Aneurin Bevan University Health Board

ANNUAL PLAN 2021/22

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

INTRODUCTION

Our mission is to reduce the health inequality experienced by our communities through improving population health. We have an 18 year gap in healthy life expectancy between our wealthiest and poorest communities, this continues to be of significant concern and unfortunately a gap that will have been worsened as a consequence of the pandemic.

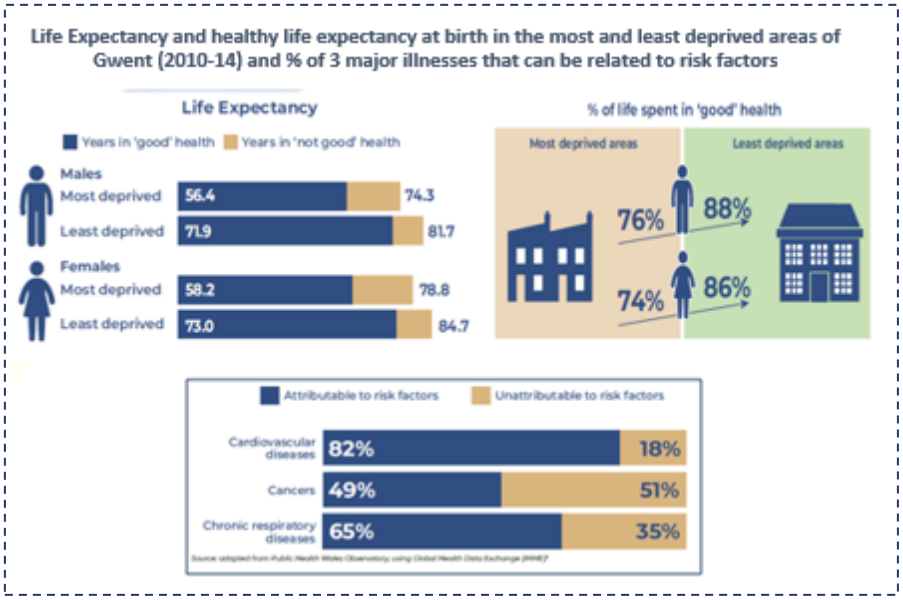
The pandemic has challenged our resolve, our resilience and our reserve. As we set out our plan for the next year, we must keep the stories of those who have been affected by COVID-19 at the forefront of our minds and focus our efforts in meeting our commitments to our communities.

As well as setting out priorities, this plan identifies the key enablers for how we will deliver and fundamental to delivery is partnership. Supporting our staff to deliver at the top of their game, to see and understand their role in the system and to have time to care is a core focus of this plan. Our residents and the wider population will remember the staff they meet and their experience whilst in our care.

Our staff have achieved incredible feats in the last 12 months. In particular successfully opening a new hospital in the middle of a pandemic is an outstanding achievement. It is an achievement which enabled the continuation of care in a safer and more appropriate environment, providing enhanced diagnostic and surgical capacity. We know that opening new facilities is only part of the story and that to support our communities we need to continue to integrate services, to improve flow through our system and focus on actions to prevent declining ill health. This plan therefore marks the continuation of our Clinical Futures programme, it focuses on the next steps to deliver improved services for our citizens.

We know the pandemic is not over, the need to be alert to the changing nature of COVID-19, delivering a vaccine programme and an effective test and trace service through partnership will all be essential for at least the next six months. We recognise the constraints and challenges of our environment, but will focus on delivering the change our communities need. Therefore this plan sets out some clear priorities for the organisation which will focus our actions, working with our staff, our communities and our partners.

'Building a Healthier Gwent', whilst acknowledging the many achievements since the NHS began, recognises that we have not changed the fact that people in some communities in Gwent live 18 years longer in good health than in others. The reason for that 18 year gap is that some people are able to live the kind of healthy lives that prevent heart disease, cancer and lung disease while others don't.



The influences on people's health are complex. The places where we live, work, learn and play are a big influence on our opportunities to live in good health. Being connected to other people as part of a strong, supportive community is good for our health. How easy we find it to use facilities and services that help us to stay healthy is important too.

Whilst it is too early to be able to measure the impact of the COVID-19 pandemic on morbidity and mortality in Gwent, it has to be a concern that a combination of reluctance by patients to attend hospital plus longer waiting times for diagnostic tests and treatment will result in increased morbidity and mortality from the three diseases that contribute most to health inequalities. Therefore, central to our plans is maintaining essential services and intelligently balancing clinical need against our systems capacity. We embrace this opportunity to transform core services as they gradually come on stream, optimised by the way in which our citizens and clinicians have embraced new ways of delivering the care that matters to people.

We anticipate an increased need for rehabilitation in the wake of this pandemic and are developing and implementing plans to address the needs of our population from those with prolonged symptoms of COVID-19, through patients whose planned care has been delayed, to those whose function has been compromised as a result of social isolation.

Reflections on 2020/21 - There has been substantial learning across the Health Board over the past twelve months which will guide how we respond to 2021/22. The learning is not simply about how we react to the challenges of the pandemic but also how crisis enables transformation to flourish across the system.

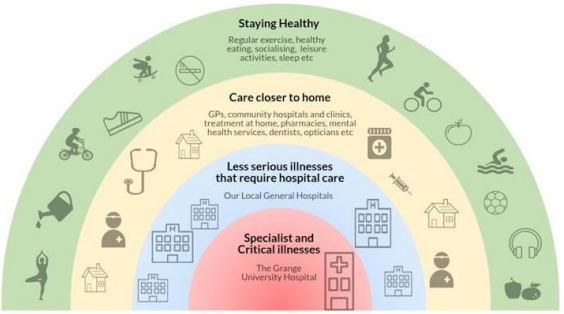
We are proud of the way in which our staff have responded showing resilience, bravery, dynamism, resourcefulness and great skills over the last year. In addition to the overwhelming challenges presented by COVID-19, our workforce have enabled our system to introduce new ways of working and to bring forward the successful opening of the Grange University Hospital as a part of our response to winter pressures and the unpreceded demands of our population during this pandemic.

Primary and Community services have been front and centre in our response to COVID-19, embracing technology, new ways of working, and peer support through buddying practices to support resilience and deliver consistent responses to rising levels of escalation. Our Mental Health and Learning Disability service have maintained all core essential services throughout the pandemic. We have literally turned services on their heads, doubling ITU capacity, changing hospital configurations and building infection prevention and control resilience across sites. We have revolutionised the number of patients that can be supported through digital consultations and reviews, agile working has been embraced, and over this coming year we will continue to evaluate people's experience of the benefits or barriers to any continued role in delivering health care. We have maintained essential services utilising all resources available to us (including the independent sector) for the benefit of our citizens.

Supporting staff physically, mentally and emotionally in response to the changing landscape that was 2020 has resulted in the consolidation and increase of Employee Wellbeing Services. We have benefited from closer working with our public sector partners and successfully introduced the Gwent Test, Trace and Protect Programme with 98% contact tracing success rate.

We have learned how to use technology to support communications between inpatients and their families at some of the most difficult times in their lives, together with bereavement services supported through our charitable funds.

Before Christmas, meticulous plans were in place to literally hit the ground running once vaccinations became available to begin the journey to protect our communities and our staff from COVID-19. To date we have given over 360,000 vaccinations (a combination of 1st and 2nd doses) across our Health Board area – this means that more than half of our adult population (51%) have now received their first dose of the vaccine.



Our Clinical Futures Strategy still holds strong as we move through the phases of the pandemic into 2021/22 with even greater importance on the need to deliver system wide change, enhancing care in the community as the cornerstone of the plan. Whilst 2020 has seen a specific focus on opening the new Grange University Hospital early and begun to embed a new model of care across the hospital system, albeit in a COVID-19 context, the next phase will require us to work with partners to further develop and accelerate the plans that support people to look after themselves in their communities and support care at home as much as possible and where safe to do so.

This Annual Plan sets out the key priorities we will focus on over the next 12 months that build on what has already been achieved and provides the greatest opportunities to move further forward with the strategy in the COVID-19 recovery / adapting environment. This period of the annual plan also provides the ideal opportunity to review and reflect on the refresh of the Clinical Futures strategy in the context of A Healthier Gwent and new opportunities for transformation and innovation possible in a post pandemic future.

Well-being of our Future Generations - There are a range of policy drivers and tools which we can utilise to support how we plan to ensure that a person's chance of leading a healthy life will be the same wherever they live and whoever they are. The Well-being of Future Generations (Wales) Act 2015 keeps us focused on

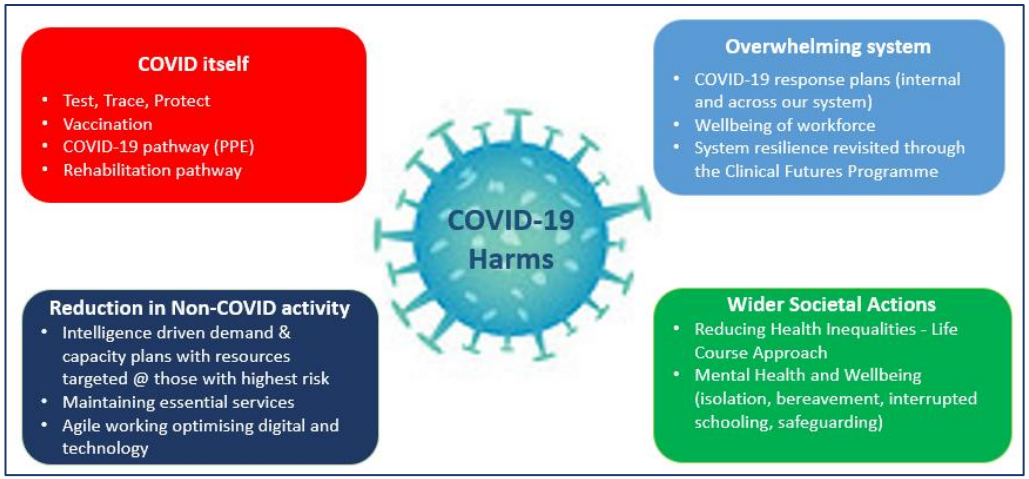
preventative approaches, Value Based Healthcare provides further tools to focus on the outcomes that matter to individuals and their families, the Quadruple Aim and Ten Design Principles in A Healthier Wales similarly provide a focus on ensuring wellbeing.

You will not find in this document a separate section listing projects we are delivering to support the Wellbeing of Future Generations Act. The Act challenges us to fully embed the five ways of working within our work. We fully share four wellbeing objectives with all of our public sector partners, they are enshrined in the 5 Public Service Board Well-being Plans that serve our citizens across Gwent.

We continue to build on the strong contribution we have made, working with partner organisations to embed the Act. Our shared focus on prevention, reducing health inequalities, improving community and personal resilience is core to our plan. Our plan is not about a series of projects or specific pieces of work but an underpinning approach to the way we design and deliver services in our system.

Our plan for 2021/22 has been developed in light of the challenges we have faced over the past year and our experiences of responding to COVID-19. We recognise that the impacts of the pandemic on our population, our workforce, our partners and our system run deep and will dominate efforts to reset health and well-being services for our communities.

Our approach to achieving the right balance across the four harms is set out within the plan, which is designed to capture our core intentions, give clarity on our priorities, be clear about how we are dealing with the incredibly difficult task of responding to COVID-19 related demand, and the risks and challenges in pivoting to more routine care. We all understand the consequences for our population are great and we must focus our collective efforts on delivery.



Our staff are exhausted, we need to focus on their wellbeing and providing tools and space to act. Asking staff to do more to tackle waiting lists, to rise to the challenge of recovery is difficult. We need to focus on sustainable cultural change, making it possible for people to see the system, enabling and encouraging staff to act.

A single document can never capture the breadth of activity that takes place across the Health Board. Planning is not about a single document and this plan should be read alongside a range of plans and the annexes that accompany it. Our plan is split into four broad sections:-

1. Our Organisational Priorities
2. Core Enablers for Delivery
3. Understanding our System
4. Our Delivery Framework

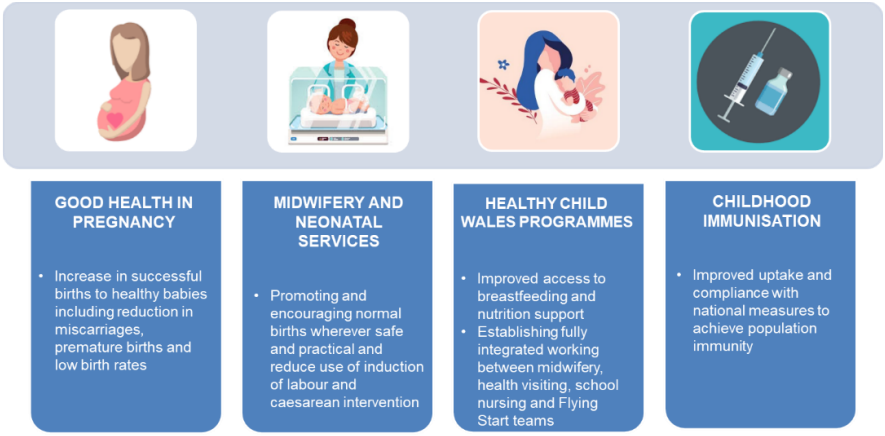
ORGANISATIONAL PRIORITIES

We are adopting a life course approach to our work this year, an approach that optimises the functional ability of individuals throughout life, enables well-being, the realisation of rights, and recognises the critical interdependence of individual, intergenerational, social, environmental and temporal factors. The main outcome of the life-course approach to health is functional ability, which is the sum of the individual and environmental attributes that enable a person to be or do what they have reason to value. For a neonate or infant, functional ability could be manifested by feeding well and playing; for older adults, by the ability to function independently without dependence on care. This requires working with our citizens (as individuals, families and communities) to deliver the change our communities need.

This approach requires holistic, long-term, policy and investment strategies that promote better health outcomes for individuals and greater health equity in the population. We are confident this approach can provide high returns for health and sustainable development, both by limiting ill health and the accumulation of risk throughout life and by contributing to social and economic development.

PRIORITY 1 – EVERY CHILD HAS THE BEST START IN LIFE

We believe that every child deserves the opportunity to make the very best start in life.



Early childhood experiences, including before birth are key to ensuring improved health outcomes, better learning, access to good work and a fulfilled later life. To deliver this priority, we will challenge traditional practices, introduce new ways of working, forge greater alliances with Local Authorities and the third sector. We intend that this will enable us to align our resources to promote early family-centred interventions, public education and improved long term outcomes for all our children.

We have identified key areas that will have a positive impact on the first 1,000 days, and we are progressing a series of actions and initiatives against which we can measure how well we are doing. A summary of these is set out below:-

Good Health in Pregnancy – a woman's health is essential to the good health of her baby. Women who eat well and exercise regularly along with regular prenatal care are less likely to have complications during pregnancy. They're also more likely to successfully give birth to a healthy baby. Making good lifestyle choices will directly impact on a baby and it is important to stop any tobacco smoking, drug misuse and alcohol consumption during pregnancy. Key areas for delivery this year include:

Smoke free environments Implementing formal smoking bans on all Health Board sites to ensure a smoke free environment for all pregnant women using our services
Support to stop smoking in pregnancy Extending smoking cessation support in pregnancy as part of routine ante-natal care to reduce the incidence of smoking amongst pregnant women, reduce miscarriages, premature births and low birth weights.
Weight management during pregnancy Strengthening the public health role of midwives through expansion of the midwifery-led weight management service
Ante-natal Education Programme Our Maternity Service will develop stronger alliances with PHW raising the public health messaging through ante-natal education programmes. Healthy eating will form a key element of this programme, further strengthened by the establishment of a midwife-led gestational diabetes management service by the end of 2022.

Midwifery and Neonatal Services - we will promote and encourage normal births whenever safe and practical, promoting the use of midwifery led birth centres and reduced use of induction of labour and caesarean intervention. We will continue to raise the profile of our dedicated public health midwives.

Sustainable Services Where a child needs neonatal support, we will ensure compliance with national 'Birthrate Plus' staffing standards, maintaining high quality and sustainable services by enhanced recruitment of midwives in acute and community settings.
Parental Accommodation There is a strong correlation between parental access to neonates and long term maternal /neonatal health outcomes. We will ensure that parents play an active role in their baby's nurture and care through the building of bespoke neonatal parents' accommodation, fully compliant with the latest national / 'BLISS' standards.

