is not specialist to these patients. It was unclear to reviewers what access there is to the limited outreach team from SCIC with no regular attendance or support for nursing staff available.		
T16-2C-305	**Management of Multiple Rib Fractures**	**Y**	**Y**
	There are network clinical guidelines for analgesia for rib fractures (adult major trauma patients). Patients with rib fractures are admitted under general surgery. The use of a blunt trauma chest tool is used to score the patient to support the treatment provided. If patient-controlled analgesia (PCA) is used the patient requires to be moved to the ward area. It would be beneficial if nursing staff in the emergency department were trained in the use of PCA to support the patient. The TARN data identifies a low number of patients seen by the pain team compared to the number of patients admitted with a rib fracture. The data was also unclear as it identifies a high number of other pain relief at 26% and only 4% for epidural. Reviewers would suggest an audit to understand this data in more detail. It was also unclear to reviewers if the chest injury pathway is being followed post emergency department. There is a patient information leaflet that is provided to all patients who sustain a rib fracture and discharged.		
T16-2C-306	**Management of Musculoskeletal Trauma**	**Y**	**Y**
	No issues were reported in relation to the management of musculoskeletal trauma. All open fractures are transferred to Morriston Hospital (MH), which is within Swansea Bay University Health Board (SBUHB) with no issues including lack of available beds discussed with the		

	reviewers.		
T16-2C-307	**Designated Specialist Burns Care**	**Y**	**Y**
	There is a network burns clinical guideline that has been adopted alongside the South West United Kingdom (SWUK) burn network referral guidance for adult burns (16 years plus) detailing for severe burns patients to be transferred to Morriston Hospital. Reviewers were informed that there is good access to the pre trauma network to specialist burns unit in Morriston Hospital. Additionally, there is a telemedicine tool that is utilised to share pictures of injuries with Morriston to gain advice or agree transfer. Reviewers were informed that the number of burns patients attending the TU is low.		
T16-2C-308	**Trauma Unit Agreement to the Network Repatriation Policy**	**Y**	**Y**
	There is a weekly multi-disciplinary team (MDT) meeting held on a Wednesday within the MTC with clear information regards the patients who are to be repatriated and the planned dates for the repatriation. Due to the excellent communication prior to the patient being ready for repatriation, this allows for 80% of patients repatriated within the first 24 hours. Internally this is supported by the rehabilitation coordinator linking directly with the team that the patient will be cared under. Reviewers were informed that on occasions it is a challenge to identify who the patient will sit under and therefore where they will be placed. An internal process should be agreed to ensure clear repatriation processes and prevent potential delays. Once the speciality is agreed a bed is prioritised for the patient. The clock starts when the patient is identified fit for repatriation.		
T16-2C-309	**Patient Experience**	**Y**	**N**
	There are plans to work in collaboration with TARN and the South Wales Trauma Network to undertake a 12-month pilot of using Patient Reported Outcome Measures (PROMS) across TUs as well as the MTC. There has been some small patient evaluation and patient stories collected by the TU which identifies areas of good practice including the discharge summary phone call. It was unclear to reviewers if there have been any developments or improvements made following the collection of patient experience data.		
T16-2C-310	**Discharge Summary**	**Y**	**Y**
	There is a detailed discharge summary that is provided to patients which includes details of what major trauma is, members of the team and contact email and phone number for the rehabilitation coordinators. There is also a section to include date of admission and details of the events that have taken place through the patient's journey. Additionally, there are pictures to allow identification where on the body the injuries are with a detailed description of the injury, management of the injury, consultant and follow up plan. There is also general advice for after discharge and a notes page for the patient to make any additional notes. This was recognised as a good practice by the reviewers.		
T16-2C-311	**The Trauma Audit and Research Network (TARN)**	**Y**	**Y**
	The TARN data for November 2021 is still provided via two sites and therefore could be inaccurate data. The team are working with TARN to improve the quality of the report.		

T16-2C-312	**Rate of Survival**	**Y**	**Y**
	Ws score is – 2.14 which is on the second deviation line as an outlier. It is suspected that this could be inaccurate as a result of incorrect TARN data. The unit do not code from the emergency department, they code the admission to the ward. The TU are still in the process of submitting the data from last year. The patients are recorded on a data base as they are admitted, and the structured query language (SQL) is run retrospectively which is given from TARN. Reviewers suggest that the TU contact TARN to highlight they have not been given an estimated number which may impact the rest of their calculations.		

Rehabilitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2D-301	**Rehabilitation Coordinator**	**Y**	**Y**
Comments	There is WTE rehabilitation coordinator who is available Monday to Friday 08:00 to 17:00 hours. There is some cross cover from the trauma coordinators during times of leave. The rehabilitation coordinator works across the MDT acting as a key worker to major trauma patients and an advocate for the patients and their families. As the key worker, they complete the discharge summary. After discharge the patient receives a follow up phone call and at this time the discharge summary is provided. Reviewers were concerned regards the lack of resilience in this role.		
T16-2D-302	**Access to Rehabilitation Specialists**	**N**	**N**
Comments	There is limited or lack of a trauma rehabilitation strategy for the organisation. For patients who have complex injuries and continue to require medical support, there is a limitation on where the patient can be cared for with support for both rehabilitation and medical needs. There is no rehabilitation provision within GUH and a lack of medical support within the community hospitals. The impact of this is that the patient could have delayed access to rehabilitation facilities while continuing to have medical input, or there could be the delay in repatriating patients back from the major trauma centre, causing a pressure on beds in the MTC and the patient may be having extended periods of care far from home. There is funding for a rehabilitation consultant for four PAs a week however, this has yet to be recruited to. There is limited access to occupational therapy (OT) and speech and language therapy (SALT), however links have been created with the wider health board team. There is a SALT post out to advert however, unable to recruit. The role requires a band 6 SALT due to the working alone, however band 6s don't want a rotational role. OT funding is an issue, there are only two OTs who cover assess to discharge and they don't cover rehabilitation. Reviewers would suggest considering for innovative plans to recruit into these roles to support the patient access to OT and SALT for rehabilitation.		

T16-2D-303	**Rehabilitation Prescriptions**	**Y**	**Y**
Comments	It was noted that the wording within the rehabilitation prescriptions include medical jargon and lack clear contact details making it difficult for a patient to understand. The TU are trialling writing the medical jargon on a communication log as per the guidance however it was admitted this does not always work due to access to the rehabilitation prescription. Patients are given their discharge summaries which include, the date of admission, the management plan for their injuries, date of discharge etc. Recently the unit have also been printing off and giving patient part A of their rehabilitation prescription which does not include the medical terminology. It was highlighted to reviewers that this is a piece of work that is being undertaken by the South Wales Trauma Network and the health board to develop and use an electronic patient held rehabilitation prescription however it was unclear on the timelines for implementation. There is a concern for the patients who get discharged over the weekend as the rehabilitation prescription is not provided for weekend discharges.		

Good Practice / Significant Achievements
(List key points covering good practice)

- Dedicated orthopaedic trauma operating theatre
- Follow up phone call with discharge summary
- Detailed discharge summary sheet
- Clear M and M process and review

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:
None identified

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve

CEO/Board Representative risk handed over to at feedback session:

1. There were concerns that the threshold for trauma team activation appears to be too high and that this could have an impact on the number of Trauma Team activation calls. There was evidence that some trauma patients are attending the trauma unit having not been proceeded by a trauma call. For cases where a trauma call has not been activated there is a risk of not receiving appropriate trauma team attendance, senior management, ongoing coordination and

management of care.

2. It was evident there is limited / lack of trauma rehabilitation strategy for the organisation. For patients who have complex injuries and continue to require medical support, there is a limitation on where the patient can be cared for with support for both rehabilitation and medical needs. There is no rehabilitation provision within the Royal Glamorgan Hospital and a lack of medical support within the community hospitals. The impact of this is that the patient could have delayed access to rehabilitation facilities while continuing to have medical input, or there could be the delay in repatriating patients back from the major trauma centre, causing a pressure on beds in the MTC and the patient may be having extended periods of care not close to home.

Areas of Improvement
(List areas of improvement)

- TTL training compliance
- Level two nurse training compliance
- Further work around capturing patient experience
- TARN data submissions and single site data
- Access to Rehabilitation Specialists
- Seven-day access to trauma coordinators and rehabilitation coordinators given volume of local and repatriated workload
- Rib fracture pathway and PCA use within the trauma unit
- Lack of resilience in the trauma coordinator role
- Lack of rehabilitation prescription to patient of a weekend

Trust Name: Cwm Taff Morgannwg University Health Board	**Date of Review:** 23 March 2022
Service: Major Trauma TU	**Type of review:** National

Self-Declaration Compliance	No compliance provided	**Peer Review Compliance**	**79% 22/28**

Contextual Information and General Comments:

Cwm Taf Morgannwg University Health Board (CTMUHB) was formed on 1 April 2019, providing and commissioning services for residents of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. The resident population for CTMUHB is estimated at 448,639. The operating model for CTMUHB incorporates three Integrated Locality Groups (ILGs) for Bridgend, Merthyr Cynon and Rhondda Taff Ely. The ILGs are accountable for the planning and delivery of all health services within their locality, bringing together leadership for primary, secondary, community and mental health services, ensuring the integration of services can be overseen and delivered at a local level.

Within CTMUHB there are three district general hospitals where trauma patients are seen in addition to other hospitals covering mental health, rehabilitation and community. There are two Trauma Units (TUs) for CTMUHB, Prince Charles Hospital (PCH) in Merthyr Tydfil and Princess of Wales Hospital (POWH) in Bridgend. The Royal Glamorgan Hospital (RGH) is a Local Emergency Hospital (LEH) that is not expected to routinely receive acute trauma patients but would ensure appropriate initial management and transfer to the Major Trauma Centre (MTC) or nearest TU, if this did occur. The RGH would be the specialist rehabilitation centre ('landing pad') to receive patients returning from specialised services with complex needs requiring specialised rehabilitation services.

The POWH has around 60,000 emergency department attendances per year with 360 beds onsite. They provide a variety of services including obstetrics, paediatrics, trauma and orthopaedics, general surgery, gynaecology, ear nose and throat, outpatient maxillofacial and urology.
There are good community services in place for patients repatriated from the MTC, with approximately 50% managing their rehabilitation in the community.

The PCH is located at the north end of Cwm Taff Morgannwg and sees a number of trauma cases from the Brecon Beacons, as well as a new national bike park which has recently been built. They see around 80,000 patients per year in their emergency department with around 2,000 trauma and orthopaedic admissions. Recently the local Nevill Hall Hospital Emergency Department has been downgraded so there has been
an increase in patients being seen who would previously have attended Nevill Hall Hospital. There have been difficulties in staffing and staff numbers in general due to being located in a very socially deprived area which brings challenges and involves a mix of local authorities. There have been major capital works ongoing meaning that the emergency department are having to operate during building work.

The RGH is the local specialist recovery centre. They serve a population of around 440,000 people, can accept moderate trauma patients as well as being able to assess and stabilise major trauma patients before transferring them to the MTC at CVUHB.

Reception and Resuscitation

Number	Indicator	SD Compliance	PR Compliance
T16-2B-301	**Trauma Team Leader**		**N**
Comments	Within POWH the emergency department consultant acts as the trauma team leader (TTL), however there are gaps in the emergency department consultant rota which are covered through the surgical team leader who acts as the TTL. However, a more robust plan is currently being introduced to cover the TTL through the trauma and orthopaedic rota. All middle grade and consultants within the emergency department are trained in advanced trauma life support (ATLS) however, those covering the rota gaps do not have the required ATLS training. At PCH all consultants who are ST3 and above are ATLS trained and any gaps in the rota are covered from the emergency department who have also received the ATLS training. All middle grades for trauma, orthopaedics and anaesthetics are up to date with ATLS and there is funding in place for this training to continue. The RGH staff have also completed the ATLS training however, as a LEH is not measured against the quality indicators.		
T16-2B-302	**Emergency Trauma Nurse AHP**		**N**
Comments	The POWH has had a large turnover of staff since October 2021 with 50% of the workforce being new into the department. This has impacted on training levels. Only 40% of nursing staff have completed level 1 training. This has been achieved through the South Wales trauma network online training application. There is a training plan for 100% of nurses to be level 1 trained by August 2022. There are only 20% of nurses trained to level 2 with no clear plan for when the training will be completed. Developing a robust plan is challenging due to the lack of ringfenced funding for level 2 training. At PCH There is 73% compliance for level 1 training however, there is 0% compliance with level 2 training. Level 1 training is completed through the network application. There is an 8a practice educator commencing in post in April 2022, with a plan to commence an in-house training programme to improve the training levels for level 2. Training staff has been an issue due to the high number of agency staff and the lack of capacity to release staff to undertake the training. The courses for level 2 are often ran in England which makes it difficult to attend and additionally, there is no secured funding for training in either the short or long term. There is a large scale planned recruitment drive which aims to provide an uplift in the number of band 6s from nine to 39 with the hope to improve retention of staff. There is 0% compliance with level 2 training at RGH. A band 7 paediatric lead has been appointed to improve paediatric trauma training, in addition to utilising the six hours make up shift to be utilised for training. There is high compliance with the level 1 training using the network application.		
T16-2B-303	**Trauma Team Activation Protocol**		**Y**
Comments	There is a network trauma team activation protocol which includes a list of roles and responsibilities and is utilised across all three hospitals. It was noted within the triage tool it designates a fall from six meters or more, this was considered to be a generous target and should be reviewed and reduced. There is a trauma team activation poster which is a visual aid that is displayed in the clinical areas to support assessment of trauma. Reviewers were informed that there is full attendance from the team however, this is not documented at the		

	time of the trauma call. Within the PCH reviewers were informed that there had been an issue with surgical attendance however, this has now been resolved and full team attendance is present following the activation call. It was noted that there are a high number of self-presented trauma at PCH and therefore a screening nurse has been placed at the door of the department to ensure early identification and any trauma call being put out in a timely manner.		
T16-2B-304	**Agreement to Network Transfer Protocol from TUs to MTC**		**Y**
Comments	There is a network agreed transfer protocol in place which is utilised across the three sites. The POWH described one incident when the TTL at the MTC could not be contacted however, this was an isolated incident and a Trauma DATIX was raised. It was noted that there are occasional delays however, these are appropriate and usually bed related. At the PCH it was noted that there have been occasions when patients have not been accepted by the MTC with the issues being related to knowledge of the pathways or the patient not being accepted by the MTC TTL. These cases were all discussed within morbidity and mortality meetings (M and M) and raised to the network to promote education on the pathways. Reviewers were informed that these incidents are improving and becoming less frequent. At RGH it was noted by reviewers that there is a high number of trauma attendances either brought in through the Welsh ambulance service trust (WAST) or self-presenting and therefore, either being treated in a department that is not a TU or requiring a transfer to a TU or MTC. There are no major trauma practitioners which impacts on the identification and follow up of trauma patients. There is an aim to recruit five patient coordinators to support the hospital use of a white board to allow better tracking of patients however, there were no timescales offered for the completion of this. The RGH is a LEH, however it is unclear if they are functioning as a TU. There is no clear oversight of admissions and the patient's pathway through a robust trauma coordination service. An audit of all ambulance attendances including those who are diverted from a TU to the LEH should be completed as a matter of urgency to gain a clear understanding of the current pathway. The results of the audit should be shared with key stakeholders to ensure collaborative working to determine the future direction and status of the LEH.		
T16-2B-305	**24 7 CT Scanner Facilities**		**Y**
Comments	There are 24/7 access to computerised tomography (CT) within each of the three sites with the radiographer being included within the trauma call. The POWH has a scanner located very close to the emergency department with dedicated in-house porters to transfer the patients. The PCH has two CT scanners, one within the emergency department and one in radiology. The CT superintendent always attends the M and M meetings along with the head radiographer. There have been some inconsistencies depending on the radiologist around silver and paediatric CT scans. There was a missed pelvic fractures and confusion between a head and neck and full body scan however, practice has changed, and the issues rectified. There is a new governance structure currently being drafted for the radiology department with completion by May 2022. The RGH has the CT situated near to the emergency department.		
T16-2B-306	**CT Reporting**		**Y**
Comments	There is the ability to provide 24/7 reporting with the use of Everlight out of hours. It is unclear to reviewers if the trauma audit research network (TARN) data is looking at the hot report within 30 minutes or the final full report. This needs to be a health board decision to ensure		

	consistency across all three sites. Within the PCH there has been two instances of missed pelvic injuries. There is now a discrepancy meeting set up to take forward any issues into their governance process. There have also been issues with fractured reporting, where reports will come through in parts rather than as a whole which has caused some confusion. This has been escalated to the network and the teams have been made aware to be careful when looking at reports. At present, the full report time is being entered into the TARN data, going forward there is an aim to meet the 30-minute hot report target.		
T16-2B-307	**Teleradiology Facilities**		**Y**
Comments	There is a Welsh teleradiology system which allows easy transfer of images between different health boards. There are no issues with the use of this system. It is the responsibility of the CT radiographer to arrange transfer of images to the MTC or other health board. Reviewers were informed that there is also the availability to create a patient identification number for unknown patients.		
T16-2B-308	**24 7 Access to Surgical Staff**		**Y**
Comments	An anaesthetist, general surgeon and orthopaedic surgeon is available within 30 minutes 24/7. Reviewers were provided with example rotas to evidence the availability.		
T16-2B-309	**Dedicated Orthopaedic Trauma Operating Theatre**		**N**
Comments	The POWH has a dedicated orthopaedic and trauma operating theatre between 8:30 and 17:00 Monday to Friday. These are not fully efficient and need to be optimised before considering adding a weekend list. There are regular morning meetings with the trauma theatre teams to improve the lists to enhance the efficiency. Additionally, there is also an audit being undertaken to follow the patient pathway to understand where the inefficacies are and the timescales within the pathway. There is the ability to add extra trauma lists if necessary, in addition to the capacity for ad hock lists on weekends, if required. At the PCH there are two sessions available Monday to Friday all day. There is an attempt to add an additional session on a Saturday morning depending on theatre staff availability. This is on the risk register to focus on weekend theatre capacity and orthopaedic lists. There has been a clinical impact assessment completed to help gain investment from the health board and part of the transformation plan is developing a seven-day workforce. The RGH have dedicated trauma lists five days per week, Monday to Friday all day and there is a confidential enquiry into perioperative deaths (CEPOD) list at weekends.		
T16-2B-310	**24 7 access to Emergency Theatre and Surgery**		**Y**
Comments	There is 24/7 access to emergency theatre and surgery however, at the PCH the CEPOD list is shared with maxillofacial and other specialities.		

T16-2B-311	**Trauma Management Guidelines**		**Y**
Comments	The trauma network management guidelines are used across all three sites. Network guidelines can be accessed through the network induction application which all staff are provided access to on induction to the department. Links to the SharePoint where the network guidelines can also be accessed are included within the emergency department handbook.		
T16-2B-312	**Transfusion Protocol**		**Y**
Comments	Within the POWH there is a transfusion protocol however, this is different to the protocol utilised in the PCH and RGH. It is recommended that the protocols are reviewed to ensure a health board wide protocol is followed. Access to the protocol is through the health board intranet.		
T16-2B-313	**Administration of Tranexamic Acid**		**Y**
	The TARN data for Q1 2021/2022 at POWH identified no patients requiring tranexamic acid. The TARN data from 2012 to 2021 shows 60% compliance with awareness of the protocol covered on the nurse internal training. The PCH shows 77.8% compliance in TARN data shared with the reviewers which shows a higher than the national average compliance from 2012 to 2021. Reviewers were informed that there is a low number of patients who arrive at RGH within three hours as 80% of patients are brought in due to falls from less than two metres. The TARN data for 2012 to 2021 identifies a 60% compliance which is just below the national average. Due to the wide dates for this data it is difficult to see any trends in addition to the number of patients not being identified.		

Definitive Care			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2C-301	**Major Trauma Lead Clinician**		**Y**
Comments	All three sites have a named clinical lead with a list of responsibilities and one programmed activity (PA) to undertake the role. It was recognised as good practice that the RGH has a clinical lead with dedicated time. It was unclear to reviewers how there is collaboration between the three sites and who takes the lead for the health board. This is exacerbated due to the lack of organisational management overseeing the trauma service.		

T16-2C-302	**Trauma Group**		**Y**
	Each of the three sites holds individual M and M meetings and integrated locality groups. The local meeting at POWH had not met for a number of months however, this has been re-established in February 2022. For the first meeting there was no orthopaedic representation, and this has been raised as a concern. There is an aim for meetings to take place every month rather than quarterly, until the group is well established, to make sure there is good representation from all areas. This meeting will feed into the health board structure via the trauma quality improvement committee (TQuIC). The local group is well attended at PCH even during Covid-19. Surgical colleague's attendance started well but dipped due to sickness however, it is expected that this should now improve following the return from sickness. Paediatrics are invited to the meetings but don't always attend. There is one TQuIC meeting that is held on a quarterly basis jointly with the three sites. Senior managers and the three leads of the hospitals attend TQUIC to share learning and share with the network however, having this fully set up is recognised as work in progress and no timescale was offered for the completion of having this meeting fully functional. No attendance lists or minutes from the TQuIC meeting were shared with reviewers and it was unclear to reviewers where the executive input into this meeting is or the managerial ownership of the issues raised across the three sites.		
T16-2C-303	**Trauma Coordinator Service**		**Y**
	At POWH there are two full time major trauma coordinators and three orthopaedic nurse practitioners onsite whose roles have some overlap. Currently there is cover Monday to Friday 08:30 to 16:30 hours and there is a plan to work towards a model of seven day working with cross cover between the two roles however, no timescales were provided for the implementation of this. Identification of trauma patients is manual as there is no central system. There has been a retrospective look at patient admissions with an injury severity score (ISS) greater than 15 which identified that there has been some missed trauma calls. All missed patients were over the age of 65 with a fall from standing and attended through the minors areas of the ED. There are now safety checks implemented with the trauma score card being displayed in minors, staff education and the daily trauma meetings which the major trauma practitioners attend and are used to pick up any trauma patients who may have been missed when admitted. Within the PCH there is currently only one trauma coordinator who is 0.5 whole time equivalent (WTE) however, a second has been appointed and it is hoped that they will commence in the role by May 2022. The service is covered Monday to Friday with no cover during leave however, this will be addressed once the second coordinator commences in post There is no automatic system to identify patients, therefore the coordinator will go through the emergency department admissions every morning, pick out any trauma patients, check their documentation and identify where they are within the hospital. There is a trauma meeting every morning attended by the trauma and orthopaedic junior medics and registrar. There has been an increased communication from wards as to the patients who need to be seen however, there is no formal process and there is a reliance on individuals rather than a system. There is a concern that patients are being missed and a more robust process is required. Within the RGH there are no trauma coordinators and therefore there is an inability to identify where the patients are being admitted from		

	despite there being a system which could be utilised to identify patients. There was no job description or operating model shared for the trauma coordinator role to the reviewers. Resilience is required across all three sites, with a sufficient number of major trauma practitioners and rehabilitation coordinators to work across all three sites.		
T16-2C-304	**Management of Spinal Injuries**		**Y**
	The health board work to the network spinal injuries guidelines with the patient predominantly transferred to orthopaedic wards. The POWH communicate and take guidance from the MTC, as required, and reported that there were no concerns with this. At present, the ward staff have raised that they are not comfortable treating patients with spinal injuries as there are not enough patients coming through to remain competent. Therefore, training videos have been created to help staff understand techniques including collar management. The PCH informed reviewers that there are no issues with pathway one and two however, pathway three can be a challenge due to not having enough beds at the MTC for spinal patients to be transferred. Pathway three is starting to improve as spinal surgeons now have a good email contact and this should lead to a smoother transition, although an e- referral system would help here. For the patients who have not been able to be transferred, there is an open communication with the MTC for advice. At RGH management of spinal patients are admitted locally if they do not meet the guidance for transfer to the MTC. Magnetic resonance imaging (MRI) is only available until 20:00 hours, therefore if the patient is arriving after this time the scan will take place the next day. All spinal patients go to an orthopaedic ward. Reviewers would suggest there is a need to grow the pathway to ensure the patient is cared for in the correct area.		
T16-2C-305	**Management of Multiple Rib Fractures**		**Y**
	The health board follows the network management of rib fractures guideline and stumble criteria. As required, advice is sought from the MTC. Rib fractures are treated in the emergency department with a rib block and kept in the department due to a lack of staff being able to maintain competencies on the ward and the low number of patients. Once the patient is stabilised they are then moved to the rehabilitation ward.		
T16-2C-306	**Management of Musculoskeletal Trauma**		**Y**
	No issues were reported in relation to the management of musculoskeletal trauma. All open fractures are transferred to Morriston Hospital, which is within Swansea Bay University Health Board with no issues discussed with the reviewers.		
T16-2C-307	**Designated Specialist Burns Care**		**Y**
	There is a network burns clinical guideline that has been adopted alongside the South West United Kingdom (SWUK) burn network referral guidance for adult burns (16 years plus) detailing for severe burns patients to be transferred to Morriston Hospital. Reviewers were		

	informed that there is good access to the pre trauma network to specialist burns unit in Morriston Hospital. Additionally, there is a telemedicine tool that is utilised to share pictures of injuries with Morriston to gain advice or agree transfer.		
T16-2C-308	**Trauma Unit Agreement to the Network Repatriation Policy**		**Y**
	There is a weekly multi-disciplinary team (MDT) meeting held on a Wednesday within the MTC with attendance from the local health boards and clear information from the MTC regards the patients who are to be repatriated and the planned dates. Within the POWH there is a daily email shared internally with any patients who are likely to be repatriated so patients are always on their radar meaning a proactive approach. The team also identify which team the patient will need to be repatriated under. The health board recognise patients have better outcomes when they are repatriated as close to home as possible rather than to a central 'landing pad'. Therefore, geographical consideration is first and whether the patient is safe to go to that area before deciding as to where the patient will be placed. Approximately 50% of repatriated patients come from the area around the RGH. Additionally, RGH has been designated as a specialist repatriation hospital for spine, head injuries, complex behavioural issues and any potential tracheostomies. Reviewers were unclear if the policy had been updated to reflect the local ways of working.		
T16-2C-309	**Patient Experience**		**N**
	There are plans to work in collaboration with TARN and the South Wales Trauma Network to undertake a 12-month pilot of using Patient Reported Outcome Measures (PROMS) across TUs as well as the MTC. The use of patient stories and experience locally has been collected to provide the service with feedback however these stories need to be integrated into quality improvement.		
T16-2C-310	**Discharge Summary**		**N**
	It was unclear to reviewers if the same format for a discharge summary is provided across the three sites. There were no examples of discharge summaries shared with the reviewers however, what was discussed identified that there are numerous contact details within the discharge summary with the key worker not being identified. Reviewers were informed that there are plans to develop a booklet as a quality improvement however, no timescales were provided for the completion of this booklet.		
T16-2C-311	**The Trauma Audit and Research Network (TARN)**		**Y**
	There is a robust collection of TARN data across all three sites with data being discussed within the TQuIC meetings. Reviewers were informed that at POWH during Covid-19, the TARN coordinators were pulled in to assist with the vaccination programme, leaving only one member of staff which has left a backlog of work. There are now four new members of TARN staff however, they are still in training currently		
T16-2C-312	**Rate of Survival**		**Y**
	Ws scores are RGH –1.03, PCH – 0.43 and POW - 1.91. This data is discussed within the TQuIC meetings. Reviewers would suggest the collaboration across the three sites to provide continuity.		

Rehabilitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2D-301	**Rehabilitation Coordinator**		**Y**
Comments	There is one team of rehabilitation coordinators who are allied health professionals and cover the three sites providing a service Monday to Friday 08:30 to 16:00 hours. Reviewers were not provided with a job description or operating mode for the role. It was also unclear to reviewers the plan for funding the rehabilitation team once the funding finishes in 2023.		
T16-2D-302	**Access to Rehabilitation Specialists**		**N**
Comments	There is access to rehabilitation specialists however, there is a lack of access to psychology and mental health. There is a rehabilitation consultant that has four PAs per week across the three sites to undertake an outpatient clinic, MDT meetings and ward reviews. At POWH there has been the recruitment of an orthopaedic geriatrician to support with the high numbers of silver trauma.		
T16-2D-303	**Rehabilitation Prescriptions**		**Y**
Comments	When patients are repatriated, one of the rehabilitation coordinators will have regular contact with the patient and will rewrite, update and explain the rehabilitation prescription with the patient. Rehabilitation prescriptions coming from the MTC are all on a database which is updated prior to being given to the patient. There are occasions where the rehab prescription sent from the MTC is not fully up to date at the point that the patient is repatriated. Only rehabilitation coordinators and major trauma practitioners can add to the rehabilitation prescriptions, this could be enriched by other clinicians also having access. The reviewers raised the suggestion that there could be a single contact number, or the number of the key worker could be highlighted, to allow easy understanding of who the patient should contact if further support is required. It was highlighted to reviewers that reviewing the rehabilitation prescription is a piece of work that is being undertaken by the South Wales Trauma Network and the health board to develop and use an electronic patient held rehabilitation prescription. The patient does not get a copy of the rehabilitation prescription until they are discharged, and it was noted that the content of the prescription contains medical jargon.		

General Comments
It was recognised that the three sites work independently with minimal cross working. Reviewers would suggest that one operational policy for the health board including shared policies and procedures with organisational management as a service as a whole to ensure equity of access and care.

Good Practice / Significant Achievements
(List key points covering good practice)

- Repatriation of patients closest to home
- Clinical lead at RGH with dedicated time in their job plan
- Recruitment of an orthopaedic geriatrician

Rehabilitation team to support patients being cared for close to home.

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:
None identified.

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve

CEO/Board Representative risk handed over to at feedback session:

1. There is a lack of operational managerial oversight within the Health Board to oversee the coordination of the services, with limited integration across the three acute sites. The impact of this is the risk of an inequity of access and service delivery and a lack of standardisation of practice and policies. In addition, there are variations in standard operating procedures and the escalation of trauma unit diverts.

