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

Integrated Medium Term Plan
2016/17 – 2018/19
TECHNICAL DOCUMENT

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Chapter 1 – Introduction

Aneurin Bevan University Health Board (ABUHB) is responsible for promoting wellness, preventing disease and injury, and providing health care to a population of approximately six hundred thousand people who live in the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys with a budget of circa £1.1billion.

The Health Board is also responsible for planning, designing, developing and securing the delivery of safe and high quality preventative, primary, community, hospital care services and specialised and tertiary services for their resident population. The Integrated Medium Term Plan (IMTP) is a statutory requirement of Health Boards and provides the organisation with a process and vehicle to review and articulate the organisation's values, future strategy, key priorities and delivery actions over a three year timeframe.

The Integrated Medium Term Plan for 2015/16 – 2017/18 for the University Health Board (UHB) was approved by Welsh Government in 2015 and therefore this document provides an overview of the refreshed plan for 2016/17 to 2018/19, reflecting on the progress made in year one, and the updated outlook for the next three years.

This Technical Document supports the Summary Plan and is divided into three sections:

Section One sets out the national, local and organisational context for the Health Board, including its vision, values and ways of working supported by the Health Board's Clinical Futures Strategy.

Section Two sets out the key components of the Three Year Plan, reflecting on the achievements of 2015/16 and the key service sustainability and service change priorities for the next three years supported by the key enablers including finance and workforce plans.

Section Three summarises the key outcomes anticipated over the three years and the governance framework that will support delivery of the plans.

This detailed Technical Document supports the Summary Plan and complies with the Welsh Government planning guidance and serves as a reference document which provides greater detail and depth to the key areas covered in this overarching plan. Performance, Workforce and Financial templates are included as annexes.

Section 1

Chapter 2 - The Health Board, our Vision and Values

Aneurin Bevan Health Board was established in October 2009 and achieved University status in July 2013. We have a budget of £1,012 million to promote wellness, prevent disease and injury, and provide health care to a population of approximately six hundred thousand people who live in the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

Local communities are diverse, with different health needs and marked inequalities in health and healthcare. The delivery of health services has to take account of a mix of rural, urban and valley communities, and increasing numbers of elderly people. The valleys experience high levels of social deprivation, including low incomes, poor housing stock and high unemployment.

The UHB's task is to improve health, and alleviate pain, suffering and sickness for the people we serve. The aim is to do this by providing high quality, cost-effective and integrated health care delivered with compassion and integrity. The patient is at the heart of everything we do, striving to improve the patients' experience and quality of service with every action that we take. Working with our partners, our job is to use the resources we receive to reduce health inequalities and ensure the public have access to high quality services that give them a positive experience and good clinical outcomes.

Our Values

- **Patient first;**
- **Personal responsibility;**
- **Passion for improvement;**
- **Pride in what we do.**

The UHB strives for excellence in healthcare by encouraging a culture of support, respect, integrity and teamwork, by monitoring and assessing our performance against national and international standards, by learning from our successes and setbacks, by striving to improve what we do through innovation and change, and by working in partnership and collaboration with all the agencies of health and social care across Gwent. All our services must be grounded in our values, which creates a shared understanding of how staff relate to patients and the public as well as each other in achieving our vision.

The UHB's strategic direction for modernising clinical services is set out in our **Clinical Futures Strategy.** A central theme is the creation of "networks" that bring care as close to the patient as possible through progressive working practices within Neighbourhood Care Networks (NCNs). We are seeking to build a new relationship with patients as experts in their own health, to use new technology and our maturing NCNs to be the sole vehicle through which local services are organised and delivered. These will become the fundamental building blocks that bind together the work of all partners in health and care in a simple and practical way.

NCNs will be supported through a streamlined hospital network, where routine hospital based services will be provided in Local General Hospitals, and all specialist, hyper- acute and critical care services will consolidated at the planned Specialist and Critical Care Centre.

Care at home or in the patient's community, with the most appropriate person, with the Right skills, delivering care, is the unequivocal aim of the UHB's future vision. Strengthening Primary and Community Care services is therefore our top priority.

Our mission is to ensure that by 2019/20:

Everyone is able to live longer healthier lives at home, or in a homely setting. We will have an integrated health and social care system built around our Neighbourhood Care Networks, with a focus on prevention, anticipation and supported self management. We aim to deliver a systematic reduction in health inequalities in our most deprived communities, and reduce premature deaths in conditions such as cancers, heart attacks and stroke.

In partnership with Local Authorities and the third sector, cohesive services for children, older and vulnerable people will be available to all the distinct communities we serve. We will have in place an up-to-date, agreed suite of care pathways that assist both healthcare staff and patients to understand and achieve the best approaches for care which are safe, citizen centred, clinically and cost effective.

We will have sustainable 24/7 primary care services to ensure that urgent and planned primary care is locally accessible to enable patients to receive their care close to home. This includes our citizens who have diverse cultural and language needs, people with physical and learning disabilities, people with sensory loss, people with low health literacy and frail older people. There will also be a focus on reaching out to those citizens who seldom seek help.

We will have established a more equal relationship between patients and professionals, based on openness and sharing information to ensure that the intensity of testing and treatment is consistent with the seriousness of the illness and the individual patient goals.

We will shift the balance of our services to primary care by increasing the number of specialist services currently provided in our hospitals to primary care settings and with seamless collaboration between practitioners across the whole system. This will necessitate some of our services working very differently to support patients in primary care, through direct patient contact, indirect support to practice teams and remote monitoring of patients.

Technological opportunities will be maximised, with an integrated electronic health and social care record system that allows clinicians and social care practitioners to share information about patients that enables new workflows (for example virtual clinics, booking systems, advice lines) across the health and social care system, which will also enable patients and carers to access appropriate, timely and relevant information. All our independent contractors will be part of the NHS network so that patients will have a single record that will facilitate shared care and patient management across all settings.

All local services will be configured within the 12 Neighbourhood Care Networks and designed to meet the health and social care needs of their communities. This will require a professional and managerial accountability structure to ensure the delivery of safe, effective, efficient services to meet the health and social care needs of the communities they serve.

When hospital treatment is required, and cannot be provided in a community setting, day case and ambulatory care treatment will be the norm. There will be 24/7 access to consultant led hyper-acute and specialist care, facilitated by consolidating these service in the newly opened Specialist and Critical Care Centre at Llanfrechfa Grange in 2019. Whatever the setting, care will be provided to the highest standards of quality and safety, with the citizen at the centre of all decisions. At all times, in every part of the system, we will strive to be “best in class”, pushing the boundaries of efficiency, effectiveness and proportional interventions in accordance with prudent healthcare. There will be a focus on ensuring that people are supported in their home or community environment as soon as appropriate.

The health service in the UHB will be regarded as a caring and improving health system built on a model where integration, partnership working, prudence and public participation are all paramount.

The UHB supports the Welsh approach for Prudent Healthcare which aims to rebalance the NHS by strengthening primary and community based care to support the establishment of a more equal relationship between patient and professionals and changing the relationship between healthcare service and the public, thorough a shared responsibility for securing and improving health outcomes. To achieve our ambitious future state we are guided by prudent healthcare principles and that we need to work on:

- Engaging with and listening to patients, relatives, carers, the public and communities we serve.
- Working with individuals, families, carers and communities to ensure they are able to access services appropriately; to prevent diseases such as those caused by obesity, smoking or the misuse of substances; and for those with chronic conditions to support them to keep well, through learning about their condition to enable them to manage their condition, where patients have the focus of control.
- Closing the health gap between people who are better off and those we are not.
- Making it easier for people to use local health services, whatever their needs.
- Reconfiguring our current hospital based services to ensure that patients receive seamless care from integrated teams, close to home.
- Making better use of technology so all our staff have the information they need about a patient's care.

The UHB's values and plans have always had a strong focus on delivering safe and high quality services and national targets in spite of challenges associated with increasing capacity pressures, the impact of financial austerity and significant recent changes at Executive level. There has been a collective determination to ensure that the values developed over recent years are sustained and that leadership continues to be based on fundamental standards, openness and transparency, candour with patients, effective engagement with communities, patients, staff, and partners in planning and delivery of services in an effective manner.

The UHB have pursued these values by ensuring that partnership and engagement remain as key drivers together with a robust governance and assurance process which assesses risks and ensures that mitigating actions are in place and focus on improvement. This ensures we continue to use patient safety and quality of services as a key driver, encouraging innovation to provide services close to patients' homes, to promote services which are robust and sustainable and are cost effective. The impact of these values are illustrated in this document particularly the work to support a greater proportion of services delivered in primary and community services, progressing local plans and priorities arising from national policy such as prudent healthcare, strong commitment to national priorities including recovery plans when performance where performance has deteriorated. We always seek to develop sustainable services which are safe and timely for patients.

Chapter 3 – Strategic Context

1. National Drivers, Outcomes Frameworks, Strategies and Workforce Drivers

Together for Health
The Welsh Government has set out the national strategic direction for Health Boards and Trusts within the overarching 'Programme for Government' and the NHS Wales Strategy 'Together for Health', underpinned by more detailed strategies and delivery plans based on key service areas or population groups and linked to the seven strategic themes of 'Together for Health', namely:

- Service modernisation, including more care closer to home and specialist centres of excellence.
- Addressing health inequalities.
- Better IT systems and an information strategy ensuring improved care for patients.
- Improving quality of care.
- Workforce development.
- Instigating a "compact with the public.
- A changed financial regime.

South Wales Programme
The South Wales Programme focused on the optimum, sustainable configuration for some specialist hospital based services (consultant-led maternity and neo-natal care, paediatrics and emergency medicine). Specifically it considered those services where seriously ill and/or injured patients who need to be in hospital will have better and faster access to care from senior and expert doctors and their teams, which will have an immediate and direct effect on their recovery.

The outcome of extensive public consultation has supported the creation of 3 Acute Care Alliances and the consolidation of these specialist services on fewer hospital sites which is an important step toward creating a modernised NHS. For the UHB this will be the Specialist and Critical Care Centre. This will in time enable more people to be cared for in their local communities, lead to better organisation and use of specialist services which will in turn allow for resources to be released from institutional based care for other health and social care services.

South Wales Collaborative
The UHB continues to play an active role in the work of the All Wales Collaborative, and in particular, ensuring that its Clinical Futures plans for medical and surgical specialties are underpinned by the work of the Collaborative Clinical Reference Groups. The UHB has actively supported the development of clinical models by the Collaborative and has tested and refined its Clinical Futures plans as a result. This has for example led to modifications to the UHB's plans for the future configuration of orthopaedics, urology, ENT and maxillofacial surgery services, with all emergency and high activity elective surgery to be undertaken at the SCCC. This is now very good alignment between the UHB's Clinical Futures detailed plans and the clinical models developed by the Collaborative, noting that the latter have not as yet been formally endorsed by the Chief Executive or subject to public engagement and consultation.

The SWHC work has however demonstrated that the further consolidation of acute services in South Wales is probable, with emergency general surgery the key determinant with a number of interdependencies. It is however the case that the analysis has confirmed that the SCCC remains central to the future reconfiguration of health services in Gwent.

The acute medicine Workstream of the SWHC has been used to underpin the UHB's future acute medicine plans, and in particular the heterogeneity of ELGHs. A common theme of the work in refining clinical models has been the need to ensure that they comply with Deanery expectations and this has been built into associated workforce plans that are clinically supported and feasible.

The UHB has ensured that its Clinical Futures patient flow, capacity and workforce planning are consistent with the outcomes of the SWP and those of the All Wales Health Collaborative. The scope of this work includes:

- Major Trauma Network Development.
- Further Strengthening of vascular services in South East Wales.
- Pathology services, including cellular pathology and microbiology.
- Sexual Assault Referral services.
- Spinal and fractured neck of femur workstreams.

Prudent Healthcare
The Minister for Health and Social Care has set out the case for delivering prudent healthcare in Wales. Through placing greater value on patient outcomes rather than volume of activity and procedures delivered, prudent healthcare aims to rebalance the NHS by strengthening primary and community-based care to support the establishment of a more equal relationship between patient and professionals and changing the relationship between healthcare services and the public, characterised by a shared responsibility for securing improved health outcomes. Prudent healthcare is build around the following principles:

- **Do no harm** (the principle that interventions which do harm or provide no clinical benefit are eliminated).
- **Carry out the minimum appropriate intervention** (the principle that treatment should begin with the basic proven tests and interventions. The intensity of testing and treatment is consistent with the seriousness of the illness and the patient's goals).
- **Organise the workforce around the "only do, what you can only do"** principle (all people working in the NHS in Wales should operate at the top of their clinical competence. Nobody should be seen routinely by a consultant, for example, when their needs could be appropriately dealt with by an advanced nurse practitioner).
- **Promote equity** (the principle that it is the individual's clinical need which matters when it comes to deciding NHS treatment).
- **Remodel the relationship between user and provider** based on openness and sharing information (the principle of co-production).

The UHB's local strategy for delivering a prudent system is described at section 4.5.

Outcomes Framework
Within the UHB 3 Year Integrated Plan we have undertaken an assessment of the critical strategic priorities which will improve clinical and/or operational delivery and patient outcomes, lead to transformational change and as a result improve our financial sustainability. The NHS Wales Planning Framework, issued in October 2014 and updated in October 2015, established the planning principles which underpin the development of integrated, medium term (three year) plans and which deliver the outcomes for catchment populations based on an alignment of key services, staff, finance and effective involvement of the public through co-production.

Figure 3.1

Well-being of Future Generations (Wales) Act
The Well-being of Future Generations (Wales) Act became law in April 2015. The key aim of the Act is to reduce inequalities in society. The Act requires public bodies to use sustainable development to shape what it does, how it does it, and how it communicates the difference made to achieving the well-being goals.

The sustainable development principle is made up of five key ways of working, that public bodies are required to take into account when applying sustainable development. These are:

- Looking to the long term so that we do not compromise the ability of future generations to meet their own needs.
- Taking an integrated approach so that public bodies look at all the well-being goals in deciding on their priorities.
- Involving a diversity of the population in the decisions that affect them.
- Working with others in a collaborative way to find shared sustainable solutions.
- Understanding the root causes of issues to prevent them from occurring.

To ensure that public bodies are all working towards the same vision, the Act puts in place seven well-being goals:

- *A prosperous Wales;*
- *A resilient Wales;*
- *A healthier Wales;*
- *A more equal Wales;*
- *A Wales of cohesive communities;*
- *A Wales of vibrant culture and thriving Welsh language;*
- *A globally responsible Wales.*

For public bodies the core duty in the Act is that they must set well-being objectives that maximise their contribution to achieving the well-being goals. The Health Board will strengthen engagement with key stakeholders in order to address the wider determinants of health and well being which are the focus of the Act and its indicators.

The Act establishes Public Services Boards (PSBs) for each local authority area in Wales the membership of which includes Health Boards. The PSBs replace the current Local Service Boards (LSBs) with greater emphasis on particular areas including leadership, integrated services, accountability, community engagement, national wellbeing goals, assessment of wellbeing and best practice. Newport LSB is taking forward pathfinder work on the establishment of PSBs.

Each PSB must assess the state of economic, social, environmental and cultural well-being in its area; and set objectives that are designed to maximise the PSBs contribution to the well-being goals. Each PSB must prepare and publish a plan (a Local Well-being Plan) setting out its objectives and the steps it will take to meet them, and carry out an annual review of their plan showing their progress. Local authority areas have historically received Welsh Government grants to support the work of LSBs however, this grant funding ceases in April 2016 with PSBs receiving funding to specifically support the development of well being assessment processes. This change reinforces the need for the collective support of all partner organisations in ensuring PSBs fulfil their role effectively and sustainably.

The first set of well-being objectives will be agreed and published by 31 March 2017, and reviewed on an annual basis.

Welsh Government is currently consulting on the 40 draft National Indicators designed to track progress against the seven well-being goals. Examples of the draft indicators include:

- babies born at a healthy weight;
- people make healthy lifestyle choices;
- people in work;
- people living in poverty;
- people who volunteer;
- people feeling safe in their communities;
- people feeling lonely;
- quality of housing;

- levels of homelessness.

Implementation of the requirements of the Act will require changes across a range of functions within the Health Board including corporate planning, workforce planning, financial planning performance management, risk management, procurement and the management of assets.

As a key part of preparatory work by the Health Board for implementation of the Act, the following areas are being addressed:

- Awareness raising across the Health Board of the requirements of the Well-being of Future Generations (Wales) Act and its implications for the organisation.
- An audit of Health Board functions against the seven wellbeing goals and five ways of working in order to understand what changes need to be made, and where, within the organisation.
- Review of the future work programme for the Public Health and Partnerships Committee to take account of the seven wellbeing goals and the five ways of working.

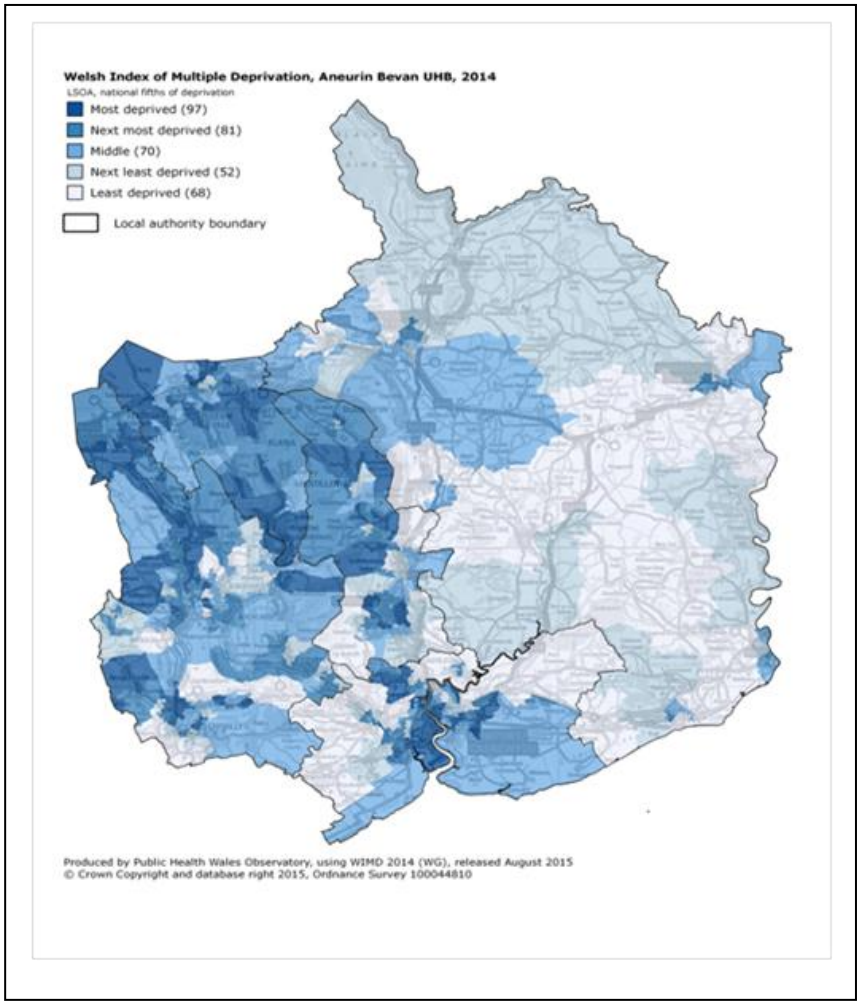
A Gwent-wide group has been established to develop an approach for the wellbeing needs assessments. Where appropriate a 'once for All Gwent' approach will be adopted. This group will also ensure alignment with the requirements of the Social Services and Wellbeing Act.

Chapter 4 – Local Context

1. Health Community Overview

Aneurin Bevan University Health Board was established in 2009 as an integrated Local Health Board responsible for planning and delivering a wide range of primary, community and secondary health services to the populations of Caerphilly, Monmouthshire, Newport, Blaenau Gwent and Torfaen. Taken together with an estimate of the patients living in South Powys and other areas that are served by the UHB for acute services, the patient population served is close to 600,000. Approximately 30 per cent of the population live in the Caerphilly local authority area and 25 per cent live in the Newport local authority area.

Figure 4.1 – Welsh Index of Multiple Deprivation



The UHB covers diverse geographical areas with a mix of rural, urban and valley communities. The valley areas experience high levels of social deprivation, including low incomes, poor housing stock and high unemployment. This is illustrated in Figure 4.1 opposite.

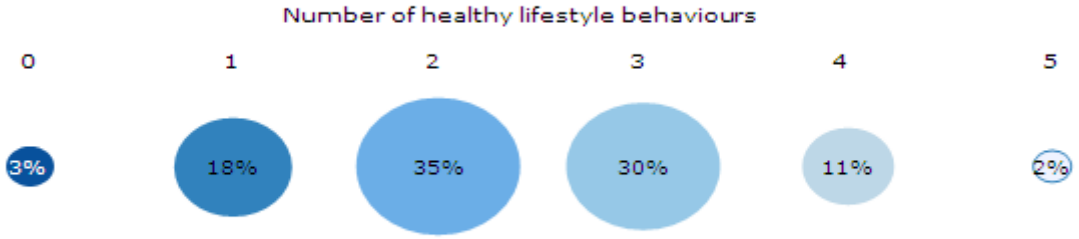
Low income is likely to reduce a household's ability to access or maintain key factors for good health and wellbeing, such as healthy food and warm accommodation. Low income is associated with low societal participation and limited access to enabling resources and choices. Those on low incomes are more likely to engage in health damaging behaviours, such as smoking and eating high calorie foods, as coping mechanisms or short term fixes.

Lifestyle factors affecting Adult Health

The number of healthy lifestyle factors an individual has is strongly associated with their risk of chronic disease, their healthy life expectancy and their risk of premature death. Only 2% of the UHB's population age 16 and over have all the healthy lifestyle factors of not smoking, being physically active, eating a healthy diet of fruit and vegetables, being a healthy weight and drinking alcohol within guidelines. The proportion of people in the UHB's area with only one healthy lifestyle factors is 18%, with 2 is 35% and with 3 is 30% (see Figure 4.2).

Figure 4.2

Healthy lifestyle behaviours*, percentage, persons aged 16 and over, Aneurin Bevan University Health Board, 2013-2014**
Produced by Public Health Wales Observatory, using WHS (WG)



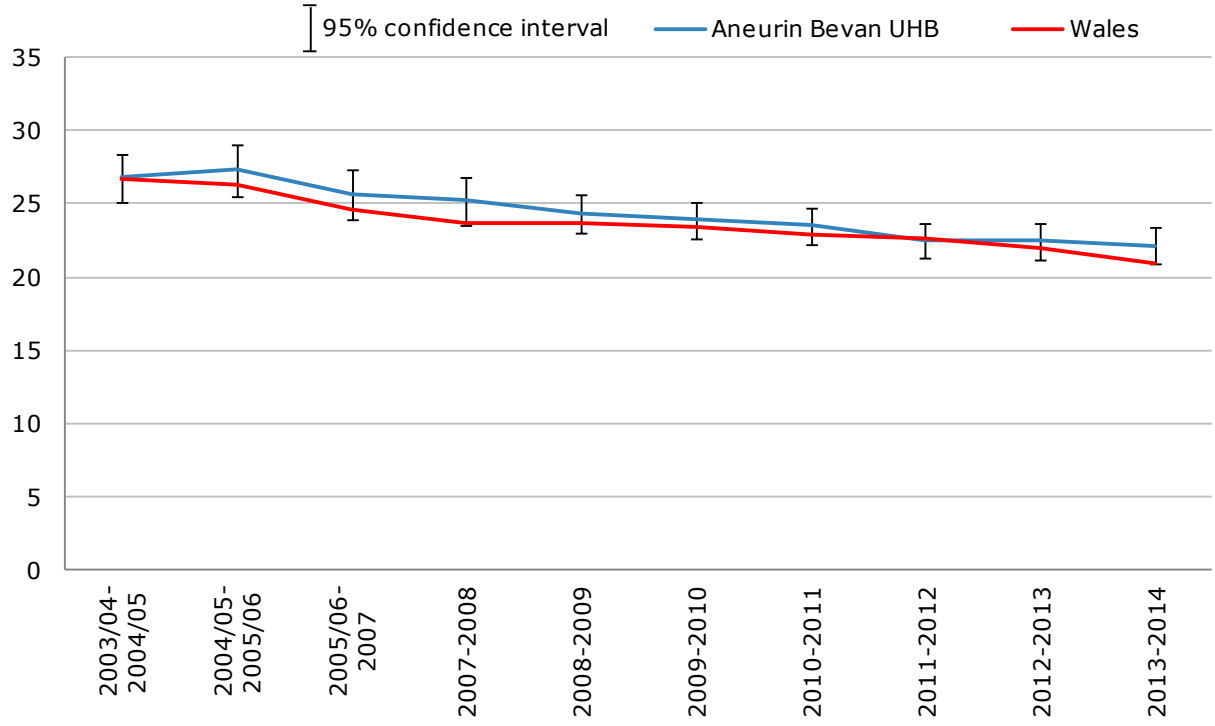
*not smoking, not drinking above guidelines, eating 5 or more portions of fruit and vegetables per day, physically active at least 5 days a week, healthy weight.

**percentage of the population with the given number of behaviours. The sum of percentages do not equal 100 due to rounding.

Smoking is a major risk factor for heart disease and remains a significant public health concern. In Aneurin Bevan University Health Board around **22 per cent of adult population are smokers** ranging from 25% in Blaenau Gwent to 19% in Monmouthshire. The proportion of the population who smoke has shown a small decline in recent years (see Graph 4.1).

Graph 4.1

Percentage of adults reporting to be a current smoker, age-standardised percentage, persons, Aneurin Bevan UHB and Wales, 2003/04-2014
Produced by Public Health Wales Observatory, using Welsh Health Survey (WG)

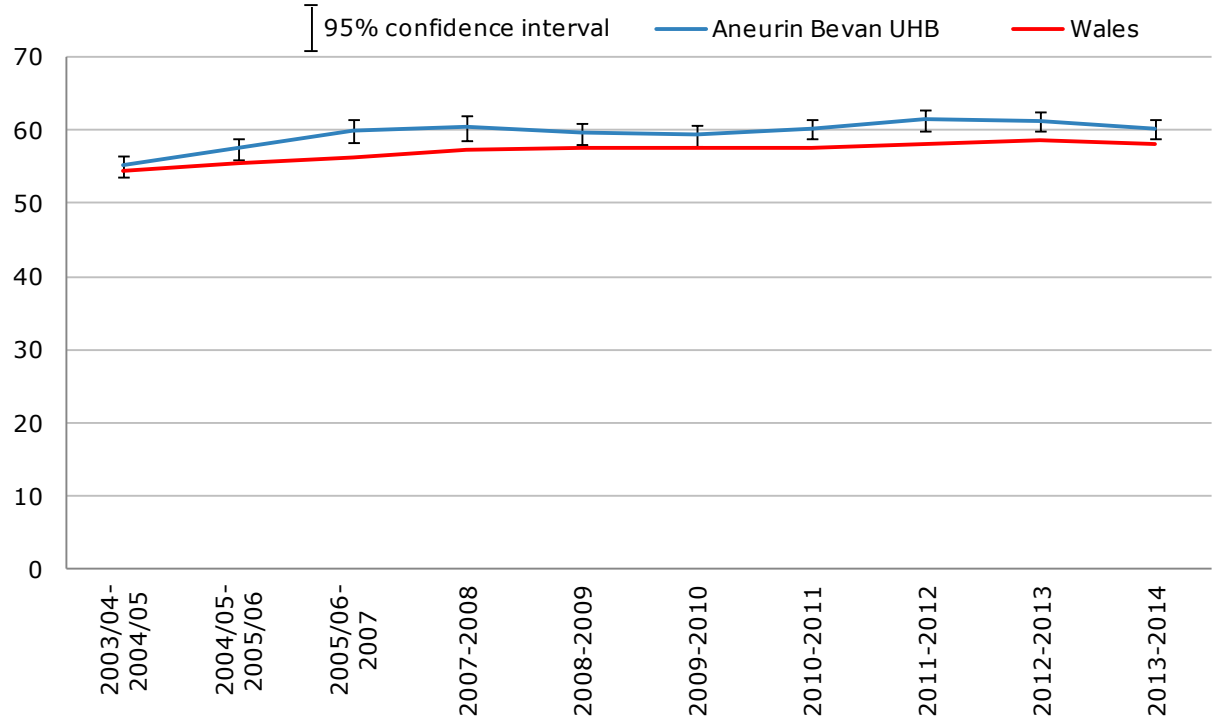


Obesity is another preventable risk factor for diabetes, heart disease and liver disease and is caused when energy intake from food and drink is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period. In Aneurin Bevan University Health Board area **60% of adults are overweight or obese (BMI ≥25**) ranging from 63% in Blaenau Gwent and Torfaen to 52% in Monmouthshire. The proportion of overweight and obese adults has risen steadily over recent years (see graph below).

Graph 4.2

Percentage of adults reporting to be overweight or obese, age-standardised percentage, persons, Aneurin Bevan UHB and Wales, 2003/04-2014

Produced by Public Health Wales Observatory, using Welsh Health Survey (WG)



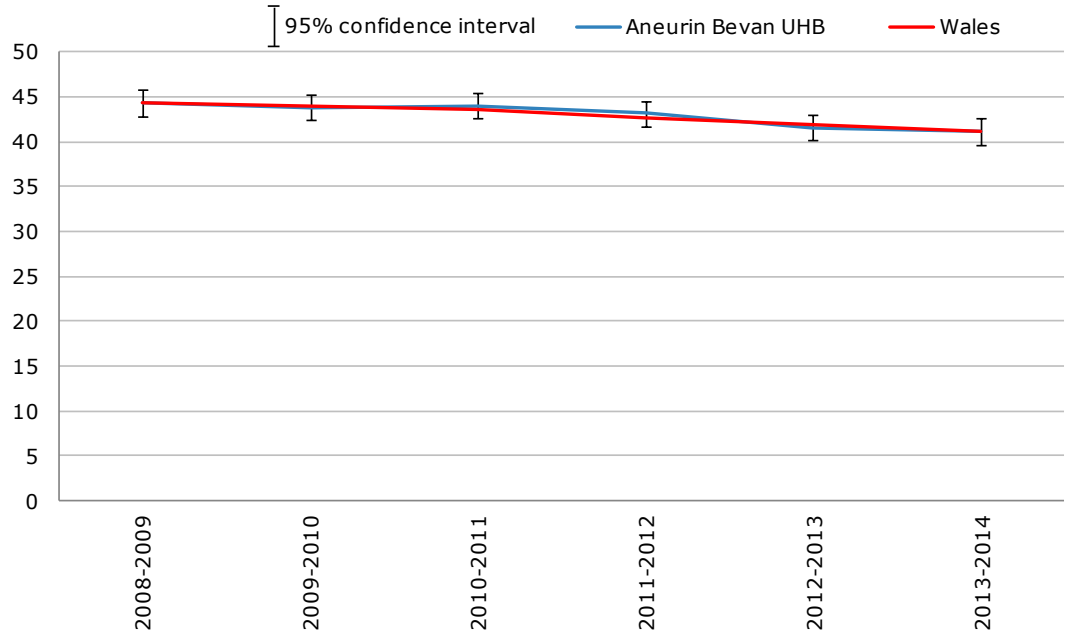
Being **physically active** lowers the risk of developing CVD as regular exercise can reduce the risk of coronary heart disease by about 30% (WHO, 2009). National guidelines suggest these cardiovascular benefits can be achieved through minimum of 30 minutes of moderate activity on five or more days per week. When adults in Aneurin Bevan University Health Board were surveyed in 2009/10, the average number days per week they engaged in moderate or vigorous intensity physical activity was **2.3 days** which has changed very little over recent years.

Diet has an important role to play in the prevention of cancer and coronary heart disease. A balanced diet which is high in fruit and vegetables and low in fat, salt and sugar can help to prevent heart disease. When surveyed in 2009/10, the proportion of adults in Aneurin Bevan University Health Board who had consumed at least five portions of fruit and vegetable in the previous day was 31 per cent which has declined slightly in recent years, and ranges from 28% in Caerphilly to 36% in Monmouthshire.

Alcohol misuse is associated with an elevated risk of heart disease, stroke, cancer and liver disease. In Aneurin Bevan University Health Board around **41 per cent of adults report drinking above recommended limits** in the previous week which has declined in recent years, and ranges from 38% in Torfaen to 45% in Monmouthshire. Around 26% of adults report drinking heavily and 15% very heavily in the previous week both of which are small declines from previous proportions.

Graph 4.3

Percentage of adults reporting drinking above guidelines on a day in the past week, age-standardised percentage, persons, Aneurin Bevan UHB and Wales, 2008-2014
Produced by Public Health Wales Observatory, using Welsh Health Survey (WG)

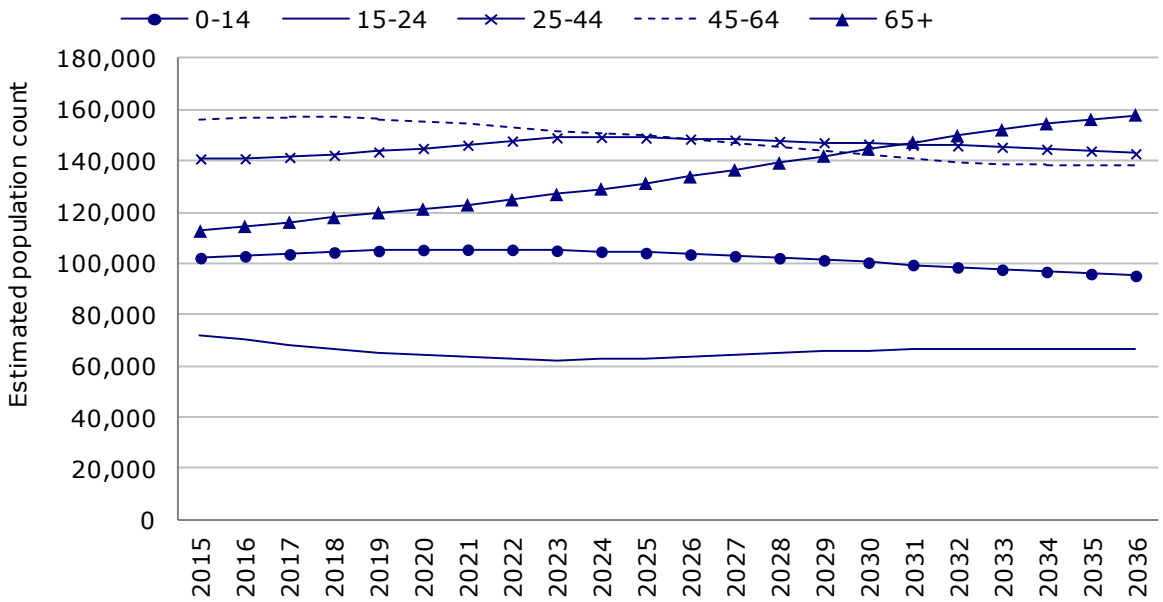


The health of the people of Gwent is varied compared with the Welsh average. Deprivation is higher than average, ill health more prevalent and life expectancy is 10 years lower for residents in the most deprived areas of Gwent than in the least deprived areas.

Population Projections

Graph 4.4 - Population Projections

Projected population, counts by age group, Aneurin Bevan University Health Board, 2015-2036
Produced by Public Health Wales Observatory, using WG population projections



The latest projections indicate that if current trends continue, the number of persons aged 65 and over resident in the UHB area will increase to 160000 by 2036. It is predicted that although the total population across the UHB area will remain stable over the next ten years, an increasing

population of elderly people will result in a generally higher dependency ratio leading to further increases in demand and pressures for change in the way services are delivered.

The increase in the number of older people is likely to be associated with a rise in long-term conditions whose prevalence is strongly age-related, such as circulatory and respiratory diseases and cancers. Meeting the needs of these individuals will be a key challenge for the UHB. In the current economic climate, the relative (and absolute) increase in economically dependent and, in some cases, care-dependent populations will pose particular challenges to communities.

2. Provider Services

The UHB contracts with independent practitioners in respect of primary care services which are delivered by General Practitioners, Opticians, Pharmacists and Dentists (see Table 4.1). Outside of normal practice hours the UHB has responsibility for and provides an Out of Hours Primary Care Service.

There are 400 General Practitioners and Salaried GPs providing general medical services from 88 General Practices. Supporting these are 214 practice nurses, 145 health care support workers and a number of administrative staff, including practice managers, receptionists, secretaries and IT officers. Around 375 General Dental Practitioners provide general dental services from 79 practices. There are 129 Community Pharmacies and 69 Optometry premises across the UHB.

A wide and growing range of community based services are increasingly being delivered in patient's homes, through community hospitals, health centres and clinics (see Table 4.1 for overview). There are a number of smaller community hospitals, integrated health and social care centres, and health centres providing important clinical services to our residents closer to home.

Table 4.1 - Distribution of Independent Contractor and Community Services by Locality

Locality	General Practice	Pharmacy	Dental	Optometry	CRTs	DNs	Specialist
Blaenau Gwent	14	16	10	11	1	Work across all areas	Complex Care Team, Palliative Care Team
Caerphilly	27	43	22	20	1		
Monmouthshire	14	18	15	14	1		
Newport	22	31	19	15	1		
Torfaen	13	21	13	9	1		
Total	88	128	79	69	5	29	

The UHB has three acute hospitals providing a range of inpatient (IP) and outpatient (OP) services; these are The Royal Gwent Hospital (RGH), Newport; Ysbyty Ystrad Fawr (YYF), Ystrad Mynach; and Nevill Hall Hospital (NHH), Abergavenny, along with six other hospitals (see Table 4.2 & 4.2A for their configuration).

Table 4.2 & 4.2A – Specialty Bed Configuration

Site	Number of beds
Royal Gwent	697
Nevill Hall	372
Ysbyty Ystrad Fawr	163
Ysbyty Aneurin Bevan	72
County	68
St Woolos	97
Chepstow	32
Monnow Vale	19
Redwood/Rhymney	11
Total	1531

Specialty	No. of beds
Adult Orthopaedics	198
Adult General Surgery	132
Medicine	527
Urology	24
ENT	9
Maxillofacial	1
Ophthalmology	8
Haematology	11
Rheumatology	0
Dermatology	7
Gynaecology	44
Paediatrics	62
SCBU/Neonates	30
Obstetrics/Midwifery	86
Critical Care	36
Community Rehabilitation	356
Total	1531

The UHB also provides comprehensive Mental Health and Learning Disabilities services in both hospital and community settings to the population of Gwent and South Powys as seen below.

Table 4.3 – Overview of Mental Health and Learning Disability Services Community

Service	Community Service	Teams	Total Beds
Adult	Community Mental Health Team	5 Gwent + 1 Powys	82 Gwent 12 Powys
	Assertive Outreach	4	
	Crisis Resolution	3 Gwent + 1 Powys	
	Liaison Services	1 covers NHH + RGH	
	Early Intervention Psychosis	1	
	PC Mental Health Support	5 Gwent + 1 Powys	
Older Adult	CMHT	5 Gwent + 1 Powys	92 Gwent 20 Powys
	Assertive Outreach	-	
	Crisis Resolution	4 In reach	
	Liaison Services	6	
	Early Intervention Psychosis	6 Memory assessment clinics – all Boroughs	
	PC Mental Health Support	3 Day Hospital (Mon, BG + Powys)	
Learning Disability	CMHT	5 CLDT	34 (including residential)
	Assertive Outreach	1 Intensive Community Service	
	Crisis Resolution	-	
	Liaison Services	1 Art Therapy	
	Early Intervention Psychosis	-	
	PC Mental Health Support	-	
Specialist Services (Pan Gwent)	CMHT	1 Eating Disorders	39 (including PICU)
	Assertive Outreach	1 Personality Disorders	
	Crisis Resolution	1 Substance Misuse	
	Liaison Services	1 Veterans Service	
	Early Intervention Psychosis	1 Forensic Psychiatry	
	PC Mental Health Support	-	

In addition, the UHB commissions a broad range of services at an annual cost of approximately £307 million secured through a complex portfolio of contracts and contracting arrangements with English, Welsh and Third Sector Providers. Around **£70m** relates to hospital provided care at a secondary care level and £100m to tertiary services commissioned through Welsh Health Specialised Services Committee (WHSSC).

3. Demographics and Health Needs

A variety of factors define Gwent's population and corresponding health needs. The UHB covers a diverse range of population groups with different health needs and sizeable inequities in health and healthcare within and between localities. Delivery of health services has to take account of a mix of rural, urban and valley areas and a growing proportion of elderly people.

Health and Wellbeing of Children and Young People
In 2013, Public Health Wales Observatory published a comprehensive summary of health and wellbeing related statistics from birth until 24 years of age. The status for Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen Local Authority areas is summarised below.

Table 4.4 - Health of Children and Young People in the UHB

Indicator	Wales	Caerphilly	Blaenau Gwent	Torfaen	Monmouth-shire	Newport
% population aged 0-24	**30.3**	30.7	29.9	30.4	27.5	32.5
% babies born preterm	**7.1**	6.6	7.6	7.1	9.1	7.2
% babies breastfed at birth	**55.5**	33.0	28.2	35.6	57.6	41.9
% children living in poverty	**22.2**	25.7	30.4	23.8	13.1	25.5
% 5-15 year olds eligible for free school meals	**19.3**	25.2	29.1	19.4	11.9	20.8
% year 11 leavers not in education, employment or training	**4.4**	4.5	6.6	6.7	3.8	6.7
% 4/5 year olds overweight or obese	**28.2**	29.2	26.9	30.0	22.0	27.7
Teenage conceptions <18s	**34.2**	30.7	25.5	31.6	18.1	38.1
% 4 year olds up to date with immunisations	**82.4**	81.0	81.8	81.7	83.8	78.1
Uptake for 3 complete doses of HPV vaccine	**86.6**	90.9	92.4	88.5	76.5	83.1
Asthma prevalence (0-24 year olds)	**51.6**	48.0	45.4	55.5	50.9	48.9
5 year olds with decayed missing or filled teeth	**1.6**	1.7	3.1	2.3	1.0	2.2
Emergency admission rates (0-24 year olds)	**100**	107	116	121	95	111
Child mortality rate (0-17 years)	**38.5**	35.6	40.4	24.3	15.5	31.3

Source: Public Health Wales Observatory 2013

Poor health and wellbeing in childhood is strongly associated with multiple deprivation and poverty. In Wales over 1 in 5 children and young people live in **poverty,** ranging within the ABUBH area form 1 in 8 in our least deprived locality Monmouthshire to 1 in 4 for Caerphilly, Newport and Torfaen and 3 in 10 for Blaenau Gwent. The Local Authority areas with a high percentage of children living in poverty have high emergency admission rates for children and young people which is evidence of children and young people having poorer health and wellbeing.

The fact that three of the local authority areas with high levels of deprivation now have a lower teenage conception rate than the average for Wales reflects the successful development of sexual health services for young people although more still needs to be done to bring the rate down in Newport. The MMR campaign in response to the measles emergency in 2013 boosted childhood immunisation rates but maintaining high child immunisation rates has remained challenging in all the local authority areas in Gwent.

The foundation of a healthy diet and prevention of adult obesity is laid down in childhood. Children

living in a deprived area in Gwent are less likely to be breast fed and more likely to have dental caries which are both indicators of a poor diet. Conversely, Monmouthshire which has a low proportion of children living in poverty has a low percentage of 4/5 year olds who are overweight or obese indicating a healthier diet. This pattern of inequality in childhood diet and obesity needs to be urgently addressed to prevent it translating into future inequalities in adult health.

Babies born preterm are more prone to poorer health outcomes. Low birth weight is associated with maternal smoking and poor nutrition, low birth weight babies are not only at greater risk of problems occurring during and after birth but there is also an association with poor health and increased risk of chronic diseases in adulthood. Breastfeeding has health benefits for both mother and baby, the presence of antibodies in breast milk give babies the best start in life by protecting them from common childhood illnesses. Breastfed babies are less likely to have to go to hospital with infections, and are more likely to grow up with a healthy weight and without allergies.

The indicators in Table 4.4 illustrate that many of our children and young people are not getting the best start in life. Poor health and wellbeing in childhood is strongly associated with multiple deprivation and poverty. Four of the Local Authority areas a high percentage of children are living in poverty.

Ageing Population

The latest projections indicate that if current trends continue, the number of persons aged 65 and over resident in the UHB area will increase to 160000 by 2036. It is predicted that although the total population across the UHB area will remain stable over the next ten years, an increasing population of elderly people will result in a generally higher dependency ratio leading to further increases in demand and pressures for change in the way services are delivered.

The increase in the number of older people is likely to be associated with a rise in long-term conditions whose prevalence is strongly age-related, such as circulatory and respiratory diseases and cancers. Older people are more likely to have at least one and often multiple chronic conditions, such as diabetes, dementia or arthritis, and have more as their age increases.

The increasing prevalence and incidence of dementia presents a significant challenge, as illustrated in the following graph.

