Health & Social Services Committee

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Date: Wednesday 6 October 2004
Venue: Committee Room 3, National Assembly for Wales
Title: Ministerial Report

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1. INSPECTION OF CHILDREN'S SERVICES IN BLAENAU GWENT:

PROGRESS REPORT

Performance as at 31 July 2004

Introduction

1.1 In accordance with the intervention protocol the Chief Inspector of Social Services for Wales has met with the Chief Executive, the interim Director of Social Services to discuss the specific improvements required, and the inspection and monitoring arrangements for evaluating progress.

1.2 Following the meeting, the Chief Inspector confirmed by letter (dated 3 June) which was discussed by Health and Social Services Committee in June, the 3 priority areas on which the authority should focus, to provide a sound basis upon which sustained improvement can be made. These are:

- Progressing Specific Casework issues
- Strengthening Quality Assurance - Systems, Processes and Procedures,
- Development of systems to generate reliable information to monitor and manage performance

1.3 The authority was required to report on progress at 31 July.

Fieldwork

1.4 SSIW has deployed Inspectors to scrutinise the information provided by the authority and undertake some reality checks. Since June, Inspectors have spent a day in the authority and the Chief Inspector has held a meeting with Senior Managers.

Progress

1.5 The authority continues to co-operate with SSIW in this process. There is evidence of considerable activity to address the serious deficiencies in children's social services and of a clear commitment on the part of the Interim Senior Management Team to bring about the necessary improvements.

1.6 The information provided by the authority demonstrates that it is by now able to provide most of the required information, although there are still questions about reliability, relating to initial and core assessments.

1.7 The information reveals that Blaenau Gwent has made only limited progress in tackling the significant problems in its children's services. A higher proportion of children have an up-to-date plan and more reviews for looked after children are being completed on time. However, compliance with statutory requirements remains too inconsistent. There are still a significant number of children on the child protection register and looked after children who do not have an allocated social worker. The

authority has been trying to rectify the deficits identified by the inspectors. The general quality of assessment and case management remains poor.

1.8 The authority has been slow in dealing with the cases referred back for further action and has made little progress in putting in place the policies and procedures needed to support practice improvement and assure compliance with regulations and guidance.

1.9 Many of first line managers have either left or are in the process of leaving the authority. Interim arrangements have been made to cover these posts, but this does mean that there is little long-term stability in the management structure.

1.10 The permanent posts for the senior management team have now been advertised, including those of Director of Social Services and Assistant Director for Children's Services. The authority hopes to have these filled by the end of 2004, with senior managers taking up post early in the New Year. The authority is now planning how to put in place the necessary arrangements to secure a smooth transition to the permanent management team.

1.11 The problems in social services reflect wider management and corporate governance problems. The authority is tackling these with the assistance of the Advisory Board set up under the Wales Programme for Improvement. With the Minister for Finance, Local Government and Public Services, I recently met the Chair of the Board, David Jenkins, to review progress. While there is still much work to be done, the Board is getting to grips with those problems and progress has been made. The authority has taken steps to strengthen the Chief Executive's department and increase the management support to social services.

Summary

1.12 The Chief Inspector has underlined the importance for the senior management team of getting to grips rapidly with the outstanding issues and will be setting targets for the remainder of the year. The authority has a recovery plan in place, but the fundamental changes needed before the authority is able to improve its performance are taking time to put in place. The Chief Inspector's next report will assess the extent of the progress the authority is making.

Monitoring

1.13 The Chief Inspector will continue to monitor the authority's performance through receipt of quarterly performance reports and continuing visits to the authority by Inspectors to discuss, reality check and scrutinise information and services. I will continue to receive regular reports of progress and will meet the leader of the Council, senior members and officers in January.

2. INSPECTION OF CHILDREN'S SERVICES IN CARDIFF: PROGRESS REPORT

Performance at 30 June 2004

Introduction

2.1 The Chief Inspector has put in place a formal programme of monitoring, with targets set on a quarterly basis that are aimed at moving the authority to the point where:

- it responds promptly and appropriately to referrals of concern about children
- the management of work with children and families is strengthened, there is compliance with regulations and guidance, and services safeguard children and promote their welfare.

2.2 These targets cover the production and implementation of guidelines and procedures, the process of strengthening management information systems, and improving service performance.

Fieldwork

2.3 Social Services Inspectorate Wales has deployed Inspectors to scrutinise the information provided by the authority and undertake some reality checks. Since the end of the reporting period, Inspectors have spent a day in the authority and the Chief Inspector has held a meeting with Senior Managers.

Progress

2.4 There continues to be evidence of considerable activity to address the serious deficiencies in children's social services, and of a clear commitment on the part of the Director of Social Services and the Chief Officer for Children's Services, supported by the Chief Executive, to bring about the necessary improvements. Progress is being made in some areas of service but it is limited in others.