2. The Royal Glamorgan Hospital is recognised as a Local Emergency Hospital (LEH)within the structure of the SWTN, however it appears that they are functioning as a trauma unit (TU) without meeting a number of the quality indicators pertaining to being a TU. Consequently, there appears to be no oversight of admissions and the patient's pathway through a robust trauma coordination service. An audit of all ambulance attendances including those who are diverted from a TU to the LEH should be completed as a matter of urgency to gain a clear understanding of the current pathway, with the results being shared with key stakeholders to work collaboratively to determine the future direction and status of the LEH.

Areas of Improvement
(List areas of improvement)

- Increasing the robustness of the TARN coordinator role and being able to backfill any gaps.
- The discharge sheet has a number of different numbers and contacts on. This would benefit from being simplified for patient's ease
- More formal links between the Major Trauma Leads at all three sites to ensure joined up working

- Resilience in the major trauma and rehabilitation coordinator service across all three sites.
- All three sites utilising the same transfusion protocol
- Having access to a dedicated orthopaedic trauma theatre during weekends
- Lack of ring-fenced training budget for nurse level two training
- Robust process for trauma coordinators to identify trauma patients

Trust Name: Hywel Dda University Health Board	**Date of Review:** 21 March 2022
Service: Major Trauma TU	**Type of review:** National

Self-Declaration Compliance	**82% 23/28**	**Peer Review Compliance**	**82% 23/28**

Contextual Information and General Comments:

The Hywel Dda University Health Board (HDUHB) covers a large geographical area which composes of both rural and urban areas. The Eastern areas of the county border England and covers a quarter of the landmass of Wales with a population of approximately 390,000. It is generally not densely populated and patients are sent to various hospitals both within England and Wales. Given the geographical location of the health board, virtually no pre-hospital incidents occur within the one-hour isochrone of the major trauma centre (MTC) at Cardiff and Vale University Health Board (CVUHB). The health board comprises of four hospitals of which three have an emergency department: Glangwilli General Hospital (GGH), Withybush General Hospital (WGH) and Bronglais General Hospital (BGH). The fourth hospital is Prince Philip Hospital which is dedicated to elective surgery and a minor injury unit. Glanglwilli is designated as a trauma unit (TU) with Bronglais and Withybush designated as rural trauma facility (RTF). The RTF's triage major trauma patients as well as providing initial resuscitation and stabilisation for patients who cannot be taken directly to a TU. There is an expectation of a quick transfer to an MTC or possibly a TU however the timescale is not identified due to a lack of clear definition of a RTF. It is acknowledged by the trauma network that the RTFs are more likely to receive major trauma patients than local emergency hospitals (LEHs) in other networks given the design of the triage tool in operation for the region.

Pre-hospital services make the decision as to which patients are taken to which TU/RTF. Stage 1 and 2 patients will be taken to the TU by default unless there are significant concerns. If the emergency medical retrieval and transfer service (EMERTS) are en-route and are expected within 20 minutes, then the expectation is for the patient to wait for EMERTS to attend. If they are outside of this time frame then the next criteria are if the patient is less than 20 minutes to a TU, they will be taken there directly. From April 2022 the criteria will be expanded to include stage 3 patients.

Reception and Resuscitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2B-301	**Trauma Team Leader**	**Y**	**N**
Comments	It was identified that there is a trauma team leader (TTL) of ST3 or above with an agreed list of responsibilities available to attend all trauma calls at Glangwili within five minutes. Within hours 08:00 to 20:00 hours this role is covered by an emergency medicine consultant and out of hours until 01.00 is covered by an emergency medicine ST3 or equivalent on site. Outside of these hours ST3 or equivalent cover in ED		

	is inconsistent. When ED cover is not available then ST3 or equivalent cover in general surgery is expected to provide TTL cover until an ED consultant is available. On occasions when this is not available the duty surgical middle grade for the hospital is identified as the TTL. The TARN data shows various compliance between October 2020 and June 2021 with Q1 data showing a higher compliance than the national average. However, not all TTLs had the required training in Advanced Trauma Life Support (ATLS) or equivalent. This is due to a lack of availability of courses during the pandemic. Reviewers were informed that all TTLs had undergone inhouse training and had competency in dealing with a trauma patient. Consultant attendance within 30 minutes was also variable within the TARN data and remains below the national average. When a trauma alert is put out the consultant on call is informed and can attend in 30 minutes. While reviewers were informed of the trauma team being in place, the evidence identifies poor performance. It was unclear the total number of trauma calls for GGH, either pre alert or self-presenting. Reviewers would encourage a review of the data collection and the documentation of attendees, along with the clinical threshold for which a trauma call is activated in house, to clinically encompass a wider cohort that will benefit from earlier senior review and rapid diagnostics. There is not 24/7 emergency medicine consultant provision within the RTFs, which is a serious concern for a unit directly receiving candidate major trauma. When the emergency medicine consultant is not available, the lead for the emergency department is best placed to provide trauma team leadership and critical decision making. If required, advice is accessed by phone from the nearest TU, which is one hour twenty minutes away or the nearest MTC which is two hours thirty minutes away. There is no clear definition for the role of the RTF. While it is recognised RTFs can offer some trauma provision due to remote geography, there is a significant concern that without a clear definition of the units, patients with an injury severity score (ISS) greater than nine are being brought to these units where there is not full TU provision. Some patients stay while others require secondary transfer. The reviewing team were not clear if the RTF role is one of enhancing the delivery of pre-hospital care or a hybrid model that delivers both minor trauma care for some and pitstop pre-hospital care for others. It was also noted that the RTFs were within 1hour 20min (Bronglais) & 45min (Withybush) of the fully designated Trauma Unit (Glangwili), where triage direct to a TU may deliver better outcomes for many, these equivalent direct transfer times are routine across the rest of the UK. It was also indicated there has been no change in the standards of trauma care or investment in trauma capability of designated RTFs since the network went live, despite trauma being proactively triaged to them, this is of serious concern. There has been a delay in some patients who require a higher level of care receiving this and being transferred to the TU in GGH or the MTC in CVUHB.		
T16-2B-302	**Emergency Trauma Nurse AHP**	**N**	**N**
Comments	There was no evidence that there is a nurse or allied health professional (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. This was due to a lack of training that has been available and due to service pressures, there has not been the ability to release staff to attend training in addition, to a high turnover of staff within the department. The department is considering putting on skills training days with the major trauma practitioner leading on this however no timescale was provided for this. In the previous 12 months, several trauma skills days equivalent to level one was provided to staff however, these are not recognised as formal training. Currently approximately four staff are level 2 trained however, the rota is not structured in a way that means there will be one level 2 nurse on every shift. All sisters are also navigators and not always available on every shift. The major trauma practitioner is trained to meet level 2		

	and are available Monday to Friday 08:30 to 16:30 hours. It was acknowledged by the reviewers that there is now a nurse educator for the TU in post to monitor and aim to improve compliance of training. There were no plans for nurse level one or two training at RTFs.		
T16-2B-303	**Trauma Team Activation Protocol**	**Y**	**Y**
Comments	There is a network trauma team activation protocol in place which includes a list of roles and responsibilities. It was noted within the trauma team activation protocol it designates a fall from six meters or more, this was considered to be excessive and should be reviewed and reduced, similarly the level of GCS should be reviewed for activation purposes. Additionally, there is a trauma team activation poster which is a visual aid that can be displayed in the clinical areas to support assessment of trauma. It was noted that not all trauma calls are captured and there is a great reliance on TARN data to retrospectively identify trauma patients with higher severity injuries, missed upon reception in the emergency department. Additionally, there is a lack of consistent attendance and documentation at trauma calls. When there is no availability of a middle grade doctor, a junior member rather than the senior member of the team attends. Additionally, evidence based on TARN data submitted suggests poor attendance to trauma calls in meeting the standard of attendance within five minutes for an ST3 plus and within 30 minutes for a consultant. The impact of this is that the patient is not getting the expert review for clinical decisions and is adding pressure to the junior role to make decisions not within their experience. It was noted that there are vacancies within BGH which have been advertised, but due to the rural area it is difficult to recruit into. These challenges are common across the country and should not deter the unit from aspiring to achieve them.		
T16-2B-304	**Agreement to Network Transfer Protocol from TUs to MTC**	**Y**	**Y**
Comments	There is a network agreed transfer protocol in place. There are limited facilities within the RTFs and the ability to transfer out is of serious concern. There have been approximately 20 transfers from the RTFs which is recognised as a significant number of patients which are not easy transfers for the distance which can take over an hour to travel. Additionally, when patients are within an RTF, there is not the full senior expertise and wrap around staff to support the patient whilst waiting for transfer. Patients who do not meet the 12-hour transfer target are reviewed and discussed within the local mortality and morbidity (M and M) meetings. Whilst the more obvious high severity trauma will no doubt be transferred rapidly, it is the lower severity trauma that also benefits from the enhanced capabilities and regular practices of a mature TU, which is likely to suffer from sub optimal outcomes if triaged direct to an RTF. It was noted that since the implementation of the trauma network and the yearly pathway evaluation sessions, there has been improvements in transfers from the TU to the MTC however, there still remains challenges for the MTC TTL to accept patients and on occasions the requirement for speciality to speciality discussions have been required after being deferred to by TTL.		

T16-2B-305	**24 7 CT Scanner Facilities**	**Y**	**Y**
Comments	Previously there was only one computerised tomography (CT) scanner which was not optimally located. In February 2022, another scanner has been added and while not co-located within the emergency department is nearby on the same floor of the hospital allowing easy access for trauma patients, reducing delays and providing a backup if one CT scanner goes down. There is a resident radiographer on site 24/7. There is a clear CT policy which includes a proforma to request a CT scan.		
T16-2B-306	**CT Reporting**	**Y**	**Y**
Comments	The CT reporting is completed in house except for out of hours when Everlight radiology service is utilised**.** There are no issues of timeliness of reports for provisional reports within 60 minutes. There is no in - house secondary reporting of scans and therefore there is a potential assurance gap in relation to missed injuries		
T16-2B-307	**Teleradiology Facilities**	**Y**	**Y**
Comments	There is a Welsh teleradiology system which allows easy transfer of images between different health boards. There are no issues with the use of this system. It is the responsibility of the CT radiographer to arrange transfer of images to the MTC or other health board.		
T16-2B-308	**24 7 Access to Surgical Staff**	**Y**	**Y**
Comments	An anaesthetist, general surgeon and orthopaedic surgeon is available within 30 minutes 24/7. Reviewers were provided with example rotas to evidence the availability.		
T16-2B-309	**Dedicated Orthopaedic Trauma Operating Theatre**	**N**	**N**
Comments	There are dedicated orthopaedic theatres running Monday to Saturday with the use of national confidential enquiry into perioperative deaths (NCEPOD) lists shared on a Sunday. This fails the standard which requires a dedicated daily list. There are issues with anaesthetic cover as this is not job planned and is reliant on extra shifts to fill the rota. There is no dedicated theatre radiographer on a Saturday as they are shared across two theatres. The lack of radiographer access is an issue for C arm manning when required. Theatre access can be an issue however; bed capacity is a bigger issue despite looking at the distribution of patients across all four sites. Whilst no doubt lifesaving treatment is continuing to happen, it is at the expense of ambulatory patients. A greater than two weeks wait for ambulatory theatre operating was indicated, which is concerning.		
T16-2B-310	**24 7 access to Emergency Theatre and Surgery**	**Y**	**Y**
Comments	There is a fully staffed CEPOD 24/7. Overnight there is a resident operating department practitioner (ODP) and scrub staff with staff on-call for obstetric and other emergency cover if a case needs theatre out of hours. There is a running of CEPOD list standard operating procedure and a trauma list standard operating procedure to support the safe and effective running of the trauma list and maximise access.		

	It is of concern that this list capacity is occasional shared with orthopaedic trauma cases on the weekends.		
T16-2B-311	**Trauma Management Guidelines**	**Y**	**Y**
Comments	The trauma network management guidelines are used with limited modification to meet local requirements. The same guidelines are used across all sites. Network guidelines can be accessed through the network induction application.		
T16-2B-312	**Transfusion Protocol**	**Y**	**Y**
Comments	There is a health board major haemorrhage procedure. The same procedure is consistent across all sites. Access to the guidelines is on the health board intranet site.		
T16-2B-313	**Administration of Tranexamic Acid**	**Y**	**Y**
	The TARN data shows there have been six patients from July 2020 until June 2021 meeting the requirement for tranexamic acid. Whilst the occurrence numbers are expectedly low, only one case did not receive tranexamic acid. This is being examined through the trauma quality improvement committee (TQuIC).		

Definitive Care			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2C-301	**Major Trauma Lead Clinician**	**Y**	**Y**
Comments	There is a named clinical lead who has one programmed activity (PA) for the role, which is an additional thirteenth PA within the job plan. There is a deputy at both RTFs. Both deputies do not have protected time and is currently absorbed into supporting professional activities (SPA). It was unclear to reviewers how the clinical lead works consistently across the three sites ensuring continuity of the service with the deputies with no protected time for the deputies.		
T16-2C-302	**Trauma Group**	**Y**	**Y**
	There is a TQuIC group that meets quarterly, with a wide membership listed within the terms of reference. Evidence of attendance at these meetings was missing and reviewers were informed that attendance of key leads is not as consistent as preferable however, all three sites are represented. The reviewers were informed that there was good attendance from emergency medicine, anaesthetics, and trauma and orthopaedics with recent improvement in attendance from radiology. Surgery and critical care attendance were recognised as less regular and it was noted that there was no executive attendance. Reviewers would recommend monitoring of attendance at these meetings with		

	executive attendance. It was noted that the support of the TU manager for this service is essential with discussions highlighting the good coordination of one service across three sites.		
T16-2C-303	**Trauma Coordinator Service**	**Y**	**Y**
	There are 1.8 whole time equivalent (WTE) major trauma practitioners who work Monday to Friday 08:30 to 16:30 hours. Cover outside of these hours is provided from the hospital patient flow team. During periods of leave, cover is provided by the major trauma rehabilitation coordinators. One major trauma practitioner focuses on the work within Glangwilli, with the second providing outreach to the other two sites and provides training. Reviewers identified this model as good practice providing continuity across three sites.		
T16-2C-304	**Management of Spinal Injuries**	**Y**	**Y**
	It was reported that there were initial issues with repatriating spinal cord injury (SCI) patients, one as an acute admission and one post rehabilitation however, significant work has been undertaken to improve this. There has been collaborative work undertaken with bed management, head of nursing and the spinal unit in Cardiff and Vale University Hospital (CVUH) to develop knowledge, skill and competence at managing people with SCI and cohorting them into two orthopaedic wards in HDUHB. This has involved drawing on knowledge and experience of the bowel and bladder specialist team and district nurses, gaining honorary contracts for staff to go to CVUH to work on the SCI unit. There are low numbers of these patients and the major trauma practitioner have train the trainer skills, in addition to nurses being able to attach themselves to a district nurse for refresher training. Prior to a patient being transferred back to the unit, nurses with the honorary contract can meet the patient in CVUH prior to the patient being transferred to ward 9 in the Prince Phillip Hospital. Going forward there are plans to develop the skills of one nurse with a specialist interest to go out with the district nurses one day a month to maintain the knowledge and skills gained. It was not clear what type of patients were further repatriated to RTFs and if the unit had the appropriate skill sets available to care for them appropriately on the wards upon return.		
T16-2C-305	**Management of Multiple Rib Fractures**	**Y**	**Y**
	There is a health board rib fracture guideline and a rib fracture decision making tool however, it was noted that there is potential delay and under recognition of rib fractures in the RFTs due to underutilisation of CT scanning. These patients are often picked up by the major trauma team much later on, at risk of increased complications and sub-optimal outcomes. The next TQuIC meeting has stumble scores on the agenda to consider if a stumble score is greater than 25, raised pain score and elderly or more than three rib fractures requires referral to the TU. The reviewers encourage that this is considered and provide operational evidence of adherence as currently there is an inequitable geographical variation in the treating of rib fractures. All three sites should follow the standards as set by the network. The reviewers were informed that currently patients requiring an epidural for rib fractures are treated within intensive care. The use of the erector spinae plane (ESP) block to treat rib fractures is being utilised and has been evaluated showing a reduction of patient pain and length of stay. It is intended that this will be made available as a treatment within a surgical unit in the future however, no timescale was provided for this. Reviewers would encourage this to be considered to ensure appropriate use of beds and ensure patients are being cared for in the most appropriate environment.		

T16-2C-306	**Management of Musculoskeletal Trauma**	**Y**	**Y**
	No issues were reported in relation to the management of musculoskeletal trauma. All isolated open fractures are transferred to Morriston hospital, which is within Swansea Bay University Health Board with no issues discussed with the reviewers.		
T16-2C-307	**Designated Specialist Burns Care**	**Y**	**Y**
	There is a network burns clinical guideline that has been adopted alongside the South West United Kingdom (SWUK) burn network referral guidance for adult burns (16 years plus) detailing for severe burns patients to be transferred to Morriston Hospital. Reviewers were informed that there is good access to the pre trauma network to specialist burns unit in Morriston Hospital. Additionally, there is a telemedicine tool that is utilised to share pictures of injuries with Morriston to gain advice or agree transfer.		
T16-2C-308	**Trauma Unit Agreement to the Network Repatriation Policy**	**Y**	**Y**
	There is a weekly multi-disciplinary team (MDT) meeting held on a Wednesday within the MTC with clear information regards the patients who are to be repatriated and the planned dates for the repatriation. Due to the excellent communication prior to the patient being ready for repatriation, this allows for 80% of patients repatriated within the first 24 hours. Internally this is supported by working closely with the bed management team and existing Sitrep system. Additionally, there is an escalation policy which has helped to facilitate timely transfers. Some transfers go directly back to the RTFs or other community hospitals, depending on patient need and patient being closer to home.		
T16-2C-309	**Patient Experience**	**N**	**N**
	There are plans to work in collaboration with TARN and the South Wales Trauma Network to undertake a 12-month pilot of using Patient Reported Outcome Measures (PROMS) across TUs as well as the MTC. The use of patient stories and experience locally would provide the service with feedback to assure the patient experience and highlight areas where service improvements can be made.		
T16-2C-310	**Discharge Summary**	**N**	**Y**
	Reviewers were informed that a detailed discharge summary is produced for every patient however, an example of this was not shared. Business cards are provided to patients with contact details however, it was unclear to reviewers when this was given and whose details were included. It was noted by reviewers that discharge summaries are on the work plan to be improved.		
T16-2C-311	**The Trauma Audit and Research Network (TARN)**	**Y**	**Y**
	There has been an increased data completeness for year two achieving 100%. It was noted that there is the requirement for additional support for data collection from RTFs if they are to continue to directly receive candidate intermediate and major trauma and reviewers would encourage the work already identified to recruit an additional TARN coordinator for the RTFs which will allow for greater oversight of the data. There were no timescales provided for the recruitment into this role.		

T16-2C-312	**Rate of Survival**	**Y**	**Y**
	Survival rates for the period of review are poor, with a Ws score in the lower quartile nationally. Survival rates are discussed within the TQuIC meeting and within the South Wales Trauma Network meetings.		

Rehabilitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2D-301	**Rehabilitation Coordinator**	**Y**	**Y**
Comments	There are 2.0 WTE rehabilitation coordinators who are both AHPs and are available Monday to Friday 8:30 to 16:00 hours. There is good communication and coordination of individual rehabilitation demands and needs, drawing on existing expertise within the organisation and from specialist units e.g. bladder and bowel management of SCI patients from district nurses.		
T16-2D-302	**Access to Rehabilitation Specialists**	**N**	**Y**
Comments	There is full access to AHPs with dedicated time to support the rehabilitation of trauma patients and referral and access pathways for further support, as required. There is a rehabilitation consultant with two sessions per week through an honorary contract with a further two sessions for virtual support and advice. There is sometimes a gap in the provision of psychology and neuropsychology support however, this is monitored by the team with attempts to link with Swansea Bay University Health Board. There are good links with tier 1 neurorehabilitation unit and SCI specialist unit, and good evidence of utilising expertise in community neuro teams, in reaching into the wards. Currently there is no availability for co-location of tier 2 rehabilitation patients however, this may be possible in the plans for the new hospital. Reviewers would encourage the team to continue to work towards the co-location of the patients to support both the training and competence of the staff in addition to improving the quality of the patients care. The community neurorehabilitation provision sustainability and capacity needs planning in the long term to ensure the continued availability of the service being aware of the risks to funding for existing community neurorehabilitation teams.		
T16-2D-303	**Rehabilitation Prescriptions**	**Y**	**N**
Comments	The TARN report for Q2 2021/2022 shows only 20.5% compliance, which is well below the national standard of 100%. It was noted that the wording within the rehabilitation prescriptions include medical jargon and lack clear contact details making it difficult for a patient to understand. It was also unclear to reviewers what other patient information is given alongside the rehabilitation prescription to aid in the patient understanding their injuries and ongoing requirements. It was highlighted to reviewers that this is a piece of work that is being undertaken by the South Wales Trauma Network and the health board to develop and use an electronic patient held rehabilitation		

	prescription.

Good Practice / Significant Achievements
(List key points covering good practice)

- Dedicated manager for major trauma coordinating a single service across three sites
- Improved TARN compliance
- Nurse trainer instructor
- Second CT scanner availability
- Trauma coordinator role including outreach support
- Significant improvement in ability to provide appropriate SCI management and care
- Impact of neurorehabilitation consultant with two sessions per week
- Communication across the network facilitating timely repatriation

Integrated working across the HB, utilising the specialist knowledge and skills of the Community Neurorehabilitation Team

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:
None Identified

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve

CEO/Board Representative risk handed over to at feedback session:

1. There is no clear definition for the role of the rural trauma facility (RTF), evidence indicates that at times patients are inappropriately directed to these units when a higher level of care is or may be required. While it is recognised the need for the RTFs to offer some trauma provision due to remote geography, there is a significant concern that without a clear definition of the role, patients with a higher injury severity score (ISS) are being brought to these units where there is not full trauma unit provision. There has been a delay in some patients who require a higher level of care receiving this and being transferred to a trauma unit in Glangwilli General Hospital or the MTC in Cardiff.

2. There is a lack of consistent attendance and documentation at trauma calls. When there is no availability of a middle grade doctor, a junior

member rather than the senior member of the team attends. Additionally, evidence based on TARN data submitted suggests poor attendance to trauma calls. The impact of this is that the patient is not getting the expert review for clinical decisions and it also is adding pressure to the junior role to make decisions not within their experience.

Areas of Improvement
(List areas of improvement)

- Lived experiences and patient feedback
- Nurse rota to identify level 2 trained nurses
- Two week wait for ambulatory trauma
- Emergency theatre shared access with orthopaedics
- No in-house secondary reporting of CT scans
- Potential delays in identification of rib fractures and inequitable geographical variation
- Increased compliance with rehabilitation prescriptions
- Development of clear discharge summaries

Trust Name: Powys Teaching Health Board	**Date of Review:** 23 March 2022
Service: Major Trauma Rehabilitation	**Type of review:** National

Self-Declaration Compliance		**Peer Review Compliance**	

Contextual Information and General Comments:

Powys Teaching Health Board supports a population of 138,000 in an area covering 25% of Wales.

Powys has no acute services and there are no district general hospitals (DGHs) therefore is largely a commissioning health board. Powys residents' access acute and specialist medical care from their nearest DGH, with approximately 50% of patients attending an English hospital, due to being very close to the English border. There are nine community hospitals spread equally across the population and all offer inpatient rehabilitation, with the vast majority of patients having been stepped down from acute care. Only 5-8% of patients are community admissions.

General Comments

There are care transfer coordinators based in neighbouring DGHs to track and discharge patients from acute sites or arrange repatriation back into Powys. Patients from mid and south Powys, either go to Prince Charles Hospital, Morriston Hospital or Bronglais Hospital, with some patients from north Powys also going to Bronglais Hospital however, the vast majority go across the border to Shrewsbury. Patients from mid and south Powys may also go to Hereford Hospital, Wye Valley Trust, from were they may access the Midlands major trauma network. There is every effort made by the team to track patients and start transfer and rehabilitation planning early alongside the home help team within the county council. The whole rehabilitation team are co-located enabling good communication between the team. Home first will see people who only need a max of 10 days rehabilitation and can support patients getting in and out of bed. Reablement social services and health care will see patients who require approximately four to six weeks rehabilitation. The same therapists work across both services. All patients are triaged daily, with good tracking to ensure patients continue through the rehabilitation process.

There is a seven-day community rehabilitation service co-located with the seven day in reach rehabilitation. There are flexible working patterns that allows for early or later visits as per the patients' requirements. There is a weekly neuro flow meeting that the
team attend. This meeting looks at current and upcoming patients and their needs enabling the team to plan their workforce.

Complex patients are repatriated to Brecon War Memorial Hospital which is led by an elderly care physician or Newtown which is a general practitioner led service. Neither of these have 24-hour cover and are used for patients with acquired brain injury or those with Guillain-Barre syndrome. Patients who have a tracheostomy can be cared for in Newton with light suction however, deep suction cannot be performed. Additionally, there is no medical support available for those who need weaning off a tracheostomy or more intensive respiratory support. Bladder and bowel management can also be managed in these areas. There are difficulties around limited medical acuity of those that need to be repatriated due to the limitations in medical staffing and not having 24/7 medical cover.

Reviewers were informed that it is a struggle to upskill nurses, due to the rural location and there are also difficulties in retaining and training staff due to the demographics. There is a new post within the training team with a project running until December 2022 to develop staff training and explore staff satisfaction.

Reviewers were informed that completion of rehabilitation prescriptions can be limited therefore, it can be difficult to ascertain what the rehabilitation needs of the patient are. The team also receive rehabilitation prescriptions for stroke and complex patients. To support the goal setting for patients and to ensure that patients are discharged to their own home if possible, rather than a community hospital, a phone call referral is utilised. The team gain the most understanding of the patient and their needs from the team that are currently caring for the patient to know it is safe to get the patient home. Through the detailed discussions within the referral phone call this increases the ability to discharge from acute site to home. Reviewers would commend the community rehabilitation team for ensuring the patient is at the centre of the service, are creative in the care to ensure it is what the patient requires with innovative and brave practices to bring the patient closest to home, if not in the patients home.

Collecting patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) is a problem and the team are going to work with the South Wales trauma network to develop this work utilising the national tool. Currently the team utilise a Microsoft forms to gain patient feedback however, this has been collected in silos. Patient feedback has been identified as increasing patient satisfaction when being discharged home from the acute setting rather than to a community hospital. The rehabilitation team are looking at setting up a stakeholder's group that will sit alongside the stroke and community steering group so that service users' voices are heard. Reviewers would encourage a more robust process for collecting patient feedback to identify the worth of the service to support the funding in the future for the community rehabilitation service and identify areas of the service that could be improved.

The team identified that there is a lack of psychological care to support patients with health conditions as well as the journey through the trauma service.

Good Practice / Significant Achievements
(List key points covering good practice)

- There is a 7-day service
- Flexible working patterns
- Patient Centred care
- Very good teamwork

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:
None Identified

Specify Serious Concerns A ‘Serious Concern’ is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve
CEO/Board Representative risk handed over to at feedback session: **None Identified**

Areas of Improvement (List areas of improvement)
• Patients experience of the service. • Access to psychological support • 24/7 medical support

Trust Name: Swansea Bay University Health Board (Morriston)	**Date of Review:** 22 March 2022
Service: Major Trauma TU	**Type of review:** National

Self-Declaration Compliance	**70% 16/28**	**Peer Review Compliance**	**74% 17 /28**

Contextual Information and General Comments:
Swansea Bay University Health Board (SBUHB) has three major hospitals providing a range of services: Morriston Hospital (MH) and Singleton Hospital in Swansea, and Neath Port Talbot Hospital in Baglan, Port Talbot. Additionally, there is a community hospital and primary care resource centres providing clinical services outside the main hospitals. MH was established in April 2020 as an adult and paediatric Trauma Unit (TU) with specialist services. Singleton Hospital is a cold site and Neath Port Talbot is a rehabilitation hospital including a specialist neurorehabilitation unit. The MH site is one of five TUs in South Wales, however, it is the only one with specialist services covering burns and plastics, including open lower limb fractures, spinal and cardiothoracics. Therefore, patients will attend from out of area if they have an isolated injury, as part of the network pathway arrangements. The Health Board provides care to a population of approximately 389,300 of which 19.9% are over 65. The Major Trauma Centre (MTC) is at University Hospital Wales (UHW) which is within Cardiff and Vale University Health Board (CVUHB).