Healthy Child Wales Programme - we believe strongly that progressing the aims and objectives of the Healthy Child Wales Programme is critical to children's health, social and educational development and to optimising their longer term potential. Our focus for delivery this year includes:

Increased support and encouragement of breast feeding for new mothers.
Increased emphasis on care closer to home, enhancing the role of the community team and supporting the pro-active management of conditions without the need for specialist paediatric intervention wherever possible.
Establishing fully integrated working between midwifery services and health visiting, school nursing and Flying Start teams.
Increased support for the public health nursing, with midwives and health visitors able to extend the 'window of support' and respond to issues such as infant feeding difficulties, low mood and anxiety.
Extension of the toileting team for children up to seven years to prevent children requiring secondary care for constipation and ensure school readiness with regard to toileting.

Childhood Immunisation is a highly effective population health measure, second only to clean water, in reducing the burden of infectious diseases. It helps a child to become protected from diseases caused by bacteria or viruses. It also helps protect others around him or her. Without immunisation, the only way to become immune is to get the disease. We will continue to deliver our immunisation and vaccination programmes which include:

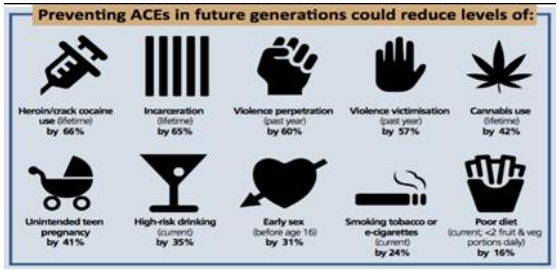
Children's Flu Programme Continue to deliver the Children's flu programme with an anticipated additional cohort (year 7) of approximately 7000 over 42 sites. We estimate that the number of children eligible for flu vaccination in 2021/22 will be just over 40,000.
Human-papillomavirus Vaccination (HPV) HPV is a very common sexually transmitted infection that can cause genital warts or cancers. HPV protection is now extended to boys alongside girls this year and we are scheduled to immunise doses 1 & 2 totalling approximately 10,000 together with around 3,000 outstanding second doses (from 2020 cohort) due to recent school closures and absent children. We expect that additional staff resources will enable us to deliver an additional 5,000 HPV vaccines by March 2022.
Men ACWY booster This vaccine protects young people against four different types of meningococcal disease for 15 – 19 year olds who are at more risk from disease than any other age group expect under 5s. We will undertake a catch up programme of teenage meningitis vaccinations to recover disruption caused by the COVID-19 pandemic.
Measles, Mumps and Rubella (MMR) We will roll out the MMR elimination plan as directed by the Chief Medical Officer, utilising hubs for school aged children and health visitor domiciliary support.

PRIORITY 2 – GETTING IT RIGHT FOR CHILDREN AND YOUNG ADULTS

Young people are an important group, nurturing of future generations is crucial to our communities. Evidence is emerging that brain structure is still developing and is not mature until the early 20s, and that after infancy, the brain's most dramatic growth spurt occurs in adolescence. The teenage years are thus a key stage for action to strengthen health behaviours, build resilience and ensure individuals reach their potential. Children and young people represent a third of the population in Wales, and their health and wellbeing will determine their future.

Adverse Childhood Experiences - stressors that impact on their future arise from the abuse and neglect of children but also from growing up in households where children are routinely exposed to issues such as domestic violence or individuals with alcohol and other substance use problems. The effects can impact on the long-term physical and mental wellbeing of an individual, which in turn can be inter-generational. Therefore, preventing and mitigating the effects of Adverse Childhood Experiences (ACEs) can improve health across the whole life course, enhancing individuals' well-being and productivity while reducing pressures and costs on the health service.

Those experiencing four or more ACEs have increased risk of health harming and criminal behaviours. Thus, health, social, criminal justice and educational systems are all likely to see better results for the Welsh population if ACEs are prevented and mitigated. The impact of ACEs is everybody's business, preventing and mitigating ACEs is our common purpose across our systems' public sector. We have therefore developed a further series of initiatives to maintain momentum and ensure that our children grow up in the best possible supportive environment and are in a position to reach their potential in adulthood. A summary of our plans are include:-



Mental Health Resilience in Children and Young adults - improved mental health and emotional resilience in children and young adults is crucial in providing resilient communities, and we recognise that the impact of the COVID-19 pandemic has been to move this to the very top of the national public health agenda. Our plans reflect this as one of the highest priorities for the Health Board over the coming year and beyond.

Iceberg Model This transformational approach ensures that children and families get the right help, first time, at the right time, and we will use the principles of this to inform our plans and measures of success. We are reviewing our priorities for delivery in the context of a post-COVID-19 needs assessment to enable us to determine the longer-term structure and functions of services that support children's mental health and emotional wellbeing. The outcome of this work is at present uncertain however partners are committed to progressing a programme of change over the 2021/22 period to embed key principles, values and practices that align with the 'Iceberg' model into how core services operate individually and in partnership. A detailed work plan relating to these themes will be completed and ratified by the Transformation Steering Board by March 2021.
Looked After Children There are currently nearly 2,000 children in the care system in our area, three-quarters of whom are aged 5-18. We will further integrate the Looked after Children service with the school nursing service to support the increased demand for places both locally and nationally.
Neurodevelopment Pathway Develop a needs-led, evidenced based service pathway for the assessment of neurodevelopmental conditions such as Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) covering pre/peri/ post diagnosis. This is intended to address children and young adults with significant needs who do not neatly fit into

thresholds/referral criteria for other Child and Adolescent Mental Health Services (CAMHS).
Welsh Government's Mental Health (Wales) Measure Prioritise the integration of the primary and secondary care CAMHS focusing on the provision of high quality, evidenced based specific interventions to young people and their families, who are requiring 'low to moderate' mental health and emotional wellbeing support under Part 1 of the MH measure; and who are experiencing 'moderate to severe' mental health difficulties under Part 2 of the MH measure.
Emergency Response Pathway Develop and implement an emergency response pathway in conjunction with adult mental health and learning disabilities services for supporting section 136 assessments under the Mental Health Act. It is planned that this will include 'Windmill Farm' to provide for those experiencing a 'psycho-social/mental health crisis'. Admission will be on a case by case basis, with CAMHS teams inputting directly into the therapeutic programme. This integrated approach is key to delivering a robust, sustainable seven day service.

Support being a Healthy Weight - it is important that children and young people can live in environments that support being a healthy weight and where they can be active in our shared open spaces and abundant natural environment. In order to promote this our focus for delivery includes:

New Initiatives to support healthy eating • Development and continued funding of an integrated Paediatric Avoidant/Restrictive Food Intake Disorder (ARFID) Service
Obesity Pathway Development • Implement planned Healthy Weight: Healthy Wales obesity pathway developments
Eating Disorder Services • A Health Board-wide review of eating disorder services with a view to designing a model that works 'upstream' to support early detection and intervention in relation to eating disorders. • As part of Health Schools Programme in Gwent, provide training in schools for staff and pupils.

Transition pathway for 15-25 years - this is often a very difficult time for children and young people, where many stressful elements combine. Typically, a young person who has been under the care of paediatric services for an extended period can face a 'perfect storm' of circumstances, where transferring to unfamiliar adult patient pathways comes together with the loss of child-based third sector support, a series of social and economic challenges in their wider life and high risks of non-compliance with previous treatment routines.

It is our ambition to deliver and maintain an optimal model of transition from child to adult services, working with Adult MH and LD / Social services teams in order to ensure that transition pathways are clear, gradual, supportive and user-friendly. In support of this, we will increase opportunities for service user participation and co-production of treatment and transition pathways; a CAMHS participation group is currently being piloted and will be rolled out during 2021.

PRIORITY 3 – ADULTS IN GWENT LIVE HEALTHILY AND AGE WELL

We want our citizens to enjoy a high quality of life into old age and we want them to be empowered to take more responsibility for their own health and care, so that they can retain independence.

MAXIMISING AN INDIVIDUALS TIME	LIVING HEALTHILY AND AGE WELL	TRANSFORMING MH&LD SERVICES	MAXIMISING CANCER OUTCOMES
Maximising citizen and staff time: • *Outpatient Transformation* • *Efficiency Programmes- Theatres and Diagnostics* • *MSK Pathway*	Reducing health inequalities and preventing disease by identifying health risks and supporting behaviour change: • *Integrated Wellbeing Networks* • *Inverse Care Law Programme; Making Every Contact Count*	Providing integrated, evidence based high quality MH&LD services • *Whole person, whole system adult crisis support* • *Complex Needs Transformation*	Improve the number of people being diagnosed with cancer at an early stage and optimise cancer treatments • *Rapid Vague Symptoms (MDT) Diagnostic Service* • *Redesign of Systemic Cancer Therapy Services; Satellite Radiotherapy Unit)*

Maximising an individual's time

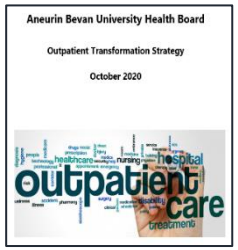
While we know that patient satisfaction with clinical care across our system remains high, it is also true that various parts of the patients' journey do not always deliver the best experience, with limited information, waits for appointments often at times and locations that are inconvenient, the waiting around in clinics and, in some cases, the repetition of entire processes particularly at times of transition from one part of the system to another. This does not deliver value for citizens or services.

Time …
Our most precious commodity

Imagine there is a bank that credits your account each morning with £86,400. It carries over no balance from day-to-day. Every evening it deletes whatever part of the balance you failed to use during that day. What would you do? Draw out every penny. Each one of us has such a bank. It is called time. Every morning, it credits you with 86,400 seconds. Every night, it writes off as lost whatever you have failed to invest wisely. It carries no balance. It allows no overdraft. Each day, it opens a new account for you. If you fail to use the day's deposit, the loss is yours. There is no going back…

Similarly, our clinicians are increasingly frustrated with, and fatigued by growing pressure from waiting lists, overbooked clinics and inefficiencies in the way healthcare resources are sometimes used. Healthcare has witnessed many changes in recent times whether it is the nature of the conditions with which our patients present, the increasing complexity and number of co-morbidities we deal with or the technology and knowledge available to us and our patients. The past 12 months have through necessity pushed the boundaries in relation to alternative methods of consultation and are overwhelmed by the acceptance of technology by our citizens. We will continue to evaluate these technologies and engage with our population to ensure that patient choice will always be at the heart of delivery.

Over the coming year, as we reset services we must start to think in terms of value and sustainability, harnessing the advances that have been made throughout the pandemic and building a more balanced system of care. Our focus for delivery this year is:



Outpatient Transformation - the vast majority of patient interactions with secondary care are through outpatient clinics and that the traditional model of outpatient care is in many cases no longer fit for purpose. Guided by "Transforming the way we deliver outpatients in Wales – three year strategy 2020-23" (April 2020) particularly the outpatient framework and toolkit, we have developed our own Outpatient Transformation Strategy (Appendix 1). Our immediate plans to transform outpatient services will focus on key elements of the outpatient journey including:

Management of Referrals Receipt and triage of referrals to ensure patients are on their optimal pathway (self-care, primary care, and secondary care) delivered through the most appropriate mode (remote, face to face).
Risk Stratification and Prioritisation Utilising intelligence and data to identify those patients that are at the greatest risk and prioritizing available face to face capacity on basis of clinical need.
Optimising Available Capacity Implementing the optimal journey from referral, triage to attendance that minimises steps and reduces requirement for multiple attendances (one stop).

We continue to work with, benefit from and adopt the output from the National Planned Care Programme which supports the delivery of the national strategy.

Efficiency Programmes – We have a well-established ***Theatre Programme*** Board that is our vehicle for driving and monitoring improvements in theatre service performance and efficiency. As we reset services sustainably over the coming months this Board will agree benefit profiles and milestones, regularly review progress, intervening and escalating where required where variation and obstacles present. Our focus for delivery aims to deliver a step change in:

- Quality and safety practices, monitoring and incident reporting
- Benchmarked levels of operational efficiency e.g. list utilisation, late starts, early finishes, short notice cancellations and activity
- Use of technology to support theatre transformation
- Finalising and implementing Clinical Futures model of service in the context of the need for resilience in the context of lessons learned over the past 12 months and the provision of an effective workforce matched to service needs

Our ***Radiology Programme Board*** work had intended to deliver a step change in performance, driven by improvements in efficiency, streamlining of patient pathways, benchmarking against best practice and optimising staffing skill mix / extended practice potential. However, our focus during 2020/21 has been targeted at enabling the early opening of the Grange University Hospital and maintaining essential services particularly in the context of acute and cancer services.

The next 12 months will focus on realising the benefits of the post Grange University Hospital radiology service model together with a series of work streams to deliver:

- A robust and stable service
- Increase the proportion of investigations undertaken within six weeks of request.
- Full elimination of reporting backlogs and consistent delivery of reporting turnaround targets
- Demonstrable efficiency levels benchmarked against upper quartile national performance comparisons
- A full establishment of high quality staff, working to their full professional potential.
- Demonstrable ability on a consistent basis to meet core demand from core capacity.
- High standards of quality and safety, underpinned by robust clinical governance processes

Musculoskeletal (MSK) Pathway – the last year has seen a change in focus regarding the progression of work related to the MSK pathway. Podiatry services were diverted to meet the needs of those patients with complex vascular issues but physiotherapy continued to provide services. COVID-19 restrictions on routine services has enabled therapy staff to develop and test new models of working within communities including virtual consultations for patients on waiting lists (telephone, MS Teams, Skype, WhatsApp) with face to face assessments and treatments for high risk patients. The team also tested the use of a virtual Osteo Arthritic Knee (OAK) group education sessions using MS Teams.

This has led to a revised programme for Community MSK Transformation with a renewed focus on development of self-care materials, an improved patient information and options grids to support people to decide on their most appropriate management for common MSK conditions, supporting shared decision making approach, and an intelligence/data driven approach to map the future pathway and model demand against current capacity. Our focus for delivery this year is to progress the transformation of services by:

- Designing a website that deliver 'population' level access to information, advice and guidance
- Validating and testing the evidence and modelling pathway options
- Finalising a detailed description of new clinical and operational model including evaluation and PROMS
- Delivering a workforce model to meet new and changing demands

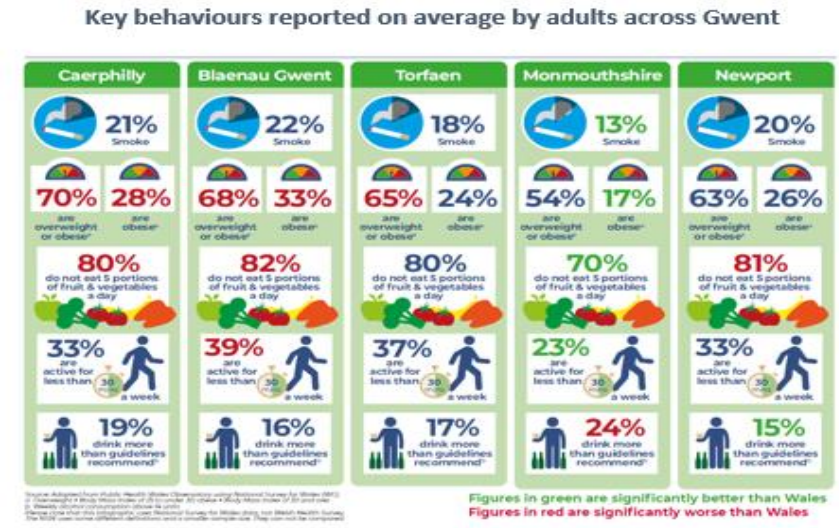
Supporting working aged adults to live healthily and age well

We know that overall the health status of our population is slightly worse to Wales, with 22% of people describing their health status as being fair or poor compared to Wales (19%). 17% of residents identified that day-to-day activities were limited because of health problems or disability compared to a Wales figure of 15%.

We know health inequalities exist across our most and least deprived communities, we also know that a large proportion of the disability due to disease and premature death in the population are because of cardiovascular disease, musculoskeletal disorders, cancers, mental ill health and respiratory disease. The development of a large percentage of these illnesses can be attributed to preventable risk factors including smoking, unhealthy diets and physical inactivity.

The difference in key behaviours reported on average by adults across Gwent in relation to preventable risk factors explains the major part of the difference in the

average number of years people live in good health and how long they live. People living in our disadvantaged communities have a greater number of unhealthy behaviours. Reducing health inequalities is a strategic priority for the Health Board and is a fundamental component of our longer term plan to reduce demand for healthcare through systematic, population scale interventions that target the underlying causes of poor health, such as lifestyle choices and socio-economic deprivation, and the uptake of screening to improve early detection and optimum treatment of disease.



Strengthening our focus on all forms of prevention is a core priority for the organisation. Its central importance is heightened in the wake of COVID-19 where the risk of health inequalities growing is real and our ability to reset services sustainably for the future makes preventing avoidable illness and supporting our adult population to age well is imperative.