2.5 As a result of the poor performance in reviews of children identified by the Inspection, in particular those on the child protection register, the authority has concentrated on this area of work. This has led to a significant improvement in the percentage of reviews of children on the child protection register completed within required timescales and the authority has exceeded the target set by the Chief Inspector for the reviews of "looked after" children.

2.6 Progress in these areas is encouraging. However, the authority has not met some of the targets set by the Chief Inspector and a number of problem areas are being addressed. The authority continues to have difficulty in providing some of the information required, particularly in relation to assessments. The rate of referrals is volatile and the number of referrals rose by one third during the last quarter, the majority of which the authority reports is due to an increase in the number of domestic abuse referrals. Senior Managers have started a dialogue with senior police officers in order to address this.

2.7 The performance in relation to completion of initial assessments is significantly below target and for core assessments is very poor. Inspectors have identified problems in the authority's procedures and data

collection processes that work against achieving the required timescales and have required the authority to review these.

2.8 The child health and disability team has now cleared the backlog of cases identified at the time of the inspection. However, social workers are still not using the Assessment Framework as required. The authority intends to introduce "assessment coaches" to work on a one to one basis with social workers in the assessment and disability teams in a mentoring and monitoring role. In addition, the authority has introduced a system of weekly reporting on performance to the Chief Officer, Children's Services. The aim is to drive up quality and to reinforce the need for timely assessments.

2.9 The authority is bringing in an external consultant to develop its commissioning strategy, which is being implemented in draft form in September. The first stage is to undertake an audit of all children placed outside the authority.

2.10 Workforce issues remain a constant challenge to the authority and the Intake and Assessment team has lost a number of experienced practitioners, which could undermine the limited progress the team has achieved. It has arrangements in place to second a significant number of unqualified staff annually onto professional training courses. The recruitment campaign mentioned in my last report resulted in six appointments being made. Managers have concluded that it is unlikely that Children's Services will fill all its vacant social worker posts in the short to medium term. A review of the shape of the workforce is about to take place, with the intention of increasing the skill mix and the proportion of non social work to social work posts, while continuing to seek to recruit social workers to identified posts. Improvements in the quality of services provided will depend on the authority's ability to retain a trained and motivated workforce. A retention package for staff has been introduced, with up to 36 staff at any one time being seconded on to professional social work training courses, which is a very high figure.

Summary

2.11 Although the authority has not met some of the targets set, the Chief Inspector is of the view that it is continuing to demonstrate progress in a number of key areas, in particular reviews of children on the child protection register and "looked after" children. It needs to build on the progress made to date and the targets set are intended to be challenging and of themselves are "drivers for change" and the Chief Inspector has reinforced their significance with senior officers of the authority.

Monitoring

2.12 The Chief Inspector will continue to monitor the authority's performance through receipt of quarterly performance reports and continuing visits to the authority by Inspectors to discuss, reality check and scrutinise information and services. I will continue to receive regular reports of progress.

3. INSPECTIONS OF SERVICES FOR ADULTS WITH A PHYSICAL OR SENSORY IMPAIRMENT (OVERVIEW REPORT)

3.1 During 2001 and early 2002, the Social Services Inspectorate carried out six inspections of social services for adults with physical or sensory disabilities. The inspections examined how well local authorities were fulfilling their responsibilities to provide services, both directly and through partnerships with others, and how well placed they were to sustain and improve services. All the authorities concerned have received individual inspection reports and have all produced individual action plans. These have been reported previously in the press. This overview report of all six inspections provides some useful checklists for social services and service users to help evaluate progress in the future.

3.2 The overview report concluded that the needs of younger disabled people could be more effectively addressed if services were developed within a clear vision. The report suggests that such a vision could be based around the concept of independent living, which empowers disabled people to control their own lives as far as possible and have the freedom to participate fully in the community.

3.3 Social Services Inspectorate Wales, together with the appropriate policy units, will be working with a range of care partners to develop approaches that will address some of the main issues arising from the report. For example, Social Services Inspectorate Wales is working with SENSE Cymru to plan regional workshops, designed to help local authorities implement guidance on the development of services for people with a dual sensory impairment. In addition, local authorities are also working with partners on several benchmarking exercises, which include services for people with a visual impairment and adaptations.

4. LOCAL AUTHORITY SOCIAL SERVICES PERFORMANCE STATISTICS 2003-04

4.1 *"Local Authority Social Services Performance Management Statistics: Year Ending 31st March 2004"* was published on 20 August 2004.