Reception and Resuscitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2B-301	**Trauma Team Leader**	**N**	**N**
Comments	There is not always a trauma team leader (TTL) who is available within five minutes and/or a consultant available within 30 minutes. The TARN data for a TTL within five minutes (54.1%, compared to 33.3% national average*) and consultant within 30 minutes (57.7 %, compared to 45.3%*) is above national average for those patients pre alerted, but below for those who are not (3.9% compared to 4% for TTL within 5 mins, and 7.6% compared to 9.7% for 30mins*) , which is likely to include silver trauma and stealth trauma. Reviewers were informed that the below expected level of TTL presence in cases of amber to red trauma, are due to issues with the recorded data rather than being a systemic problem. Reviewers would suggest an audit and review of these cases would be beneficial to evidence that the TTL and consultants are present and identify areas of improvement. For every trauma call there is a dedicated scribe. There have been difficulties with ensuring that a surgical or orthopaedic registrar is available for these trauma calls, this has been managed internally through the consultant escalation processes. There are eight out of 17 consultants and eight out of 15 speciality doctors/registrars who are trained in Advanced Trauma Life Support (ATLS) or equivalent. Reviewers were informed that there have been difficulties accessing courses due to Covid-19 and the geographical		

	area meaning it can be quite a distance to the nearest course. Reviewers suggest investigating running a course locally to improve training as quickly as possible. *figures taken from Clinical Report issue 3 November 2021		
T16-2B-302	**Emergency Trauma Nurse AHP**	**N**	**N**
Comments	There are only eight nurses (16%) that have successfully achieved level two training as described in the National Major Trauma Nursing Group guidance. The unit is working towards having a nurse trained in advanced trauma nursing course (ATNC) for major trauma at all times however, planned training has not been completed due to staffing pressures. There were no timescales provided for this to be completed. There was no evidence for level two training for paediatrics. There are 53 nurses (76%) who are trained at level one and completed the required competencies. The use of the South Wales Trauma Network (SWTN) online training package has assisted in the completion of this training. The nursing rota identifies those nurses that are level two or paediatrics trained, however, there is not always the required cover for every shift. There are three band seven nurses who are dedicated trainers within the TU however, dedicated training time has been lost to clinical pressures.		
T16-2B-303	**Trauma Team Activation Protocol**	**Y**	**Y**
Comments	There is a network trauma team activation protocol which includes a list of roles and responsibilities. It was noted within the triage tool it designates a fall from six meters or more, this was considered to be a generous target and should be reviewed and reduced. Additionally, there is a trauma team activation poster which is a visual aid that is displayed in the clinical areas to support assessment of trauma. The criteria for trauma calls is taught on in-house emergency department trauma training days which are held every six months. Separate focused training sessions have been run by an emergency trauma registrar on silver trauma which is open to doctors and nurses. Two training sessions for emergency department medical trainees on trauma calls and pathway awareness have been provided. A short awareness session aimed at nurses-in-charge that includes the trauma call criteria was developed for the network by one of the SBUHB major trauma teams and runs twice a year in the emergency department and shared widely amongst emergency department senior nursing staff. There is a silver and paediatric trauma tool in place and for all other instances there is one standard trauma call. Reviewers were informed that there has been a large rise in the number of silver trauma cases in the past 12 months, likely due to enhance awareness of this group. There have been significant issues with increased waiting times for ambulance attendance to patients who have been involved in an incident meaning a rise in patients being brought into hospital in a car or private vehicle resulting in there being no trauma pre-alert for these patients. It is recognised that this is a sub-optimal way to run a trauma call. It is vital that the emergency department has ambulance and ambulatory triage staff that are both aware and informed about the trauma activation criteria, to pick up patients that self-present with suspected major trauma.		
T16-2B-304	**Agreement to Network Transfer Protocol from TUs to MTC**	**N**	**Y**
	There is a network agreed transfer protocol in place. Patients being transferred from the TU to the MTC including those with an injury		

Comments	severity score (ISS) greater than 15 the numbers are small, performance is variable and review of this is encouraged as the patients that need to be transferred within 12 hours by definition are sick and need urgent treatment. In the first two quarters, in 2020/21 there were no patients transferred, then in quarter three and four the TU was above the national average, and quarter one 2021/22 the TU was under the national average. Individual patients are discussed with consultants at both the TU and MTC before deciding the best course of action. An audit of patients who were not transferred has been conducted. Eight patients were queried for transfer and of those, four should have been transferred to the MTC. Two of those four patients were for nonoperative management. These cases were discussed at the trauma quality improvement committee (TQuIC) and network meetings. These findings have been shared with staff and incorporated into in house training sessions. A continuous review of ISS greater than 15 patients is required with outcomes, to determine if more patients should be going to the MTC.		
T16-2B-305	**24 7 CT Scanner Facilities**	**N**	**N**
Comments	There are currently two computerised tomography (CT) scanners available at MH. The nearest CT scanner is 50 yards down the corridor and not co-located within the emergency department. There are plans in place to gain an additional scanner within the hospital and the review team would support this being co-located in the emergency department to aid timely trauma patient access. There is 24/7 radiology onsite however, out of hours the radiologists are also dealing with ward enquires and therefore could be anywhere within the hospital which may lead to non-compliance of the patient receiving a CT scan within 60 minutes within the emergency department. From Q2 2020/2021 to Q1 2021/2022, patients who received a CT scan within 60 minutes of entering the TU ranged from 27.1% to 42%. The TARN data identifies for the period 1 September 2020 to 31 August 2021 of the 384 patients, median time to CT was 131 minutes (ranging between 53 to 318 minutes) which is less than the National TU average of 142 minutes.		
T16-2B-306	**CT Reporting**	**N**	**N**
Comments	There has recently been an improvement in reporting abilities with CTs being reported from a dedicated registrar room. There is an ABCDE digitalised report available within 30 minutes. Second view and validation at consultant level turned round in less than 12 hours. The TARN data identifies for the period 1 September 2020 to 31 August 2021 of the 384 patients, median time to provisional report 65 minutes (ranging between 43 to 101 minutes) and median time to final report 204 minutes (ranging between 93 to 608 minutes) which is above the National TU average of 105 minutes. The TU should also now be working towards hot reporting of all major trauma CT scans uniformly across the radiology department as per new TU quality indicators.		
T16-2B-307	**Teleradiology Facilities**	**Y**	**Y**
Comments	There is a Welsh teleradiology system which allows easy transfer of images between different health boards. There are no issues with the use of this system. It is the responsibility of the on-duty CT radiographer to arrange transfer of images to the MTC or other health board.		
T16-2B-308	**24 7 Access to Surgical Staff**	**N**	**N**
	A general surgeon, trauma and orthopaedic surgeon or anaesthetist of st3 or above are not always within 30 minutes therefore, non-		

Comments	compliance with these specialities attending trauma calls at times. It was noted that the TARN data for time to operation has decreased. An example of the on-call rota was shared ith reviewers. The data presented in the TARN Clinical Reports from November 2020 and 2021 shows a continued decline in the median minutes to first operation, (01 Sept 2018- 31 Aug 2019 456 minutes, 01 Sept 2019- 31 Aug 2020 734 minutes, 01 Sep 2020- 31 Aug 2021 828 minutes), it is noted however that all of these remain under the national average for the same time period.		
T16-2B-309	**Dedicated Orthopaedic Trauma Operating Theatre**	**Y**	**Y**
Comments	There is a dedicated orthopaedic trauma list with appropriate staffing running a three-session day, Monday to Friday, and a two-session day Saturday, and Sunday. On occasions, the elective theatres on a Tuesday and Friday can be converted to trauma capacity, as required, dependent on theatre staffing. Additionally, there are lists at Singleton Hospital which are case specific and not general anaesthetic cases. They are also split based on demand and consultant cover between orthopaedics and plastics. Polytrauma patients are transferred to the MTC at CVUHB, isolated open fractures are treated at MH. There is no dedicated orthoplastic list for these complex combined cases, they are done as and when required, based on clinical need and occur on any given day Monday to Friday, utilising orthopaedic and plastic surgery theatre staff from the respective trauma theatres. These cases predominantly take place in the plastics trauma theatre, displacing other plastics general trauma patients. There are plans to introduce a two-session day on a Wednesday, when adequate orthopaedic staff are available. Reviewers were informed that there is a lack of resilience within the theatre staff for orthopaedics and fix and flap in plastics. When the TU was being developed the business case to support the orthoplastic service planned for approximately two to four open fractures a month and currently there is two to four open fractures a week. Therefore, there is a deficit between what was planned and cases being seen. Whilst it is recognised that not all Open Fractures are represented on TARN, it is concerning to see and hear that the number of patients presenting has far exceeded those planned for. Orthoplastic care is complex and resource intensive and the reviewers would suggest looking again at the demand on the service to ensure patients are receiving safe and timely care. It is encouraging to see that over 95% of the patients reported in TARN are operated on by consultant orthopaedic surgeons and over 92% of patients by a consultant plastic surgeon. This should continue with the aim of all patients having consultant surgeons delivering their care.		
T16-2B-310	**24 7 access to Emergency Theatre and Surgery**	**N**	**Y**
Comments	There is one emergency theatre available with the ability to open a second theatre, if necessary, utilising cardiac team staff who are not onsite along with onsite anaesthesia and support from intensive care unit, if required. Interventional radiology is not readily available onsite as these cases go to the MTC. Vascular surgeons are onsite 24/7 who will take on a bleeding vascular patient with the support of the one interventional radiologist. This support is carried out as a good will gesture and not formalised. The TARN data for January 2020 to December 2020 identified 65 patients with a median time to theatre as 812 minutes (ranging between 322 to 1037 minutes). This is below the national average.		

T16-2B-311	**Trauma Management Guidelines**	**Y**	**Y**
Comments	The trauma network management guidelines are used with limited modification to meet local requirements. The same guidelines are used across all sites. Network guidelines can be accessed through the network induction application. This is an application that can be downloaded onto phones or tablets that gives access to all network guidelines and training. There has been promotion of the induction application by the major trauma team in meetings, in person, in internal lessonslearnt bulletins and through display of posters. Feedback on clinical guidelines is provided within morbidity and mortality (M and M) meetings and replayed back to the network, as required.		
T16-2B-312	**Transfusion Protocol**	**Y**	**Y**
Comments	There is a SBUHB massive haemorrhage policy in place. Non-adherence to the policy is typically flagged by blood bank staff via telephone or through the health board datix system, with feedback required on actions taken to address issues raised.		
T16-2B-313	**Administration of Tranexamic Acid**	**Y**	**Y**
	The TARN data from Q2 2020/2021 to Q1 2021/2022 shows compliance of administration of tranexamic acid between 91.7% and 77.8% all above the national average. Patients are often given tranexamic acid by the prehospital team prior to the arrival at MH.		

Definitive Care			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2C-301	**Major Trauma Lead Clinician**	**Y**	**Y**
Comments	There is a major trauma lead clinician with one programmed activity (PA) a week to undertake the role who is supported by the rehabilitation medicine consultant. The PA is on a Tuesday morning for the one session however, there is flexibility which is supported by the department to allow for attendance at the SBUHB M and Ms and TQuIC which are held on Thursdays as this day best suited the majority of participants. It was unclear to reviewers the benefit of the PA being on a Tuesday when the majority of requirements were on a Thursday, and would suggest reviewing the job plan of the major trauma lead clinician. The rehabilitation medicine consultant who provides support to the lead clinician, does not have dedicated time in their job plan for trauma patients.		

T16-2C-302	**Trauma Group**	**N**	**N**
	The TQuIC meets quarterly and following a standard agenda will discuss clinical incidents and learning opportunities, which scrutinise pathways and governance processes. The purpose of the TQuIC is to provide assurance that there are reliable mechanisms within the SBUHB to respond and treat patients that present with serious injuries. The committee is directly accountable to the SBUHB and a reporting line into the SWTN operational delivery network, via the network clinical and operational board (COB) to provide assurance on its performance in exercising the functions set out in these terms of reference on a quarterly basis. Minutes for the previous five TQuIC meetings were provided to reviewers. Meetings are well attended from the range of specialities that would be expected for the service and meet the quoracy. The reviewers suggest that the group would benefit from having pre-hospital involvement as this has been poor, despite being invited. The minutes are widely circulated after the meeting.		
T16-2C-303	**Trauma Coordinator Service**	**Y**	**Y**
	There are two major trauma practitioner (MTP) part time roles of 0.8 whole time equivalent (WTE) and 0.67 WTE covering Monday to Friday 07.30 to 15.30 hours. There is an overlap on a Wednesday and Thursday which allows both MTPs to attend the network wide multi-disciplinary team (MDT) meeting. Other meetings attended, including but not limited to, fortnightly network wide practitioners/co-ordinators meeting, SBUHB M and Ms, TQuIC, network education and network case quality reviews. A copy of the MTP job description was shared with reviewers. Having no coordinator cover over the weekend has caused issues with repatriation. The reviewers identified that the trauma coordination service is fragile and that 1.47 WTE does not provide enough cover for the patient cohort. The trauma service at MH has a significant case load due to being a TU with specialist services and both patients and the trauma team would benefit from increased cover, to provide a seven day service working towards the most recent MTU quality indicators. The MTPs keep track of patients via a virtual ward board.		
T16-2C-304	**Management of Spinal Injuries**	**N**	**N**
	There is a trauma network clinical guideline for spinal injury (adult major trauma patients) with a definitive framework setting out which patients would automatically be taken to the MTC. Of those that could potentially stay at MH, the spinal consultants will decide on a case by case basis whether it is safe for the patient to remain or whether they need to be transferred to the MTC. There is no dedicated on-call spinal team, instead the orthopaedic registrar and senior house officer (SHO) are utilised. Pelvic injuries are taken directly or transferred to the MTC as there is no onsite consultant. Outreach from spinal cord injury centre is limited with no regular attendance. In the TARN clinical report from Nov 21 it can be seen that the median length of stay has increased from 8 to10 days for all patients and from 9 to 13 days for patients with spinal cord injuries. Which might be reflective of the lack of outreach service.		
T16-2C-305	**Management of Multiple Rib Fractures**	**Y**	**N**
	There are network clinical guidelines for analgesia for rib fractures (adult major trauma patients). Patients are admitted to the cardiothoracic		

	ward for treatment. There are low numbers of patients being seen by the pain team (2 out of 161 patients as reported in the chest wall report submitted as evidence) however, the reviewers were informed that the patients are seen by the anaesthetic team rather than the pain team. There needs to be a local audit conducted to ensure that there is an appropriate pathway in place, and this is accurately represented in the data ensuring that TARN data reflects the clinical practice with regards to pain management and access to pain relief for patients. Rib fixation does occur at MH, however, is limited due to only 1.5 WTE thoracic surgeons trained in the procedure. The rib fixation pathways should be re-evaluated by the TU in conduction with the wider network.		
T16-2C-306	**Management of Musculoskeletal Trauma**	**Y**	**Y**
	No issues were reported in relation to the management of musculoskeletal trauma. All open fractures are transferred to MH by primary or secondary transfers and the reviewers were informed there has been an increase in the number of patients due to pathways awareness. There are network clinical guidelines for pelvic injury (adult major trauma patients), open fractures (adult major trauma patients), MTC acceptance policy (incl. automatic acceptance), orthoplastic management standing operating policy (SOP) and orthoplastic quick reference guide.		
T16-2C-307	**Designated Specialist Burns Care**	**Y**	**Y**
	Burns care is managed through the specialist burns network. The health board is signed up to the SWTN clinical guideline for the treatment of burns, which includes the referral pathway to the specialist burns centre. The MH hosts the centre for burns in Wales. There is a telemedicine referral system which allows the referring hospitals to send images of the patient injuries as part of the referral process.		
T16-2C-308	**Trauma Unit Agreement to the Network Repatriation Policy**	**Y**	**Y**
	There is a network operational policy care for treatment closer to home (incl. automatic repatriation) with the TU working within the agreements. There is a weekly virtual MDT meeting held on a Wednesday with the MTC with clear information regards the patients who are to be repatriated and the planned dates for the repatriation. Due to the excellent communication prior to the patient being ready for repatriation, this allows for 80% of patients repatriated within the first 24 hours. It was unclear to the reviewers the process for repatriating complex patients and there was a lack of ownership by specialties of these patients. The team would benefit from all trauma patients being co-located in a dedicated trauma ward rather than distributed across the hospital, to ensure that staff have the skills and knowledge to care for this cohort of patients. Traumatic brain injury patients can be cared for within Neath Port Talbot Hospital however, outreach from CVUHB is not provided equitably.		
T16-2C-309	**Patient Experience**	**N**	**N**
	There are plans to work in collaboration with TARN and the SWTN to undertake a 12-month pilot of using Patient Reported Outcome Measures (PROMs) across TUs as well as the MTC. There is a feedback questionnaire in place which is posted out to the patient post discharge. Also, face to face feedback is collected prior to discharge by the rehabilitation coordinator. A service development that has taken place following patient feedback is the change of staff uniform. Patients fed back that they did not know the difference of personnel who was visiting them.		

	Previous patient stories depicting the patients journey from injury to discharge including community rehabilitation have been used to aid funding bids.		
T16-2C-310	**Discharge Summary**	**Y**	**Y**
	Discharge summaries are completed on the Welsh clinical portal by ward-based doctors at the point of patient discharge or when transferred out of network. Included in the discharge summary is a list of all injuries, details of injury management including any operation notes, follow-up arrangements for all disciplines involved, any on-going rehabilitation needs and if/where any ongoing referrals have been made i.e. community physiotherapy. Patients are also provided with contact details at the point of discharge, via a booklet that is issued to most patient's during their stay. It was unclear what written information is given to patients who do not receive a booklet. Patients are encouraged to contact post discharge, with any queries or concerns regarding their major trauma injury. No examples of discharge summaries were shared with the reviewers.		
T16-2C-311	**The Trauma Audit and Research Network (TARN)**	**Y**	**Y**
	Case ascertainment (97.1%) and data accreditation (94.9%) is above the required level. Some issues were raised around whether there is a need for further education around key data fields, for example it appears that the main gaps for the data accreditation are in recording incident date and time which was only complete in 69% of cases. The TARN data analyst is also a national TARN trainer.		
T16-2C-312	**Rate of Survival**	**Y**	**Y**
	Ws scores, which demonstrate the rate of survival for the unit are around the predicted level. The latest report shows the TU within 2 standard deviations of the mean, although the data points are below zero, in the data presented showing the rolling outcome analysis the confidence levels pass through zero.		

Rehabilitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2D-301	**Rehabilitation Coordinator**	**Y**	**Y**
Comments	There are two physiotherapists undertaking the rehabilitation role working 0.6 WTE and 0.4 WTE with a third position of 0.5 WTE recruited with a commencement date in May 2022. The availability of the rehabilitation coordinator is Monday to Friday 08:00 to 16:00 hours. The rehabilitation practitioners cover the trauma practitioner role when there are absences. A job description for the band		

	seven major trauma rehabilitation coordinator was provided to reviewers. The coordinator element of the role is approximately 50% of the job plan with the other 50% holding a clinical case load in their own professional field. The coordinator element of the role takes priority over the clinical element as there is no one else employed by the SBUHB to complete these tasks. The rehabilitation coordinator is the single point of contact for the rehabilitation pathway for trauma patients. It was noted that there are several non-patient facing roles that are undertaken by the rehabilitation coordinators that can take them away from patient facing activities. It was unclear to reviewers if there was sufficient recourse to provide a robust service due to the complex needs of the patients and should consider whether a seven-day service is required and this would be working towards the most recent quality indicators. The post discharge telephone service offered by the rehabilitation practitioners was noted as good practice to support patients following discharge however, it was unclear to reviewers if this was an equitable service for all trauma patients.		
T16-2D-302	**Access to Rehabilitation Specialists**	**N**	**N**
Comments	A rehabilitation consultant commenced in role in February 2022 for four PAs a week. Prior to this, rehabilitation was off site at Neath Port Talbot Hospital. There is a lack of a referral and access pathway to psychology and neuropsychology. There is a lack of traumatic brain injury (TBI) in-reach and therapy support with the appropriate skills to treat this cohort of patients. The Welsh health specialised services committee (WHSCC) have stated that the MTC are expected to visit the health boards to deliver spinal and brain outpatient clinics however, this has not happened and it was unclear the reasons why or if there was a timeframe for implementation of this. This has been highlighted to WHSCC as the sessions have been funded. Patients are admitted to various 'landing pads' across the TU and the MTPs keep track of this well, however, it was noted that a significant benefit to the patients and trauma service would be to have major trauma patients cohorted in one ward area. Through cohorting of patients this would develop training and skills of nurses to manage tracheostomy, orthopaedic and trauma etc. and would support the rehabilitation coordinators provide the service required in key areas. Reviewers were informed that head injury patients can be an issue, as it is unclear who will own the patient. There has been recruitment of ten clinical fellows in trauma geriatrics. This is recognised as a good practice to support the high numbers of silver trauma patients. It was noted that there is a lack of rehabilitation for orthoplastics. Consideration of a dedicated ward area for these patients would assist in the development and maintenance of staff skills and support the patient journey.		
T16-2D-303	**Rehabilitation Prescriptions**	**N**	**N**
Comments	The TARN proportion of patients with a score of more than ISS 8 that have a rehabilitation prescription completed for Q1 2021/2022 is 52%, which is greater than the national mean average of 28.6%. It was noted that the wording within the rehabilitation prescriptions include medical jargon and lack clear contact details making it difficult for a patient to understand. The rehabilitation prescription is continually updated during a patient's stay by the rehabilitation coordinator or major trauma practitioner, and will be finalised and signed off at the point		

	of discharge. It was also unclear to reviewers what other patient information is given alongside the rehabilitation prescription to aid in the patient understanding their injuries and ongoing requirements. It was highlighted to reviewers that this is a piece of work that is being undertaken by the SWTN and the SBUHB to develop and use an electronic patient held rehabilitation prescription however there were no timescales for completion of this piece of work.

General Comments
The orthoplastic service is on the risk register due to the unexpected volume of patients coming through the service.

Good Practice / Significant Achievements (List key points covering good practice)
• CT reporting registrar from dedicated room and in-house consultant reporting • Recruitment of 10 trauma geriatricians • Recruitment of rehabilitation medicine consultant since early 2022 • Strong rehabilitation coordinator service • TARN data input with national trainer responsibilities • Nursing rota that has the ability to identify Level 2 nursing staff on a shift • Trauma co-ordinator role • Post discharge telephone service

Specify Immediate Risks An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action
CEO/Board Representative risk handed over to at feedback session: **None identified**

Specify Serious Concerns A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve
CEO/Board Representative risk handed over to at feedback session: **None identified**

Areas of Improvement (List areas of improvement)
• Training for medical staff • Level 2 training for nursing staff • Out of Hours availability of radiology for scanning to allow timely access and reporting • Hot radiology reporting for major trauma CT and MRU within 30mins. • Repatriation for complex patients (TBI and spine) and specialty ownership • Patients to be offered outreach for brain injuries as this is being funded but not provided • Cover from major trauma practitioners and rehabilitation coordinators over the weekend. • Lack of operating capacity and dedicated ward space for orthoplastic cases • Cohorting of patients on a trauma ward • Lack of rehabilitation for orthoplastics • High volume of patients in numerous areas, require consideration of cohorting patients • Management of pain management pathway to link to TARN • Rehabilitation prescription not patient friendly Work with network to definitively improve rib fixation pathway.

Trust Name: Swansea Bay Pre-Hospital - EMRTS	**Date of Review:** 21 March 2022
Service: Major Trauma – Pre-Hospital	**Type of review:** National

Self-Declaration Compliance	**100%**	**Peer Review Compliance**	**100%**

Contextual Information and General Comments:

The emergency medical retrieval transport service (EMRTS) deliver critical care via air from four bases in Wales (two in south Wales, one in mid Wales and one in north Wales). There is a combination of consultants and senior trainees (from emergency medicine, anaesthesia, and intensive care backgrounds) and critical care practitioners (including paramedics and nurses) who deliver the full range of interventions required by trauma and medical patients. The service has two main areas of activity, pre-hospital critical care for all age groups (i.e. interventions/decisions that are outside standard paramedic practice) and undertaking time-critical, life or limb-threatening adult and paediatric transfers from peripheral centres for patients requiring specialist intervention at the receiving hospital. Care is coordinated through a critical care hub.

The service was established in 2015 to aid the equity between north and south Wales and is hosted by Swansea Bay University Health Board (SBUHB) and is a partnership between NHS Wales, the Wales Air Ambulance Charity Trust (WAACT) and the Welsh Government. The service is commissioned by the Emergency Ambulance Services Committee. The EMRTS has been developed to provide reductions in geographical inequity for patients with critical care needs, health gains by improving clinical outcomes, improved clinical and skills sustainability, recruitment and retention in key acute care areas. There is also a service provision for the enhancement of neonatal and maternal pre-hospital critical care (both for home deliveries and deliveries in free-standing midwifery-led units (MLUs)).

From 1 July 2020 night operations have been introduced with a 24/7 service via road, with the air ambulance service commencing on 1 December 2020. Within 2021/2022 there have been almost 4000 missions completed, with at least half of these trauma related.

South Wales patients are generally taken to the major trauma centre (MTC) at Cardiff and Vale University Hospital Health Board (CVUHB). Patients are only taken to North Bristol NHS Trust (NBT) if they are an English patient. Dependent upon several other factors, within north Wales patients are generally taken to Royal Stoke University Hospital (RSUH) or University Hospitals Birmingham NHS Foundation Trust (UHBT), if appropriate.

Number	Indicator	SD Compliance	PR Compliance
T16-2A-101	**Pre-Hospital Care Clinical Governance**	**Y**	**Y**
Comments	There is a quarterly clinical and operations board meeting which provides a clinical governance structure and is attended by EMRTS colleagues regularly however, there was no evidence of attendance provided to reviewers to gain an understanding of representation at the		

	meetings; at the review meeting the reviewers were informed this could be made available. Reviewers were informed that until recently there has been no representation from Cwm Taff Morgannwg University Health Board however, all other health boards had regular attendance due to having an EMRTS consultant working within their health board. It was noted that a more formal feedback arrangement is required to ensure as personnel leave or change roles there continues to be a liaison link for each organisation, and additionally it was unclear if the individual attending the EMRTS clinical and operational board meeting also attends their own organisational trauma group meetings. The EMRTS lead is invited to CVUHB MTC morbidity and mortality (M and M) meetings. There is also representation at all the larger meetings but not necessarily at every health board meeting. Despite not attending all meetings, copies of agendas and minutes are shared. The EMRTS colleagues in north Wales dial into MTC M and M meetings at NBT, RSUH and UHBT. Additionally, there are EMRTS consultants who work within these MTCs meaning there is also internal representation. Any concerns regarding treatment of patients from a trauma unit (TU) would be raised via a trauma related issues database (TRID). All individuals who were involved with the patient would be asked to put their information in regarding their input with the patient. If the issue was involving an EMRTS consultant, this would be dealt with as a one to one and through the electronic incident reporting system, Datix. The Datix systems across all organisations can communicate with each other and information can be passed backwards and forwards however, this is currently having to be done manually. There is a new Datix system being launched in June 2022 which will be central and will reduce duplication. The interconnectivity across organisation was identified as an area of good practice. The ambulance call and dispatch data, accessed via the 24-hour desk along with trauma audit research network (TARN) data, is used to record any issues or any potential opportunities where a resource could have been sent if one had been available. This is used to shape and develop the service. In addition to this the patient liaison and aftercare service nurse attends the CVUHB MTC rehabilitation sessions and team meetings every week. They will identify individual cases where there could have been a benefit to the patient if EMRTS had been involved. Any patients that are considered as being missed, a TRID is raised at a network level. On a larger scale, the cohorts of missed patients are actively monitored. An example of this is, patients who had a secondary transfer but EMRTS could have attended as a primary mission, these incidents are then targeted in terms of resources going forward; this is again highlighted as an area of good practice If there is a period where it becomes clear that there is not enough resource, this would then feed back into the next business case for service development. Pre-hospital anaesthetic times are decreasing year on year however, there is a large variation in leaving scene times which are between one minute and one and a half hours. This has improved since becoming a metric which is measured and monitored within the clinical operations board meeting. The discrepancy appears to be caused by confusion when the metric was introduced around how the timings were defined, some teams took it to be the time the patient started moving and others took it to be the time the helicopter took off. This has now been redefined to make it clearer. In a recent audit of intubations there was only one failed intubation in one thousand cases. There are close links between EMRTS and Welsh Ambulance Service Trust (WAST). The trauma desk function is delivered by both services. The Datix systems for both services are integrated. Strategically, EMRTS are under the ambulance service commissioning and both EMRTS and WAST are part of the delivery assurance group. There are monthly trauma meetings which can be evidenced. The Associate Medical Director for WAST is also a top cover consultant for EMRTS which again strengthens links.

T16-2A-102	**24/7 Senior Advice for the Ambulance Control Room**	**Y**	**Y**
Comments	There is a senior paramedic in the control room 24/7. There is also a paid consultant available 24/7 who has no other clinical commitments and provides top cover advice. The WAST colleagues cover the desk for 12 hours between 09:00 and 21:00 with a senior paramedic, and 21:00 to 09:00 is covered by EMRTS with a critical care practitioner. There is mutual aid provided from both services to cover breaks or any periods where there is no cover. There is a handover process with occurrence logs to ensure consistency across the 24-hour period. There have been times when shifts have been uncovered, this is rectified by offering overtime to staff or utilising a remote desk function. Top cover is only covered by EMRTS colleagues. There is an aim in the future to have a pan Wales desk which will provide consistency across the whole region. The emergency critical care hub (ECCH) dispatch staff are also trained to the pathway elements of the network, this is a dedicated training session which is updated periodically to include areas of lessons learned.		
T16-2A-103	**Enhanced Care Teams available 24/7**	**Y**	**Y**
Comments	From 1 July 2020 there has been 24/7 provision of care. There are three teams available during the day and one team through the night. Currently a review is being undertaken to ensure best use of resources to cover the widest geographical area. It is recognised that there is still a difference in response times, especially at night with a wide amount of seasonal variability. In instances where there have been dropped shifts and there has only been the opportunity to have one critical care practitioner (CCP) available, the decision was made to use the person on the trauma desk operationally to cover the gap. In these instances, the mode of operation is changed, and a second dispatcher/allocator will be provided to act as the communications contact. They will then go to the crew on the ground for any trauma advice required. There is also a signpost to the top cover consultant who can provide any assistance needed. There have been approximately ten dropped shifts since the service started in July 2020. There are 44 doctors available across the service and on occasional instances where a doctor has not been available, there has been CCP cover. Covid-19 has had an impact on staffing levels, however the service has been maintained. The reviewing team commended the level of operational cover provided. A formal written process is in place whereby a specialised message goes out to ambulance crews, sent in advance, to inform them that there is no clinician on the desk. The EMRTS carries full remit of equipment and offers a comprehensive range of pre-hospital emergency medicine interventions including the delivery of pre-hospital emergency anaesthesia, surgical interventions and blood products delivered at scene. The service is consultant led and consultant delivered providing highly skilled individuals to develop the service and provide the high-quality care on scene. Additionally, there are a high number of trainees who are requesting to have placement with the team.		

T16-2A-104	**Clinical Management Protocols**		
Comments	All required protocols are available and accessible to all staff electronically. A copy of protocols was also shared with reviewers. The assistant medical director of WAST is part of the EMRTS team and is responsible for reviewing some of the standard operating policies (SOPs) to ensure applicability to both organisations. The SOPs are reviewed regularly and go through the operational board to ensure there is no conflict with WAST. Whilst it was recognised that EMRTS are at the forefront of developing pre-hospital standards and protocols across Wales, reviewers would recommend that the EMRTS team reach out to TUs to be integrated with the development and use of the same SOPs. This will ensure parity and consistency of care and will facilitate subsequent transfers.		
T16-2A-105	**Hospital Pre-Alert and Handover**	**Y**	**Y**
Comments	There is a South Wales Trauma Network trauma team activation criteria operational policy which includes paediatric, adult and silver activation criteria. There is good direct communication in the form of a recorded conference call through the critical care hub.		