Graph 4.5

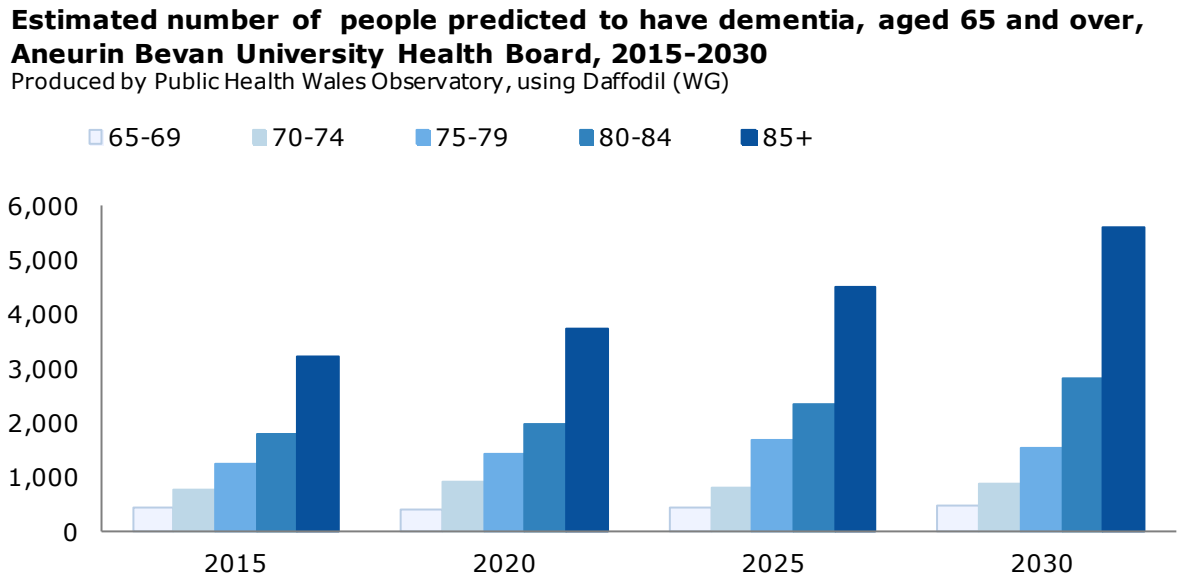


Table 4.5

Estimated numbers of people predicted to have dementia, Aneurin Bevan University Health Board, 2015 - 2030

Age	2015	2020	2025	2030
65-69	440	400	420	480
70-74	750	890	800	860
75-79	1,220	1,400	1,680	1,530
80-84	1,800	1,980	2,320	2,830
85+	3,200	3,750	4,500	5,590
65 and over	**7,410**	**8,420**	**9,720**	**11,290**

Produced by Public Health Wales Observatory, using Daffodil (WG)

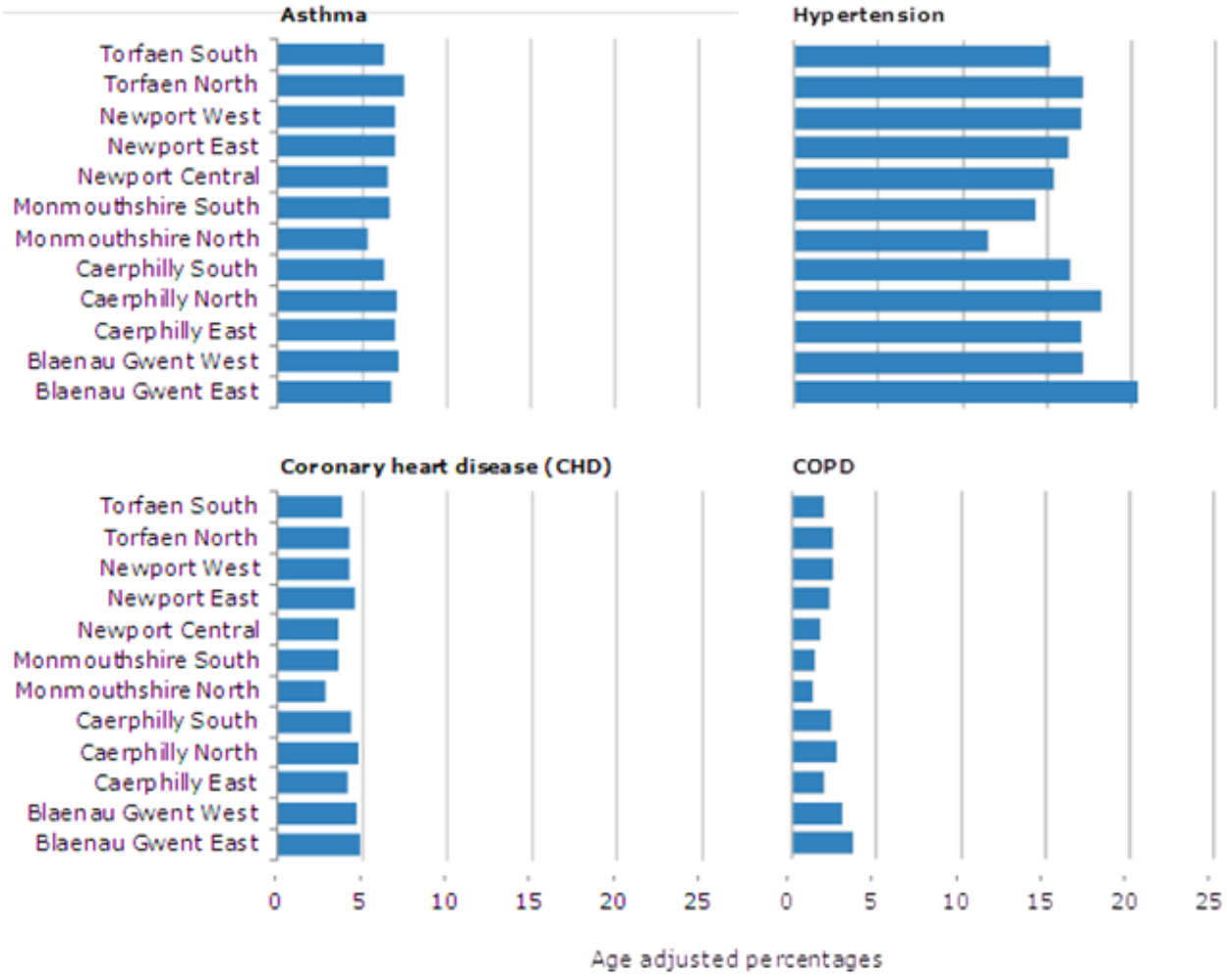
Chronic Conditions

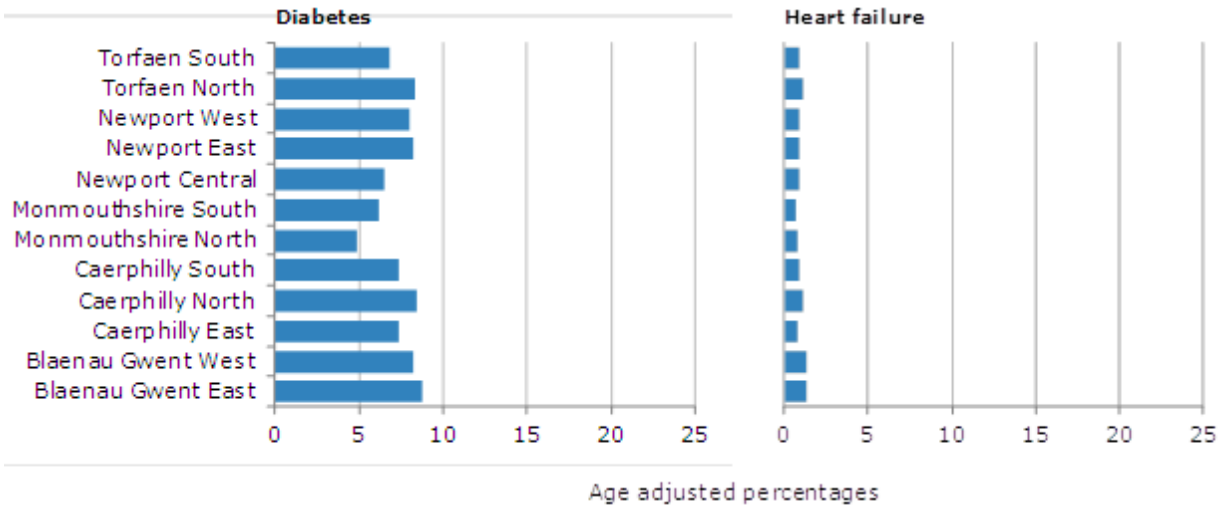
The burden of chronic illness is substantial and growing at a significant rate. The graph below shows the scale of the challenge demonstrating the number of patients on selected chronic conditions registers by Neighbourhood Care Network.

Graph 4.6

Patients on chronic condition registers by GP cluster, age adjusted percentages, Aneurin Bevan University Health Board, 2014

Produced by Public Health Wales Observatory, using Audit+ (NWIS)



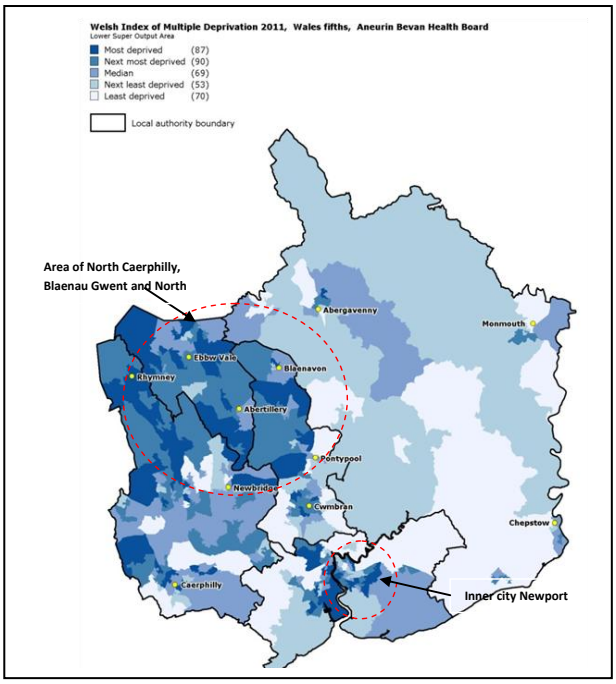


Health Disparities

Within the population served by the UHB there are some significant disparities in health status. There is new evidence of the widening gap in healthy life expectancy between the most and least deprived groups in Gwent, which can be up to 20 years difference within some localities (comparing the most deprived and least deprived people in our population), Actual life expectancy for the most deprived fifth of the population has risen more slowly than for any other group. For instance, people living in Monmouthshire and Ebbw Vale have a 10 year difference in average length of life. One of the main challenges for us and our partners is "levelling up" the premature mortality (death) rate from the worst to the best, by tackling health inequalities within our most deprived populations.

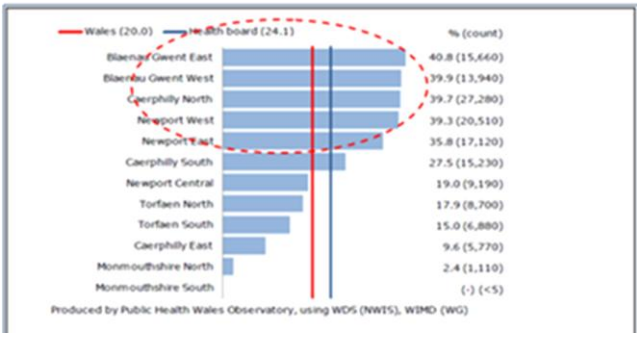
There are distinct areas of deprivation within the UHB. The map below (Figure 4.3) shows the pattern of deprivation in the UHB, highlighting local authority boundaries and selected major towns.

Figure 4.3 - Map showing the pattern of multiple deprivation in the UHB by Wales' fifths of small areas (LSOA)



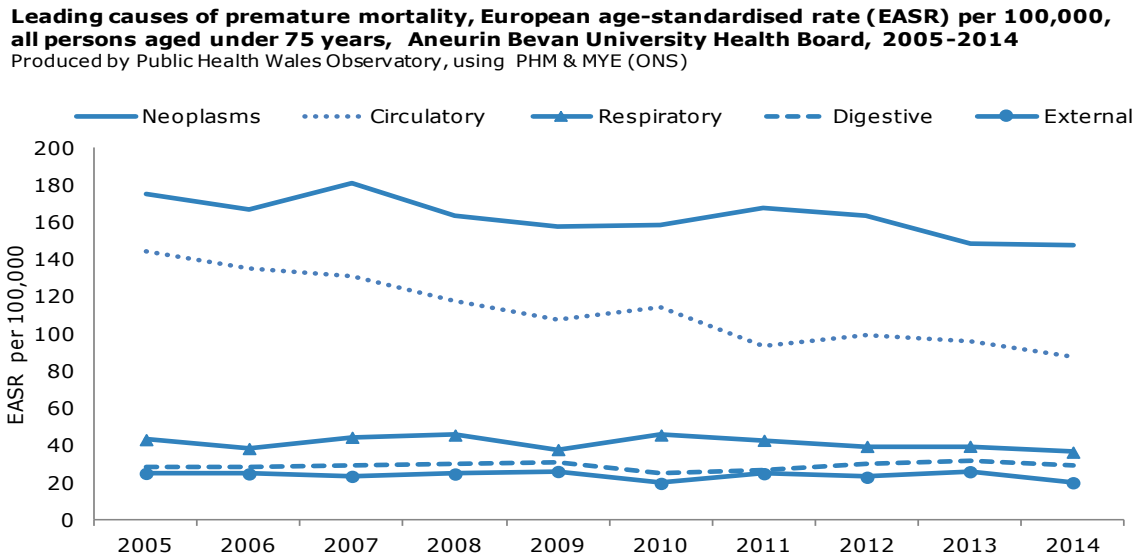
The main clustering of deprivation in the UHB can be seen in the South Wales Valleys communities in North Caerphilly, Blaenau Gwent and North Torfaen and inner city Newport. Of the 141,930 patients living in the most deprived fifth of areas in Wales, a total of 94,510 (66 per cent) were registered within the catchment area of the 5 NCNs.

Graph 4.7



If things stay as they are, not only will people in more deprived communities die earlier, they will also have fewer years in good health without disability than those who reside in our least deprived communities. Premature mortality is an area of considerable concern for the UHB; the graph below shows the leading cause of premature (less than 75 years) mortality in the Aneurin Bevan area.

Graph 4.8 - Leading causes of premature mortality in the UHB (1998-2008, ONS)



Many of the causes of poor health are deep-rooted and they are often difficult to tackle. The main causes of premature mortality are cancers and circulatory diseases. The lifestyle risk factors that are precursors to these conditions are evident in our population. Gwent faces an obesity epidemic with over 60% of the population overweight or obese and our rates of smoking and drinking to excess continue to concern because other substance misuse is a relatively small number.

4. Service Pressures

The external operating environment is influenced by a range of service, legislative, financial and demographic factors, which provide a wider context in developing plans that are ambitious but deliverable. The external environment challenges include the ageing population, increasing demand in some specialties, public expectations, and sustained austerity in public sector finances that have profound implications in planning complex health and well-being for the population of Gwent and South Powys.

Whilst there has been additional funding agreed for the NHS in recent years, Local Authority funding has been subject to increasing financial pressures which is likely to further impact on capacity within Health and Social Care. Demographic changes, and the ageing population, places increased demand on our services. Whilst older patients represent a minority of emergency admissions they account for nearly 70% bed occupied by emergency admissions and their complexity continues to increase, with the UHB's Frailty programme central to managing demand through providing community alternatives. Recognizing the strategic importance of this issue, the UHB's integrated response is described in our Integration SCP (Section 6.4).

Levels of occupancy in our hospitals often exceed 99% for adults, with improvements to patient flow and capacity a key outcome of engagement. This has a profound effect on the provision of emergency services, and in particular the delivery of Tier 1 targets. Whilst the UHB performs well by comparison with other Health Boards in Wales, current performance does not match our ambition. Our Urgent and Emergency Care Plan describes how the pathway will be reformed through an integrated approach to planning and service improvement, addressing a range of demand management and patient flow process improvements, and aligning demand to capacity, within the day and consistently across the week, months and year.

With regard to elective care, whilst we have made progress in shifting the balance between secondary and primary care for services as oral surgery and ophthalmology to develop new and

sustainable clinical models, we acknowledge that we have much to do to clear our backlogs and to deliver recurrent demand within recurrent capacity. Central to this will be our detailed delivery plans (which maximize operational efficiency) and a wider transformation approach encompassing Prudent Healthcare, our contribution to the All Wales Planned Care Programme and our Outpatient Transformation programmes, which has demonstrated sustained improvement in a number of specialties.

5. Workforce – Key Themes to Deliver Clinical Strategy

"Working Differently, Working Together" Focuses on four workforce and organisational development objectives which set out the high level components of what needs to be delivered and the key enabling actions to support Together for Health. The four objectives focus on improvements in engagement of the workforce, a sustainable and skill workforce focused on prevention and well being of the people of Wales, a redesigned workforce and a workforce that aims at excellence within available resources

Impacts of Clinical Futures and the South Wales Programme
While the medium term plans will focus on the next 1- 3 years, we will ensure that these align with those underpinning our Clinical Futures plan which has given a strong vision and focus on workforce planning for the longer term. A large number of workforce plans have been developed to support the development of the Specialist Critical Care Centre, and these will be used to ensure alignment with 1- 3 year workforce plans

Prudent Health Care and Workforce
The drive for efficiency and improvement, which underpins all the prudent healthcare principles, means that in a system with limited resources health professionals have a duty to establish not only that they are doing well, but that they are doing better than anything else that could be done with the same resources. The concept of 'only do what only you can do' remains a fundamental tenant of a prudent health and social care workforce. In essence this means that we should continue to use this concept and ensure that no professional should routinely be providing a service, which does not require their level of clinical ability or expertise.

The UHB has developed a good track record of applying prudent workforce principles. For many years midwifery nurse assistants have been supporting midwives in the delivery of care; assistant practitioners in radiology support routine plain film x rays; healthcare support workers within therapies delivering care and educational packages; nurse led clinics for sexual and reproductive clinics delivering care to young people.

Some of the schemes already developed and currently being developed will also assist with meeting the junior doctor challenge and meeting deanery 1:11 rota compliance. During 2015, the UHB made further progress in key areas where prudent health care principles had been implemented during that period, they include:

Within Secondary Care:

- Pharmacy technicians are being used within medicines management, thus releasing pharmacists to undertake more appropriate skilled tasks.
- The numbers of pharmacy independent prescribers within secondary care has increased to support decision making.
- The "green ward" will be implemented in the Royal Gwent Hospital in December 2015 and is a more cost effective way of providing lower acuity care for patients who remain in hospital due to delayed transfers of care. These patients in future will be cared for on one 30 bed ward instead of being cared for in multiple wards across the hospital. Savings and efficiencies are generated through this approach, since the ward will require fewer registered nurses than an acute ward.

An advanced nurse practitioner will manage the care of patients on the ward, which will reduce the need for medical interventions.

- Radiographers are reporting plain film images in radiology, thus releasing scare radiologist resource.
- New technologies such as Digitisation of Health Records are assisting with the prudent healthcare agenda and the programme is in the second year of a longer term implementation plan. The new technology will enable a significant reduction in labour intensive tasks, whilst improving accessibility of health records across the health board, and reducing cancelled appointments in outpatients because of the non availability of the health record.
- Surgical care practitioners have been introduced and this will enable improved flow within theatre recovery, releasing anaesthetic medical resources.
- Senior Midwifery Clinicians are supporting the junior doctor rota within obstetrics.
- Emergency Nurse Practitioners are treating minor injuries within the emergency department and there is 4 year programme of training to develop more for Clinical Futures.
- Building on the Government 'best guess' that £11 is saved in social care and health associated care for every £1 spent on contraception, the integrated sexual health midwife (ISH) was introduced in 2014. As a result the numbers of teenagers taking long acting reversible contraception increased post pregnancy or termination to prevent and avoiding another pregnancy in teenage years. There are plans to extend this service and build an outreach team around the ISH Midwife utilising staff currently sub-contracted to partnership organisations to support all vulnerable people.

Within Primary Care:

- Pharmacists have been introduced into Primary Care Resource teams.
- Transfer of care from a secondary setting and providing care closer to home has been achieved in a number of services through utilising existing independent contractors in Primary care such as optometrist's and dental practices.
- Securing financial resources through Primary Care funding has assisted the development of workforce models to manage a number of chronic conditions in a Primary Care setting. For example, the appointment of diabetes nurses in Primary Care will have the potential benefits of reducing referrals into secondary care and consequently reducing the demand for consultant care and delays in secondary care follow up.
- Healthcare support workers are assisting in the delivery of the Community Neuro-rehabilitation Service.

The following are schemes are in development for 2016 and beyond:

Within Secondary Care:

- The graduated care ward is based on similar principles to the green ward, where patients require a level of care, but who do not require the same professional skills as that of an acute ward. The principles can be applied to both discrete surgical ward areas and community hospitals wards. .
- Improving access to Psychology therapies will result in the reconfiguration of the skill mix within the workforce to support the delivery of care. Traditionally Psychology therapy has been provided by psychologists working at a band 8b. The new workforce model will utilise band 4 and band 5 skills to support band 8b psychology roles through the principles of delegation of care. This is being achieved through no additional resource and through the restructuring of band 8b vacancies.
- The organisation has implemented nurse practitioners to assist with procedures previously undertaken by doctors. These roles are numerous but with particular reference to colposcopy nurses and hysteroscopy nurses, the workforce plan is to increase the numbers over the next 2 years which will release capacity of consultants currently undertaking routine procedures in gynaecology.

- Assistant practitioners are being developed in audiology to undertake hearing aid assessments previously undertaken by audiologists.
- Advanced critical care practitioners are being developed to support junior grade doctor rotas, with an incremental training programme to develop more to achieve the Clinical Futures anaesthetic model of care.
- Advanced Practitioners working in Care of the Elderly, GP Out of Hours and OOH mental health services are being planned.
- Ophthalmology Nurse Practitioners will be undertaking injections and this will release medical capacity.
- The number of pharmacists with independent prescribing skills will increase.

Within Primary Care:

- There are plans to implement the new role of Physicians Associate to assist in addressing the concerns with junior doctor sustainability in secondary care and also to support GP sustainability by working collaboratively with the primary care service.
- There will be further development of the primary care workforce and NCN development which will entail ongoing workforce redesign and skill mix.
- Heath and social care will increasingly have to work together to re-design care pathways to ensure seamless care is delivered across the sectors.

6. Teaching and Research – University Status and Medical Education

In the UHB our philosophy is to foster a strong culture of Research and Innovation which will feed into policy and practice. Embracing this philosophy over the coming years will ensure growth in the research portfolio and develop a culture where research is a core activity that is offered to patients as part of their routine clinical care.

Health and Care Research Wales has set key indicators for Health Boards across Wales to increase the number of Clinical Research Portfolio (CRP) trials by 10% year on year and the number of patients recruited to those trials also to increase by 10%.

The UHB had a positive performance for 2013/14 against those targets:

- 10% increase in the number of portfolio studies opened in 2013/14 compared to 2012/13.
- 122% increase in the number of patients recruited to clinical trials in 2013/14 compared to the previous year.

Other highlights in the UHB as work continues towards achieving the ultimate aim include:

- Investment in Mental Health research resulted in the UHB being the highest recruiter in Wales to the National Centre for Mental Health study last year. 229 patients were recruited and this year the recruitment figures are already higher.
- Investment in pathology to ensure patients are able to access clinical trials in Velindre.
- Investment in ITU where the research portfolio is growing; last year 635 participants were recruited into the FREE study (Family Reported Experiences Evaluation).
- In order to grow the R and D as a key aspect of University Status, a commitment has been made that a minimum of 45 Consultant Supporting Professional Activities (SPA) sessions will be allocated to research from April 2015, with named individuals to take the work forward.
- The UHB conference attracted over 300 delegates which enabled the organisation to showcase research excellence and encourage new researchers to come forward.

The UHB philosophy is to foster a strong culture of Research and Innovation which feeds into practice. Research activity will grow in quantity and quality in a culture where research is a core activity, offered to patients as part of their routine clinical care.

Specific behaviours will identify Aneurin Bevan as a UHB:

- Strong partnership working with Universities, in and outside Wales.
- Continue the Gwent Partnership Board.
- Ensure that service development and service evaluation projects submitted to Board include robust evaluation prior to approval by Board.
- Continued visibility at Board through the Medical Director.
- The conduct of Chief Investigator led research.
- Engendering a vibrant research environment that attracts the best clinical and other staff to work in the UHB.
- Providing funding for capacity building through the NHH Thrombosis Fund PhD Scheme, and uptake of HEI and WG funded places.
- Converting 5% of medical SPAs into research sessions, which establishes research as a core activity.
- Protecting Research SPAs to ensure research activity can be prioritised in these sessions.
- Fully utilising the Clinical Research and Innovation Centre at St Woolos for conducting commercial and other non commercial research.
- Continue submitting applications to WG and other funding bodies including Research for Patient and Public Benefit (RfPPB), NIHR and others.
- Continue to publish in high impact journals and disseminate the results of our research widely.
- Continue to run the R&D Conference to disseminate research and innovation, and attract HEI, Industry and Third Sector attendance.

7. Clinical Futures

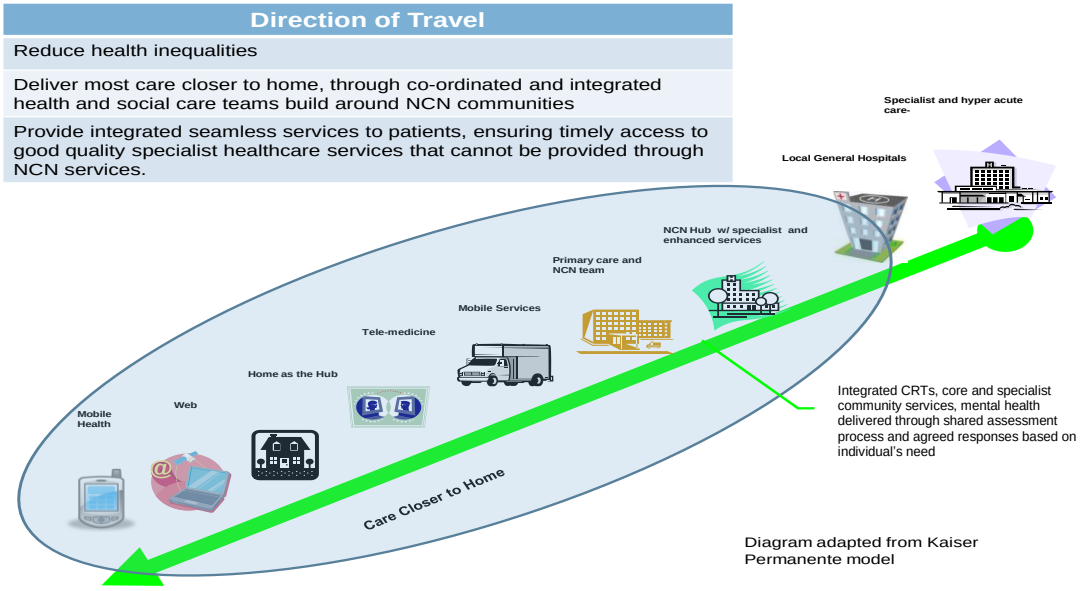
The UHBs' strategic direction for modernising clinical services is set out in our **Clinical Futures Strategy.**

As part of the work undertaken in support of the UHB's Clinical Futures Programme Business Case and SCCC Full Business Case, the UHB's Clinical Futures Strategy was reviewed and updated and has been proven to be remarkably resilient.

A central theme is the creation of "networks" that bring care as close to the patient as possible through progressive working practices within Neighbourhood Care Networks (NCNs), a new relationship with patients as experts in their own health, the use of new technology, and our maturing NCNs as the sole vehicle through which local services are organised and delivered. They will become the fundamental building blocks that bind together the work of all partners in health and care in a simple and practical way.

NCNs will be supported through a streamlined hospital network, where routine hospital based services will be provided in Local General Hospitals, and all specialist, hyper- acute and critical care services consolidated in the Specialist and Critical Care Centre. Figure 4.4 illustrates the new system of care.

Figure 4.4 - System Redesign, our Clinical Futures Vision



In this system the power of patients' as partners in preserving, maintaining and improving their own health and well being is harnessed. Primary, community and care services are strengthened and integrated to create the capacity to support and treat patients in their homes and communities. Enhanced access to primary care services (urgent and planned) over seven days are a key component of the model. Importantly, it shows the quantum shift to most care being delivered close to home.

Dependent on clinical need, patients will flow through the system to access hospital based services. The aim, at all times, is to minimise the time spend away from home and from local services. The new system relies on doctors and hospitals working together across different care settings, with high degrees of integration and co-ordination across agreed pathways of care.

7.1 Delivering Care Closer to Home

Care at home or in the patient's community, with the most appropriate person, with the right skills, delivering care, is the unequivocal aim of the UHB's future vision. Strengthening Primary and Community Care services is therefore our top priority and the central tenant of our Clinical Futures Strategy.

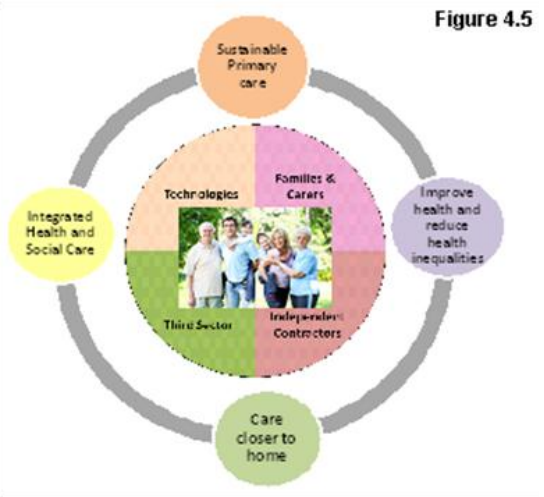
Primary care is the front door to health-care with the patient's first point of contact often being with their GP, pharmacist or dentist. The case for primary care is well established; stronger primary care leads to better health outcomes and more efficient healthcare delivery. The UHB continues to develop and refine its ambitious plans for primary and community care services that are founded on improving outcomes for citizens by adopting a social approach to primary care delivery.

In 2011, the UHB established twelve Neighbourhood Care Networks; these are collaborative networks comprising all primary care, health and social care, housing and third sector community providers operating within the boundaries of the neighbourhood. By 2014, the UHB committed to ensuring that the twelve Neighbourhood Care Networks become the fundamental building blocks within Gwent to organise care on a local basis, integrate community health and social care, and integrate primary and acute care. NCNs are ***the vehicle*** that will drive the implementation of the UHB's key priorities, described as the Triple Aims of:

Aim 1 - Strengthening the role and sustainability of primary care - whilst General Practice is a core element of primary care it also includes services such as pharmacy, dentistry, optometry, therapy, community nursing, health visiting and mental health workers.

Primary care also has a unique role in co-ordinating access for people to the wide range of services delivered by the whole healthcare system. As Primary Care is a crucial component of the strategic solution for sustainable healthcare, the Minster for Health and Social Services has therefore challenged Health Boards to make primary care the engine room of the NHS.

Figure 4.5



This is a priority of the plan and sets out a range of work programmes to ensure core sustainable primary care services and include:

- Optimising in hours and out of hours GP Access.
- 24/7 district nursing services.
- Community phlebotomy services.
- Increased and appropriate primary care access to diagnostics.
- New workforce models – including practice based Pharmacists, Advanced Nurse Practitioners, Therapists, Support Workers, Third Sector and maximising the capacity which already exists within other independent contractors i.e. Dentists, Community Optometrists and Community Pharmacists.
- GP referral variation – to identify and reduce preventable referrals by aiming to achieve Best in Class (27,500 preventable referrals, prioritising the highest return first).

Aim 2 - To deliver integrated care closer to home - the nature of work delivered in primary care settings is changing. We want to enable people to live at home independently, with their families, in their communities, for as long as possible. This requires re-designing services across a new integrated system, moving from models of care based in hospital which treat single conditions, to a population-based approach with much greater emphasis on managing co-morbidity and enabling self-management. This includes:

- Anticipatory care planning for nursing homes (projected 50% reduction in Emergency Medicine Admission to Hospital).
- Integrated assessment for older people.
- Further development of the Frailty Programme.
- Improving patient flow – Step up/step down beds in residential settings.
- Ophthalmic Diagnostic and Treatment Centres.
- Extended minor surgery in primary care.
- Primary Care minor oral surgery.
- Neighbourhood Care Network development to become integrated health and social care delivery systems.

Aim 3 - To improve Chronic Conditions Management services - chronic conditions management is a key priority for the UHB and its partners through the Single Integrated Plans agreed by the Local Service Boards in Gwent and across the divisional service change plans. The aim of these plans is based on the principles of prudent healthcare by tackling the root causes of ill health, improving early detection and management of chronic conditions and offering optimal treatment and continuity of care. It is also aimed at supporting peoples to self-manage their chronic conditions and a co-production approach.

Examples of programmes included in the plan are:

- Integrated diabetes services leading to over 90% of Type 2 diabetes being exclusively managed within primary care;
- Integrated respiratory service
- Primary care anti-coagulation programme to deliver all INR monitoring and management closer to home;
- Ambulatory-care sensitive conditions programme – to reduce emergency medical admissions.
- End of life care in the patients preferred place of care.
- Primary Care Cardiology service
- Lower back pain service
- Osteo arthritis of the knee programme
- Cataract schools.

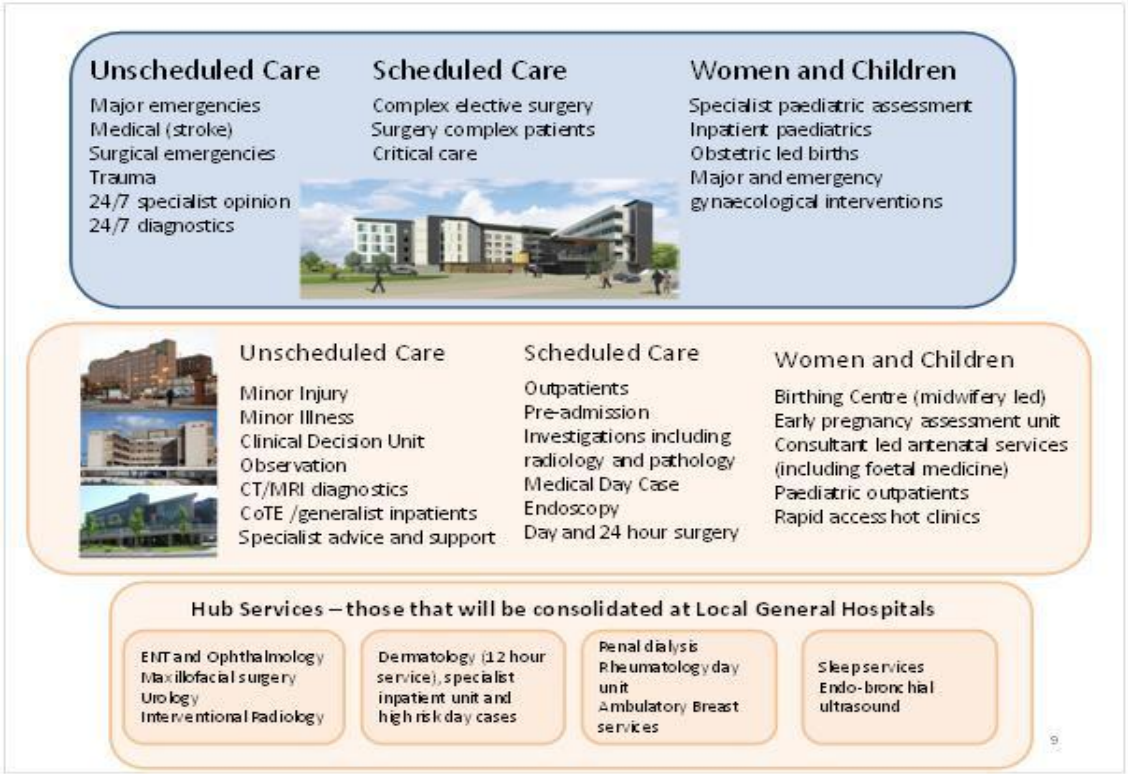
7.2 Supporting Hospital Network

The Clinical Futures Service Strategy set out to modernise and re-balance the way in which hospital services are configured in order to support a primary and community led system of care. Figure 4.6 shows the key components of the supporting hospital network.

The need to consolidate those services that people access relatively infrequently but which are acute and/or specialised in nature at the proposed Specialist Critical Care Centre, located at Llanfrechfa Grange, near Cwmbran. This is necessary to ensure these services are more reliable and robust 24 hours a day, 7 days a week by developing single, integrated teams and extended working days.

The concept of the SCCC is to create a highly specialised environment to support the treatment of complex morbidity and acute emergency care. Treatment is delivered with the aim of rehabilitating the patient back to their home; integrated health and social care unit for on-going recovery or to their local general hospital as appropriate.

Figure 4.6 - Key Components of the Hospital Network



Routine hospital care such as tests, investigations, outpatient services (where alternatives to attending a hospital based clinic are not appropriate), minor injuries, elective surgery and other day case treatments, therapies and inpatient care, would be provided through a network of Local General Hospitals (LGHs). LGHs also play an important role in supporting the delivery of the most efficient and effective operating model for the Specialist and Critical Care Centre (SCCC). They form an important part of the “hub and spoke” model of care that underpins our clinical model.

We continue to critically review future service models to ensure that we deliver the optimal configuration of hospital based care to support our NCN led healthcare system. The UHB faces significant challenges in optimising hospital based care that delivers quality outcomes in a testing economic climate. It is becoming increasingly difficult to duplicate services across multiple sites and is not sustainable in the medium term. The South Wales Programme set out the urgency driving proposed critical and specialist service changes, particularly in respect of delivery of standards and service sustainability in the medium term, recognising that the SCCC is an essential enabler of change for the UHB.

Over the 3 year period the UHB will develop interim sustainability solutions for vulnerable service areas and work with the South Wales Collaborative and its associated Acute Care Alliances to develop solutions.

Key Messages (service strategy)

- Prevention and anticipation.
- People having a greater part to play in looking after themselves, being supported to do so, and able to make informed decisions about accessing healthcare services appropriately.
- Closer integration and teamwork between health and social care, voluntary organisations and private care homes to provide a system that binds health and social care together.
- Clear patient pathways which combine the strength of primary and community care with the specialist services provided by our acute hospitals.
- New services, where community and hospital staff work together to provide care for patients who need more than is normally provided in primary care but don’t need the specialist services of the acute hospital particularly for older and vulnerable adults.
- Acute hospitals providing skills and services that cannot be provided more locally.

Chapter 5 – Our Ways of Working

1. Population Health and Commissioning

Strategic Approach within the University Health Board
Commissioning is the process of specifying, securing and monitoring services to meet individual needs at a strategic level. It involves the commitment of finite resources to evidence based interventions, particularly but not limited to health and social care sectors with the aim of improving health, reducing inequalities and enhancing patient experience.

The UHB intends to develop a more structured and rigorous 'commissioning' approach to planning and delivery of services. This approach will be informed by 'Value Based Healthcare' principles to ensure the development of a commissioning system that prioritises resources to drive performance improvement in healthcare outcomes for patients and residents, within an ethical framework of decision making.

The statutory responsibilities and planning framework for Health Boards includes the requirement to effectively commissioning services and achieve financial balance. The current economic environment means we must use the available resources in the most cost effective way for greatest health gain.

This means the UHB must be clear on:

- The priorities of the UHB.
- The current and future performance and aspirations of the UHB.
- The tools we will require to drive improvement.
- The structure & culture for driving change and improvement.

The above elements will require the commissioning 'system' to act as an enabler, with business intelligence and clinical evidence, along with transparency in decision making being the critical tools to success.

Delivery of the commissioning intentions will fall to both internal divisions and external providers from all sectors, with robust monitoring of delivery to ensure best value is being delivered.

The challenge is clear for the UHB's divisions and external providers have received and will continue to receive UHB commissioning intentions clarifying our expectations.

Development of Commissioning within the UHB
The Board through the Planning & Strategic Change Committee will be engaged in agreeing the preferred approach to commissioning in the UHB. This will take a wider perspective on population need and relevant resource usage, with the aim of prioritising resources to achieve best results for the Gwent population.

Aligned to this is the need to drive service design and delivery through evidence based models, structures and systems will be strengthened to align current delivery to best practice and focus on service provision on the most clinically effective care, including challenging thresholds.

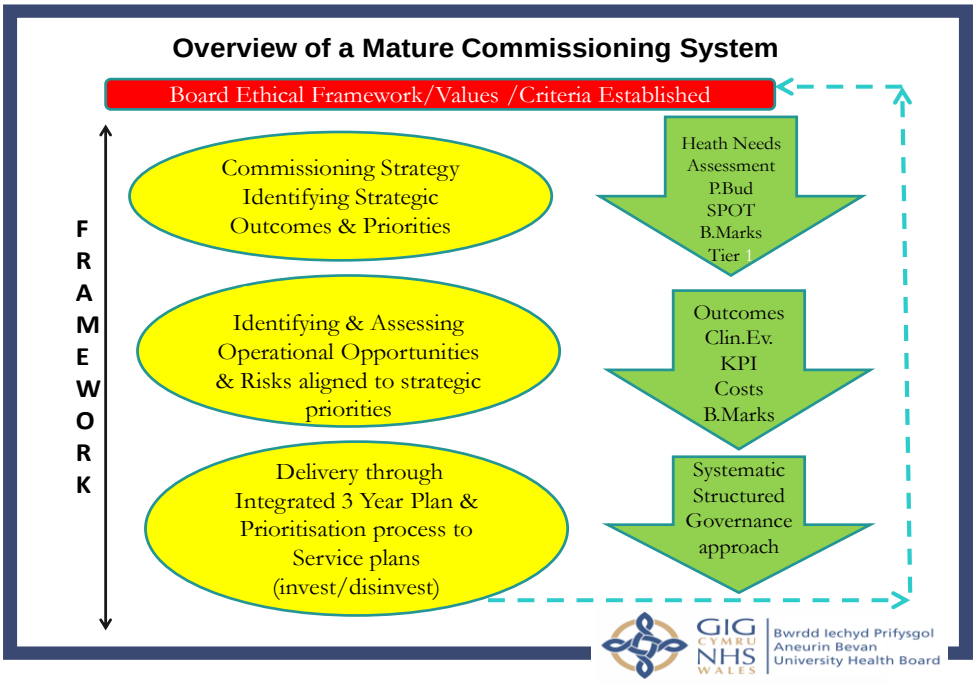
Developing an ABUHB Commissioning Framework & Commissioning Strategy
The Board is undertaking a significant programme of work to develop a robust commissioning framework, arrangements and Commissioning Strategy identifying the community focused outcomes and priorities for the UHB. In order to shift the organisation's culture and approach to decision making (in both the short and longer term) there is a need for systematic clinical and Board discussions on future priorities to ensure that resources are targeted to best effect. This

decision making process will need to be based on the components of:

- Knowledge derived from scientific or other systematic approaches (evidence).
- Patient and carer perspectives.
- Clinical expertise.
- Incorporate the wider perspective on population needs.
- The opportunity for improvement in health outcomes, patient experience or use of resources.

By applying all these components of intelligence to the 'commissioning' of services will support the UHB in taking an evidence based approach to decision making, support priority setting and facilitate the re-design of clinical pathways. This will require a clear policy to be developed for the UHB, including a transparent and inclusive decision framework, a clear set of criteria for determining priorities and robust monitoring, governance and information systems to be established. Decision making will need local intelligence to support cases for investment and/or disinvestment and service change will need to include patient views.

Figure 5.1 - Stages of the Commissioning Framework Development



This will require a clear policy to be developed for the UHB, including a transparent and inclusive ethical framework, clear criteria for determining UHB priorities and robust structural, governance and information systems to be established. Decision making will need intelligence to support cases for investment, disinvestment and service change and will need to include patient views. Key elements to be developed include:

Clinical Leadership to provide support for prudent healthcare and a value driven approach. Pro-active use of clinical effectiveness evidence and public health needs assessments to truly influence decision making and challenge current practice.

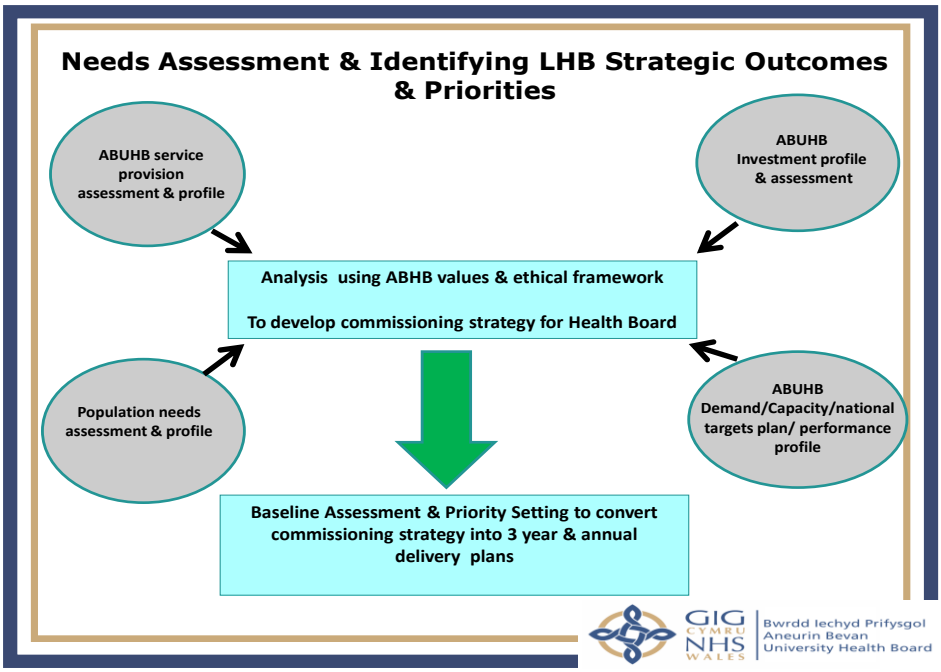
Ethical frameworks, prioritisation methodology and other governance frameworks - To support the application of the evidence base arising from these initiatives, it is important that the appropriate infrastructure is put in place to support ethical decision making within the UHB and to ensure the important aspects of an investment or disinvestment decision is highlighted and evaluated.

Development of business intelligence to support decision making - In order to support

informed decision making within the UHB, Business Intelligence will be critical. Currently, there is a disparate approach to gathering and reporting information and it can be onerous to gather a comprehensive triangulated picture of service delivery and performance, both internally and externally.

Becoming an 'informed' commissioner is key to future decision making and has already achieved success for the UHB in some areas.

Figure 5.2 – Establishing Commissioning Priorities



The challenge for the UHB is to not only to make choices but to make the right choices. There is an expectation that the best evidence based clinical care will be provided to our patients, but choices may need to be made for the benefit of the population of the UHB to ensure equity of access and outcomes are achieved. This may mean choices being made to shift resources to areas of greatest need, i.e. focusing on reducing the 'inverse care law' impact.

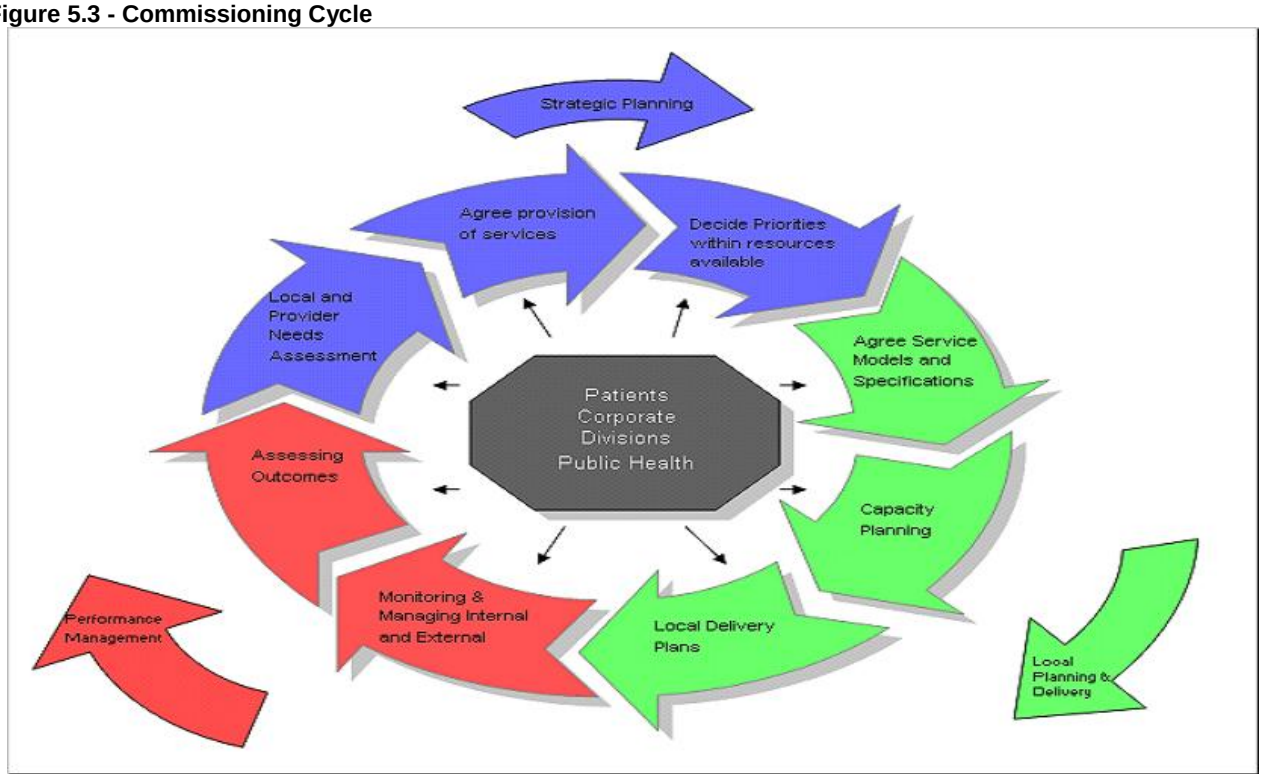
Systematic Commissioning Approach in ABUHB

It is proposed that 'Commissioning' within the UHB will be a whole system approach. The commissioning cycle includes several elements of activity:

- needs assessment;
- demand/Capacity assessment;
- opportunity to improve clinical services and well being of our population;
- prioritisation;
- planning;
- setting service specifications;
- contracting;
- performance management;
- monitoring & review.