Key results were:

- a fall in the numbers of care leavers with one or more GCSE (45% down to 41% - the Release comments on the small numbers of children involved)
- an increase in first placements of looked after children beginning with a care plan in place from 66% to 81%
- an increase in appropriately reviewed child protection cases from 73% to 81%
- a fall in the average delayed discharge rate
- an increase in the rate of assessments of people aged over 65
- increases in the rates of elderly and disabled supported to live at home

4.2 Data for the year ending 31 March 2004 are available for the 15 social services National Assembly for Wales Performance Indicators, together with other background statistical information on the

provision of services to help set the context for the indicators. More detailed data including figures for each local authority are available from the website of the Local Government Data Unit. The next annual release is planned for August 2005.

4.3 In addition work is underway to further develop and improve performance information as follows:-

Performance Information (WPI and SSIW)

4.4 There are two working groups at the present time, one looking at adult services and the other considering children's services. The information on adult services and children's services information has been developed and is at a final stage prior to consultation between October and December. The PI's are in four sectors / domains which are in line with SSIW's performance evaluation and Wales Programme for Improvement (WPI).

- Use of Resources, e.g. staffing; finance (gross costs of services).
- Access to services, e.g. meeting assessed needs.
- Service Delivery/Quality, e.g. proportion of assessments receiving services.
- Strategic/Policy Outcomes, e.g. access to mainstream community activities; carers offers of assessment; people supported to live in own home.

4.5 The next steps are expected to be:

- Confirmation of PI set (February 2005).
- Data collection begins in April 2005.
- Information ready for analysis by July 2006.

5. CARE COUNCIL FOR WALES CORPORATE AND OPERATIONAL PLANS

5.1 As required by the accountability and corporate planning frameworks for Assembly Sponsored Public Bodies, the Care Council for Wales has submitted its Corporate Plan for 2004-08 and its Operational Plan for 2004-05.

5.2 Both plans set out objectives and targets that underpin the Governments objectives for social care and reflect the priorities that I set out for the Council in its annual Remit letter.

5.3 The Council is clearly progressing its business within a strong governance framework, and this, too, is reflected in both plans.

5.4 I have agreed the high level objectives in the Corporate Plan and the targets set out in the Operational plan. I will be discussing these in more detail with the Council at the annual accountability meeting on 30 September 2004.

5.5 I look forward to this committee's scrutiny of the Council's work later in the year.

6. *"HEALTHCARE ASSOCIATED INFECTIONS – A STRATEGY FOR HOSPITALS IN WALES"*

6.1 You will know from statements I have issued and questions I have answered previously on healthcare associated infections that this is a subject I take very seriously indeed. The Welsh Assembly Government is committed to the prevention of as many healthcare associated infections as possible in Welsh hospitals. This includes MRSA, which forms a small percentage of all healthcare acquired infections.

6.2 On 9 September 2004, I launched "*Healthcare Associated Infections – A Strategy for Hospitals in Wales*". To support its implementation, I announced an extra £260,000 funding for Trusts.

6.3 The new strategy sets out clear measures for the NHS that will help reduce the spread of infection. The strategy focuses on the personal responsibility that all healthcare staff have to patients, other staff, visitors and themselves for maintaining infection control procedures. It is vital that everyone understands the role he or she has to play in reducing infection. This Strategy will require commitment from everyone involved, across the board, and we will be monitoring its implementation closely. Working together is key in reducing the number of infections.

6.4 It is important to note that this new Strategy builds on work already under way in Wales. We have one of the most robust systems of disease surveillance in the UK. The Assembly Government previously provided funding to each Trust, specifically for IT equipment and Infection Control Teams to allow them to develop their surveillance systems. We also have Infection Control doctors and teams in each trust but, as the new Strategy makes clear, prevention of infection is the responsibility of all staff.

7. ACCREDITATION OF HOSPITAL STERILISATION AND DECONTAMINATION UNITS

7.1 I allocated £8 million over three years to the Decontamination Project Board, which I established to oversee the improvements to be made to Hospital Sterilisation and Decontamination (HSDU). This project is now bearing fruit. At present 65% of HSDUs in Wales are fully accredited to the Medical Device Directive of the European Union. Other units are very close to achieving accreditation, and the project board has recommended a target date of December 2004 for all HSDUs to be accredited. Most of these remaining departments will meet this target, with one reporting a date in the New Year.

7.2 The accreditation process is similar to other industry quality management schemes which need to demonstrate consistent quality and audit over a period of time. Wales continues to lead the way for the UK in this field.

7.3 Accreditation brings benefits:

- Benefits to patients

  A quality assured product means that if there are unfortunate incidents that require backtracking (and the principle concern here is vCJD) it will be possible to minimise the number of patients who would need to be contacted.

- Benefits to Trusts

  Accreditation means that products are CE marked. Therefore, a catastrophic failure in one Trust would allow another HSDU to undertake sterilisation on their behalf while the failure is rectified and keep a hospital running.

- Benefits to other parts of the service

  One part of the project has looked at provision of services to GPs and I reviewed this very successful pilot running from Withybush Hospital.