Clinical Outcomes – TARN Data	
Comments	There is a data manager who is pivotal to the service providing good quality data which is well managed, and the team will benefit from this robust data going forward. The existence of this role and the benefit it clearly delivers is commented by the reviewers. The patient liaison role oversees the collection of patient experience PROMS and PREMS are collected through various means. There is an aim to write to patients following discharge and follow patient outcomes. A weekly multidisciplinary team meeting (MDT) is held to discuss outcomes along with meetings with patients via patient liaison nurses. Feedback is given to all staff, so everyone knows the outcomes of the patients. The information gathered through these means has been used to help prevent accidents and these stories are shared with patient consent. An area to consider development is to build a formal feedback session between the MTC, EMRTS and WAST to hear patient journeys and learn together where areas of improvement can be made. Members of the EMRTS team have published on various aspects of pre-hospital care including undertaking a study on blood products and survival which has been published and peer reviewed.

Good Practice / Significant Achievements
(List key points covering good practice)

- A good commissioning model with excellent links to WAST
- 24/7 provision of the service
- Patient liaison role and good patient feedback approach
- Good data collection and understanding of missed jobs
- Published work that is peer reviewed

- Top cover service is an active role
- Comprehensive paramedic development programme
- RSI to leaving scene times improving year on year
- Consultant led, consultant delivered service which carries a full remit of kit and blood products to scene
- Popular placement for trainees
- Regional Datix reporting system
- Data manager ensuring robust data

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:
None Identified

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve

CEO/Board Representative risk handed over to at feedback session:
None Identified

Areas of Improvement
(List areas of improvement)

- Need to be more integrated into the wider system to ensure formal feedback into each of the Health Boards is achieved to assist patients from all corners
- EMRTS team to reach out to TUs to be integrated with the development and use of the same SOPs. This will ensure parity and consistency of care and will facilitate subsequent transfers
- Collaborating to develop patient story sessions

Trust Name: Welsh Ambulance Service Trust	**Date of Review:** 24 March 2022
Service: Major Trauma – Pre Hospital	**Type of review:** National

Self-Declaration Compliance	**100%**	**Peer Review Compliance**	**100%**

Contextual Information and General Comments:
The Welsh ambulance service trust (WAST) is commissioned by the seven local health boards in Wales and supported by the national commissioning unit. The WAST additionally host the NHS 111 service in Wales. The WAST service covers a population of three million and covers 8,000 square miles spread across a diverse and challenging urban, coastal and rural landscape. Around half a million 999 calls are received a year. Following the launch of the South Wales Trauma Network in September 2020, this brought a change to the working of WAST which included the bypassing of local emergency departments with patients going to a trauma unit (TU) or the major trauma centre (MTC) at Cardiff and Vale University Health Board. A further change of working was the introduction of the trauma desk to support decision making and patient flow with a newly developed trauma triage tool with the implementation of the trauma network. To implement this, staff required education which was made more difficult due to the covid 19 pandemic. Education was provided via e-learning with some face to face, where possible. Additionally, leaflets were produced to be on all vehicles and educational resources were made available in bases.

Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-2A-101	**Pre-Hospital Care Clinical Governance**	**Y**	**Y**
Comments	There is a quarterly WAST pre-hospital major trauma board meeting which is attended by directorate leads and members of the South Wales Trauma Network. The group provides clinical and operational leadership and oversight of the areas of the trauma network delivered by WAST. Outcomes from this group are then reported through the Ambulance Practice Steering Group and then approved at the Clinical Quality Governance Group. Minutes from the August 2021 WAST pre-hospital major trauma board meeting were shared with reviewers and identified good attendance at the meeting. There has been paucity on meeting over winter due to operational pressures, so work is required to re-invigorate these meetings. The head of clinical operations is the sole attender at external governance meetings, with unnamed cross cover available during times of absence. Information from governance meetings is shared with the wider team through emails and cascaded to front line crew through a clinical bulletin. However, there was a concern that the responsibility for attendance was placed on one individual which does not allow for resilience and reviewers would recommend that a deputy is named.		

	Trauma related issues database (TRIDs) are sent to WAST directly from the trauma network to be investigated. An individual is then assigned to the TRID to investigate and fed back to the Network and with front line crew through the clinical bulletin. The WAST have introduced a new clinical team of 40 senior paramedics, four of which are based on the trauma desk. The new team are front line and are working operationally, with 25% of their time as Cymru hyper acute response units (CHARU) to support crew at cardiac arrests and 25% of the role as non-clinical. Each paramedic has approximately 30 paramedics assigned to them and they will undertake "ride outs" with crew to observe their practice with an electronic record being produced to capture the learning and discussions and identify any lessons learnt and direct future learning. If required, a second ride out can be undertaken. Reviewers identified this as a good practice having senior clinical leaders providing education and learning, however, would encourage that there is a review and collection of the themes and trends identified through the ride outs which is then shared wider. All crew members have been allocated an iPad with electronic patient care reports installed. This allows for the clinical bulletins to be shared with all crew members and allows reports to be gathered to assess what percentage of staff have accessed these reports. There are bi-monthly meetings between WAST and emergency medical retrieval and transfer (EMRTS) with a standing agenda item to discuss TRIDs. The WAST clinical leads attend local mortality and morbidity reviews within the health board or the MTC if WAST had involvement in the case being discussed.		
T16-2A-102	**24/7 Senior Advice for the Ambulance Control Room**	**Y**	**Y**
Comments	There is a 24/7 trauma desk which is operated by WAST from 09:00 to 21:00 hours and EMRTS covers 21:00 to 09:00 hours. There is mutual aid provided from both services to cover breaks or any periods where there is no cover. There is a handover process with occurrence logs to ensure consistency across the 24-hour period. There is a standard operating policy for the trauma desk that was shared with reviewers and is followed by EMRTS and WAST. The trauma desk listens to live 999 call, once resource is allocated the desk will communicate, assess the call against the trauma tool and decide on destination, as per policy. A pre-alert is sent to the TU or the MTC. All transport comes through the desk with no delays reported to reviewers. Top cover, which is only provided by ERTS staff, also dials into the same call. Staff on the desk are senior clinicians, experienced paramedics, or work with British association for immediate care (BASICS) and some are educated to master's level. It was noted by reviewers that the job description for the trauma desk stated that trauma experience is desirable. Reviewers would consider that this experience is essential, and that the job description is reviewed. The staff who work on the trauma desk are rotated between desk work and on the road to ensure their knowledge and skill set is maintained. There are an additional four senior paramedics who have been recruited who will commence in April 2022. There is no video view from the scene to the desk to support decision making however, it is in the workplan to introduce the ability to share photographs of open fractures, although there was no timescale for the implementation of this.		

	There is a daily regional escalation meeting held at 11:00 hours where the regional escalation level will be assessed and diverts applied, as appropriate. There is an aim in the future to have a pan Wales desk which will provide consistency across the whole region and this development would be clearly supported by this peer review, however, there are no timescales for this to be implemented. Furthermore, there is a desire for the trauma desk to hosted in one of the current organisations over a 24hrs basis, clarity is sort on confirming the future arrangements.		
T16-2A-103	**Enhanced Care Teams available 24/7**	**Y**	**Y**
Comments	Enhanced care support comes from EMRTS, on scene clinicians can also request support. The BASICS follow the national criteria, with all practitioners having the skill set necessary to manage patients. They are automatically notified within a footprint, then have the opportunity to attend the call however, they are not automatically dispatched. The standard operating procedures mirror EMRTS. The development of a regular combined governance meeting with EMRTS would be beneficial to ensure all protocols are being adhered to.		
T16-2A-104	**Clinical Management Protocols**		
Comments	Clinical practice guidelines for UK Ambulance Services are developed by multi-disciplinary, subject matter experts through sub-groups of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). The guidelines are produced on behalf of the Association of Ambulance Chief Executives and National Ambulance Service Medical Directors group and form the basis of UK training and education programmes. Utilising these guidelines ensures uniformity in the delivery of high quality, evidence-based patient care. The WAST have procured JRCALC licences for all its frontline staff so they have instant access to the latest digital guidelines via their individual iPad. The service is currently at the highest escalation and are coming out of the monitor phase after the pandemic. The military are currently assisting for the third time since September 2020 however, 200 military staff will be leaving at the end of March 2022. There are 50% of clinicians who have attended the face to face trauma training and 85% are compliant with e-learning. Currently it is only senior paramedics who use patient group directions (PGDs). Senior paramedics are supportive and are not included within the stop the clock first on scene. This was identified as good recognition that the crews are less exposed to critically injured patients and there is good implementation of CHARU. Some advanced practitioners are independent prescribers, which are a new tier of staff that has been introduced who have capacity to administer a response to an urgent case mix.		
T16-2A-105	**Hospital Pre-Alert and Handover**	**Y**	**Y**
Comments	There is a South Wales Trauma Network trauma team activation criteria operational policy which includes paediatric, adult and silver activation criteria. There is good direct communication in the form of a recorded conference call through the critical care hub. Policies are followed depending on the type of emergency and where a patient should be admitted to. Automatic acceptance supports the decision making and there is good consistency through the trauma desk. There is an escalation process in place if people do not agree.		

Good Practice / Significant Achievements
(List key points covering good practice)

- Senior clinical leaders – provided learning to front line staff through the ride out process
- CHARU role supporting crew at cardiac arrests with non-clinical time
- Developing the trauma desk during a pandemic

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:
None Identified

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve

CEO/Board Representative risk handed over to at feedback session:
None Identified

Areas of Improvement
(List areas of improvement)

- Pre-Hospital Care Clinical Governance - Head of Clinical Operations solely attending meetings is a single point of failure. Improve resilience.
- EMRTS and trauma desk interaction. (Biannual meeting suggested)
- Future provision of the trauma desk. Equity of access to the trauma desk.
- Overall handle of the governance and bringing everyone together.
- Trauma desk job description to consider essential criteria

Trust Name: Swansea Bay Operational Delivery Network	**Date of Review:** 22 March 2022
Service: Major Trauma Operational Delivery Network	**Type of review:** National

Self-Declaration Compliance	**87%**	**Peer Review Compliance**	**87%**

Contextual Information and General Comments:
The South Wales operational delivery network (ODN) went live in September 2020 following several years of significant work in developing the business plan. The ODN covers a large geographical area which composes of both rural and urbans areas and serves a population of circa 2.5 million, excluding transient populations. The service is hosted by Swansea Bay University Health Board (SBUHB) and is commissioned by the Welsh hospitals specialised services committee (WHSSC). There is a close working relationship with the SBUHB who provide strategic support for the service. The ODN has day to day clinical and operational oversight and authority for all partners within the network. The ODN also host the Veterans' Trauma Network for Wales.

Reception and Resuscitation			
Number	**Indicator**	**SD** Compliance	**PR** Compliance
T16-1C-101	**Network Configuration**	**Y**	**Y**
Comments	The network consists of one major trauma centre (MTC), five trauma units (TU), one local emergency hospital (LEH), two rural treatment facilities (RFT) and pre hospital services, the welsh ambulance service (WAST), emergency medical retrieval and transfer service (EMRTS) and rehabilitation services. There are 26 spinal injury beds and 22 acquired brain injury beds based at University Hospital Llandough in the newly constructed specialist neuro-rehabilitation unit in Cardiff and 12 acquired brain injury beds at Neath Port Talbot hospital		
T16-1C-102	**Network Governance Structure**	**Y**	**Y**
Comments	There is a comprehensive governance structure in place with a quarterly Delivery Assurance Group (DAG) which sits as a sub-committee of the WHSSC joint committee and provides the mechanism for clear lines of accountability and responsibility across the pathway. The DAG is chaired by a WHSSC executive director and the chief ambulance services commissioner is vice chair. Reporting into DAG is a Clinical and Operations Board (COB) who meet quarterly and are responsible for operational delivery, timely escalation, management, and resolution of operational issues. This meeting is chaired by the ODN clinical director. There is an electronic incident reporting system called Datix, which is used across the ODN. The Datix system communicates across all organisations and allows information to be passed backwards and forwards however, currently this is having to be done manually. There		

	is a new Datix system being launched across the ODN in June 2022 which will be central and will reduce any duplications. Incidents are submitted through Datix which are screened by the ODN and accepted as a trauma related issue database (TRID) or if not trauma related the datix process is continued. The TRID focuses on cross organisational issues, which datix does not capture, to gain an overview of network related issues. Clinical incidents are passed to one of the consultants within the network, with an email response requested from the clinicians involved. Once these are submitted, this will generate a response and from that, a lesson learned report. Turn around for these varies but there is an aim for these to be completed within four to six weeks. There have been 149 TRIDs submitted in 2020/2021 which was the first year of the network. The majority of TRIDs related to delays in repatriation, followed by pathway awareness/inappropriate pathways and delays to the pathway for three patients. Reviewers recognised that there are a wide range of stakeholders included within the governance process, which is demonstrated through attendance at meetings and the high level of incident reporting, including low level incidents. A lesson learnt bulletin is collated quarterly and shared across the network through email and being added to the induction application. The ODN has established a mortality and morbidity (M and M) process across the network, which has been in place since the ODN was initially set up and feeds into the COB. The network has close links to providers with a weekly catch up with the MTC and a bi-monthly catch up for all other providers. Additionally, there is a monthly meeting with the critical care network and north Wales colleagues. There are intermittent meetings with the network surgical specialities which can be stepped up or down depending on the situation. There is an extensive training programme across the network that has been developed which was paused due to Covid- 19 however, plans are in place to commence the European trauma course (ETC), damage control surgery (DCS) and damage control orthopaedic courses. Additionally, online training resources are available for nursing staff to gain level one, with competencies to be achieved in practice, that includes recorded situations to give virtual experience of being within the trauma room. The network is planning to create a bespoke level two nursing course with the network matron leading on this. No timescales for completion of implementation of these training courses were provided to reviewers.		
T16-1C-103	**Patient Transfers**	**Y**	**Y**
Comments	From inception of the ODN, primary transfers have worked very well however, there were concerns and issues regarding secondary transfers. These issues are due to the wide geographical area covered by the network which means that patients who are over an hour from Cardiff are having to have a secondary transfer. This has caused delays in some patient's pathways. There were also initially some issues with the MTC accepting secondary transfer patients. The numbers of secondary transfers, delays in patient pathways and acceptance of patients by the MTC are monitored by the network and discussed within COB. There has been a focus on the patients who are outside of the 60-minute window from Cardiff to ensure equity of care, through reviewing the patient journey and the pathway which has seen some improvement. There were also concerns from the MTC around over triaging of patients. Due to all these concerns, every three months all patients who are transferred to the MTC, had a stay of less than three days and who are not from the Cardiff and Vale health board, were audited. From 60 patients, three were identified as potentially having been over triaged, of these two were primary transfers and one was a secondary		

	transfer. Data regards the transfer of patients is presented within the COB meetings. To rectify the issues around secondary transfers, the ODN has provided training sessions to raise pathway awareness, included details within the trauma team leader (TTL) training and monitoring the TRIDs as to lessons learned. Under-triage is also reviewed by the ODN with injury severity scores (ISS) >15 not transferred to MTC patients. The TUs review their own cases where patients with an ISS>15 that were not transferred to the MTC and the LEH and RTFs review their own ISS 9-15 cases. The reviewed cases are submitted to the ODN, for validation by the network clinical lead. Any cases identified as not being suitable are sent back as feedback to the heath board's and these patients are reviewed as part of the health board M and M process. For patients needing transfer to the MTC, this is arranged via the TTL and the trauma desk who facilitate the call including the top cover consultant on a recorded line. Any further individuals who are required to aid the situation can be included within the call, meaning the situation can be described once without the need for multiple calls.		
T16-1C-104	**Network Transfer Protocol from Trauma Units to Major Trauma Centres**	**Y**	**Y**
Comments	There is a network agreed transfer protocol in place with standardised documentation used by the MTC and the TUs. Acceptance into the MTC is coordinated via the trauma desk using a split model. During hours, the calls are picked up by a senior paramedic from WAST at a desk which is co-located with the EMRTS desk. Out of hours, this reverts to the EMRTS desk as activity levels drop and is staffed by critical care practitioners. The ODN recognise that there would be a benefit of a single provider to deliver this service with considerations to extend this desk to become national which would benefit patients in the border areas. These discussions need to be agreed jointly between the network and the commissioners however, there was no timescale provided to reviewers as to when a final decision regards this would be made. There was a structured checklist described to the reviewers however, a copy was not provided to the reviewers.		
T16-1C-105	**Teleradiology Facilities**	**Y**	**Y**
Comments	There is a Welsh teleradiology system which allows easy transfer of images between different health boards. Reviewers were informed that this worked well for image transfer from the TU to the MTC however, there have been some delays when transferring from the MTC to the TU. There are planned developments to the all Wales images transfer system which would remove some of the current issues via the Welsh clinical portal with a timescale of June 2022 for this to be completed.		
T16-1C-106	**The Trauma Audit and Research Network (TARN)**	**Y**	**Y**
Comments	It was noted that there have been gaps in data due to some health boards not being Trauma Audit and Research Network (TARN) members and having to implement collections, as this data had not been collected before. Case ascertainment is good with most providers giving 100% with an upwards trajectory since the inception of the network. Reviewers were informed that there had been a serious error in how ascertainment rates were being calculated however, this has now been rectified and resolved. In underperforming areas all providers are engaging well. The health board TARN co-ordinators and ODN meet on monthly basis. There have been issues in resilience across the network due to new staffing which has caused some delays in data being processed. The ODN are trying to solve this by TARN co-ordinators cross site working to support colleagues. The ODN are working with TARN on how orthoplastics is calculated in a two-site model		

	as currently it is difficult to be able to benchmark performance when both sites are submitting data independently.		
T16-1C-107	**Trauma Management Guidelines**	**Y**	**Y**
Comments	A full range of guidelines have been created by the ODN using TARN, best practice, and National Institute for Health and Care Excellence's (NICE) metrics. There is a robust mechanism for developing and sign off of guidelines using subject matter experts in the network. There is a network trauma team activation protocol which includes a list of roles and responsibilities. It was noted within the triage tool it describes a fall from six meters or more, which is considered a generous target and should be reviewed, and a reduction considered. Reviewers would suggest an audit programme to review compliance against the guidelines and identify areas of good practice and those that need improvement. There is a specific online training session provided by WAST regarding silver trauma recognition. There are silver trauma criteria within the activation protocol for trauma teams and a copy of this is kept at ambulatory and ambulance triage within the trusts in a way which is visible to the triage nurses. Organisations are asked to use silver trauma calls. Reviewers would suggest this is audited on a regular basis.		
T16-1C-108	**Management of Severe Head Injury**	**N**	**N**
Comments	The TARN clinical report three, 2021 shows that 67% of NICE criteria patients had a computer tomography (CT) within 60 minutes. This is below the national average of 77%. This has improved from the previous year by 8% however, is not consistent across the health boards. The ODN recognises that work still needs to be done relating to timely access to CT, the efficiency of trauma calls and the prioritisation of non pre-alerted patients. The network is currently developing new ways to display the TARN data and new tools to explore the data as to where the target is not being met.		
T16-1C-109	**Management of Spinal Injuries**	**Y**	**Y**
Comments	Protocols are in place for the management of spinal injuries. However, the reviewers were concerned that there wasn't the nursing and allied health professionals (AHP) knowledge in the TUs to care for these patients. The reviewers would support the business case to improve management of spinal injuries, including the development of an outreach service. There were no timescales for completion of this business plan provided		
T16-1C-110	**Emergency Planning**	**N**	**N**
Comments	There is an all Wales mass casualty plan in place however, there is a new plan currently being developed. The old plan will continue to stand to avoid any confusion, this is underwritten by the Welsh government. As part of the development for the new plan, the old plan was analysed. The ODN highlighted the areas that are no longer appropriate, and a sub- group has been set up to progress work on this. There needs to be a consideration as to how the trauma desk is involved, as work progresses. There is a planned exercise to test the new casualty plan in May 2022 however, reviewers suggest that the ODN ensure the right level of executive support is in place for casualty distribution matrix to be available for the planned exercise		

T16-1C-111	**Network Director of Rehabilitation**	**Y**	**Y**
Comments	There is a named network rehabilitation lead with one programmed activity (PA) within their job plan to undertake the role. The job description was shared with reviewers which highlighted a list of roles and responsibilities for the role. The network rehabilitation lead also chairs the network rehabilitation group with the terms of reference shared with reviewers. This role is also inclusive of engaging with community provision as this is required due to a high number of patients being discharged home from the MTC. The AHP lead also supports the network rehabilitation lead.		
T16-1C-112	**Directory of Rehabilitation Services**	**Y**	**Y**
Comments	There is a directory of rehabilitation services that identifies good AHP support. There is joint working between mental and physical rehabilitation services. Reviewers were informed about the mathematical model currently being introduced to deal with the heterogeneous population. It was recognised that this will help to form a business case for therapy provisions going forward if there are identified gaps. A large number of patients are discharged directly home from the poly trauma unit at the MTC site, meaning there is a greater focus on community rehabilitation.		
T16-1C-113	**Referral Guidelines to Rehabilitation Services**	**Y**	**Y**
	There are referral guidelines to rehabilitation services which are based on the Welsh national referral guidelines for specialist rehabilitation services and are set by WHSSC, who are the commissioners for the service. Specialist services which are included in the referral guidelines are neurological specialist rehabilitation, spinal cord injury rehabilitation and neuropsychiatric rehabilitation. There was a review by the network of the spinal cord rehabilitation in September 2021 which has identified the need for outreach into the MTCs.		
T16-1C-114	**Rehabilitation Education Programme**	**Y**	**Y**
	There is extensive training provided by the ODN that exceeds rehabilitation education. There is an online training platform which covers a mix of formal training and more relaxed information sharing. This is an online space that all learners across the network can access, and this will continue to be developed. Content on the site includes filmed clinical skills in 360 environments and is used to supplement other forms of training. Whilst not rehab focused the reviewers heard there is an ETC running in the summer of 2022. There have been two definitive surgical trauma skills (DSTS) courses provided in 2021 with more scheduled to take place in 2022. Level one nurse training has been an issue due to a high turnover of staff and the ability to release staff to attend training. The network has attempted to standardise the training with an online portfolio and clinical skills lesson plans put together for both adults and paediatric patients within the online training platform. The network recognises that there is a gap in knowledge for agency staff and there is an aim to use the online resources with them also. The network recognise that level two nurse training is more difficult to provide however, network training sessions have been carried out and the ODN is in the process of developing a level two training plan. It was noted that the network has access to a generous training budget to allow the funding for numerous courses with some help from health boards. All training information is shared through a SharePoint page which is easily accessible. There is an induction application which can be downloaded to electronic devices with links to		

	the SharePoint page and to useful numbers and contacts.		
T16-1C-115	**Network Patient Repatriation Policy**	**Y**	**Y**
	There is a network agreed patient repatriation policy. The ODN monitor any delays in repatriation via TRIDs. Between September 2020 and September 2021, 231 patients required repatriation from the MTC. Of these, only 47 patients were delayed beyond 24 hours and 15 delayed transfers resulting in an 80% successful repatriation rate within 24 hours of repatriation request.		

Good Practice / Significant Achievements
(List key points covering good practice)

- Good education plan and online training sessions
- Good use of informatics and good online incident reporting
- Good ethos and ambition from staff
- Good TARN co-ordinator support
- Good rehabilitation director who wants to improve the service
- Rate of 80% repatriation within 24 hours

Specify Immediate Risks
An 'Immediate Risk' is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action

CEO/Board Representative risk handed over to at feedback session:
None Identified

Specify Serious Concerns
A 'Serious Concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality of clinical outcomes of patient care and therefore required urgent action to resolve

CEO/Board Representative risk handed over to at feedback session:
None Identified

Areas of Improvement (List areas of improvement)
• Access to imaging at a weekend, especially when patients are being transferred between the TU and the MTC. • Ensuring that TARN data submission continues to improve • Currently not meeting the target for 60-minute review for a patient with a head injury, which needs to be improved • Support the development of resources for spinal nursing and therapy outreach • Auditing policies and procedures to make sure they are being followed • Continue to monitor the two centre orthoplastic service to ensure that care is delivered in a timely manner

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Handling of Organisational Peer Review Reports and Next Steps

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Date: 27th June 2022 | **Version:** FINAL

Purpose and Summary of the Document: This paper provides an overview of how the organisational peer review reports will be managed and next steps, in order to guide organisational activities.

Publication/ Distribution: Network Clinical and Operational Board, Delivery Assurance Group

Draft Number & version		Author/ Editor	Date
1	1.0	Beth Hughes	1st June 2022
2	2.0	Dindi Gill/Andrea Bradley	15th June 2022
3	3.0	Sian Harrop-Griffiths/Karen Preece	16th June 2022
4	4.0	Dindi Gill/Beth Hughes	21st July 2022

The South Wales Trauma Network inaugural peer review process took place during the week commencing 21st March 2022. During this week, each of the partaking organisations attended an interview based discussion with external peer reviewers led by the NHSE Quality Surveillance and Nursing National Specialised Commissioning Team.

Serious concerns

1. No immediate risks were raised from the peer review process. Four organisations were informed of serious concerns prior to release of the full reports.

2. Consequently, the ODN developed a process for handling the serious concerns and subsequent action plans as outlined in the embedded document below:

Doc 3- Peer Review– Briefing No

3. All four organisations submitted action plans to the peer review team and have now received feedback in relation to these actions plans from the peer review team. The responsibility for revising the action plans in light of the feedback and completing these actions, now sits with the ODN.

4. Action plans and subsequent feedback is now a standing agenda item on all organisational/ODN meetings to monitor progress. Assurances will be sought on completion of these actions through the Network Governance Group Meeting, Clinical and Operational Board and ultimately the Delivery Assurance Group (standing agenda items). The action plans were presented at the Network Governance Meeting on the 23rd June 2022, and provided members with an update on progress and feedback from peer reviewers.

5. Following discussion with the NHSE peer review team, the ODN have determined that a six-month benchmark is used from the time serious concerns are raised to broadly when actions against the serious concerns have been addressed. Thus, we would anticipate assurance is provided by **3rd October 2022.**
   Clearly, some serious concerns may have resource implications in which case a judgement will need to be made as to whether the action is completed in its entirety or not. This addendum to the report (point 5.) was agreed at the Clinical Operational Board, 21st July 2022.

Handling of final peer review reports

1. Formal reports for each of the providing organisations are being authored by the NHSE QS Nursing team and will contain the following-
   - Immediate risks - these are provided verbally on the same day as the peer review and formally one week thereafter. There were no immediate risks across the SWTN.
   - Serious concerns - notification letters of high level findings, including the detailing of serious concerns have been received by some organisations as outlined above.
   - Notification of areas of improvement.
   - Good practice.

2. The reports have been received by the provider organisations on the 27th June 2022. There is then a two-week response time to reply with any factual accuracies; the content of the findings and subsequent recommendations from the panel will not be subject to change. Following this the formal reports will be shared with respective Chief Executives, SROs for Major Trauma, Major Trauma Clinical and Operational Leads, SRO for the SWTN, Clinical Director and Operational Manager, SWTN and the Director of Planning, WHSSC, Chief Ambulance Service Commissioner (for WAST/EMRTS). The estimated date for release of the formal reports is the 22nd July 2022.

3. As a guide, provider organisations will be asked to share and discuss their respective final peer review reports within the following forums (incl. a discussion about next steps):

   - Trauma Quality Improvement Committee (or equivalent).
   - Quality and Safety Committee or equivalent.

On receipt of the final reports the ODN will immediately share with members of the Network Governance Group, Clinical and Operational Board and Delivery Assurance Group.

4. A summary of the reports will be presented at WHSSC Management Group (August) and WHSSC Joint Committee (Sept).

5. Serious concerns will need to be addressed in a timely fashion, as outlined above. Any actions where it appears progress has not been made against the agreed timescale, will be escalated to the respective organisations SRO and network, including commissioning leads (where appropriate).

6. All providers will have an up to date workplan for 2022/23 pre-peer review. Notifications of areas of improvement will need to be built into revised organisational work plans for 2022/23 (incl. any actions arising from serious concerns) and 2023/24. Essentially, these work plans, considering the outputs of the peer review, will provide a roadmap for network developments. As a reminder, work plans for TUs MUST address any gaps against the new quality indicators for TUs that the network should now be working towards.

7. There will be requirement for these work plans to be signed off at Trauma Quality Improvement Committees (or equivalent) and shared at the Clinical Operational Board on the 20th October 2022 and subsequently at the Delivery Assurance Group Meeting on the 15th November 2022. Through its regular meetings with organisations, the ODN will provide oversight to ensure any developments at a local level align with the overall strategic direction of the network as described in the Programme Business Case.

8. The ODN will undertake a themed analysis to determine if there are serious concerns and areas of improvement common to several providers (incl. any changes to pathways and processes at network level). The ODN will also produce a combined report with summary of the peer review process incl. sharing of areas of good practice, available at the Clinical Operational Board on the 20th October 2022 and subsequently at the Delivery Assurance Group Meeting on the 15th November 2022. Providers will be given the opportunity to share areas of good practice identified at peer review at the network conference on 15th September 2022 OR the governance group meeting – 29th September 2022. Finally, once the final reports are available, the ODN will circulate a questionnaire to gain feedback on the process, for the NHS QS Nursing Team to consider.

9. There may be resource implications as a result of actions arising from serious concerns and areas of improvement identified in work plans. These are considered in the paper entitled 'workforce and service development plans 2022/23'. These will be intrinsically linked with the outputs of the peer review process.

10. The current plan is to also deliver the 1 year evaluation of the network to the at the Clinical Operational Board on the 20th October 2022 and subsequently at the Delivery Assurance Group Meeting on the 15th November 2022. The scope of the benefits realisation plan to be evaluated has already been defined and agreed through the network governance structure. The report is being developed by the network data analyst and research and quality improvement lead. It will be validated externally through Swansea University. Combined with the peer review, this will provide a rich picture of how the network is performing, and form the basis of the subsequent Gateway 5 review.