The approach within the UHB will be for commissioning processes to recognise and bring together the expertise provided by different teams, within a structure that encourages joint working and optimises the outcomes sought for the UHB and its patients.

Figure 5.3 - Commissioning Cycle



Essentially, commissioning encapsulates the following key functions in order to deliver high quality and effective healthcare to patients:

- **Assessment and Planning** that demonstrates the evidence base for commissioning services captured in clear strategic and operational plans with agreed commissioning outcomes.
- **Contracting and Procurement.** This relates to agreeing, auditing and validation of contracts and ongoing monitoring of financial, clinical efficiency and patient outcomes performance of contract providers.
- **Performance management, settlement and review** by ensuring providers produce timely and accurate information, benchmarking activity and costs, regular financial and performance reporting, risk sharing arrangements and establishing clear rules of engagement with service providers.
- **Ensuring a value based approach to service provision** that is focused on quality and outcome measures, comparison to “best in class” and evidence based guidelines.
- **Patient and public engagement** through the establishment of mechanisms for ensuring the public and patients have an input into decision making and establishing internal and external engagement and communication strategies.

In establishing a Commissioning Framework and Commissioning Strategy, the UHB will be seen as having an investment role in four different outcomes. These are improvements in:

- Health outcomes: focussing on population well being and health gains for specific or general communities through service improvement or redesign (this includes promoting people’s independence, reducing inequalities and promoting social inclusion).
- Prudent healthcare principles and their application.
- Allocation efficiency: ensure resources are aligned to areas of greater health need.
- Community outcomes: that could result in another part of the system improving, for instance through a regeneration programme, in ways that enable health gains.
- Clinical and care outcomes: the results of health and social care interventions, for example clinically effective care pathways and improvement in the quality of services provided.

Contributing to and leading on elements of the national approach to commissioning will be a key

part of the UHB agenda with existing 'Collaborative Commissioning' proposals being further developed. This will provide opportunities for shared learning, reduced duplication and development of a shared 'intelligent commissioner' portfolio.

Contracting as an element of the commissioning cycle will be developed to help act as a key catalyst to drive change with provider organisations, significant early benefits have been achieved through analysis of service delivery at a macro and micro level. Moving into the clinical challenge arena of contracting and focusing on outcomes will be the next stage of development to ensure best value is being delivered. This approach should be developed for adoption as best practice and encompass all contracts and SLA's that the UHB commissions.

Commissioning as an enabler - to ensure it is reflective of the Welsh Government's National Planning Framework requirements for commissioning and incorporates a clear, robust approach to using commissioning to integrate and enable programmes of work within and outside the organisation.

Value Based Commissioning - that it builds on the concept of value based clinical services articulated within the UHB's Three Year Framework through the introduction of 'value based commissioning'.

Driving and influencing national and regional commissioning initiatives across Wales - by developing the necessary technical expertise and business intelligence to support the wider organisation and act as a significant contributor to the supra regional and national commissioning agenda.

Development of Business Intelligence to support decision making
Decision making will need intelligence to support cases for investment, disinvestment and service change and will need to include patient views.

Improving Business Intelligence is seen as a key priority for the UHB for commissioning, with significant early steps taken to provide improved financial and service benchmarking. Triangulating clinical evidence, patient pathway and financial information against best practice benchmarks is critical to identify opportunities for improvement.

Becoming an 'informed' commissioner is key to future decision making, the challenge for the UHB is to not only to make choices but to make the right choices. Prudent healthcare principles indicate there is an expectation that the best evidence based clinical care will be provided to our patients, but choices may need to be made for the benefit of the population of the UHB to ensure equity of access and outcomes are achieved. This may mean choices being made to shift resources to areas of greatest need, i.e. focusing on reducing the 'inverse care law' impact.

The opportunity to improve patient care commissioning through prioritisation, is linked to triangulating relative population health needs with quality and outcomes and clinical evidence. Then iteratively testing this to ensure workforce, financial and infrastructure limited resources are available to meet the commissioning plan.

2. Quality Improvement

2.1 Quality at the Heart of Our Mission and Values

Quality and Patient Safety is at the centre of our work in seeking to achieve excellence, with the patient at the heart of everything we do as we strive to improve the patient's experience and quality of service with every action that we take in primary care, in community services and in our hospitals.

Our purpose therefore is to transform patient experience and nurture a consistently person-centred approach in everyone, every day. Evidence suggests that patients who are more actively involved in their health care experience better health outcomes and incur lower costs, with person-centered care leading to better patient experience. This is at the core of Prudent Healthcare and co-production – both of which are part of a quality service. This is also reflected in our values, which define what is important to us and how we behave in delivering care. They support a shared understanding about how staff relate to patients, the public and each other.

Figure 5.4 – Living Our Values

Living our values (Figure 5.4) requires every member of staff to consider five simple questions, which align behaviour and culture, providing an environment in which quality flourishes, with the patient at the centre and an equal partner in their healthcare.

Our thinking about quality in the UHB is guided by the Institute of Medicines dimensions of quality (Table below). However, as indicated above, these dovetail with the Prudent Healthcare principle, which emphasise value and co-production.

Table 5.1

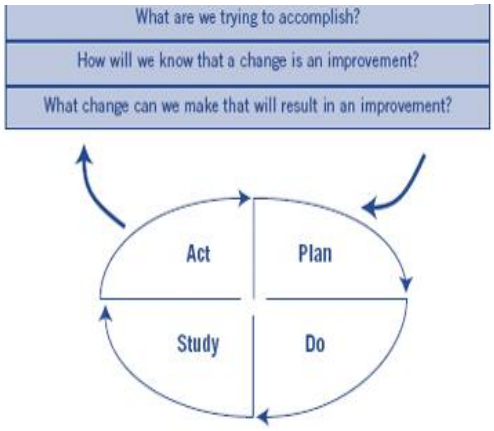
Aim	This Means ….
Safe	Avoiding injuries to patients from the care that is intended to help them.
Effective	Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
Patient-Centred	Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that the patient's values guide all clinical decisions.
Timely	Reducing waits and sometimes harmful delays for both those who receive and those who give care.
Efficient	Avoiding waste, including waste of equipment, supplies, ideas, and energy.
Equitable	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

2.2 Our Approach to Quality Improvement

To provide high quality care, we seek to improve all the time through both addressing gaps or risks, and in striving for excellence. Our approach to improvement is that all staff have two roles: to do their job and to improve their job, seeing patients as equal partners in their care, and the services we provide through their eyes. We believe that this will ensure that we have the highest quality services for the people we serve. To empower all staff to be able to do this our staff need to learn, master and employ modern methods for quality improvement.

The **National Programme of Training in Quality Improvement**, "Improving Quality Together", is our core training programme, and we are building capacity within the organisation by training all staff to bronze level. The silver level training has been rolled out across the organisation and forms the next step in building capacity for improvement in the workplace.

Figure 5.5 - IHI Model for Improvement



Our core improvement method is the Institute for Healthcare Improvement's (IHI) Model for Improvement, which is well tested and embedded within NHS Wales as the core tool used in the 1000 Lives Plus and the Improving Quality Together programmes (Figure 5.6).

Using the Plan, Do, Study, Act cycle, it requires clinical teams to be clear about:

- the problem they are addressing;
- the aim of the improvement they want to make;
- the measures they will use;
- the change that will result in an improvement.

ABC*i,* the Aneurin Bevan Centre for Improvement, is the UHB's centre of improvement and innovation, supporting staff to develop a culture of patient focus, curiosity, courage and creativity across all our services. This service draws together people working on quality, innovation, leadership, mathematical modelling and service improvement from across the UHB, and is described in greater detail in Section 9.3. ABCi tends to focus, but not exclusively, on service improvement – the changes a specialty or service want to make to their model of care.

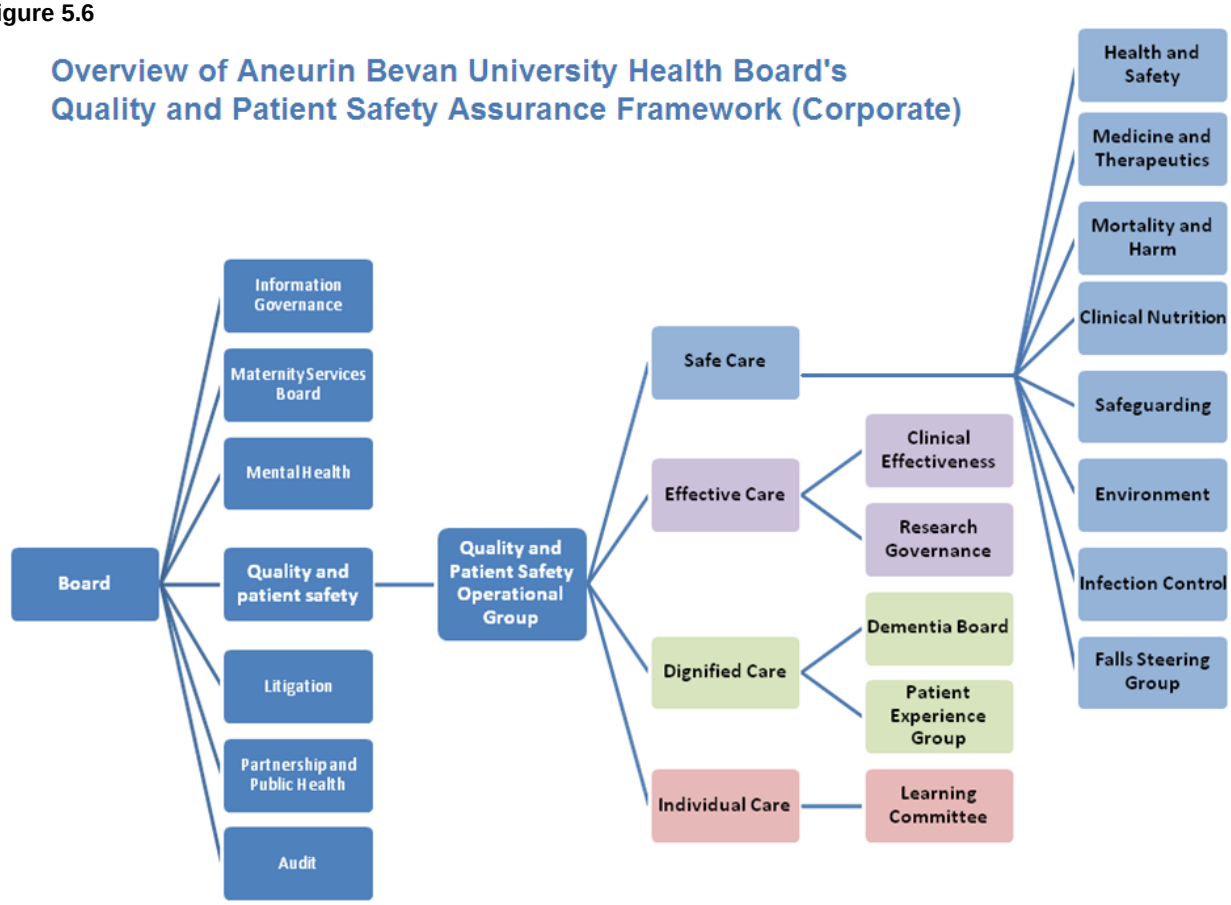
The Quality and Safety improvements described in this chapter are those challenges that are not specific to a service but occur right across the healthcare system and are not owned by any one part of the service – sepsis, healthcare associated infections etc. The quality improvement required to tackle these challenges needs an organisation wide approach, with the changes being made through the operational delivery of the service so that they are "the way we do things around here". They are therefore included in this section, but are not picked up in the service delivery plans, as these focus on the quality improvements/service improvements specific to that service. However, the changes are made using the approach to QI described above with a high level, ambitious aim, but the changes being tested in a small number of areas before being spread more widely.

2.3 Quality Assurance

The quality of the care we provide is assured primarily by the Board's Quality and Patient Safety Committee (QPSC), which meets every 2 months and receives reports on issues that fall within its terms of reference. An overview of the framework is shown below (Figure 5.4), demonstrating how the UHB aligns quality assurance and improvement efforts around the key themes of safe care, effective care, dignified care and individual care. Reporting lines on the work of the various groups and committees feed up to the Quality and Patient Safety Committee through the Operational Group which escalates issues to the Board as appropriate.

The QPSC receives a Quality Improvement Report at every meeting, monitoring high level outcome measures and key process measures for the main areas of improvement described in the section, as well as an overview of themes from Mortality Reviews, Complaints and Incidents. Some of the themes in the Health and Care Standards are led by other Board Committees – such as Staying Healthy by the Public Health and Partnerships Committee, and aspects of Clinically Effective Care through the Information Governance Committee.

Figure 5.6



The Health and Care Standards provide the framework against which we assess all our services, to identify gaps, risks and areas for improvement. These are embedded at Divisional and Directorate level, with any gaps identified taken forward through improvement plans and risk registers. All the Standards have a standard lead and are mapped to a Supporting Committee corporately, and this is mirrored within the Divisions. The Corporate Standard leads develop driver diagrams which set out the systems and processes for the standard at a Corporate level and what the Divisions need to have in place to meet the standard.

For a number of years, the Risk Adjusted Mortality Index has been used as the high level indicator to show whether the organisation is providing quality services. In reviewing the risk adjusted mortality data for Welsh Hospitals, the Palmer Report (2014) concluded that RAMI as a measure of quality could be misleading and potentially could divert attention away from more meaningful approaches to measuring and improving hospital care. In place, he recommended that the public should take assurance about the safety and quality of hospital care from timely medical records reviews of all deaths in hospitals, following national protocols. He also concluded that assurance about the quality of care in hospitals in Wales should be underpinned by full participation in National Clinical Audits. In response to this, the UHB is continuing to conduct mortality reviews by senior, independent clinicians, whilst participating in the piloting of a national process for the mortality review. The UHB is also building the robustness of its processes for National Clinical Audit, with an initial focus on participation, so that the reports provide meaningful data on our

services that we can use to make improvements. The next area of focus is to ensure the results of reports are being more widely disseminated within the organisation, to ensure areas for improvement are quickly identified and changes agreed and implemented. The aim is to see year on year improvement in the UHB results in National Audits. Professor Palmer also recommended that condition specific mortality data should be used to monitor the quality of services. The UHB regularly monitors data for Stroke, Myocardial Infarction and Fractured Neck of Femur. Stroke mortality data is monitored alongside National Audit data, and the UHB is looking to develop this approach, and see whether this can also be combined with condition specific mortality reviews.
NICE guidance, standards and pathways lay out the evidence base for our services, with results of local and national audits providing assurance or highlighting areas for improvement. There is a process for ensuring that results of National Clinical Audits are known about and escalated where necessary. These can lead to major service changes/improvements, as is shown with the National Hip Fracture Database and the work on the Fractured Neck of Femur Pathway that is now taking place. A range of external bodies, including the Community Health Council and Health Inspectorate Wales, also undertake formal, independent reviews of our systems, processes and practice, which also underpin our quality assurance processes and enable a triangulation of data.

The UHB's Quality Approach seeks to address the outcomes of the Francis, Keogh and Berwick reports (2013). The actions identified to address the challenges are spread throughout this plan, covering our values and behaviours, changes to the workforce, and improving patient experience through listening to our patients and listening to our staff. In 2014 Wales saw the publication of **'Trusted to Care',** following a Minister-commissioned independent review of care provision, particularly for older people, in Abertawe Bro Morganwyg University Health Board**.** An Assurance Framework has been produced describing our response to the report's 14 recommendations, and a Trusted to Care Steering Group has been set up to oversee the implementation of all the changes.

We are committed to enhancing our engagement with patients and their families to seek their views on the care we provide so that we can listen and learn with the aim of improving patient and family experience. This year we have continued to build on the outcomes of the Evans Report, "Using the Gift of Complaints" on complaints handling in NHS Wales. This concluded that "Putting things right" is the right approach for managing complaints and concerns, although there are variations in how this has been implemented across Wales. The UHB has reviewed its processes for the management of complaints and can demonstrate this year almost as many complaints have been dealt with informally and resolved quickly to the satisfaction of the patient and their families. A training programme has been developed to ensure that staff have the skills to respond to complaints in an effective, timely and empathetic way.

Our assurance processes are supported by many sources of data that we use to learn about how we can do better, which include incidents, complaints and claims, Mortality Reviews, the review of routine and CHKS data, from listening to our staff and from patient stories, patient shadowing and patient surveys. Much of this forms our Quality Triggers, so that we can identify when we need to take action to improve our care. A 'concerns matrix' has been developed which highlights a range of metrics that singularly or multi-dimensionally indicate that an area may require additional support or intervention. It is hoped that this work will advance to predictor status, enabling proactive interventions before problems occur.

Key Quality Triggers include serious incidents, with 'never' events being monitored within serious incidents. Serious Incidents all have an Executive Lead, and are investigated to identify the lessons that need to be learned. The resulting actions plans are monitored at the UHB's Learning Committee. Any recurring themes inform the UHB priorities for quality improvement – such as recognising and responding to deteriorating patients, including those with sepsis, and ensuring that Ophthalmology follow-up appointments are not delayed for patients with high risk of harm.

Never Events are those things which should never happen within Healthcare and are listed by the

Welsh Government. During 2015-16 to date, we had three never events, relating to a misplaced naso-gastric tube, a retained swab post procedure and a wrong implant. Each incident has had a root cause analysis and actions have been put in place to prevent them recurring.

Suicides are also reported as incidents, and a chronology is completed for each incident of suicide, with a more in depth review undertaken for incidents where required. These reviews are discussed within the Mental Health Serious Untoward Incident Meeting to ensure that lessons are learned and disseminated. The National Confidential Inquiry into Suicide and Homicide in people with a mental illness Annual Report July 2015 showed the UHB area had the second lowest rate of suicide in Wales. The data for the last 3 years is given below:

Table 5.2

Year	Total Serious Incidents (not including suicides)	Never Events	Suicides
2012-13	26	1	28
2013-14	27	3	31
2014-15	21	1	16
2015-16 - Jan 2016	75	3	22

The Serious Incidents reported to Welsh Government now include Pressure Damage and Inpatient Falls that result in a fractured neck of femur. These numbers will therefore increase significantly for 2015-16 and subsequent years.

Patient Safety Solutions are received and disseminated through one designated manager. The responsibility for compliance with the alerts and notices depends upon the nature of the alert or notice. However, the UHB is proactive in its implementation of Patient Safety Solutions, and compliance is good.

Transparency is crucial in building our relationship with our citizens, and in driving improvement. We therefore publish data on our internet site, and in our **Annual Quality Statements** which are open and honest about where our services should be better, and what we were doing to improve them (http://www.wales.nhs.uk/sitesplus/866/opendoc/248860).

Building on the above, and to close the assurance loop, the table below summarises the "looking forward" actions from our Annual Quality Statement 2013-14 and the progress we made in the year 2014-15. The "Looking Forward" Actions in the 2014-15 AQS, which build on the progress achieved and cover some alternative issues, will be reported in the 2015-16 AQS, which is currently in development.

Table 5.3

AQS Priority Area	2013-14 "Looking Forward" Actions	2014/15 Progress Achieved
Sepsis	We will integrate the approach to early recognition and response to sepsis across all our services, with an identified set of measures to demonstrate progress.	ACC Sepsis was launched on 7 January 2015. This has tested and is now spreading the reliable recognition and response to sepsis and measurement of process and outcomes.
Healthcare Associated Infections	We will reduce C. diff. to 31 cases per 100,000 population over 18 months, a 53% reduction year on year.	We are the most improved Health Board in Wales. In 2014-15, the rate per 100,000 population decreased 42% from 66.14 to 38.4.
In Hospital Falls	We will build on the pilots of new	We have reduced the number of falls

AQS Priority Area	2013-14 "Looking Forward" Actions	2014/15 Progress Achieved
	practice, following the publication of the Falls Policy, to reduce falls in areas with high numbers of falls.	in wards at YYF, an area with a high number of falls. The reduction in falls at YAB seen last year has been sustained.
Nutrition, Hydration, Medicines and Continence Care (Trusted to Care)	We will continue to conduct multidisciplinary, themed reviews of our practice to ensure that these fundamental aspects of care are never overlooked.	All themed fundamental audits have been undertaken in line with the UHB requirements for maintaining care standards as laid out in the Trusted to Care action plan.
Hospital Acquired Thrombosis	We will examine each case of HAT to identify whether we are risk assessing patients and putting in place appropriate interventions, and learn from cases where this has not been completed.	HAT cases are being sent out to consultants for review of medical records and learning in relation to risk assessment and prophylaxis.
Dementia Care – Care Planning	We will embed identification and treatment of dementia across all areas.	The RAID project has enabled the identification of dementia in patients at RGH and the project is spreading to NHH.
Pressure Damage	We will further reduce the number of cases of pressure damage acquired in hospital to below 380 cases.	There were a total of 308 hospital acquired pressure ulcers in 2014-15, well below our interim target.
Prudent HealthCare, Patient Engagement and Co-production	We will implement Prudent Radiography and ensure that patients are equal partners at our improvement events.	We are including guidance on the use of scans in the clinical pathways for the conditions we prioritised for this work. New information is being developed for the public about the need for a scan or x-ray. Coproduction events have been held with patients as equal partners in the improvement of services.
End of Life Care	We will implement the All Wales work on the "Do Not Attempt Resuscitation" process.	The new DNACPR forms are in place across the Health Board and an audit of compliance is planned.
Improving the Quality Improvement Skills of Staff	We will continue to roll out IQT across the workforce to achieve 35% compliance during 2014-15.	IQT roll out progressing well. 2,707 staff have now been trained on the bronze level IQT at end of March 2015.
Staff Experience and Engagement	Every Division will have new ways of engaging staff to enhance staff experience.	Every Division has a new way of engaging staff to enhance patient experience, as it is recognised that if staff feel looked after and supported in their work, then patients are more likely to have a good experience.

2.4 ABUHB Components of Quality

Simply put, health care quality is getting the right care to the right patient at the right time, every time. There are three basic dimensions to this: structure, process and outcomes. Together, these components are the foundation of providing care that is consistently safe, timely, effective, efficient, equitable, and patient-centered. Quality is a golden thread that runs through the plans of all our services in primary, secondary and community care, and in our commissioning of services. This is reflected in our strategic change plans that address structural and process gaps in our systems of care that impact on quality and patient experience (as illustrated in the table below).

Table 5.4

Dimension of Quality	Key Service Change Plans	Intended Impact
Structure (Staff, skills, facilities, infrastructure)	Strengthening Primary and Community Services (create capacity around NCNs to increase range of care provided in out of hospital settings).	Community focused model of care for older people with complex care needs.
	Sustainable clinical services (consolidate services to maximise timely access to specialist care - interim plans in lead up to the SCCC will be the focus of effort in the medium term). Rightsizing the workforce **(e.g. All Wales Nursing Principles & Revalidation).**	Services will deliver consistent high quality outcomes irrespective of day of week or time of day. The right staff, with the right skills, in the right place, doing the right thing at the right time, in the right way and at the right cost.
Process	Value based clinical services (eliminate low value procedures, repatriation and prioritisation). Improved Delivery (Tier 1 including efficiency and productivity). Unscheduled Care Transformation. Scheduled Care Transformation.	Patients will have confidence that the UHB is doing the right thing, in the right way to add value to their health and wellbeing. Improving flow through the system to minimise the patient journey and maximise clinical outcomes.
Outcomes	Reducing Health Inequalities/Inverse Care Law. Quality and patient experience.	Reduce morbidity and mortality related to Cardiovascular Disease. Reduce avoidable harm (e.g. HCAI, Pressure Ulcers, Sepsis). People receive compassionate care.

2.5 Quality Improvement Baseline and Priorities

Everything we do as an organisation impacts on the quality of care, safety and the patient experience of that care. Through our assurance processes and learning, we have identified the following priorities as these are the areas which impact across the whole organisation and that we can have maximum impact in reducing harm to our patients. Many of these require integrated working across the whole patient pathway in primary, community and secondary care. Through doing this we will also reduce length of stay and readmissions, and therefore also improve patient flow. where action plans have been developed and where improvement projections have been identified. These are included within our Patient Safety Improvement Plan, which aims to reduce the number of avoidable deaths and incidents of harm in the organisation. In addition, areas are prioritised on a National basis through the Delivery Framework, and the National Outcomes Framework.

2.5.1 Trusted to Care - Nutrition and Hydration, Medicines and Continence Care

The UHB has set up a Trusted to Care Steering Group, which receives reports updating the Group on the action plans for all the main areas of focus of the Trusted to Care Report. These include Continence, Medicines Safety and Nutrition and Hydration. The University Health Board is undertaking regular audits in the areas of nutrition, hydration, medicines and continence care. These show a range of compliance against key measures of between 70-90%. Our aim is that all

areas have 95% compliance and therefore we will need to focus on areas where compliance is not improving, or is decreasing in order to ensure that these fundamental aspects of care are never overlooked.

One barrier in this area is that there is a lot of data, but much of it is not collected and collated in a way that allows it to be aggregated and monitored over time. A task and finish group is meeting to determine the core measures that should be collated across all areas and where they should be reported. This will then support in 2016-17 the prioritisation of certain actions within the action plans for each area, with targets for improvement.

In this area, and dementia and falls, the UHB is developing its approach to meet the requirements of the Older People's Commissioner for Wales for acute care. This involves having a qualitative narrative on patient outcomes, in addition to the more quantitative data that we have but need to collate more systematically. Action plans are also in place to support Nursing Homes to address the OPCW Report "A Place to Call Home", which covers these areas, but with an emphasis on the fact that the Nursing Home is a person's home.

2.5.2 Dementia Care

The UHB is committed to the provision of excellent care for patients who attend general hospitals, acute and community, with medical or surgical conditions and who have dementia. The challenge for the people of Wales is the same as the global challenge. Put simply, the next 20 years will see a 31% increase in the numbers of people who will have dementia across the country. People with dementia will therefore increasingly be accessing all our services and we need to be able to care for them as individuals, with dignity and compassion. Where appropriate, we need to prevent admission of people with dementia.

To do this, we need to work closely with local authority colleagues across acute, community and primary care services. Consequently, the Dementia Board has been restructured to cover Health and Social Services. Its aim is to support people to Live Well with Dementia. The Dementia Board has working groups to take forward particular areas of work. These include:

- Training and Development – Aim to ensure 50% of UHB staff across acute, community and primary care have dementia awareness training by 2016 and 75% by 2017. This is being achieved through training Dementia Champions who can cascade the dementia friends training, and through the All Wales Dementia Awareness training on-line. Initial data shows that we are on track to meet the 2016 target.

- Dementia Diagnosis – Aim to increase dementia diagnosis rates recorded in primary care to 50%. A Dementia Link Nurse is being recruited to improve diagnosis rates across the UHB area. The Group has also worked with the Alzheimer's Society to recruit 6 Dementia Support Workers and these are being aligned to the Memory Assessment Service in the community so they can support people with a new diagnosis of dementia.

- Dementia Friendly Communities – Aim to achieve accreditation of a dementia friendly community in each Local Authority by April 2016. This has been achieved and the Group is working to increase the number of accredited communities over 2016-17.

- Care in General Hospitals – Aim to develop and deliver the Cognitive Impairment Pathway. The aim is that this is in place and supported by RAID in all DGHs by April 2016.

2.5.3 In Hospital Falls

Falls, whether they take place in the community or in the hospital, can have a huge impact on a person, whether they cause an injury or whether they simply affect the person's confidence to get around independently. They are also costly with quoted figures of £15 million to treat falls across England & Wales, so a key prudent health care agenda. Falls are a complex phenomenon and

present a significant safety challenge for the UHB. The UHB Falls Steering group covers falls in the community and in the hospital. The number of falls incidents reported for patients in our community and acute hospitals means that our initial focus is on being able to measure and reduce the number of inpatient falls, particularly those that result in significant harm to the patient. In 2015-16, we aim to introduce metrics developed by the All Wales Steering Group for in-patient falls and that align with the care metric being developed in the Trusted to Care Audit tool. In 2016-17 we will establish the baseline for these new measures. In addition, we will review the falls risk assessment tool and care plan to ensure that they are easy to use and support the identification of the appropriate effective measures that can be taken at the front line to try and prevent falls.

However, we also need to prevent and manage falls in the community and a lot of work has been done by the community services to develop falls pathways, for people who have had a fall in their home, starting with a risk assessment to prevent and minimize the risks of a further fall. The metrics for the community falls should relate to the falls pathway. In 2016-17, the Falls Steering Group will develop metrics, building on the base of the 1000Lives registers.

Results from the National Hip Fracture Database indicated that the hospitals in the UHB treat a high percentage of fractured neck of femurs that result from in-patient falls. We are therefore focussing on this initially as an area of harm from falls. In 2015-16, we have set up a Falls Scrutiny Panel to ensure there is a root cause analysis on all inpatient falls that result in fractured neck of femur. This will establish baseline data on inpatient falls that result in fractures. The learning will result in changes to practice where appropriate after every individual fall, but also the identification of hot spots and good practice. In 2016-17, changes that are effective in reducing falls and falls with harm will be spread across wards and departments. The data will be monitored to understand the impact of the changes made to ensure that they are effective in reducing falls and harm from falls.

2.5.4 Risk Adjusted Mortality Index (RAMI)

In the Palmer Report, Professor Palmer concluded that the RAMI could be misleading and was not a meaningful measure of the quality of care in a hospital. We have therefore been developing other ways to understand the quality of our care, as described in section 3 of this chapter. Professor Palmer did say that the RAMI can be useful if it is used over time for a hospital, rather than as a comparison between hospitals. We will therefore continue at the moment to use the RAMI as one indicator within this plan, as we further develop other areas as measures of quality.

The UHB has been successful over the years in reducing its Risk Adjusted Mortality Index (RAMI). A review of RAMI data for our 3 main sites shows that, although the RAMI was highest for the RGH, we needed to take action across the UHB to improve patient safety, and reduce RAMI overall to 90 or below for the UHB, but also for each of our acute hospitals. To focus this work, we developed a Patient Safety Improvement Plan (PSIP) which focuses on:

- Improved surveillance and review: using mortality case note reviews triangulated with other sources of patient experience and safety data to identify issues that need to improve within a team, a hospital, or across the UHB.
- Improved accuracy of record keeping and coding: to ensure the data that drives the RAMI is as accurate as possible.
- Optimising Care Delivery using information from the surveillance and review to focus change on a few key issues at a time, that will impact on the safety of our care and treatment for our patients, with close working with the Divisions and Directorates on changes within their areas.

Using the 2013 rebasing, the UHB RAMI has shown a consistent reduction in 2014/15 compared to the previous year, which also demonstrated a reduction on 2012/13. This demonstrates that the UHB is on track to achieve its 2015/16 RAMI target.

Table 5.5

Hospital	CHKS RAMI (2013) for period August 2014 to July 2015	CHKS RAMI (2014) for period August 2014 to July 2015
Royal Gwent Hospital	95	110
Nevill Hall Hospital	84	96
Ysbyty Ystrad Fawr	85	104
Overall UHB	**91**	**106**

To maintain a downward trend in RAMI, our processes are being reviewed regularly to ensure they continue to reflect learning from mortality reviews and complaints and litigation. There has been continued success in the downward pressure on C. diff rates, which will have contributed to the reduction in RAMI.

Building on achievements in 2014/15, our aim is to reduce RAMI to 90 (2013 rebase) by March 2017 and sustain this reduction through subsequent rebasing, and to reduce/eliminate variation across our hospital sites.

Table 5.6

Baseline (2013)	2015-16	2016-17	2017-18	2018/19
99	93	90	90	90

2.5.5 Healthcare Acquired Infections - Clostridium difficile (C difficile) and Staphylococcus aureus (S aureus)

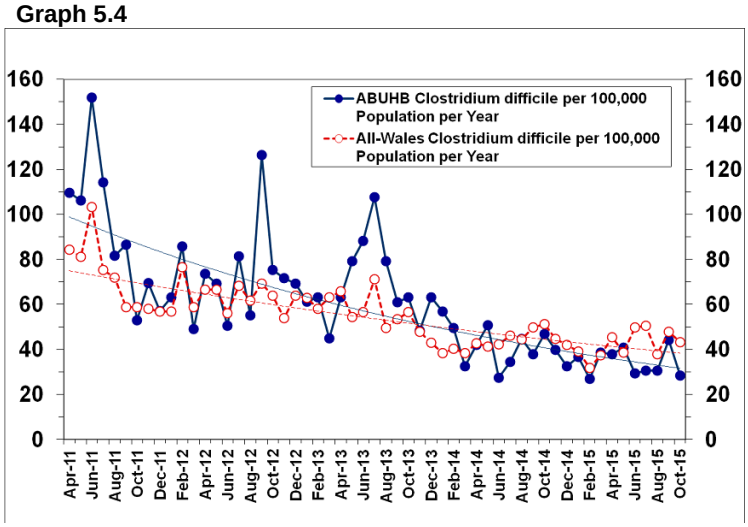
In response to the incidence of C difficile infections increasing in early 2013, the UHB established a C difficile Champions Group that led the UHB's multidisciplinary response which successfully reduced and sustained further reductions in the incidence of infection (Table 5.6). The UHB achieved a reduction of 47% between the 2012/13 baseline and the target reduction period of April 2014 to September 2015. In this period the population denominated rate of infection for the UHB fell from 70.1 per 100,000 (which was above the All Wales average of 62.9) to 37.3 per 100,000, which is now below the All Wales average of 43.3.

The UHB continues to maintain a dynamic detailed action plan, through which it ensures compliance with the recommendations of the external review of the UHB's management of C difficile undertaken in March 2014 by Professor Duerden. Reflecting the changing pattern of infection and the increased relative importance of non-hospital acquired cases, the plan involves working in primary care as well as secondary care. The GPs appropriate choice of antibiotics in these circumstances is a key component of any C difficile strategy and RCAs are undertaken routinely to determine risk factors and potential interventions. A Primary Care Clinical Director is a member of the UHB C difficile Champions Group and drives improvement in the C difficile rates for both hospital and community acquired infections. The UHB's strategy for C difficile is being extended to MRSA and MSSA to implement a range of evidence based measures to reduce HCAI underpinned by MDT working, RCAs, systematic review of data, Executive leadership and divisional engagement. The work programme identifies a number of work streams which will require focus and engagement from Board to Ward and wider community, namely:

- Executive led Infection Prevention Committee;
- Site Infection Prevention Groups;
- Infectious Cleaning Strategy;
- Antimicrobial Pharmacy Strategy;
- Hand Hygiene Strategy;
- Critical Friend Review;
- Community Strategy;
- Environment Strategy.

Aim: The UHB is seeking to further reduce the incidence of C difficile infection to deliver a rate of 28 per 100,000 between October 2016 and March 2017.

Graph 5.4

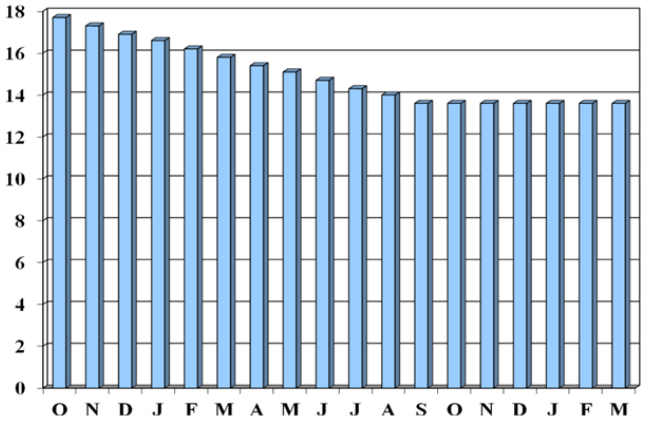


The UHB has profiled its planned improvement (Graph 5.4) and this has been built up from Division specific profiles which identifies target numbers of cases weekly, monthly and cumulatively. There is weekly monitoring of performance and feedback to Divisions with the UHB's current performance below the profile (profile 35, actual 32, albeit after 2 months).

Summary of actions in the UHB's HAI Action Plan:

- Extended scope of Champion's Group.
- Divisional targets and accountability.
- Adherence to IC policies and procedures.
- Pro-active clinical engagement.
- Trend analysis of RCA findings.
- Post cause analysis.
- Antimicrobial stewardship.
- HPV chairing.
- Focus on community acquired C.difficile.
- Education and training.

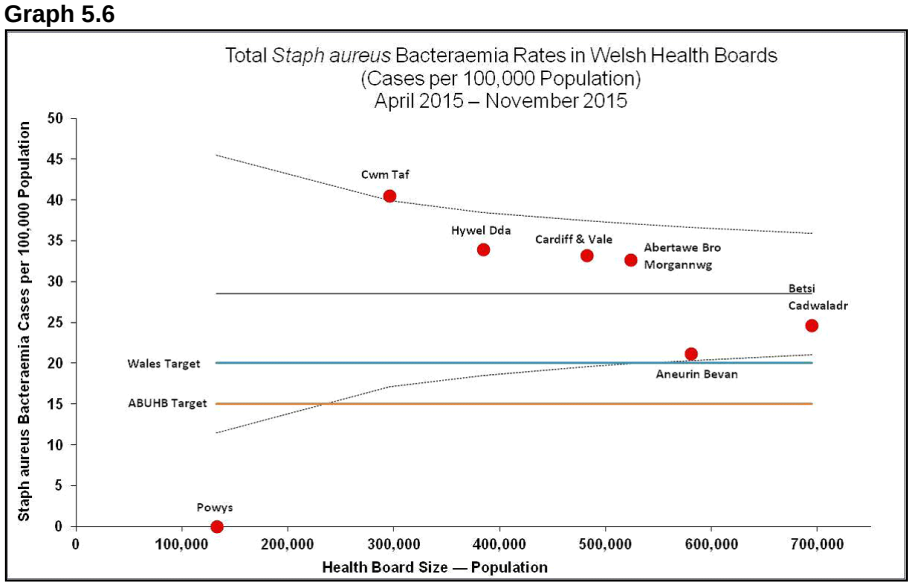
Graph 5.5 – Profile reduction in the number of C difficile infection (Oct 2015 to Mar 2017) which will deliver the population denominated target



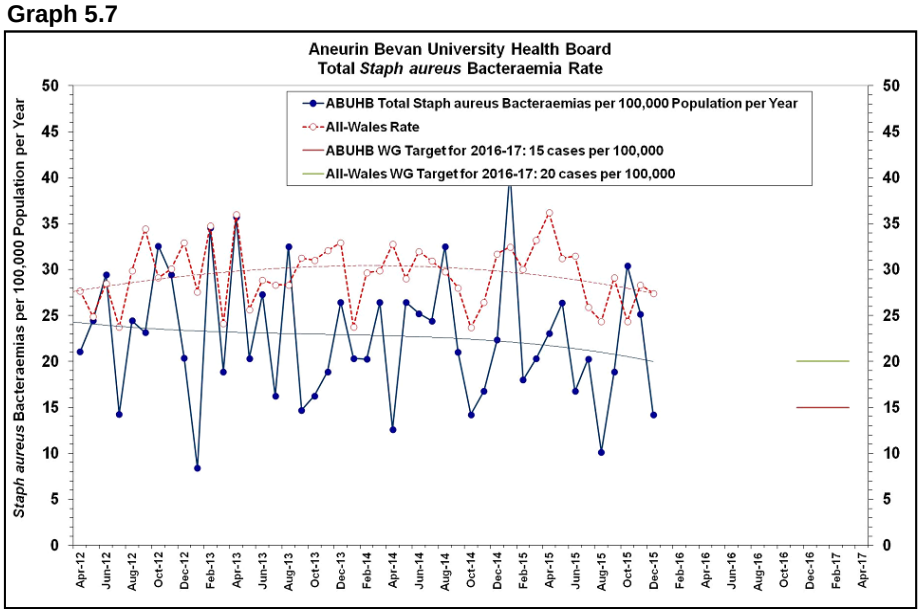
Aim: The UHB has proposed that it further reduce the incidence of S aureus bloodstream infections from 21 per 100,000 population to a rate of 15 per 100,000. This represents a reduction of 30% on the current rate, with the UHB's performance already the best in Wales (Graphs 5.3 & 5.4).

For S aureus, the key strategy is a sustained campaign of pre-emptive testing and treating patients to reduce risk, embedding the PVC and Central Line bundle and detailed root cause analysis to establish learning when cases arise.

Graph 5.6



Graph 5.7



2.5.6 Hospital Acquired Thrombosis (HAT)

The UHB has used RADIS and discharge data to obtain data on the number of HATs each month, with the table below showing the number of cases in the UHB in 2015-16 to date. The vast majority of these cases are not preventable.

Table 5.7

April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Total
17	11	15	25	14	12	17	12	5	9			**137**
Quarter 1 Total		**43**	**Quarter 2 Total**		**51**	**Quarter 3 Total**		**34**	**Quarter 4 Total**		**9**	

During 2014-15, we introduced a process of review of the case notes of every HAT patient by the Consultant responsible for their care. The review seeks to identify whether they had a full thrombosis risk assessment, and whether they were given the appropriate thromboprophylaxis. In cases where this was done, the case is designated as not preventable. In cases where this was not done, the Consultant is asked to identify their learning about how to make the process more reliable, and whether this is local learning or organisational learning. In 2015-16 we are ensuring that all Consultants return the completed RCA. During 2014/15, we identified that the highest number of cases of HAT were in Trauma and Orthopaedics and that we needed to ensure there was a standard approach to prophylaxis. In 2015/16 we are putting in place organisational changes to risk assessment processes and thromboprophylaxis in orthopaedics identified from the learning. In 2016-17 we will audit the impact of the changes and spread to the area with the next highest number of cases of HAT.

Our aim is to **reduce HAT by ensuring that all patients have appropriate mechanical and chemical prophylaxis, so that there are no cases of potentially preventable HAT in the UHB. The outcome should be that all cases of HAT have had a full risk assessment and appropriate prophylaxis i.e. they were not preventable, rather than a specific numerical target.**

2.5.7 Sepsis

Senior Doctors from our hospitals and primary care undertake reviews of the cases of every patient who dies in hospital at NHH and RGH and whilst these reviews often find that care was of a good standard, we do find areas where we could do better. Of these reviews, sepsis is responsible for

significant mortality, with sepsis a major contributor to death in 15% of cases, and present with a minor contribution in 22% of cases.

Early recognition of the deteriorating patient and effective treatment of sepsis is a key focus for us, as sometimes we do not recognise and respond to patients who are deteriorating by escalating their care as quickly and effectively as we should. We have implemented a system, based on the routine, physiological observations, that supports the recognition of deterioration, called the National Health Service Early Warning Score (NEWS). To support this we put in place one observation record chart, combined with NEWS scoring, used right across all of acute care. This has been revised in 2015-16 based on comments from nursing staff in order to make it simpler to identify deterioration.

In addition, we piloted a sepsis data base in ITU at NHH, completed by the nurses from the Outreach Team, and since extended to RGH. The data is therefore robust for 8am-5pm, Monday to Friday, the hours when the Outreach Teams are available at RGH and NHH. This provides us with additional data on our response to the deteriorating patient and sepsis, and the outcomes for the patient. We have also combined this data with data on deaths in hospital, to provide data on mortality from sepsis.

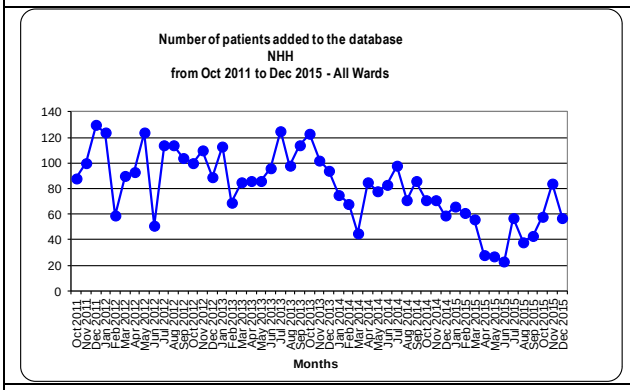
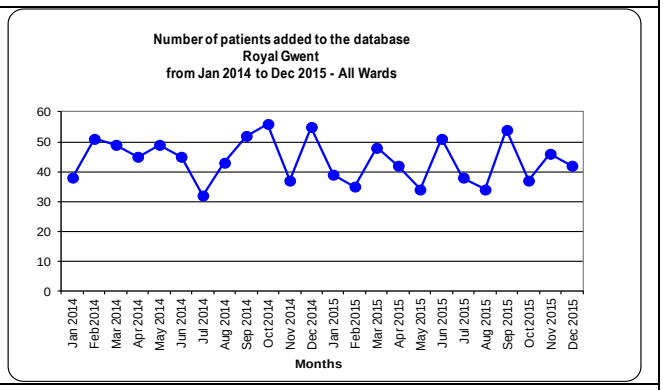
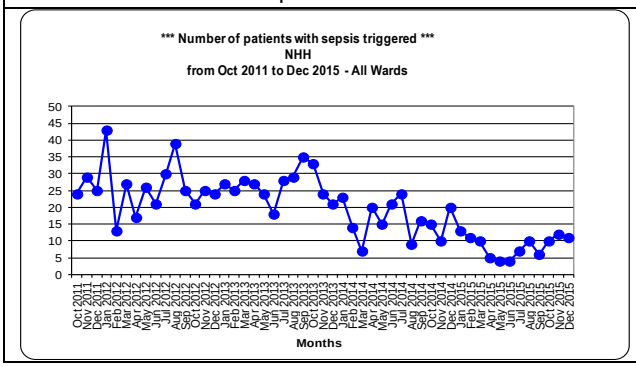
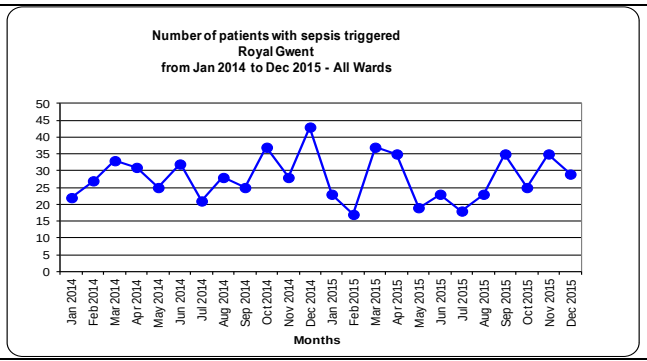
In October 2014, 1000Livesi chose the UHB to work with them on a pilot project to reduce mortality from sepsis, because of the commitment shown by the organization to reducing sepsis, and the baseline data available from the Outreach databases. A team from the UHB and 1000 Lives undertook a study tour to Dartmouth Hitchcock in the USA, as they had made changes that produced a demonstrable reduction in mortality from sepsis. A small senior team in the UHB, with support from 1000 Livesi, have developed the Aneurin Bevan Collaborative on Sepsis (ABC Sepsis) to work with wards and departments.

***Our aim is* to eliminate avoidable deaths and harm from sepsis.**

ABC Sepsis was launched on 7th January 2015. The pilot commenced in the Emergency Departments at RGH and NHH, and on an acute ward in each hospital and has subsequently spread to additional wards and to YYF. The process and outcome measures have been established and tested in the pilot areas, including a measure of sepsis mortality. Three cycles of improvement will have been completed by April 2016, and will in encompass the work in primary care and the Medical Assessment Unit. It will be evaluated and effective interventions rolled out across Wales through 1000 Lives in 2016-17 with 1000 Livesi.