Although the Health Board entered 2020/21 with ambitious objectives to reduce health inequalities, we also began the year under the shroud of the developing COVID-19 pandemic. As a result, planned activities for the last 12 months were largely suspended or delayed while services reacted to the worsening situation with population health protection taking and continuing to take precedence.

Integrated Well-being Networks (IWNs) are at the core of our plans, providing a framework to support the establishment of integrated, place based, well-being systems across all 11 NCNs in Gwent. IWNs are not about creating more services that attempt to solve people's problems, instead they capitalise on what is already available locally and bring in the unique strengths and assets that are within individuals and communities. Wherever possible we want people to find the support they need to stay well within their communities, reducing the need for them to access support from the care system. We will contribute to creating healthy communities by:

Promote the well-being of the workforce across Gwent (NHS, Public sector and beyond) We will ensure that our workforce:- • Are aware of the dangers of smoking and have access to NH Stop Smoking Services • Are supported for active travel • Have access to a holistic workforce health programme supporting the implementation of Clinical Futures Strategy
Strengthen community well-being and resilience • Greater collaboration between agencies and communities to strengthen community assets for well-being (people, places & provision) • Information on well-being assets and support is easily accessible and can be found in a timely way • Those working in communities see well-being as an important part of their role and have the knowledge and skills to signpost people and support behaviour change
Improve population mental well-being • Improved awareness of and access to self-help support for mental well-being and resilience by integrating and making visible services which build resilience in the face of stress and community assets • Improved confidence, knowledge and skills of the well-being workforce to respond to mental distress and support good mental well-being

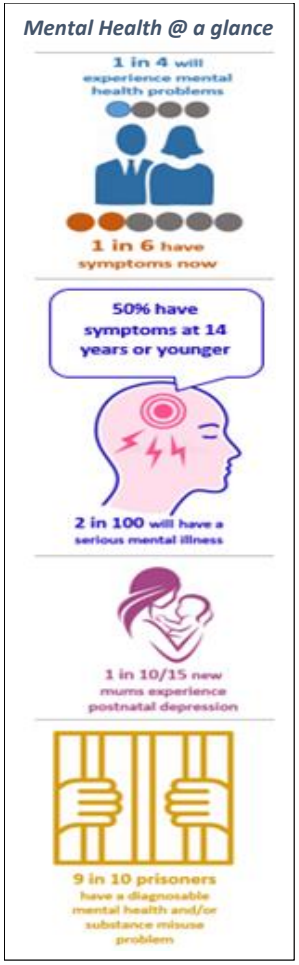
As we move over the coming year to reset the Living Well Living Longer Programme (our local response to the Inverse Care Law Programme) we will focus on capturing more working aged adults from eligible communities to have a Health Check, support those that attend to set personal goals and access support to reduce their lifestyle risk factors as well as to access appropriate treatment for high blood pressure, high blood lipids or diabetes.

Transforming adult mental health services

We support a rights-based approach that explicitly promotes the recovery model, with the empowerment and involvement of service users throughout the life

course. Our mental health and learning disability services have a long history of strong community focused services with a well-developed network of generic and specialist services across communities that are supported by specialist local inpatient services. Our services are delivered through multi-disciplinary teams in collaboration with our public and third sector partners.

The infographic illustrates the scale of the mental health challenge for our population. The COVID-19 pandemic is likely to heighten this challenge as people experience further adverse effects on mental health and well-being. These diverse problems may include anxiety about one's own illness or death, fear of illness or death of a loved one, worries about unemployment, and the effects of social and physical isolation in response to the pandemic.



Over the last three years we have focused on transforming our Older Adult Mental Health Services and our Learning Disabilities Residential Services. Now our attention is on transforming Adult Mental Health Services (Appendix 2) and we have begun the conversation with our communities to seek their thoughts, experiences and feedback on the ideas that we are proposing at this time. This engagement process ended on 22nd February 2021. Our plans aim to:

1. Increase and improve the services that are provided in our communities to support mental well-being
2. Improve the support available in Primary Care
3. Transform Crisis services
4. Improve the range of local service to better support people with complex needs

Prior to the COVID-19 pandemic, only 50% of our adult population reported good mental well-being. To Increase reported levels of good mental health well-being and reducing the gap between our most and least deprived populations , we continue to work with our partners to deliver more joined up working, increasingly supported by digital technology and accessed through a central point of contact. Key areas for delivery in 2021/22 include:-

Mental Health and Learning Disability model of care

Staying Healthy (Foundation Tier) - Improving the mental wellbeing of the population helps individuals realise their full potential, cope with life challenges, work productively and contribute to family life and communities.

Raising Awareness – A sustained campaign raising awareness of available support, targeted at groups/ people at greatest risk of having poor mental health & wellbeing	**Effective Community Insight & Self-help resources** – Melo Cymru; Digital technology; Integrated well-being networks; Voluntary sector services; Sanctuary; National Helplines
A Branded and Trusted Website – Develop a branded and therefore trusted website with up-to-date information and resources signposting to local support.	**A Sustainable Training model** – Establish a Gwent Connect 5 Training Hub to support all front line workers feel confident and competent to talk about mental health and wellbeing and are able to support and signpost people to the information and services they need.

Care Closer to Home (Tier 1) - we are committed to ensuring that all communities across Gwent have access to modern, high quality care, based as close to home as possible. We know that there is variance in provision and access to primary care mental health support and we will seek to enhance care by moving to a hub model of delivery, supporting a group of GP practices. A full range of individual and group therapies will be available through these hubs ensuring access for assessments and treatments will be the same across Gwent. Key areas for delivery are:-

Establishing Locality (hub) based model - Standardised electronic GP referrals. Face-to-face activity, including mental health assessment, individual and group based therapeutic intervention. A dedicated email advice service will be introduced to provide timely support, consultation and advice to GPs. Patients will have the choice to attend appointments in person or 'virtually' using video technology or telephone.

Psychological Wellbeing Practitioners - A named practitioner will be allocated to each GP practice to support individuals whose needs cannot be fully met through core Primary Care services.

Crisis Care Closer to Home **-** the Gwent Regional Partnership is committed to crisis support and acute care within the context of a Whole Life, Whole System approaches that meet the unique needs of people in crisis, recognising the social determinants of mental health and the need to address these as they relate to individual need. Practice, thinking, and culture needs to promote recovery and wherever possible the prevention or early intervention to crisis. We will move from our hybrid model with assessment provided through locality based team in-hours and centralised in the out-of-hours period to a single point of access, where assessments will focus on home first, with support from local community based services wherever possible. Our key areas for delivery are:-

A centralised assessment unit with enhanced local home treatment teams - Single point of contact for crisis referrals 24 hours a day, 7 days a week. Local appointments offered to patients between the hours of 9am and 9pm.
Expansion of Shared Lives for Mental Health - Shared Lives provides an alternative to and facilitates discharge from hospital care. It offers emergency placements with selected and trained families for people presenting to mental health crisis teams. Piloted in the Newport area it shows excellent patient-focussed outcomes, reduced admissions and re-admission to hospital compared with rates prior to the scheme. This year a business case will be developed to expand the scheme across our five Local Authorities in a partnership model with Caerphilly County Borough Council.

Inpatient Care (Tier 2) **-** there are many ways in which an individual may find themselves having hospital based care which include crisis assessments, mental health act assessments including Sections 135 and 136 in addition to treatment and recovery inpatient based care. Adult mental health services are supported by four inpatient wards, our focus has been on localities where each ward provides assessment, treatment and recovery services for their local populations. This means patients irrespective of the various stages of their crisis and pathway to recovery are supported within the same environment which does not provide the optimal patient experience for those who are acutely unwell and those in recovery.

Our key area for delivery this year, subject to public support, is to separate admission assessment and recovery services by consolidating assessment into a single ward that would take all new admissions across Gwent. Patients would stay there for a short period of assessment and treatment before being discharged home or transferred to a local recovery ward if needed.

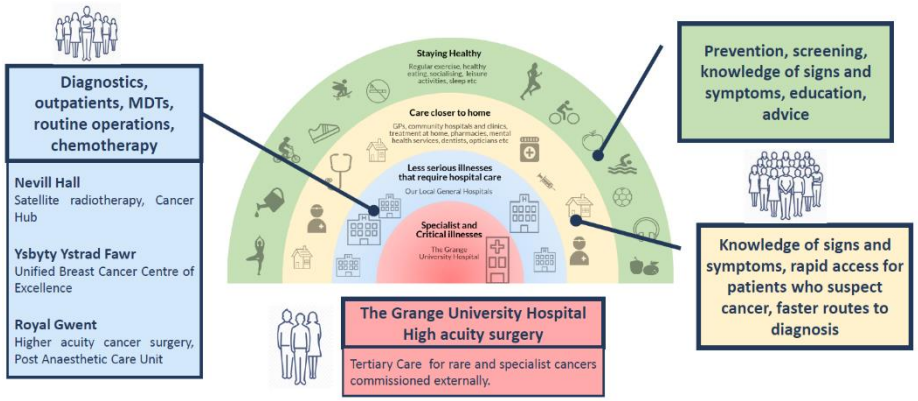
Specialist Services (Tier 4) **–** people with complex mental health needs are supported through a range of specialist inpatient services that include psychiatric intensive care, locked rehabilitation units (male and female), forensic rehabilitation and learning disabilities acute care unit. We also commission low secure services from both NHS and independent providers, the majority of which are sited outside of our area. Some are sited outside Wales.

We would like to develop a Specialist Inpatient Service Unit that brings together existing in-house services that are provided across multiple sites in some of the oldest accommodation within the Health Board. In addition we are seeking to develop, subject to public support, a low secure unit and have been in discussion with Welsh Government and are grateful for their support. Our key area for delivery is developing an outline business case for submission to, and approval by, Welsh Government by November 2021, proceeding to Full Business Case by July 2022.

Maximising Cancer Outcomes

We know that cancer outcomes need to be improved although we have made progress in recent years, we recognise the need to accelerate the rate of improvement. Through our local Cancer Strategy, Delivering a Vision 2020 - 2025 (Appendix 3) we have challenged ourselves to make enhancements in cancer outcomes through focusing on transformation right across the cancer system. Whilst it is too early to be able to measure the impact of the COVID-19 pandemic on morbidity and mortality from cancers, we are concerned that a combination of reluctance by patients to attend primary care and hospital together with the temporary suspension of national screening programmes and longer waiting times for diagnostic tests and treatment will result in increased morbidity and mortality from one of three diseases that contributes most to health inequalities for our population.

Model of Care for our Cancer Services



Despite the obvious challenges, the pandemic resulted in significant adaptations to our traditional ways of working, some of which will undoubtedly shape the future of services. **We are proud of the efforts of our Cancer Services who have continued to provide diagnostic and treatment pathways throughout each phase of the pandemic**, and have established a Vague Symptom Assessment Service during this time. We are now seeing a gradual return to more standardised delivery of treatments as opposed to the risk stratified approach adopted during the height of the pandemic.

Notwithstanding this, the delivery of cancer services continues to be affected by the necessary infection control measures which are reducing throughput in outpatient, diagnostic and treatment services by up to 50% at a time when GP referrals are within 10% of pre pandemic numbers. This is currently being managed by hosting additional clinics and waiting list initiatives, however the impact of reduced capacity is showing through longer wait times for patients.

Improving Cancer Outcomes – A Whole System Approach

Reducing the risk of cancer	Our approach to help our citizens find the support they need to stay well within their communities is set out at Priority # 3. We will also explore how this Integrated Wellbeing Network and our core services can capitalise on 'teachable moments' when a suspected cancer diagnosis is discounted.

Early Detection	For National Screening Programmes to reach their potential, uptake needs to improve and a combination of raising awareness and more acceptable testing is required. There needs to be targeted action in areas of high social deprivation where uptake of screening is at its lowest particularly in Newport East and West, and in Blaenau Gwent.
Timely Diagnosis	We know that there is variation across primary care in respect of their confidence and competence to spot signs and symptoms of cancer and refer appropriately in a timely manner. We will address this to do as much as possible to prevent late diagnosis Although significant progress has been made, we continue to support and implement an improvement programme in our endoscopy and imaging services and patient pathways. We know we need to continue this work and maximise capacity to speed up the diagnostic process. Rapid Multi-disciplinary Diagnostic Centres for people with vague symptoms opened mid pandemic will consolidate and options to expand will be explored.
RADIATION THERAPY	As part of Transforming Cancer Services, proposals are being progressed to develop a Full Business Case (FBC) in close collaboration with Velindre NHS Trust for a 2 Linear Accelerator project to provide additional more locally accessible radiotherapy capacity. The estimated capital cost is circa £16 million excluding enabling works and equipment. The FBC will be completed by November 2021. We are also preparing a Strategic Outline Context (SOC) for a Cancer Services Hub at Nevill Hall Hospital, to sit alongside the FBC. The Cancer services will consist of out-patient and Systemic Anti-Cancer Therapy (SACT) facilities utilising redundant accommodation in Nevill Hall Hospital following relocation of services to the Grange University Hospital. The SOC will explore the optimum function of a Cancer Services Hub to support delivery of care closer to home, improving patient experience and outcomes.
Acute Oncology	We continue to support and develop services to meet patients' needs who require acute admission as a result of their cancer treatment. Working closely with our stakeholders and partners across the South East Wales (SEW) region we have collectively developed and agreed an optimal service model. We are now developing a series of robust business cases to support the implementation of the agreed model at local, regional and specialist level.

	We are focused on embedding Acute Oncology Services (AOS) within the Division of Urgent Care. We are finalising our local model in the context of our unique system of care. We are seeking to clarify pathways for the regional and specialist components of AOS to fully understand what that means for our population. This work will deliver detailed workforce plans to drive change, pathways for local, regional and specialist components of the model that ensure patients receive the right care, first time. These together with capacity, finance, benefits and delivery plans will form a business case for investment that will be subject to the Health Boards Business Planning Process.

We continue to work closely with specialist and tertiary centres that provide components of the Cancer Pathway. The importance of joined up thinking and an agile commissioning framework to ensure our citizens have the best opportunity and choice to achieve optimal outcomes is reflected in and a key component of our cancer strategy.

Single Cancer Pathway

Cancer pathways are now being managed against the single cancer pathway target to ensure equity for all patients to timely treatment. Through our established Cancer Board structure, we continue to progress actions through a number of work streams to be able to more accurately report performance and to demonstrate continuous improvement against reported performance.

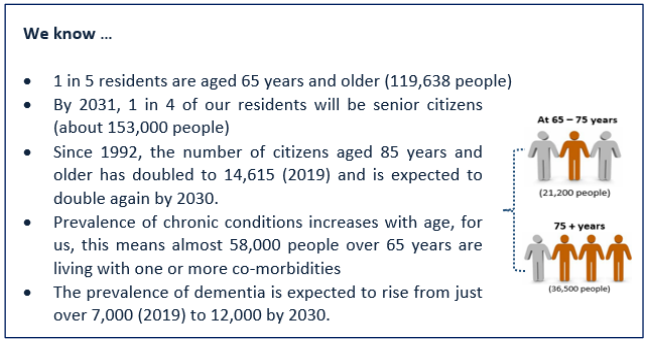
To ensure successful implementation and delivery, the three key areas of focus for us continue to align to three key work streams:

- **Information and Intelligence** - leading on ensuring processes are in place to accurately capture relevant patient data across all stages of the pathway and ensuring our IT systems are integrated and fit for purpose for tracking and reporting. We have and continue to develop our Cancer Dashboard which supports each Tumour Site multidisciplinary team (MDT) to manage their caseloads. We are proactively managing our processes to ensure that delays and barriers are identified, escalated and resolved in order to optimise each patient's journey through their cancer pathway.
- **Demand and capacity** – working to identify the gap and implement solutions to balance demand and capacity in the short term and on a sustainable basis. We have further work to do to understand our demand and capacity profile and recognise that there will be local and regional challenges in terms of balancing demand and capacity.
- **Pathway Improvement** – in parallel with improving timeliness of access to outpatients and diagnostics, we also need to pursue pathway improvement and new ways of working. We are committed to implementing the nationally agreed optimal pathways for specific cancer disease groups, and deliver incremental improvements, with the ultimate goal of reducing variation and improving outcomes for our patients.

PRIORITY 4 – OLDER ADULTS ARE SUPPORTED TO LIVE WELL AND INDEPENDENTLY

We believe this to be a fundamental principle of social justice and is an important hallmark of a caring and compassionate community.

Gwent has some of the highest percentages of older people population at a Local Authority level when compared across all 22 Local Authorities in Wales. Within our older adult population we have a higher percentage of people living with multiple morbidities, frailty, dementia and those needing help with daily living compared to other Health Boards in Wales.