Members of the Clinical and Operational Board and Delivery Assurance Group are asked to:

- Note the content of this paper.
- Note the approach required within each provider in handling the peer review reports and next steps.

Benefits Realisation Plan

Strategic Benefit	Benefits Number/Description	Actions Necessary to Realise Benefits	Measurements	Target date for demonstrating benefit	Responsbile for delivering benefits	Accountable	SWTN Position July 2022	Consideration for 1 year Evaluation
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	Sep-24	ODN Providers	WHSSC/EASC/health board commissioning		Benefit will be visable in the fourth year of data- at a network level but to be considered at a provider level also We would expect to see an improvement in TARN on this evaluation In general some effect of regionalisation will already have occurred prior to go live- we need to understand whether there is sufficent data for analysis of earlier years. In any case narritive needs to reflect this fact.
	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	Sep-25	ODN providers (specifically rehabilitation providers)	WHSSC/health board commissioning	July 2022- Project Support Manager in place. Phased programme to roll out PROMS SWTN wide in development. To be initiated at MTC with further roll out to providers thereafter.	**Out of scope for year 1** Plans for rolling out PROMS & Neuroproactive (via Value Based Healthcare with backign of TARN); appointing B6 project lead to get baseline data (yr 2 & 3 of network data will represent baseli, albeit following some changes in the rehab model Are there other rehab outcome measures that will be available? **- DOR to speak to JT**
	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	Sep-21	ODN Provider	WHSSC/EASC/health board commissioning	All Network Clinical Guidelines and Operational Policies and pathways reviewed in Jan/Feb 2022 and ratified through SWTN governance structure. All documents shared with organisations and available via the Induction App. All data currently provided throughout the network via * Network Governance Meetings from ODN * Clinical reports & dashboards provided via TARN and circulated to ODN and appropriate organisations when published	Can demonstrate benefits now Has there been an improvement in the process of care indicators from TARN? Look at clincal reports, dashboards (looking to identify measures that are counted twice) There's enough there to analyse year 1- next evaluation will look at 3 years of data/evaluation. This evaluation will look at speciality measures for Paediatrics & Orthoplasics
	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	TARN PROMS/PREMS (patient experience component) Example provided in Appendix 23. Frequency on usage of patient centred communication tool (e.g. application) Patient surveys (themed annually)	Sep-23	ODN Providers	WHSSC/EASC/health board commissioning		Patient stories to be included for qualitative analysis but out of scope for quantiative analysis
	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 and disability	Sep-23	ODN Providers	Welsh Government	SWTN Operational manager to lead on this programme of work throughout 2022/23. Update to be provided in Q1 2023/24. Injury prevention work started with * South Wales Police- Knife Crime * South Wales Police- eScooters * Cardiff University/South Wales Fire & Rescue/Swim Wales/Third Parties- Open Water Safety *Public Helath Wales- Button Battery Ingestion	**Out of scope for year 1 evaluation**
	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	Sep-22	ODN Providers	WHSSC/EASC/health board commissioning	ODN formally working with National Mass Casualty Group to ensure integration of Network in national plans. National Mass Casualty walk-through event organised for August 2022 with anticipated sign off of revised plan September 2022, SWTN instrumentally involved.	**Out of scope for analysis**- reports back from forthcoming Mass Casualty excercise will be considered.
	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	Sep-21	ODN Providers	WHSSC/EASC/health board commissioning	Ongoing monitoring of TARN case ascertainmnent & accreditation. Network wide TARN support solution being developed. Monitored by ODN and discussed with local organisations at bi-monthly meetings. TARN PROMS/PREMS to be initiated in collaboration with National Value Based Healthcare support across SWTN- plans for HB's to commence in May 2022	Can demonstrate benefits now Has there been an improvement in the process of care indicators from TARN? Look at clincal reports, dashboards (looking to identify measures that are counted twice) There's enough there to analyse year 1- next evaluation will look at 3 years of data/evaluation. This evaluation will look at speciality measures for Paediatrics & Orthoplasics
	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 definitively within a TU. The number of patients with ISS ≥15 managed locally outside of MTC & outcome	Sep-21	ODN Providers	WHSSC/EASC/health board commissioning	The data required is currently being utilised to inform the ODN, network governance team and local Health Boards. Analysis of the measurement metrics within the network being considered within the ODN using TARN and SWTN Major Trauma Database data. Where not available at present, work is ongoing to develop an interim suitable reporting mechanism. Patients with ISS >15 reviewed by each HB clinical lead quarterly to ensure equity of access for patients Will be included in the one-year evaluation due October 2022.	In scope Benefits should be seen already Measure of equity Measure of outcome The way you divide patients **Action- RT to contact Penninsula & NE networks to ask for data demonstrating improved outcomes for pt's in the most rural parts of their networks** DG & DOR to further consider the questions:before vs after as opposed to equity between remote & central ? metric used to capture- survival benefit
	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.	Sep-21	ODN Providers	WHSSC/EASC/health board commissioning	Monitored by the ODN via the Trauma Related Incident Database (TRID) and reported through the network governance mechanism. Landing pad model being re-invigorated across all Health Boards. Will be monitored and guided by the WF&SD group and SWTN Governance Group.	In scope About timely transfers rather than number of transfers Look at all wales repat database reports for evidence

Equity	**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.	Sep-23	ODN Providers	WHSSC/health board commissioning	Formal Orthogertiatrician service commenced in MTC in June 2021. SWTN Silver Trauma group commenced it's inaugral meeting April 2021 and is ongoing quarterly with a clear workplan discussed to progress. Funding for identified SWTN Sliver Clinical Lead being progressed through formal processes.	Dashboard outcome captured above
	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	Sep-21	ODN Management	WHSSC/health board commissioners	Management of the veteran trauma network transferred to the ODN. SWTN operational policy for VTN authored. Data capture of demand & outcomes ongoing. Recent successful application for funding of veteran HCP from the Covenant Fund to be based at the VTC however will outreach across the SWTN as requried and facilitate the triage of VTN Wales referrals. Additional support from DMWS confirmed to start in VTC and will also outreach across the SWTN as required.	**Out of scope**
	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)	Sep-21	ODN Providers	WHSSC/EASC/health board commissioners	Suitable training & education plan developed with T&E clinical Lead in response to Covid related restrictions. Network Senior nurse Educator post created to lead on creation, maintenance and further development of network training package and provide any focused T&E throughout the network as required. Post holder commenced in role in July 2021, recurrent funding has been approved therfore post made substantive in June 2022 and appointed to. Two phases of VR scenario training videos created for TTM and TTL including focused clinical skills training. Clinical Skills and TTM training launched across NHS Wales via SharePoint in November 2021. Hosting platform with full monitoring capabilities for all education launched July 2022. Induction App reporting mechanism available and reported in ODN quarterly network activity report	**Not for analysis** Presentation of descriptive qualitative data
	013/Enhanced engagement of the MTC with the wider network	Strategy for supporting wider network	Number of engagement sessions led by MTC	Sep-21	MTC	WHSSC	Virtual meetings with LHB's and MTC clinical director taking place. Regular virtual meetings taking place for, MTP & RC's, TARN CoOrdinators. Weekly virtual MDT hosted by the MTC & attened by all LHB's taking place. MTC Senior Nurse & SWTN Senior Matron progressing cross working at a MTP/RC level across the network.	**Not for analysis** Presentation of descriptive qualitative data
	014/Enhance new recruitment across the region	Implementation of an inclusive network Workforce strategy	Identified staffing recruited Number of joint appointments made Number of rotational appointments made Publication of strategy	September 2020 onwards September 2020 onwards	ODN providers ODN management	WHSSC/EASC/health board commissioners	Consultant AHP post recruited to within C&V but to have a central role across the SWTN Lead nurse educator for the network made substantive in March 2022. Workforce and service development group meeting taking place quarterly focussing on progression of rotational roles within the network and network wide honorary contracts in response to operational challenges experienced. Workforce strategy to be developed, formally monitored and scrutinised through this group.	**Not for analysis** Presentation of descriptive qualitative data
	015/Improved staff retention	Workforce strategy	Turnover rates	Sep-21	ODN Providers	WHSSC/EASC/health board commissioners	Workforce and service development group meeting taking place quarterly- the next meeting due to take place in March 2022. Workforce strategy to be developed, formally monitored and scrutinised through this group.	**Out of scope (too early (covid effect))**
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	Sep-25	ODN Providers	WHSSC/EASC/health board commissioners		**Out of scope- too early**
	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	Sep-23	WAST/EMRTS/health boards	EASC/health board commissioners		See above Look at bed days vs days where nothing happened- detailed analysis- Discuss with Ronan re how practical this will be?- scope cost to carry out this analysis
	018/Reduced length of stay in critical care	Implementation of MTC	Reduced length of stay (TARN/ICNARC datasets)	Sep-23	ODN	WHSSC/EASC/health board commissioners		In scope- within TARN data Financial implicaions reqire further work
	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	Sep-21	ODN Providers	WHSSC/EASC/health board commissioners	Orthoplastic consultants working across both C&VUHB (MTC) and SBUHB (TUss) to provide orthoplastic services. Rehabilitation consultants formally working across healthboards to provide rehabilitation services throguhout the network. SWTN SM & MTC SN working through plans for a 2 year rotational post programme within the SWTN for newly qualified nursing staff. MTC senior nurse developing work plan to facilitate cross working at MTP/RC level across network.	**Out of scope**
	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	Sep-21	ODN Providers	WHSSC/EASC/health board commissioners	The ODN has supported the development of the programme for a Spinal Services Network (SSN). A proposal was submitted to WHSSC for the SSN to be managed by the ODN with an uplift in ODN staff- currently undertaking formal processes for approval. The ODN is supporting the development of a Regional cardiothoracic service	**Out of scope**

Report Title	**Specialised Services Strategy Development and Engagement Process**	**Agenda Item**	2.2
Meeting Title	**Joint Committee**	**Meeting Date**	06/09/2022
FOI Status	Open		
Author (Job title)	Bank Project Manager		
Executive Lead (Job title)	Managing Director, WHSSC		

Purpose of the Report	The purpose of this report is to inform the Joint Committee of the planned development of a ten year strategy for specialised services for the residents of Wales, and to describe the proposed approach to communication and engagement with key stakeholders to support its development.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s):

Members are asked to:

- **Approve** the overall approach to developing a ten year strategy for specialised services and provide feedback on the key documents presented.

SPECIALISED SERVICES STRATEGY DEVELOPMENT AND ENGAGEMENT PROCESS

1.0 SITUATION

The purpose of this report is to inform the Joint Committee of the planned development of a ten year strategy for specialised services for the residents of Wales, and to describe the proposed approach to communication and engagement with key stakeholders to support its development.

2.0 BACKGROUND

The last specialised services strategy was published in 2012. During the intervening period there has been significant challenge related to the pace of development of innovative treatments, an increasingly austere financial climate and more recently the unprecedented and disruptive impact of the COVID-19 pandemic on NHS care.

The policy context within NHS Wales has also changed during this time and any strategy will need to be aligned to a number of major policy developments. In addition, the May 2021 Audit Wales Report into the Committee Governance Arrangements at WHSSC included a number of recommendations related to developing a new specialised services strategy. The report advised that, post COVID-19, developing a strategy would now provide opportunity to shape the direction to focus on recovery, value, and to exploit new technologies and innovative ways of working.

Further to the Welsh context, in July 2022, the Health and Care Act 2022 for NHS England legally established 42 Integrated Care Systems (ICSs) which will plan and manage health and care services in their ICS area, including more integrated commissioning of specialised services from April 2023.

3.0 ASSESSMENT

3.1 Engagement and Communication Plan

As previously agreed at a Joint Committee meeting in March 2018, an engagement process will be undertaken to support the development of a strategy using a blended approach of written/electronic feedback via an online survey and general feedback from stakeholder meetings.

The survey responses and general feedback will be used to develop a draft strategy document for consideration by both the Joint Committee and Welsh Government (WG).

To support the process, an Engagement and Communication Plan has been prepared, see ***Appendix 1***. The plan provides an outline context for why the development of a strategy is pertinent at this time and describes the three overarching themes and supporting questions that will be posed to stakeholders through the engagement process, via an online survey approach, in order to inform and influence the development of the strategy. In addition, the plan identifies, analyses and prioritises the key stakeholder groups and defines the engagement activities, allowing for differing levels of interest and understanding of specialised services.

The engagement and communication plan was shared with the Management Group at its meeting on 28 July 2022 to discuss the themes and questions for understanding, reasonableness, and relevance to support the direction of travel and optimise the effectiveness of the engagement process.

Feedback has been received from Swansea Bay University Health Board and the Regional and Specialised Services Provider Planning Partnership (RSSPPP), which has been noted and amendments made to the plan and survey questions where appropriate. At its meeting of 25 August 2022, management group members were asked to test the survey to ensure the questions capture the key issues, whether they feel there are any questions missing and to provide an assessment of how long the survey might take to complete. In addition, it has been tested by the WHSSC Senior Planning Managers. The survey can be found in ***Appendix 2.***

3.2 Key Themes

The three overarching themes that have been identified for reflection when engaging with our stakeholders are set out below. Recognising that whilst the overall messages should remain consistent, as the scope of stakeholders to be engaged with is wide-ranging, it is recognised that certain questions will be more relevant to some organisations than others.

The first theme relates to WHSSCs core purpose.

1. **What?** The key element of this theme is our strategic ambition for specialised services and how can WHSSC offer the greatest value to NHS Wales. This is therefore a theme, which must be considered within the context of the wider priorities of NHS Wales and will be the primary consideration for WG and provider and commissioning Health Board's (HB's) in Wales.

The second and third themes relates to the approach to the commissioning of specialised services and reflects the principles contained within A Healthier Wales (2018). These themes will need to be considered by all our stakeholders.

2. **Where?** This theme relates both to the location of providers and the models of care.

3. **How?** This identifies a set of principles and specific functions that WHSSC will adopt to *'ensuring that there is equitable access to safe, effective and sustainable services for the people of Wales, as close to home as possible within available resources'.* This includes the quality and performance management of both NHS England and Welsh providers and the role of specialised services in driving value from clinical pathways. The question for consideration by our stakeholders is whether certain functions are the role of WHSSC or better suited to another organisation to perform.

3.3 Timescales

The critical path can be found within the Engagement and Communication Plan. To note, the timeline for the engagement process will run between 20 September and 22 December 2022 with the aim of a draft strategy being presented to the Management Group at its February 2023 meeting in preparation for final approval by the Joint Committee in early March 2023. Regular updates will be provided to Management Group during the engagement process on the themes and issues arising from stakeholder feedback to minimise 'surprises' in the drafting of the strategy.

4.0 RECOMMENDATIONS

The Joint Committee is asked to:

- **Approve** the overall approach to developing a ten year strategy for specialised services and provide feedback on the key documents presented.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Development of the Plan Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Developing a Specialised Services Strategy for the Residents of Wales
Health and Care Standards	Safe Care Effective Care Dignified Care
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation Care for Those with the greatest health need first
NHS Delivery Framework Quadruple Aim	People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcome Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	The aim of developing a specialised services strategy is to ensure that residents in Wales can now and in the future, receive equitable access to high quality specialised services, which are clinically effective, and that offers the best outcomes and experience for patients, as well as providing the greatest value for our population.
Finance/Resource Implications	No specific resource implications outlined within the report. However any strategic decision identified as a result of the development of the strategy such as a transfer of service, would require financial assessment.
Population Health	To ensure equitable access for all patients in Wales.
Legal Implications (including equality & diversity, socio economic duty etc)	As identified within the EQIA
Long Term Implications (incl WBFG Act 2015)	–
Report History (Meeting/Date/ Summary of Outcome	Corporate Directors Group Board (CDGB) – 14 July 2022 – Approved Management Group – 28 July 2022 – Supported

	Management Group – 25 August 2022 - Supported
Appendices	Appendix 1 – Engagement and Communication Plan Appendix 2 – Stakeholder Survey

Specialised Services Strategy Development and Engagement Process

6th September 2022

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Context

- Last specialised services strategy published 2012
  - Number of policy developments since then
  - Growing demand/cost/options
- **Audit Wales Report:** WHSSC should develop and approve a new strategy during 2021
- **NHS England:** Establishment of 42 Integrated Care Systems (ICS) with more local commissioning of specialised services April 2023
- WHSSC offering 'Once for Wales' function delivering collaborative approaches in joint commissioning arrangements

Purpose and Scope

- Ensure best experience and outcome for residents in Wales when accessing specialised services
- Define the approach for Wales for the future of specialised services and its priorities
- Cover current commissioned services, new services and those which no longer may be considered specialised
- Partnerships and how they can be strengthened
- The role of WHSSC in non-specialised commissioned services; in particular for pathways to access specialised services

Outside scope (Regs and SOs)

- Organisational position of WHSSC within NHS Wales
- Governance structures
- Funding mechanism
- Funding level

Engagement with our Stakeholders

First step in developing the strategy.

Three overarching themes with supporting questions.

1. **What?** Strategic ambition for WHSSC and specialised services. How can WHSSC offer the greatest value to NHS Wales. Primary consideration for WG and Health Boards in Wales

2. **Where?** This theme relates both to the location of providers and the models of care.

3. **How?** This identifies a set of principles and specific functions that WHSSC will adopt to *'ensuring that there is equitable access to safe, effective and sustainable services for the people of Wales, as close to home as possible within available resources'.*

Engagement with our Stakeholders (cont.)

- Engagement and Communication Plan developed
- Stakeholder analysis undertaken identifying key groups and individuals
- Survey built around the 3 themes with supporting questions
- Engagement activities consist of written/electronic responses and feedback from stakeholder meetings
- Engagement exercise to run 20 Sept. - 22 Dec. 2022
- Responses and feedback to inform the development of draft strategy for consideration by JC and WG
- Strategic direction and actions arising from the strategy to inform the ICP and HB's IMTPs for 2024 and beyond

Timeline

Critical Path	Timeline
Initial Engagement with WHSSC staff	14th July 22
Brief Board of CHCs on Planned Engagement	11th July 22
Discussion at Management Group	28th July & 25th August 22*
Launch at Joint Committee	6th September 22
Commence Social Engagement Process	20th Sept – 22nd Dec 22
Engagement at Health Board Development Sessions	22nd and 27th October 22
Engagement Responses Compiled	2nd – 6th January 23
First Draft Strategy Produced	9th – 27th January 23
First Draft Strategy to WHSSC Corporate Directors Group	6th February 23
Final Draft Strategy to Management Group	23rd February 23
Final Strategy Document to Joint Committee	14th March 23
Share with Welsh Government	21st March 23
Formally Publish Strategy	31st March 23

Any Questions?

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

ENGAGEMENT AND COMMUNICATION PLAN FOR THE DEVELOPMENT OF A TEN YEAR SPECIALISED SERVICES STRATEGY

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Status	For Review
Version Number	6.0
Publication Date	

Document Management

Revision History

Version	Date	Summary of changes
1.0	05/06/22	Added Appendix 3 – Equality Engagement Opportunities
2.0	07/07/22	Section 7.4 Communication Channels Table, Principle 3 – Added '*We will test our materials through Learning Disability Wales and People First'*
3.0	13/07/22	Section 3 Context – Added paragraph on Once for Wales. Section 6 Stakeholder Messages – Revision to questions following feedback from SL Appendix 3 Equality Engagement Opportunities – Revision to impact identified for some groups following feedback from SL
4.0	14/07/22	Section 6 Key Messages – Revision to questions following feedback from CDG Section 7.2 Communication Channels – Added WHSSC commitment to the Welsh Language Section 7.4 Communication Channels Table – Amendments to Stakeholders Section 7.5 Timescales – Added HB Development Session dates
5.0	26/07/22	Section 7.2 Stakeholder Analysis – Added Stoke Association, Future Generations Commissioner, SWAN UK, NHS Blood and Transplant, Welsh Blood Service. Moved WHSS Team and Velindre NHST to key players
6.0	28/07/22	Sections 1, 2 , 3 and 5 – Revisions to narrative following feedback Section 5 Scope – Amendments following feedback to recognise health boards as commissioners of some specialised services. Section 7.2 Stakeholder Analysis – Added EYST. Moved WAST and Digital Health and Care Wales to keep satisfied stakeholder group. Added Appendix 2 – Key Stakeholder questions

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Contents (will need refreshing when Doc finalised)

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1. Introduction

The purpose of this document is to describe the approach Welsh Health Specialised Services Committee (WHSSC) will take in communicating and engaging with key interest stakeholder groups to support the development of a 10 year strategy for specialised services for the residents of Wales.

This Engagement and Communication Plan summaries the context for why the development of a strategy is pertinent at this time and outlines the key themes and questions that will be posed to stakeholders through the engagement process. In addition, it identifies and prioritises the key interest stakeholder groups and defines the approaches of the stakeholder engagement activities.

The plan aims to help people understand what to expect from the engagement process, how they can have their say and how long the process will take.

To ensure the engagement process is meaningful, consideration will be given to the form of communication used to reflect the various stakeholder groups. Stakeholder messages and questions will be produced for the specific audiences being engaged with and may differ accordingly.

The strategy for specialised services will be developed as a product of the engagement process in readiness for March 2023 to inform the WHSSC Integrated Commissioning Plan and Health Board's Integrated Medium Term Plans (IMTPs) for 2024 and beyond.

2. Background

Welsh Health Specialised Services Committee (WHSSC) is a Joint Committee of the seven Local Health Boards (LHBs) in Wales. The seven LHBs are responsible for meeting the health needs of their resident population, and have delegated the responsibility for commissioning a range of specialised services to WHSSC.

It is important to note that not all specialised services, as defined in the NHS England Prescribed Services Manual, have been delegated to WHSSC and remain the commissioning responsibility of health boards.

Specialised services generally have a high unit cost as a result of the nature of the treatments involved. They are a complex and costly element of patient care and are usually provided by the NHS. The particular features of specialised services, such as the relatively small number of centres and the unpredictable nature of activity, require robust planning and assurance arrangements to be in place to make the best use of scarce resources and to reduce risk. Specialised services have to treat a certain number of patients per year in order to remain sustainable, viable and safe. This also ensures that care is both clinically and cost effective.

3. Context Outline

The last specialised services strategy was published in 2012. During the intervening period there has been significant challenge related to the rapid pace, and often unpredictable development of innovative treatments, an increasingly austere financial climate and more recently the unprecedented and disruptive impact of the COVID-19 pandemic on NHS care. A key focus of the strategy will be on WHSSCs ability and agility to respond to evolving challenges and risks as they present themselves.

The policy context within NHS Wales has also changed during this time and any strategy will need to be aligned to a number of major policy developments including Welsh Government's "a Healthier Wales: Long Term Plan for Health and Social Care"[1] (2021), Prudent Health Care[2] (2018), Welsh Government's NHS Quality & Safety Framework[3], the provisions of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, in relation to the new duty of quality and duty of candour, and of course the Well-being of Future Generations Act 2015. A key driver for renewal of the strategy arises from the recent Audit Wales Report into the "Committee Governance Arrangements at WHSSC", presented at Appendix 1 for information, which included a number of recommendations related to developing our new specialised services strategy.

Wales has its own distinctive approach to health and care provision. Integration and co-operation between health organisations is a key principle of healthcare policy, along with a commitment to avoid duplication and do things 'Once for Wales'. To realise the benefits of an integrated health and care system in Wales, it is vital to secure the best possible services through effective commissioning. Services must also be decommissioned where they are no longer needed, could be better provided elsewhere, or are not providing the expected outcomes or value. NHS Wales established WHSSC in order to support collaborative commissioning and as health boards and trusts develop integrated care and services with local authorities, collaborative approaches based on evidence must play through in these joint commissioning arrangements to ensure shared values, common goals and joint aspirations. It is important to recognise that a number of specialised services remain the commissioning responsibility of individual health boards and may be better commissioned by WHSSC where value can be added through a once for Wales approach.

In addition to the Welsh context, in July 2022, the Health and Care Act 2022[4] for NHS England legally establish 42 Integrated Care Systems (ICSs) and Clinical Commissioning Groups will be abolished. The ICSs will plan, and manage the NHS budget, to deliver health and care services in their ICS area. As part of this, a roadmap setting out the direction of travel towards more integrated commissioning of specialised services with local commissioners, has been shared. The Roadmap sets out which specialised services may be both suitable and ready for greater local leadership from April 2023. NHS England will continue to set national policies and standards and will remain ultimately accountable for the commissioning of all specialised services.

The strategic challenge for WHSSC will be to navigate the new NHS England system and develop new sets of relationships with the ICSs who will have an influence on the future direction for some of our providers in England of national and regional/supra-regional services. This will be of significant importance for patients from North and Mid Wales.

Alongside all these policy changes, we have an ageing population and increasing number of treatment options for patients with more advanced disease, all creating a growing demand for specialised services. It is against this backdrop that it has becoming increasingly important that we renew the strategy and ensure it can meet the needs of the population of Wales for the next 10 years.

[1] A healthier Wales: long term plan for health and social care | GOV.WALES
[2] Prudent healthcare | GOV.WALES
[3] NHS Quality and Safety Framework | GOV.WALES
[4] Health and Care Act 2022 (legislation.gov.uk)

4. Purpose

Every person in Wales who uses health services or supports others to do so, whether in hospital, primary care, their community or in their own home has the right to receive excellent care as well as advice and support to maintain their health. All health services in Wales need to demonstrate that they are doing the right thing, in the right way, in the right place, at the right time and with the right staff.

The aim of developing a specialised services strategy is to ensure that residents in Wales can now and in the future, receive equitable access to high quality specialised services, which are clinically effective, and that offers the best outcomes and experience for patients, as well as providing the greatest value for our population.

Development of a specialised services strategy post COVID-19 now provides the opportunity to shape the direction to focus on recovery, value, and to exploit new technologies and innovative ways of working.

Key to this will be the recognition of the diverse relationships that exist between North, Mid and South Wales with Welsh Providers and NHS England where both patient pathways and direct access to specialised services differ.

The objective of this process is therefore to define the overall approach for Wales to the future development of specialised services from a local, regional and national perspective, our priorities in relation to the wider NHS and our priorities within specialised services.

Because of the pace of change in specialised services this strategy will require a review in 5 years to consider whether it remains fit for purpose for the following 5 year period.

5. Scope

The strategy needs to encompass not only current WHSSC and health board commissioned specialised and highly specialised services, but to also recognise their evolution, and therefore the approach to commissioning new services. In addition, it will consider those services which are no longer considered specialised and which may be better commissioned by health boards themselves, or alternatively where health boards may want to transfer specialised services currently within their commissioning responsibility to WHSSC.

It will also consider the role of WHSSC and health boards in non-specialised commissioned services where pathway development directly impacts on access to specialised and highly specialised services, or which have a direct interface or interdependency with specialised services. The strategy will consider where WHSSC can add value outside the commissioning of specialised services to support a once for Wales approach.

The strategy will consider the role of partnerships with a view to strengthening existing partnerships and developing new partnerships. This will include NHS partners inside and outside Wales as well as non-NHS partners such as social care, universities and the new Citizens Voice.

Strategic development of the WHSSC team where it impacts on delivery of the strategy is also included.

The strategic position of WHSSC within NHS Wales, its governance structures and funding mechanism are outside the scope of this review.

6. Key Stakeholder Themes

Three overarching themes have been identified for consideration when engaging with our stakeholders.

The first theme relates to our core purpose and will need to be considered by our key player stakeholders.

1. **What?** The key element of this theme is our strategic ambition for specialised services and how can WHSSC offer the greatest value to NHS Wales. This is therefore a theme, which must be considered within the context of the wider priorities of NHS Wales and will be the primary consideration for Welsh Government and provider and commissioning health boards in Wales. Within this theme are a number of specific questions for consideration and

The second and third themes relates to the approach to the commissioning of specialised services and reflects the principles contained within A Healthier Wales (2018). These themes will need to be considered by all our stakeholders.

2. **Where?** This theme relates both to the location of providers and the models of care.

3. **How?** This identifies a set of principles and specific functions that WHSSC will adopt to '*ensuring that there is equitable access to safe, effective and sustainable services for the people of Wales, as close to home as possible within available resources*'. This includes the quality and performance management of both NHS England and Welsh providers and the role of specialised services in driving value from clinical pathways. The question for consideration by our stakeholders is whether certain functions are the role of WHSSC or better suited to another organisation to perform.

A survey has been built around these themes and a series of questions developed to prompt stakeholder's views and feedback. The survey can be found in Appendix 2.

7. Delivering the Engagement Process

7.1 Methodology

As previously agreed at a Joint Committee in March 2018, an engagement process will be undertaken to ensure stakeholder's input using a blended approach of written/electronic responses and feedback from stakeholder meetings.

The views and general feedback received will be collated and used to inform the development of a draft strategy document for consideration by both the Joint Committee and Welsh Government.

7.2 Stakeholder Analysis

A stakeholder analysis has been undertaken to identify the key groups and individuals that WHSSC will want to engage with to support the development of the strategy. The engagement approaches highlight the different ways in which we will interact with various stakeholder groups, allowing for differing levels of interest.

Stakeholder Groups	Engagement Approaches	Individual Stakeholders
Key Players	Inform, engage and collaborate. Regular interaction, specific details and direct / bespoke communications.	• WHSSC Executive Director Team • WHSS Team • Local Health Board x7 • Velindre NHS Trust • Management Group • Joint Committee • Health Education and Improvement Wales • Executive Peer Groups • Director General for Health and Social Services • Minister for Health and Social Services • WG National Clinical Director • WG Chief Nursing Officer • Medical Royal Colleges and Other Professional Bodies • NHS England and Scotland – Provider Trusts • NHS England and Scotland – Highly Specialised Services Commissioning Bodies • NHS England Integrated Care Boards • Board of Community Health Councils • Community Health Councils x7

Keep Satisfied	Inform and engage. Regular interaction / direct communication.	• NHS Executive –
		  ○ NHS Delivery Unit
		  ○ Finance Delivery Unit
		  ○ Improvement Cymru
		  ○ National Collaborative Commissioning Unit
		• Clinical Networks and National Implementation Groups
		• Stroke Association
		• NHS Blood and Transplant
		• Welsh Blood Service
		• SWAN UK
		• WG Health & Social Services Group Directorates
		• WG Policy Leads
		• Children's Commissioner for Wales
		• Older People's Commissioner for Wales
		• Future Generations Commissioner for Wales
		• Learning Disability Wales
		• Disability Wales
		• Stonewall Cymru
		• Welsh Local Government Association
		• Regional Partnership Boards
		• Race Council Wales

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Stakeholder Groups	Engagement Approaches	Individual Stakeholders
		• Ethnic Minorities and Youth Support Team • Emergency Ambulance Services Committee • Welsh Ambulance NHS Trust • Digital Health and Care Wales • Cwm Taf University Health Board Audit Committee
Show Consideration	Inform and involve as needed. Generic information.	• All Wales Medicines Strategy Group • National Institute for Health and Clinical Excellence • Health Technology Wales • Health Inspectorate Wales
Inform	Generic information, one way / limited engagement.	• Wales Council for the Voluntary Sector • WG Director Social Services / Chief Social Care Officer

7.3 Communication Plan

To ensure the engagement process is meaningful, the overall messages will remain consistent, however to reflect the various stakeholder groups, the approach to how the questions are posed, alongside the supporting information and guidance, will be produced for the specific audiences to ensure they are clear and easy for people to understand. This will help people to engage in the process.