The data below captures all patients seen by the Outreach Team on the wards at NHH and RGH. It gives data over time – providing baseline data before ABC Sepsis and data from January 2015 onwards. The first run charts show the number of patients the teams are asked to see with acute deterioration (all causes, including sepsis), and there appears to have been a shift in early 2015 at NHH, although there is no change at RGH. The second run charts demonstrate that at RGH, about 30 patients with sepsis are seen by the outreach team each month, and this has not changed. However, at NHH, the number of cases of sepsis seen by the outreach team appears to have reduced in 2014, and then again in 2015. Anecdotal evidence from NHH indicates that cases of sepsis are now being picked up and treated in A&E, and are therefore not going through to the wards, where they would be seen by the outreach team.

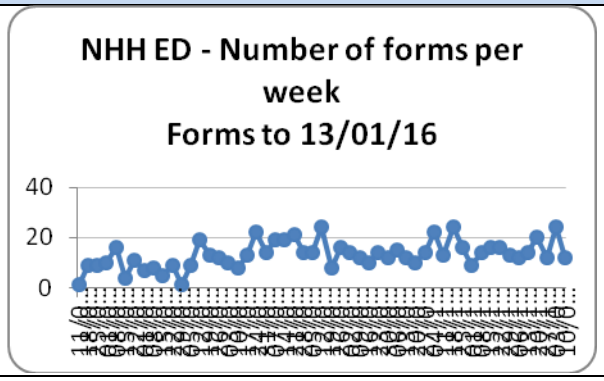
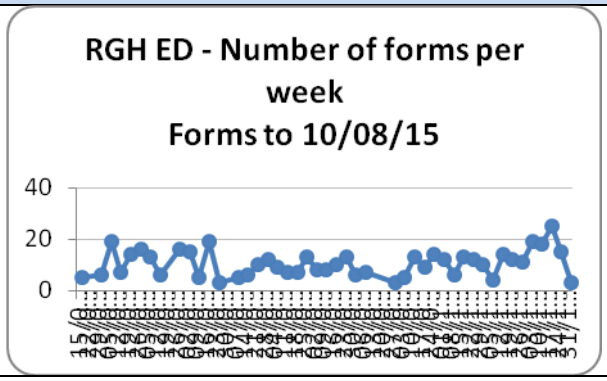
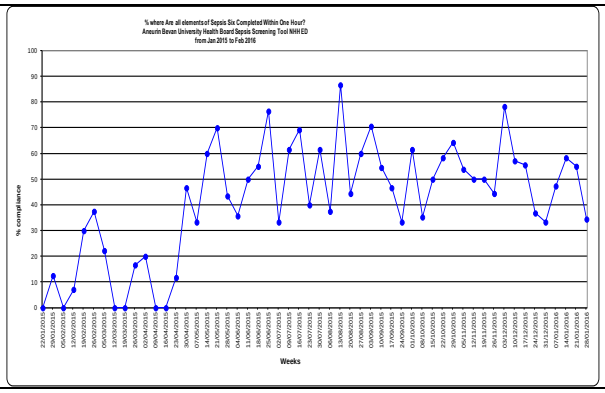
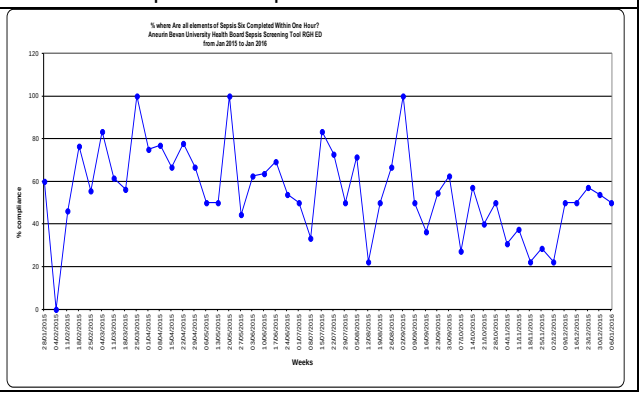
Graphs 5.8 – 5.11

Nevill Hall Hospital	Royal Gwent Hospital
Incidence of Acute Deterioration	**Incidence of Acute Deterioration**
	
Sepsis Incidence	Sepsis Incidence
	

The data below comes from the ABC Sepsis databases and shows that at NHH, there have been a consistent number of cases of sepsis recognised in A and E - about 15 per week. This is the number that we would expect to see at NHH. The compliance with the sepsis 6 bundle within 1 hr, the gold standard, increased and has been stable at about 60%. However, there are a number of cases that are compliant with the 6 components of the bundle, but the care is given within 2 or 3 hours. This is still good timely care and will prevent severe sepsis. This will therefore have led to a reduction in sepsis on the wards, and a reduction in harm to the patients as the sepsis is being picked up and treated faster.

At RGH, the number of cases of sepsis recognised in A and E is lower than would be expected. Compliance with the bundle has decreased. A new medical champion is in place and the department are refocusing as we come out of the winter period.

Graphs 5..12 – 5.15

Number of forms completed A and E NHH	Number of forms completed A and E RGH
	
Sepsis 6 Compliance A and E NHH	Sepsis 6 Compliance A and E RGH
	

During 2015/16, ABC sepsis will conclude its 90 day action periods and evaluate the outcomes of the Collaborative. In 2016/17, the learning will be embedded in the A&E and MAU/EAUs. We will also test a whole hospital roll out of ABC Sepsis at YYF to test whether the synergies of a whole hospital using the same approach to recognising and responding to sepsis improves compliance and sustainability. We will also test using a Patient Group Directive with ANPs recognising and responding to sepsis at a Community Hospital. Working with 1000 Livesi, the learning will also be spread to other Health Boards across Wales.

2.5.8 Pressure Damage

Pressure ulcers are costly to the NHS and debilitating and painful for patients. With an aging population, and those with co-morbidities, the risk of developing pressure ulcers increases, presenting a key challenge for health professionals. The occurrence of pressure ulcers is often used as a key indicator as to the quality of care. Pressure Ulcers have a huge negative impact on a person's quality of life and more severe categories can be life-threatening. Prevention strategies are multifaceted and include risk assessment, skin care, continence care, nutrition and hydration, mobility and repositioning and the use of pressure relieving/redistributing equipment.

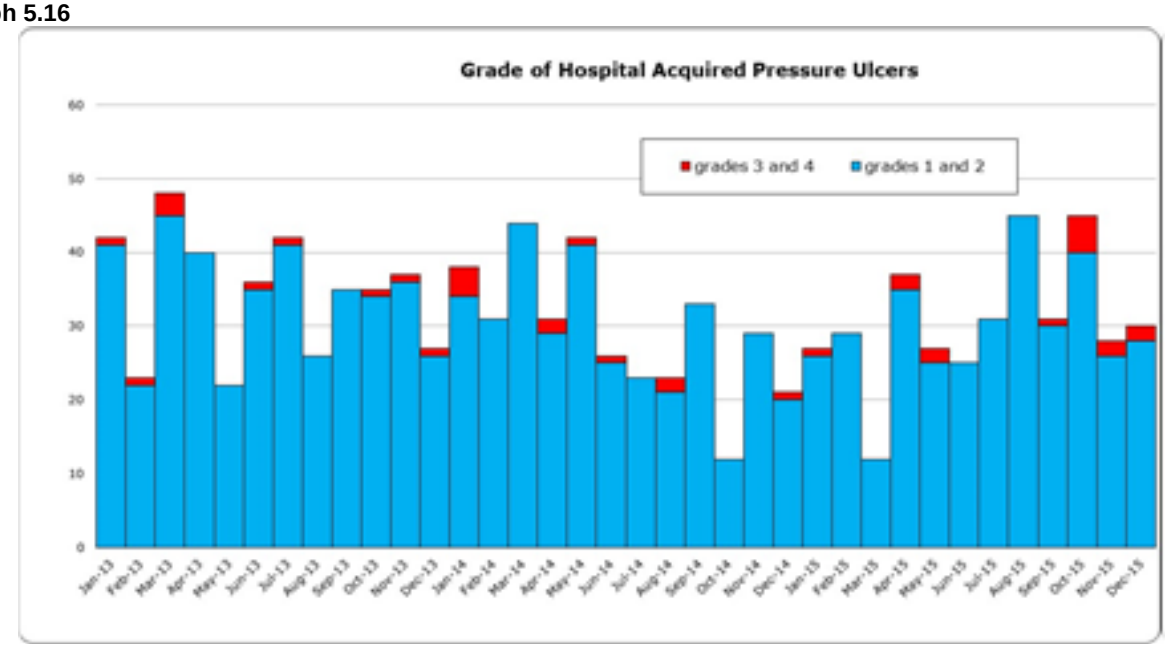
Although recognised as a key patient safety issue, benchmarking pressure ulcer acquisition with other organizations across the UK is problematic with a majority of Health Boards/Trusts utilising ***prevalence*** rather than ***incidence*** data. This is despite the fact that ***incidence*** data is considered best practice by Tissue Viability experts. The UHB collects incidence data and is committed to this method of pressure ulcer surveillance. In response the Health Board will identify HBs/Trusts who robustly measure pressure ulcers using incidence data – in order to benchmark pressure ulcer acquisition.

In 2014/15, the UHB met its pressure ulcer reduction target. The continued reduction in pressure damage is supported by the following:

- A new Policy for the Prevention & Management of Pressure Ulcers, based on NICE Guidance.
- Hospital Acquired Scrutiny Panel for all Grade 3 & 4 Pressure Ulcers, enabling targeted intervention by the Tissue Viability Team.
- A Tissue Viability Webpage, with a host of resources for staff.
- The Tissue Viability Team have been co-located focusing on patient need as opposed to geographical alignment.
- The launch of the Incontinence-Associated Dermatitis Pathway (All Wales).
- Re-design of DATIX, streamlining reporting & categorization.
- Active engagement in the global STOP Pressure Ulcers Campaign.
- Health Board wide study days on management & prevention of pressure ulcers.
- A guide to the care of foam mattresses.
- Improved data on pressure damage in people's own homes.
- Close working with Care Homes to improve monitoring of and prevention of pressure damage.

In addition to the interventions outlined above a Task and Finish Pressure Ulcer reduction group will convene in February chaired by the Executive Director Nursing. Utilising a strategic action plan and mirroring the C.difficile reduction model the barriers to effective pressure ulcer prevention will be addressed, identifying equipment deficits that are prevalent both in Hospital and community and work is ongoing to identify and allocate pressure ulcer reduction targets by Division.

Graph 5.16



***Our aim* - Zero Tolerance (through year on year reduction)**

Table 5.8

	2013/14	2014/15	2015/16	2016/17	2017/18
Hospital Acquired Pressure Ulcers	416	380	348	304	270

2.6 Improving Patient Experience

A good patient experience is at the heart of the quality in healthcare as it encompasses all the dimensions of quality as illustrated in the figure below. In order to achieve this, we need to be able to see the patient experience through the patient's eyes, whilst recognising that every patient is an individual. This means that the patient voice needs to be present and listed to at all levels of the organisation, and that the patient is welcomed as an equal partner in their own care and in the processes of designing and delivering care.

Figure 5.7

There are high expectations on us to improve the quality and care we provide to patients, quite rightly in the aftermath of the Francis Review of Mid Staffordshire Hospital and more recently Trusted to Care. Past success is no reason to be complacent and continuing improvements mean that people's expectations will appropriately continue to rise. Working with communities to assess and design services improves those services, whilst seeing individuals as equal partners in treatment decisions and self care management improves outcomes. The challenge is to develop a new relationship with the public as co-producers in their own care, empowering the public to make informed decisions about the appropriate use of healthcare. A Framework for Patient and Family Engagement needs to be developed, embracing levels of engagement, consultation, involvement, partnership and shared leadership.

Our clinicians wish to provide patient-centred services, with the key challenges they face:

Time: The main task in a clinical consultation is to build a relationship with the patient, collect data and agree a management plan. The time taken to gather data and agree a management plan will depend on the baseline knowledge of the patient, the health professionals and the patient's ability to communicate effectively and the complexity of the patient's problems.

Within primary care for example, the average consultation in general practice lasts 7 – 8 minutes, these consultations are often multifaceted, with social as well as medical issues to be tackled. In hospital the average consultation time is not much longer. Our challenge is to shift the emphasis from throughput to input and quality of patient interactions.

Improving the patient's experience of care is a key priority for us. A focus on what it is actually like to be a patient in the NHS - the 'patient experience' – is seen as vital in the drive to improve quality in the NHS. 'Patient experience' encapsulates the *totality* of patients' needs and preferences. It includes both clinical and non-clinical care, and embraces everything from the success of clinical interventions to issues of access, responsiveness, choice, and the state of the physical environment of care.

We have therefore reviewed and updated the driver diagram for Patient Experience that was contained within the Patient Experience Framework (Figure 5.4) and identified the key drivers. A good patient experience is influenced by a multitude of factors, some of which overlap with other areas of work within this 3 year plan, for example the priorities for improving patient safety and the OD Framework. These are the main drivers as described in the diagram:

- A culture that enables staff to put patients/carers first.

- Leadership that demonstrates by example that quality of care and patient experience is at the top of their priorities.
- Safe, effective and efficient care, so the patient outcome is good from the patient and professional's point of view.
- A good staff experience, so staff feel positive about their experience of providing care.
- The citizen/service user/carer voice is heard and heeded at all times and all levels of the service.

Some of the changes in the driver diagram will be properly defined through the aims and measures work below. Other key areas of work for patient experience, that are defined include:

Clear Aims and Measures for Patient Experience
The Patient Experience Steering Group have updated the aims and continue to measure and lead the patient experience agenda in collaboration with other departments, staff and service users/carers. An action plan embracing the All Wales Standards for Accessible Communication and Information for People with Sensory Loss is in place and monitored to deliver change and embed the All Wales Standards for Accessible Communication and Information for People with Sensory loss.

Citizen/service user/carer voice
Obtaining direct feedback from patients/service users and acting on it is essential. Our current mechanisms are listed below, covering most of the 4 quadrant framework in the Framework for Assuring Service User Experience:

- Patient surveys:
  - All Wales Core Questions;
  - Health and Care Standards Compliance Tool Patient Experience Survey.
  - Nutrition Reviews
  - Trip advisor

- Observation of Care:
  - HIW reviews and Dignity and Essential Care Inspections (DECI);
  - Trusted to care reviews
  - Community Health Council spot checks and inspections;
  - Patient Stories.

- Complaints Analysis.

- Patient/service user participation via service improvement approaches:
  - Kings Fund and Health Foundation Patient and Family Centred Care Programme;
  - Kafka Brigade Reviews.
  - Shadowing
  - Listening Events

"Hootvox" – an Electronic Patient Feedback Pilot – is being tested in 2016. This will provide immediate feedback via e-mail or SMS text. The organisation has agreed the questions, which can be altered so that they are appropriate to the different areas. The Governance processes related to the system have been developed, through a working group for the pilot. The system was launched in February 16 and is already providing rich feedback on the areas it covers. This will be evaluated within 2016 and presented at the Patient Experience Steering Group.

We will continue to collect and use patient stories throughout our services, to help us to see our services through the patient's eyes. Carer's stories will also be introduced as part of the Carers Measure implementation

Co-production
Our current model of health care is based on clinicians deciding what treatment will work best for patients and requiring (sometimes supporting) their compliance with the treatment programme. Whilst this approach has served us well in the past, in the face of the rising tide of long term conditions, it has faltered and stalled. Something else is required to complement clinical expertise and health services. The answer lies in recognising what people and communities want and could do for themselves and reorienting and reshaping health and other services to support them. This new co-productive approach requires major culture change with patient's 'lived experience' being given equal weight alongside the expertise of clinicians. The new approaches will also require a redesign of pathways around people, rather than diseases, and a reshaping of budgets and incentives.

There is a growing body of evidence that coproduction improves health and produces consequent savings through reduced use of A&E, GP consultations and hospital admissions, The 'People Powered Health' Project shows saving of between 7 -20%. The potential benefits include:

- people gaining control over and improving their own health;
- clinicians increasing their job satisfaction as they visibly make a difference;
- UHB realising cost savings that help secure the long term future of our services.

Compassionate Care
During 2014 and 2015 we developed a Volunteering Strategy which focuses on improving the patient experience and our corporate social responsibilities and a Volunteering Policy has been introduced with a resource guide for staff. Our aim is to have volunteering activities embedded in each and every Division. The new Volunteering Expansion Group is leading this drive to increase volunteering through a collaborative, multi-partner approach. We have continued the implementation of the Carers Strategy, with work on young carers being a feature of the last year.

The UHB will be progressing the actions that are clear over the medium term to improve patient experience, but some of the actions will be further refined as part of the aims and measures work.

Reducing Cancellations
The cost and inefficiency impact is substantial; the effect on the individual patient is of greater concern. Preparing to undergo surgery is a significant life event in terms of both physical and psychological preparation. Social adjustments are also needed – such as altering work arrangements. This situation can be made worse if a patients operation is postponed on more than one occasion. Unfortunately, multiple postponements have occurred within the UHB.

Although the reasons for operating procedure postponement are varied, most frequently resulting from patient choice; being unfit for surgery; and no available admission bed on the day the opportunities for improvement can be categorized into three areas, namely:

1. Improvement in pre-operative booking and clinical processes.
2. Improvement in admission access on the day or the day before the procedure.
3. Re-designing clinical models such as increasing day surgery rates and pursuing value based/prudent procedures.

We set out our plan to reduce postponements in SCP 6.4. Our first priority is to address the relatively small number of multiple postponements and then reduce the overall volume. Our aim is to reduce maximum multiple postponements to 3 by June 2014 and to 2 by September 2014. We will also aim to reduce the overall volume of repeat postponements by 25% in year one.

Safeguarding
Safeguarding is central to all aspects of Health Board activity and the safety of service users and their families is a priority for us. The safeguarding agenda has increased in breadth and complexity

in recent years and is concerned with children and young people; vulnerable adults, particularly the frail elderly; domestic abuse; sexual exploitation, human trafficking and slavery; female genital mutilation and counter terrorism. We recognise the role that the Health Board plays in all of these circumstances. Close partnership working is through representation on the regional Children's Safeguarding Board; Adult Safeguarding Board and Multi- Agency Public Protection Strategic Management Board. This supports service development and through the scrutiny of inter-agency practice, provides assurance and identifies where improvements can be made. Over the coming year we will be working with partner agencies to further strengthen safeguarding processes and practice in meeting the requirements for implementation of the Social Services and Well-being (Wales) Act 2014 and the Gender-based Violence, Domestic Abuse and Sexual Violence (Wales) 2015. This is reflected in the review of the Aneurin Bevan University Health Board safeguarding strategy. Implementation is overseen by the Health Board Safeguarding Committee, chaired by an Independent Member, reporting to the Quality and Patient Safety Committee. Priorities for the coming year will include implementing a programme of training that incorporates all aspects of safeguarding at an appropriate level to the right staff; participation in the Welsh Government Gwent pilot of 'Ask and Act' to support in recognising and responding to domestic abuse and to ensure that the health board takes a lead role in the investigation of significant pressure damage wherever this occurs.

Over the next three years...

- The views of patients, carers and the public directly inform and impact on the way we deliver care.
- Integrate patient/carer stories and experiences into everything we do and our operational and key strategic decision making.
- All Wales Nursing Principles will be introduced across all Medical & Surgical Wards.
- We will be transparent about our successes and our shortfalls and will be open and honest as to how we will respond/act.
- Patients will experience optimal clinical outcomes comparable with **'Best in Class'.**
- We will operate within an organisational culture that challenges suboptimal care (including interventions of limited value), attitudes and/or behaviours.
- A zero tolerance to health acquired infections.
- A zero tolerance to Hospital Acquired Pressure Ulcers, together with a focus on reducing incidence in the community & Care Homes.
- Mortality rates comparable with the best.
- Work will continue to reduce avoidable falls and improve risk minimisation.

Patients and their carers will be equal partners in their care

Every clinical contact, procedure and/or intervention will add value to the patient.

3. Engagement and Partnership Working

3.1 Approach to Engagement

The policy context in Wales offers a clear framework for strengthened engagement between individuals, communities and public services. A number of legislative frameworks and supportive publications/guidance have reinforced this, examples include:

- Future Generation and Well-Being Act;
- Social Care and Well-Being Act;
- NHS Planning Guidance.

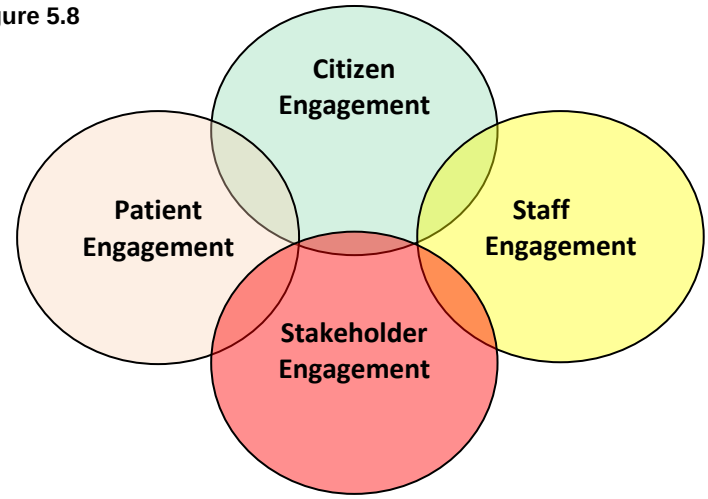
Based on the commitment in public services in Wales to engage more strongly with people, there is a need to continually build awareness and understanding in the UHB in relation to the benefits that early and ongoing dialogue in advance of any formal consultation can have on service change.

The UHB has demonstrated its commitment to the need for continued engagement through approving its Engagement Strategy in January 2015, and subsequently resourcing an Engagement Team within the UHB with a direct reporting line to the Chief Executive and Board. This strategy made clear the reasons that enhanced engagement with the population is required, not least the need for a shared agenda between communities and public services in pursuit of good health and well-being.

The UHB has a clear and ambitious agenda of modernisation and reform which is articulated through the Gwent Clinical Futures Strategy and the Integrated Medium Term Plan. Effective engagement with communities and citizens is essential to this agenda, and whilst there are a number of well established programmes already underway in some of our communities i.e. 'Living Well Living Longer' and 'Community Health Champions', and the UHB has a well established profile through the work of its Communications Team, it is clear that our engagement activities with all communities in Gwent need to increase to ensure that people can inform and understand health services as well as share perspectives on them.

It is clear that a fully engaged relationship with the public we serve will take time to develop and that there will undoubtedly be phases of maturity. The first phase will be building on existing good relationships to establish trust and confidence through being a familiar presence in communities in Gwent that will in time act as the basis upon which more structured service redesign and development conversations can take place. The UHB's approach encompasses 4 distinct areas of engagement:

Figure 5.8



An on-going and continuous dialogue with the public is enabled through the citizen engagement work-stream. It has a current working title of *'ABUHB Engages'*.

Issues that have emerged from our engagement activities to date are:

- An overwhelming gratitude for NHS services and staff.
- Limited awareness of service developments or Health Board strategy.
- Difficulty in getting through to GP practices.
- Contact details for dentists taking NHS patients.
- Contact details for GPs in peoples areas.
- Some confusion about Minor Injuries services and what can be accessed where.
- Environmental issues (parking, cleaning, and control of infection).

- Carer support.
- Advice on how to follow up on a waiting times issue (strongest appear to be in Ophthalmology and Orthopaedics).
- Advice on how and where to access low level mental health support.
- Ambulance waiting times and patient transport.
- Parking for cardiac rehabilitation services.
- Existing complaints/enquiries that people are awaiting feedback on.

ABUHB Engages has 4 key kinds of activity:

Engage4Change **(street level engagement) -** The Engagement Team has committed to be in areas of high footfall in one of the 5 areas of Gwent every week. As such there is a rolling programme underway of UHB presence in neutral public spaces such as supermarkets, market halls, one stop shops and leisure centres, offering the opportunity to reach into communities to hear their thoughts and views in a neutral environment. This appears to be an approach welcomed by the general population.

To offer a sense of potential reach through this approach, during the three month period, 25th September - 25th November 2015, ***1911*** people have been directly engaged with through this programme. ***624*** of these people were engaged in a longer conversation related to a specific area of healthcare in the area (e.g. Primary Care access).

Better 2gether **-** We are not the only organisation seeking to engage more strongly with our communities at this time. It would therefore seem prudent to work alongside others who are engaging with communities to share and join with opportunities that are already planned. Many organisations have been extremely generous in enabling our participation in their existing activities.

Community Connects **-** This activity relates to when we reach into particular communities (either of common interest or geographically specific) i.e. Pill regeneration project, Markham Winter Soup event, Communities First activities, 50+ fora.

Service Redesign & Development **-** The UHB has an ambitious strategy in its Clinical Futures Programme which the next cycle of the IMTP will see being realised. It is essential that this work is not only understood but informed by communities across Gwent. We will build on the activities of the past 5 weeks to further strengthen this approach. The engagement team will work within our Clinical Futures and IMTP processes to advise on engagement, developing and sharing resources across the organisation.

Building Organisational & Community Capacity
All of the activity outlined above, is really useful in helping us get a perspective on people's perception of the NHS locally. We also need however to demonstrate that when we listen, we also act. There are a number of mechanisms being established to enable this:

Organisation/Divisional responders **-** A lead member of staff has been identified in each division of the UHB to ensure timely follow up to enquiries raised. This approach also ensures that Divisions to have a co-ordinated approach to responses and indeed a log of issues raised.

Partners on board **-** When the UHB is present in communities, there are often enquiries in relation to a service area for which the UHB is not directly responsible, i.e. ambulance response times, patient transport and Welsh Blood service. The UHB will work closely with partners to ensure joint listening opportunities wherever possible.

Virtual network **-** The UHB engages widely with a variety of different stakeholders across Gwent, a live virtual network is being developed, which will offer a resource to the UHB of networks and individuals that we can engage with and through. It has only recently been established but already

has 105 different networks contained within it. The Nurse Director has also developed a patient's network and there is undoubtedly value in consolidating the two over time. A people network is also being established which will offer citizen views and perspectives, as well as underpinning the organisations approach to Co-production.

Table 5.9

Stakeholder	What success looks like …
Citizens/ Communities	▪ There is regular UHB presence in Communities and an on-going and informal dialogue. ▪ People in communities across Gwent have a strong relationship with the UHB based on trust and mutual respect. ▪ People in communities know what health services are in their area, and how to use them. ▪ People have sufficient information with which to make effective life choices which impact health behaviours and outcomes.
Patients	▪ People and Patients are fully engaged in their care. ▪ Patients are engaged in conversation and choices about alternates to healthcare support where it exists.
Staff	▪ Communication through multiple mediums is strong across the UHB. ▪ All staff will be better informed and have improved knowledge, understanding and access to information. ▪ Staff are engaged within the UHB business and able to act as advocates for the UHB through both their working and everyday life. ▪ Staff at all levels feel able to influence and share ideas for improvement.
Stakeholders	▪ There is a strong relationship with all stakeholders of the UHB built on trust and mutual respect. ▪ Stakeholders are engaged in the work of the UHB and feel they are well informed, can offer feedback and have influence.

Engagement and Approval Arrangements

Internal

The UHB believes that Engagement is at the very heart of how it does its business. As such it is an integral component of governance and reporting. The Communications and Engagement group held its inaugural meeting on 17th September 2015. The aim of the group is to:

Connect the organisation and its programmes of activity with the community it serves, through ensuring a programme of co-ordinated activity for communications and engagement across the strategic and operational functions of the Health Board.

The Group brings together members of staff from across the UHB in order to co-ordinate and drive consistent messaging and engagement activities through all stakeholder groups and in a co-ordinated fashion. The initial task of the group is to develop a baseline position of engagement in each of the citizen, staff, patient and stakeholder areas.

The group will report on a quarterly basis to Executive Team via the Associate Director of Engagement. A bi-annual report will also be produced for the Board.

To ensure that there is not only a clear line of accountability and reporting for engagement, but also that the activity is felt across all aspects of the UHB, a 'You Said We Did' Newsletter will also be produced to:

- Share with the public and the organisation what key messages are coming from our listening activities.

- Share with the public and staff what action we have taken in which areas as a result of our on-going listening opportunities.
- Identify themes for consideration and improvement.

Regular updates will also be provided into the Operational Management Team and Patient Quality and Safety groups.

In Partnership
The UHB has for many years worked closely with partners to engage the population of Gwent together. Over recent months this relationship has strengthened through the emergence of the Greater Gwent Partnership. The Partnership has an emerging approach to citizen engagement which will enable partners to work more strongly together within the ethos of sustainable development as outlined in the Future Generations and Well-Being Act.

3.2 Collaborations and Partnerships

Internal Partnerships
The UHB has a number of internal mechanisms for involving its staff, including our Health Professionals Forum, Staff Survey Transformation Group and Trade Union Partnership Forum.

Stakeholder Reference Group
The Stakeholder Reference Group provides independent advice on any aspect of the UHB business on behalf of stakeholders and citizens. This may include:

- Early engagement and involvement in the determination of the UHB's overall strategic direction.
- Provision of advice on specific service proposals prior to formal consultation.
- Feedback on the impact of UHB services and functions on the communities it serves.

The purpose of the Group is to facilitate engagement and active debate amongst stakeholders from across the communities served by the Board, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform UHB decision making. Membership of the Group is drawn from key stakeholders across the UHB catchment area including local authorities, the police, fire and rescue service, Third Sector and Independent Sector.

Matters considered by the Group include the UHB strategic plan (Clinical Futures), Winter Plan, In One Place Programme, Scheduled Care challenges, Children and Young People services and Public Health.

Healthcare Professionals Forum
The Forum is an advisory group of the UHB, it reports formally to, and is accountable to, the UHB. The role of the Forum is to:

- Provide a balanced, multi-disciplinary view of professional issues to advise the Board on local strategy and delivery.
- Facilitate engagement and debate amongst the wide range of clinical interests within the UHB's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the UHB's decision making.

Membership of the Forum comprises representation from the seven health Statutory Professional Advisory Committees set up in accordance with section 190 of the NHS (Wales) Act 2006.

Matters considered by the Forum include implementation of Prudent Healthcare principles, delivery of integrated care in Wales, Mental Health Measure, Primary Care Strategy, Clinical leadership, staff sickness absence management and medical recruitment. The Forum also receives regular updates on, and informs the development and implementation of the UHB's IMTP.

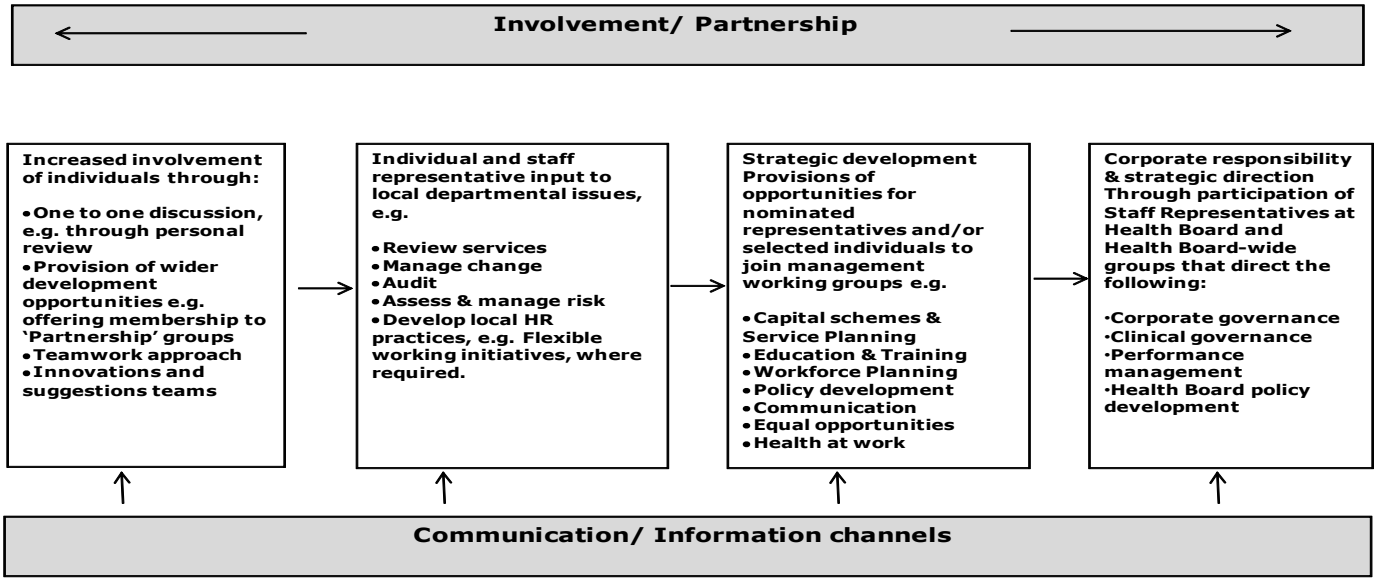
Trade Union Partnership Forum

The Trade Union Partnership Forum (TUPF) reports directly to the Board and has responsibility for engaging with staff organisations on key issues facing the organisation. The TUPF provides the formal mechanism for consultation, negotiation and communication between our staff and the UHB, embracing the Trades Union Congress principles of partnership.

The group is jointly chaired by the Staff Chair for Trades Unions, George Puckett and the Chief Executive Judith Paget and is attended by Executive Directors, Senior Managers and a maximum of 30 accredited staff representatives, providing a fair range and balance of Trades Unions in the organisation. The Forum offers opportunities to have detailed discussions about matters of particular importance to the UHB such as finance, our medium term plans and partnership working. The Forum has provided an excellent opportunity for managers and Trades Unions across the UHB to meet and discuss a number of strategic issues impacting on delivery of services and workforce.

The model below is intended to illustrate a range of areas where involvement and partnership can be developed to influence the performance of the UHB.

Figure 5.9



In addition, the UHB is developing more effective and sustainable mechanisms to facilitate continual engagement of staff and the widening of the role of staff in order to strengthen links with our communities. There is recognition of the potential role of staff as engagement conduits, both communicating with and gathering feedback from our communities through their non-work related membership of community based groups. The UHB Engagement and Communication Strategy aims to ensure that engagement and communication is taken to another level and delivers significant communication improvements for our staff, patients and wider stakeholders.

External Partnerships

Successful implementation by the UHB, with its partner agencies, of the requirements of the Social Services and Well Being (Wales) Act (SS&WBA) and the Well-being of Future Generations (Wales) Act (WBFGA), will require a step change in the way that we collectively do business and a continued commitment to evolving collaborative partnerships that enable innovative service change and improvement that responds to identified need across our catchment population areas. The UHB does not underestimate the cultural change required In order to achieve more universal and sustainable joint health and social care service provision, including budget pooling, budget transfer, lead commissioning and other mechanisms which vest control of resources in other partner organisations. However, our ability to address the stark differences in health and well being

outcomes across the five borough areas, served by the UHB, will require momentum and pace by all partners.

The financial challenges facing the NHS and partner organisations provide the catalyst for innovative joint service planning and delivery with the aim of implementing responsive, multiagency service pathways based on care closer to home. This approach will also demonstrate how our citizens, patients and staff have both influenced and informed service planning and delivery in the context of prudent principles and a greater emphasis on co-production of care provision.

Progress has been made in establishing the mechanisms for delivery of the SS&WBA including the Greater Gwent Health, Social Care and Well Being Partnership with membership comprising local authority Cabinet members and UHB non-officer members plus Leadership Group members and the Chairs of Gwent Association of Voluntary Organisations (GAVO) and Torfaen Voluntary Alliance (TVA). The key aim of the Partnership is 'promoting well being and prevention and supporting the transformation of health and social care across the region'. The Leadership Group comprises the 5 Directors of Social Services, UHB Executive Directors and the CEOs of GAVO and TVA. A Citizen Panel and Provider Forum have also been established. Based on information collated through the regional self-assessment, the Partnership has developed a high level Regional Implementation Plan and Workforce Development Plan from which a number of workstreams have been established. For example, workforce training and development to support staff in working differently, to work in partnership and acquire relevant new skills.

Examples of collaborative working across the Greater Gwent Partnership include:

- jointly developed operational frameworks for the twelve Neighbourhood Care Networks which reflect the needs of local populations and include joint teams and services.
- The 'In One Place' programme which facilitates joint identification of service change priorities across health, social care and housing partner organisations. Areas of focus include bespoke accommodation solutions for individuals with a learning disability, review of accommodation needs of older people and delayed transfers of care.
- Jointly developed and implemented services through the Intermediate Care Fund programme.
- Joint staff training initiatives, for example staff dementia training and carer awareness training.
- Joint development of an alcohol treatment pathway for implementation across the region.
- Joint working through the Area Planning Board in order to achieve improvements in substance misuse services for adults across the region based on the implementation of a region wide services contract. Work is now underway to implement a region wide substance misuse contract for children and young people.
- Frailty Programme.
- Development and implementation of the 'Living Well – Living Longer' early identification and treatment programme, established in some of our most deprived communities.

Further detail on progress in implementing the requirements of the Well-being of Future Generations (Wales) Act (WBFGA) is set out in **Chapter 3, Section 1.**

Progress on our partnership arrangements with Universities and other educational agencies will be described within the workforce and research and development sections of our Plan.

Sustaining Partnership Support for Carers
The Carers Strategies (Wales) Measure came into force in 2012 and placed a legislative duty upon Local Authorities and the National Health Service (NHS) to produce a joint Information Strategy for family/unpaid carers. The development and implementation of the Strategy included staff training and awareness raising regarding the identification and support of carers.

The Measure will be repealed in April 2016 with the introduction of the Social Services and Well being (Wales) Act however, the Act also recognises the key role played by carers giving them the

rights to support which are equivalent to the rights of those they care for. The Act sets out the requirements for co-operation, integration of care & support and partnership arrangements in order to respond to the care needs of adults and adults who are carers.

In order to build upon the effective partnership arrangements, established as part of implementation of the Carers Measure requirements, and progress in supporting carers, the Director of Nursing is leading work to establish a sustainability programme with the aim of presenting proposals and options to the Greater Gwent Health, Social Care and Well Being Partnership early in 2016.

3.3 Acute Care Alliances

The Acute Care Alliances (ACAs) were established in 2014 as the mechanism through which the outcome of the South Wales Programme (SWP) would be implemented, monitored and reviewed. The UHB has used its Clinical Futures structures to take forward the work of the South East Acute Care Alliance, in partnership with its Community Health Council, Powys Teaching Health Board and staff representatives. For the UHB, the outcome of the SWP was the reconfiguration of services in line with the Board's Clinical Futures Strategy, with the Specialist and Critical Care Centre (SCCC) the enabling development. Significant work was undertaken in 2015/16 in finalising the Clinical Futures Programme Business Case and the SCCC Full Business Case, and in refining the UHB's detailed plans to ensure that they are clinically owned, robust and consistent with the emerging outcomes of the South Wales Health Collaborative (SWHC) for medical and surgical specialties.

The UHB has worked closely with neighbouring ACAs and Health Boards on a number of service issues, notably in the development of contingency plans for vulnerable services, particularly paediatric and neonatal services, and in the capital required to support neonatal services in South East Wales. The UHB is now a part of the South Central ACA structures and is playing a full role in the detailed planning of service change.

The UHB has undertaken a detailed analysis of patient flows both before and after the opening of the SCCC and determined that while there may be some changes in flows at a local level after the opening of the SCCC these will be largely neutral in their impact on both the UHB and other Health Boards and this has been agreed as principles underpinning the detailed planning work of ACAs.

Whilst undertaking an active role in both ACAs and All Wales Collaborative structures, the UHB continues to recognise its role as the discussion making body and retains full accountability.

Whilst recognising that the SCCC was a fixed point in the public consultation supporting the SWP, the UHB is implementing plans to sustain services prior to the opening of the SCCC in early 2019. With regard to paediatric, obstetric and neonatal services, the UHB has maintained the clinical configuration of services at Royal Gwent and Nevill Hall Hospitals, whilst centralising medical training for these specialties at the Royal Gwent Hospital. This continues to be challenging and the UHB will be reviewing the robustness of this model as part of its 2016/17 service sustainability plans (Section 7.7).

With regard to Neonatal services, the UHB is working closely with the All Wales Collaborative, other Health Boards and the Deanery to determine the optimal configuration of medical trainees in South Wales in the light of the planned reduction in medical trainees. Work undertaken to date has concluded that the retention of 3 neonatal ITUs in South Wales is essential and that whilst a new non-trainee delivered model is possible, this cannot be delivered to the proposed timetable without significant risk and without a current service continuity plan.

With regard to Emergency Medicine, the UHB has undertaken an initial appraisal of the potential reconfiguration of services prior to the opening of the SCCC and concluded that the current

infrastructure at the Royal Gwent Hospital would be entirely inadequate to accommodate a significant increase in activity and that to invest further capital above and beyond that already planned to make the unit fit for current purpose would be a poor use of limited capital when the SCCC will provide a bespoke facility in the time it would take to reconfigure services at the Royal Gwent Hospital.

The other work of the UHB undertakes with the All Wales Health Collaborative and is described in Section 3.1.

4. Prudent Healthcare

The UHB have made a commitment to make prudent healthcare an active movement for change within and outside the organisation. It is a vehicle to deliver new ways of working within a clinical value based framework and will enable lower healthcare costs whilst also providing improved quality for patients and offering opportunities for outcomes to be collaboratively and co-produced with patients and the public. We have been focusing on three key areas in taking forward prudent healthcare – these are innovation and improvement, communication and engagement and measurement and delivery.

We seek to ensure that resources are used most effectively to deliver the highest quality of care for patients, to reduce costs, limit harm and variation in delivery and contribute to positive outcomes for patients. This includes treatment(s) which have no, or limited evidence base and tests which may lead to over diagnosis and over treatment with the associated harms.

A full scale engagement programme will be undertaken to ensure education and development opportunities are fully enabled across all areas. Targeted audits will be carried out and inappropriate actions brought to the attention of the responsible manager in order for best practice to be reviewed and any training needs addressed. The prudent healthcare projects will feature across all divisions in secondary, primary and community care and will require the support and engagement from key stakeholders and patients (with key milestones summarised below).

The Project Lead is Dr Paul Buss, Medical Director, with project support from Dr Sally Lewis, Assistant Medical Director, value-based care, Dr Stuart Linton, Assistant Medical Director, Clinical Effectiveness, Dr Marysia-Hamilton-Kirkwood, Assistant Medical Director, Public Health and Ann-Marie Matthews, IPFR Manager/Lead for Value Based Healthcare. The programme reports to the newly formed Clinical Effectiveness Group and the Quality and Patient Safety Committee.

2015/16 Work Programme
In order to ensure that we are providing the right care for our population we are seeking to ensure we systematically capture outcomes that matter to patients. Therefore, we must invest in joint working between patient and their clinicians. Our approaches include:

- Prevention and early indication.
- Choose Wisely.
- Patient information/material.
- Commitment to outcome measures and co-production.
- Formation of a strategic partnership with the International Consortium for Health Outcome Measurement (ICHOM).
- Development and utilisation of costing methodologies to support value based care e.g. time driven activity based costing and patient level information and costing systems (PLICS).
- Commencement of health structures around integrated practice units e.g. disease programmes.
- Time driven activity based costing (TDABC).

Table 5.10

Key milestone for delivery 2016/17
▪ Anti-TNF in gastroenterology. ▪ Reduction of anti-depressant prescribing in primary and secondary care. ▪ Antibiotic pregnated wound healing product usage. ▪ Anti TNF in dermatology. ▪ Overuse of diagnostic imaging (Choose Wisely). ▪ Inflammatory bowel disease. ▪ Management of non-attendees and review of methods of communication across all service areas. ▪ Review of Alteplase in Stroke. ▪ Stock control improvement across all areas. ▪ Review of diabetes management in patients planned for/undergoing surgery. ▪ Service review for patients with heart failure. ▪ Review of inhaler therapy techniques for respiratory patients. ▪ Primary care diagnostics for cancer. ▪ Review of support services within Primary care for ENT patients. ▪ Access/review of biosimilars.

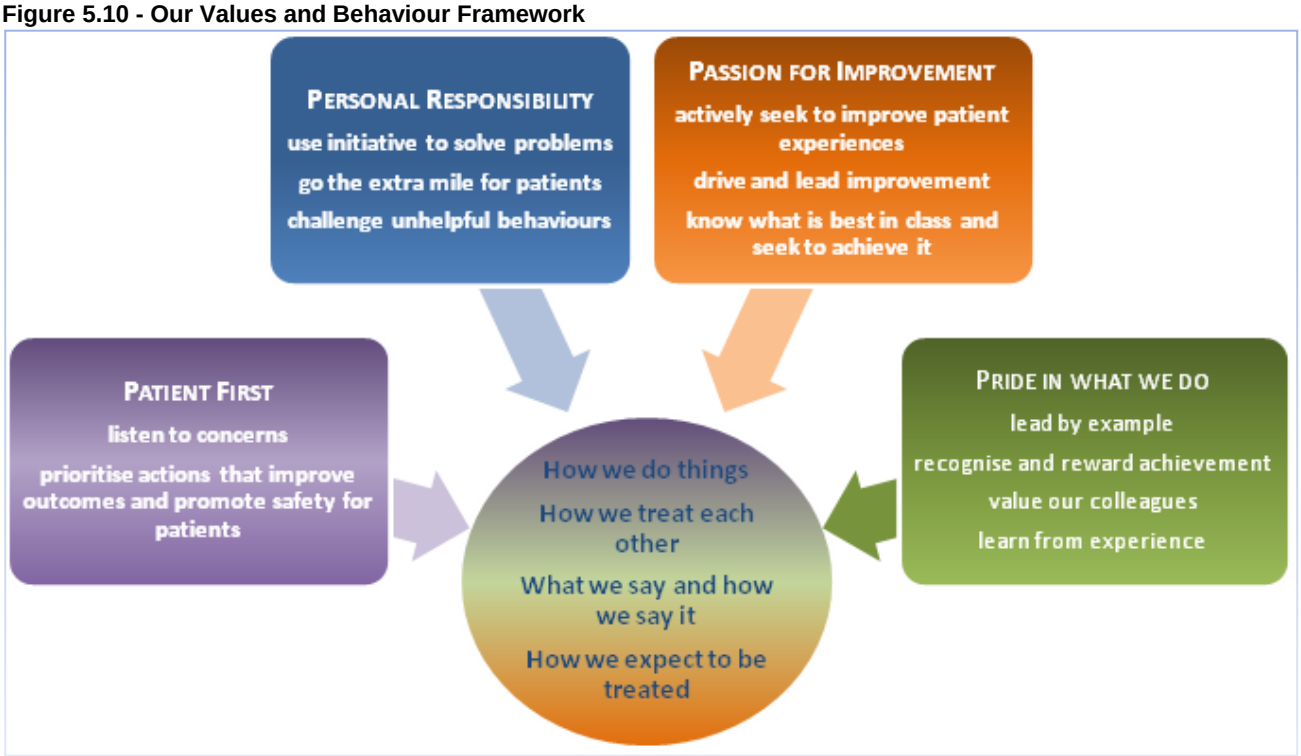
5. Organisational Development and Workforce

The 13,456 health workers employed by the Health Board, together with independent contractors and the many people who volunteer, provide care and services to the individuals, families and communities across Gwent, are our greatest asset. Optimising workforce utilisation is a key goal for the next three years and beyond.

In a time of national and international health workforce shortages, the Health Board must build capacity to respond to the healthcare needs of our citizens by generating creative solutions to managing the supply of and demand for health workers. Reducing reliance on traditional medical models of care through optimising the use of a variety of health professionals to their full scope of practice is crucial. Innovation in health service delivery is needed to achieve the goals of improving quality and increasing timely access to health care while making the system more effective and accountable.