In recent years we have delivered significant transformation of services for older adults through our Frailty Programme. Many of our resources sit in communities, delivering integrated services jointly with our Local Authorities, Independent and Third Sector partners. Notably, in the past year we have embedded the Home First programme and merged this with the hospital discharge service to provide a single point of discharge. We have also embarked on the 'Discharge to Recover then Assess' pathway (D2RA), identifying surge capacity within care home settings to support recovery before a determination is made on discharge destination increasing the opportunity for a person to return to their own home.

Notwithstanding the progress that has been made we need to ensure that our system is as aging-friendly as possible. We know that as people age, their health needs tend to become more complex with a general trend towards declining capacity. There is a danger that care can be over medicalised, particularly when an older person is admitted to hospital based services that are designed to cure acute conditions or symptoms and tend to manage health issues in disconnected and fragmented ways that lack coordination across care providers, settings and time. Consequently older people can experience extended stays in hospital environments and compromise our ability to sustainably, predictably and reliably deliver our planned care programmes.

Our system needs further transformation to ensure that older people can access evidence-based medical interventions that respond to their needs, in the context of what matters to them and ensuring that the care they receive helps prevent dependency later in life.

Our integrated framework is built on 4 pillars: Prevention & Anticipatory Care; Proactive Care & Support at Home; Effective Care at times of transition; Hospital & Care Homes, to help us transform our offer for older adults. It recognises the enormous amount of work that has already been achieved across our 5 regional integrated partnerships, which have supported localism and resulted in variations in the existing patterns of care, often driven by demography and services structures. We know that the answers, although complex, lay in building upon the patchwork of services across health and social care that have been developed over recent years.

For our primary and community services to be delivered most effectively, we together with our partners are committed to implementing a model of 'placed based care' to foster greater integration across health, social care and third sector and reduce complexity for both patients and those who provide care. Our first order priority is to align existing services to provide a consistent model which

provides health and social care staff, patients and their carers with the confidence to remain in their usual place of residence for as long as possible. During 2021/22 we will focus on:

Single Point of Access For each Borough combining health & social care knowledge with decision maker at 'front door' to direct person to services that meet their needs.
Establishment of 'places' The operational boundaries for what people will recognise as natural communities (typically populations of 25,000 people) to implement integrated place based teams that will be key to co-ordination of care for their population.
Establishing neighbourhood nursing through combining previously segmented nursing teams (District Nursing, Rapid Response, Chronic Conditions Management and Continuing Health Home Care Teams) local nursing provision will become more resilient and patients will experience greater continuity of care through dedicated key workers with fewer hand-offs between professionals.

Planning and provision of services as people age is a continuum, from stay well planning for those who have yet to become or are midely frail, through anticipatory care planning for those with more moderate and severe frailty or specific illness (e.g heart failure) through to advanced care planning for those nearing the end of life. Together with our partners across the region, we are also refreshing our dementia action plan to encorpoate the new dementia standards and improve peoples experiences of the dementia care pathway. Our immediate focus is on:-

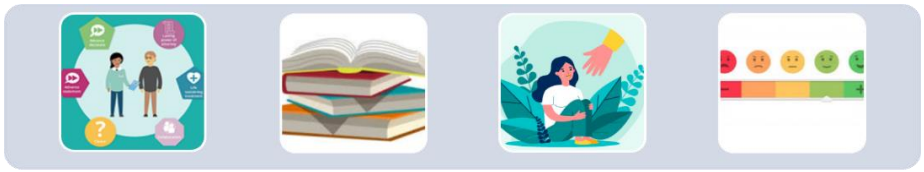
Risk stratification of our moderate and severely frail populations to allow primary care and our partners to understand the true scale of demand and target interventions to meet their needs. Primary Care based data provides a rich source of information, using tools like the Electronic Frailty Index (eFI) routinely will enable us to monitor our ageing population and proactively meet their needs closer to home.
Widespread adoption of Advanced Care Plans (ACP) with an ACP adopted for any person identified as moderately or severely frail. We will seek to develop electronic ACPs that are easily accessible to patients, their carers, clinicians, ambulance staff and others involved in their care to support informed decision making at times of transition and in urgent situations.

Graduated Care is being progressed to ensure greater alignment between patients' wishes and needs and the skill mix provided by our services. This is intended to release highly specialised resources to patients who truly require medical intervention and moreover to avoid overmedicalisation of the ageing process. Our focus is on establishing 5 levels of graduation in our hospitals.

1. Acute Care of the Elderly – consultant (COTE) led providing a combination of care for patients with acute episode, ongoing medical needs post specialist episode and acute exacerbation of chronic condition.
2. Medical sub-acute – consultant (Frailty) providing combination of sub-acute care for patients with ongoing medical conditions and rehabilitation.
3. Assessment Beds – locally based assessment beds (72 hour stay) as alternative to MAU attendance/admission.
4. Nurse-led rehabilitation – rehabilitation and recovery from illness for patients who do not require medical interventions.
5. Virtual home – for patients who do not require nursing or medical intervention but cannot be discharged home. Mimics care calls at home delivered through healthcare support workers.

PRIORITY 5 – DYING WELL AS A PART OF LIFE

Death and dying are inevitable. The quality and accessibility of end of life care will affect all of us and it must be made consistently better. We have embraced the principles of the 'A Compassionate Country – A Charter For Wales' and are committed to continuously improving what we do to ensure that the needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities are addressed, taking into account their priorities, preferences and wishes.



ADVANCED CARE PLANNING

- Improved care for people nearing the end of life and enable better planning and provision of care including developing treatment escalation plans with patients and to help individuals to live and die well in the place and manner of their choosing

EDUCATION PROGRAMME

- Professionals caring for people with end of life care needs are equipped in all health care settings to support shared decision making with patients and their families

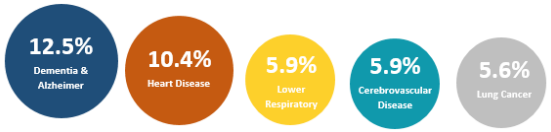
BEREAVEMENT SERVICES

- Bereavement service in place for people affected by a death that includes sensitive communication and provision for immediate and ongoing bereavement, emotional and spiritual support

VALUE BASED OUTCOME MEASURES

- Adoption of 'Care Aims' model to better understand what good looks like from a patient and carer perspective and support the development of patient reported quality outcome measures to influence service plans and delivery

Each year around 6,000 people die in Gwent which equates to around 16 people a day. Around 90 of these are children and young people. It is predicted that the number of deaths in Gwent will increased by almost 10% to around 6,600 by 2039. Around 40% of deaths occur in people's usual place of residence, either a home (26%) or nursing/care home (14%). 56% of deaths occurring in NHS hospitals. The leading causes of death in Gwent include:



The Health Board has made excellent progress by focusing on promoting and embedding the principles of Advanced Care Planning (ACP) into practice. A focus has been on educating staff on serious illness conversations with the understanding that a healthy approach to dying, planning ahead and informing family and friends of their wishes can result in improved person centred care at the end of life. In recent years the Health Board has implemented an ACP Primary Care pilot where GP practices piloted Vision 360 to capture ACP related outcome data. Additionally, there is a well-established priority work stream which is exploring outcome measures that reflect patient experience. We have been working hard to drive foundation and advanced communication skills across the Health Board and deliver communication training courses for staff.

Despite the achievements made, many challenges remain. We know that current trends in population aging show that, in the near future, whilst more people live longer, more will also die at any one time. Our system will need to change its practice to manage the number of people dying in the coming years, many with multiple co-morbidities. Our plan is built on four key areas of focus:

Advanced Care Planning - The first key area of focus is Advanced Care Planning (ACP) which is key in terms of improving care for people nearing the end of life and enabling better planning and provision of care, to help them die well in the place and manner of their choosing. It enables people to discuss and record their future health and care wishes and also to appoint someone as an advocate, therefore making the likelihood of these wishes being known and respected at the end of life.

We will build upon the work achieved over previous years with the continued implementation of the Advanced Care Plan Facilitators programme, supported by a business case to ensure the sustainability of this role, recognising their importance in embedding Treatment escalation plans and improving information sharing between primary and secondary care. Additionally, we will continue to promote and raise awareness of ACP through our recruitment of ACP Champions training programme.

Implement Advanced Care Plan Facilitators across from Primary and Acute Care We will continue to implement ACP Facilitators across both primary and acute care in order to embed Treatment Escalation Plans across the organisation and improve information sharing between primary and acute settings. This will be supported with the development of a Business Care to ensure the sustainability of this role.
Promote suitability of ACP with recruitment of ACP Champions Through the identification of Clinical ACP Champions to facilitate ACP training, we aim to raise awareness of the benefits of ACP and in turn embed good practice across all settings.

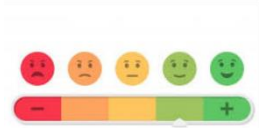
Education Programme – Education and ensuring a well-trained workforce has remained a priority for the Health Board for a number of years and will remain a priority moving forward. Communication, including both foundation and advanced communication skills has remained a key component of the education work stream. Training is delivered in partnership with the third sector and feedback has already been evaluated positively. For example, over 90% of participants feel as though the training delivered will influence their practice.

Embed Advanced Care Planning across all settings in Gwent using the Triple E model We will continue to the roll out of the e-learning programme including the facilitation of workshops in order to raise public awareness of the benefits of ACP and increase the knowledge and skills to engage with ACP discussions.
Continue delivery of foundation and advanced communication training We are committed to continuing the delivery of both foundation and advanced communication skills training for staff to support patients and families to make informed choices.

Bereavement Services –Bereavement is associated with significant mental and physical health consequences, and risk factors for illness. The detrimental effects of long term, unresolved grief, are well-documented. Bereavement services help to reduce immediate physical and emotional distress while ameliorating long-term morbidities associated with unresolved grief. We recognise the importance of effectively supporting bereaved relatives from the initial time of death to improve experience. We will build upon the foundations of work already taking place across the Health Board to improve bereavement services across Gwent.

Review of existing Bereavement Services across Gwent We are committed to improving both the equity and access to bereavement services in Gwent and will review the existing bereavement service offered across the Health Board and with third sector partners. Following on from the review, we will identify any gaps in provisions and determine what service change is required in order to provide a service that improves family and carer experience in compliance with NICE standards.

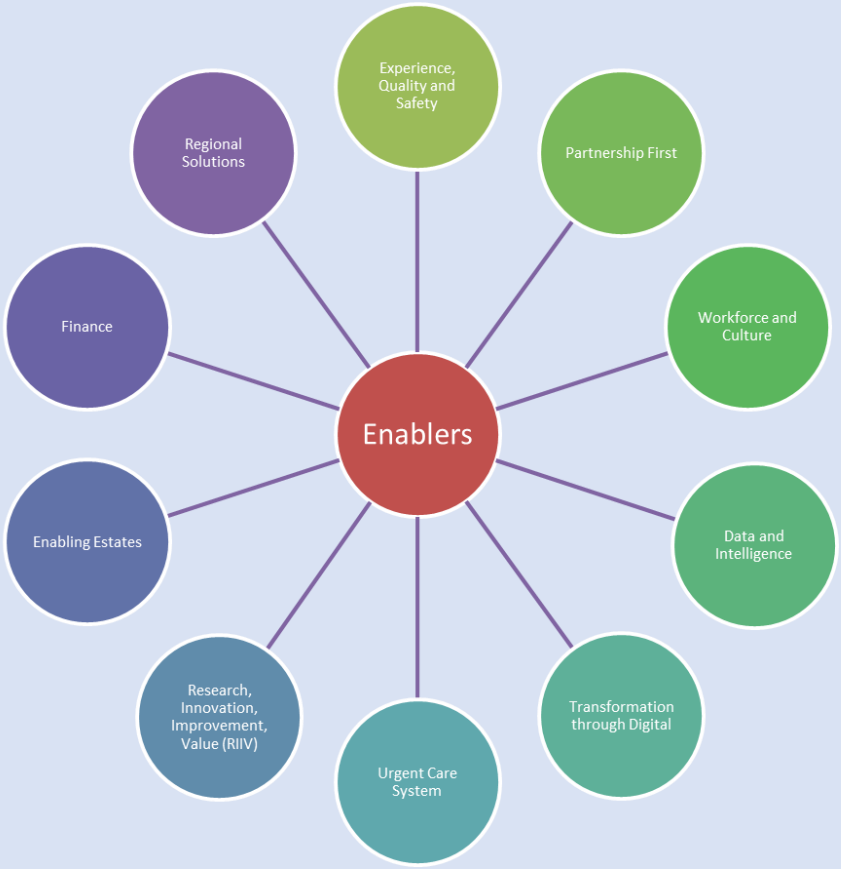
Value Based Outcome Measures – We are working at both a national and local level to identify a meaningful set of performance indicators. The aim is to develop an end of life performance dashboard that will provide meaningful, measurable data. This is a challenge that needs addressing in order to effectively evaluate the service. We will also continue the adoption, at pace and scale, of the 'Care Aims' model to truly embed 'what matters' principles and provide us with the evidence of feedback required to influence service plans and delivery. Additionally, we are committed to continuing with the participation in reviewing the options for Electronic Palliative Care Coordination Systems in order to improve information sharing.



Adoption of 'Care Aims' model The Health Board will adopt, at scale, the Care Aims model across multi-disciplinary teams by truly embedding 'what matters' principles, improving patient experience, voice, value and choice. This will provide us with improved metrics for patience experience and evidence of feedback influencing service plans, delivery and improvement.
Continue engagement with the All Wales Advanced Care Plan (ACP) Strategic Group We will continue to participate and review options for Electronic Palliative Care Coordination Systems. This aims to improve information sharing and improve patient choice to where they wish to be cared for and die through the completion of ACP.

KEY ENABLERS

Enablers are the factors which increase the probability of successful implementation of key priorities. We know that implementation is inseparable from context within the organisation, across our communities and the wider system. Our goal is to deliver sustainable changes to our system, this means that 'not only have the process and outcome changed, but the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed as well'.



1. EXPERIENCE, QUALITY AND SAFETY

Experience, quality and safety is at the centre of our work in seeking to achieve excellence. We aim to put the person first, so that every individual using our services, whether at home, in their community, or in hospital, has a positive experience. To do this, the quality and safety of our care and services is a core focus throughout all our plans, both for the service we provide now, and for the changes we are proposing to our models of care from small changes in one service to the driving force for delivering our Clinical Futures Strategy. Experience, quality and safety is underpinned in the Organisation Quality Assurance Framework (2021) which will have a focus on:

Enabling a Safety Culture - developing a robust patient safety culture requires a systems wide approach that minimises preventable harm, improves outcomes and experience and eliminates variation and waste. Embedding a standardised clinical governance system that functions from operational level to the board that is designed around the NHS Wales Health and Care Standards will provide the organisation with assurance around quality and risk. Key areas for delivery include:-

Reviewing the assurance framework and function of groups and committees across the Health Board including Divisional participation in all aspects of Quality, Safety and Patient Experience.
Reviewing the Quality Safety structure and Patient Experience across all Directorates and Divisions to ensure clear lines of responsibility, accountability, escalation and assurance through to the Board.
Clearly defining the support from corporate teams associated with the quality safety and patient experience agenda and setting the expectation.

A Learning Organisation - is one where people continually expand their capacity to develop and improve; this can be on an individual, team or organisational level. Quality, Safety and Patient Experience should be integral in informing a direction of travel in learning and education and should support a responsive approach in relation to emerging themes and trends. This should be undertaken through the

principles of coproduction and the Care Aims Framework. Key areas for delivery include:-

Identification of key quality and patient safety priorities and sources of information, to inform the learning and education agenda taking account of the views of service users.
Collaboration between corporate and educational teams to support the development of health professionals around key quality and safety priorities.
Facilitation of multi professional approaches to education aligned to quality, safety and patient experience.
Representation of learning and education on key quality and patient safety groups across the organisation.
To facilitate divisions and directorates to prepare a standardised annual improvement strategy based on information collated from review of complaints, incidents and audits.

A Just Culture - considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution or reprisal.

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by ensuring staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the risk of the same errors reoccurring can be minimised is a powerful tool in promoting cultural change.

Understanding the role of unconscious bias when making decisions will help ensure all staff are consistently treated equally and fairly no matter what their staff group, profession or background. Key areas for delivery include:-

To embed the use of the NHS Just Culture Guide in parallel with patient safety investigations when there is suggestion that a member of staff requires support or management to work safely.
To formalise an approach to supporting staff involved in patient safety incidents.
To further promulgate safe reporting culture.
To adopt national standards for consistent, high quality reviews.