7.4 Accreditation of our HSDUs is an important part of the management of healthcare associated infection. The Welsh Risk Pool Standard 36 is one of the principle standards identified in our recently published *Healthcare Associated Infections – A Strategy for Hospitals in Wales*.

8. HEPATITIS C: ELIGIBILITY OF INFECTED PARTNERS TO BENEFIT FROM SKIPTON FUND

8.1 Further developments have taken place since the update in my last report on the ex-gratia payments scheme for people infected with Hepatitis C from NHS blood or blood products.

8.2 The Skipton Fund began processing applications on 5 July 2004. Over 2,500 application forms have been received in the UK to date. Application forms for the Stage 1 payment have been sent to all those who have registered, and Stage 1 payments have been made to all those for whom valid completed application forms have been received.

8.3 People infected with Hepatitis C as a result of the virus being transmitted from someone else, such as a partner, who was themself infected as a result of receiving blood or blood products from the NHS prior to September 1991, will be eligible for the scheme.

8.4 It is estimated that 350 people in Wales could benefit from the ex-gratia payments scheme.

9. EXPERT PATIENTS PROGRAMME (GWYNEDD AND SWANSEA): END OF

PILOT PROJECT REPORT

9.1 The Expert Patients Programme is a NHS based training programme to help people living with long-term chronic conditions develop new skills to manage their condition better on a day to day basis. The courses are based on a chronic disease self-management course developed at Stanford University, and are delivered in local community settings over 6 weeks of 2½ hour sessions.

9.2 The Local Health Board (LHB) structure in Wales enabled the trial of the Expert Patients Programme based on the Primary Care Trust model in England. Gwynedd and Swansea LHBs were selected to enable the Expert Patients Programme to be tested in both an urban and rural setting. The pilots commenced in March 2003 and ran until the end of April 2004.

9.3 Throughout the development of the pilots a great deal of work has been done to further develop local partnership working with social services, voluntary organisations and community groups. The expertise of the voluntary sector has been invaluable throughout the development of the pilots. Existing self-management tutors within the voluntary sector have participated in the delivery of the Expert Patients Programme courses, the assessment of new tutors and in pilot site monitoring visits.

9.4 During April/May 2004 an independent evaluation of the pilot sites was undertaken and led by Professor John Borland, University of Bangor. The report confirms that both pilots had succeeded against the initial objectives set requiring the delivery of two courses. Gwynedd delivered four courses and Swansea delivered three courses. The Welsh pilots were deemed successful in comparison with the 65 Expert Patients Programme pilots in England. The performance of the Gwynedd pilot was described as exceptional in terms of achievement during the first year of operation.

9.5 It is pleasing to note how the evaluation identified that the Expert Patients Programme courses had a profound effect on the lives of patients in terms of:

- Increased confidence and ability to self-manage their condition
- Enhanced sense of well being and happiness
- Acquisition of important life changes, they feel calmer and less angry
- Being deeply committed to the programme and its benefits
- Wanting to share their experiences with other people living with chronic illness and spreading the word about the benefits of the Expert Patients Programme
- Having developed a sense of belonging and 'community'

9.6 The evaluation report also confirmed the viability of the LHB-led process to embed the Expert Patients Programme in two very different areas in Wales. The model emerging from the experience of the pilots is for LHBs to work collaboratively within a health community. The programme also requires an investment in a facilitator in order to provide the necessary support for the Expert Patients Programme volunteers involved in the delivery of courses.

9.7 Arrangements are being made to develop national and local frameworks to support the continued development of the Expert Patients Programme in Wales, and to secure a national rollout within 3-4 years.

10. LAUNCH OF HEALTHCARE CONCORDAT

Healthcare Commission's First Visit to Wales

10.1 The Healthcare Commission held its first public meeting in Cardiff on 23 September 2004. The Commissioners also held a reception on the evening of 22 September where Professor Sir Ian Kennedy, Chair of the Healthcare Commission, Dr Ruth Hall, Chief Medical Officer and Mrs Ann Lloyd, Chief Executive NHS Wales gave a brief presentation to the Commissioners and senior officials from NHS organisations throughout Wales. A key feature of the presentations was the way in which Wales is working in close collaboration with the Healthcare Commission on a number of important areas including taking forward the proposals for a Welsh Concordat, progressing a programme of national clinical audits for England and Wales, and the approach Wales is taking in developing healthcare standards.

10.2 The Healthcare Commission's public meeting on the 23 September covered a number of areas including, Equality and Human Rights, The Healthcare Commission and the Welsh Language, and a joint paper by the Healthcare Commission, the Audit Commission in Wales and National Audit Office in Wales, on working together to minimise the burden of external inspection in Wales.

10.3 I also met with Professor Sir Ian Kennedy on 23 September to discuss a number of issues including the Healthcare Commission's annual state of healthcare report, co-operative working, and the role of the Healthcare Commission in Wales.