Our Values and Behaviours Framework, developed in partnership with staff, sets out the core values and behaviours that every member of staff, regardless of their role or grade in the organisation, will demonstrate. These organisational Values are underpinned and supported by both the NHS Wales Core Principles and the Public Service Values and Well-being Delivery Principles.

Figure 5.10 - Our Values and Behaviour Framework



The principle areas for delivery to embed the Values and Behaviours Framework in 2016 will be:

- A formal review of the Values and Behaviours Framework.
- A phased implementation of Values Based Recruitment.
- A review of evidence provided by staff that demonstrates that they are living the values.

The ***Clinical Futures Strategy*** sets out plans for a sustainable service model, implementing this will require staff to work in new and exciting ways, to be part of multi-disciplinary teams that span sector and professional boundaries in order to build care around the needs of individuals. Staff will need to develop new skills, or to use existing skills in different ways.

Changing patterns of need are impacting on the shape and expectations of the workforce, including delivering more care closer to home, seven day services, new technologies and advances in medicine. Job design, organisation structures and processes, management and leadership, recognition, team working, health and wellbeing, performance, equality and diversity and staff engagement are all important facets of the Organisational Development Strategy.

The Health Board will continue to ensure that the basic skills training and development are in place both in terms of clinical and managerial practice. Over the next three years we will commission a workforce that meets present and future needs whilst ensuring appropriate development and training is in place for our staff to adopt new roles. The Personal Appraisal Development Review (PADR) and medical appraisal systems remain key mechanisms for assuring that skill levels within the workforce are robust, appropriate and underpinned by our values and behaviours that support them.

5.1 Organisational Development

The UHB's Organisational Development Strategy was approved by the Board in August 2015. The Strategy clearly articulates the necessary actions to support the step change in culture, systems and leadership needed to ensure the organisation and its services are regarded as a caring, open, candid and improving health system. These are the characteristics set out by the Francis and

Andrews Reports as fundamental to the delivery of high quality safe services.

OD Transformational Model
The challenges facing the UHB are significant but not as big as the opportunities available to make positive changes to the way we work. Transformation to a more sustainable organisational model requires a systemic and holistic approach in order to remain connected to our community and delivering on our Corporate Social Responsibilities. This encompasses each of us being the best that we can be, getting the best from others and working in systems that are safe, effective and efficient.

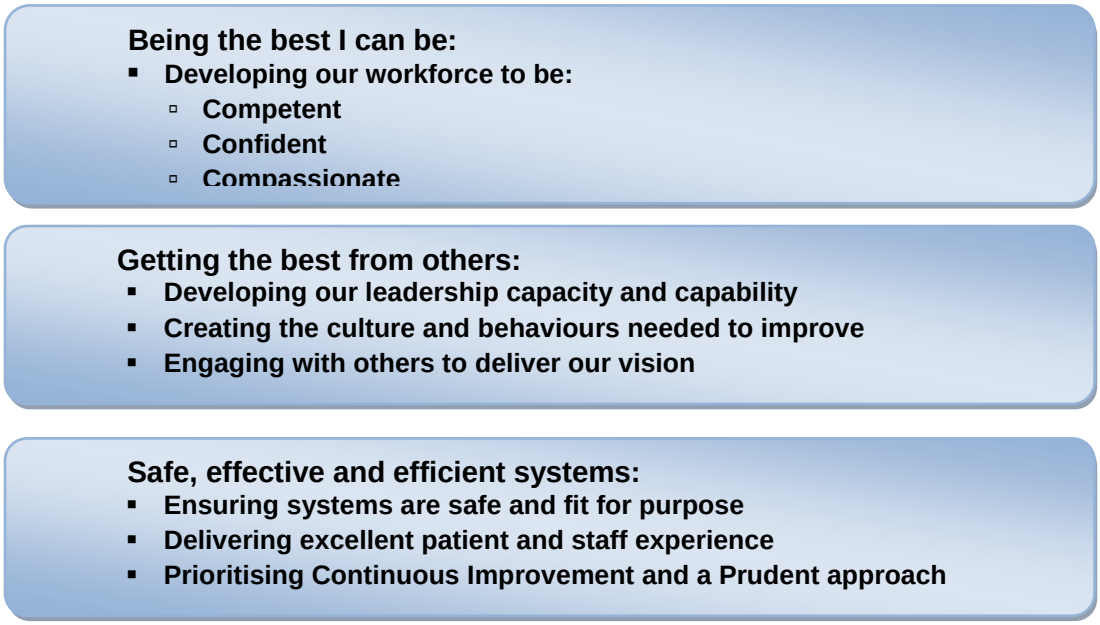
Organisational Development is a shared responsibility; it is an ongoing challenge to ensure we make the most of the strengths, opportunities and challenges presented to us. The diagram opposite is a visual representation of this OD Transformational Model.

The three core themes for the Organisational Development Strategy.

Figure 5.11

Figure 5.12

Core Themes of our OD Strategy



From these themes within the Strategy, the principle areas for delivery will be through the following priority areas:

- Developing Leadership and management potential.
- Improving Staff Experience and Engagement.
- Bringing our organisational Values to life.
- Facilitate talent management and succession planning at all levels.
- Supporting the delivery of the Service Change Plans.
- Supporting Primary care transition and integration.
- Enhancing and protecting the Well-being and Health of staff.
- Building reciprocal relationships with the community we serve.

Our action will be focused to achieve these by equipping our staff with the knowledge, skills, experience and competencies required. Underpinning this will be the need to continue to build levels of trust through employee engagement, a clear focus on staff experience and working in partnership with the wider workforce, Trade Union colleagues, patients, clients, their families and external partners. Staff who are both confident and competent will have skills to work collaboratively with the community we serve to develop a prudent approach to care and service provision.

5.2 Aneurin Bevan Centre for Improvement (ABCi)

The ongoing collaborative working with ABCi continues to ensure quality improvement in patient care at the very core of all leadership and management development. The project work undertaken by ABCi acts as a key enabler in supporting teams to transform the way they work. The continued use of the Aston team based working model continues to be a platform on which clinical and management teams are supported to work together to deliver excellence.

5.3 Partnerships

Trade Union Partnership Forum

The Trade Union Partnership Forum (TUPF) reports directly to the Board and has responsibility for engaging with staff organisations on key issues facing the organisation. The TUPF provides the

formal mechanism for consultation, negotiation and communication between our staff and the UHB, embracing the Trades Union Congress principles of partnership.

The group is jointly chaired by the Staff Chair for Trades Unions and Chief Executive Officer, and is attended by Executive Directors, Senior Managers and a maximum of 30 accredited staff representatives, providing a fair range and balance of Trades Unions in the organisation. The Forum offers opportunities to have detailed discussions about matters of particular importance to the UHB such as finance, our medium term plans and partnership working. The Forum has provided an excellent opportunity for managers and Trades Unions across the UHB to meet and discuss a number of strategic issues impacting on delivery of services and workforce.

In addition, the UHB is developing more effective and sustainable mechanisms to facilitate continual engagement of staff and the widening of the role of staff in order to strengthen links with our communities. There is recognition of the potential role of staff as engagement conduits, both communicating with and gathering feedback from our communities through their non-work related membership of community based groups. The UHB Engagement and Communication Strategy aims to ensure that engagement and communication is taken to another level and delivers significant communication improvements for our staff, patients and wider stakeholders.

5.4 Equality Diversity and Welsh Language

The reduction of inequalities is a cross cutting theme throughout the plan. Specific equality objectives are described in detail in the Strategic Equality Plan:

http://www.wales.nhs.uk/sitesplus/866/opendoc/191353

The Strategic Equality Plan and Objectives recognises that promoting equality and human rights is key to securing the best possible life chances and health outcomes for the people we serve. Its delivery also supports the creation of working environments that are safe, effective, caring and compassionate. Our revised Strategic Equality Plan will be published following engagement and formal consultation in April 2016.

Work has continued in response to the All Wales Standards for Accessible Communication and Information for People with Sensory Loss. The Standards set out the level of service delivery that people with sensory loss should expect when they need healthcare.
Domestic violence remains a considerable challenge affecting the wellbeing and health outcomes of our community. We continue to support to the White Ribbon Campaign in support of the raft of work already in progress to prevent domestic violence.

The UHB has a long established Lesbian, Gay, Bisexual and Transgender Advisory Group. We have continued to participate in engagement activities with the LGBT community which has helped us develop a greater understanding of their needs. We are members of the Stonewall Diversity Champions programme and have made significant progress in creating a more inclusive work place.

We recognise that Wales is a country with two official languages, Welsh and English and that the community we serve has the right to live their life through either or both languages. Welsh speakers can be found in all areas of the community we serve (ABUHB Bilingual Skills Strategy 2014). Those who have the greatest language need are likely to be among those recognised as coming from the most vulnerable groups. This includes older people, children and those with mental health or learning disabilities. Provision of a bilingual service is a statutory requirement (Welsh Language (Wales) Measure 2011 which is further strengthened by the Welsh Government Strategic Framework for Welsh Language Services in Health, Social Services and Social Care - 'More Than Just Words……', Welsh Government response to the Welsh Language Commissioner's Primary Care Inquiry Report, impending Welsh Language Standards and the requirement for community health needs assessment to identify issues of language and population

assessment to be undertaken in line with the Social Services and Well-being (Wales) Act 2014.

Challenges
Community engagement, issues raised through concerns and legal requirements all highlight the need to improve service provision in relation to bilingual patient care, patient and public engagement and general communications. There are likely to be considerable challenges to this in relation to recruiting potential applicants in many staff groups where there are already shortages such as nursing. Translation of key documents, patient information, web site and social media is a considerable challenge and is currently outsourced. This has presented issues in relation to timeliness, quality control and a backlog of patient and public information currently available in English only

Opportunities
Recruiting more Welsh speakers is being tackled through the Recruitment Strategy and Bilingual Skills Strategy and the requirement to apply criteria to identify all job roles as either Welsh 'essential', 'desirable' or not required. Up skilling the existing workforce is being tackled through the Welsh Language Skills Training Plan. A focus on community engagement and volunteering opportunities will help us to make best use of the Welsh language skills available within our community. Where possible we are working with other public services to share the costs of translation, however much of what we require is bespoke. A business case has identified the need to recruit a Welsh Language Translator (Band 5) and a Welsh Language Media Officer (Band 4) based within the corporate communications team.

Milestones and Governance
Performance indicators will be tracked through the implementation of the Bilingual Skills Strategy, Training Plan, compliance with the Welsh Language Standards, annual report to Welsh Government on the implementation of the Strategic Framework 'More than just words..' and annual report to the Welsh Language Commissioner. These are reported to the Workforce and OD Committee which is a sub group of the Board.

Benefits – Outcomes
Recruiting more Welsh speakers where possible, supporting our existing Welsh speaking staff and up skilling staff in Welsh awareness and Welsh language skills will improve the quality and safety of service provision for Welsh speaking patients and carers. Having an in-house translation service will also contribute to this and decrease the risks associated with failing in our statutory duty to provide a bilingual service. These measures will result in improvements in patient experience, quality and safety as measured by patient feedback and concerns monitoring. Staff training and skills will be tracked through the Electronic Staff Record.

The principle areas for delivery in 2016 will be:

- The delivery of the second year objectives contained in the 'Welsh Language Strategic Framework….More than just words' with particular focus on the promotion and embedding of the 'active offer'.
- Implementation of the Welsh Language Standards Continued collaborative working with primary care colleagues to support the implementation of the recommendations as a result of the Welsh Language Commissioners Inquiry in to Primary Care.
- Greater focus on workforce planning and recruitment in relation to Welsh language and the training of staff to support the delivery of the Bilingual Skills Strategy
- The continued implementation of a strategic action plan to improve the experience of those with sensory loss
- Further embedding of the equality impact assessment process to support the inclusive design and delivery of services
- Following Board approval, publish and implement the Strategic Equality Objectives 2016 - 2020

5.5 Social Sustainability

There are a number of ways that we will engage with the community to get people back into work. This will build on the range of work that we are currently undertaking in partnership with Careers Wales through the Business Ambassadors Scheme. We recognise that young people develop maturity and confidence when they are given the opportunity for meaningful work experience and regularly facilitate a range of experiences across the organisation. Potentially, this can help us to recruit and prepare future employees, supports and raises the profile of the Health Board within our local community, helps young people to plan their career and can motivate and develop the skills of our staff. In addition to providing work experience our staff enhance work related learning by giving talks to students within their school, hosting visits, taking part in mock interviews, and acting as advisers to young people involved in careers related and enterprise activities. We also recognise the important role that we can play in supporting teachers to keep up to date with the range of roles and skills we require and offer 'teacher placement' visits.

6. Innovation/ABCi Improvement Plan

Aneurin Bevan Continuous Improvement (ABCi) service provides the UHB with a systematic approach to innovation, service improvement and leadership. The service is embedded within the organisation, whose aim is to support the development of an organisational culture that enables its employees to be curious, courageous and creative, providing opportunity to seek different ways to provide healthcare and improving and innovate services. Therefore, as well as improving and optimising current provision the changes in demand, technologies and the economic environment create the condition and drive to rethink and re-engineer some of our services. Such innovation requires a culture that creates headroom for reflecting on demand and the potential for responding in new and different ways to that demand; a culture which welcomes safely managed trials and accepts and learns from those trials which do not deliver expected outcomes and a culture which encourages a diversity of thinking with real collaboration and engagement with other agencies and organisations both private and public. This is underpinned by insuring that all services are as effective and efficient as possible. These improvements and innovations are supported through the development of leadership, teamwork and awareness of improvement methodologies.

A key objective of ABCi is building a network of organisations recognised as being leaders in their fields. An outcome of this has seen ABCi develop key links with Universities across the UK and Canada. **SCP 9.7** illustrates the effect of these relationships - modelling Systems Dynamics for Unscheduled Care. **SCP 10** Out Patient Transformation illustrates the importance of the role of an embedded improvement and innovation centre in the UHB's core business.

ABCi is been the key mechanism for contact with the Bevan Committee for the purpose of innovation and the following UHB projects are currently being supported through the Bevan Innovators Programme:

- Postcard Scheme for mental health service users who attend the Emergency Department.
- Developing a flexible workforce for the facilities department.
- SOAP a care planning analysis tool.

ABCi has developed and maintained its Innovation links with the South East Wales Academic Science Partnership and have supported the development of a database for Innovation across Wales.

ABCi empowers and enables the workforce within the UHB with skills and competencies to ensure that improvement and innovation is part of their work. The training is underpinned by supporting teams and individuals to lead improvement within the workplace. During 2015 ABCi has further

supported the roll out of the “Improving Quality Together” (IQT) Bronze and Silver improvement methodology.

In 2016 ABCi developed a Gold Improving Quality Together network, which is a forum to discuss and disseminate innovation in the workforce, this is a network extended to all employees and contractors of the UHB.

An indication of success is the number and quality of improvement and innovation projects being undertaken by staff in their workplace across the organisation and the systematic measurement the impact of the improvement has in the work place.

A further objective for ABCi has been to develop further leadership capacity within the UHB in order to achieve this we have been instrumental in the development of the leadership initiative Enhanced Leadership programme. An indicator of success is the number of strategic improvement/innovative projects aligned with the IMTP that are completed and the continued measurement of the impact of the improvement.

Table 5.11

Achievements	
Improving Quality Together: ▪ Bronze compliance 28% of the workforce have completed Bronze IQT training ▪ Silver compliance 5% of the workforce have completed Silver training	**2016:** 40% compliance with Bronze IQT training Planned IQT Bronze sessions for 2016 Development of a Gold Network within the UHB
39 projects submitted Wales NHS Quality Awards 5 shortlisted across all of the categories 3 projects won awards Outstanding innovation in care Citizens at the centre of service redesign delivery award winners developing a flexible workforce) Promoting the clinical research and application to practice	**2016:** To identify and support the submission of improvement and innovation projects for 2016 NHS Wales Awards
Leading Quality Together Programme ABCi have supported 17 improvement projects through LQI during 2015	**2016:** To support cohorts for 2016 To support the development of additional modules-leading teams
Leading People 21 individuals on cohort 1	The Leading People programme established in 2015 an innovative approach to leadership in the workplace, developed on a multi-agency, multi-disciplinary basis. **2016:** A further cohort will commence in May 2016
Enhanced Leadership Programme Multi-disciplinary leadership programme	. **2016:** All improvement/innovation projects are aligned to the IMTP
Increasing understanding of mathematics within the UHB, with	An escalator of training/prospectus within Mathematical modelling has been established

Achievements	
associated CPD credits for medical staff	Excel Skills training Basic Statistics Which graph when? Geographical Modelling Introduction to Mathematical Modelling Part Time Masters in Operational Research
Develop links with Universities across the UK and Canada Developed University links with and collaborative working with: Cardiff University Swansea University Bangor University Limerick University Toronto University Plymouth University Cumberland Innovative University of South Wales University of Exeter Cognitive Edge- David Snowden	**2016:** To continue to work with professional bodies, in relation to the spread of quality improvement and innovation.
Through the collaboration with the department of Mathematics at Cardiff University, ABCi have been successful in: THE Times Awards- Innovation and Technology Innovation and Impact Awards Cardiff University	**2016:** To continue to look for opportunities to promote ABCi

7. Research and Development

7.1 Enabling Research and Development - Three Year Plan

The Division of Social Care and Health Research (DSCHR) is the national body that funds some research through NHS funding allocations, Activity Based Funding (ABF). The amount received by the UHB is circa £800k out of a total budget of £13.45m. DSCHR funding is only available for Clinical Research Portfolio Trial activity. Clinical research in the UK is evolving, with a new style of research trials emerging that require fewer participants recruited to more studies. These include stratified medicine. Whilst this speeds up the research process and produces results faster, it has a consequence for Wales and the way in which performance is managed in the NHS. Here, DSCHR WG has set KIs for the NHS to increase the number of Clinical Research Portfolio (CRP) trials by 10% year on year and the number of patients recruited to those trials to also increase by 10%. Having more studies means that the first KI is easily achieved but the second becomes a huge challenge. Previously we were hosting studies requiring sample sizes of between 10 - 50, however these are now reduced to 2-3 patients. In order to retain these very high quality studies whilst meeting our KIs for WG the following strategies will be deployed:

- Balancing hosting studies with low participants with bringing in more studies that require higher numbers of participants. So having a ‘balanced’ portfolio. This will enable the UHB to continue to support these new, stratified medicine studies and protect them by bringing in high recruiting

studies. This process has already begun.

- Joint working with WG Research Support and Delivery Infrastructure to ensure that our KIs are met, and that the UHB maximises the use of resources external to it.
- Weekly R&D Office monitoring of patient recruitment into trials and Clinical Research Portfolio (CRP) studies in set up.
- Allocating the UHB resources effectively and efficiently to maximise participant recruitment.
- Investing in a flexible UHB workforce.
- Joint working with WG Support Centre to identify commercial studies.
- Investment in new areas of research including Mental Health, Child Health, Social Care, Long Term Conditions & Primary Care.
- Continue to invest resource in Pathology, Radiology and Pharmacy to support Research Portfolio Trials (CRP).
- Strong partnership working with Universities, in and outside Wales to develop Chief Investigators and develop our research ambitions.
- Continue the Gwent Partnership Board.
- Research representative at Board to ensure that service development and service evaluation projects submitted to Board include robust evaluation prior to approval by Board.
- Continued visibility and representation at Board through the Medical Director.
- Increase the number of high quality applications to external and internal funding bodies.
- Engage with staff across the UHB to raise awareness, increase the number of Principle Investigators, increase the quality and quantity of research and capitalise on existing research active and research ready staff.

As a UHB it is essential that we demonstrate the value that this status has brought across the whole organisation from Board to Ward, and how our behaviours have changed. Indicators of success include the way that Board engages with its HEI partners and works collaboratively with them for the benefit of its patients and staff. The ways in which Board reaches out to HEIs to bring in their expertise to inform the development and delivery of services and works in true partnership will provide reassurance that university status has made a real and demonstrable difference to the UHB.

At the Research and Innovation Department has increased the number of academics and HEI departments that it partners with, bringing in more high quality research into the UHB. Through membership of the South East Wales Academic Health Science Partnership (SEWAHSP), the alliance of 9 NHS and HEI organisations in SE Wales, more academic and commercial research and development has been brought into the UHB. The development of funding schemes and the increased applications to high quality funding bodies demonstrates a culture where research is central to the development and delivery of services.

Ownership of research at Divisional Director level is essential to securing the status of research and clinical trials as a core activity in the UHB. This priority area will involve a culture change where Divisional and Directorate Managers embed research is recognised treatment option available to all patients alongside routine clinical care. Fundamental to achieving this are named clinicians ,who from April 2015 will be allocated, as a minimum, an additional 45 SPA sessions ring fenced to support and enable research.

Key objectives:

- To provide a ‘balanced’ portfolio of trials accessible to patients and staff.
- To increase the number of CRPs by 10% annually and to increase the number of patients entered into CRPs by 10% annually.
- To increase the number of commercial trials by 5% and increase the number of patients entered into commercial trials by 5%.
- Increase the number of Clinical Academic Posts to develop Chief Investigator (CI) roles.
- Allocate a minimum of 5% SPA sessions to be used on research, to develop Principle

Investigator (PI) and CI (Chief Investigator) roles.

- Reinstate the Gwent Partnership Board to ensure links are maintained with Higher Education Institutes (HEIs).
- Support the Medical Workforce staff to include research activity in new consultant posts.
- Support Medical Workforce staff to attract consultants into hard to fill posts through including SPAs for research into the job plans.
- To maximise the use of the Clinical Research & Innovation Centre at St Woolos Hospital.
- To maximise the bench testing laboratories at the new Clinical Research and Innovation Centre at St Woolos. This will be through attracting and repatriating commercial testing of devices and products.
- To support high quality applications to funding bodies.
- To facilitate new research relationships between CU and USW and other HEIs to develop
- To maximise the potential of the Research Nurse and Officer posts at NHH funded by the Nevill Hall Research and Thrombosis fund.
- Invest in Clinical Research Facility (long term) SCCC.
- Support Divisions to embed research as a core function.
- Divisions and Directorate to own research with set KIs reported to QPSOG.
- Understand the savings achieved through research and ensure that this is reinvested in research.
- All new project plans approved by Execs and Board to include formal and robust evaluation.
- Maximise the value of Activity Based Funding (ABF) by ensuring the availability of a flexible workforce.
- Maximise membership of the South East Wales Academic Health Science Partnership (SEWAHSP).
- Meet the research requirements of the disease specific delivery plans, cancer, diabetes, heart disease and stroke.
- Support applications to the NHH PhD scheme via the Nevill Hall Research and Thrombosis fund.
- Gain approval for Intellectual Property policy and exploit the potential to generate income and drive innovation.

Capacity Building: A key area to focus on is commercial trials and working more closely with Industry. Commercial research will also support the growth and development of research facilities in the UHB.

Innovation: The R&D Department will continue to work closely with the ABCi, where R&D supports the generation of new evidence, the organisational mechanism for the translation of research into practice and spread of innovation and good practice across the UHB is supported by the ABCi.

As part of WG functions for R&D, The UHB will continue to develop the Intellectual Property Group and implement the Intellectual Property Policy to ensure new ideas are nurtured, protected, patented and trialled within the UHB.

Benefits Realisation: The benefits derived from participating in research include improved quality of patient care; increased availability of treatment opportunities for patients and enhanced financial prospects for the UHB. There is a stronger body of evidence that NHS organisations that support research at their core and have clinical research teams and dedicated facilities attract the best doctors and nurses and provide better treatments and outcomes for their patients. They are also able to sustain their services through cost recovery and income generation.

Being a University Health Board: Close and collaborative working with HEIs will ensure that minds and resources are pooled to develop evidence and innovation in medical care and new interventions. Patients of UHBs have a higher chance of receiving the latest innovations in healthcare and University Hospitals tend to be among those that have the nation's most cutting

edge medical facilities. The planned Specialist Critical Care Centre will be a noteworthy example of such a facility and will provide the UHB with a platform to deliver high quality research. This is an opportunity not to be missed.

Table 5.12

Key Development 2016-2017	Benefits
1. Work with partners (i.e. DSCHR, Health and Care Research Wales Support Centre and Workforce, RDCS, SEWAHSP, SEWTU, HRW) to take full advantage of their resource to facilitate: ▪ joint posts with Universities ▪ clinical research fellow awards ▪ clinical research time awards ▪ shared clinical trials health/universities ▪ shared clinical trials health/industry	Clinicians who work across Health, Industry and Academia are best placed to undertake CI roles. CI roles: ▪ attract ABF from Non Commercial trials which enables reinvestment ▪ ensure local leadership/ownership of research portfolio ▪ increases the number of Commercial Trials and income generation ▪ the relationship between user and provider will be remodelled on the basis of co-production.
2. Continue the Gwent Partnership Board	Ensures links with Higher Education Institutes (HEIs) and facilitates the increase in clinical academic posts.
3. Identify and protect the mandated additional and minimum 45 SPA sessions to develop Principle Investigator (PI) roles.	SPA sessions provide clinicians with protected time to grow research portfolios within their directorate. Benefits include: ▪ meeting research KIs ▪ delivering on disease specific delivery plans (cancer, heart disease, diabetes and stroke) ▪ increasing the number of CRP trials ▪ increasing the number of patients participating in trials ▪ increase in ABF to enable increase in research investment ▪ research services will be sustainable
4. New consultant posts to include a research profile. Continue engagement with new consultants by presenting at the Consultant Induction day.	Ensures a supply of clinicians prepared to work as PI.
5. Invest in localised research facilities; e.g. St Woolos and Forglen House.	Enables research, provides a base for PIs and CIs to meet the requirements of research protocols. Widens scope for accepting new trials.
6. Divisions and Directorate to own research with set KIs reported to QPSOG.	▪ This culture change will begin to embed research as a core function. ▪ Divisions and Directorates will begin to understand the savings achieved through research and realise the benefits of reinvestment. ▪ Addresses Health Inequalities
7. All new project plans to include formal and robust evaluation.	New projects will be evaluated to ensure adjustments are made in accordance with evidence so that the end result will be a service that functions efficiently and effectively.
8. Develop financial management procedure to remove barriers to co-opting staff into research projects and maximising the	Research nurses and administrators will be moved flexibly into directorates to support new and ongoing clinical trials, enabling the best

Key Development 2016-2017	Benefits
benefit of ABF.	value for money, the outputs of research studies to be maximised and the generation of ABF for reinvestment. Demonstrates visible leadership and evidences that R&D is actively integrated into financial and decision making structures.
9. Identify funding stream to fund pathology, pharmacy and radiology (PPR) research posts ensuring research PPR requirements are prioritised equally to routine care. Even though posts are currently funded through ABF some services continue to turn down studies due to capacity. ABF should not be used in the way as it is required to support research studies within directorates; therefore the funding allocated to PPR posts must be released.	▪ ABF will be released to support work that generates ABF. ▪ Clinical trials will be embedded as routine practice. ▪ UHB patients will not be subject to health inequalities but will be enabled to participate in studies hosted by Velindre hospital if they are receiving their treatment there. ▪ Services will be person centred.
10. Update R&D Strategy.	A new strategy will align R&D to new Welsh Government and organisational objectives going forward from 2016.
11. Continue support of GP Practices to register for the Primary Care Research Incentive Scheme (PiCRIS) at Affiliate and Levels 1 and 2. Continue support from the R&D Office for Primary Care research. Support GP practices to undertake research by working jointly with the Health and Care Research Wales Workforce.	▪ Research will become embedded in primary care giving patient's sustained access to research projects. ▪ Promotes a culture that values and promotes research through leading and/or hosting studies, and recognition and understanding by all staff of the role that research plays in increasing and delivering good quality care.
12. Work with the Board to meet DSCHR WG KPI to include an R&D report at Board meetings and include research in the UHB Annual Report.	Demonstrates visible leadership including representation of R&D on the Board of the organisation.

Table 5.13

Key Development 2016-2017	Benefits
1. Continue to increase the number of Clinical Academics in joint posts to undertake Chief Investigator (CI) roles.	Meet the WG KI. The CI role is essential to ensuring the UHB is able to lead research studies, both Commercial and Non Commercial. Investing in these roles will ensure that the UHB is able to fully realise the benefits of ABF premiums and commercial income.
2. As research becomes a core activity increase frequency of which patients are invited to participate in CRP studies.	Research becomes embedded as a routine option offered to patients.
3. Develop Intellectual Property portfolio.	Drives innovation in terms of 'new knowledge' Potential to generate income though patented initiatives.
4. Management of local clinical trials units to sit within directorates.	▪ This culture change will begin to embed research as a core function. ▪ Divisions and Directorates will begin to understand the

Key Development 2016-2017	Benefits
	savings achieved through research and realise the benefits of reinvestment. ▪ Patients will be offered new and innovative treatment options. ▪ Promotes equity across disease specialties ▪ Research will be organised around the 'only do, what only you can do' principle.
5: Ensure research is integral to all UHB future plans.	New services will be designed that enable research to be provided routinely. Demonstrates visible leadership and evidences that R&D is actively integrated into local planning.

Table 5.14

Key Development 2017-2018	Benefits
1. Invest in Clinical Research Facility (long term) SCCC	The UHB would: ▪ Become a centre of excellence for social care and health research. ▪ Attract the best doctors and nurses. ▪ Provide the best, innovative treatments and outcomes for patients in a safe and controlled environment. ▪ The facility would sustain services through cost recovery and income generation.
2. Complete audit of 60% of active trial files.	Ensure clinical trials are being conducted in accordance with ICH GCP and MHRA guidance.

7.2 Outputs

Quality and Safety
The core values that influence research outputs mirror the values of the NHS in Wales:

1. Putting quality and safety above all else.
2. Integrating improvement into everyday working.
3. Focusing on prevention, health improvement and inequality.
4. Working in true partnership with partner organisations and with staff.
5. Investing in our staff.

To achieve this, the R&D office undertakes mandatory Research Governance on behalf of the UHB and ensures compliance with Good Clinical Practice Guidelines and the Research Governance Framework for Wales.

The department monitors and minimises risks associated with clinical research trials on behalf of the organisation through the following mechanisms:

- Providing training and support to researchers.
- Carrying out feasibility studies to ensure the organisation has the necessary services/facilities/resources/staff to carry out the proposed clinical trial and that there is a mechanism in place to reclaim excess treatment costs.
- Assessment of studies to ensure they pose no risk to the organisation.

Finance
The R&D Office receives a ring fenced budget to meet the costs of the research governance office and an activity based budget which must be spent on support costs and research portfolio development.

Further to this the R&D Office receives a number of funding and competition opportunities throughout the year that are distributed and coordinated across the organisation to ensure full advantage can be taken. These include opportunities to receive funding for research in primary care, awards for Intellectual Property and innovation, clinical research time awards, clinical research fellow awards and funding of equipment for research.

Other funding is received through commercially funded research studies and also through Charitable Funds awards.

As the success of research in the UHB grows, so will the level of financial income and financial responsibility. Being a Sponsor will require the R&D office to receive, manage and distribute large research grants across the research network which can be local, national or international.

Productivity/Efficiency
The R&D Office:

- Registers on average 100 new projects every year and has around 900 studies active at any one time. This includes carrying our feasibility, risk assessment and approval processes for all studies;
- Issues an average of 35 honorary contracts and 50 letters of access to external researchers;
- Has recently embarked on an audit programme aimed at auditing at least 60% of active trial files across the UHB.

Fully embedding R&D into the UHB over the next three years will require:

- A focus over the next 12-18 months on:
  - Rebranding Research and Development as a core activity.
  - Securing funding streams and research grants to enable the expansion of the UHB's research portfolio.
  - Supporting researchers to make the transition to chief investigator status; where they will take overall responsibility for the design, conduct and reporting of studies within the UHB will be a priority.

- Pursuing the long term vision:
  - To deliver research through a dedicated clinical research facility where patients can receive innovative treatments on their doorstep and clinicians will have access to the support they need to grow, and develop innovative new ideas and to support clinical trials. Overtime such a facility has the potential to become self sufficient with a significant turnover that will ensure the future growth of research within the UHB is assured.

Section 2

Chapter 6 – Progress in 2015/16

1. Progress in Delivering the 2015/16 Plan

Introduction/overview
The 2015/16 IMTP was organised into ten Service Change Plans (SCPs) and five underpinning work programmes aligned to the UHB's priority areas. These work programme areas were derived from national programmes and priorities, our organisational clinical service strategies including Clinical Futures and divisional IMTPs.

An executive led delivery framework was established in May 2015 to oversee implementation of the SCPs and ensure that further opportunities to improve services and realise benefits continued to be explored and developed. In addition, monthly assurance meetings monitored delivery of divisional plans and performance, and executive led 'deep dives' were arranged to focus on specific areas of concern.

Future success will be measured by the health and wellbeing of our population, people's ability to understand how and when to access local health services when they need them and the UHB's ability to deliver these services in a timely manner and to the highest standards within sustainable budgets.

Key Achievements to Date
Detail about the work programmes in each SCP is provided in **Chapter 6** on the refreshed plans for 2016/17**.** This includes progress on milestones, key risks and priorities for the next period. Some of the key achievements to date for 2015/16 are outlined below.

SCP 1 - Reducing Inequalities in Health
The Living Well, Living Longer programme was launched by the Minister in Blaenau Gwent West Neighbourhood Care Network area. Over 2,060 patients had attended or booked appointments for cardiovascular risk assessment by end September 2015. Of these, 29% were referred for further clinical assessment for hypertension, atrial fibrillation, familial hyper-cholesterolaemia or diabetes. In addition, 28% of smokers were referred to Stop Smoking Wales, 7% with BMI>30 to Adult Weight Management Service and 25% of moderately inactive/inactive patients were referred to the National Exercise Referral Scheme.

SCP 2 - Health Promotion and Prevention
To date, the plan for tobacco control and smoking cessation has delivered level 3 training and accreditation for smoking cessation in a total of 38 community pharmacies across Gwent. The year-end target is for 50 pharmacies.

The Liver Disease Local Delivery Plan was submitted to Welsh Government and included proposals for the development of an integrated alcohol treatment pathway.

Vaccination and immunisation programmes have been delivered for all age groups, although some backlogs are developing for children under 4 years old. A recovery plan is in place to resolve this.

SCP 3 - Strengthening Primary Care Services (Independent Contractors)
A Primary Care Improvement and Support Team was developed to provide a central pool of multi-disciplinary support for fragile GP Practices including out of hours, to support specific improvement programmes such as Living Well, Living Longer, and to test out new models of service delivery. The team includes salaried GPs, pharmacists, nurse practitioners, nurses and Health & Social

Care (H&SC) support workers. The new team is expected to be operational by the end of December 2015.

SCP 4 – Integration: Bringing Care Closer to Home
Enhanced Primary Care (PC) ophthalmology management was delivered through the commissioning of glaucoma follow up Local Enhanced Services (LES) from eleven sites until March 2016. This was critical to eliminating delayed follow ups by the end of December 2015. Additional Welsh Government funding was also secured to fund a Wet Age-related Macular Degeneration (AMD) Ophthalmic Diagnostic and Treatment Centre (ODTC) pilot. A tender process has commenced for two glaucoma ODTCs and one Wet AMD ODTC.

SCP 5 - Chronic Conditions Management
A new scheme for the management of osteo-arthritis of the knee in Primary Care commenced in July in 4 NCN areas. Initial take up was quite low but has since improved, e.g. in the first 2 months 166 patients were invited and 84 attended. The evaluation from the attendees demonstrated a successful adoption of Prudent Healthcare principles with a significant improvement in the patients' understanding of their conditions and options for self care and clinical management. It also reported that a number of patients were planning to make lifestyle choices following the sessions such as weight loss rather than immediately opting for surgery.

SCP 6 - Continuing Health Care (CHC)
A strategic review of CHC services was completed in June. Since then, new interim management arrangements have been implemented in Community Adult Complex CHC and a 12 point plan commenced to stabilise clinical operations and deliver immediate financial savings. The plan has already delivered over £1m savings this year through operational efficiencies and improved capacity. Meanwhile MH/LD CHC has achieved savings of £692k this year so far.

SCP 7 - Service Sustainability
Services have been sustained at Nevill Hall Hospital for paediatrics, obstetrics and neonatal services with medical training centralised to the timetable agreed with the Deanery to deliver the revised educational contract. A new medical model has also been introduced at Ysbyty Ystrad Fawr (YYF) to enable the centralisation of medical training in acute medicine at Nevill Hall and Royal Gwent Hospital sites.

SCP 8 - Improving Mental Health and Learning Disabilities Services
The Rapid Assessment, Interface and Discharge (RAID) project delivered a successful pilot at RGH and is now being rolled out to NHH. There have also been significant improvements in service performance for Primary Care Mental Health Support Services.

SCP 9 - Urgent and Emergency Care
Plans are on track to redesignate a Care of the Elderly (COTE) ward at RGH as a 'green to go' nurse led ward from 1st December. The ward model will focus on discharge planning that enables more patients to be discharged to their normal place of residence by reducing long hospital stays and maximising independence.

Significant progress has been made in defining the service model and securing pump prime funding for Acute Care of the Elderly (ACE) and its associated Elderly Frail Unit (EFU). This interface service is designed to ensure that 30% of patients complete their hospital episode of care on the same day and a further 30% can be discharged within 72 hours. Of the remaining cohort, just under half will be admitted to the CoTE specialty and the rest to other medical specialty inpatient services.

SCP 10 – Planned Care (Scheduled Services)
Improvements on Referral to Treatment Time (RTT) targets, service sustainability and elective access for planned care services have been delivered through a number of measures including the

commissioning of external elective capacity for orthopaedics and ophthalmology. For example, local orthopaedic activity is 500 cases above that delivered in the first six months of last year.

As summarised in the Summary Plan these are the achievements in Year 1 of the Plan:

- Living Well Living Longer project extended with over 2000 patients attended with 29% referred for further clinical assessments.
- 28% of Smokers referred to Stop Smoking Wales and 38 community pharmacies now accredited for smoking cessation services, 7% with BMI>30 to Adult weight management service and 25% of moderately inactive individuals referred to National exercise referral scheme.
- Liver disease delivery plan approved with proposals for an integrated alcohol treatment pathway.
- Establishment of the Primary Care Improvement and Support Team to support fragile practices.
- Greater pace with Care Closer to Home enabled by significant investment in Primary Care Services. Over 5,000 outpatient appointments undertaken in primary care as part of the glaumcoma follow up and oral surgery projects with well developed plan to implement Ophthalmic Diagnostic Treatment Centres in 2016/17 supporting further transfer of care closer to home.
- Service redesign projects implemented using the prudent principles implemented such as the development of the osteoarthritis knee pathway and teledermatology service resulting in over 1000 outpatient appointments being avoided to date.
- Significant (47%) reductions in incidence of C.difficile.
- Significant progress in mitigating forecast CHC growth delivering breakeven in year.
- Transformation of Stroke Services in ABuHB and early indications of performance improvements.
- Implementation of new clinical models in Paediatrics and Obstetrics to sustain services at NHH and for acute medicine at YYF.
- Extended Rapid Assessment Interface and Discharge (RAID) model for older adults with MH to cover both RGH and NHH.
- Introduced the “Green to go” nurse led ward
- Reduction in bed related cancellations through improved Winter Plan.
- Improvements in Category A response times and Emergency Department performance at Nevill Hall
- Reduced delayed transfers of care over time despite levels still being high
- Clinical Futures and SCCC cases submitted for funding approval.
- Strengthened engagement function with over 5,000 direct contact with the general public.
- Delivery of financial balance.
- Delivery of improvements in elective access in the last 6 months of 2015/16
- Delivered and sustained improvements in cancer access.
- Exemplary delivery of the NMC Nurse Revalidation Pilot.
- Implementation of a Choice of Accommodation Policy to improve patient experience and transition to Nursing or Residential Homes.
- Extension of prudent healthcare programmes to encompass value based healthcare and collaboration with ICHOM.
- Collaboration with neighbouring Health Boards in the agreement of a case for capital investment in neonatal services in South East Wales.
- Updating of the Clinical Futures plan to reflect the clinical models defined by the Collaboration’s Clinical Reference Groups for medical and surgical specialties.
- Increased the volume of paper records to electronic (100,000 patients records now digitised);
- Implement a text reminder service (DrDoctor) to facilitate a 30% reduction of ‘Did Not Attends’;
- Improve clinical communications between primary and secondary care with 8,000 discharge notifications, 10,000 referrals and 7,000 clinical letters now delivered electronically per month;
- Implemented the award winning Information Governance Stewardship programme.

Key Challenges
The main causes of slippage were attributed to a small number of common issues and challenges faced by most work programmes.

- **Recruitment and retention difficulties** – a number of plans involved building capacity through recruitment and retention of additional staff from a diminishing pool of potential applicants.
- **External dependencies**, e.g. availability and timing of investment funding. The UHB will, in future, need to consider whether to implement service changes at risk or provide longer lead in times for implementation to allow for potential delays in external investment decisions.
- **Operational pressures** requiring services to redirect resources from service development to frontline service delivery.
- **Benefits realisation** – Failure to realise benefits when or to the level expected following implementation. This is being addressed through recovery plans and developing skills in benefits measurement.
- **Organisation planning development**, e.g. insufficient time calculated for key activities such as stakeholder engagement processes, recruitment, benefits realisation, poorly defined benefits measurement and lack of contingency planning. These are system issues which need to be addressed through training and development and more corporate scrutiny. There is also clearly a role for improving planning capacity and skills at a national as well as local level.

The UHB has also noted a number of areas where planning could be strengthened to provide better alignment with national priorities and infrastructure developments. In this refreshed IMTP therefore, Local Delivery Plans (LDPs) have been firmly incorporated within the SCP work programmes and more explicit links made to Clinical Futures and approaches such as prudent healthcare, value and health technologies.

Some of our SCPs were intentionally organised to provide a mechanism for coordinating related work streams that spanned a number of divisions. However this has sometimes led to confusion around accountabilities. It has been agreed that there will be some realignment of schemes under the different SCPs to clarify reporting lines for 2015/16. Other aspects of the Delivery Framework will also be reviewed to improve assurance and the alignment of executive and non-executive challenge and support.

Chapter 7 – Our Plans for the Next Three Years

1. Approach to Planning in 2016/17

As part of the IMTP refresh process, the updated plan is being developed using the three levels of planning, i.e. Operational, Tactical and Strategic as set out below to support the development and understanding of the components of the plan which will support the delivery of the key objectives and ambitions of the organisation.

Figure 7.1

These three well known levels of planning help identify the programmes of work across the different levels and those that lend themselves to short term operational planning and those that are longer term system wide change programmes.

These are described below in the following sections and provide an overview of the work programme under each level.

2. Operational Planning – Improving Operational Efficiency

The UHB has a clear ambition to maximise the use of its resources through achievement of delivering Best in Class performance in its efficiency and effectiveness. Whilst it is giving increased emphasis on value through Prudent Healthcare, we recognise the importance of a comprehensive benchmarking programme to give a holistic assessment of service performance and potential including:

- Quality and outcome measures;
- Operational efficiency;
- Workforce and financial benchmarking;

The UHB has strengthened its intelligence support by providing a comprehensive data set which has been made available to Directorates and Divisions as part of the Integrated Medium Term planning process and this has included:

- Comparison with other Welsh NHS organisations.
- CHKS data.
- Financial benchmarks.
- Public Health Observatory information.
- Prescribing Indicators.
- NHS Benchmarking club.
- PWC Workforce Report.
- Albatross/Patient Level Costing.

The stated objective is the delivery of 'Best in Class', not just within the organisation, and across Wales but by comparison with UK and international peers. The analysis below covers operational efficiency with quality, workforce and financial benchmarking covered within relevant sections of the plan.

GP referral rates

Benchmarking of GP referral rates across the UHB show opportunities to review current practice with compared with Welsh peers. The table below summarises the potential opportunity by specialty and demonstrates that across 11 specialities there is an excess of >35,000 referrals.

Table 7.1

Specialty	UHB rate (/10,000)	Best in Wales	Reduction in referrals if 'BiW' achieved
General Surgery	27.5	23.6	2,678
Urology	11.8	9.3	1,745
Orthopaedics	33.9	17.3	11,108
ENT	21.5	18.2	2,246
Ophthalmology	10.0	7.6	1,593
Oral Surgery	8.1	4.0	2,757
Dermatology	20.0	14.9	3,472
Rheumatology	4.7	3.5	827
Paediatrics	10.9	6.2	3198
Gynaecology	14.2	12.7	1011
General Medicine	22.8	20.4	1597

The UHB's approach to addressing both an apparent excess in GP referrals and high DNA rates, and its linkage with reducing component outpatient waiting times is described in the Outpatient Transformation Service Change Plan.

Outpatient DNA rates

Comparison of DNA rates against Best in Wales demonstrates the potential to release the equivalent of >10,000 outpatient appointments each year. Specialty specific analysis shows rates of new DNA of >10% in Paediatrics, Urology, Combined Medicine, Dermatology and ENT.

Table 7.2

DNA indicator	UHB	Best in Wales	variance	Potential slots gained
New OP DNA rate	8.5%	5.7%	2.8%	4,185
FU OP DNA rate	9.2%	7.3%	1.9%	3,557

Length of Stay

The UHB has assessed the potential for operational improvement associated with achievement of **'Best in Wales'** and these are summarised below. This has reaffirmed the potential to review clinical models in both emergency and elective length of stay to reduce reliance on inpatient beds and establish new service models to enable this. The scale of reduction is consistent with the UHB

Clinical Futures bed profile, which seeks to reduce bed numbers by 41 beds in 2015/16.

Table 7.3

Efficiency Indicator	Bed Days	Bed Equivalent
Elective length of stay (specialty)	5,576	15.3
Day of Surgery Admission	1,541	4.2
Daycase rates	2,555	7.0
Emergency LOS (acute)	22,436	61.5
Total	32,108	88.0

Specialty specific analysis shows that the greatest areas for potential bed reduction potential are, which is confirmed by comparison with upper quartile CHKS data, with detailed analysis showing that the UHB cohort of patients whose LOS is >20 days is a significant factor in the overall LOS:

Elective LOS: Orthopaedics (9.1), General Surgery (1.8)
Emergency LOS: Trauma (24.9), Combined Medicine (17.6), General Surgery (14.3)

The key areas that feature under this work programme include:

- **Workforce Efficiency** – improved rostering, reducing current levels of sickness absence and high levels of agency usage, using workforce benchmarking to target interventions and enabled by improved recruitment and retention and staff deployment. Benchmarking information both internal and external also identifies opportunities for improved clinical productivity with significant variation across a range of specialties.
- **Procurement** - working with Shared Services to optimise non-pay expenditure across the UHB in support of the UHB financial plan.
- **Medicines Management** - using benchmarking and local variation data, the Medicine Management Strategic Group and deep-dive methodology will be used to maximise opportunities to mitigate forecast growth in medicine expenditure.
- **Theatre Utilisation and Productivity** - using the recent WAO benchmarking report findings and local data, the Planned Care Board will focus on actions to improve both theatre utilisation and productivity in support of the delivery of elective access targets. This will also include the output of the National Planned Care Programme.
- **Outpatient Management and Utilisation –** high DNA rates above the welsh average identifies a potential for over 10,000 outpatient appointments lost each year with some specialties reporting DNA rates in excess of 10%.
- **Bed Utilisation** –the assessment of potential for operational improvement associated with achieving best in Wales Average Length of Stay equates to an equivalent of 88 beds with a key component relating to long stay patients.
- **GP Referral Rates** – benchmarking of referral rates across the UHB sets out the potential opportunity by specialty and demonstrates that across 11 specialties there is an excess of over 35,000 referrals. This will link in with the Outpatient Transformation programme and prudent healthcare reviews around demand management.