7.4 Communication Channels

A range of materials and methods to enable people to take part in the engagement process will be utilised. WHSSC will commit to the following principles and activity methods during engagement.

WHSSC is committed to treating the English and Welsh languages on the basis of equality and we endeavour to ensure the services we commission meet the requirements of the legislative framework for Welsh Language, including the Welsh Language Act (1993), the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No.7) Regulations. Where a service is provided in a private facility or in a hospital outside of Wales, the provisions of the Welsh language standards do not directly apply but in recognition of its importance to the patient experience we ensure that wherever possible patients have access to their preferred language. In order to facilitate this WHSSC is committed to working closely with providers to endeavour that in the absence of a welsh speaker written information will be offered and they will have access to either a translator or 'Language-line' if requested. We will also encourage, in those services where links to local teams are maintained during the period of care, that this can provide access to the welsh language if possible.

Principles	Activity Method
1. Providing our key player stakeholders with a range of opportunities to be involved in the engagement process	• We will arrange workshops and meetings in a variety of methods. These will include face to face or virtual approaches dependent on the stakeholder's preference.

Principles	Activity Method
	• Where possible, feedback through face to face or virtual meetings will be recorded through either audio and/or video systems. • We will provide regular updates to our key player stakeholders throughout the engagement process. These updates may take the form of generic or bespoke feedback.
2. Providing a range of opportunities for a patient and public voice to be considered within the engagement process regardless of who they are and where they live within Wales.	• We will map out the national organisations and clinical bodies representing the wider patient and public view. • We will work with a variety of community and voluntary organisations and NHS bodies to make the most of all opportunities to gather the views of the people they represent. • We will provide a blend of written/electronic feedback and face to face events through which to engage. • Questionnaires will be gathered electronically through the use of the Microsoft Teams tool. • Any face to face feedback will be captured in the same way as our key player interactions, recorded through audio and/or video systems.
3. Providing accessible information in clear simple language and in a variety of formats	• We will produce targeted communications to reflect the intended audience we are aiming to engage with. • Information and communication materials will be made available on our website and at all our engagement events. • We will test our materials through Learning Disability Wales and People First • We will stick to plain English and provide an easy read version for our engagement document and questionnaire. • We will provide materials in other formats should they be requested. This will include translation of written materials into Braille, British Sign Language or other languages locally spoken by the communities we are engaging with. • All materials will be translated into the Welsh language as a standard.
4. The process will be open and transparent	• We will publish all feedback received at the end of the engagement process. • We will be accessible for stakeholders to ask questions.

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Principles	Activity Method
	• We will update our website with frequently asked questions. • We will be transparent about our decision-making process.
5. Careful management of resources	• We will endeavour to use evidence based methods of engagement to make sure we deliver good value for money.

7.5 Timescales

The strategic direction and any actions arising from the strategy will need to inform the Integrated Commissioning Plan and Health Board's Integrated Medium Term Plans (IMTPs) for 2024 and beyond. For WHSSC this means that the engagement process and therefore the strategy development will need to be finalised by March 2023.

Starting the process of engagement is therefore critical if these timelines are to be achieved. To enable this the strategic themes and engagement process will be considered at Management Group in July 2022, with a subsequent opportunity in August 2022 should this be required, and launched at Joint Committee in September 2022.

The engagement process will start with WHSSC's own staff first prior to the launch and the remaining engagement events will commence in mid-September 2022 for a 3 month period. The Board of CHCs was briefed on the engagement process, as a key stakeholder, on 11th July 2022.

Critical Path	Timeline
Initial Engagement with WHSSC staff	14th July 22
Brief Board of CHCs on Planned Engagement	11th July 22
Discussion at Management Group	28th July & 25th August 22*
Launch at Joint Committee	6th September 22
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Final Draft Strategy to Management Group	23rd February 23
Final Strategy Document to Joint Committee	14th March 23
Share with Welsh Government	21st March 23

Critical Path	Timeline
Formally Publish Strategy	31st March 23

* Subject to agreed amendments requested at July Mgt Group

8. Equality

The engagement process will draw from the findings from the Equality Impact Assessment (EQIA) to inform the engagement approach in obtaining views from demographic groups who may experience a disproportionate or differential need for specialised or highly specialised services. The EQIA can be found in Appendix 3.

As already noted earlier in this document, a range of materials and planned activities to enable people to take part in the engagement process will be utilised.

9. Governance Structure

The following structure will be used to steer the strategy development.

- **Management Group** will act on behalf of the Joint Committee. They will receive update reports at their monthly meetings and provide advice on areas they feel the Joint Committee may require further information.
- **Joint Committee** will act as the Project Board. Update reports will be brought to them at their bi-monthly meetings. They will be the ultimate decision maker on the content of the strategy and they will receive the outcome from the engagement process.
- **Corporate Directors Group Board** comprises the WHSSC Directors and meets monthly. This group will act as the project team. They will steer the development of the strategy and lead the engagement process. They will be responsible for all project documentation and ensuring appropriate papers are produced for Joint Committee.
- **Senior Responsible Officer** for the project will be the WHSSC Managing Director.

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APPENDIX 2.

2.1 Key Stakeholder Survey

Not all questions are relevant to all our stakeholders. If you feel a question is not directly relevant to you please complete the box with not applicable (N/A) and move on to the next question.

Section 1. Information about you.

1. Are you responding on behalf of a group/organisation or as an individual?
2. What is the name of your group or organisation?
3. What geographical area does your group or organisation fall under?
4. If other, please state?
5. What is your age?
6. What is your gender?
7. How would you describe your national identity?
8. If other, please state?
9. How would you describe your ethnic group?
10. If other, please state?
11. What geographical area does your group or organisation fall under?
12. If other, please state?

Section 2. What?

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14. What other features would these be?
15. Do you think there should be specific minimum costs and case numbers in place?

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21. What do you think is our role in influencing or changing the pathways in non-WHSSC commissioned services?

22. What do you think we should do when we can see variation in access rates i.e. low access rates or very high access rates?

In some of our services, we commission from more than one provider organisation. An example would be paediatric surgery where our main providers are Cardiff and Vale University Health Board for patients from south Wales, and south Powys and Alderhey Children's hospital for patients from north Wales and north Powys. If there are problems with the quality of the service or the waiting times at one of our providers what would you expect from us?

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41. Should WHSSC aim to develop specific professional development opportunities for staff in the NHS in Wales?

42. Are there particular opportunities which you think would be of value?

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46. Can you think of any situations where we would not want to develop a cross border strategic partnership?

47. What situations would these be?

We currently have a number of services particularly in south Wales where the units are very small and therefore difficult to sustain. For example some of our specialist children's services have only 2 consultants working in them. This means that in the event of sickness we might no longer be able to offer a service and or be able to provide urgent specialist access. A way of strengthening services therefore would be to try to pro-actively develop networks with regions in NHS England. This might mean that sometimes patients have to go to England for their care or, as is increasingly the case, they might see a nurse or doctor or dietician via video link.

48. Are there circumstances where we should not pro-actively seek to develop cross border network arrangements?

49. What circumstances would these be?

Typically specialised services are centralised in a small number of centres often great distances from the patents' homes, however, innovation in the pandemic and the evolution of digital systems has meant that there are radically new models of patient care available. For many, although not all, of our patients this has improved or increased access to specialist care. One example is our Gender Identity Service which was able to reduce waiting times during the pandemic through the use of virtual clinics with very positive patient reported experience. Currently we include in our Service Level Agreements an expectation that digital systems should be developed. We also run Innovation and Improvement days where we bring our different providers together to share performance and good practice on a specialty basis however this is not possible for all our specialist services.

50. As part of our drive to deliver care closer to home should we be more proactive in driving digital and service innovation?

51. What incentives do you think we could use to drive innovation?

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52. Are there any other opportunities for WHSSC to support this policy direction?

53. What other opportunities might these be?

Section 4. How?

This section sets out the specific activities that the WHSS Team undertakes to deliver '*equitable access to safe, effective and sustainable services for the people of Wales, as close to home as possible within available resources*'. It seeks to understand your views on synergies with other NHS organisations in Wales and the UK and understand how we can most effectively play our part in an integrated health system.

WHSSC is a national commissioner with a significant part of its commissioned activity delivered outside Wales. To help drive improved performance WHSSC has invested in and strengthened quality and information systems working wherever possible on UK wide platforms and registries, using real time reporting and benchmarking.

54. Are there any partnerships that WHSSC should develop to strengthen its capacity and capability in this area?

55. What partnerships would these be?

56. What other tools can WHSSC use to measure the wider value of a service to inform future commissioning?

WHSSC has committed to embedding outcome evaluation and outcome based commissioning into specialised services. It is important to understand however, that as a commissioner of only one part of the patient pathway, the options for using outcomes and increasing value are different to those with health boards. For example, WHSSC commissions' in-patient Children and Adolescent Mental Health Services (Tier 4 CAMHS) however, the numbers of patients referred into the service and the length of time children stay in the service varies between health boards. There is some evidence that this variation is related to differences in services within health boards. WHSSC however does not commission the health board services and therefore cannot, for example, increase investment in secondary care CAMHS (Tiers 2 and 3) to potentially avoid admissions into Tier 4 services.

57. Given the limitations outlined above, what opportunities are available to WHSSC to drive value from the patient pathway or use outcome data to drive continuous improvement?

WHSSC now has good quality data in many specialty areas on access rates to specialist services. These data are shared on an ad hoc basis with the boards of health boards and staff

from commissioning teams within health boards have direct access to the Power BI system which holds the data. It is important to WHSSC use these data to drive equitable access to services and to ensure it can meet its socio-economic duty.

58. What other mechanism could WHSSC use to raise awareness of access rates within HBs and drive improved access where appropriate?

The first step in commissioning of effective services is to understand population need. WHSSC identified a number of years ago that it needed to strengthen its capacity to do this work but has struggled to recruit into these roles, this situation worsened during the pandemic.

59. Should health boards, as part of their own population needs analysis, do this work on behalf of WHSSC?

60. Are there any other NHS organisations or non-NHS organisations who could undertake this work on behalf of WHSSC?

61. What organisations might these be?

WHSSC has expertise in horizon scanning and evidence evaluation and uses this expertise to collate information and evidence from a variety of sources. This ensures that our services are under-pinned by research, knowledge and information, whilst embracing and promoting new therapeutic, technological and digital innovations to drive value from specialised services. It is key to informing our prioritisation process for introducing new interventions in Wales.

62. Does this approach adequately meet the needs of NHS Wales and if not what additional approaches should we take?

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APPENDIX 3.

Equalities Engagement Opportunities (Services to be populated)

Protected Characteristic	Relevant Group	Specialised Service(s) This is not exhaustive but gives examples of key services these groups may access	Identified as having a Disproportionate or Differential need (for Specialised Services)	Face to Face Events	Virtual Events	Online Questionnaire
Age	Children under the age of 16	Paediatric Services, Gender Identity Services for CYP, CAMHS, Forensic Adolescent Consultation and Treatment Service, Cochlear and BAHA Services	Y	Y	Y	Y
	Young people 16-18	Gender Identity Services for CYP, Specialised Eating Disorder Services, CAMHS, Forensic Adolescent Consultation and Treatment Service	Y	Y	Y	Y
	People of working age		N	N	Y	Y
	People aged 65+	Complex Cardiology, Cardiac Services, Cancer Services	Y	Y	Y	Y
Sexual Orientation and Gender Identity	LGBTQI+, Trans men and Trans women	Gender Identity Services	Y	Y	Y	Y
Ethnicity	People from BME communities	Hereditary Anaemias Service	Y	Y	Y	Y
Disability	Physical disability, sensory and/or visual impairment, long term condition	Mental Health Services for Deaf People, Cystic	Y	N	Y	Y

		Fibrosis Service, ALAC Services				
	Mental health condition	High Security and Medium Secure Psychiatric Services, Traumatic Stress Wales	Y	Y	Y	Y
	Learning or neurological disability and autism	Neuroscience Services	Y	Y	Y	N
Pre-Pregnancy, Pregnancy or Maternity	Women trying to conceive / pregnant women/had a child in last year / adolescent mothers and fathers	Specialised Perinatal Services, Neonatal Services, Fetal Services, IVF	Y	Y	Y	Y
Sexual Orientation	LGBQ+ Population		N	Y	Y	Y
Gender	Women	von Willebrand Disease Services	Y	Y	Y	Y
	Men	Complex Haemophilia Services	Y	Y	Y	Y
Marital Status	Married, civil partnership, separated, divorced		N	Y	Y	Y
Religion or Belief	Religious holidays, pharmaceutical ingredients, certain treatments		N	Y	Y	Y
Carers	Young, adult, parent carers		N	N	Y	Y
Social and Economic Deprivation	Health literacy, mobility/ability to travel, digital literacy		N	Y	N	N
Seldom Heard	Gypsy, Roma and traveller communities		Y	Y	N	N
	Homeless people and people in temporary accommodation		N	Y	N	N
	Refugees, migrants and asylum seekers		Y	Y	Y	Y
	Substance misuse difficulties		N	Y	N	N
	Housebound people		N	N	Y	Y

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Specialised Services Strategy Development
Key Stakeholder Survey

Welsh Health Specialised Services (WHSSC) is writing a new 10 year strategy for specialised services for the residents of Wales.

Welsh Health Specialised Services Committee (WHSSC) is a Joint Committee of the seven Local Health Boards (LHBs) in Wales. The seven LHBs are responsible for meeting the health needs of their resident population, and have delegated the responsibility for commissioning a range of specialised services to WHSSC.

The aim of developing a specialised services strategy is to ensure that residents in Wales can now, and in the future, receive equitable access to high quality specialised services, which are clinically effective, offer the best experience and clinical outcomes for patients and the population, and increase the value that is derived from the resources available.

Specialised services generally have a higher unit cost as a result of the nature of the treatments involved. They are a complex and costly element of patient care. The particular features of specialised services, such as the relatively small number of centres and the unpredictable nature of activity, require robust planning and assurance arrangements to be in place to make the best use of scarce resources and to reduce risk. It is critical that specialised services treat a certain number of patients per year in order to remain sustainable, viable and safe. This also ensures that care is both clinically and cost effective.

Treatments have improved and there are an increasing number of treatment options available for patients with more advanced disease, all creating a growing demand for specialised services.

Development of a specialised services strategy post COVID-19 now provides the opportunity to shape the direction to focus on recovery, value, and to exploit new technologies and innovative ways of working.

Because of the pace of change in specialised services the strategy will require a review in 5 years to consider whether it remains fit for purpose for the following 5 year period.

WHSSC is looking for your support in writing the plan by asking a number of questions that they would like your view on.

All replies to these questions will be kept anonymous, but we will share the feedback

received so people can see that WHSSC has listened to people's views.

Not all questions are relevant to all our stakeholders. If you feel a question is not directly relevant to you please complete the box with not applicable (N/A) and move on to the next question.

Where questions are relevant to you, please provide as much information in your response as possible.

Section 1. Information about you.

1. Are you responding on behalf of a group/organisation or as an individual?

- [ ] Group/Organisation (answer questions 2 – 4)
- [ ] Individual (answer questions 5 – 12)

2. What is the name of your group or organisation?

3. What geographical area does your group or organisation fall under?

- [ ] Betsi Cadwaladr University Health Board
- [ ] Powys Teaching Health Board
- [ ] Hywel Dda University Health Board
- [ ] Swansea Bay University Health Board
- [ ] Cwm Taf University Health Board
- [ ] Cardiff & Vale University Health Board
- [ ] Aneurin Bevan University Health Board
- [ ] National/All Wales
- [ ] NHS England
- [ ] Other

4. If other, please state?

5. What is your age?

- [ ] Under 16
- [ ] 16 – 18
- [ ] 19 – 49
- [ ] 50 – 69
- [ ] 70+
- [ ] Prefer not to say

6. What is your gender?

- [ ] Female
- [ ] Male
- [ ] Non-binary
- [ ] Prefer not to say

7. How would you describe your national identity?

- [ ] Welsh
- [ ] English
- [ ] Scottish
- [ ] Northern Ireland
- [ ] British
- [ ] Other
- [ ] Prefer not to say

8. If other, please state?

9. How would you describe your ethnic group?

- [ ] White
- [ ] Mixed or multiple ethnic groups
- [ ] Asian, Asian Welsh, Asian British
- [ ] Black, Black Welsh, Black British, Caribbean or African
- [ ] Other Prefer not to say

10. If other, please state?

11. What geographical area does your group or organisation fall under?

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55. What partnerships would these be?

56. What other tools can WHSSC use to measure the wider value of a service to inform future commissioning?

WHSSC has committed to embedding outcome evaluation and outcome based commissioning into specialised services. It is important to understand however, that as a commissioner of only one part of the patient pathway, the options for using outcomes and increasing value are different to those with health boards. For example, WHSSC commissions' in-patient Children and Adolescent Mental Health Services (Tier 4 CAMHS) however, the numbers of patients referred into the service and the length of time children stay in the service varies between health boards. There is some evidence that this variation is related to differences in services within health boards. WHSSC however does not commission the health board services and therefore cannot, for example, increase investment in secondary care CAMHS (Tiers 2 and 3) to potentially avoid admissions into Tier 4 services.

57. Given the limitations outlined above, what opportunities are available to WHSSC to drive value from the patient pathway or use outcome data to drive continuous improvement?

WHSSC now has good quality data in many specialty areas on access rates to specialist services. These data are shared on an ad hoc basis with the boards of health boards and staff from commissioning teams within health boards have direct access to the Power BI system which holds the data. It is important to WHSSC use these data to drive equitable access to services and to ensure it can meet its socio-economic duty.

58. What other mechanism could WHSSC use to raise awareness of access rates within HBs and drive improved access where appropriate?

The first step in commissioning of effective services is to understand population need. WHSSC identified a number of years ago that it needed to strengthen its capacity to do this work but has struggled to recruit into these roles, this situation worsened during the pandemic.

59. Should health boards, as part of their own population needs analysis, do this work on behalf of WHSSC?

- [ ] Yes
- [ ] No

60. Are there any other NHS organisations or non-NHS organisations who could undertake this work on behalf of WHSSC?

- [ ] Yes
- [ ] No

61. What organisations might these be?

WHSSC has expertise in horizon scanning and evidence evaluation and uses this expertise to collate information and evidence from a variety of sources. This ensures that our services are under-pinned by research, knowledge and information, whilst embracing and promoting new therapeutic, technological and digital innovations to drive value from specialised services. It is key to informing our prioritisation process for introducing new interventions in Wales.

62. Does this approach adequately meet the needs of NHS Wales and if not what additional approaches should we take?

Section 5. Final Comments.

Thank you for your time in completing this survey. Your feedback will be used to support the development of a ten year strategy for specialised services.

Please use the box below to provide any further comments or feedback you may have.

Paediatric Services deep-dive

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Background

- Request at July Joint Committee to undertake paediatric deep dive

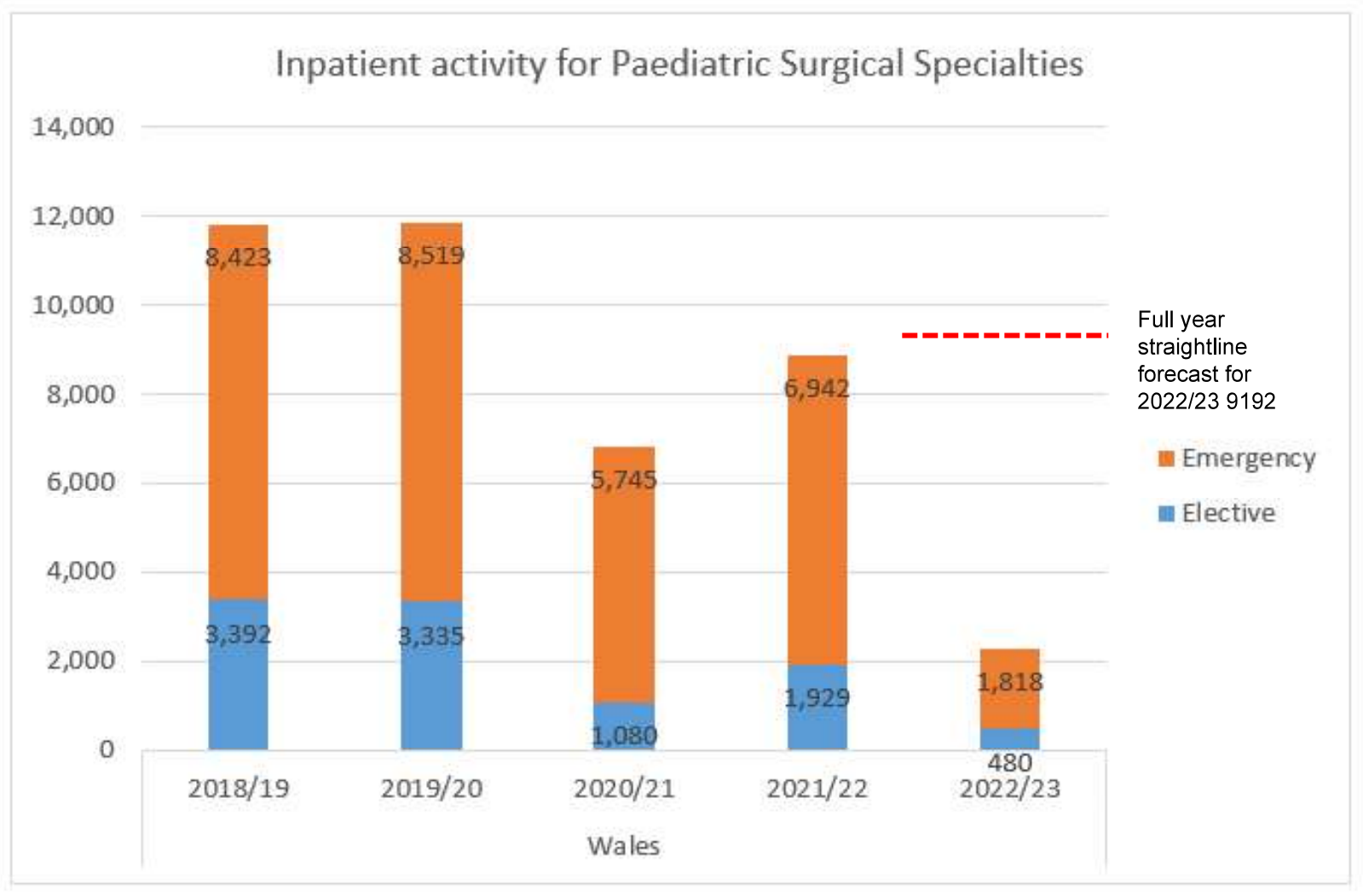
- Agreed to consider
  - Any changes in patterns referral / activity
  - performance data for children's services by both provider and HB of residence

Data source and caveats

- Data source - Digital Health and Care Wales (formerly NWIS) APC and RTT database.
- All surgical specialties between 1/04/2018 and 30/06/2022 on 'episode end date'
- Patients 0-15 years (up to 16th birthday) resident in Wales.
- The data does not identify whether the patient had a surgical procedure.

Paediatric surgical activity delivered by all Health Boards

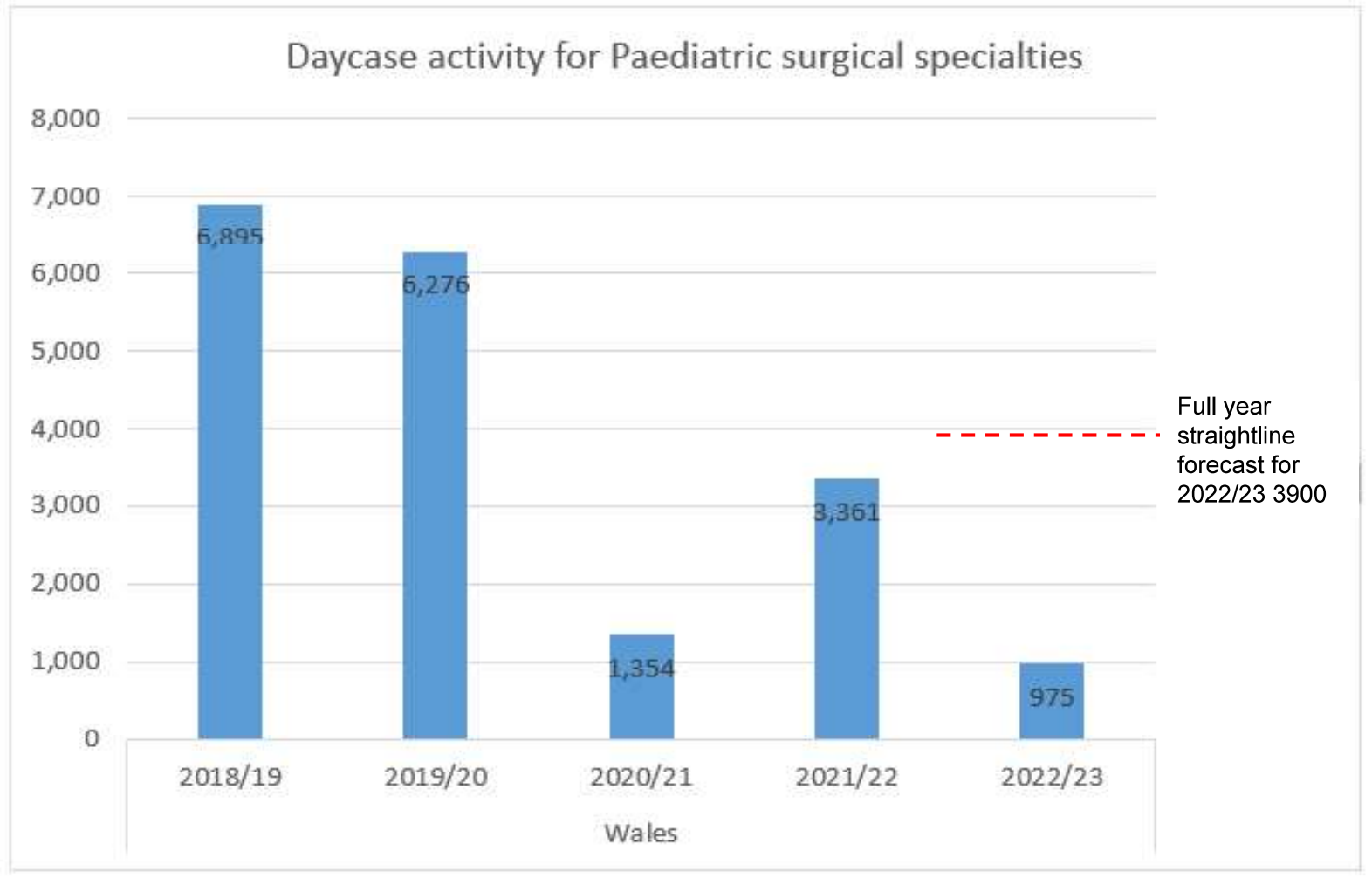
Inpatient activity for Welsh residents for paediatric surgical specialties undertaken by Welsh providers by financial year



5

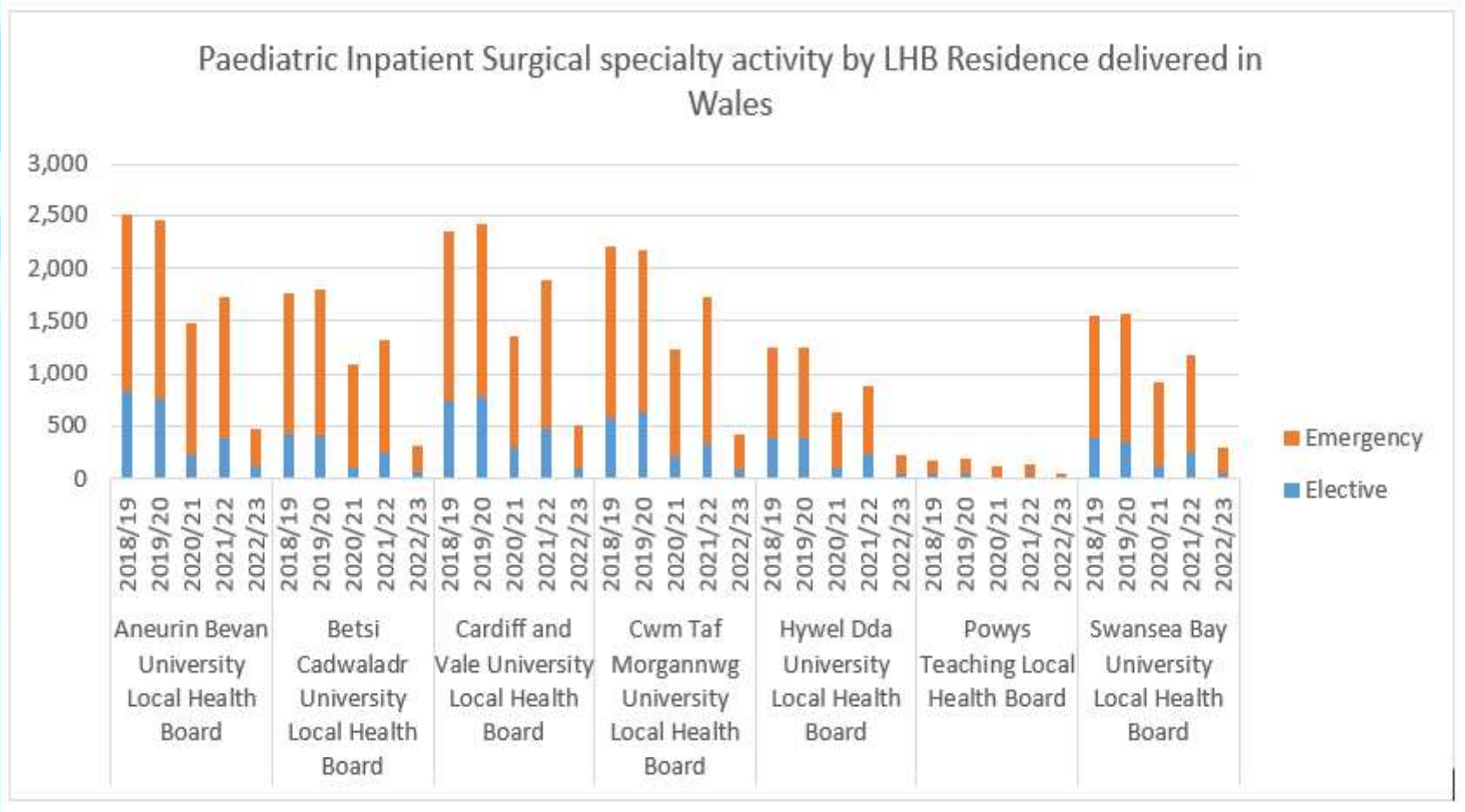
Source: DHCW

Daycase activity for Welsh residents for paediatric surgical specialties undertaken by Welsh providers by financial year.