Welsh Concordat

10.4 The Healthcare Commission, in June 2004, published a Concordat between bodies inspecting, regulating and auditing healthcare in England which is designed to support the improvement of services for the public and to reduce unnecessary burdens on front line staff.

10.5 The Concordat commits each organisation to the following set of principles, which aim to support improvement in health services while minimising disruption and duplication, ensure that information is shared appropriately and encourage joint inspections.

- Inspections are co-ordinated with other reviews and collections of data
- Inspections of healthcare focus on the experience of patients, other service users and carers
- Inspections support improvements in quality and performance
- Inspecting bodies continuously improve their methods
- Inspections are independent, consistent and fair

- Inspections are targeted and proportionate
- Inspections are transparent and accountable
- Inspecting bodies use co-ordinated and proportionate methods of enforcement
- Inspectors are suitably qualified, trained and skilled
- Inspecting bodies continuously monitor their practices in line with the concordat

10.6 The Concordat states that "signatories with a remit in Wales will extend its principles to their work in the Principality". The following signatories have an England and Wales remit:

- Academy of Royal Colleges
- Health and Safety Executive
- Healthcare Commission
- Mental Health Act Commission
- National Audit Office
- Post Graduate Medical Education and Training Board

10.7 The Welsh Assembly Government, which had observer status on the forum that oversaw the development of the concordat, strongly supports the objectives of the concordat.

10.8 It is the intention of the Welsh Assembly Government to lead the process to consider whether a Concordat, or similar arrangements, may be adopted for the following bodies inspecting, regulating and auditing health and social care in Wales –

- Academy of Royal Colleges
- Audit Commission in Wales (ACIW)
- Health and Safety Executive
- Healthcare Commission
- Mental Health Act Commission
- National Audit Office
- Post Graduate Medical Education and Training Board.
- Welsh NHS Estates
- Welsh Assembly Government Inspectorates
    - Care Standards Inspectorate Wales (CSIW)
    - Healthcare Inspectorate Wales (HIW)
    - Social Services Inspectorate Wales (SSIW)

- Welsh Risk Pool

11. AIR AMBULANCE FUNDING

11.1 I have been asked about funding Wales’s air ambulances, relating to the model used in Scotland.

11.2 The service in Scotland is the only publicly funded air ambulance service in the UK. This came about from the requirement that the Scottish Regional Hospital Boards were obliged to see that an efficient and adequate ambulance service was provided in its area.

11.3 It is important, however, to recognise significant differences between the circumstances and services provided in Scotland and those in England and Wales.

11.4 The geography of Scotland, with its very remote, sparsely populated areas and its island communities, air support is often the only means of providing an efficient and adequate ambulance service. Some 75% of air ambulance missions in Scotland involve patients being airlifted from Islands Boards and other NHS Boards that have a significant number of populated islands.

11.5 The Air Ambulance Service in Scotland is currently provided by a mixture of four fixed-wing aircraft and two helicopters, managed by the Scottish Ambulance Service, under contract with commercial operators. Around 3,000 air ambulance missions are undertaken annually, the majority of which are carried out by the contracted aircraft, although in severe weather conditions Ministry of Defence or Coastguard aircraft may be commissioned into service. Annual costs are around £6.5 million, and are fully funded from the overall revenue allocation made by the Scottish Executive's Health Department to the Scottish Ambulance Service. A new air ambulance contract is due to start in April 2006 and will run for 7 years at an approximate value of £40 million.

11.6 Both England and Wales's air ambulance services are based round helicopters and work on a smaller scale. The charitable funding model has proved very successful

12. AMBULANCE SERVICE: SPENDING BREAKDOWN OF ADDITIONAL 2003-04 £2.5 MILLION FUNDING

12.1 In the 23 June HSSC you asked for details on how the 2.5 million additional funding in 2003-04 was spent on the Ambulance Service. The breakdown at Annex A provides this information.

13. NORTH WALES CLINICAL SCHOOL

13.1 The Assembly is committed to expanding the number of medical students educated in Wales. The annual intake at UWCM has already increased by 100, to 290. To accommodate the increased numbers and to improve the quality of the clinical stage training a clinical school has been established at Swansea.

13.2 Additionally the Medical Graduate Entry Scheme at Swansea commenced last month (September 2004), and will contribute to increasing the intake figures for Wales to 360 per annum by September 2005.

13.3 Further developments across Wales are also underway to provide clinical schools in North Wales and Gwent.

13.4 The development of a Clinical School in North Wales will result in a greater number of year 4 and 5 students undertaking their clinical placements in North Wales. It is projected that the maximum number of students being taught per week in North Wales will increase from 55 to 164 by 2008-09.