These work programmes will be underpinned by a number of key enablers that continue to be strengthened across the Health Board during 2016/17. These include:

- Robust demand and capacity modelling to identify current performance issues.
- Comprehensive benchmarking programme which helps identify opportunities.
- Improved business intelligence to support clinical decision making and performance management.
- Use of evidence and research to identify and support opportunities for improvement.

These work programmes will be embedded at a divisional and directorate level and will support the delivery of divisional plans and performance managed through the overarching delivery and

assurance programme.

3. Technical Planning - Service Change Plans

The UHB's priority plans have been aligned and organised around 10 Service Change Plans (SCPs) set out in Table 4.1 below, together with the suite of Local Delivery Plans. The SCPs have been developed through engagement processes established as part of the UHB's Planning Framework and are aligned to the UHB's objectives and clinical services strategy (Clinical Futures), together with Welsh Government NHS Planning Guidance.

Table 7.4

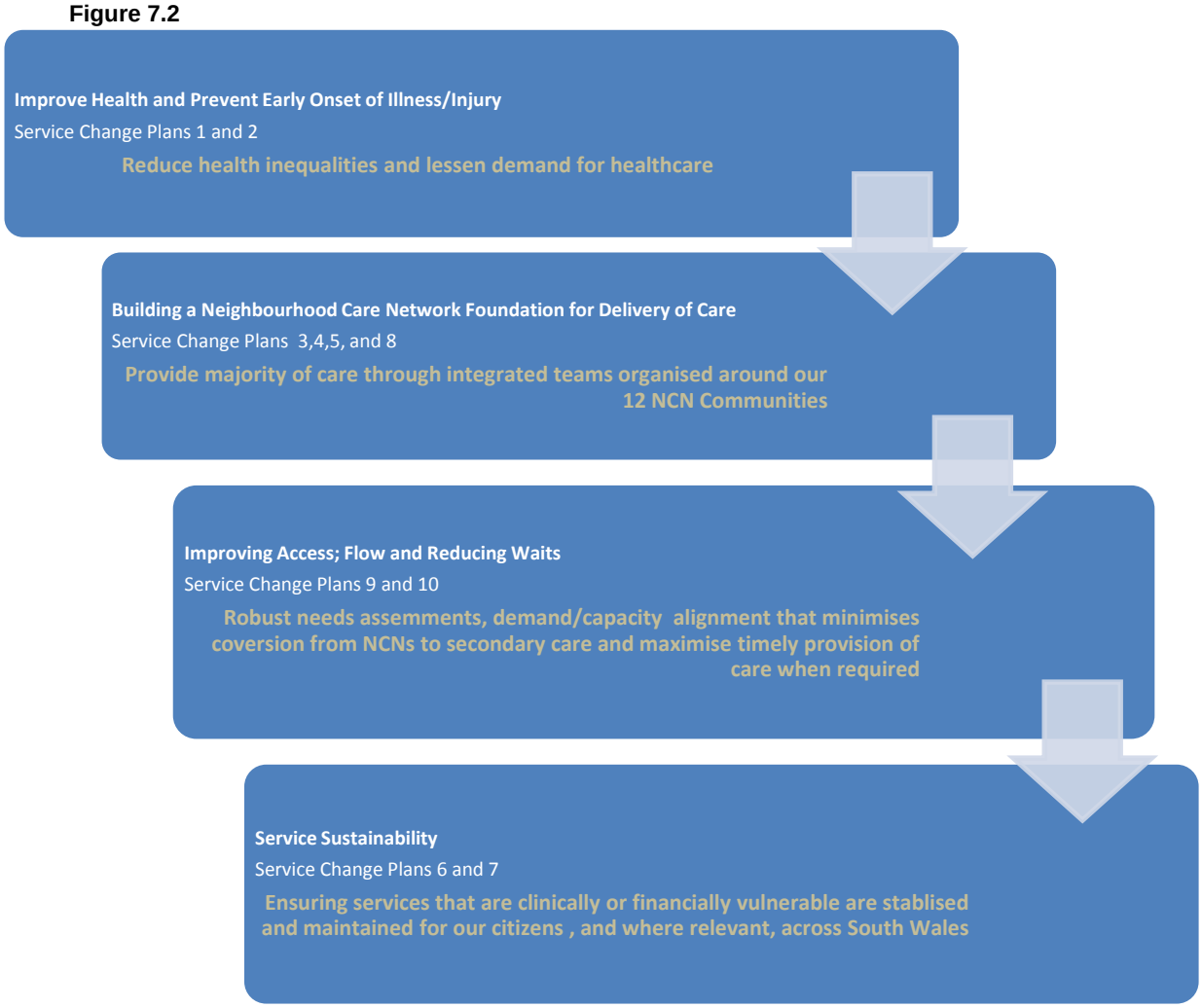
SCP	Title	SCP	Title
1	Reducing Health Inequalities	**6**	Continuing Health Care
2	Prevention and Improving Population Health	**7**	Service Sustainability
3	Primary Care and Provider Services	**8**	Mental Health and Learning Disability
4	Integration – Bringing Care Closer to Home	**9**	Urgent and Emergency Care
5	Chronic Conditions Management & Local Delivery Plans	**10**	Planned Care

These SCPs seek to describe the key changes required over the next three years to enable the UHB to address significant challenges and to realise the vision set out in the Clinical Futures Strategy by:

- Increasing the focus on helping people and communities stay healthy.
- Meeting the needs of a growing ageing population and people with chronic disease.
- Addressing disparities in low socioeconomic populations.
- Providing care in the most appropriate setting and in a timely manner.
- Improving access to a range of services delivered through Neighbourhood Care Network teams and improving patient flow across the system.
- Developing a workforce that will meet future needs and provide a flexible, challenging, safe and satisfying work environment.
- Realising the benefits of our integrated health system by adopting quality clinical practices including standardising pathways of care, anticipating needs, fostering innovation and promoting better outcomes.
- Improving information and measurement systems to support decision making and delivery.

The Figure below illustrates how these programmes align and the intended outcomes or contribution they make to deliver our vision.

Figure 7.2



There will be a shift in the balance of services to Neighbourhood Care Networks, by increasing the range of hospital based services that will be delivered in primary and community care settings and there will be seamless collaboration between practitioners across the whole system. This will necessitate working very differently to focus on supporting patients in a primary care setting, through direct patient contact, indirect support to NCN teams and remote monitoring for patients.

Significant enabling plans related to finance, infrastructure, workforce, delivery and information technology are being developed and aligned with the priorities and outcome targets identified in each of the Service Change Plans.

In addition to the Service Change Plans, the UHB has developed a comprehensive series of Local Delivery Plans (LDPs) based on the *Together for health* national delivery plans, covering the following:

Table 7.5

Local Delivery Plan	SCP	Local Delivery Plan	SCP
Heart Disease	5	Cancer	10
Diabetes	5	End of life care	3
Critically ill	9	Stroke	5
Respiratory	5	Neurological conditions	5
Liver	5	Mental health	8
Primary care	3	Maternity	Divisional Plan
Oral health	3 & 10	Eye health	3 & 10

Many of these contribute to the SCPs previously described with the majority mapped to SCP 5. Each LDP has a clinical lead and a managerial lead, together with an Executive sponsor.

The ten SCPs are set out in more detail below. The majority have been refreshed for 2016-18 building on the progress achieved in year 1 (2015/16). A small number have however been rewritten (e.g. SCPs 3, 4 and 5) in response to internal structural changes necessitating some realignment of schemes.

SCP 1 – Reducing Health Inequalities

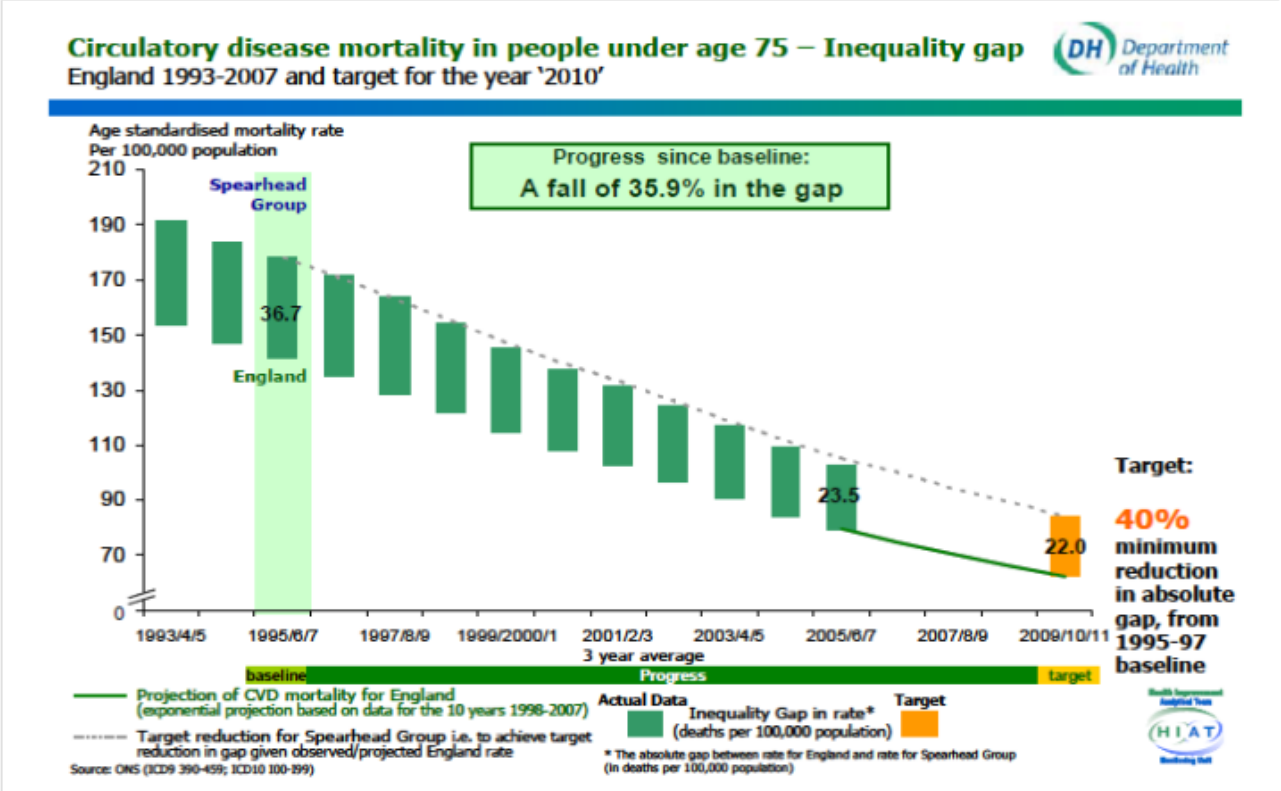
Aim
The aim of this Service Change Plan is to reduce health inequalities across the UHB's area. This has been achieved elsewhere in the UK (Graph 7.1.1) through systematic, population scale programmes targeted to areas of poorest health.

The principle underpinning this Service Change Plan is 'proportionate universalism', a term defined by Sir Michael Marmot to explain that to reduce health inequalities;

> "actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage"[1].

This is because focusing all efforts on 'the most disadvantaged will not reduce health inequalities sufficiently'.[2]

Graph 7.1.1 - Reduction in the inequality gap in premature mortality in circulatory disease for the Spearhead Group of Primary Care Trusts and the population average[3]



Baseline Position

Health inequalities across the UHB's area have proved persistent and difficult to change (Graph 7.1.2 and 7.1.3). The measure of success of this Service Change Plan will be a narrowing of the gap in premature mortality (death under 75 years) between the most deprived fifth of the population and the population average.

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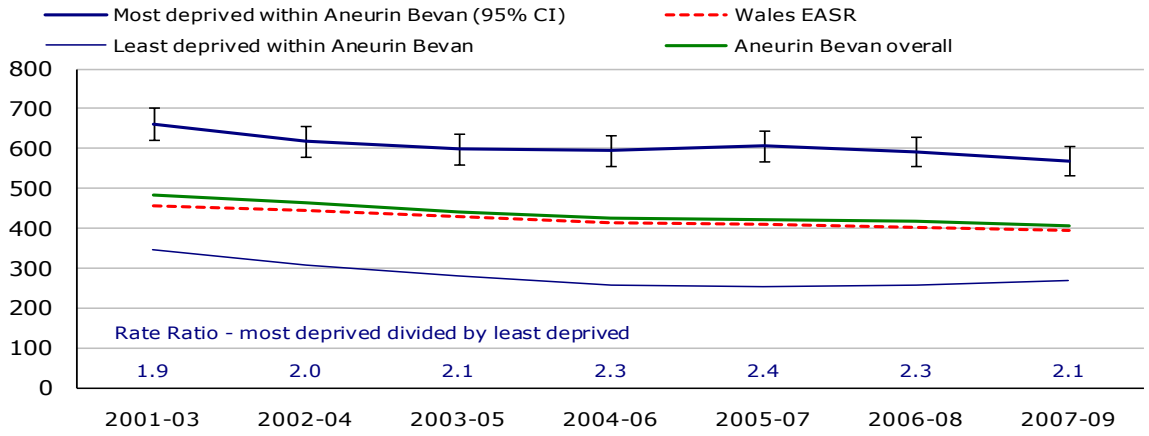
[1] Marmot, M (2010) Strategic review of health inequalities in England post-2010 *Fair Society, Healthy Lives The Marmot Review.* [Online] The Marmot Review. Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review [Accessed 12January 2015]

[2] *See above*

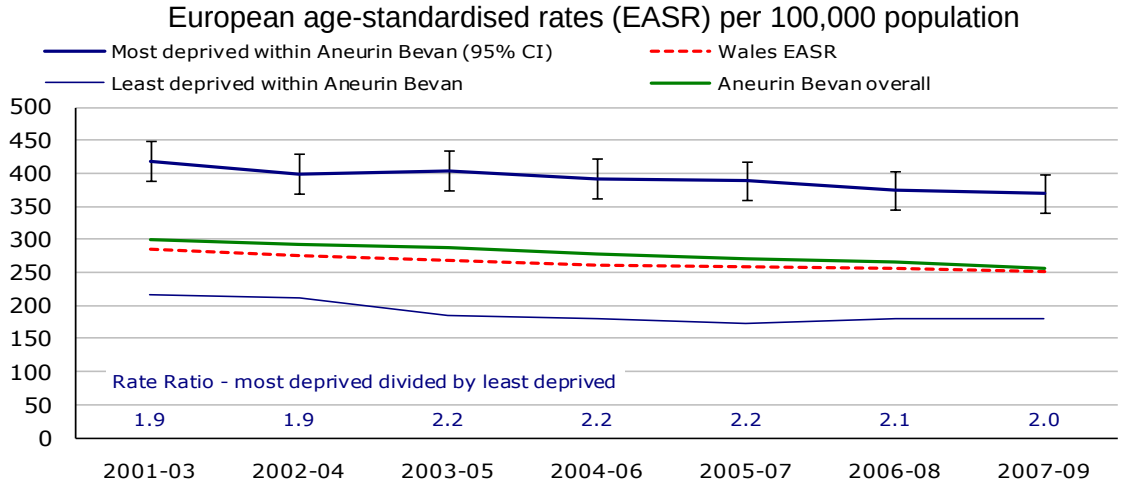
[3] Department of Health (2007) *Mortality Target Monitoring.* [Online] London: DH. Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088873.pdf [Accessed 13 January 2015]

Graph 7.1.2 - Mortality in males under 75 in Aneurin Bevan[4]



Produced by the Public Health Wales Observatory, using ADDE/MYE (ONS), WIMD 2008 (WG)

Graph 7.1.3 - Mortality in females under 75 in Aneurin Bevan[5]



Produced by the Public Health Wales Observatory, using ADDE/MYE (ONS), WIMD 2008 (WG)

This Service Change Plan is the UHB's strategy to meet the requirements of the Welsh Government 'Tackling Poverty Strategy'. And sets out a systematic, population scale programme to increase the prevention, early identification and optimal primary care management of heart disease, stroke, diabetes, cancer and liver disease in the most deprived parts of the Heath Board's area, where the rates of these diseases are highest. The programme will start to reverse the 'Inverse Care Law', as defined by Dr Julian Tudor Hart, namely:

> *"the availability of good medical care tends to vary inversely with the needs of the population served."*[6]

Why reducing health inequalities matters

Reducing health inequalities across the ABUHB area matters because, on average, there is nearly a 9 year difference in average life expectancy at birth between men in the very least and very most

[4] Public Health Wales Observatory (2011). *Measuring inequalities: Trends in mortality and life expectancy in Aneurin Bevan.* [Online] NHS Wales. Available at http://www.wales.nhs.uk/sitesplus/922/page/58379 [Accessed 12 January 2015]

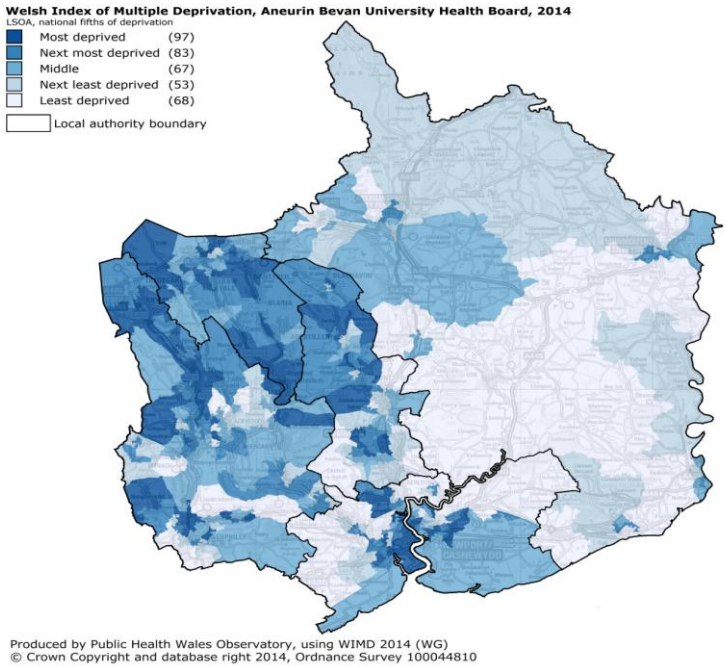
[5] *See above*

[6] Tudor Hart J (1971) *The Inverse Care Law* [Online] The Lancet: 297; 7696 405-412. Available at: http://www.sciencedirect.com/science/article/pii/S014067367192410X# [Accessed 20 January 2015]

deprived fifths of the population and around a 20 year difference in healthy life expectancy[7]. A similar pattern is true for women too (see Graph 7.1.2 and Graph 7.1.3). This gap can be explained by differences in rates of disease attributable to different lifestyle risk factors, rates of early diagnosis and access to optimal treatment. Much of the inequality in health is due to heart disease, stroke, cancer, diabetes and liver disease.

Evidence suggests that, as well as the burden of ill health for individuals, health inequalities also have economic consequences for society. It has been estimated that health inequalities costs the economy approximately £31-33 billion per year in loss of productivity and £20-32 billion per year in lost taxes and higher welfare payments[8]. Treatment of the disease outcomes of these health inequalities consumes approximately a third of the NHS budget, with direct treatment costs in England amounting to around £5.5 billion per year[9]. Reducing the current rate of heart disease, stroke, cancer, diabetes and liver disease for the most deprived fifth of the population to nearer the rate for the least deprived fifth would make a significant contribution towards the UHB's ability to achieve.

Figure 7.1.1- Local fifths of deprivation in Aneurin Bevan University Health Board[10]



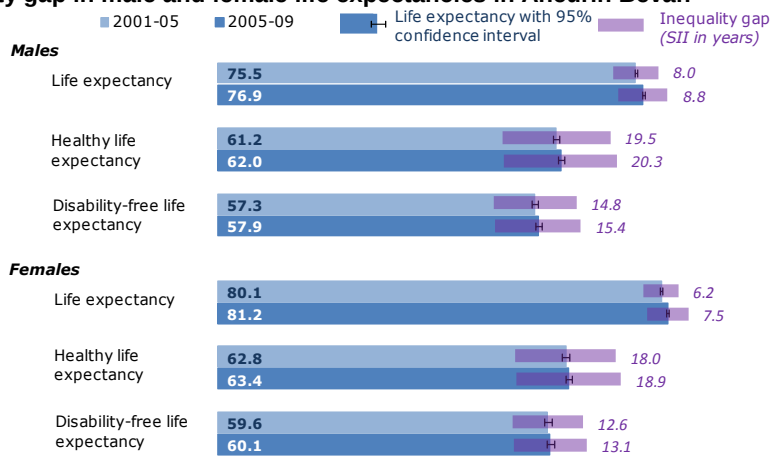
[7] Public Health Wales Observatory (2011). *Measuring inequalities: Trends in mortality and life expectancy in Aneurin Bevan.* [Online] NHS Wales. Available at http://www.wales.nhs.uk/sitesplus/922/page/58379 [Accessed 12 January 2015]

[8] Marmot, M (2010) Strategic review of health inequalities in England post-2010 *Fair Society, Healthy Lives The Marmot Review.* [Online] The Marmot Review. Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review [Accessed 12January 2015]

[9] *See above*

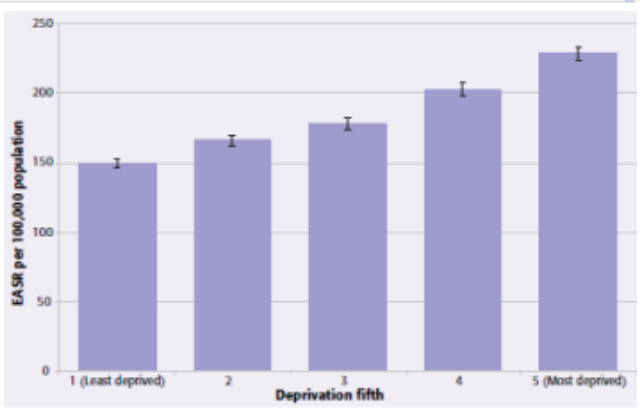
[10] Public Health Wales Observatory (2014) *Welsh Index of Multiple Deprivation 2014 Health Board Map.* [Online] NHS Wales. Available at: http://www.wales.nhs.uk/sitesplus/922/page/76683 [Accessed 12 January 2015]

Graph 7.1.4 - Inequality gap in male and female life expectancies in Aneurin Bevan[11]



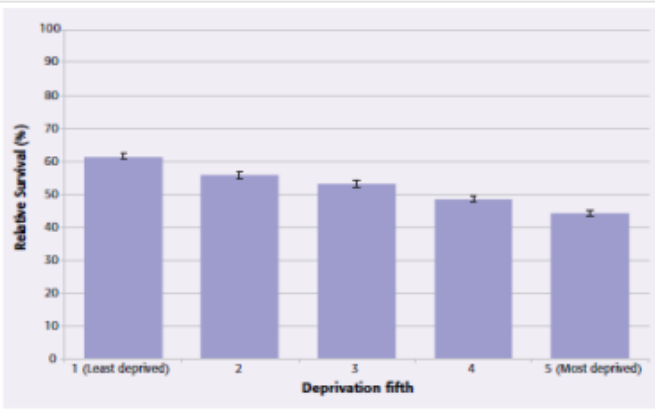
Inequalities are particularly evident in cancer incidence, mortality and survival. Cancer incidence is 20 per cent higher in the most deprived areas compared with the least, whilst mortality is 50 per cent higher (Graph 7.1.5), which reflects the gradient in survival. The chance of survival at five years is 28 per cent less in the most deprived areas compared to the least (Graph 7.1.6).

Graph 7.1.5 - Gradient of cancer mortality rate (EASR) for areas with increasing deprivation (fifths) in Wales, persons of all ages, 2007-2011[12]



Source: Welsh Cancer Intelligence and Surveillance Unit's Cancer Registry
www.wcisu.wales.nhs.uk

Graph 7.1.6 - Five year cancer survival gradient for areas with increasing deprivation (fifths) in Wales, persons of all ages, 2003-2007[13]



Source: Welsh Cancer Intelligence and Surveillance Unit's Cancer Registry
www.wcisu.wales.nhs.uk

The difference in both life expectancy and healthy life expectancy is illustrated clearly by the almost five-fold difference in premature mortality rates from circulatory disease between people living in the most deprived parts of the UHB area compared to the rates for the least deprived parts of the UHB area (Figure 7.1.2). For emergency hospital admissions, there is around a 2.5 times higher rate for people living in the most deprived parts of the UHB area compared to the rates for least deprived parts of the UHB area (Figure 7.1.3).

[11] Public Health Wales Observatory (2011). *Measuring inequalities: Trends in mortality and life expectancy in Aneurin Bevan.* [Online] NHS Wales. Available at http://www.wales.nhs.uk/sitesplus/922/page/58379 [Accessed 12 January 2015]
[12] Public Health Wales; Welsh Cancer Surveillance and Intelligence Unit. (2014) *Cancer in Wales A summary report of population cancer incidence, mortality and survival – includes new 2012 data released as official statistics on 9th April 2014.* [Online] NHS Wales. Available at http://www.wcisu.wales.nhs.uk/sitesplus/documents/1111/CANCERinWALESapril2014FINAL%28Eng%29.pdf [Accessed 12 January 2015]
[13] *See reference above*

Figure 7.1.2 - Mortality from circulatory disease in Aneurin Bevan University Health Board, persons aged under 75 year, 2004-2008[14]

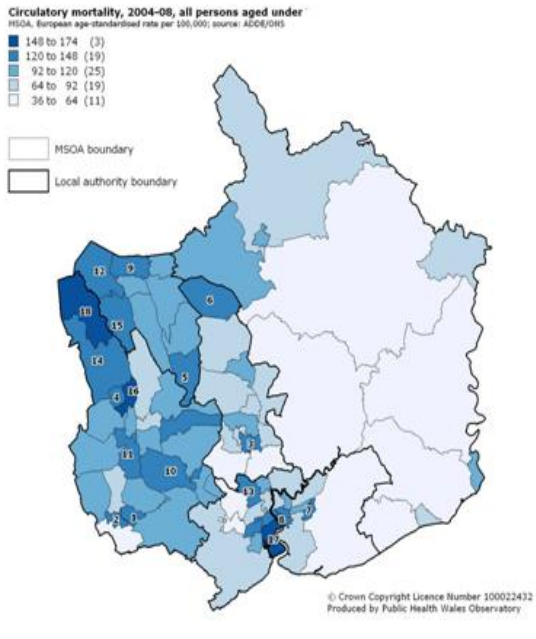
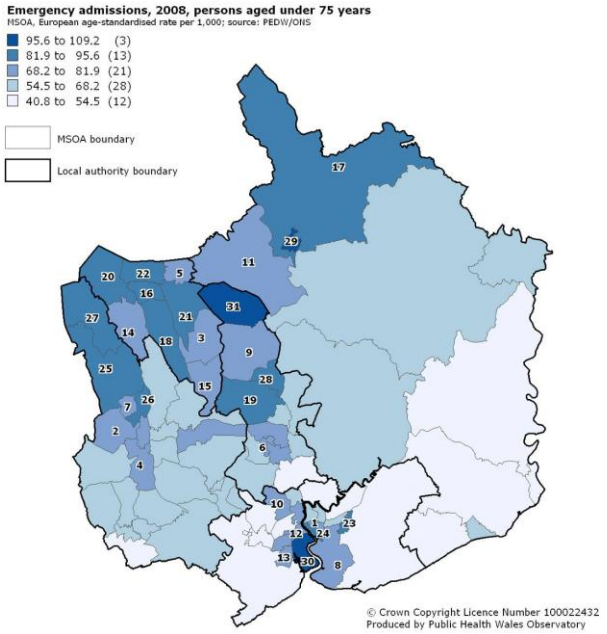


Figure 7.1.3 - Emergency hospital admissions in persons aged under 75 years, in Aneurin Bevan University Health Board, in 2008[15]



1.1 The Living Well Living Longer Programme

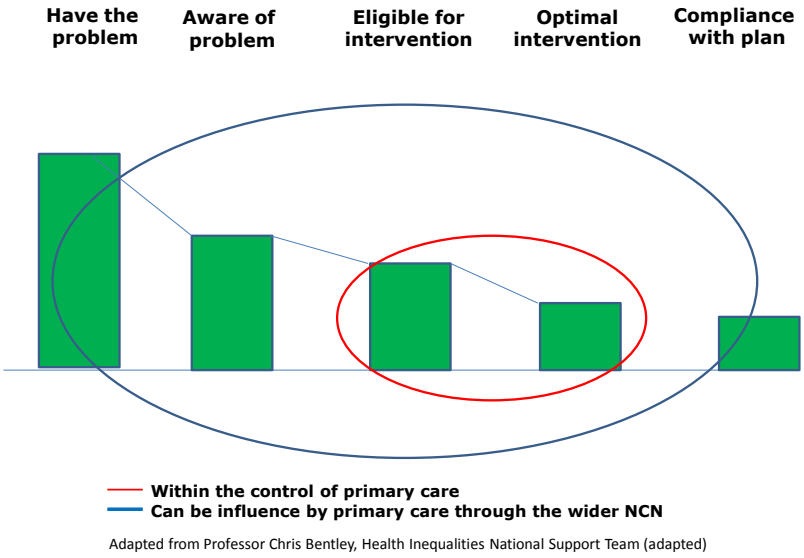
The UHB's Living Well Living Longer programme has been designed to have population impact on inequalities in health over a three to five year time period, through a systematic, population scale approach to addressing the 'implementation decay' of proven, effective interventions (Figure 7.1.4). This term explains *'the loss of potential impact of evidence based interventions, particularly in vulnerable communities'*[16].

The programme will address inequalities in access to primary healthcare (the 'Inverse Care Law') and develop a sustainable primary care system for identification and management of chronic cardiovascular disease, cancer and diabetes, in the areas of highest need. The programme is being planned and implemented through the Neighbourhood Care Networks (primary care clusters) covering the most deprived areas within the UHB area.

The Living Well Living Longer programme has been designed to meet the requirements of the Welsh Government's 'Tackling Poverty Strategy'. It will begin to reverse the 'Inverse Care law' and over time will increase healthy life expectancy. The Living Well Living Longer programme is a core part of the UHB delivery plans for heart disease, stroke, diabetes and liver disease.

[14] Public Health Wales Observatory (2010) *Health needs assessment support 2010: key small area indicators Aneurin Bevan Health Board.* [Online] NHS Wales. Available at: http://www.wales.nhs.uk/sitesplus/922/page/49835 [Accessed 20 January 2015]
[15] Public Health Wales Observatory (2010) *Health needs assessment support 2010: key small area indicators Aneurin Bevan Health Board.* [Online] NHS Wales. Available at: http://www.wales.nhs.uk/sitesplus/922/page/49835 [Accessed 20 January 2015]
[16] Bentley, C. [Online] Available at: http://www.shu.ac.uk/research/hsc/about-us/professor-chris-bentley [Accessed 20 January 2015]

Figure 7.1.4 - The 'implementation decay' of proven, effective interventions and the spheres of control and influence on these interventions within primary care and wider Neighbourhood Care Networks (NCNs) [17]



Identification and reduction of risk of cardiovascular disease

The initial focus of the Living Well Living Longer programme will be on the identification and reduction of cardiovascular disease (CVD) risk through lifestyle changes and medication when required. For people at risk of CVD, the programme will increase the proportion on optimal management by addressing the 'implementation decay' of proven, effective interventions. The programme will enable primary care to work more closely with local people and communities to reverse the 'Inverse Care Law'.

Reducing inequalities in cancer incidence and survival

A UHB strategy for addressing cancer inequalities is being developed, covering five cancers of particular population health significance: lung, colorectal, head and neck, breast and liver cancers. The focus of the initial phase of the strategy being delivered through the Living Well Living Longer programme is the prevention of cancer by tackling the major modifiable lifestyle risk factors and encouraging uptake of cancer screening programmes.

The focus of the next phase of the strategy will be early diagnosis and referral of patients with cancer and will cover health seeking behaviour of patients, improving symptom awareness in both patients and professionals and further increasing uptake of screening services. The next phase of the strategy will be informed by an analysis of the results of the audit of new cases of lung and gastrointestinal cancer being undertaken by GP practices as part of the General Medical Services contract.

Reducing inequalities in health due to lifestyle risk factors

The shorter healthy life expectancy and premature mortality rates in the most deprived parts of the UHB area are in large part attributable to the higher rates of lifestyle risk factors in those areas (Figures 7.1.6 and 7.1.7). Inequalities in lifestyle risk factors have a large economic burden for society. Treatment of inequalities in health from obesity alone is estimated to cost around £2 billion per year in England and Wales, with a predicted rise to nearly £5 billion per year by 2025[18].

The Living Well Living Longer programme will co-produce with communities a network of support for people to make healthy changes to their lifestyle (stop smoking, increase their physical activity,

[17] Aneurin Bevan University Health Board (2014) *2014/15-2016/17 Integrated Medium Term Plan.* [Online] NHS Wales. Available at: http://www.wales.nhs.uk/sitesplus/866/opendoc/237980 [Accessed 10 January 2015]
[18] Marmot, M (2010) Strategic review of health inequalities in England post-2010 *Fair Society, Healthy Lives The Marmot Review.* Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review [Accessed 12January 2015]

eat a healthier diet, lose weight, drink less alcohol), building on local assets and developing sustainable approaches. Communities First will have a critical role in developing the network, in conjunction with Neighbourhood Care Networks and building on existing community assets such as housing associations and health champions. The programme will include a new team of health trainers to support people at high risk of heart disease, stroke and diabetes, to set and achieve personal goals to reduce this risk through lifestyle modification.

Figure 7.1.5 - Alcohol-specific hospital admissions in Aneurin Bevan University Health Board[19]

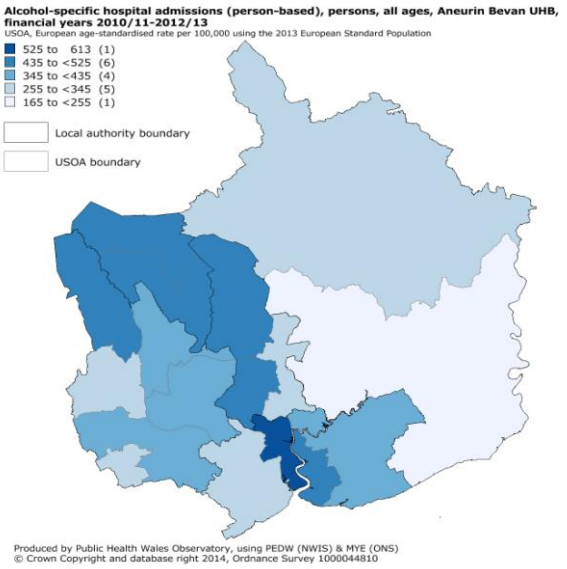
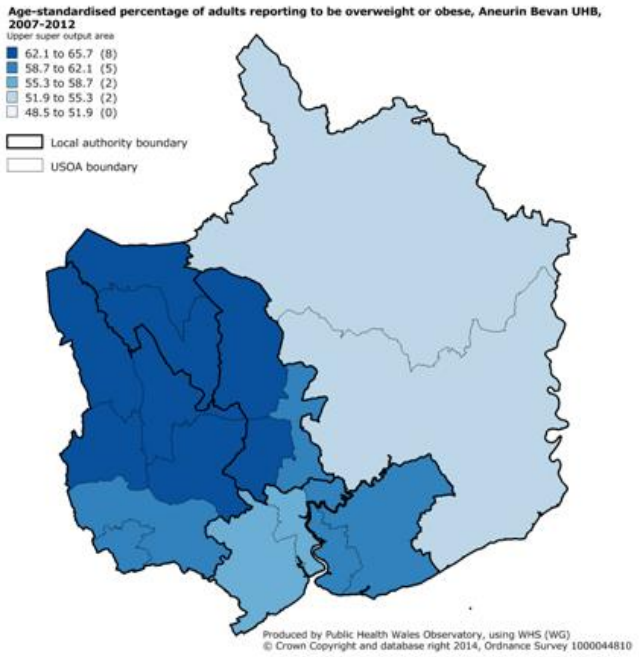


Figure 7.1.6 - Percentage of adults who are overweight or obese in Aneurin Bevan University Health Board[20]



1.2 Reducing Inequalities in Child Health

As well as action to reduce inequality in healthy life expectancy for today's adults, the Welsh Government's 'Tackling Poverty Strategy' encompasses action to reduce inequalities in health which both increase the risk of illness and death in infancy and the risk of cardiovascular disease and diabetes in adult life. A Gwent regional action plan has been developed in a partnership between the UHB, Public Health Wales and the Local Authority Anti-Poverty Champions. The plan focuses primarily on prevention of smoking and smoking cessation (particularly during pregnancy) and reducing teenage conceptions.

1.3 Homeless People and Vulnerable Groups

Homeless people and other vulnerable populations experience significant ill-health, often have complex needs, and have worse health outcomes than the general population. A health needs assessment for homeless people has been completed and is informing the development of a UHB Homeless People and Vulnerable Groups' Health Action Plan, including some reorientation of dental service provision. A health needs assessment for asylum seekers and refugees has been completed. This is informing the delivery of the Living Well Living Longer programme to ensure that the programme reaches these groups. The UHB is also working with local authority partners on the Syrian Resettlement Programme and is represented on the Operational Delivery Board at a national level.

[19] Public Health Wales Observatory (2014) *Alcohol and health in Wales 2014 Aneurin Bevan UHB Summary*. [Online] NHS Wales. Available at: http://www.wales.nhs.uk/sitesplus/901/news/34433 [Accessed 21 January 2015]

[20] Public Health Wales Observatory (2014) *Welsh Health Survey obesity resource: key outputs Aneurin Bevan UHB July 2014* [Online] NHS Wales. Available at: http://howis.wales.nhs.uk/sitesplus/922/page/60386 [Accessed 21 January 2015]

Key Milestones for Delivery of SCP 1 - Reducing Health Inequalities

Table 7.1.1

Reducing Inequalities in Child Health	
Reduce the gap between the rate of those reaching the age of 2 years, who are fully up to date with scheduled childhood immunisations, across all NCN's	Q4 2016/17
Reduce the gap between the rate of those reaching the age of 4 years, who are fully up to date with scheduled childhood immunisations, across NCN's	Q4 2017/18

Table 7.1.2

Reducing inequalities in Lifestyle Risk Factors and Mental Health	
Community Health Champions network extended in Blaenau Gwent East NCN area	Q1 2016/17
Working with Communities First in Blaenau Gwent East NCN area, complete mapping of services to support people to change their lifestyle (stop smoking, increase their physical activity, eat a healthier diet, lose weight, drink less alcohol), including services to improve mental wellbeing and make it easier to make lifestyle changes	Q1 2016/17
Community Health Champions network extended in Newport West NCN and Newport East NCN areas	Q3 2016/17
Working with Communities First in Newport East NCN and Newport West NCN areas, complete mapping of services to support people to change their lifestyle (stop smoking, increase their physical activity, eat a healthier diet, lose weight, drink less alcohol), including services to improve mental wellbeing and make it easier to make lifestyle changes	Q3 2016/17
Mental Wellbeing Foundation Tier reviewed and action taken to ensure access to services that culturally appropriate and accessible for Black and Minority Ethnic communities in Newport East and Newport West NCN areas	Q3 2016/17
Working with Communities First in all NCN areas with a Communities First area, complete mapping of services to support people to change their lifestyle (stop smoking, increase their physical activity, eat a healthier diet, lose weight, drink less alcohol), including services to improve mental wellbeing and make it easier to make lifestyle changes	Q4 2017/18
Community Health Champions network extended and delivered through NCN partners in all areas of high disease prevalence	Q4 2018/19
Working with NCN partners in all areas of high disease prevalence, complete mapping of services to support people to change their lifestyle (stop smoking, increase their physical activity, eat a healthier diet, lose weight, drink less alcohol), including services to improve mental wellbeing and make it easier to make lifestyle changes	Q4 2018/19

Table 7.1.3

Reducing avoidable inequalities in heart disease, stroke, cancer, diabetes, respiratory disease and liver disease through access to preventative healthcare	
Implement campaign to raise public awareness of lung cancer symptoms and encourage early presentation to primary care, particularly in deprived populations	Q2 2016/17
Blood Borne Virus action plan agreed for awareness raising and testing among vulnerable high risk groups, in line with the Liver Disease Delivery Plan and ABUHB review of the BBV Hepatitis Action Plan for Wales	Q2 2016/17
A 'Health Check' for CVD, cancer and diabetes risk assessment and management programme offered to all eligible adults in Caerphilly North and Blaenau Gwent East NCN areas through the Living Well Living Longer programme	Q3 2016/17
Scope business case for outreach service for homeless and vulnerable groups, including an expansion to the existing Asylum Seeker service for	Q3 2016/17

Reducing avoidable inequalities in heart disease, stroke, cancer, diabetes, respiratory disease and liver disease through access to preventative healthcare	
refugees arriving through the Syrian Vulnerable Persons Resettlement Scheme	
Increase the level of, and reduce the gap in uptake of cancer screening programmes at NCN level	Q4 2016/17
Implement learning from the primary care cancer significant events audit	Q4 2016/17
Increase the level of, and reduce the gap in influenza vaccine uptake in all at risk groups at NCN level.	Q4 2016/17
A 'Health Check' for CVD, cancer and diabetes risk assessment and management offered to all eligible adults in Newport West and Newport East NCN areas through the Living Well Living Longer programme	Q4 2017/18
Tailored smoking cessation services scoped for population groups with high smoking prevalence (e.g. prisoners, people with mental health problems)	Q4 2017/18
Complete initial evaluation of the Living Well Living Longer programme	Q4 2017/18
Increase the level of, and reduce the gap in influenza vaccine uptake in all at risk groups at NCN level.	Q4 2017/18
Increase the level of, and reduce the gap in uptake of cancer screening programmes at NCN level	Q4 2017/18
A sustainable 'Health Check' system of CVD, cancer and diabetes risk assessment and management established in Blaenau Gwent West & East, Caerphilly North and Newport East & West NCN areas	Q4 2018/19
Complete Equity Audit of uptake of the 'Health Check' system by Homeless and Vulnerable Groups	Q4 2018/19
Increase the level of, and reduce the gap in influenza vaccine uptake in all at risk groups at NCN level.	Q4 2018/19
Increase the level of, and reduce the gap in uptake of cancer screening programmes at NCN level	Q4 2018/19

Table 7.1.4

Wellbeing of Future Generations Act	
Agree ABUHB membership of Gwent Public Service Boards (PSBs)	Q1 2016/17
Scope the opportunities to apply the Sustainable Development principle and five ways of working to ABUHB activity.	Q2 2016/17
Contribute to the Gwent Strategic Wellbeing Assessment process	Q3 2016/17
Advocate for implementation of the Gwent Childhood Obesity Strategy by PSBs	Q3 2016/17
Set ABUHB Wellbeing Objectives	Q4 2016/17
Agree ABUHB element of PSB Wellbeing Plans	Q4 2017/18

Desired Outcomes and Quantifiable Benefits

Table 7.1.5

Living Well Living Longer Programme	2016/17	2017/18	2018/19
Number of eligible adults offered a Health Check	11,584	27,817	To be determined subject to funding
Eligible adults having a Health Check (50% uptake)	5792	13909	To be determined subject to funding

Resource Implications

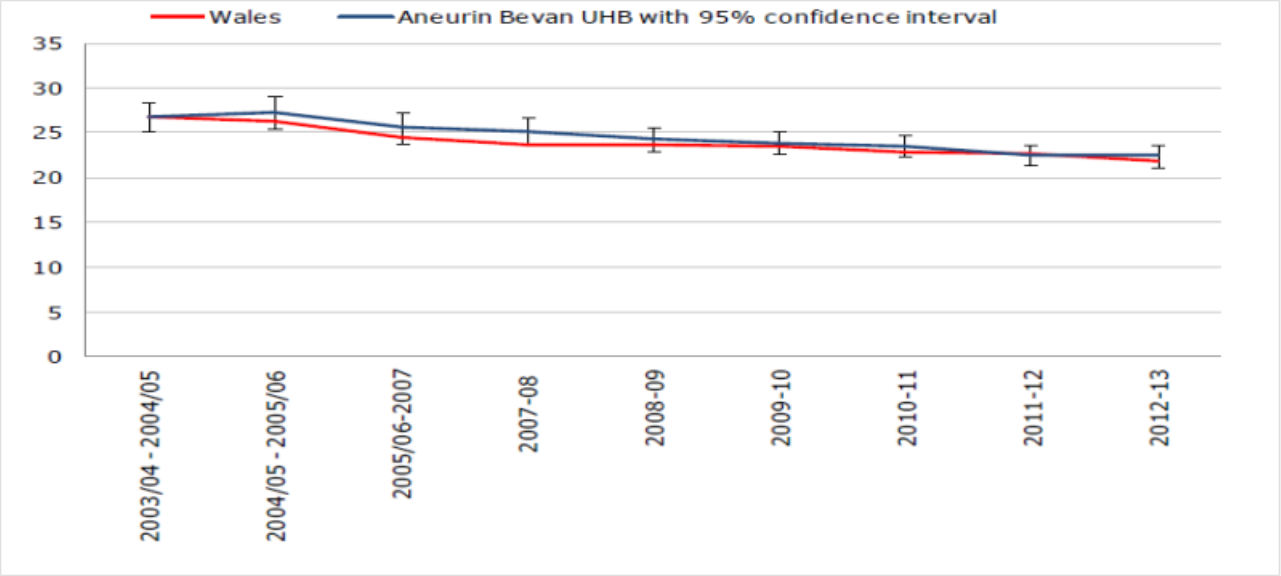
The workforce and financial implications of this SCP are included within the UHB's workforce and financial plans.

SCP 2 - Prevention and Improving Population Health

Aim
The aim of this Service Change Plan is to improve the health and wellbeing of the UHB's population which will benefit both individuals and the sustainability of our healthcare system. The measures of success will include achieving the Welsh Government ambition to reduce the proportion of the population who smoke from the current 22% to 16% by 2020, a reduction of around 30,000 smokers, from an estimated 105,000 to 75,000 adults[21].

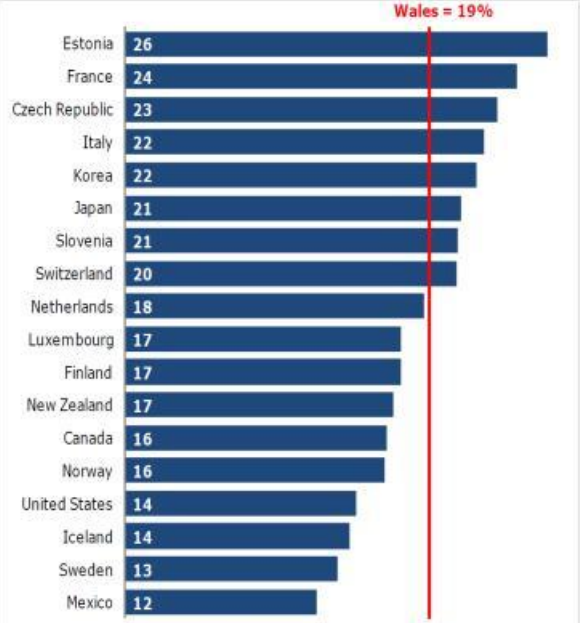
The percentage of people who smoke in Wales had been declining since the late 1970s; however, over the last decade, this decline has slowed (Graph 7.2.1). Data from 2012 demonstrated that the percentage of adults smoking *daily* was higher in Wales than several other European and international comparators, including the USA and Canada (Graph 7.2.2). However this data has also shown that the Welsh Government's target of 16% of the population smoking has been achieved in other countries (Graph 7.2.2). The percentage of people smoking *daily or occasionally* in the UHB is in line with the national percentage, at 22%, however there is marked variation in this across the Health Board, with higher levels in areas of greater deprivation, such as Blaenau Gwent and Torfaen, where percentages of smokers are above the national average (Graph 7.2.3).