Data for Quality and Improvement - both qualitative and quantitative data are critical in understanding the quality of care provision and in evaluating and guiding improvement. Increasing the availability of data and the capability and capacity to analyse, understand and utilise the data will ensure a focus on quality. Key areas for delivery include:-

To increase the capacity and capability of divisions to utilise data that underpins quality and patient safety priorities.
To increase the capacity and capability of the corporate Quality and Patient Safety Team to utilise data to support their agenda.
To develop a quality and patient safety dashboard with meaningful quality indicators that drives improvement and provides assurance.
To provide quantitative evidence that provides assurance in relation to the NHS Wales Health and Care Standards.
To introduce the Once for Wales Concerns Management System (OFW) to capture accessible real time feedback from our service users.

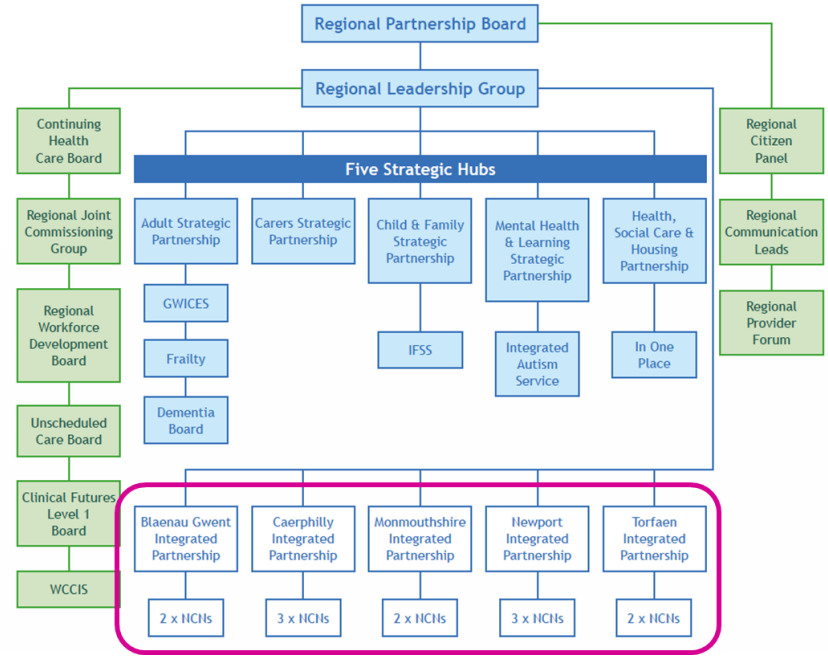
A Safe Environment - Hospitals and care settings have shown to be high-risk environments for COVID-19 transmission presenting a significant risk to patient safety, resulting in severe harm and death in certain circumstances. Surveillance and monitoring of COVID-19 infections acquired within hospitals (nosocomial transmission) has been essential to identify sources, minimise risk of further transmission and to ensure learning. We will be using the new, recently published national framework to ensure a consistent approach to the identity, review and reporting of patient safety incidents for nosocomial transmission of COVID-19, embracing the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

We have and will continue to undertake investigations into cases of nosocomial transmission of COVID-19 to determine instances of actual or potential patient harm, and to learn lessons to improve communicable disease control for the future, in collaboration with Legal and Risk services. Investigations will be proportionate to the degree of actual or potential harm identified with the overarching principle of investigating once, investigating well and learning.

2. PARTNERSHIP FIRST

Delivering services in partnership across Gwent is a key enabler in this plan. The Regional Partnership Board (RPB), the 5 Integrated Service Partnership Boards and the 11 Neighbourhood Care Networks deliver integrated services to people across

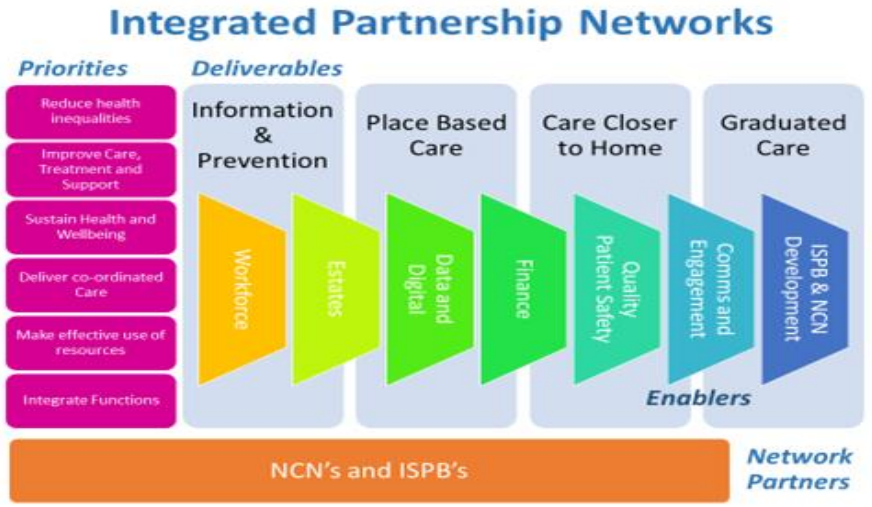
Gwent with Health and Care needs. These arrangements have varying levels of maturity and integration and the challenges presented by COVID-19 now create opportunities for the partnership to adapt to changing needs.



Driven by national and local strategies including, 'A Healthier Wales', 'Primary Care Strategy for Wales', 'Clinical Futures' and 'Building a Healthier Gwent' the long term priorities of the RPB will be delivered through a Placed Based approach (Appendix 4). Through partnership working, collaboration and integration, together we seek to provide seamless care to our communities, reducing complexity, hand-offs and making services more responsive and accessible.

A Place Based approach may vary across each "place" aligned with the needs of the area. To be effective each place will need to have shared goals, strong and clear leadership, and effective governance, responsive and prioritised assessment of needs, local decision making and meaningful citizen engagement. Deliverables follow a spectrum of need from graduated care to prevention activities and citizen information for self-care and support.

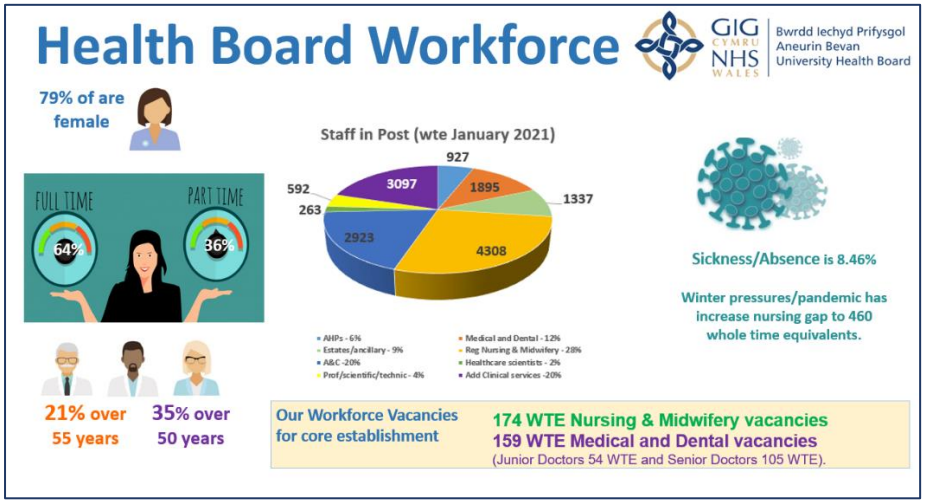
- Information and Prevention is made up of Integrated Wellbeing Networks, supported self-care and systemised care, early interventions and public health messages.
- Place Based Care includes making the best use of shared resources including physical locations and financial resources, strong partnership arrangements, clear partner boundaries and strong governance.
- Care Closer to Home will develop integrated pathways and integrated multidisciplinary teams, extended roles and support for carers.
- Graduated Care includes, step up, step down beds, the discharge to recover and assess model (D2RA), community hospitals and long term care and care homes.



Several enabling pillars support the delivery including a focus on workforce, data and digital solutions and strong communications and quality and patient safety. Underpinning this approach we are setting up a Neighbourhood Care Network (NCN) Office, to be the delivery engine of the developments, supporting governance arrangements, the review of population needs post COVID-19, citizen engagement and the sharing of best practice across the whole partnership space.

3. WORKFORCE AND CULTURE "Putting People First"

The Health Board employs 12,115 whole time equivalents (WTE) and 15,343 people (January 2021) and is the largest employer in Gwent.



Note: Health Education and Improvement Wales (HEIW) have requested additional Workforce and Organisation Narrative (Appendix 5) which underpin our workforce planning and educational commissioning assumptions

Over the last 12 months the number of staff has increased by 569 WTE (602 people). Recruitment has been across a range of specialty medical roles, radiographers, pharmacists, nurses, healthcare support workers and estates/ancillary staff to support the opening of the Grange University Hospital in accordance with our Clinical Future Strategy plans. In addition, there has been an increase in workforce in response to Test, Trace, Protect (TTP) and mass vaccination requirements, noting that many of the staff in mass vaccination are volunteers that chose to have more flexible working arrangements such as additional hours and bank (health care professionals who take on temporary shifts). On the 1st April 2021, Laundry Services staff will TUPE (Transfer of Undertakings Protection of Employment) Transfer to NWSSP (NHS Wales Shared Services Partnership) as a result of a nationally agreed process. This will result in a reduction of 49.56 WTE Facilities staff.

Our staff responded with dedication, professionalism and compassion in delivering the necessary changes required to support the early opening of the Grange University Hospital in November 2020. Our Workforce and Organisational Development (OD) dashboard routinely reports key workforce metrics that informs the design and implementation of our workforce plans and enables us to be responsive in how we organise our workforce.

We are using this data, together with our intelligence on staff experience to refresh our People Plan. This will outline our workforce ambitions to deliver organisational priorities which have been influenced by our Employee Experience Framework and our organisational values and most importantly our belief that our staff experience shapes patient experience. We will continue to focus on doing the basics well but also on issues that will help change the dial in critically important areas such as the recovery and wellbeing of our staff. Our People Plan will focus on the following strategic programmes of work to deliver a sustainable workforce to deliver high quality patient care:

Employee Well-being – we are in unchartered territory given the predicted scale of the problem where we are seeing evidence of chronic fatigue, burnout and mental health issues. The evidence suggests that these issues will be with us for 5 – 7 years post pandemic. The well-being of our staff is therefore our top priority for this year, we have developed an evidence based medium to long term strategy that adopts a two pronged approach:-

- Firstly, identifying and responding to the mental health needs of our staff by strengthening our current well-being service
- Secondly, developing a systematic way of supporting teams to identify and address symptomatic causes of poor wellbeing.

We recognise that our plans will have to address chronic stress and acute mental health issues. Our ambitious plans include the development of a Well Being and Education Centre that incorporates a Centre of Excellence to promote research and development and new approaches that will have benefits for all staff across NHS Wales. This will establish the Health Board as an exemplar in this field within the United Kingdom, which will in turn have a positive impact on staff recruitment and retention. This centre will also offer a unique contribution to 'A Healthier Wales' by becoming the first Welsh NHS Employee Well-being Service to proactively

address the complex psychosocial determents of poor well-being at work. An outline business case for the development of the centre has been submitted to Welsh Government for consideration.

Continued Response to the COVID-19 Pandemic - responding to the various stages of the pandemic will require focused, flexible and collaborative approaches to resourcing the Test, Trace, Protect (TTP) and Mass Vaccination Programme. Working with our local partners and military personnel will be integral to this work.

Agile Working/New Ways of Working - The pandemic has catapulted the agile working agenda into the here and now and will mean very significant changes for our workforce, our citizens and our health system. Our Agile Working Framework provides our workforce with a one stop shop for support and resources. We are currently reviewing agile working in the context of our Estates Strategy to understand how we can provide our accommodation differently along with digital solutions to support agile working and more effective use of resources.

We plan to retain much of the new and innovative ways of working which have served us well during the pandemic. This will include building on the way services have supported patients to access digital consultations and review where appropriate, for example reducing outpatient waiting times. Maintaining these changes supports the delivery of care closer to home, our response to the challenges of COVID-19, and delivering our commitment to becoming carbon neutral by 2030. Importantly it takes account of the changing needs of our staff and their wellbeing. Our plan is to ensure that we capture the learning from the pandemic and apply it so that we become a more innovative, agile, socially responsible organisation aligned to our Clinical Futures Strategy and the Well Being of Future Generations Act. New ways of working will be supported by an OD programme focused on developing and nurturing innovative and collaborative behaviours.

Reviewing the shape of the workforce - Our workforce plans will optimise the opportunity to develop and implement sustainable workforce models across all aspects of our patient pathways. Our plans will focus on

reviewing skill mix, development of new roles and maximising the contribution of the unregistered workforce through promoting top of licence working. This will include training and education within Primary Care and nursing homes to support admission avoidance into secondary care through improved advanced care planning. We will continue to work closely with HEIW to maximise our workforce planning capacity and skills.

The restarting of core services will require a greater focus on maximising opportunities for new ways of working. This will involve the use of established standards and frameworks and encouraging the development of new workforce solutions for areas of staffing under pressure through increasing skill mix, blended roles and extended roles. Job planning will also need to be more flexible to support different and emerging models of health care.

Recruitment and Retention - We will build upon our very successful programme of recruitment for the early opening of the Grange University Hospital and the positive recruitment campaign for the mass vaccination programme and COVID-19 surge. Whilst progress with recruitment has been positive it is essential that this activity remains one of our top priorities, recognising that some roles such as Care of the Elderly (COTE), Intensivists, Psychiatrists, Stroke, and other speciality consultant and junior doctors posts and other clinical support roles such as sonographers remain specialities which are hard to recruit to across the UK.

We will continue to work proactively with national programmes such as Train, Work, Live and Student Streamlining recruitment streams. We will continue to comply with the Capital Nurse Staff Wales Act (2016) which will be extended to include Paediatrics during the next year. We will maintain our focus on intensive recruitment campaigns for Registered Nurses (RN) and Health Care Support Workers (HCSW) and all vacancies. Our recruitment activity for 2020/21 has reduced RN vacancies from 336 WTE reported in April 2020 to 174 WTE and we have recruited an additional 126wte HCSWs.

We recognise that we are operating in an increasingly competitive market and want to be an organisation that people choose to work in and one where they choose to stay. Our Retention Framework includes a tool kit that facilitates staff to

have a voice, be engaged, supported & developed whilst maintaining their well-being to reach their full potential. This ensures that we put staff at the centre of what we do and ensuring we embed our core values which creates a positive workplace culture.

Our recruitment and retention strategy supports succession planning through development of career pathways for our current and future staff. We will continue to use Health Education and Improvement Wales (HEIW) succession planning frameworks and the People Academy to ensure there is a pipeline of talent. We will continue to support the provision of apprenticeships and widening access for school leavers and unemployed including our volunteer workforce. We embrace the opportunities of volunteering across the life course, encompassing the opportunities for individuals regardless of age or ability to derive the well-being benefits of volunteering. We also see volunteering as a route for people to consider careers in health and social care through our inter/multi-generational programme. We value the importance of volunteering in sustainably supporting vulnerable people across our communities. We will also look at opportunities to strengthen career pathways through the development of the Middle Doctors Strategy and our Middle Manager Transformation modules.

Learning and Development - Working with HEIW we will deliver leadership and other development programmes to ensure our staff have the necessary skills to succeed in a rapidly changing environment and where multi-disciplinary working is key. We are constantly reviewing and modifying the existing suite of development programmes to ensure they remain relevant and accord with the latest thinking and best practice. Our focus will also be on stimulating clinical leadership to drive service improvement.

Equality, Diversity and Inclusion – The disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic groups highlights the entrenched inequalities in wider society and puts a spotlight on the need for a greater focus on equality, diversity and inclusion within the NHS. Led by our Chief Executive, we are conducting a listening exercise to ensure that staff views and concerns shape and develop the approach we take to this important agenda. Our aim is to have an open conversation across our workforce to improve understanding of this complex area and inform the development of new approaches. This work will be overseen and scrutinised by the People and Culture Committee which is a subcommittee of the Health Board.

Our Focus…
Listening and learning from lived experience
Reliable baseline ethnicity and equalities data
Mechanisms that support psychological safety and culture competence

Welsh Language Standards - we recognise the importance of meeting Welsh language needs and the positive impact this has on patient experience and the delivery of safe, high quality care. We have made excellent progress in the implementation of the Welsh Language Standards and our increase in resources to deliver these. This has been achieved through the development of Health Board wide working groups adopting project management methodology, ensuring divisional ownership and feedback on progress. Significant advancement has been made in translation of key documents, patient information leaflets, patient correspondence, and staff policies.

The pandemic has had a significant impact on the way work is organised and delivered, and its shadow will necessitate constant review of our workforce plans. Our response will always be driven by our values where we take personal responsibility, demonstrate passion for improvement, take pride in what we do and in particular put people first.