13.5 The first increase in medical student placements in North Wales NHS Trusts started last month - September 2004.

13.6 The Clinical School development in North Wales will contribute towards achieving many of our all-Wales and local objectives, through:

- Meeting the long term workforce needs of the NHS in Wales
- Widening access to medical education
- Encouraging more students to remain in North Wales after graduation.
- Enabling more students from North Wales to undertake their training in their home area
- Encouraging greater interaction between clinicians and academics
- Assisting the recruitment and retention of high quality professional staff, and
- Establishing a larger number of clinical placements in a bilingual environment.

14. THE WELSH LANGUAGE IN HEALTHCARE

14.1 This year has seen some significant steps forward in the delivery of Welsh languages NHS services.

14.2 I established the All-Wales Task Group for Welsh Language Services in 2001 in response to the low level of bilingual services being offered in some parts of healthcare. The group has been taking forward a programme to improve and facilitate the provision of Welsh language services across the NHS. In addition, a team of officials has been driving forward improvements across healthcare. These include sharing good practice, establishing networks of champions and contact points, and setting up a site on the NHS's intranet (HOWIS) for sharing information and advice, which has consistently been one of the most visited sites.

14.3 A notable success is the Welsh Language Awareness Video and Training Pack, which I launched in Wrexham in April 2004. The training pack was piloted successfully in three Trusts and five Local Health Boards (LHBs) – receiving favourable comments – and has now been rolled out to all the Trusts and LHBs in Wales. This autumn the pack will also be delivered as part of healthcare courses within higher education. This groundbreaking resource has been well received across Wales; indeed, a number of other public and private sector providers are keen to emulate the module.

14.4 Sharing best practice has been greatly facilitated by the annual Welsh Language in Healthcare Conference. At the first Conference in 2003, I launched the Welsh Language in Healthcare Awards, and

I was pleased to present these very successful awards to a packed audience at the second conference in May 2004. Around 80 nominations were received, showing a variety of local initiatives from all parts of Wales. The winners included the Speech and Language Therapy Service at Pontypridd and Rhondda NHS Trust, the Health Visitors Team in the Gwendraeth and Amman Valley, and Youthlink Wales from the Voluntary Sector, with North West Wales NHS Trust taking the overall award. I hope that next year's awards can be an even bigger success.

14.5 As part of the All Wales Task Group's programme, the Assembly commissioned a survey of Welsh language awareness amongst healthcare practitioners. This was recently completed and has been included as a paper to note at this Committee meeting.

14.6 Given the pressures on the NHS and the relative scarcity of Welsh speaking staff, moving towards an appropriately bilingual service is inevitably a long-term project, but there has been noticeable progress. Almost all the Welsh Language Schemes submitted by LHBs have now been approved by the Welsh Language Board. The Board's recent snapshot survey of Welsh language provision in all the NHS Trusts noted improvement – though there remains much work to be done. As well as continuing to lead further improvement across the hospital sector, we are turning our attention to primary care. This is where most patient contact with the NHS takes place, but where the challenges of bilingualism are greater.

15. BBC SOCIAL ACTION CAMPAIGN FOOD & FITNESS ADVISORY GROUP

15.1 Unhealthy diets and physical inactivity are leading causes of the major non-communicable diseases, including cardiovascular disease, type 2 diabetes and certain types of cancer.

15.2 The issue of food and fitness is high on everybody's agenda, particularly in relation to the increasing levels of overweight and obesity. Over 50% of people in Wales are overweight or obese.

15.3 It is important that we make it easy for everybody to make healthy lifestyle choices. One way of achieving this is working with the Welsh media to ensure that appropriate lifestyle messages are portrayed.

15.4 As you may be aware we recently supported the BBC Wales Social Action Campaign *Big Fat Problem*, to tackle overweight and obesity. The campaign took place over an eight-week period. Focusing on healthy lifestyle advice, it challenged people across Wales to eat more healthily and get active.

15.5 The campaign featured innovative programming, roadshows, and advertising. The roadshows provided an opportunity for individuals to sign up to a diet and exercise plan and to obtain advice and support from local dieticians and physical activity specialists.

15.6 Access to the diet and physical activity plan was also available via NHS Direct Wales and was

supported by an advice booklet and a dedicated website. Different BBC television and radio programmes followed the progress of a number of members of the public who signed up for the campaign. A final 30-minute television programme was broadcast to highlight the progress of these individuals.

15.7 The campaign was the biggest and most ambitious social action campaign ever attempted by BBC Wales. According to BBC Wales, the television campaign reached 2.2 million people, 75% of the Welsh population. The number of hits to the dedicated website broke all previous records for a BBC Wales social action campaign. Some 100,000 support booklets have been distributed and almost 6,000 people signed up to the campaign. A sample of 272 people participating in the programme were monitored and over an eight week period they lost a total of 745lbs (339kgs).

15.8 The Food and Fitness Task Group for Children and Young People has been established, and is co-chaired by myself and Professor Stephen Tomlinson, Provost, Wales College of Medicine, Biology, Life & Health Sciences and Deputy Vice-Chancellor, Cardiff University.