Graph 7.2.1 - Percentage of adults who reported smoking *daily or occasionally*, Aneurin Bevan UHB and Wales, age-standardised, persons aged 16+, 2003/4 – 2013[22]

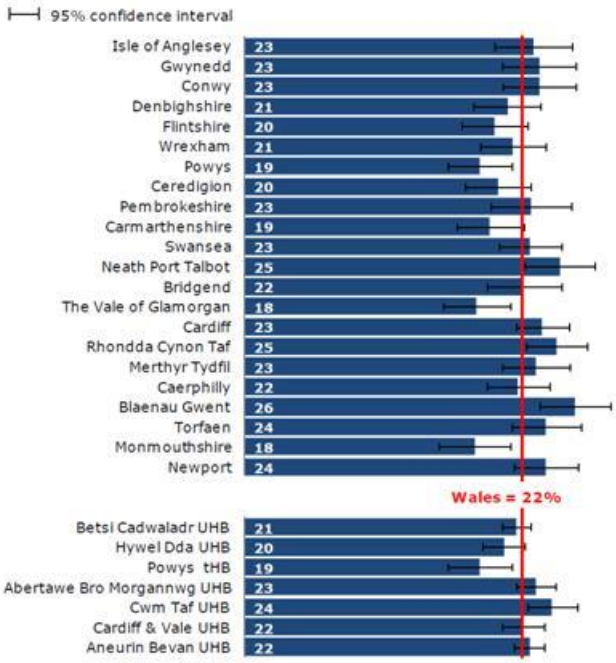


[21] Data from Public Health Wales Observatory, using Welsh Health Survey 2012-13
[22] Graph produced by Public Health Wales Observatory (2015), using Welsh Health Survey (WG)

Graph 7.2.2 - Percentage of adults who reported smoking *daily*, Wales and selected Organisation for Economic Co-operation and Development (OECD) countries, 2012[23]



Graph 7.2.3 - Percentage of adults who are overweight or obese in Aneurin Bevan University Health Board[24]



Why it is important to improve population health

As well as the burden of preventable disease for the individuals, the current scale of preventable disease due to lifestyle risk factors is putting NHS treatment services under considerable strain and there is a high risk that the projected increase in lifestyle related disease will create an unsustainable strain on NHS services and finances. Reducing the proportion of the population who smoke, who are obese and who drink harmful amounts of alcohol would have population impact on rates of heart disease, stroke, diabetes, cancer and liver disease. The aim of this Service Change Plan is to help large numbers of people to stay healthy and to reduce demand for treatment services for preventable conditions, thereby reducing system-wide costs and delivering best value from the NHS.

This plan builds on the achievements of the UHB's Public Health Strategic Framework 2011 - 2015, with the continued aspiration that:

- Babies are born healthy.
- Pre-school children are safe, healthy and develop their potential.
- Children and young people are safe, healthy and equipped for adulthood.
- Working age adults live healthy lives for longer.
- Older people age well into retirement.
- Frail people are happily independent.

The plan encompasses actions that will have different gestation times before they have an impact on population health. Some actions will have population impact over a relatively short time period of three to five years, some over a ten year period and others over a twenty year period or longer.

[23] Figure produced by Public Health Wales Observatory (2015), using Welsh Health Survey (WG) and OECD data

[24] Public Health Wales Observatory (2014) *Welsh Health Survey obesity resource: key outputs Aneurin Bevan UHB July 2014* [Online] NHS Wales. Available at: http://howis.wales.nhs.uk/sitesplus/922/page/60386 [Accessed 21 January 2015]

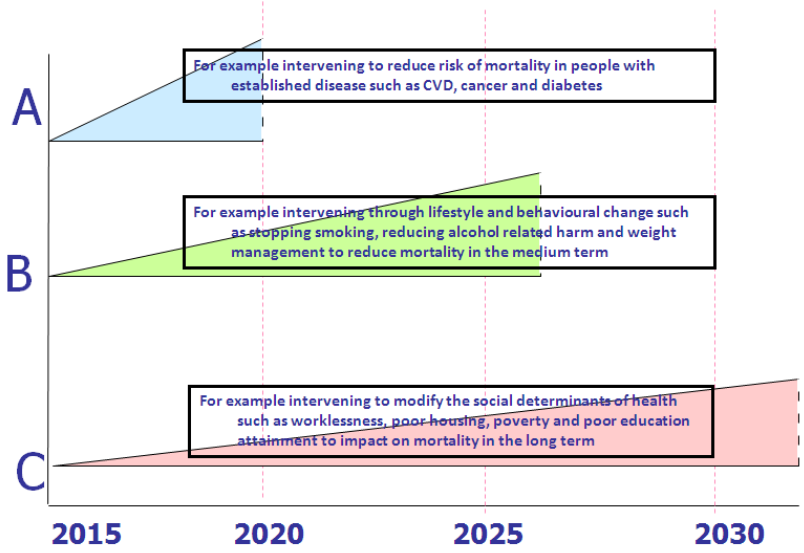
Population scale health improvement services

To achieve impact at a population scale will necessitate reaching thousands of adults living in the UHB area to encourage and support them to make lifestyle modifications to reduce their risk of preventable disease. The scale of the challenge can be determined from the results of the 2013 Welsh Health Survey which tells us that in the UHB adult population, approximately:

- 22% of adults are smoking, which is 105,500 people[25].
- 26% of adults are obese, which is 121,100 people[26].
- 42% of adults are drinking 'above guidelines', which is 195,600 people[27] .
- At least 1 in 6 adults in Gwent experiencing poor mental health, which 95,741 adults.

The UHB's plans for scaling up smoking cessation, weight management and alcohol treatment services are described below. In addition the plan for increasing the provision of support to improve mental wellbeing, beyond the provision of Primary Mental Health Support Services (referred to as the Foundation Tier), is outlined below.

Graph 7.2.4 - Gestation time to impact of different interventions on population health[28]



Making Every Contact Count

Providing information and support to thousands of people to modify their lifestyles can only be achieved through the thousands of contacts that NHS services have with the adult population on a daily basis. There is a role for the UHB's partners too, to use the thousands of contacts they have with people, to provide information and advice about making healthy lifestyle changes. This scheme is therefore called 'Make Every Contact Count'. Key milestones are outlined below.

Achieving high population immunisation levels

The UHB has a work programme aimed at improving immunisation levels because immunisation is one of the most cost effective interventions for improving population health through prevention of serious infectious disease.

[25] Data from Public Health Wales Observatory, using Welsh Health Survey 2012-13; 95% confidence intervals for adults smoking are (21% - 24%) and (99,800 – 111,200 people)

[26] Data from Public Health Wales Observatory, using Welsh Health Survey 2012-13; 95% confidence intervals for adults who are obese are (25% - 27%) and (115,300 – 127,000 people)

[27] Data from Public Health Wales Observatory, using Welsh Health Survey 2012-13; 95% confidence intervals for adults who are drinking 'above guidelines' are (40% - 43%) and (188,900 – 202,200 people)

[28] Adapted from Bentley, C and Leaman J: Health Inequalities National Support Team. *Priority actions based upon best practice that could impact inequalities in mortality and life expectancy in the short term.* [Online] London: DH. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215329/dh_130949.pdf [Accessed 18 January 2015]

Addressing the social determinants of health
The health of individuals and the population of Gwent as a whole is affected by multiple factors and individual life chances including genetic make-up, education, employment prospects, the socio-economic environment in which we live, work and play, where we live, the presence of risks to health, individual lifestyle choices and access to health services and support. Taken together, these factors determine how healthy we are as individuals.

The UHB has a leadership responsibility for improving the health of the population in conjunction with partners on Local Service Boards and other partnerships. The forthcoming legislative requirement for Wellbeing Plans will strengthen the expectation that a partnership approach is adopted to address the social determinants of health. Local Authorities have a crucial role to play in improving population health, particularly through their influence on the physical environment and local communities. The UHB is working with all partners (the public, voluntary sector, Local Authorities, and independent sector e.g. Housing Associations) to collectively invest expertise and resources towards improving population health.

This SCP proposes using the World Health Organisation (WHO) Ottawa Charter (1986) framework for the organisation of partnership actions to address the social determinants of health[29]. That framework is:

- **Building healthy public policy**: putting health on the agenda of policy makers in all sectors and at all levels.
- **Creating supportive environments:** the creation of supportive environments, being aware of the impact of rapidly changing environments and working towards transforming physical, social, resource and political environments so that health can be more easily protected and improved.
- **Strengthening community action:** empowering communities to recognise their own problems, enable communities to seek to improve their own health through strengthening community action.
- **Development of personal skills:** supporting personal and social development through the provision of information and education for life enhancing skills.
- **Re-orientation of health services:** developing the prevention role of health services, moving beyond only providing clinical and curative services.

Interdependency with the Public Health Wales IMTP
This SCP has informed and is consistent with the Public Health Wales Integrated Medium Term Plan priorities (figure SCP 6.2.1). There is an interdependency between the two plans.

Aneurin Bevan UHB and the Aneurin Bevan Gwent Local Public Health team are working closely with Public Health Wales to plan and implement prevention and wellbeing programmes for 2016/17-2018/19. During Q3 and Q4 2015/16 a series of national workshops have taken place between PHW and local public health teams and LHBs, on priority prevention topics. To date these have covered tobacco, childhood obesity, primary care and immunisation. The workshops have identified key areas for further work at national and local level, and ensure work undertaken by PHW and LHBs is aligned and avoids duplication or significant gaps in coverage.

An additional meeting took place in January 2016 between PHW and local public health team IMTP leads to discuss and co-ordinate the approach to planning. These workshops and meetings will occur annually (with operational meetings throughout the year as required) to feed into the planning cycles of the LHBs and PHW. The LHB Executive Directors of Public Health for the seven LHBs meet regularly as a group with PHW Executive Directors to discuss strategic public health issues.

[29] World Health Organisation (2015) *The Ottawa Charter for health promotion*. [Online] Geneva: WHO. Available at: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html [Accessed 9 January 2015]

Figure 7.2.1 - Public Health Wales Integrated Medium Term Plan priorities[30]

Source: adapted from Public Health Wales Strategy Map 2015-2019

Key Milestones for Delivery of SCP 2 – Prevention and Improving Population Health

Table 7.2.1

Healthy Children and Young People	
Maternal smoking cessation services reviewed and plan for further improvement agreed	Q4 2016/17
Improve the percentage of those fully up to date with the childhood immunisation at the age of 4 years towards the target level	Q4 2016/17
Improve coverage of 2 doses of MMR in children and young people up to 18 years of age	Q4 2016/17
Achieve UNICEF Baby Friendly accreditation in the community	Q4 2016/17
Increase the number of secondary schools taking a whole school approach to promoting healthy lifestyle choices through the Wales Network of Healthy Schools Scheme and PSHE teaching	Q4 2016/17
Childhood obesity delivery plan for ABUHB developed and implemented.	Q4 2016/17
Develop and implement an Integrated Weight Management Service for children and families (subject to funding)	Q4 2016/17
Implement Healthy Child Wales Programme	Q4 2016/17
Evaluate the delivery of the Childhood obesity delivery plan	Q4 2017/18
Develop a range of healthy weight services for children in NCN areas	Q4 2017/18 NCNs

Table 7.2.2

Reduce the population prevalence of heart disease, stroke, cancer, diabetes, respiratory disease and liver disease through universal, population scale healthy lifestyle services	
Make Every Contact Count (MECC) strategy agreed by ABUHB Board	Q1 2016/17
Establish an Alcohol Care Team at RGH and NHH, in conjunction with GDAS in-reach provision, and telephone support at YYF (subject to funding being identified).	Q1 2016/17

[30] Personal correspondence with Public Health Wales (2015)

Reduce the population prevalence of heart disease, stroke, cancer, diabetes, respiratory disease and liver disease through universal, population scale healthy lifestyle services	
Scope business case for the development of a GP Enhanced Service for Alcohol Misuse and GPwSI roles to NCN priorities and funding decisions	Q1 2016/17
Further development of the role of the UHB as a Responsible Authority under the Licensing Act 2003, building on the learning from successful representations and further developing data sharing	Q4 2016/17
Continue to advocate for a Minimum Unit Price for alcohol in advance of the expected new legislation in the Public Health Bill for Wales	Q4 2016/17
MECC training programme commissioned and evaluated	Q4 2016/17
Continue to deliver, evaluate and improve patient outcomes the Adult Weight Management Service	Q4 2016/17
Implement action plans to increase uptake of smoking cessation services to reach 5% target.	Q4 2016/17
Alcohol Care Team extended to 5 day working at RGH and NHH and 3 days at YYF (subject to funding).	Q1 2017/18
Epidemiological assessment of estimated incidence and prevalence of Alcohol Related Brain Damage (ARBD) completed and capacity modelling undertaken to meet current and future demand	Q2 2017/18
Scope business case for expanding the existing ARBD services	Q3 2017/18
Based on MECC evaluation outcomes extend MECC programme roll-out out to additional Divisions	Q4 2017/18
Develop a range of healthy weight services for adults in NCN areas	Q4 2017/18
Alcohol Care Team extended to 7 day working at RGH and assertive outreach service introduced for the most frequent attendees (subject to funding)	Q1 2018/19
Evaluate the impact of MECC programme across ABUHB and review strategy and MECC improvement plan.	Q4 2018/19
Full implementation of the All Wales obesity pathway (subject to funding)	Q4 2018/19

Table 7.2.3

Promote population mental wellbeing	
Gwent suicide and self-harm action plan 2016-2020 developed and signed off by Welsh Government (dependent on release of national guidance from WG)	Q4 2016/17
Suicide and Self Harm Prevention priority actions for 2016/17 agreed and implemented through Gwent Mental Health and Learning Disability Partnership Board	Q4 2016/17
Mental Health Third Sector Commissioning Strategy aligned with the strategic development of the Foundation Tier for Mental Wellbeing	Q4 2016/17
Guidance provided to NCN clusters (in areas not participating in Living Well Living Longer) to enable them to co-ordinate / commission effective Foundation Tier Mental Wellbeing provision	Q1 2017/18
Suicide and Self Harm Prevention priority actions for 2017/18 agreed and implemented through Gwent Mental Health and Learning Disability Partnership Board	Q4 2017/18

Table 7.2.4

Promote the Health and Wellbeing of ABUHB staff	
Develop and implement a staff influenza policy and deliver influenza immunisation programme to improve uptake amongst ABUHB staff to achieve 50% uptake.	Q4 2016/17
ABUHB Staff Food and Fitness guidelines implemented	Q4 2016/17
Deliver staff influenza immunisation programme and improve uptake	Q4 2017/18

Promote the Health and Wellbeing of ABUHB staff	
amongst ABUHB staff, with all Divisions achieving 50% uptake.	
Deliver staff influenza immunisation programme and improve uptake amongst ABUHB staff, with all Divisions achieving 50% uptake.	Q4 2018/19

Table 7.2.5

Keeping well in older age	
Deliver influenza programme and improve uptake amongst patients aged 65 years and older	Q4 2016/17
Deliver influenza programme and improve uptake amongst patients aged 65 years and older	Q4 2017/18

Desired Outcomes and Quantifiable Benefits

Table 7.2.6

Programme		**2016/17**	**2017/18**	**2018/19**
Childhood Obesity		24.6	24.6	24.00
Smoking Cessation		3.3% TOTAL 1.4% (SSW) 1.9% (ABUHB Pharmacy Level 3/Hospital Smoke Free Support Service)	4% 2.1% (SSW) 1.9% (ABUHB Pharmacy Level 3/ Hospital Smoke Free Support Service)	5% 2.8% (SSW) 2.2% (ABUHB Pharmacy Level 3/ Hospital Smoke Free Support Service)
Flu immunisation				
	Staff Flu immunisation	50.00	50.00	50.00
	Over 65's flu immunisation	67.00	70.00	70.00
	Under 65's at risk groups flu immunisation	48.00	50.00	55.00
	Pregnant women flu immunisation	75.00	75.00	75.00
Childhood Imms % uptake of childhood scheduled vaccines up to the age of 4:		**2016/17**	**2017/18**	**2018/19**
	5 in1 age 1	95.0%	95.0%	95.0%
	MenC age 1	95.0%	95.0%	95.0%
	MMR1 age 2	95.0%	95.0%	95.0%
	PCV age 2	95.0%	95.0%	95.0%
	HibMenC Booster age 2	95.0%	95.0%	95.0%

Resource Implications
The workforce and financial implications of this SCP are included within the UHB's workforce and financial plans.

SCP 3 - Primary Care, Networks and Community Services

Aim
The overall aim of this Service Change Plan (SCP) is to strengthen primary and community care in order to establish sustainable services that support the delivery of care closer to home. The aim is to provide person centred models of care as close to home as possible, focussed on prevention, early identification of problems, early intervention to respond to needs, comprehensive management of chronic conditions, preventing avoidable admissions to hospital and facilitating timely and effective discharge. However, our ability to deliver the necessary shift in service emphasis from hospital to home/the community will be dependent upon a wider service planning and provision focus which recognises the pivotal role of services provided by our partner organisations including social services, housing, third sector and independent sector. The emphasis of service planning and delivery will be predicated upon agreed, multiagency patient pathways. These services will be provided in partnership with patients using co-production as the means to maximise self management and decision making and ensure the appropriate support of a skilled, multiagency workforce which makes full use of the wider primary care team.

There are clear links, in this regard, between the work programmes cited for SCP3, and those set out in SCP1 (Reducing Health Inequalities), SCP2 (Health Prevention and Promotion), SCP4 (Bringing Care Closer to Home) and SCP5 (Chronic Conditions Management). In addition, and in the context of strengthening the primary care element of the Clinical Futures Strategy, work is underway by the UHB to develop a 'Care Closer to Home Strategy' that will articulate how a shift of focus from hospitals and illness to an integrated health and social care system will build capacity in out of hospital services and thus improve patient experience and outcomes. The Strategy will include all services delivered in primary care and will be underpinned by a five year delivery programme.

Recognising the wider context in which this SCP sits, the workstream areas cited focus on the development of wider primary and community care services.

3.1 Baseline Position

3.1.1 Primary Care
Primary care comprises those services which provide the first point of contact and care with the NHS for more than 90% of patients. Whilst General Practice is a core part of primary care, current and future service models will increasingly draw upon the expertise and function of community pharmacy, dentistry, optometry, therapy, nursing, health visiting and mental health services in order to broaden and extend appropriate points of service contact for patients. Primary Care also has a unique role in co-ordinating access for people to the wide range of services delivered by the whole healthcare system and the challenge now lays in making primary care the 'engine room of the NHS'.

In this UHB area, General Practice conducts approximately 12,000 consultations in their surgeries and around 600 home visits each day. Improving access and service quality within GP Practices is linked to the wider service improvement agenda of optimising patient outcomes and reducing overreliance on secondary care services through enabling patients to access services appropriately, based on identified patient need. In the context of the whole system, alignment of priorities across relevant SCP areas will ultimately ensure greater focus overtime on prevention and the management of patient demand primarily in primary care and the community. The UHB has implemented a range of schemes focused on improving access to General Practice. The schemes have contributed to an increase in Practice opening hours and extended hours opening, identified and reduced variation in capacity at Practice level and have included the use of technology such as facilitating online booking for patients through *My Health On Line*.

It is recognised that sustainable General Medical Services will be key to the delivery of future, community focused service models and yet there remain UK wide challenges in achieving this related to increasing workloads, linked to the need for GPs to manage patients with more complex conditions and coupled with current and projected workforce recruitment and retention issues. The workforce challenges also include staff turnover issues with high numbers of GPs either retiring or close to retirement. Whilst, to date, the UHB has not experienced the difficulties seen in other parts of Wales, recruitment is becoming a very real concern and requires support at an all Wales level in terms of workforce planning and education/training aimed at developing new roles as well as addressing skill mix needs. The UHB is currently developing strategies for supporting GP Practices to further develop skill mix and to consider the benefits of innovative new roles at a Practice level. This approach also includes the wider contractor professions in primary care.

There are currently 67 Optometry Practices across the UHB area which provides eye care services through the Welsh Eye Care Examinations. Additionally, the UHB commissions a number of Enhanced Services including mobile eye tests in hospital settings, intra-ocular pressure readings and post operative cataract reviews. Noting available specialist capacity across the Optometry Practices, the UHB has expanded the range of services provided closer to home including a Glaucoma Assessment Local Enhanced Service which has released capacity in specialist hospital based ophthalmology Services.

General Dental Services are provided by 107 dental practices and include UHB commissioned domiciliary dental services and minor oral surgery services. The UHB also commissions primary care orthodontic services from a number of dental practices. The UHB five year **Local Oral Health Plan** identifies opportunities for further increasing service provision in primary care settings, where clinically appropriate, including work with the Oral Health Advisory Group, in partnership with the Local Dental Committee, to optimise the provision of dental health services closer to home.

There are currently 129 Community Pharmacies across the UHB area which comprise of a mix of large corporate and small independent contractors. In addition to providing essential and advanced services, some Pharmacies provide a range of enhanced services, for example, flu immunisation and Level 2 and 3 smoking cessation. The UHB recognises the important role to be played by Community Pharmacies including harnessing the clinical skills and competencies of our Community Pharmacists to deliver “first point of contact”. This SCP explores options to optimise this, hitherto, underutilised clinical resource through closer working with GP Practices in order to improve access for patients and reduce service demand pressures on GPs. Enhanced services are also being provided in the out of hours period to support the Primary Care Urgent Out Of Hours Service through the provision of emergency supply of medicines and extension of opening hours enabling repeat prescriptions activity to be diverted at the call handling stage. In addition, further work is underway to maximise the service community pharmacies can provide for people suffering with minor ailments.

Whilst the unique and pivotal role played by primary care in the wider NHS is fully acknowledged within *The Primary Care Plan for Wales up to 2018*, the historical pattern of investment and delivery of health care services, with greater focus on hospital based services, has left a legacy of under-investment in primary care service development and provision. Recent targeted investment in primary care has, and will continue to, enable the necessary development of primary care capacity. Investment in out of hospital services will need to include shifts in relevant financial and human resources towards primary care based on the re-engineering of system wide patient pathways and a rebalancing of the system to support care closer to home. The current work programmes for specific patient pathways, in this regard, are detailed in SCP4.

3.1.2 Community Services

The following profile illustrates the variety of services provided.

Table 7.3.1

Sites and Boroughs	Sub Acute Beds	Rehab Beds	Stroke Beds	CRT/ Frailty	Frailty Medical Model	Integrated District Nursing	24/7 Community Nursing	Long Term Condition	Step Up/Down Facilities
Blaenau Gwent				✓	✓	✓	✓	✓	✓
YAB		✓	✓						
Caerphilly				✓	✓	✓	✓	✓	✓
NRC									
YYF	✓	✓	✓						
Newport				✓	✓	✓	✓	✓	✓
SWH		✓	✓						
CCH		✓							
Monmouth				✓		✓	✓	✓	
Monnow Vale		✓							
Mardy Park		✓							
Torfaen				✓	✓		✓	✓	
County Hospital		✓							

Key: - ✓In development ✓In Place

Both palliative care and community dental services are peripatetic and as such provide Gwent wide services from a number of bases across the county.

One of the key priority for 2015-16 was to progress integration and co-location of Community Resource Teams and District Nursing services and plans are continuing to be progressed within each borough:

- Blaenau Gwent teams are co-located on two sites aligned to the NCN footprint and are progressing work to integrate services further.
- Caerphilly CRT and DN services have integrated the twilight service and continue to progress the wider integration.
- Newport are integrating the twilight service with DN services aligning to the 8-8 frailty service.
- There are fully integrated teams throughout Monmouthshire.
- Torfaen teams are operating in a more integrated manner but have not all co-located. Co-location of South teams in support of integration and the development of an ambulatory care clinic to maximise the ability to support patients locally and reduce pressure on acute services is planned for the County Hospital site. This is dependent upon capital funding available to make the potential bases suitable for the clinic and office accommodation.

3.2 Desired Future State – Priorities for Improvement

In line with the future development of primary care services requirements, as set out in *The Primary Care Plan for Wales up to 2018*, and in support of the Clinical Futures clinical services strategy, this SCP sets out planned action and progress linked to the five core principles as set out in the *Primary Care Plan for Wales*:

- Planning care locally.
- Improving access and quality.
- Equitable access.
- A skilled workforce.
- Strong leadership.

In responding to the *'Planning Care Locally'* principle, work is underway to strengthen the UHB's twelve Neighbourhood Care Networks (NCNs) and their future sustainability which will be pivotal to the delivery of the *Primary Care Plan* requirements. The NCNs are being developed to undertake both the planning and delivery of health care services for their local communities. Preparatory work, with partner organisations, to ensure implementation of the Social Services and Well Being (Wales) Act and Well-being of Future Generations (Wales) Act requirements, with a clear emphasis on joint planning and delivery of services, also cites the important role to be played by the multiagency NCNs at a local level. Facilitated by the additional funding for Primary Care services, the NCNs have provided a focus for planning service developments to support out of hospital care and keeping people well at home. The plan includes the development of practice population risk stratification and care co-ordination to mobilise appropriate multi-agency services to provide care in accordance with Stay Well plans and 24/7 Community Nursing services aimed at carer break-down, palliative care, care for the frail and elderly who have fallen and catheter care. Also included within the plan is the development of enhanced services in Care Homes encompassing anticipatory care planning, training to identify the deteriorating resident and improved medicines management. NCNs have also locally identified and developed practice based roles for pharmacists, social workers and therapists.

The requirements of the *'Improving Access and Quality'* principle are being addressed through a programme of work which includes:

- Facilitating appropriate access to primary care services based on more accurate profiling of available capacity and effective signposting of patients to the most appropriate service to meet their needs.

- Effective use of IM&T to enable timely access to shared patient information for primary care professionals in order to optimise the coordination of patient care. The UHB has supported the implementation of the new shared Welsh Community Care Information System (WCCIS), encouraged patient use of the 'My Health Online' system and is reviewing use of systems such as "Ask My GP" which use telephones and IT to provide patient consultation and signposting to appropriate services.

- Ensuring continual review of commissioned enhanced services to ensure alignment with strategic intent and value for money.

- Strategic development of the primary care and community services estate aimed at improving access to services, including the extended range of services that can be provided in a primary care setting. The vision for delivering sustainable and enhanced General Medical Services is via the development of consolidated delivery models e.g. federated GP Practices which, in the longer term, will result in fewer individual Practices. However, such Practices would be better placed to respond to changes in the type and level of service demands and the requirement for more innovative and flexible service delivery. An incentive scheme has been implemented aimed at encouraging relevant Practice mergers but 'fit for purpose' primary care estate is key to the success of this strategy.

- A review of services delivered at GP Practice level. There are currently a range of community services delivered from GP Practice and Health Centre settings and, through the work of the NCNs, there is an opportunity to develop hubs of services in line with the NCN action plans and priorities. Based on the mapping of these services, a strategic plan is being developed in each NCN area to enable the consolidation of services across primary care and the identification and implementation of the necessary workforce skill mix for delivery. Implementation of extended skill mix at GP Practice level has already begun with the implementation of Practice based pharmacists, physiotherapists, social workers, phlebotomy services and tissue viability nurses.

The key elements of responding to the *'Equitable Access'* principle are:

- To 'Reduce Inequalities in Health' (with key schemes and priorities set out in SCP 1). The 'Living Well Living Longer' programme has commenced with the cardiovascular risk assessment phase being undertaken through a collaborative approach with Primary Care.
- To reduce variation in the provision of healthcare services. Populations and individuals have distinct needs, and some of the variation observed is a reflection of the responsiveness of the service to meeting particular needs. Unwarranted variation is:

  "variation that cannot be explained on the basis of illness, medical evidence, or patient preference" (John Wennberg).

The existence of unwarranted variation in healthcare is evidenced through data on equity of access to services, the health outcomes of populations and efficient use of resources. In relation to primary care services, there is significant variation in GP referrals at a Practice level and subsequent conversion to treatments. The successful improvement of outcomes at a Practice level through targeted action on such variations is illustrated through work undertaken on variations in the management of patients with Chronic Obstructive Pulmonary Disease using a GP Practice comparison dashboard approach to identification and management of variation. The Neighbourhood Care Networks have commenced the process of discussing variation in emergency admissions and referrals for the basket of 8 conditions in the Tier 1 targets. This data is included at Practice level in the NCN Performance Framework. The NCNs will lead a programme of work to identify and reduce variation in terms of clinical outcomes and referrals. This programme of work will be a continuum of the work in relation to COPD and diabetes (see SCP 5 – Chronic Conditions Management), but is being extended to review cancer referrals and, on a NCN basis, other planned and emergency referrals.

Delivery of the requirements of the *'Skilled Workforce'* principle includes an effective response to the challenge of sustaining recruitment and retention of GPs. As stated in the *Primary Care Plan for Wales*:

"*Primary care is fundamentally about trusted relationships between people and professionals. We need to plan and build a workforce with the right numbers and mix of skills to meet the majority of people's needs closer to home in flexible ways and flexible facilities".*

Key to the UHB approach will be a change in culture and a move away from the tradition of GPs treating the majority of patients attending the Practice to implementation of a GP workforce whose role will increasingly be to provide overarching leadership to multi-professionals at a Practice level in order to create a more sustainable workforce. Included in this approach is the implementation of a 'Primary Care Improvement and Support Team' comprising a central team of salaried general practitioners, nurse practitioners, nurses, support workers and pharmacists to provide support to GP Practices. This team will support Practices in times of difficulty, including out of hours, and will enable the opportunity to test out new models of service delivery such as 7 day General Medical Services as well as supporting GP Practices actively involved with the 'Living Well, Living Longer' programme and service improvements.

As well as 'in hours' services, a revised service model has been developed for the Out Of Hours service, with a 5 year programme to increase the numbers of advanced nurse practitioners, advanced paramedic practitioners and pharmacists to provide alternative capacity to meet demand, as the traditional GP service cannot be sustained. It is planned for nurses and paramedics, appropriately trained, to provide home visiting services and to concentrate the available GP resource for patient triage. A nurse bank is also being established to provide support for both the in hours and out of hours primary care nursing service.

Work to respond to the *'Strong Leadership'* principle has already begun, in partnership with the LMC and GPC Wales, with the aim of developing and supporting implementation of a GMS workforce model which is clinically led by GPs but which maximises the skills and expertise of

other primary care professionals such as advanced nurse practitioners, community and district nurses, midwives, health visitors, pharmacists and other members of the multi-disciplinary team. This approach also includes support for new forms of partnerships such as federated GP Practices or cooperative forms of service organisation and delivery that maximise the use of resources through serving larger catchment populations e.g. through GP Practice mergers.

3.3 Progress since March 2015 IMTP Submission

The following provides a summary of progress made in delivering the requirements of the Division 2015/16 IMTP, including identified outcomes and patient-centred benefits:

Independent Contractors

Table 7.3.2

Area	Achievements
General Medical Services	Robust Vacant Practice Process – Successfully recruited independent contractor to merge with manage practice. Management of a further 3 vacant practices.
	Successfully supported the mergers of 3 practices.
	Launched the "ABUHB Supporting Practice Mergers Discretionary Payment Scheme"
	Implemented the Sustainability Framework
	Implemented the "Optimising Access" work programme: Developed the definitions in supporting reasonable access to urgent, soon and planned care. Implemented Quality Improvement Scheme Increased 5 "A" status to 62 Commission and additional 81 clinical hours provided outside core via Extended Hours LES
	Maintain a robust process for the management of QOF and Annual Reviews.
	Continue to commission a wide range of enhanced services
General Dental Services	Maintained a robust contractual monitoring framework for quarterly and annual reviews process.
	Established the Integrated Oral Health Advisory Group
	Continued to monitor access to NHS dental services
	Continued to monitor the Minor Oral Surgery pathway and work with SC to identify patients that are suitable for transfer.
	Reviewed and updated the Local Oral Health Action Plan and reported delivery of actions to WG.
	Arranged successful CPD event
Community Pharmacy Services	Maintained a robust contractual monitoring framework for the performance of Community Pharmacies across the UHB via the Annual Monitoring Review process. 51 contractor monitoring review visits undertaken from September 2015 to December 2015
	Successful evaluation of the Level three smoking cessation service pilot. 42 Community Pharmacies currently accredited to provide this service, with scope to extend this to all Community Pharmacies wishing to provide this service.
	Converted the Pick and Mix scheme to a Local Enhanced Service, commissioned within 5 Community Pharmacies
	Completed the pilot for Integrated Care Fund Medication Administration Service. Service Currently we are still commissioning this service which improves patient independence and well being.
	Commissioned Community Pharmacy Flu Vaccination with 33 Community

Area	Achievements
	Pharmacies
General Optometry Services	Continued to commission a wide range of enhanced services.
	Established 2 ODTCs – Glaucoma and Wet AMD
	Successfully completed a referral filtering pilot
Primary Care Estates	Undertook a robust prioritisation exercise and identified schemes to progress in 2015/16.
	Progressed the development of Brynmawr Resource Centre, planned commencement of build in September 2017
	Secured the third party developer for the Llanbradach Primary Care Centre.
	Initiated the review the Newport East Initial Proposal Document.
	Delivered 4 major improvement grants with a further 1 expected to complete by March 2016. Delivered 3 minor improvement grants and a further 7 expected to complete by March 2016.
IM&T	Successful migration of all GP clinical systems.
	100% connectivity for dental
	97% connectivity for optometry
	78% of practices using elements of MOHL

3.4 NCN Development and Key Achievements

NCN Plans 2015/16
The following population and local health need priorities were agreed across the NCNs to take forward in 2015-16:

Population Health Needs
- Smoking Cessation
- Tackling obesity
- Increasing uptake of influenza vaccinations
- Living Well Living Longer
- Bowel Screening
- Public Engagement
- Dementia services

Local Priorities
- Access to dementia support services and information
- Tackling the effects of alcohol misuse
- Obesity care pathways (managing pre-diabetes and diabetes prevention
- Utilise available data sources to review NCN activity
- Local access to Pulmonary Rehabilitation
- Access to Primary Care – Tackling Did Not Attends (DNAs)
- Access to diabetic care (including tackling obesity)
- Access to local services via Integrated Services Hubs
- Emerging NCN Management Teams
- Community First pilot project
- GP Practice sustainability project
- Improve access to CAMHS
- Work towards the development of a Newport Directory of Services
- Training for practice3 and community based staff

NCN Spending Plans
A Programme Framework for the management and governance of all the wide range of projects

and programmes funded through the NCNs was developed and agreed with the NCN Leads in relation to the WG £1.1m funding for 2015. The Framework included:

- Reporting and Recording Mechanisms
- Decision Making Framework and Decisions Required Template
- Accountability Governance Framework
- Financial Governance for Implementation of NCN Spend Plans
- Management of impacts and outcomes for each project

The NCN Spending Plans are linked directly to the NCN Delivery Plans, and to the Local Authority Single Integrated Plan priorities. Some of the initiatives were:

NCN Practice based Pharmacists
Practice based pharmacists have been employed in Caerphilly, Newport, Torfaen and Monmouthshire. The Pharmacists will work directly with GP Practices to increase capacity within Practices and improve the quality and effectiveness of medicines management within GP practices;

Health Care Support Workers
Health Care Support Workers have been appointed into the District Nursing Service to provide basic care including a phlebotomy service. This will free up District Nursing time to take on the more specialist elements of their role.

Bowel screening
The national Bowel Screening Programme is undertaken to reduce mortality from bowel cancer by detecting cancer early. Invitations and testing kits are sent to men and women aged 60-74, every two years. Identifying that there is no follow-up mechanism in place for non-responders for screening, the NCNs have funded a pilot whereby practices will send out letters to non-responders to encourage them to get screened.

Signposting
The Neighbourhood Care Networks, Primary Mental Health Team and Third Sector are working together to improve sign posting to local mental health support services.

A social prescriber, based in GP practices, has been jointly funded by North Torfaen NCN and the council to help signpost patients to local services and information. NCNs in Torfaen are also working with partners to produce a benefits guide to help signpost to local services those seeking support as a result welfare reform.

Caerphilly LEAP (Listen, Engage, Act, Participate) – a multi-agency mental health and wellbeing team made up of health and social care professionals has been established in some of the GP practices in the North of Caerphilly Borough The Team are helping and supporting people with mental health issues and referring and signposting them into community based support, building excellent working relationships and networks with these services.

Newport Older Persons Pathway Pilot
The three Newport NCNs have pump-primed the innovative Older Persons Pathway pilot, which has been developed in partnership with Newport City Council, and aims to develop a Wellbeing Plan for people in the 3-7% band of frailty indicators, to support them to remain in their own homes and reduce their risk of admission to hospital or long term care. The NCN allocation will speed up the roll-out of the pathway across the GP practice populations in the city.

Dementia Roadmap
NCNs have funded the development of a web based dementia roadmap, a computer based application which provides local signposting information to help professionals and those diagnosed with dementia and their families navigate through services from diagnosis to end stage.

Training
NCN funding has been used to provide packages of training and education programmes for all NCN members on a wide range of topics.

Practice based Social Workers
NCNs in Caerphilly have funded 3 primary care based Social Workers on an initial 1 year pilot basis who will provide a greater focus on achieving people's well-being outcomes through integrated assessments

Complex wound service – South Caerphilly
South Caerphilly Practices are able to refer patients with complex wounds to a service provided by a Specialist Nurse at Nantgarw Road Medical Centre who has extended skills. Patients can receive care here and practice will receive advice regarding wound management.

Community Dietetic Service
Community Dieticians have been appointed in Blaenau Gwent and North Monmouthshire to provide a community based service including helping pregnant women lose weight.

Open Access Physiotherapy Service
The service has commenced in Blaenau Gwent, and direct access allows people with joint or back pain to access physiotherapy directly without the need to see a GP first.

Improved access for Pulmonary Rehabilitation service
South Monmouthshire NCN is piloting a locally based pulmonary rehabilitation service, patients previously had to access services in Newport, which meant that due to distance the uptake was poor.

Lead Nurse Quality Improvement & Clinical Governance
A nurse has been appointed in the Blaenau Gwent NCN areas to provide support and training to nursing homes and act as the safeguarding link between GP practices and nursing homes. She will act as a governance and quality link between core NHS services and secure access to core NHS patients e.g. dieticians, COPD nurse specialists etc., and will be able to refer direct negating need for GP to make referrals. The role is integrated with the primary care nursing team to ensure access to clinical support and expertise.

A range of other initiatives have been taken by the NCNs, including:

Smoking cessation
NCNs across Gwent have fully engaged with the Smoking Cessation programme, GPs have nominated Smoking Champions within their Surgeries, and community pharmacies across the UHB area now provide level 3 enhanced smoking cessation support.

Influenza
NCNs are working with partners to increase the uptake of flu vaccinations, particularly in the most vulnerable groups including people aged 65+ and pregnant women.

3.5 Partnerships

The Division continues to provide the main basis for partnership working with Local Authority developments and 3rd sector organisations. This involves being the Aneurin Bevan University Health Board representatives on a number of priority forums as follows.

IMTP 2015/16 Partnership Activity Summary
The Heads of Partnerships and Networks represent the Health Board on the Single Integrated Plan (SIP) Boards (the executive groups of the Local Service Boards (LSBs)) in each Local Authority area, and provide the Health Board leadership into the implementation of the agreed LSB priorities, specifically through leadership of the Health and Wellbeing themes work.

In 2015/16 for the first time all the NCN plans have been cross-referenced with the SIP priorities for Health and Wellbeing so that the plans correlate and the wider partnerships contribute to the delivery of the Health Board NCN priorities and the LSB priorities.

Examples of wider partnerships contributing to the delivery of the NCN plans include:

- A joint plan to develop a 'wet house' in Newport, which will provide homes for a group of homeless people with alcohol problems, and reduce hospital admissions associated with homelessness.
- The instigation of the Newport Integrated Partnership, which manages and develops the Older persons pathway Pilot, and will also from April 2016 result in reorganisation of the adult social care team on the NCN footprint, improving integrated working
- The further development of integrated service hubs in Monmouthshire, which has resulted in a range of additional services being available locally, including the recent instigation of a pulmonary rehabilitation service in Chepstow operating from the leisure centre and supported by the Monmouthshire national exercise referral team as well as a range of health professionals.
- Practice based social workers pilot in Caerphilly NCNs will provide a greater focus on achieving peoples well being outcomes through integrated assessments, potentially improving access to GPs.

3.6 Nursing Directorate, Primary Care

Dementia Support Workers
In partnership with the Alzheimer's Society, 6 Dementia Support Workers have been appointed to work across NCN areas. Closely aligned to the Memory Assessment Service, the DSW's will support people from the point of diagnosis. A multi agency project board has been established and an action plan agreed through the Dementia Board.

Deprivation of Liberty Safeguards (DoLS)
The Primary Care and Networks Division hosts the DoLS Team on behalf of the pan Gwent consortium. Numbers of referrals for assessment continue to rise following the Cheshire West judgement. The team has been instrumental in developing a screening tool to best identify those individuals most at risk. This has gained legal approval and has been scared across and beyond Wales.

CPD
An annual programme of CPD is in place for registered nurses working in GP practice.

Governance Focused Induction
A governance focused induction programme has been developed for nurses and healthcare support workers new to GP practice working. This covers essential elements such as safeguarding, delegation, infection control, and record keeping.

Revalidation
A bespoke appraisal framework that supports revalidation for practice nurses has been approved. Primary Care Nurses are assigned to support practice nurses through the process. The Nursing Directorate are working with the independent sector in regards to support for registrants employed within nursing homes to meet NMC revalidation requirements.

Health Care Support Worker Diploma
A pilot of a new Diploma for Healthcare Support Workers in Primary Care is being evaluated. A 'celebration' event for those who have successfully gained the diploma is being held in May 2016. A second cohort is due to commence February 2016 and is being financially supported by NCN's.

Improving Quality Together (IQT) Silver Award
A number of nursing homes are undertaking the IQT Silver award to ensure that Advance Care Planning is embedded across homes using improvement methodology. This is the first time the independent sector/care homes have been involved in the IQT Silver Award.

Nursing Awards
Since March 2015, the Nursing Directorate have won a number of National Awards:

- Patient Experience Network National Award (Engaging Patients and Families)- CHAaT and Think About me.
- National RCN Nurse Awards- Enhancing the Experience of Care- CHAaT and Think About Me.
- National Kate Granger Compassionate Care Award- CHAaT and Think About Me.
- Medi Wales Innovation Award- CHAaT and Think About Me.
- Betsi Cadwalader Scholarship- Prison Healthcare.
- National Nursing Times Award- Promoting Dignity- Prison Healthcare.

3.7 Pharmacy Services and Medicines Management

Key Achievements to Note
- Recruitment of practice based pharmacists.
- Improvement in antibiotic prescribing and reduction in the use of tramadol.
- Developed a proactive approach with secondary care for the delivery respiratory initiatives.
- Continence service repatriation commenced.
- Additional level 3 smoking cessation services commissioned.
- Initiatives presented at the UHB research conference (high INRs on admission to hospital, audit of gliptins in primary care, benefits of a Clinical Pharmacist in the CRT Team).
- Jackie Reynolds won the poster award at the 1000 Lives Conference for her work on the IQT project – reducing inappropriate prescribing of high dose Inhaled Corticosteroids (ICS).

Achievements – Acute Pharmacy
Roll out of vending machines – this is time intensive but will provide direct clinical benefits to staff and patients through improved access to medicines.

Royal Gwent – A & E, D6 and ITU. Main Theatres in February 2016.
Nevill Hall – A & E, Wards 3.3, 4.3 and ITU in early 2016.

3.8 Frailty Service

Torfaen CRT
- Integrated service model is progressing in Torfaen.
- Robust in-reach model into local Community Hospital.
- Medical cover across Torfaen and Blaenau Gwent has evidenced an increase in Rapid Medical to Blaenau Gwent.

Blaenau Gwent CRT:
- Developing summary letters to GP Practices following discharge from CRT services.
- Commencement of "Personal Outcomes Work" within East Hub linked to Social Services and Wellbeing Act.
- Step Up/Step Down Beds established and promoted utilising ICF and number of beds increased to support Winter Pressures.

Monmouthshire Integrated Service:

- Delivering practice change across health and social care workforce around setting personal outcomes in line the Wellbeing Act.
- Roll out of Raglan Model of delivering person-centred support to people with dementia.
- Improved collaboration with NCN leads to take forward new community service models e.g. pulmonary rehabilitation
- Improved collaborative approaches with voluntary sector e.g. stroke association, community connections, GAVO
- Successful ICF bids to deliver enhanced enablement and step down service models.

Newport CRT:

- Ongoing integration of shared working practices between District Nursing and Newport CRT, including the support of single referral access for professionals to District Nursing to allow dual access for CRT and District Nurses to complement better shared working practices.
- Innovative E-discharge process by Rapid Medical/Nursing Team which enables clearer clinical governance and patient flow information with GPs.
- Ongoing support and involvement with Newport City Council to develop and manage the Step Down/Reablement Step up support service.
- One of UK Research sites for "Hospital at Home" Research project, which includes identifying and randomising appropriate patients and support for project Research Nurse.
- Daily support from CRT to Royal Gwent Hospital EFU MDT to assist in appropriate timely discharge of Gwent Frailty patients and care package provision.