4. DATA AND INTELLIGENCE

Whole system understanding provides the ability for services to operate, improve, and focus interventions to deliver optimal care along the entirety of the patient pathway. We have a wealth of rich information and data available. How this data is used should be conversant and seamless along the whole patient pathway providing shared understanding between all those involved regardless or system role or organisation. Data should be used as the evidence base on which we plan and make decisions at all levels to deliver safe, effective and timely patient care.

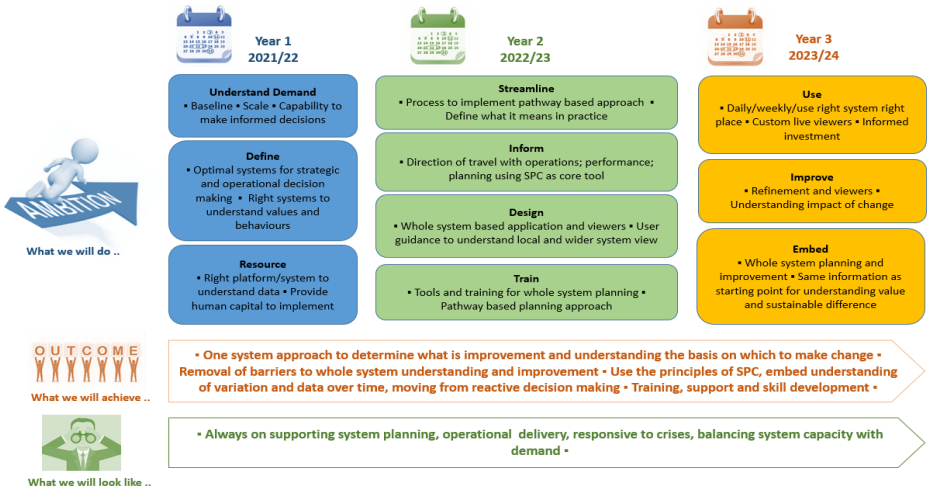
Our primary goal is to place live real time data that everyone across the system understands and trusts, using this as a basis to plan and make decisions. Using data intelligently means working in a way that is:

▪ Meaningful ▪ Providing insight into decisions ▪Improvement focused at every level of the organisation ▪

Control to establish and understand our baseline and evaluating how we currently operate. This will enable assessment as to whether the changes made are making a sustainable difference.

This goal is a core enabler to building a high trust low bureaucracy culture and will support system planning through seeing systems together. This whole-system perspective translates our information into a facilitator for change ensuring we no longer plan in silos connecting services into coherent end-to-end pathways for sustainable change. We know evidence-based decision-making and collaboration leads to better outcomes and being able to expose the opportunities for sustainable change improves patient care.

The COVID-19 pandemic has caused sustained disruption to service delivery with wide ranging implications for the health of our population and the ability to receive treatment to prevent further harm. After a prolonged period of system stress and especially on our workforce, making informed planning decisions are important now more than ever.



To plan for 2021/22 we have opted for a realistic and balanced approach to understanding our true demand and system capacity. Through understanding our unmet demand, and using our previous system behaviour as an indicator, scenarios have been run based on the prevalence of COVID-19 activity that we can achieve remaining for some time. This has enabled us to understand the realistic levels of activity and the key areas where new ways of working, partnership approaches and pathway changes will need to be developed to address unmet demand and improve patient experience and outcomes.

5. TRANSFORMATION THROUGH DIGITAL

We need to ensure we make the most of technology to improve the care and support we provide. In July 2019, the Health Board approved our Digital Strategy designed around four themes to help up to achieve our ambition to develop a sustainable system of care with patient safety and care closer to home at its heart. The past 12 months have enabled us to test and stretch the boundaries of technology in enabling significant system transformation, as demonstrated by the accelerated change that has been delivered in the context of COVID-19 and the early opening of the Grange University Hospital in November 2020. The role of digital has never been more important in enabling change, over the past year it has been instrumental in establishing:

Remote Collaboration - MS Teams from sourcing and setting up of MS Teams (equipment, training) to enable and support staff to work safety from home. We have delivered a step-change in agile working and through this technology we can secure a range of lasting benefits.

Virtual Consultations – Attend Anywhere has enabled 32,000 patients to access care through video consultations, reducing the risk of exposure to COVID-19 for 85% of patients. This technology will help us to deliver more care closer to home whilst avoiding the costs, time and

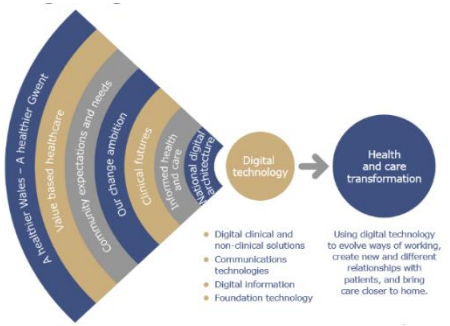
stresses involved in patients travelling to hospitals where this is their preferred and most effective method of consultation.

Robotic Process Automation (RPA) was introduced by the Health Board in April 2020 to determine whether automation of the manual transcription of hospital admissions, transfers and discharges from our Clinical Work Station application to the Welsh Patient Administration System would improve the quality and timeliness of bed status and bed availability. We now process 6,000 transactions each week, which are processed around the clock (24/7) and have eliminated delays, previously 2-3days between the two systems. Automation has also facilitated the release of staff previously engaged in routine work to undertake more challenging work that would not lend itself to automation including supporting the Mass Vaccination programme,

The Grange University Hospital – in response to the pandemic the Health Board expedited the opening of the new hospital which resulted in the need to deliver the Information Communication and Technology (ICT) infrastructure and software systems and ensure staff were trained in time for the opening in November 2020.

Delivering our Strategy – our digital strategy 'Transformation through Digital' sets out our ambition to make the best use of digital technology to enhance health and care in our area by enabling people to manage their health and care needs more independently and enabling our staff to deliver holistic care and high quality services.

As we enter 2021 with a portfolio backlog as a consequence of the pandemic we are strengthening clinical leadership within informatics through a Chief Nursing Information Officer role, we aim to strengthen this with a case for a Chief Clinical Information Officer and the establishment of a Clinical Council.



Our areas for delivery this year are set out against the four themes that underpin our approach to transformation.

Digital Community
Enables people to manage their health & care needs independently

The delivery of a citizen portal is essential to empower patients to take more control and responsibility for co-producing their health and wellbeing and managing their conditions. Self-management will lead to a reduction in face to face and unnecessary appointments whilst improving the patient experience. Working in collaboration with the emerging all Wales programme supporting Digital Services for Patients and the Public which aims to deliver a citizen platform so that people can access their health service from a 'one stop shop' platform. This programme is sponsored by the Planned Care Programme Board and we are fully committed to supporting the development and delivery of the Citizen Platform. This year we will implement the Welsh Community Care Information System in our Mental Health Services, and begin to rollout to Community Nursing.

Digital Organisation
Enables staff to be equiped to deliver holistic care and high quality services

Digital Ward Programme is delivering key capabilities for our staff encompassing Patient Flow, Clinical Work Station and development of other digital data capture tools including support for the national e-nursing docs work. This year we will develop the use of the Careflow product for managing the deteriorating patient, clinical team task management and prioritisation and implementation of clinical data capture and re-use.

Will will also focus on Clinical Communications through technologies supporting hospital clinical voice, video and messaging initially bringing together existing platforms including pagers, phones, mobile devices, applications and the Vocera system for peer to peer messanging.

We will be driving a project to procure a digital health record solution for Maternity services to replace our existing system that is not fit for purpose and we will continue to implement the second phase of our Theatres System.

Working closely with NHS Wales Informatics Service (NWIS) and NHS Wales Shared Services Partnership (NWSSP) we will continue play our role in supporting the implementation of national programmes. In partnership with neighbouring Health Boards we continue to facilitate the sharing of information for regional level clinical specialty networks. A regional group has been established to ensure South East Wales priorities are consistent to make it easier for NWIS to prioritise activity for the region.

Digital Foundations
Provide fast, highly reliable and secure devices, storage and networks

We will continue to invest in our existing ICT infrastructure and user equipment to ensure they are safe, secure and reliable. Significant resilience work will be undertaken in Clinical Work Station to ensure that its performance, availability and disaster recovery procedures reflect best practice. This work will include improved facilities for digital clinical data capture. Our strategic focus this year will be on supporting the establishment of Integrated Wellbeing Centres that bring care closer to home.

Digital Data, Information and Intelligence
Getting the maximum we can from data and information

Our focus is on getting the maximum we can from our data and information. We continue to invest in the development of our systems to facilitate the collection and use of structured clinical data. This will support our clinicians and facilitate cross-NHS Wales flows suppporting patient journeys of care in collaboration with the National Data Repository.

Working with NWIS and using 'Open Architecture' we are planning how to deliver a solution to enabling visibility of the GP record, test results and patient care documentation on our digital platform.

We will also test the application of robotic process automation (RPA) in Clinical Coding (a function that involves the translation of written clinical statements into a code format) working through clinical coding scenarios to see if this technology can assist with more timely coding of clinical episodes.

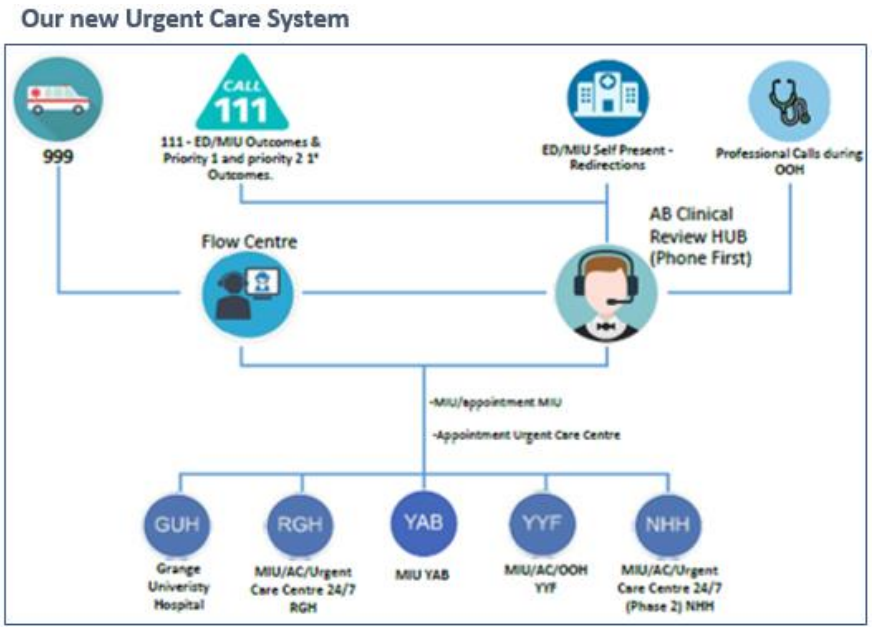
A key enabler for delivering a new "Always On", approach with a greater focus on System Planning, Operating, COVID-19 Re-Planning and balancing Demand with Capacity, are the functional components and tools available. Building on the performance and reporting capabilities we have available in Qlik, the ability to understand system behaviours in order to improve services, review and revise pathways and project forward will be available using the Lightfoot SFN platform. SFN will be used to implement our dynamic approach to understanding where we are now, and identifying opportunities during a time of high variability and uncertainty, enabling us to plan for sustainable change and connect services into clear end-to-end pathways.

6. URGENT CARE SYSTEM (Emergency Care)

Urgent care encompasses any illness or injury that requires urgent attention but is not a life-threatening situation and may involve a range of existing services including phone consultations through the NHS111, pharmacy advice, same day and out-of-hours primary care appointments, and referral to an urgent care centre. However a significant proportion of people with urgent care needs present in secondary care, our ongoing analysis of demand across the system demonstrates that the needs of many of these patients could be delivered safely and effectively in other settings.

Our ambition for our urgent care system is to deliver the right care, to the right patient, in the right way, at the right place by the right person(s). Not only is this best for the patient, it is also a fundamental enabler for the rest of the system where urgent care flow places demands on the system that are inextricably linked to our ability to deliver emergency, urgent and non-urgent care.

Our proposed new system seeks to simplify access for patients, providing clarity on the best route to care, with all access to urgent care services provided via the 111 or 999 contact numbers. Three major work streams are driving the changes needed to develop and embed the new model namely the Flow Centre, Contact First (clinical review hub) and Urgent Primary Care Hubs, together with full engagement and consultation with the public and Aneurin Bevan Community Health Council.



Flow Centre - As a core feature of our reconfigured urgent care system the Flow Centre provides a single point of contact to optimise patient flow and ensures that appropriate transport arrangements are made to support all admissions, inter-site transfers and discharges across the hospital system, aligned to whole system flow.

Initially established as a pre-hospital streaming service, we are building on our learning from the earlier opening of the Grange University Hospital and developing the Flow Centre to deliver a more comprehensive model that includes the development of a multidisciplinary workforce (system now utilising temporary and shielding staff) and incorporates redirection of patients to primary care, community services or ambulatory planned specialist care); single point of contact for all routes of referral into same day urgent care; robust information/data capture software and becomes a training hub to ensure consistent service provision. Key areas for delivery include:

Workforce • Confirmation of sustainable medical staffing model • Implement transitional staffing plan for review after six months • Ongoing data capture of service demand to inform long term workforce plan
Estates Completion and costing of option appraisal process for Flow Centre location. Move to identified location with associated infrastructure.
Informatics • Finalise procurement of interim IT system and formalise capital / revenue requirements that will enable us to deliver our new system of urgent care
Business Change • Finalisation, sign off and engagement / communication with all standard operating procedures and pathways to system stakeholders e.g. LMC, CHC • Mandating of the service to ensure comprehensive coverage and operational effectiveness • Review and optimisation of patient pathways integral to the Flow Centre
Operational Ownership • Embedding of new system into operational management structures and processes • Confirmation of Governance and Professional Accountability

Clinical Review Hub ('Contact First') - Phase 1 of 'Contact First' launched in December 2020 via the Urgent Primary Care Service at Vantage Point House, Cwmbran. We have sought to establish 111 as the first point of contact / entry into Urgent Primary Care, Emergency Department (ED) and Minor Injury Units (MIU) for all contacts other than a 999 emergency call. This is to ensure that:

Senior Clinicians from Urgent Primary Care, ED and MIU in conjunction with the Welsh Ambulance Services NHS Trust (WAST) have defined an 'Always ED' list for those patients who should be advised at 111 stage to attend ED due to the severity of their condition. This system has been reviewed and informs learning and actions that will be progressed this year when we fully launch the service in April 2021 subject to confirmation of funding from Welsh Government. This will give people the option of phoning first to enable them to access the system at the most

appropriate point and at the right time to meet their needs. Currently, around 7% of people accessing urgent care can avail of this service. Key areas for delivery include:

Contact First Hub • Formalisation of all booking system requirements and procedures • Consolidation of close links with WAST to ensure 111 capacity is available to manage the additional patient calls
Communication and Engagement • Full engagement with our Community Health Council and other key stakeholders • Comprehensive public communications strategy
Enhanced Management of Patients Waiting on Stack We will also progress a joint pilot with WAST to provide enhanced management of patients via C3 remote stack to ensure system wide oversight of the WAST stack and will enable senior clinicians to assist in the patient journey via appropriate pathways, improving patient safety and care closer to home.

Urgent Primary Care Centre - The introduction of the two Urgent Primary Care Centres, one at Royal Gwent Hospital (RGH) and one at Nevill Hall Hospital (NHH), has ensured a smooth transition of patients with urgent primary care needs from our four Minor Injury Units (Newport, Abergavenny, Ebbw Vale and Ystrad Mynach) and from ED at the Grange University Hospital. The Urgent Care Centres are currently staffed with a GP, Nurse Practitioner and Receptionist with plans in place to develop the multidisciplinary team this year. Data collection and initial demand and capacity work has been undertaken to inform the evaluation, alongside engagement with our population of the pacesetter initiative and share best practice across Wales.