15.9 The aims of the group are:

- To respond to Health Challenge Wales, by taking forward the food & well-being and physical activity agendas for children and young people;
- To contribute to strategic planning and co-ordination of food and fitness initiatives for children and young people;
- To identify opportunities for links between existing strategies relating to nutrition and physical activity;
- To act as champions for the concept of initiatives on food and fitness operating in tandem;
- to advise on the development of additional interventions which are evidence-based, or innovative with structured evaluation, to meet identified gaps in local and national provision.
- To consider research and evaluation requirements;
- To consult with organisations engaging children and young people on food and fitness issues.

15.10 The group has met on two occasions, on 6th May and 1st September; with a Research and Evaluation sub-group meeting on 18th August.

15.11 Members have identified some gaps and priorities for future provision which are currently being worked up into proposals for action.

15.12 Proposals will enhance and support existing programmes such as the Welsh Network of Healthy School Schemes, which currently involves half of the schools in Wales.

16. UPDATES

16.1 SECOND OFFER SCHEME (SWANSEA): FURTHER INFORMATION ON THE

REASONS FOR DECLINE OF A SECOND OFFER, AND MEASURES BEING TAKEN TO IMPROVE UPTAKE

16.1.1 The Second Offer Scheme was introduced in April 2004. It is designed to ensure that all patients in Wales who are waiting, or likely to wait, over the target maximum waiting time (in most cases 18 months) are given the opportunity of having their treatment provided at an alternative hospital. In June 2004, the target maximum waiting time was reduced to 12 months by 31 March 2005.

16.1.2 As the scheme was developed, it became apparent that some patients chose to refuse the second offer, opting instead to continue to wait. The number of patients declining was particularly high in Swansea the numbers where, at the end of July 2004, 363 patients had declined.

16.1.3 Reasons for turning down a second offer elsewhere include:

- a lack of clarity around where the treatment would take place, whilst contracts with other hospitals were being put in place,
- not wanting to change their consultant, and
- transport difficulties.

16.1.4 In order to encourage the uptake of second offer and improve data collection, several measures have been developed, including the following:

- provision of Patient Information leaflet,
- protocol for the management of patient contact,
- an information pack for GPs, and
- confirmation with individual Trusts of agreed alternative providers.

16.1.5 Within Swansea NHS Trust specifically, there will be a clinical review of all patients, led by a nurse specialist to help the patient make an informed decision. Patients will receive as much relevant information available as possible.

16.1.6 There will always be a cohort of patients who wish to remain at their original hospital. To help understand the reasons why, and to improve future take up, I have asked the Second Offer Team to commission a survey of responses. The results of this survey should be available in the next few months.

16.2 NHS DIRECT WALES

16.2.1 This month in addition to the regular update on the performance on NHS Direct (Wales) I am including details of a policy review we have undertaken on this service. This review has confirmed a clear service vision and agreed a number of key recommendations to ensure we develop NHS Direct (Wales) in a way that best meets the needs of the wider NHS and the public.

16.2.2 This service model has been developed following the ongoing review of Local Health Board Out of Hours plans and discussions with Health Commission Wales, NHS Direct (Wales) and the Primary Care Division as the new policy lead. The model that has emerged is an "All Wales" call-handling/triage and information service, with NHS Direct (Wales) standards in place, NHS Direct (Wales) delivering to its economic capacity but also partnership arrangements with other providers. Within three to five years NHS Direct (Wales), through both telephone and possibly direct face to face triage, is to act as gatekeeper for a wide range of unscheduled care services.

16.2.3 The key recommendations also include:

- NHS Direct (Wales) will gradually expand capacity to become the first triage service for key Welsh services including all GMS out of hours and unscheduled care

- A new Commissioning Team that will ensure NHS Direct (Wales) is brought firmly into the NHS family and that services are fully aligned with Welsh Assembly Government policy

- The management arrangements between Swansea NHS Trust and NHS Direct (Wales) will be simplified, with accountability for NHS Direct (Wales) being delivered through the new Commissioning Team

- A review of NHS Direct (Wales) estates and management arrangements to ensure Value for Money

16.3 OUT OF HOURS PROVISION

16.3.1 The implementation of the new General Medical Services contract in Wales, allowed for General Practitioners to "opt out" of the provision of Out of Hours services. It was anticipated that all GPs would take advantage of this opt out. The responsibility for providing this service would then pass to Local Health Boards. Where GPs indicated they wished to opt out of these services, the latest date for LHBs to take over this responsibility is the 31st December 2004.

16.3.2 Local Health Boards, supported by colleagues from the Primary Care Division have been developing plans to implement new Out of Hours services across Wales. The guidance that LHBs received, advised LHBs to plan to provide these services from September / October 2004 to ensure a smooth transition of services and I am pleased to be able to report that this has happened. As of today almost all LHBs have introduced their new service models and according to plan. The remaining LHBs will be implementing their plans in the forthcoming weeks, but all will be well within the deadline of 31st December.