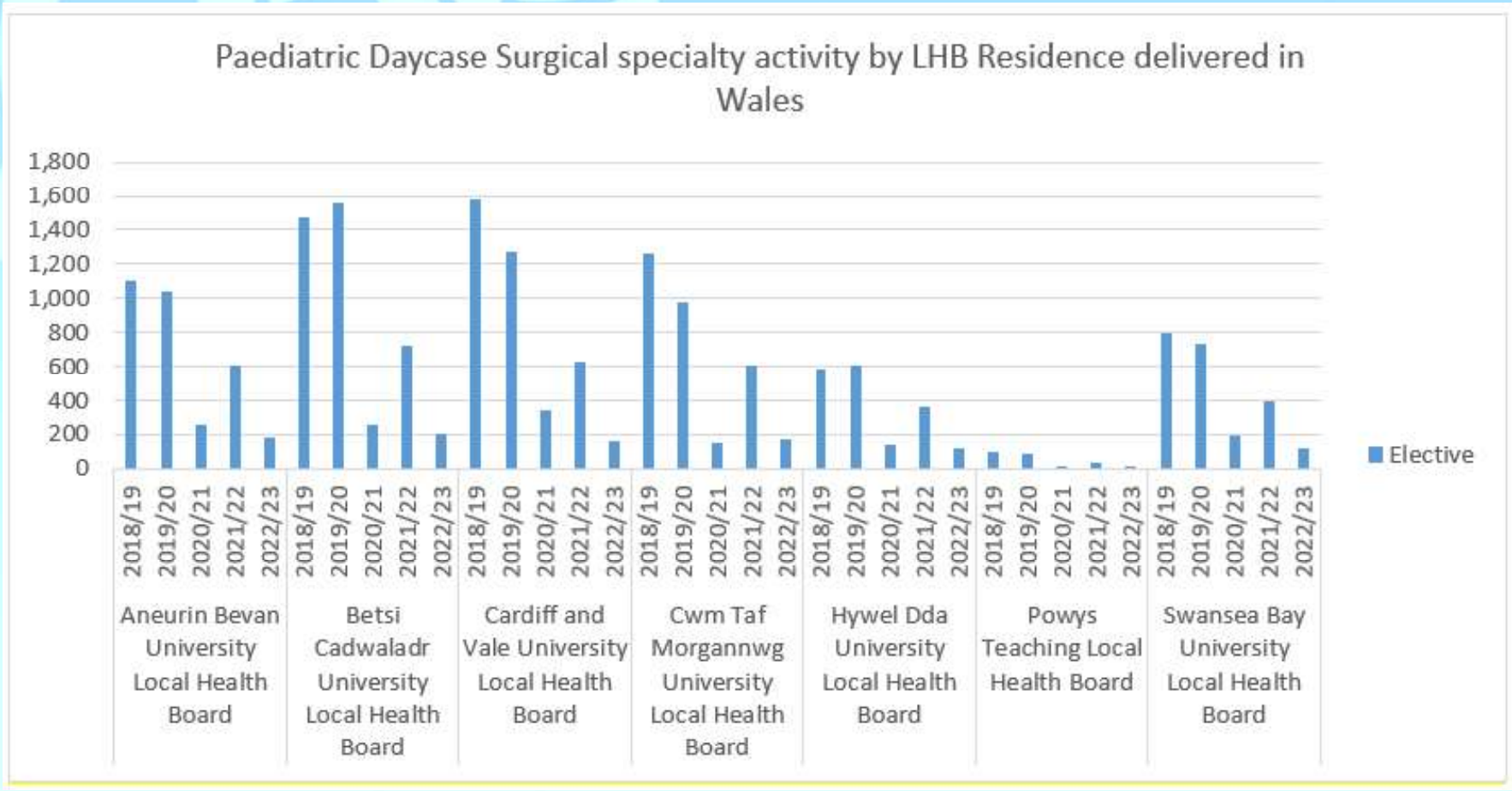
Source: DHCW

Inpatient activity by LHB residence for paediatric surgical specialties for Welsh providers combined



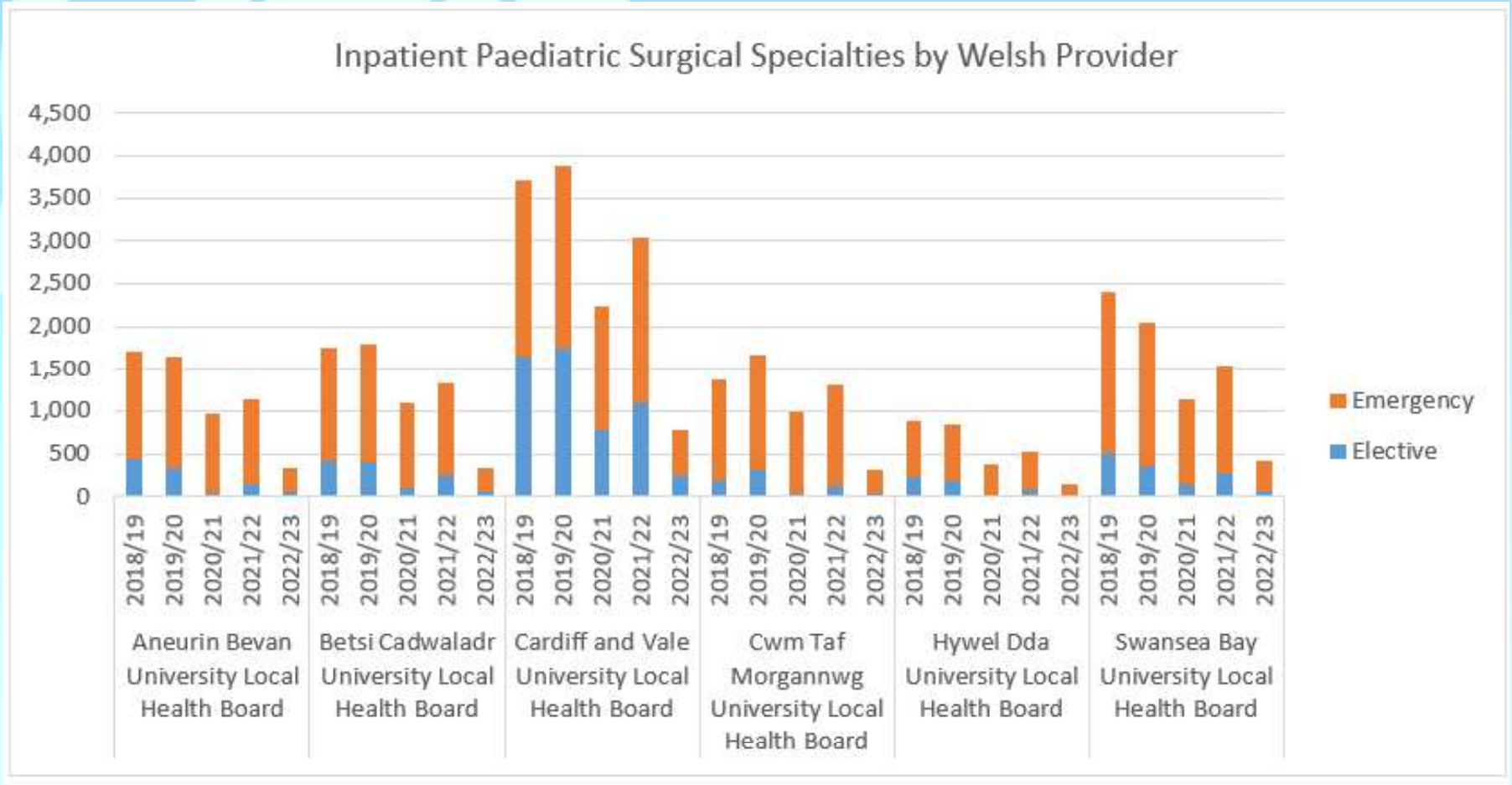
Source: DHCW

Daycase activity by LHB residence for paediatric surgical specialties for Welsh providers combined



Source: DHCW

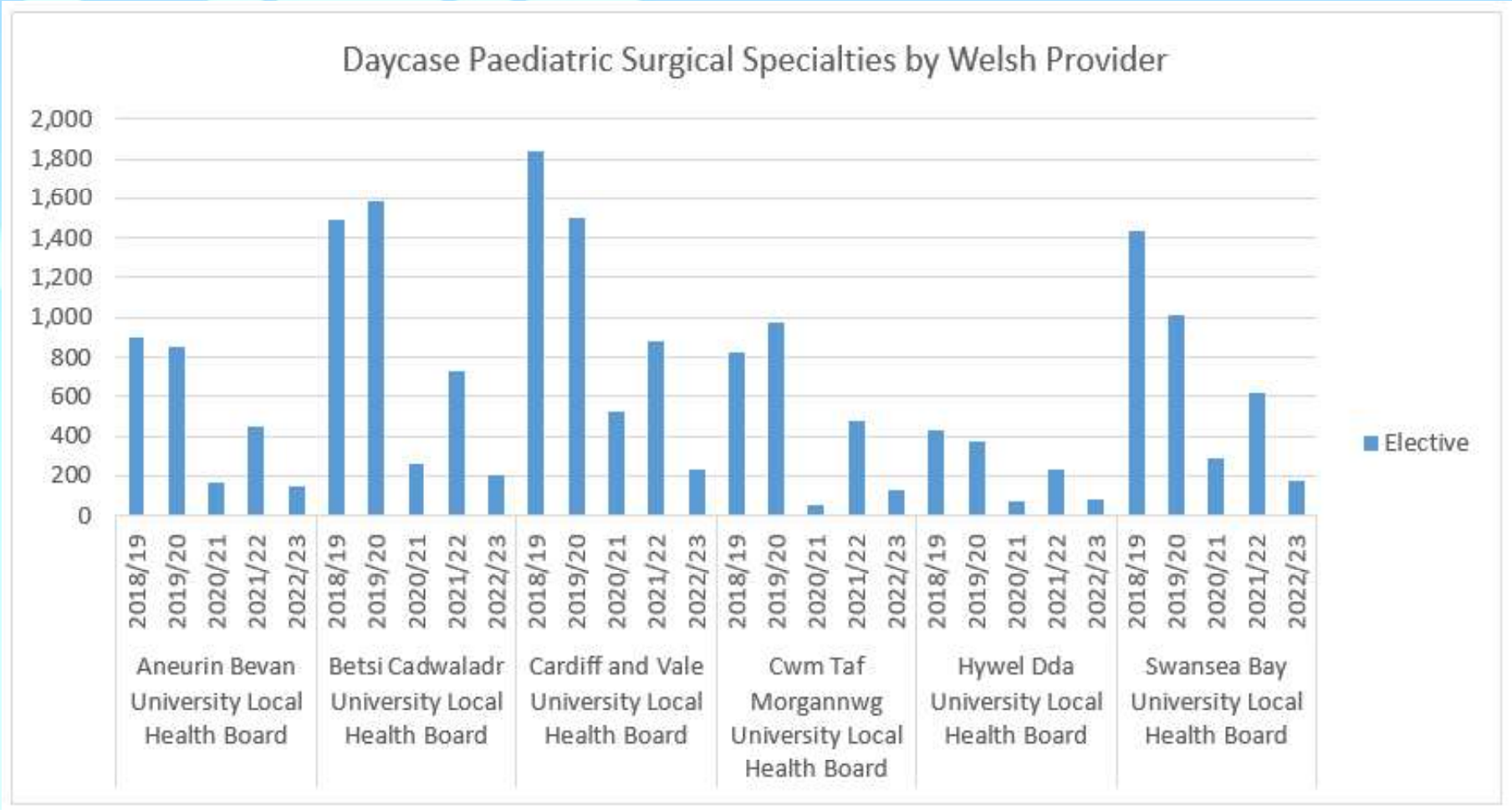
Inpatient activity for paediatric surgical specialties for individual Welsh providers



9

Source: DHCW

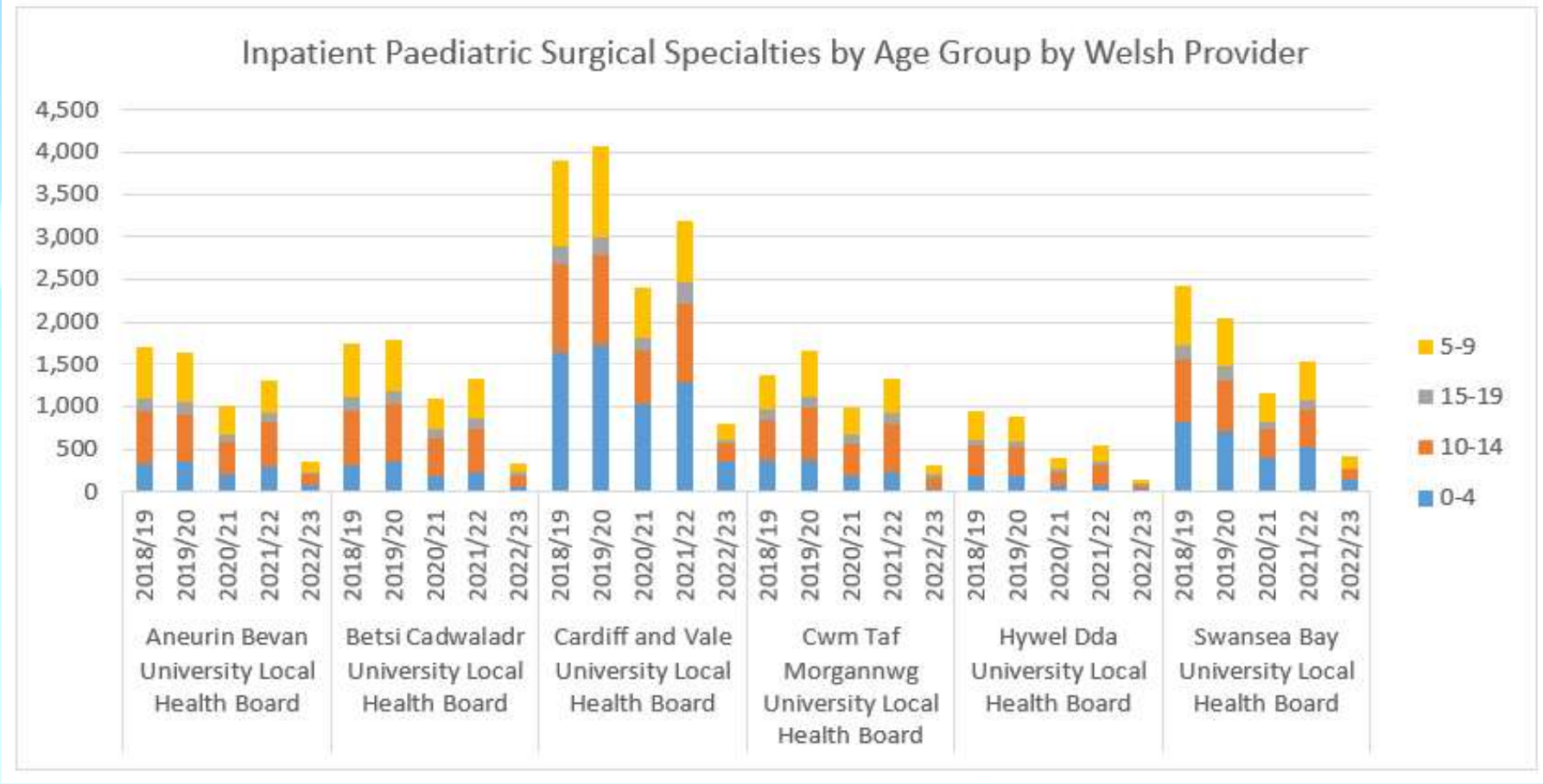
Daycase activity for paediatric surgical specialties for individual Welsh providers



10

Source: DHCW

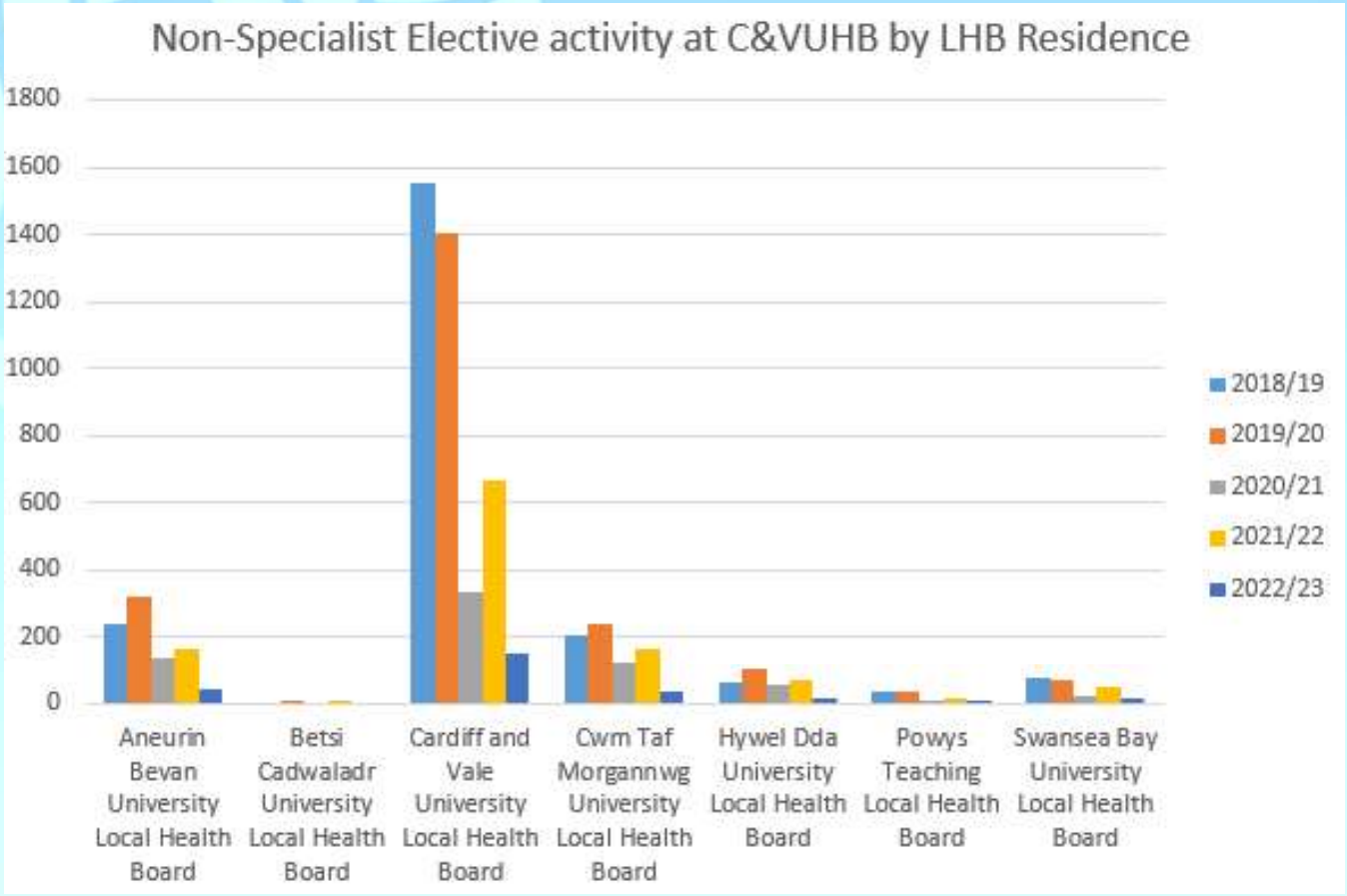
Age Groups for inpatient paediatric surgical specialties for individual Welsh providers, for Welsh children



11

Source: DHCW

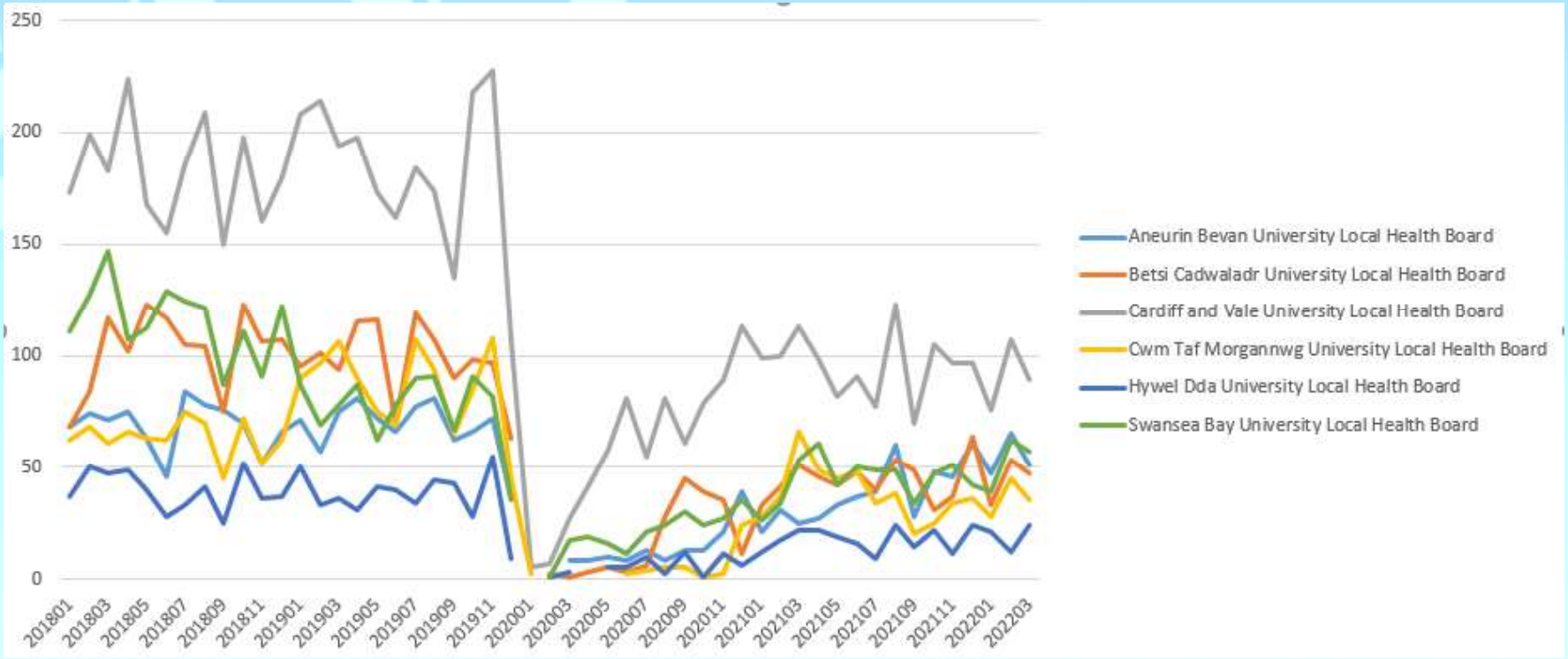
Assumed non-specialist activity at C&VUHB for all LHBs (based on Alder Hey coding)



12

Source: DHCW

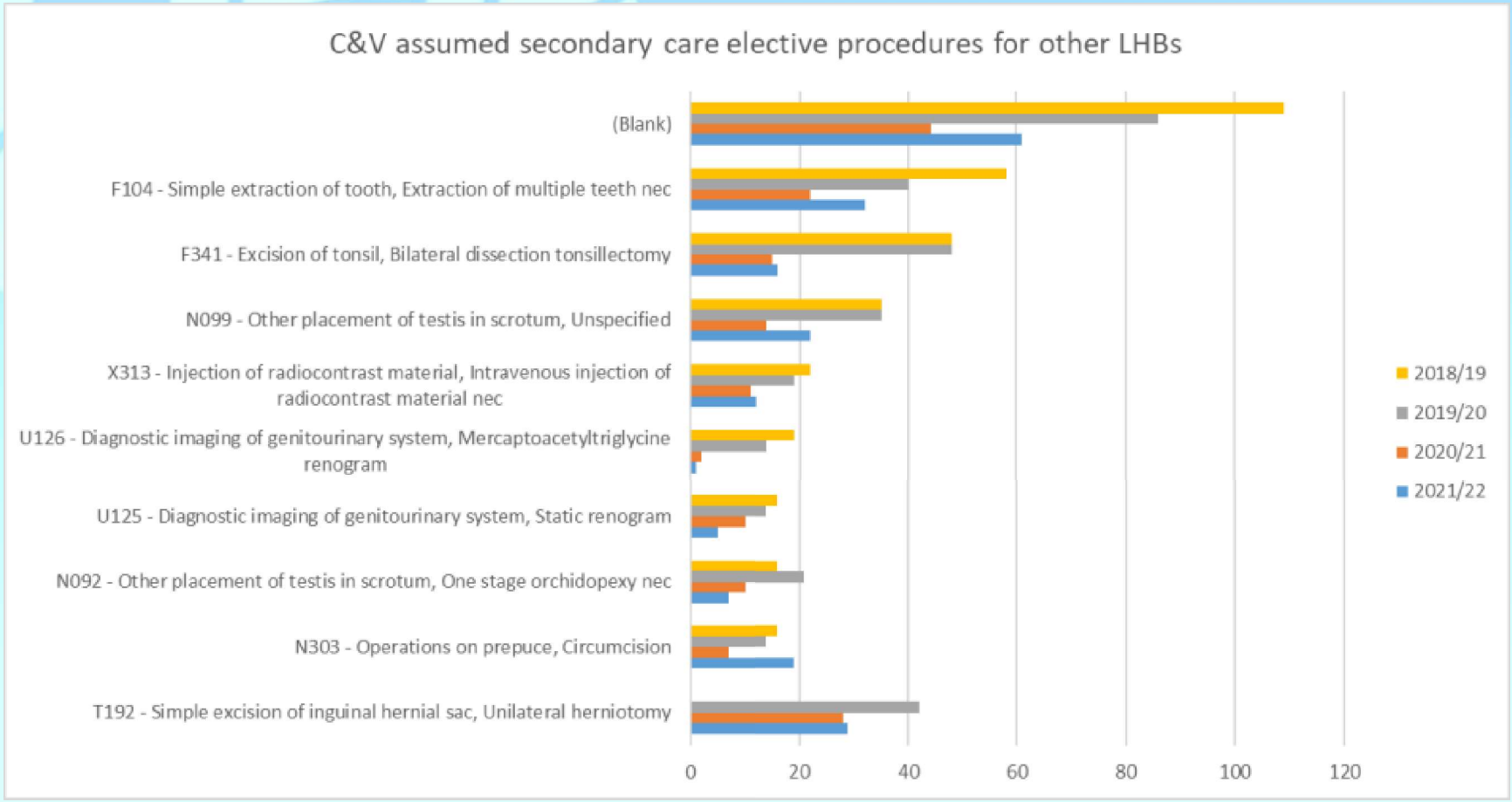
Non-specialist activity trends for all LHBs (based on Alder Hey coding)



13

Source: DHCW

C&VUHB assumed secondary care elective procedures for other LHBs (excl. C&VUHB residents)