To date, the service has enabled patients to be seen on the same day for any urgent Primary Care need or to be re-directed to other services if more appropriate for their need, for example opticians. Work is ongoing to increase re-directions across all sites, especially our main ED at the Grange University Hospital with the support of clinical, managerial and non-clinical staff across ED, MIU and Urgent Primary Care. The introduction of the Urgent Care Centres has already seen enhanced working relationships across all service areas, facilitating the availability of more streamlined pathways, thereby making changes system-wide. Key areas for delivery include:

Multidisciplinary Workforce • Introduction of physiotherapy support • Provision of additional mental health support
Pathways • Development of revised deep vein thrombosis pathway
Data and Intelligence • Analysis of demand and capacity to determine need for a further Urgent Care Centre (initial focus Blaenau Gwent)

7. RESEARCH, INNOVATION, IMPROVEMENT AND VALUE (RIIV)

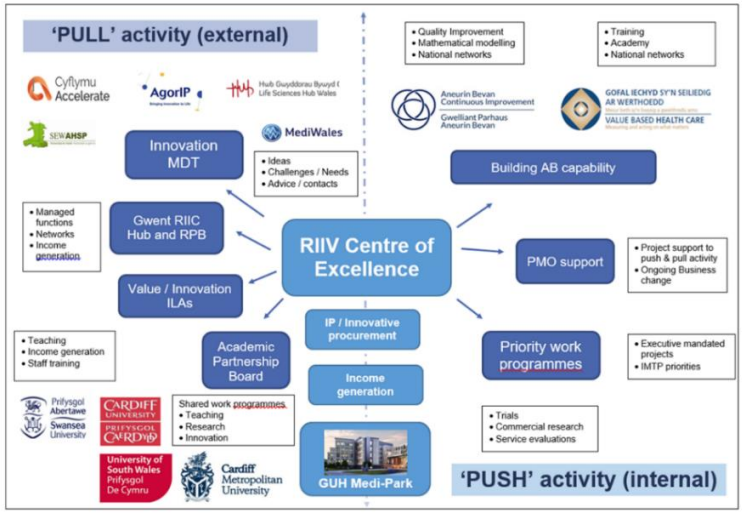
We have invested in and supported the development of Research, Improvement, Innovation and Value Based Healthcare (RIIV) functions, all of which have a shared purpose to support the organisation to think and work in different and more effective ways. Until now each function had a discrete portfolio:-

- **Research and Development (R&D)** – 'Generating evidence and developing new thinking, knowledge and understanding' through commercial / non-commercial research for clinical and scientific areas. Welsh Government funding enables us to contribute to the national and international generation of evidence, mostly through recruitment into clinical trials. We have strong academic links where we make joint applications to fund research that answers research questions specific to the needs of our population.
- **Aneurin Bevan Continuous improvement (ABCi)** – 'Doing things better' Quality Improvement and mathematical modelling.
- **Innovation** – 'Doing new and different things' developing an innovation culture, platforms and infrastructure; learning from COVID-19, developing innovation capacity through training, creating ideation routes for new products and services, securing new funding sources, refocusing academic and industry partnerships, intellectual property and new revenue streams.
- **Value Based Healthcare** – 'Measuring and acting on what matters', assessing the real value of healthcare activity; patient outcomes, experience and resource efficiency.

Now our focus is on creating a more integrated RIIV approach, one that supports the ambition within 'A Healthier Wales' to establish Research, Improvement and

Innovation Hubs across Wales to share best practice and knowledge. We believe that better alignment and coordination of RRIV portfolios will provide a more joined up offer for the organisation to think and work differently. This will better support meeting our internal priorities and challenges, whilst providing a strong platform for our external engagement through platforms such as the Academic Partnership Board, Gwent RIIV Coordination Hub. Our priority for 2021 is to align our RIIV capability to delivering our organisational priorities.

What might an RIIV model look like?



In the longer term, an integrated RIIV approach will be the key Aneurin Bevan University Health Boards offer to the proposed Grange University Hospital Medi-Park, providing a significant and unique platform to engage externally with academia and industry - bringing with it innovation, economic and health benefits.

8. ENABLING ESTATES

Our 10 year Estate Strategy (2018-28) (Appendix 6)approved by the Health Board in January 2019, seeks to support the implementation of the Clinical Futures Strategy where more care is delivered closer to home, requiring the development of 'hubs', both physical and virtual, at key locations across our communities together with a transformed network of Local General Hospitals (LGHs) and the Grange University Hospital that delivers a hub and spoke model of secondary care services. The Strategy contains 18 Strategic Objectives, organised around five sub-categories including our approach to the Decarbonisation Strategic Delivery Plan for NHS Wales.

Our vison – a sustainable future focused, fit for purpose estate supporting delivery of patient outcomes and experience, which motivates and enables staff with partners to deliver safe, efficient, quality services that are financially viable and sustainable.

Service Area		Objective	
Hospital	Acute	1	Reconfigure & rationalise RGH as an LGH and Elective Care Centre
		2	Reconfigure & rationalise NHH as an LGH and Cancer Centre
		3	Ensure existing services at YYF are appropriate and sustainable
	Community	4	Reconfiguration of services at St Woolos Hospital
		5	Review service provision required at County Hospital – re-development potential
		6	Ensure existing services at YAB, Chepstow and Monnow Vale are appropriate and sustainable
		7	Ensure VFM in existing facilities funded under PFI arrangements
Mental Health		8	Development of a Low Secure Unit within the Health Board
		9	Explore rationalisation of facilities at St. Cadoc's Hospital Site
		10	Relocate YTC services to NHH, explore reuse for primary and community based services
		11	Explore potential use for MCH including part disposal of site
		12	Determine future use of Llanfrechfa Grange site (areas not needed for Healthcare)
Primary and Community		13	Review location, content, condition and utilisation of all community based facilities by NCN area in context of other public sector facilities and the Clinical Futures Strategy
		14	Following comprehensive review to develop a costs and prioritised plan for the creation of 'hubs' and a sustainable, fit for purpose community estate.
Leased/ non-clinical		15	Develop and implement a clear policy on adoption of agile workforce principles to facilitate rationalisation of office accommodation
Backlog maintenance		16	Validate Six Facet Survey calculation of risk for backlog maintenance, develop a prioritised action plan to address and reduce high and significant risks
		17	Benchmark maintenance costs with other relevant organisations and develop plan to address shortfall
Environmental management		18	Implement the Health Board's Energy Strategy 2019-2024 with specific, costed and targeted initiatives that reduce emissions and achieve WG Energy Performance Targets

Our capital programme is a key enabler to delivering our strategy and maintaining our estate. £10.814m discretionary capital funding will support our plans for meeting statutory obligations, maintaining the fabric of our estate and the timely replacement of equipment. The following major capital projects being supported through the All Wales Capital Programme (our 2021/22 allocation - £7.95m Capital Resource Limit and £2.6m brokerage) are enabling us to undertake post completion works at the Grange University Hospital including the phased opening of the Hospital Sterilisation and Disinfection Unit (HSDU) this summer. We are also making head way with progressing Health and Wellbeing centres in Tredegar and Newport East, the Breast Unit and the Satellite Radiotherapy Unit to approved full business case. In addition an Outline Business Case is being prepared to support a Specialist Inpatient Unit for Mental Health and Learning Disability Services. A number of emerging projects are underway in relation to Endoscopy, Pharmacy and other eLGH related projects.

9. FINANCE

Our Annual Operating Framework for 2021/22 continues to focus on the aims of the 2020/21 to 2022/23 Integrated Medium Term Plan (IMTP) and assumes that it will continue to meet its statutory financial duties, recognising the uncertainty and risks during 2021/22. Strategic plans will be cognisant of the expectations to consider the requirements of 'A Healthier Wales', 'Wellbeing of Future generations Act', the 'Socio-economic duty' and the aims of the 'Clinical Futures Strategy' for Gwent.

The immediate focus is to ensure resources are available to respond to the uncertainties in 2021/22, capitalise on the GUH / e-LGHs as a catalyst for change and drive sustainability plans to improve the underlying financial position. The ability to generate savings during the pandemic has been a significant challenge and opportunities for transformation have been limited, so 2021/22 presents the opportunity to refocus on transformation and innovation for sustainable efficiency gain, whilst acknowledging risks to full year delivery exist while the pandemic continues. As part of developing service, workforce and financial plans we have tested its overall cost growth and savings assumptions by taking account of:

The financial plan discretely identifies the financial implications of responding to and recovering from the COVID-19 pandemic during 2021/22.

Resource Allocation - We welcome the additional funding announced by Welsh Government, through the 2021/22 Allocation letter, allocation movements consist of new allocations, consolidation of 2020/21 recurring in-year allocations and some previously anticipated allocations, resulting in a net uplift of £20.8m (2%) for Aneurin Bevan University Health Board for the 2021/22 financial plan. This excludes the funding allocations being held centrally by Welsh Government.

We will apply the additional funding, along with agreed anticipated allocations and other income as part of the total core allocation of £1.4 billion, in line with the agreed resource allocation principles agreed by the Board.

Funding that is being held centrally by Welsh Government for mental health, has not been reflected in this plan. Unless otherwise confirmed, no allocation funding has been assumed for either COVID-19 response or COVID-19 service recovery. Further discussions on resourcing to accelerate benefits realisation from Clinical Futures system transformation would be welcomed. Exceptionally for 2021/22, a quarterly financial budget planning process will be implemented, to ensure that the uncertainties of responding to the pandemic are appropriately mitigated, resourced and managed within our governance framework.

Value Based Health Care, Savings and Efficiency Improvement - Significant recurrent savings of £33m were planned for 2020/21 before COVID-19 redirected management attention. Cash releasing savings for 2021/22 have been assessed as circa £8.5m at this point and cost avoidance opportunities have been used to mitigate expenditure estimates. Based on the opportunities identified within the various Efficiency Frameworks, both national and local, there are further opportunities worth circa £25m to increase cash releasing savings and productivity improvements to deliver improved value and break even.

Underlying Financial Position - Our Health Board reports a forecast underlying position for the 1st April 2021 of £21m, reflecting a reduced level of recurrent savings achievement. The aim is to improve this position during 2021/22.

2021/22 Spend Commitments - Our priorities identified for 2021/22 include:

- First 1% of Pay Awards 2021/22 & LTA 2% directed uplifts
- WHSSC Specialised Services & EASC expansion and growth
- Commissioned Services directed uplifts
- 111 Project & Urgent Care Flow developments
- Cleaning Standards
- Preventative Partnership services – including early years/children services
- Transformation fund schemes

We have assumed within the financial plan the re-provision of £0.4m funding for Neighbourhood Care Networks (NCN).

Uncertainty exists with cost pressures as part of 'normal operational business' but in these exceptional times the risk is exacerbated and will need to be managed. These and other local priorities will need to be managed within available allocations and income of circa £1.4bn.

COVID-19 Financial Planning - The financial plan discretely identifies the financial implications of responding to and recovering from the COVID-19 pandemic during 2021/22. Service profiles are likely to require a full COVID-19 response to be in place for Quarter 1 2021/22 with more specific responses (like MVP and TTP) continuing over future COVID-19 Response Plans, where they have not received confirmed allocations are identified separately for spend planning purposes – subject to further Welsh Government guidance. COVID-19 Recovery Plans have not been included within the spend plans and will be subject to further discussions with Welsh Government to support both internal and externally commissioned services for 2021/22. Response plans include:

- Mass Vaccinations Programme
- Contact Tracing service
- COVID-19 Testing service
- PPE COVID-19 requirements
- Pathology testing costs
- Surge Ward & Staffing
- Acute service actions
- Externally commissioned 'green pathway' services

Estimates indicate a potential cost of circa £18m for Quarter 1, with the possibility for further costs related to Welsh Government central policy decisions, e.g. care home and primary care support. Recovery Plans include:

- Elective Medicine
- Elective Surgery
- Scheduled Diagnostics
- Endoscopy (key for cancer services)
- Ophthalmology (Wet AMD)

Quarter 1 assumes no additional recovery activity or costs at this point as some core restart activity is within budget, however additional services may be commissioned. Initial recovery cost estimates could be circa £19m for 2021/22. Externally commissioned services would increase this estimate. These implications will be subject to discussions with Welsh Government to ensure financial plans are aligned with Welsh Government allocations during 2021/22.

Risks - We face significant uncertainty related to the COVID-19 pandemic and its service, workforce and financial implications in the short, medium and long term.

- COVID-19 Response Plans, where they have not received confirmed allocations are identified separately for spend planning purposes – subject to further Welsh Government guidance.
- COVID-19 Recovery Plans have not been included within the spend plans and will be subject to further discussions with Welsh Government to support both internal and externally commissioned services for 2021/22.

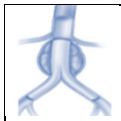
- Delivery of identified cash releasing savings plans and improvement in the underlying financial position of the organisation.
- Delivery of further cost avoidance savings and productivity improvements.
- Implementation of the wider Clinical Futures programme within available resources.
- Managing cost growth in line with or below assumed levels, whilst ensuring delivery of key priorities.
- IFRS16 - it is understood that the implementation of IFRS16 (lease accounting) in NHS Wales will go live in April 2022.
- NHS Pension Scheme Regulations - It is assumed that any increase in employers' pension contributions will be met from additional government funding, including discount rate changes and medical staff specific incentives,
- Holiday pay (voluntary overtime) - this challenge is currently going through a legal process. The potential costs of meeting this liability, should it arise, have not been assumed within the Health Board's financial plans.
- Enhanced Sick Pay – if there is a decision to continue funding this pay element, the impact has not been included within this plan.
- Annual Leave Provisions – exceptionally agreed for 2020/21 are sufficient for actual costs incurred during 2021/22 and 2022/23.

Summary and Conclusion - Our financial plan is based on a financial assessment of the service and workforce plans developed for the financial year 2021/22, and assumes the delivery of financial balance within available funding, recognising the increased risk of delivering savings not achieved during the 2020/21 financial year as well as the ongoing savings requirement. The cost implications of financially managing the COVID-19 pandemic implications will be further reviewed and discussed with Welsh Government as part of the 2021/22 in year financial management process, recognising the potential additional national funding for specific priorities.

10. REGIONAL SOLUTIONS (collaboration across NHS Wales)

As Health Boards we know success is not driven by individual organisations but how we collectively work as systems, the NHS can only deliver in partnership. An important relationship is that we work collectively across Health Boards and Trusts to deliver pathways of care. There are a great number of services that are delivered only by individual organisations where it has been appropriate to centralise expertise, there are services which span organisations and services where different parts of a pathway are delivered in different organisations. What is most important is that patients receive great care, they do not see the name of the organisation but receive continuity regardless of geography.

The pandemic has strengthened cross organisation relationships, rallying to provide mutual aid, sharing good practice and providing much needed support for staff has been a collective effort. As we recover planned services we will need to continue to work with neighbouring Health Boards and Trusts to meet the needs of our collective populations. In order to support this work a collective demand exercise has been undertaken across Aneurin Bevan University Health Board, Cardiff and Vale University Health Board and Cwm Taf Morganwg University Health Board. This has confirmed the collective challenges in planned care across organisations and importantly confirmed that ongoing regional projects are focussed on the right activities to provide sustainable solutions to planned care. There are a number of specific areas of focus for 2021/22:



Vascular Services subject to the outcome of the public engagement we remain committed to the full implementation of a SEW Vascular Network and establishment of a centralised SEW Vascular Surgery service at University Hospital Wales with supporting services in each Health Board by 2022.

Ophthalmology a Regional Electronic Patient Management System is being implemented across organisations and will become fully operational in 2021/22. We are working collectively to develop proposals to meet the needs of cataract patients. Waiting lists have risen as a result of the pandemic and we are working to develop collective solutions which provide sustainable services for the future

Transforming Cancer Services we continue to play an active role in the Cancer Collaborative Leadership Group to drive, participate and support the transformation of cancer services. Collectively and within our own services we are seeking to deliver the single cancer pathway, continually improve standards by updating pathways, where appropriate integrating services and delivering more care closer to home. Our aim is to provide the highest standard of care for everyone with cancer.

This year we have a specific focus on ***Acute Oncology Services (AOS).*** AOS brings together multi-disciplinary clinical expertise to facilitate the rapid identification and appropriate prompt management of patients that present an emergency need as a result of their cancer. People living with cancer may need acute or emergency hospital care for a variety of reasons but an admission to acute care often heralds a change in disease trajectory and often leads to uncertainty about the future. Health Boards across SEW are working collectively with Velindre NHS Trust to enhance Acute Oncology Services to support the need of this patient cohort.

Welsh Health Specialised Services Committee (WHSSC) working as a member of the joint committee we will support the national commissioning arrangements. The joint committee agreed that whilst there will be a need to focus on recovery of specialised services that provide opportunities to improve, the sustainability of services should not be missed and therefore agreed to focus on the implementation of innovative technologies which will in the longer term deliver significantly improved patient outcome and on undertaking strategic planning around services where there are service sustainability issues – "Fragile Services".

WHSSC "On behalf of Health Boards, to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."