16.3.3 As with the existing services, the new services will be delivered by several different methods. These models include collaborations between NHS organisations, provision through LHBs in partnership with existing GP Co-operatives and Commercial agencies. All providers will be required to

provide regular reports detailing aspects of service quality to LHBs and the Primary Care Division.

16.4 VARIANT CREUTZFELDT-JAKOB DISEASE (vCJD)

16.4.1 Further developments have taken place since my last report on the possible transmission of vCJD through blood on 5 May 2004.

16.4.2 Following advice from the Advisory Committee on Microbiological Safety of Blood and Tissues for Transplantation, the Welsh Assembly Government, together with NHS Wales, decided that, with effect from 2 August 2004, two further groups who have received blood transfusions since January 1980 are to be excluded from giving blood. These are:

- donors who are unsure if they have previously had a blood transfusion
- apheresis donors who have previously had a blood transfusion.

16.4.3 January 1980 has been chosen as the cut-off date as it is generally accepted that there would have been no dietary exposure to BSE in the UK before then. It is estimated that these changes will affect around 3% of blood donors.

Annex A

AMBULANCE SERVICE: SPENDING BREAKDOWN OF ADDITIONAL 2003-04 £2.5 MILLION FUNDING

Use of Development Monies 2003/4

Development	Cost £	Description of Development
First Responder Scheme	25,000	Senior Officer to oversee the role out of the National Scheme
Increased Relief Staff	271,000	Monies to allow the increase in staff to cover off training, annual leave etc.
Air Ambulance Staff	104,000	Staffing costs of the Paramedics who man the two Helicopters
Swansea	87,000	Increasing Staffing of one ambulance from 3 days to 7 days
		1x Rapid Response Vehicle 7 days a week, for 12 hours
Bryncthein [Bridgend]	103,000	1x Rapid Response Vehicle 7 days a week, for 12 hours

		1x Intermediate Care Vehicle 8 hours a day for 7 days a week
Neath	157,000	1x Rapid Response Vehicle 7 days a week, for 12 hours
		Increasing Staffing for 12 hours a day to provide additional cover 24 hours a day
Brecon [Powys]	43,000	1x Intermediate Care Vehicle 8 hours a day for 7 days a week
Pembroke Dock	98,000	Increasing Staffing for 12 hours a day to provide additional cover 24 hours a day
Aberystwyth [Ceredigion]	23,000	Conversion of a RRV to a two manned ambulance
New Quay	43,000	1x Intermediate Care Vehicle 8 hours a day for 7 days a week
Llangefni [Ynys Mon]	23,000	Increase in shift cover from 9 hours to 12 hours for 1 vehicle 7 days a week
Queensferry [Flintshire]	28,000	1x Intermediate Care Vehicle 8 hours a day for 7 days a week
Bassaleg [Newport]	96,000	Intermediate Care Vehicle increased from 8 hours a day to 16 hours a day for 7 days a week
Monmouth	36,000	1x Intermediate Care Vehicle 8 hours a day for 7 days a week
Aberbeeg [Blaenau Gwent]	60,000	1x Rapid Response Vehicle 7 days a week, for 12 hours
Aberdare [RCT]	60,000	1x Rapid Response Vehicle 7 days a week, for 12 hours
Pontypool [Torfaen]	60,000	1x Rapid Response Vehicle 7 days a week, for 12 hours
Merthyr	60,000	1x Rapid Response Vehicle 7 days a week, for 12 hours
Blackweir [Cardiff]	124,000	Intermediate Care Vehicle increased to 24 hours a day for 7 days a week
Bargoed [Caerphilly] And Blackwood	124,000	1x Rapid Response Vehicle 7 days a week, for 12 hours
		1x Intermediate Care Vehicle 8 hours a day for 7 days a week
National Control Centres	195,000	Additional 1st Responder Desk at each Control to handle increase in schemes across the Country

National Training College	78,000	Two additional full time trainers, to cover additional staff employed above.
Clinical Operating Expenses	143,000	Equipment for new vehicles, plus cost of initial equipment for the 1st Responder schemes.
Non Clinical Operating Expenses	15,000	Equipment for new vehicles, plus cost of initial equipment for the 1st Responder schemes.
Staff Uniforms	20,000	New Staff
Office Expenses	8,000	Ad hoc training expenses
Accommodation Charges	94,000	Student Accommodation , whilst at Training College
Fleet Maintenance	200,000	Cost of leasing additional RRV's x 8 plus ITV ambulances x 5
Fleet Fuel costs	70,000	Additional fuel costs
Premises and Fixed Plant - Rents	48,000	Barry Station Rent
Total Expenditure	**2,496,000**	