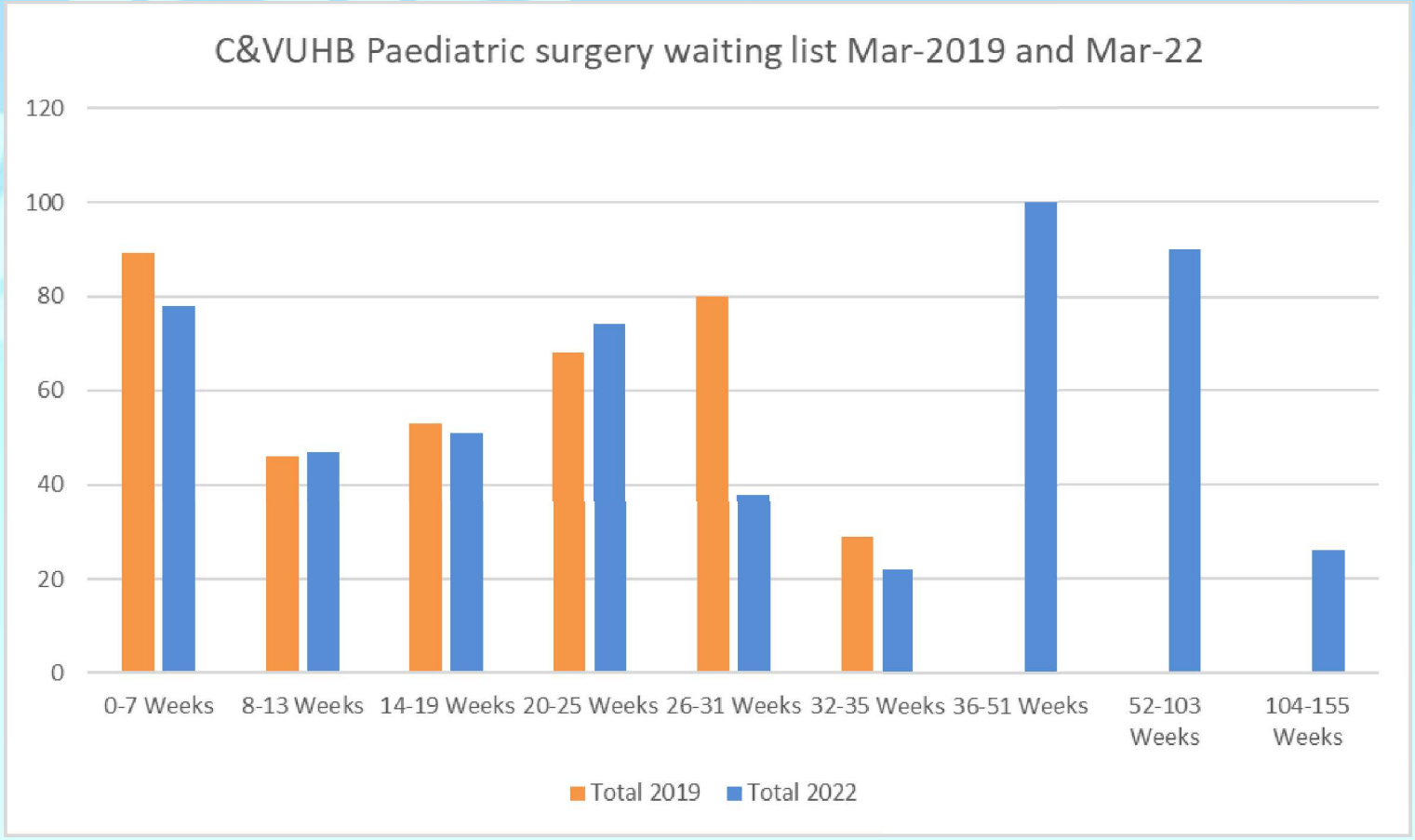


14

Source: DHCW

Cardiff and Vale UHB waiting list analysis

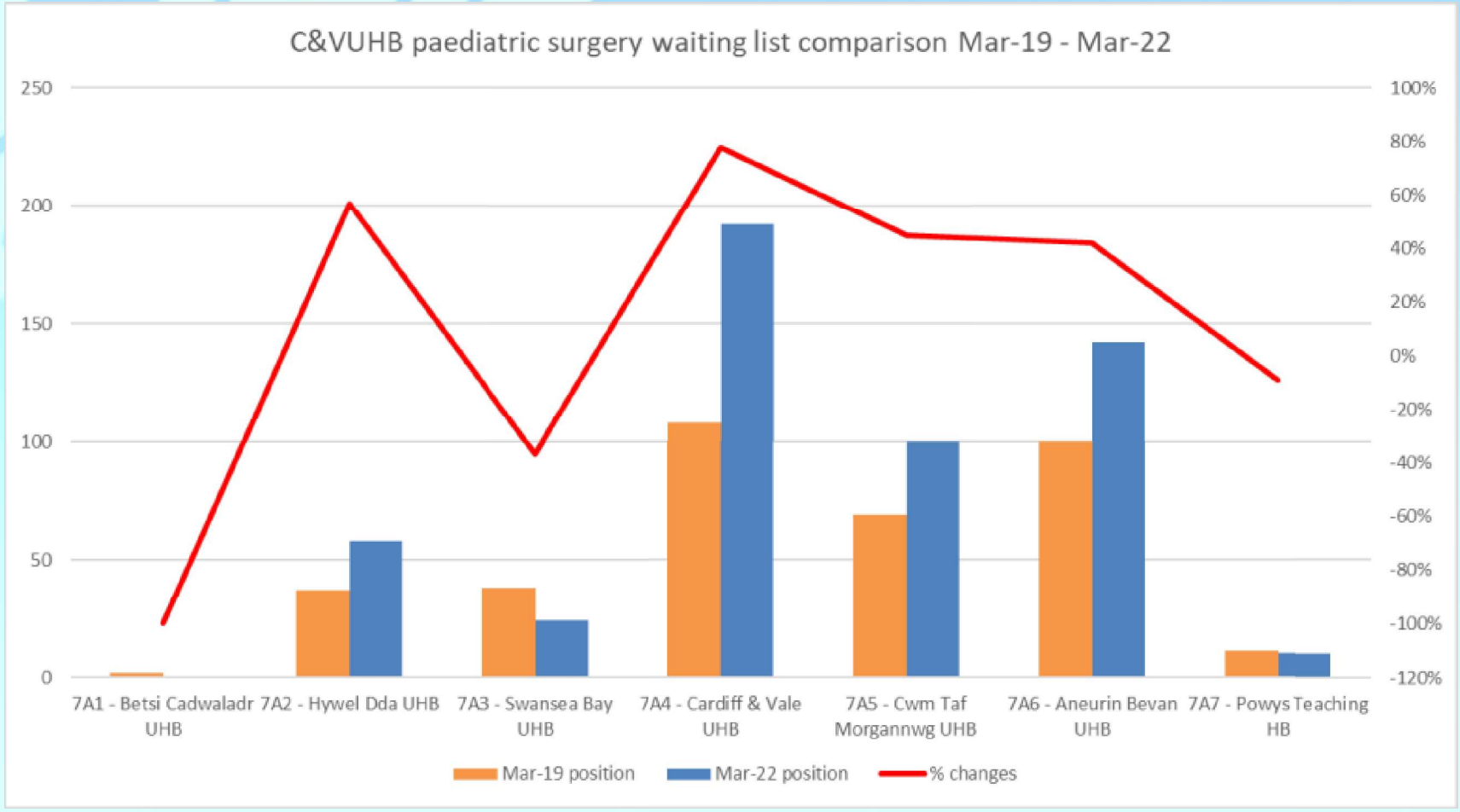
C&VUHB Paediatric surgery waiting list Mar-19 and Mar-22



16

Source: C&VUHB

C&VUHB Paediatric surgery total IP/DC waiting list comparison Mar-19 – Mar-22

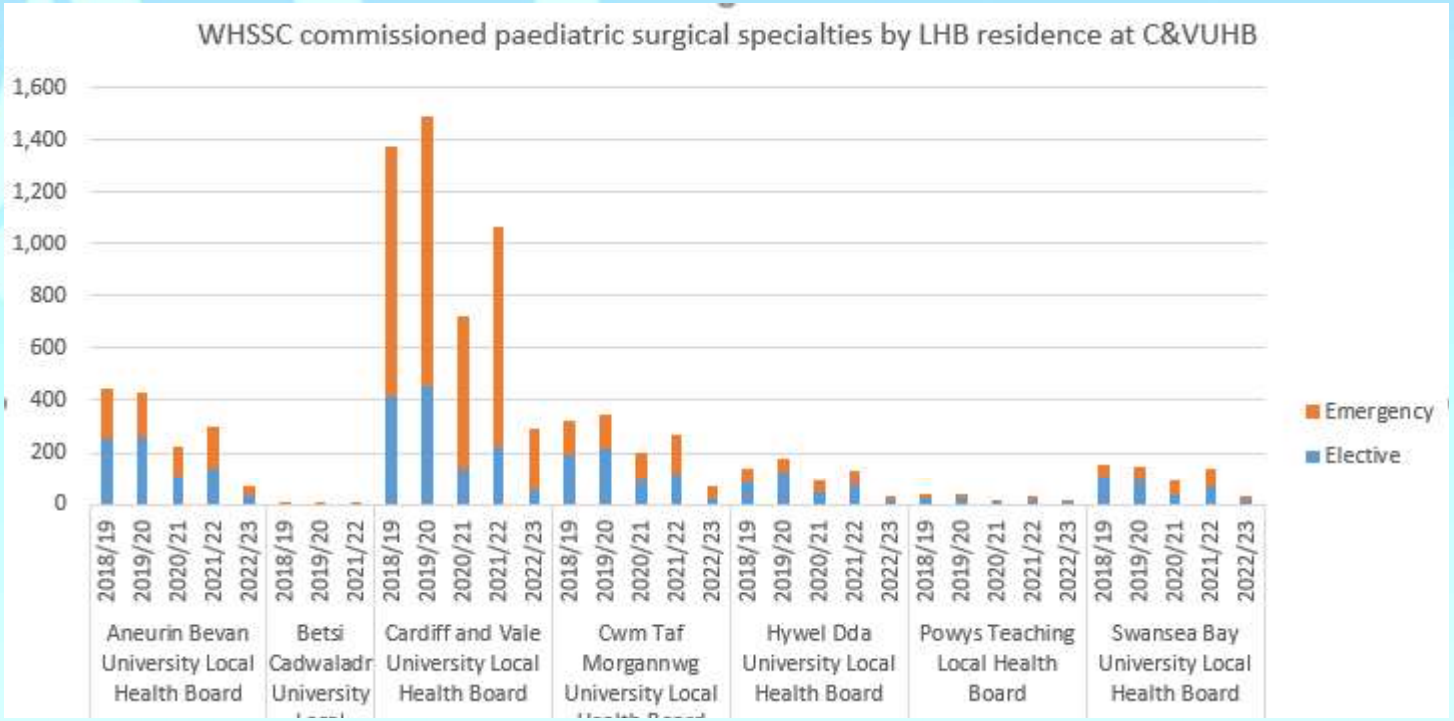


17

Source: C&VUHB

Activity – WHSSC commissioned services

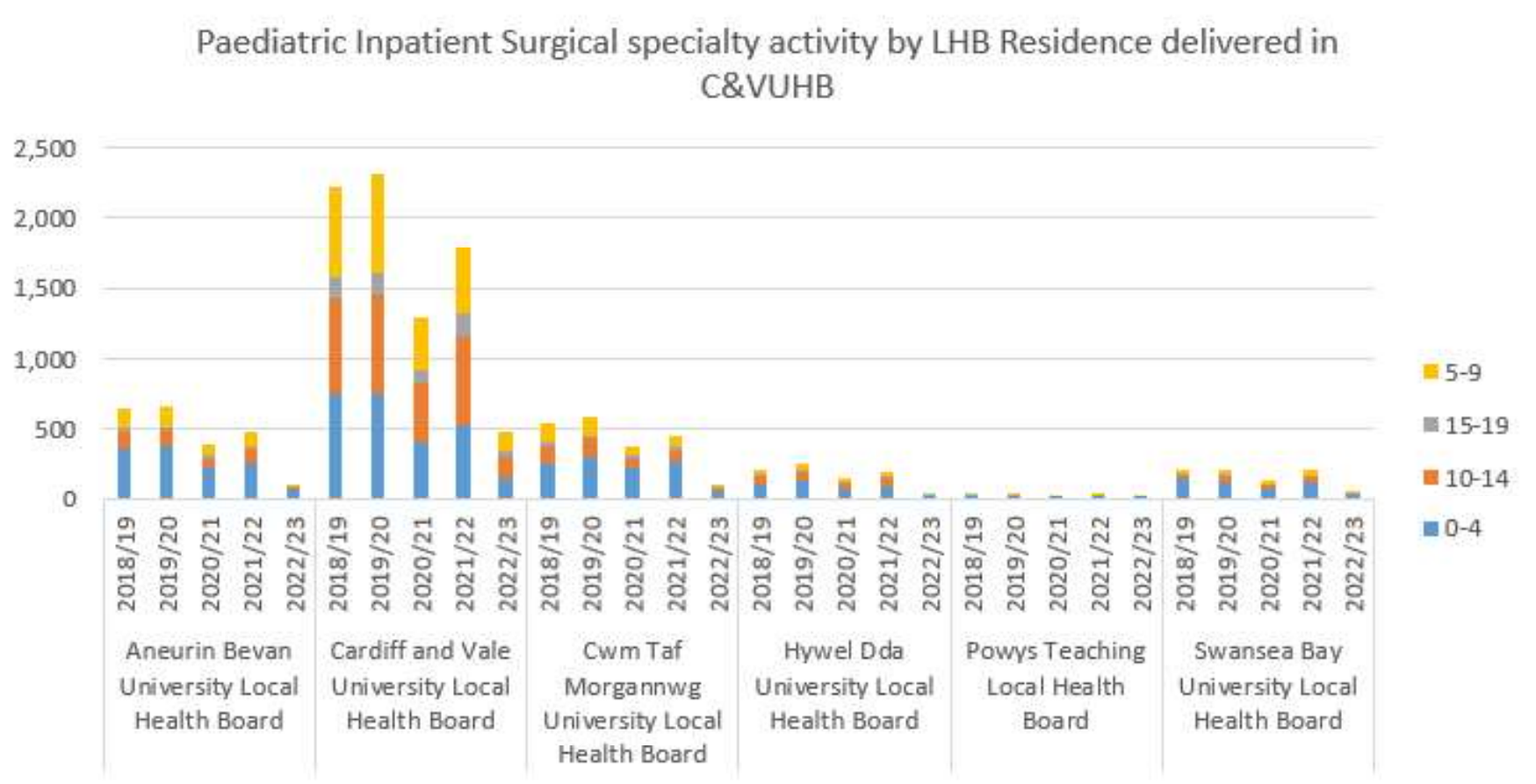
WHSSC commissioned inpatient activity for paediatric surgical specialties for C&VUHB



19

Source: DHCW

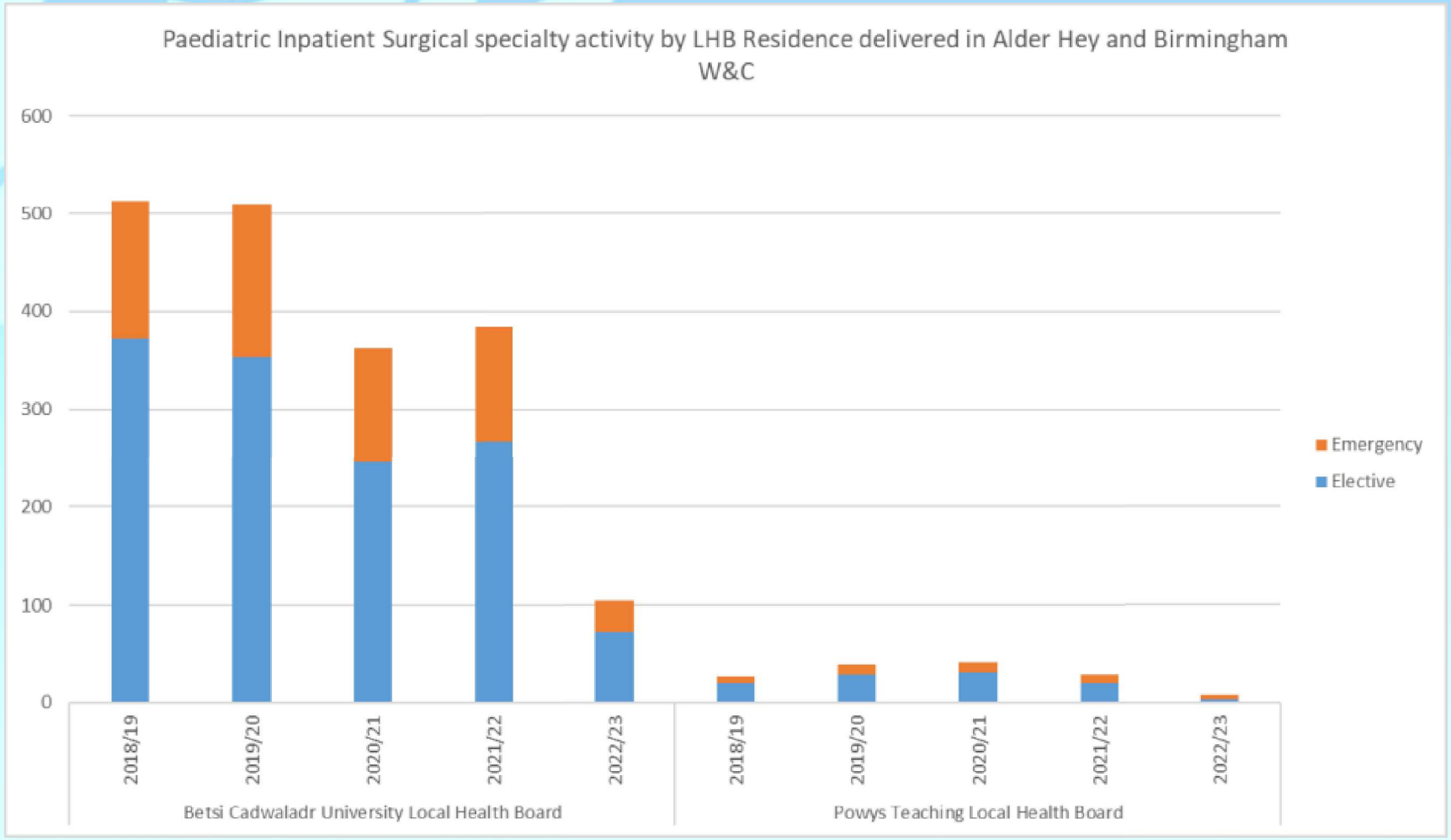
Age Groups for inpatient paediatric surgical specialties at C&VUHB, for Welsh children



Source: DHCW

WHSSC commissioned English provider analysis

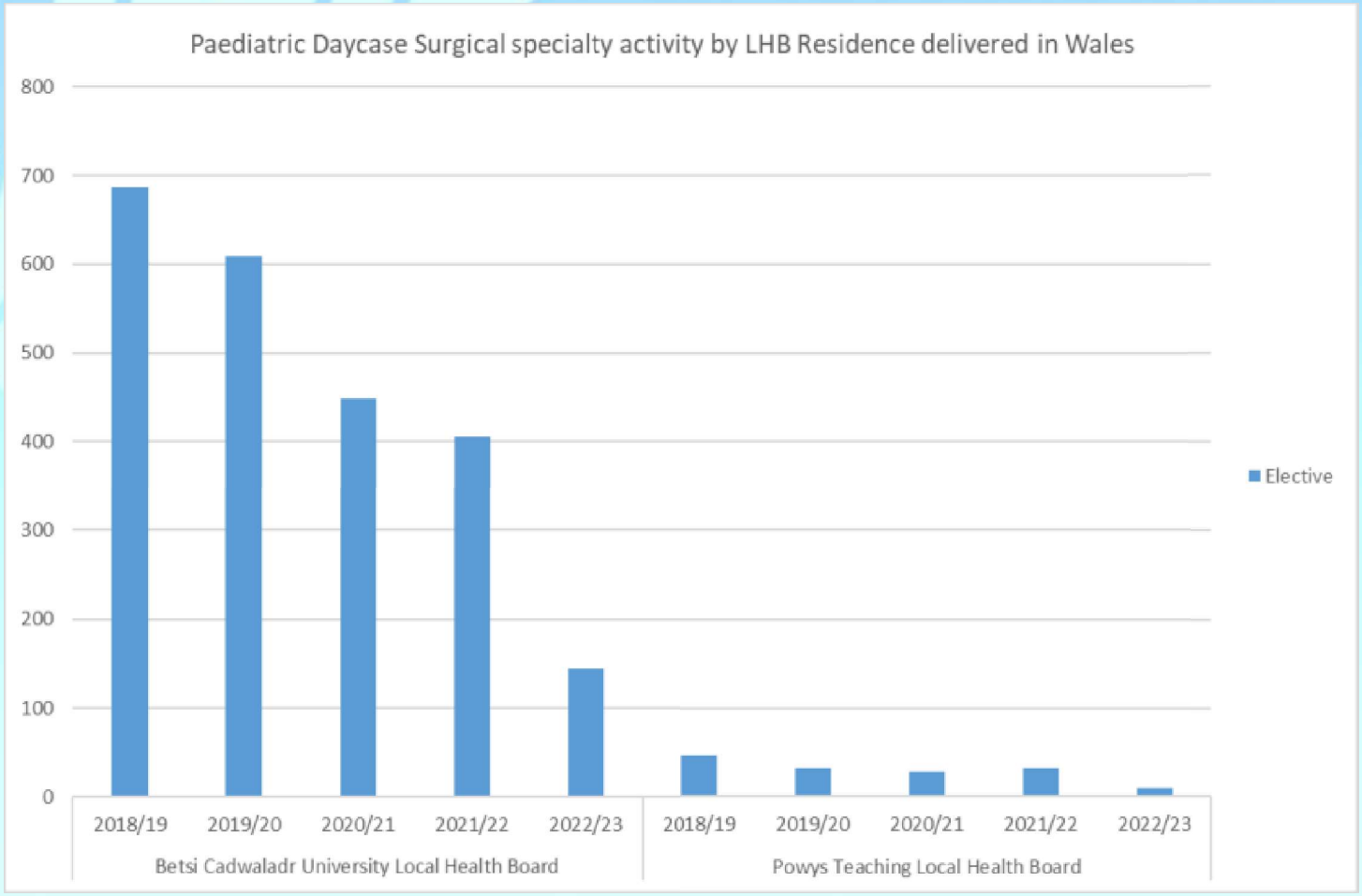
WHSSC commissioned inpatient activity for paediatric surgical specialties for Alder Hey and Birmingham W&C



22

Source: DHCW

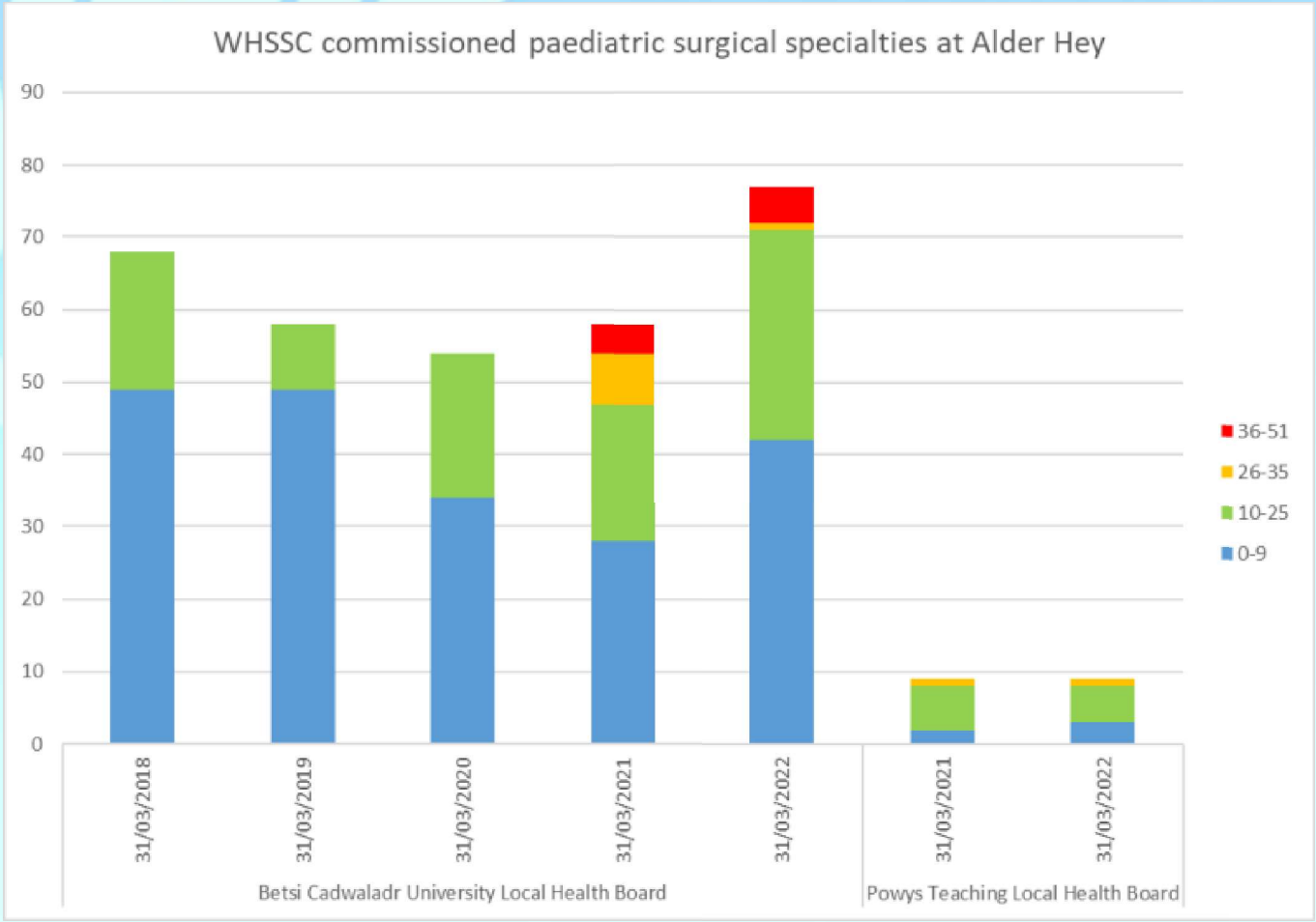
WHSSC commissioned daycase activity for paediatric surgical specialties for Alder Hey and Birmingham W&C



23

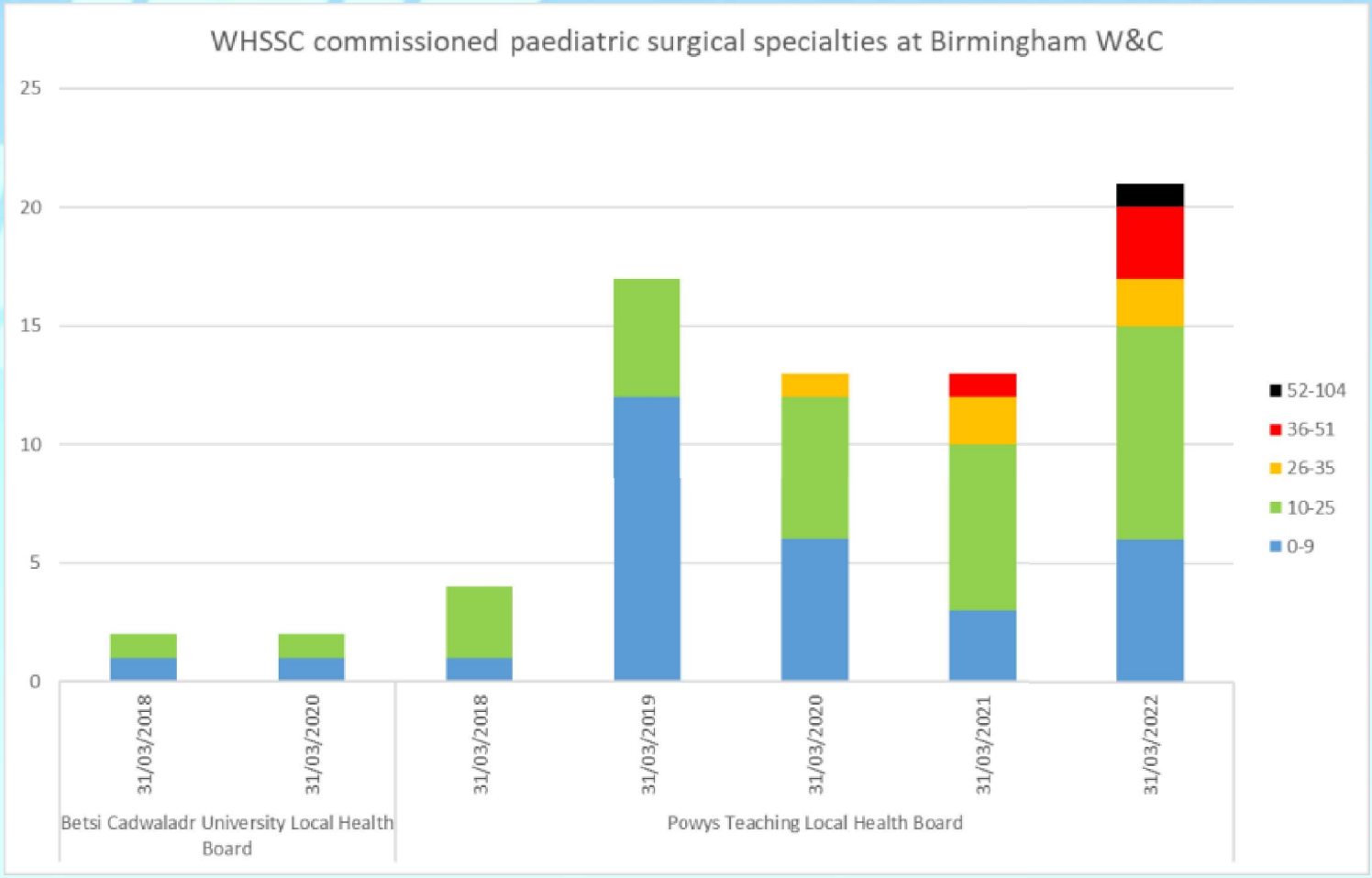
Source: DHCW

Alder Hey Paediatric Surgery waiting list positions for paediatric surgical specialties



Source: DHCW

Birmingham W&C waiting list positions for paediatric surgical specialties



25

Source: DHCW

Conclusions?

- Patterns suggest that there is no differential treatment of children in CHfW
- There is nothing from these data to suggest increased activity in CHfW from other HBs
- But there maybe some INNU activity at CHfW?
- Waiting lists at CHfW remain long and longer than Alder Hey

GIRFT Report Paediatric General Surgery & Urology

- Published February 2021
- Reviewed 89 Trusts in **England**
- Headlines
  - Expertise is spread too thinly
  - Unequal system for pre term babies
  - Care for children with acute appendicitis needs to improve
  - Boys with testicular torsion need prompt surgery
  - Need widespread adoption of evidence based children's surgery
  - Need to improve experience for children

What can we do?

- Review INNU list, cross match with referral to ChfW and tighten as required
- ? Look for outsource options to reduce waits at ChfW
- Develop different prioritisation criteria for children and implement
- This means that additional capacity would need to be brought on line
- All implement GIRFT recommendations