The WHSSC commissioning process identified additional services for investment based on risk, in 21/22 these include:

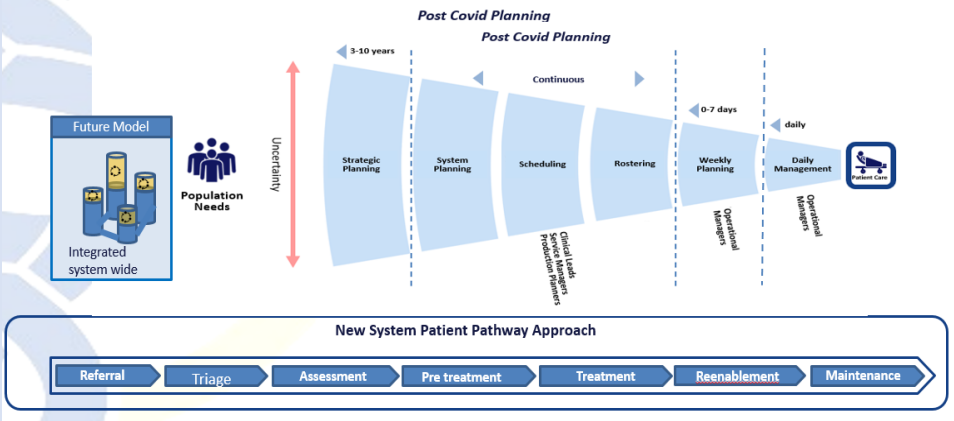
- A number of paediatric specialist services to support sustainability, including clinical immunology, cycstic fibrosis and radiology
- Cardiac services including investment in Cardiac MRI and inherited cardiac conditions
- Further development of the All Wales Gender Service

Full details can be found in the WHSSC Integrated Commissioning Plan published on the WHSSC website.

UNDERSTANDING OUR SYSTEM

Data is now a widespread reality of modern life, and a skilled workforce that is able to manipulate, analyse and interpret data is essential for our modern healthcare system. This is even more crucial at a time of high variation and uncertainty, which is why, at this unprecedented juncture, we are fully committed to delivering a dynamic planning model capable of understanding variations in real time so that we can plan in advance and develop options to mitigate the impact of variations on our population.

We are moving away from traditional approaches to planning, operating and balancing demand with capacity that focused on functional components of our system on largely annual cycles to a new "Always On" approach with a greater focus on System Planning, Operating, COVID-19 Re-Planning and balancing Demand with Capacity.



We are placing greater emphasis on live, real-time data that everyone across our system understands and trusts, and this year will see a determined effort to implement this approach at pace.

MINIMUM DATA SET

The Minimum Data Set (MDS) provides a comprehensive understanding of our starting point, the difference to pre-COVID-19 norm across our whole system and an assessment of capacity to sustain and provide services next year.

As part of developing this understanding we have also completed an assessment of the potential unmet demand in each service area and the risk this poses to the health of our population. Bringing all of this information together we have gained an understanding of how much has changed.

The following summary sets out the assumptions that have been made for completion of the dataset. The scope of the data included is reportable data and the baseline information is as of February 2021.

Primary Care **-** There has been a significant reduction in core activity over the past 12 months as primary care services refocused their resources to respond to the pandemic. Throughout this time essential services have been protected and primary care services have been instrumental in supporting the rapid roll out of the Vaccination Programme. For instance, there has been a 69% reduction in acute eye care referrals and 37% reduction in GP non Cancer referrals. This year it is expected that eye care capacity will return to 100% baseline with a small reduction in projected GP activity for Urgent and Non Cancer referrals at -7%.

All primary care services have recovery plans in place although we recognise capacity constraints due to infection, protection and control measures and the continued pandemic response.

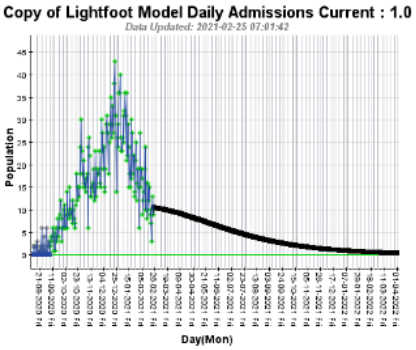
Mental Health – We have maintained all Mental Health and Learning Disability services throughout the past year, with much support being provided virtually for community based services. In addition to sustaining crisis, inpatient and residential services, we have also maintained the needle exchange programme throughout the period. In the last year, crisis referrals have reduced by 42% and are expected to return to 100% of baseline within the next few months. We are anticipating a long term impact of COVID-19 on the mental health of our population and are planning with partners to develop improvement in a range of services at foundation tier to provide additional support and activities within the community.

Acute Care **-** In total there has been a 25% reduction in attendances and a 22% reduction in admissions during 2020/21. The projections show that based on the experience between COVID-19 Wave 1 and Wave 2, there is the potential for a +10% in overall demand which is informing the ongoing work to ensure the population are directed to the appropriate care setting to best meet their need. This is especially important as we know the headline numbers includes a significant demand drop in the last 12 months for emergency Paediatric patients and is projected to return to normal. The capacity available through the opening of the Grange University Hospital is projected to be able to provide sustainable services.

Bed Planning **-** The data demonstrated that hospital flow and average length of stay have both been significantly impacted by COVID-19 and in order to accurately predict demand the modelling work we have completed combines of the COVID-19 SIR Model (model for disease spread) prediction with daily hospital flow data to predict bed numbers required for 2021/22 and the return to normal. This is a live dynamic model that will inform how we track against the planned assumptions on a weekly, monthly and quarterly basis.

COVID-19 occupancy will continue to impact our hospital system until late summer. The demand assessment shows that a mean average of 1573 beds will be required as we enter a transitional year continuing the Clinical Futures Transformation Programme.

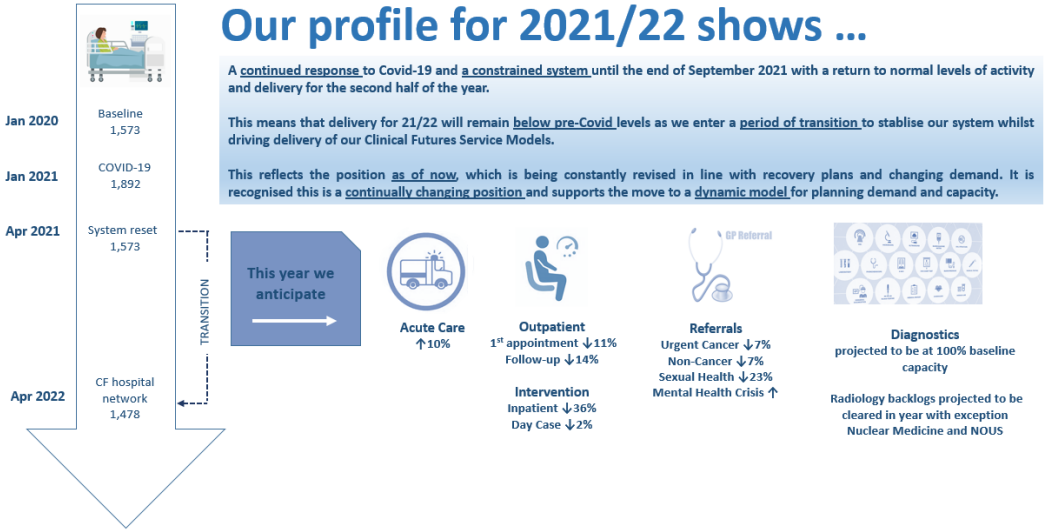
Elective Care **–** Our inpatient elective / planned care capacity will continue to be constrained for the first half of the year and is projected to deliver 60% of the baseline with a more positive outlook for day cases, which will deliver 98% pre COVID-19 baseline.



However this is highly variable to the ongoing COVID-19 response, acuity, the effect of PPE, testing and workforce availability. This is being factored into recovery and restart planning.

Diagnostics **-** Key highlights from the diagnostics profile shows a positive outlook for Radiology with the benefits of the early opening of the Grange University Hospital and the new model and pathways now being in place. It is projected that within the year CT and MRI waits will fall below 8 weeks with work to reduce the residual risk in Ultrasound and Nuclear Medicine.

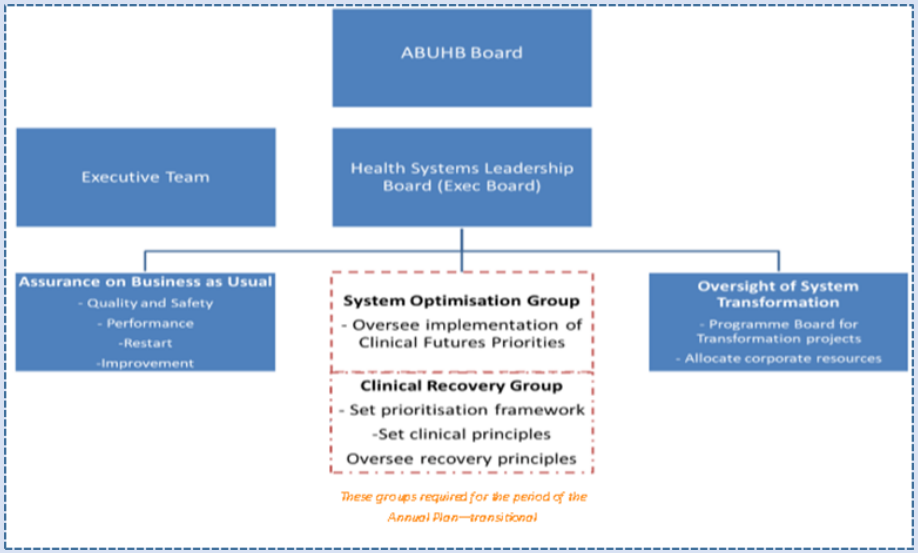
Where data has been omitted, it is either not available or not currently being reported in the same format. We will continue to work with the teams to standardise the MDS and align with what is available to improve our own reporting systems.



DELIVERY FRAMEWORK

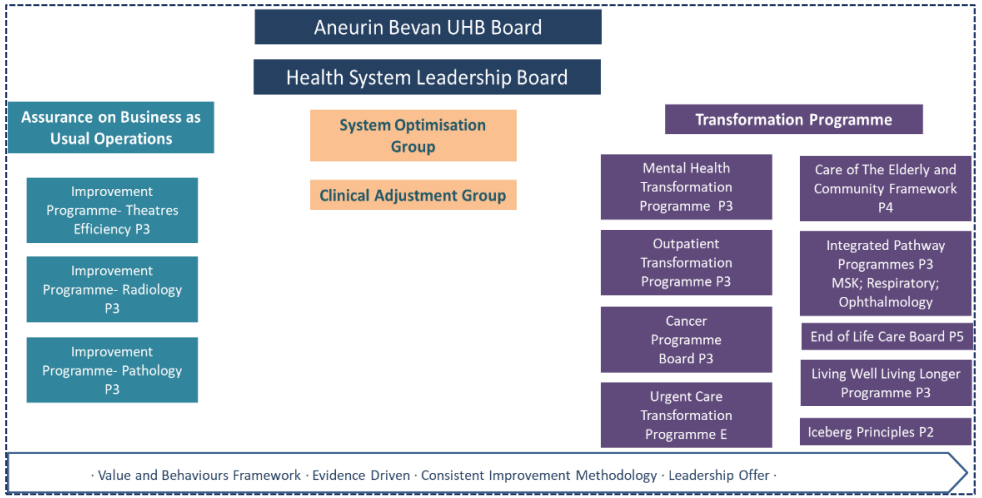
The most important part of any plan is not the document but how it is implemented. Partnership is core to delivery. We will be working with our Regional Partnership Board to oversee implementation of the plan, in particular to ensure an integrated approach and oversight of each of our life course priorities. Within the Health Board we want to ensure we have a clear approach to how we deliver the core priority programmes from this plan. We are establishing a clear clinically led delivery arrangement which will provide oversight of our priority programmes.

We also know that in this transitional year, as we come out of the pandemic, we need to give attention to two specific areas. Ensuring we have clear principles to support clinical prioritisation and we restore services and build greater sustainability. Secondly as an organisation we need to ensure we optimise the opportunities of opening the Grange University Hospital, the early opening supported our pandemic response but we need to ensure our system is optimised to meet future challenges and there are a number of outstanding programmes which need to be implemented to support this.



Our learning from the Clinical Futures programme of work which allowed us to open the Grange University Hospital is that clear and consistent programme arrangements are important to supporting delivery. The culture, values and consistent approach to change are essential to delivery alongside consistent clinical and operational leadership. Therefore we will be applying this approach to plan delivery.

Our plan sets priorities and describes our approach to delivery. In a large organisation no single plan can capture the totality of work. Areas of work which are not captured in this plan and not prioritised for programme support are still important. Through our development processes we still have methods to allow ideas and developments to come forward from our frontline teams, we will continue to support these where they align with our plan principles and improve care. However it is important that as an organisation we set clear priorities and drive core pieces of work to provide focus and support delivery.



We will develop a clear Performance Outcomes Framework by the end of Quarter 1 to support the implementation of the plan and enable the monitoring of delivery. In addition, localised delivery plans will be developed to provide further detail with regards to deliverable actions and intended outcomes.

SUMMARY OF PLAN

This annual plan sets out our priorities and approach to delivery in 2021/22. Through implementing this plan we hope to deliver improved services for our population. By April 2022 we will have, restored services suspended through the pandemic, have a robust prioritisation framework and approach to meeting unmet demand and we will have strengthened partnership arrangements further to meet the needs of our communities. Importantly we will have vaccinated our population against COVID-19.

We will be developing a clear outcomes framework to support the implementation of the plan and enable the monitoring of delivery. We will also make great strides in delivery against our priorities and enablers including: -

Priority One - By April 2021 we will have implemented the ban on smoking to de-normalise smoking across our premises, supported women in pregnancy and developed our integrated community approach to supporting children and families to be a healthy weight. We will have implemented roll out of the HPV vaccine for boys and have made progress towards the MMR elimination plan.
Priority Two - In order to support children and young people we will have established a structured programme based on the Iceberg model to support children's emotional and mental wellbeing, established a needs-led pathway following a neurodevelopmental diagnosis, established an emergency response pathway for children with an emergency mental health need. We will continue to coproduce the transitional pathways for those moving from child to adult mental health services, meeting the needs of service users.
Priority Three - In supporting adults we will have, implemented efficiency programmes to improve flow through theatres and diagnostics focussed on maximising a patients time. Reviewed the pathways for musculoskeletal and eye conditions, coproducing value based approaches which we will begin to implement. We will have made progress in implementing our plans for outpatient transformation, continuing to engage with the population and evaluate the potential continued roll out of virtual appointments, undertaking a risk based approach to follow up and optimising the use of face to face appointments. We will have restarted our Integrated Wellbeing programme, supporting those in our most deprived communities to act on preventable conditions. We will be well on the way to implementing the transformation in our adult mental health services, pending public support, moving care closer to home. For our cancer patients improved diagnostic and MDT process will speed up diagnosis, an approved business case for satellite radiotherapy services will support the next steps in bringing cancer care closer to home.
Priority Four - In supporting our older adult population we will have established our neighbourhood nursing teams and single point of access for each borough to support access to the right care first time. Importantly we will have established a consistent model of care to support people to remain in their usual place of care. We will review our Care of the elderly pathway focussing on ensuring those who require hospital care receive it in a timely way and are not unnecessarily held up in our complex systems.
Priority Five - We will have supported more people to have Advance Care Plans in place, enabling our services to respond to the wishes of individuals. We will have embedded advance care planning across our settings and reviewed our bereavement offer to ensure we are meeting the needs of families and carers.

Enablers

Through focussed effort on our enabling actions we will:

- Implement a new approach to planning utilising demand and capacity tools and analytical capability to support service level decision making
- Deliver and embed potential changes to our urgent care system to support getting citizens to the right service first time
- Have a robust wellbeing offer in place for our staff and work in new ways taking on the learning from the pandemic on agile working
- Continue our digital transformation giving our clinical teams the tools to support decision making and supporting patients to live independently
- Support cutting edge research and innovation focussing on placing evidence and learning at the heart of our practice
- Be on our way towards sustainable high trust culture, where people can see and understand the system, patient outcomes are captured and staff are empowered to act.

Conclusion

Through delivery of this plan we will work towards our ambition of reducing health inequality for our population. Implementing this plan will not be without challenge and we must remain vigilant to the threat of COVID-19, however we are optimistic we can meet this moment to improve services for our population.

Dyfodol Clinigol
Clinical Futures

Gofalu amdanoch chi a'ch dyfodol
Caring for you and your future

OUR CHANGE AMBITION

In our area, people are looking after their own health and well-being and that of their families. When they need help, this is readily available at home and in their community and supported through innovative technology.

We work with partners in a modern system that delivers the best quality outcomes in the most appropriate setting. Our service provides truly holistic care from home to home and continuously evolves so it remains leading edge.

Compassionate care is delivered by respected, talented and creative teams that we trust to put the needs of our patients at the heart of everything we do.

Our staff tell us they feel empowered, equipped and driven to make a difference to the lives and well-being of people. Our teams feel listened to and valued.

We are a dynamic organisation that cares, learns and improves.