Community Services

Table 7.3.3

Scheme	Actions	Outputs/Outcome
Newport Inpatient services St Woolos Community Hospital (StW)	Reconfiguration of Ruperra Ward to support the implementation of the Stroke pathway and improve current SNAP targets for Stroke patients.	This has worked extremely well and the numbers of patients delayed at RGH awaiting a non acute bed has dramatically reduced. Ward Manager runs a monthly carers clinic with Stroke Association colleagues to support the patients and their families. Providing an opportunity to discuss any issues.
Monmouthshire Inpatient services Monnow Vale Health and Social Facility (MV)	Pilot a new model of service delivery – Case Coordinator. The Case Coordinator functions as part of the nucleus of the integrated hub, under the Monnow Vale Integrated Services Manager. The role involves case-managing the discharge plans of complex patients and	The pilot will be measured and evaluated after which the results will inform if the model is a viable and sustainable for future service delivery. The new model of service is based on joint record keeping for patients within the catchment area, and works with Hospital Nursing staff, Social Workers, Reablement / Enablement teams, District Nursing teams, CMHT, and others to case manage discharges and those at high risk of re-admission to hospital. It is hoped the model would provide more effective Collaboration, Communication, Seamless service user

Scheme	Actions	Outputs/Outcome
	playing an active part in facilitating the flow of patients, ensure that there are no delays in services being set up with a focus on facilitating a safe and timely discharge process, in particular CHC and complex discharges incorporating the importance of communication and use of the Choice Policy.	experience, Shared Vision of care with people being cared for / their families and professionals within the Nursing family & wider Integrated service. Potential Benefits (not prioritised): 1. Reduction in Delayed Transfers of Care by ensuring close working relationships with all service providers. 2. Reduced emergency admissions by improved team working and awareness of 'fragile' home care arrangements which could break down and result in emergency admission without intervention. 3. Improved record keeping and integrated care records for each 'hub' will begin with the closer working relationships with the district nursing team, which would cover the same population. Potential to better manage chronic conditions in the community by developing a shared knowledge base and identifying 'at risk' patients and recent discharges to avoid future admissions, and care manage the patients. 4. Recognition of the link between mental health and community services, by forming relationships with mental health professionals working in the same locality, and following patients through the mental health systems to ensure that both mental and physical health needs are known on discharge and jointly managed to avoid duplication of service provision. 5. Reduction in the number of patients admitted to District General Hospitals (DGH), by working closely with DGH Discharge Practitioners, arranging early transfer to a Community Hospital. Ultimately direct admission to Community Hospitals will be included. 6. Liaise with Community Teams regarding admission of patients from within the catchment area, thus enabling them to follow up these patients quickly to start discharge packages. This will also prevent unnecessary visits being made by Community Team members when patients are in hospital. 7. Enable other practitioners to concentrate on their areas of expertise and positively contribute to the patient journey. 8. Improve patient experience and satisfaction with hospital stays **Evaluation- The above list will form the basis of the evaluation. This will then identify if the model adds value to the patient / family and the service and performance measures will be identified against each factor. This will then be**

Scheme	Actions	Outputs/Outcome
		utilised to inform future workforce planning / establishment.
Reduce LOS within Community Hospital	Improved PSAG Boards, Focused MDT Patient Flow Meeting Collaborative working with Local Authorities Use of Discharge to Assess Models Role of the Discharge Liaison Nurses Bed reduction within YAB Embed complex list across all community hospitals	The divisional flow senior nurse has taken a lead role in conjunction with the Divisional Nurses to ensure that processes are uniformed and embedded across the community hospitals to ensure that the targeted reduce in LOS is achieved. PSAG boards are in place with a consistent management approach. The early indication of patient needs ensures that full engagement occurs at the beginning of the patient journey to reduce delays along the pathway. This work is being supported by the Discharge Liaison Nurses although it has been recognised that variation across the boroughs currently exists. This will be addressed in a planned workshop at the beginning of February. Through the achievement in a reduced LOS within YAB the division were able to reduce the bed numbers as planned. Further work is required to continue to support a reduction in the overall LOS. The rollout of the complex list occurred in December 2015 which was in advance of the initial timeframe. The system is maturing and assisting in the early identification of delays.
Variable Pay Reduction	Reduction in Variable Pay Irradiation of Off Contract Nursing	The division continue to focus on reducing variable pay through focused management on roster efficiencies, sickness management, PADR compliance. A robust project team is now in place to ensure that e-rostering is fully embedded across all sites. A number of local recruitment drives have taken place and have been successful in recruiting a small number of staff. The division are part of the ongoing overseas recruitment drive The divisional nurses have developed a robust plan to eradicate off contract nursing by April 2016
Improved Communication and reporting	Development of a systemic flow dashboard with the ability to predict demand across the system Demand management Use of EDD's Roll out of Complex List Implementation of Choice of Accommodation Policy	The flow management tool is well developed and embedded within the division. This is formally reviewed with the senior nursing team on a weekly basis to ensure that we are achieving the targeted numbers to support the flow across the whole system. EDDs are being used across all community hospitals. The ongoing flow management programme continues to support the use of EDDs to ensure that they are used consistently to support demand management and patient flow The choice policy was verified by the board in August 2015 and has been implemented across the division. The teams are being supported in using the policy to support patients and their families in identifying choice of accommodation within a

Scheme	Actions	Outputs/Outcome
	Develop Graduated Care Model at County Hospital Performance reviews within each borough Develop electronic tool for management of district nursing caseloads. Rollout out to all teams	set timeframe A pilot model has been developed and is currently being progressed Performance reviews are undertaken bi-annually within each borough with the development of clear work programmes in line with the IMTP The district nurse dashboard has been developed and rolled out at the end of 2015. The work is still in its infancy but initial data is providing beneficial data to support service management and review
Integrate Services	Implement the 24/7 Community nursing model. Implement the Community phlebotomy service	Recruitment of the HCSW is complete. There are still outstanding vacancies for registered nursing staff. As a result of this only one team will be implemented in February 2016 with the second team being implemented once recruitment is complete Staff have been appointed. Services are being introduced slowly across the communities once the recruitment and training is complete. Clinical capacity is being developed across the whole community including within community hospitals
Palliative Care	Review clinical models, job plan, team job plan, develop ANP roles, review role of CNS Launch Gwent Palliative Care Strategy Award new contract for hospice at home service Education & Training, ACP & PPC/PPD work streams deliver year 1 milestones	Dates for Job Planning are set for January and February 2016. Once complete agreement has been made to complete a team job plan. One ANP post has been appointed into and the second post is due to be recruited by the end of January 2016 The strategy was launched at the end of 2015 as planned The contract is due to be awarded at the end of January 2016 Work streams have been developed and are progressing at pace
Community Dental Services	Implement new CDSWR in line with WG Engagement of dental services/primary care in SE Wales through Managed Clinical Networks for Special Care Dentistry and implement agreed programmes Development of Special Care Dentistry training programmes through Wales Deanery and Dental School for under/postgraduate and trainees in Special Care Dentistry(WHC/2015/002) Adults in Hospital	This work is progressing within the service and will have continuing ongoing developments and milestones

Scheme	Actions	Outputs/Outcome
	Implement WHC/2015/001 Oral Health Care in Care Homes and 1000Lives Mouth care for . To develop access and improved skill mix in the service by implementing 'Direct Access' to dental therapist assessment for appropriate patients.	
	Development of central triage for children referred for GA to reduce the number of GAs – integrated working with Primary and Scheduled Care	The service developed a pilot for the central triage which proved to be extremely successful. The success has seen a large reduction in children receiving GA's. The service was inundated and required further development. Agreement for transfer of funding from scheduled care to community to support the development of the service.

Urgent Primary Care Out Of Hours Service

Achievements

- Improved performance in comparison to previous years with consistent improvement across all targets since December 2015.
- Filling of GP shifts - which have continued to improve at 91% - the service has had a consistent fill rate of 80%.
- Programme underway for Nursing Workforce redesign based on demand coming into the service.
- Improving Timely Triage – improvement of 30% since December 2015 against the WG targets.
- Reiteration of Working Guidelines for all staff.
- Working with Unscheduled Care Division on improvement on Redirection of appropriate patients to and from OOHs
- Analysis and audit of individual cases for Direct Admission and urgent care into MAU/CAU.
- Home Triage working guidance and pilot in place.
- Working with NCNs, WAST and Community Services on understanding and joint management of Frequent Fliers.
- Introduction of Pharmacy repeat prescribing – direct to community pharmacists.
- Implementation of a new Telephony infrastructure – including new telephone numbers and telephone system.
- Development of new clinical pathways for non clinical staff to appropriately direct patients into the right place in the system or give advice on self care.
- Staff communication evening open events in place across all sites – every 2 weeks.
- Put in place new training programme for non clinical staff – awaiting permanent appointment of lead trainer.

Work Programme Overview

Key Milestones for Delivery in SCP 3 – Primary Care and Community Services

Desired Outcomes and Quantifiable Benefits

Table 7.3.4

Service Change Plan	Outcome	Baseline Measure	Target Measure
Optimising Access	Improved access to primary care services. Improved access to timely, shared information which supports care co-ordination Improved patient experience (time taken to book appointment)Reduction in "inappropriate" attendances for emergency and planned care	▪ No. of GP practices meeting local access standard ▪ outcome of patient satisfaction survey ▪ ED, MIU & OOH attendances ▪ n direct GDS referrals to primary care minor oral surgery services ▪ max fax RTT ▪ n patients accessing Glaucoma, LES and PC ODTCs ▪ Ophthalmology RTT	▪ Increase GP practices meeting improvement targets ▪ outcome of patient satisfaction survey ▪ reduction in ED, MIU and OOH attendances ▪ achievement of Max Fax RTT ▪ achievement of Ophthalmology RTT ▪ reduction in follow-up numbers of patients and waiting times for ophthalmology ▪ % uptake of the 5A scheme ▪ %increase in provision of extended hours ▪ %practices needing support ▪ Number of mergers ▪ Number of support hours provided ▪ OOH roster fill rate ▪ %uptake of MHOL ▪ Improved patient satisfaction ▪ Improved response times in OOH
Skilled Workforce	Increased use of all professionals in primary care to ensure workforce across the system focus on "doing what only they can do" Matching capacity and demand across entire primary care workforce – to reduce duplication of effort, smooth demand across healthcare professionals and reduce	▪ Development of a Primary Care improvement support team ▪ n of practice based pharmacists ▪ workforce analysis ▪ n of vacant practices as result of partner resignations ▪ n of GP training places ▪ n of community pharmacists providing enhanced services	▪ GP practice sustainability ▪ Increase number of practice based pharmacists ▪ Increase service provided by Community pharmacists ▪ Increased number of nurse practitioners ▪ Increased GP workforce ▪ Increased number of Practice Based Pharmacist ▪ Increased use of physiotherapist and specialist nurses

Service Change Plan	Outcome	Baseline Measure	Target Measure
	pressure on General Practitioners. Improve recruitment and retention of General Practitioners. Reduce demand for secondary care services leading to: ▪ Reduction in outpatient follow up waiting times ▪ Improved RTT performance		
IM&T	Improved access to timely, shared information which supports PC care coordination. Improved patient experience through reduced time taken to book appointments or repeat prescriptions. Development of an integrated IM&T system to allow seamless services to patients. Development of e-learning for ACP in palliative care. Pilot of Hootvox – patient engagement Good Care Guide – Care Homes	▪ n GP practices using My Health on Line (MHOL) ▪ n of GP practices receiving electronic discharge letters ▪ n GP practice archives with GPTR ▪ n dental practices with NHS connectivity ▪ n optometry practices with NHS connectivity ▪ Open eyes roll out across primary care sites ▪ Current staff who have received training ▪ Number of staff who have received training ▪ Compliance with Patient Satisfaction Questionnaires ▪ Web based system in place	▪ 100% practices using MHOL ▪ 100% practices using electronic discharge letters and GPTR ▪ 100% dentists with NHS connectivity ▪ Complete roll out of open eyes ▪ All community staff, including Care Homes, to have accessed the e-learning tool ▪ Improved feedback from patients and increased numbers of patients expressing views ▪ % take up of system
Poly-pharmacy	Reduce risk of adverse events in elderly due to poly-		▪ More community pharmacies undertaking complex medicines reviews.

Service Change Plan	Outcome	Baseline Measure	Target Measure
	pharmacy.		▪ n Practice medication reviews undertaken ▪ % Reviews undertaken by Practice Based Pharmacists
Reducing Variation	Reduce inequalities of service provision Better experience for patients Improved clinical outcomes Better value of care	▪ Measure variation in referral rates by practice and secondary care speciality to sub specialty level ▪ Identification of unwarranted variation ▪ GMS variation dashboard for primary care management of Diabetes and COPD	▪ Improved quality of information for referrals to specialists ▪ n of inappropriate referrals for all specialties ▪ n/% of patients with Diabetes and with COPD receiving optimal care by practice (reduction in variation as measured by GMS variation dashboard)
Primary Care Estate	Infrastructure to develop larger GP practices to deliver sustainable GMS services Improvement to existing premises to increase the range of services that can be provided locally Improved patient experience	▪ New developments where required aligned with WG Critical Success Factors ▪ n Practice mergers ▪ Patient satisfaction surveys ▪ n practices that are DDA compliant	▪ Annual PC estates prioritisation and plan ▪ Commission Brynmawr and Llanbradach developments ▪ Develop IPD for Newport East ▪ Rationalisation of primary care and community estate ▪ Improvement grants delivered
Care Homes	▪ More anticipatory plans in place Less unplanned hospital admissions ▪ Improved and targeted referrals to other services ▪ A safer, better quality service.	▪ Number of anticipatory care plans ▪ Reduction in unplanned hospital admissions from care homes ▪ Improved & targeted referrals to other services ▪ Improved skill set of Care Home staff ▪ Release of GP time from unnecessary care home visits	▪ Increase in number of anticipatory care plans ▪ Decrease in unplanned hospital admissions from care homes ▪ Improved & targeted referrals to other services ▪ Improved skill set of Care Home staff ▪ Release of GP time from unnecessary care home visits
NCN Development	▪ Achievement of actions in NCN Plans ▪ Management of budgets and outcome of additional spend ▪ Measurement of team maturity	▪ Current performance ▪ Robust spend plans in place ▪ Current performance on outcome ▪ Baseline maturity matrix analysis ▪ Analysis of Leadership questionnaires	▪ Improved performance compared to benchmark ▪ Expenditure achieved and services delivery ▪ Improved performance ▪ Achievement of action plan developed as a result of the maturity matrix ▪ Achievement of action plan developed as a result of the

Service Change Plan	Outcome	Baseline Measure	Target Measure
	▪ Leadership development NCN Leads		leadership questionnaire
Newport Older Persons Pathway	▪ Improved access to social networks and reducing social isolation (measured by ongoing analysis of Stay Well plans and people "stories.") ▪ Improved access to benefits (the pilot has identified an additional 100K benefit income to date – this measure will be maintained) Improved access to community equipment(measured by monitoring equipment issued) Referrals to the wider primary care team, including OT, Frailty, Long Term Conditions nurses. ▪ Evidence of prompt, flexible service response (measured by analysis of time and ease of response)	▪ No. of people on stay well plans and their admission to long term care or in receipt of packages of care ▪ No. of people on stay well plans and their unplanned admission to hospital ▪ No. of people on stay well plans who are assessed out following attendance at emergency assessment unit.	▪ Reduction in no. of people on stay well plans and their admission to long term care or in receipt of packages of care ▪ Reduction in no. of people on stay well plans and their unplanned admission to hospital ▪ Reduction in no. of people on stay well plans who are assessed out following attendance at emergency assessment unit.
24/7 COMMUNITY NURSING	▪ Increased number of specific scheduled duties calls to Primary Care OOHs undertaken by HCSWs; ▪ DN teams operate consistent hours across 5 boroughs; ▪ DN input 24/7 providing unscheduled response ▪ Reshaping of skill mix across teams with increased	▪ Emergency admissions to secondary care ▪ GP OOH Demand ▪ A&E Attendances	▪ Reduction in unplanned hospital admissions ▪ Reduction in palliative/end of life unplanned hospital admissions ▪ Reduction in demand on GP OOHs service ▪ Reduction in demand on A&E ▪ Improvement in quality of care and continuity of care as care provided closer to home ▪ Equity of access for patients across the UHB

Service Change Plan	Outcome	Baseline Measure	Target Measure
	proportion of HCSWs; ▪ Release of DN time to focus on LTCs reflected in number of LTC patients supported; ▪ Release of DN time to support patients with more complex needs reflected in greater time spent with them and / or more frequent interventions; ▪ Number of DNs enabled to undertake specialist training to upskill to support patients with complex needs.		
OOH	Improvement of the whole patient pathway through the Redesign Programme by: ▪ The pay rates for GPs will be set and steady – which will enable better planning for the service and the individual clinician which gives stability to the rotas going forward into 2016/17. ▪ Increased shift fill which improves the working environment which can lead to better recruitment and retention. Leads to stability and sustainability of the workforce. ▪ Recruitment of skill mix of nursing staff to support the redesign linked to 24/7	▪ GP rotas fill rates ▪ WG performance targets.	▪ Filling of GP rotas – increase fill rates by 10% by end of March. ▪ Improvement of WG performance targets. ▪ Improving the patient pathway to ensure timely clinical priorities are met in the most appropriate way - self care rates improving, timing system reducing through triage, urgent base visits being prioritised, more appropriate home visiting targeted at maintaining patients in the community.

Service Change Plan	Outcome	Baseline Measure	Target Measure
	community nurses. ▪ Appropriate redirection of patients both in and out of OOHs service ensuring the pathway of the patient seamless. ▪ Recruitment of Advanced Paramedic Practitioners. ▪ Introduction of supportive decision software (algorithms) at call handling with appropriate training. ▪ Introduction of home triage services for escalation purposes. ▪ Linking the training posts and programmes to improvement of patient care and recruitment and retention of staff. ▪ Increased direction of demand to Community Pharmacies. ▪ To increase the skills and availability of non-clinical staff and HCAs to support the service. ▪ Demand modelling to be focused on where clinical and non-clinical staff need to be rostered where needed – through shift pattern changes and skill mix changes.		
LOS	▪ Reduced ALOS resulting in fewer delayed discharges	▪ Community Hospital ALOS ▪ DTOCs	▪ Reduction in Community Hospital LOS ▪ Reduction in number of delayed discharges

Service Change Plan	Outcome	Baseline Measure	Target Measure
	and better patient outcomes. ▪ Reducing Health Inequalities: Realignment of community hospital beds and ALOS targets based on national benchmarking intended to reduce inequalities existing across Gwent / Wales ▪ Improved patient experience through fewer hand offs, better continuity of care, better management of patients with dementia. Supported early discharge.	▪ Bed Numbers	▪ Reduction in DTOC bed days lost
Medicines Management Plan	▪ To achieve outcomes identified for practice based pharmacists ▪ To achieve outcomes in the Medicines Management Plan re generic prescribing and switches	▪ No of medication reviews ▪ Compliance with asthma reviews ▪ No of medications revised ▪ % of generic prescribing ▪ % of switches	▪ % improvement in all baseline measures
Palliative Care	▪ To deliver a high quality and personal service which is safe, dignified and respectful. ▪ To ensure a consistent model of service is available across boroughs with accessibility to all aspects of specialist palliative care. ▪ Patients and their carers receive a person centred service which meets their	▪ Independent service review to be established ▪ % level of patient and family satisfaction ▪ Development of a medical action plan ▪ Clarity of roles and responsibilities	▪ Achievement of objectives and recommendations resulting from the review ▪ Improved rate of satisfaction ▪ Implementation of plan ▪ Governance document established and agreed

Service Change Plan	Outcome	Baseline Measure	Target Measure
	individual needs. ▪ Medical sessions are deployed across Gwent to meet patient's needs; Macmillan GPFs support primary care alongside Macmillan Pharmacist and CNS/ANP staff work in line with advanced nursing skills framework		
Community Dental	▪ To continue to improve oral health care and services for vulnerable children and adults across Gwent. ▪ To ensure all appropriate patients receive highest quality of oral care according to their needs ▪ Reduction in the number of inappropriate requests for dental general anaesthesia for children by implementing a centralised triage system. Continue to integrate bariatric service and dental domiciliary care. ▪ Continue to increase oral health care for vulnerable adults and children by following the principles of prudent health care by utilising appropriate care pathways, integrated oral care and dental skill mix	▪ % of inappropriate requests for children's dental general anaesthesia ▪ Development of oral health pathway ▪ Development of integrated oral care and dental skill mix	▪ Reduction of requests, reduced number of children receiving inappropriate GAs. ▪ Pathways developed and measured ▪ Developed skill mixed teams

Other benefits include:

- Brings care closer to home and provides timely seamless services to patients more locally.
- Patients will know how to access the various parts of the system for urgent care.
- Improved outcomes for patients, through supporting wellbeing and maintaining independence.
- Make best use of current resources across health, social services and the third sector, both financial and in the use of staff.
- Improve access to services – e.g. by developing cohesive referral and access pathways to service provision for both health and social care agencies.
- Reduce duplication of effort.
- Co-location of teams to improve the communication between agencies.
- Support the implementation of the Specialist and Critical Care Centre

Interdependencies
All Divisions across the UHB, local authorities, independent contractors, third sector, HMP Usk and Prescoed, Care Forum Wales, LMC, LDC, CPW, SEWROC, Trade Unions, Public Health Wales, NWIS, WG, Community Health Council, third sector organisations.

Potential cost associated with any improvement plan to address the findings of the ongoing optimising access to General Practice review.

Securing funding through WG Pathfinder allocation for Glaucoma LES and primary care ODTCs plans.

Extension of Community Pharmacy Level 3 smoking cessation is subject to confirmation of funding stream.

Resource Implications
The workforce and financial implications of this SCP are still being updated and will be included within the UHB's March submission of the IMTP.

Governance
This will be through the Primary Care and Network Development Board, Chaired by the Chief Operating Officer. This approach will be supported by sub-groups which will progress workstreams that are cross Divisional. Individual accountability at a Divisional level for delivery is clarified in the relevant SCP.

Key Risks and Mitigation
In the absence of necessary cross Division ownership and culture change across the organisation and local communities in terms of the significant strategic system changes necessary to shift care closer to home, this SCP will not succeed in delivering the desired benefits. Successful delivery of the SCP needs to be supported by robust organisational development and engagement activities, including frontline staff. Any potential additional workload for independent contractors needs to be accurately identified and discussed with the relevant professional groups to enable agreement.

If there is inconsistent access to appropriate and necessary estate and facilities it may be difficult to deliver the enhanced services in Practices. The estate issues and challenges are being identified for action through the UHB's Primary Care and Community Estate Group.

If current and future recruitment of GPs is unsuccessful it may be difficult to provide sufficient capacity to deliver more care closer to home. The response to this challenge is based on the development of a broader skill mix within Practices and implementation of innovative new roles to support primary care.

SCP 4 – Integration - Bringing Care Closer to Home

Aim
The historical focus of investment and delivery of healthcare services has been on illness and hospitals as opposed to population health, prevention and primary and community care.

In a time where population changes are increasing the demand on healthcare services, the ages and number for people with long term conditions are increasing and resources available are not increasing at the same rate, the way we currently use our hospitals is becoming unsustainable.

Improving our out of hospital services will make care better and will cost less. By intervening earlier, joining up care better and supporting patients at home who are currently being admitted to hospital, we will be able to improve outcomes and patient satisfaction.

Bringing care closer to home is our way of delivering sustainable healthcare services to our population in the face of increasing demand and limited resources.

We intend to deliver service transformation which results in a significant shift in the way services are provided across hospitals and the community, with some provision moving from hospitals to the community where safe and effective to do so. In rebalancing the system we will support Care Closer to Home for our frail and elderly population, our patients with chronic conditions and those requiring long term care whilst allowing our hospitals to concentrate on what they do best - providing both planned and emergency care when it is needed.

The UHB emphasis on providing Care Closer to Home can only be achieved through ensuring that we have robust sustainable primary and community care services.

Desired Future State
The UHB's vision is predicated on strengthening primary and community care services and delivering most care closer to home, in an integrated pro-active way, to improve patient experience whilst sustaining the whole system.

Our vision is to ensure that our health care system keeps patients well and at home, living happily independent; when patients do become ill, they will receive quality, timely care at the right place, appropriate to their needs.

The concept of care closer to home features throughout the Integrated Medium Term Plan where there are specific plans on:

"Care at home or in the patient's community with the most appropriate person, with the right skills, delivering care, is the unequivocal aim of the Health Board's future vision. Strengthening Primary and Community Care services is therefore our top priority".
ABUHB March 2015 IMTP

- Prevention (SCP 1 and 2);
- Anticipatory care (SCP 3);
- Rapid community response, rehabilitation and enablement to support early discharge (SCP 3 and 9);
- Long term conditions management (SCP 5);
- Palliative and end of life care (SCP 3);
- Long term care (including continuing healthcare) (SCP 6);
- Primary and community mental health services (SCP 8).

This section of the plan focuses specifically on how we will deliver an agreed suite of integrated, system wide pathways to re-engineer the whole pathway of care with the expressed intention of providing most care closer to home. It specifically identifies priority services that are currently delivered in secondary care which in future will be delivered in full or in part in primary care.

Approach
The March 2015 IMTP involved specific work programmes in relation to care closer to home. However, it has been recognised by the Board that at present there is no over-arching Strategy demonstrating how primary and community services need to look in the future to support the UHBs Clinical Futures Strategy.

Consequently, it has been agreed that a ten year Care Closer to Home Strategy will be developed which will clearly articulate how out of hospital services need to transform to support the whole system change required within the UHB. This Strategy will be presented to the Board in July 2016. This will be aligned to the emerging guidance for implementing the Social Services and Wellbeing (Wales) Act 2014.

The Strategy will be developed with its stakeholders including Local Authorities, the third sector, professional bodies, managers, clinicians, front line staff and citizens and will be underpinned by a rolling five year delivery and outcomes framework.

The Strategy will be based on the principles of prudent healthcare to ensure the whole system transformation required is as efficient as possible and represent value based care.

Progress since March 2015 IMTP Submission
The following provides a summary of progress made since the March 2015 submission:

- 1,645 post operative cataract outpatient appointments have been undertaken in primary care opticians.
- 1,629 patients have received their Glaucoma follow up assessment in primary care opticians.
- 1,798 patients have received their minor oral surgery treatment in a primary care dental surgery;
- The number of paediatric dental GAs performed has been reduced by circa 45% (741) as a result of a new community dental service clinical triage assessment and treatment model. This scheme is also the first example of significant resource shift from secondary acre budgets to community care budgets to reflect the shift in activity.
- In excess of 150 patients have attended the community based Osteoarthritis of the knee education and support groups.
- An extended skin surgery service has been commissioned since the beginning of December 2015 whereby, via the support of teledermatology, circa 960 patients per annum will receive their surgery in a primary care setting (historically in a hospital setting).
- Two contracts have been awarded to develop Glaucoma Ophthalmic Diagnostic and Treatment Centres in Newport and Torfaen from January 2016. It is anticipated that between 3,000 and 4,000 new and follow up outpatient appointments pa will be transferred to these primary care based Centres from hospital based eye clinics.
- One contract is currently out to tender for a Wet AMD Ophthalmic and Diagnostic Treatment Centre in Newport from March 2016 where 7,000-9,000 new, follow up and treatment episodes per annum will be transferred to this primary care centre from hospital based eye clinics.
- The implementation of the Community Pharmacy enhanced MUR service which will identify and review those patients with asthma who never attend their surgery for annual review thereby optimising management and improving safety in response to the National Audit of asthma deaths.
- Appointment of community diabetes specialist nurses to ensure patients have better controlled HbA1Cs and support as many patients out of hospital as possible.
- Appointment of community based respiratory nursing team to improve the quality of life through greater support in the community and reduce the risk of admission to hospital.

Care Closer to Home Plan 2015/16-2018/19
A summary of the plan for the next three years is set out in Table 7.4.1. The plan below includes schemes included in the March 2015 IMTP and new schemes identified by Divisions since March.

The plan is summarised into the three sections:

- those which have been approved and are being progressed to implementation (blue shading);
- those which have been scoped in outline and agreed in principle but requires further detail work to secure final approval and funding (grey shading);
- those where there has been early discussions and are yet to be scoped, but have been identified as priority areas (white).

Table 7.4.1

SCP	Scheme	Secondary Care Service	Forecast Activity Shift (hospital to primary care)	2015 /16	2016 /17	2017 /18	2018 /19	Status
4.1	Glaucoma ODTC	Ophthalmology	3,000 new and FU assessments per annum.	√	√			Commenced and on track
4.2	Wet AMD ODTC	Ophthalmology	7,000-9,000 new follow up and treatment slots per annum.	√	√	√		Commenced and on track
4.3	Minor Oral Surgery	Maxillofacial	2,300 treatments per annum.	√				Implemented
4.4	Extended Skin Surgery (teledermatology)	Dermatology	960 treatments per annum.	√				Commenced and on track
4.5	Osteo Arthritis of the Knee community groups	Orthopaedics	Reduction of circa 100 knee operations per annum.	√	√	√		Implemented pilot Evaluation then roll out
4.6	Primary Care Anti-coagulation service	Haematology	Phase 1: 3,900 patients per annum. Emergency admission avoidance. Phase 2: additional 2,000 patients per annum.	√	√			Commenced and on track
4.7	Lower back pain programme	Orthopaedics		√	√			Commenced and on track
4.8	DVT community diagnostic service	Urgent care & diagnostics	100% DVT diagnostics undertaken within the community 24/7.		√	√	√	Not started
4.9	Children's abdo pain/constipation service	Paediatrics	TBC		√			Not started
4.10	Community Cardiology Service	Cardiology	TBC		√	√	√	Commenced and on track
4.11	Understanding demand programme (GP referrals)	Planned Care	TBC		√	√	√	Not started
4.12	Ambulatory care sensitive conditions	Urgent Care	TBC			√	√	Not started

SCP	Scheme	Secondary Care Service	Forecast Activity Shift (hospital to primary care)	2015 /16	2016 /17	2017 /18	2018 /19	Status
	programme							
4.13	Primary Care diagnosis for cancer programme	Cancer Services	TBC		√	√	√	Not started
4.14	Enhanced primary care – ENT programme	ENT	TBC		√	√	√	Not started
4.15	Integrated Audiology service	Audiology	TBC		√	√		Not started

The schemes included in the three year plan have been identified via discussions with staff that plan and deliver services, Neighbourhood Care Networks and National Fora and priorities.

Improving patient outcomes is at the heart of this plan and delivering services more prudently in a primary and community care setting.

Where plans have been developed and programmes have been approved there are detailed templates below setting out the anticipated outcomes and quantifying the shift of activity from secondary care to primary care.

Where schemes have not yet been scoped, a summary overview of the programmes is included and full detailed templates will be added to the IMTP as and when progressed and approved internally.

7.4.1 Approved Schemes

Table 7.4.2

Scheme (4.1)	**Glaucoma Ophthalmic Diagnostic and Treatment Centre**	
Overview	To provide assessment, diagnosis and treatment for Glaucoma via two primary care based ODTCs, to improve access to ophthalmology services across the whole system and reduce the risk of harm as a result of long waits and delayed follow up assessments.	
Anticipated Outcomes	▪ Improved patient experience – care closer to home and reduced waits; ▪ Reduction in delayed follow ups; ▪ Reduction in hospital based follow up outpatient appointment demand; ▪ Reduction in waiting times for new outpatient appointment and treatment; ▪ Sustainable ophthalmology services which allows specialists to focus on more complex work and meet RTT; ▪ Reduce clinical risk of patients coming to harm by reducing waiting times; ▪ Development of an integrated model for delivering ophthalmology services to the population.	
Quantifiable shift of activity from secondary to primary care.	Approximately **3,000** new and FU outpatient appointments per annum will be transferred from hospital based eye clinics to the primary care based ODTCs.	
Milestones	Award contracts to two ODTC providers.	Q4 2015/16
	Finalise Contracts for provision of services.	Q4 2015/16

Scheme (4.1)	Glaucoma Ophthalmic Diagnostic and Treatment Centre			
	Set up KOWA cameras in ODTCs.			Q4 2015/16
	Set up the UHB IT connectivity in ODTCs.			Q4 2015/16
	Finalise Standard Operating Procedures.			Q4 2015/16
	Commission two Glaucoma ODTCs			Q4 2015/16
	Develop PREMs for use to measure patient experience.			Q4 2015/16
	Monitoring of outcomes and impact			Quarterly/ongoing
	Develop clinical criteria and SOP for Optometry led management/monitoring of low risk and stable patients			Q2 2016/17
	Implement optometry led management of low risk/stable Glaucoma patients.			Q4 2016/17
Funding		**£'000s 2016/17**	**£'000s 2017/18**	**£'000s 2018/19**
	Pay	84	84	84
	Non-Pay	156	156	156
	Total Spend	**240**	**240**	**240**
	Funding Secured: WG Pathfinder funding	240	240	240
	Cost pressure:	**0**	**0**	**0**
Workforce	Additional UHB workforce requirements include: Band 7 Project Manager Band 4 Integrated ophthalmology co-ordinator These posts are funded from the money secured from WG and both posts have been appointed to. Consultant job plans are to be amended to ensure sufficient capacity is factored in to undertake virtual review OP clinics. Additional optometry capacity required will be managed by the two ODTC providers and secured via the terms of the contract.			

Table 7.4.3

Scheme (4.2)	Age Related Macular Degeneration (Wet AMD) Ophthalmic Diagnostic and Treatment Centre
Overview	To provide assessment, diagnosis and treatment for Wet AMD via a primary care based ODTC, to improve access to ophthalmology services across the whole system and reduce the risk of harm as a result of long waits and delayed follow up assessments. The ODTC will have two elements as follows: ▪ Optometry led imagining/assessment of all new suspected Wet AMD cases for consultant virtual review; ▪ Follow up and treatment of Wet AMD patients by UHB consultants and nurse practitioners.

Scheme (4.2)	**Age Related Macular Degeneration (Wet AMD) Ophthalmic Diagnostic and Treatment Centre**			
Anticipated Outcomes	▪ Improved patient experience – care closer to home and reduced waits; ▪ Meet 14 day NICE target for Wet AMD; ▪ Reduction in hospital based activity and thus improvement in all ophthalmology services; ▪ Sustainable ophthalmology services which allows specialists to focus on more complex work and meet RTT; ▪ Reduce clinical risk of patients coming to harm by reducing waiting times; ▪ Development of an integrated model for delivering ophthalmology services to the population.			
Quantifiable shift of activity from secondary to primary care.	Approximately **7,000-9,000** new follow up and treatment slots per annum will be transferred from hospital based eye clinics to the primary care based ODTCs.			
Milestones	Finalise tender process and award contract and lease to ODTC provider.	Q4 2015/16		
	Set up OCT scanners and UHB IT connectivity within ODTC.	Q4 2015/16		
	Purchase and fit all new equipment for ODTC.	Q4 2015/16		
	Finalise Standard Operating Procedure for service and development.	Q4 2015/16		
	Undertake staff consultation and amend job plans and contracts for virtual sessions and working flexibly from the ODTC site.	Q4 2015/16		
	Commission ODTC (limited sessions)	Q4 2015/16		
	Develop PREMs to manage patient experience	Q4 2015/16		
	Develop and deliver communication strategy in conjunction with the CHC to notify patients of the changes and provide re-assurance	Q4 2015/16		
	Finalise performance framework to measure and monitor impact.	Q1 2016/17		
	Phased implementation.	Q2 2016/17		
	Full implementation of ODTC	Q3 2016/17		
	Continuous monitoring, collection of PREMs and measurement of impact.	Quarterly		
	Expand service to include: diabetic macular oedema and retinal vein occlusion	Q1 2017/18		
	Please note this service delivery model is new to NHS Wales and is subject to the provider being able to provide circa 146 m^2 of dedicated space (plus shared areas). At the time of writing this report the outcome of the tender is not known. If the UHB is not able to award the contract then an alternative service delivery model will be sought.			
Funding		**£'000s 2016/17**	**£'000s 2017/18**	**£'000s 2018/19**
	Pay	47	47	7
	Non-Pay	114	114	114
	Total Spend	**161**	**161**	**161**

Scheme (4.2)	Age Related Macular Degeneration (Wet AMD) Ophthalmic Diagnostic and Treatment Centre			
	Funding Secured: WG Wet AMD funding	161	161	161
	Cost pressure:	**0**	**0**	**0**
	In addition to WG revenue funding non-recurring capital funding of £63k has been secured in 2015/16 from WG.			
Workforce	Additional UHB workforce requirements are as follows: Band 7 project manager (also managing Glaucoma ODTC) Band 3 administrative support/receptionist for the ODTC Part-time medical photographer for the ODTC In addition there is a requirement for existing nurse practitioners and medical staff working at the Royal Gwent Hospital to transfer to the primary care based ODTC site. Discussions are ongoing with staff to agree the terms and conditions and amend job plans and job descriptions as appropriate. There is full support from this cohort of staff in relation to the transfer to the ODTC.			

Table 7.4.4

Scheme (4.3)	Primary Care Minor Oral Surgery
Overview	A new primary care MOS service has been commissioned, delivered from two GDP premises (via oral surgeons) across the UHB to deliver local anaesthesia and conscious sedation MOS services above the competency of GDPs. This service allows GDPs to make direct referrals to the primary care MOS service and thus reduces the number of avoidable referrals to hospital based dental services. Additionally the UHB reviews the hospital waiting lists and re-directs any patients referred who could be treated, based on the referral to the primary care service.
Anticipated Outcomes	▪ Improve patient experience by providing closer to home and reducing waiting times; ▪ Manage annual growth in referrals to hospital dental services (circa 7% per annum); ▪ Reduce annual referrals to hospital dental services; ▪ Via direct referral and waiting list review, transfer circa 2,000 cases per annum previously treated in secondary care to primary care; ▪ Meet RTT for maxillofacial

<table>
<tr><td>Quantifiable shift of activity from secondary to primary care.</td><td>This service has now been fully implemented and a recent evaluation reports the following:

▪ A total 1,798 patients have been referred to the primary care service between April and November 2015 of which 98% have been managed in a primary care setting with no referral onto hospital based services;
▪ It is anticipated that in excess of 2,300 patients per annum will receive their treatment in a primary care (previously would have received in secondary care)
▪ Annual growth in referrals of circa 7% has been eradicated;
▪ There has been a 17% reduction in annual referrals to hospital based dental services;
▪ Patient satisfaction survey results report an overall satisfaction rate of between 97% and 100%;
▪ Current waiting times for the primary care service are between 2-6 weeks.</td></tr>
<tr><td>Milestones</td><td>This service is now fully implemented and is subject to ongoing quarterly review.

As a result of the continuous review a new HDS referral form has been developed and implemented and also clinical triage of GDP referrals to the PC MOS service is in place to ensure all referrals are appropriate and also identify where training and education is required for GDPs.</td></tr>
<tr><td>Funding</td><td><table>
<tr><th></th><th>£’000s 2016/17</th><th>£’000s 2017/18</th><th>£’000s 2018/19</th></tr>
<tr><td>Pay</td><td></td><td></td><td></td></tr>
<tr><td>Non-Pay</td><td>344</td><td>344</td><td>344</td></tr>
<tr><td>Total Spend</td><td>344</td><td>344</td><td>344</td></tr>
<tr><td>Funding Secured:
WG funding</td><td>344</td><td>0</td><td>0</td></tr>
<tr><td>Core UHB budgets</td><td>0</td><td>344</td><td>344</td></tr>
<tr><td>Cost pressure:</td><td>0</td><td>0</td><td>0</td></tr>
</table></td></tr>
<tr><td>Workforce</td><td>This service is delivered via GDP providers under the terms of a Personal Dental Services Contract.</td></tr>
<tr><td>Scheme (4.4)</td><td>Extended Skin Surgery</td></tr>
<tr><td>Overview</td><td>Currently low risk basal cell carcinomas are removed in secondary care, either after an appointment in outpatient clinic or after a teledermatology diagnosis.

The UHB will commission an Enhanced Service from GP primary care specialists to provide an extended minor surgery service in primary care and thus transfer activity currently undertaken within a hospital setting to primary care.

This will enable care to be delivered safely, closer to home, whilst releasing capacity in dermatology outpatients through extending the scope of the existing teledermatology service.</td></tr>
<tr><td>Anticipated Outcomes</td><td>All low risk basal cell carcinoma to be removed in primary care.

▪ Capacity released in dermatology;
▪ Reduction in RTT breaches;
▪ Capacity and financial efficiencies in secondary care to target other more complex cases;
▪ Delivers care closer to home for patients.</td></tr>
</table>

<table>
<tr><td>Quantifiable shift of activity from secondary to primary care.</td><td colspan="4">Current plan and associated funding assumes transfer of 960 cases per annum from secondary acre to primary care.

If demand exceeds the 960 cases then discussions will take place to transfer resources from secondary care to primary care to fund additional activity.</td></tr>
<tr><td rowspan="8">Milestones</td><td colspan="2">Appoint medical photographer to support service.</td><td colspan="2">Q2 2015/16</td></tr>
<tr><td colspan="2">Develop service specification, pathway and SOP.</td><td colspan="2">Q3 2015/16</td></tr>
<tr><td colspan="2">Obtain UHB and stakeholder agreement of service change and LES documentation (CHC and LMC)</td><td colspan="2">Q3 2015/16</td></tr>
<tr><td colspan="2">Offer LES to all GPs across the UHB subject to accreditation.</td><td colspan="2">Q3 2015/16</td></tr>
<tr><td colspan="2">Commission service from GPs already meeting accreditation criteria.</td><td colspan="2">Q3 2015/16</td></tr>
<tr><td colspan="2">Identify GPs who wish to provide and arrange supervised session in accordance with accreditation criteria.</td><td colspan="2">Q4 2015/16/ongoing</td></tr>
<tr><td colspan="2">Continue to commission as and when accreditation complete.</td><td colspan="2">Ongoing</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="6">Funding</td><td></td><td>£’000s 2016/17</td><td>£’000s 2017/18</td><td>£’000s 2018/19</td></tr>
<tr><td>Pay</td><td>45</td><td>45</td><td>45</td></tr>
<tr><td>Non-Pay</td><td>120</td><td>120</td><td>120</td></tr>
<tr><td>Total Spend</td><td>165</td><td>165</td><td>165</td></tr>
<tr><td>Funding Secured:
WG funding</td><td>165</td><td>165</td><td>165</td></tr>
<tr><td>Cost pressure:</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Workforce</td><td colspan="4">Additional workforce requirement relates to dedicated medical photographer capacity to support the service change.</td></tr>
<tr><td>Scheme (4.5)</td><td colspan="4">Osteo Arthritis of the Knee – Community Support Groups</td></tr>
<tr><td>Overview</td><td colspan="4">This scheme is designed to enhance the management of osteoarthritis in primary care, recognising the constraints which currently exist during the GP consultation.

The community arthritis groups set out to equip patients with the knowledge to make fully informed and appropriate decisions about their own care that relate to their personal context.

The pathway provides an alternative for GPs, whereby they can refer the patient to the community group as opposed to directly to secondary care orthopaedic services. This group is managed by nurses and physiotherapists who will have the ability to refer on to alternative services.

It should be noted that this service is not a barrier to admission to secondary care orthopaedic services but rather an opportunity to ensure patients are empowered to understand their condition and ensure they are fully educated and engaged in their treatment and what is required of them to increase their outcomes prior to presenting to secondary care services.</td></tr>
</table>

<table>
<tr><td>Anticipated Outcomes</td><td colspan="4">▪ Patients are fully informed about their options;
▪ Patients who are active in self management including weight management and smoking cessation, optimal management of co-morbidities;
▪ Patients are fully informed about their treatment options including knee replacement surgery and the active part they need to play for effective rehabilitation;
▪ Improved patient satisfaction (patient related outcomes) following knee replacement surgery;
▪ Reduction in secondary care orthopaedic new outpatient appointment time as patient fully informed when present;
▪ Potential reduction in number of knee surgery procedures per annum;
▪ Reduction in orthopaedic OP follow ups.</td></tr>
<tr><td>Quantifiable shift of activity from secondary to primary care.</td><td colspan="4">The core principles of this scheme are:

▪ Empower patients - for both informed decision making upfront and feedback post intervention
▪ Deliver sustainable outcome focussed services – and as a subset of this, investment in primary care to allow patients with chronic conditions to be optimised through self management and self help is also an important strand of this work programme.</td></tr>
<tr><td rowspan="18">Milestones</td><td colspan="3">Develop project group to plan and deliver the scheme.</td><td>Q1 2015/16</td></tr>
<tr><td colspan="3">Develop service specification and pathway.</td><td>Q1 2015/16</td></tr>
<tr><td colspan="3">Consult and agree with CHC and LMC</td><td>Q1 2015/16</td></tr>
<tr><td colspan="3">Develop and agree content of the groups</td><td>Q1 2015/16</td></tr>
<tr><td colspan="3">Run test session with expert patients and other stakeholders</td><td>Q1 2015/16</td></tr>
<tr><td colspan="3">Implement in four NCN areas.</td><td>Q2 2015/16</td></tr>
<tr><td colspan="3">Ongoing evaluation and patient satisfaction surveys</td><td>Monthly</td></tr>
<tr><td colspan="3">Evaluate pilot.</td><td>Q4 2015/16</td></tr>
<tr><td colspan="3">Agree roll-out to all NCNs with stakeholders and Executive Team.</td><td>Q1 2016/17</td></tr>
<tr><td colspan="3">Appoint to substantive posts</td><td>Q2 2016/17</td></tr>
<tr><td colspan="3">Implement across all NCN areas in the UHB</td><td>Q2 206/17</td></tr>
<tr><td colspan="3">Ongoing monitoring and evaluation including PREMs</td><td>Quarterly</td></tr>
<tr><td colspan="3">Develop pathway and service specification for community groups – shoulder</td><td>Q3 2016/17</td></tr>
<tr><td colspan="3">Implement shoulder groups across all NCNs</td><td>Q4 2016/17</td></tr>
<tr><td colspan="3">Develop pathway and service specification for community groups – hip</td><td>Q4 2016/17</td></tr>
<tr><td colspan="3">Implement hip groups across all NCNs</td><td>Q1 2017/18</td></tr>
<tr><td rowspan="4">Funding</td><td></td><td>£’000s 2016/17</td><td>£’000s 2017/18</td><td>£’000s 2018/19</td></tr>
<tr><td>Pay</td><td>68</td><td>68</td><td>68</td></tr>
<tr><td>Non-Pay</td><td>42</td><td>42</td><td>42</td></tr>
<tr><td>Total Spend</td><td>110</td><td>110</td><td>110</td></tr>
<tr><td></td><td>Funding Secured:
WG funding</td><td>110</td><td>110</td><td>110</td></tr>
</table>

	Cost pressure:	**0**	**0**	**0**
Workforce	Additional substantive posts will be appointed to support this scheme as follows: ▪ Part-time nurse(expert) ▪ Part-time administrative support ▪ Part-time physiotherapy lead			
Scheme (4.6)	**Anticoagulation Service Transformation**			
Overview	Anticoagulation is an effective treatment for prevention of recurrence of serious conditions, such as Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) and Stroke (CVA/TIA). Of all medications, anticoagulants are one of the most common reasons for medication related admissions, causing significant morbidity and mortality by under or over dosing patients. The National Institute for Health and Care Excellence (NICE) identified a series of potential benefits for an effective anti-coagulation therapy service: ▪ Appropriate patients receive anti-coagulation therapy and prompt monitoring; ▪ Reduced inequalities in access to anti-coagulation therapy; ▪ Improving ant-coagulation control in patients; ▪ Reducing drug associated complications. At present 14 GP practices within the UHB provide a full anticoagulation service which provides a one stop shop for patients. For the remaining 71 practices patients must rely on the hospital for either laboratory analysis and/or dosing of warfarin.			
Overview cont'd…	There are currently delays in initiation of warfarin within hospital services and also there can be delays in results and dosing instructions having an impact on of the OOH service. Additionally demand for hospital based anti-coagulation services impacts on capacity in other related services such as DVT clinics which are sometimes cancelled to prioritise anticoagulation clinics. Consequently this plan aims to deliver anticoagulation services closer to home.			
Anticipated Outcomes	▪ Better clinical outcomes and management of INR via improved time in therapeutic range; ▪ Reduction in number of emergency admissions; ▪ Reduction in number of prescribing errors; ▪ Reduction in demand for pathology services; ▪ Improved access for patients and care delivered closer to home; ▪ Consistency and equity in the management of anti-coagulation patients.			
Quantifiable shift of activity from secondary to primary care.	Phase 1 (GP practices provides for own patients): **Transfer circa 3,900 patients** currently being managed in secondary care to primary care via GP practice confirmation that they wish to provide for their own patients. Phase 2 (GP practice or community service provides for non registered patients): **Transfer balance circa 2,000 patients** to primary care to be managed via intra practice agreements or community clinics. **Total transfer circa 5,900 patients.**			

<table>
<tr><td rowspan="12">Milestones</td><td colspan="3">Develop Project group to driver delivery of programme</td><td>Q2 2015/16</td></tr>
<tr><td colspan="3">Develop project initiation document and secure funding</td><td>Q2 2015/16</td></tr>
<tr><td colspan="3">Secure stakeholder and Executive Team support and agreement to progress (including POC Committee and LMC)</td><td>Q2 2015/16</td></tr>
<tr><td colspan="3">Seek expressions of interest of those GP practices who wish to provide for their own patients (Phase 1)</td><td>Q3 2015/16</td></tr>
<tr><td colspan="3">Develop Enhanced Service Specification (being led Nationally)</td><td>Awaited</td></tr>
<tr><td colspan="3">Tender for re-agent rental for provision of POCT machines, IQA and anti-coagulation strips</td><td>Q4 2015/16</td></tr>
<tr><td colspan="3">Purchase relevant decision making software and ensure access in each GP practice providing Phase 1</td><td>Q4 2015/16</td></tr>
<tr><td colspan="3">Deliver INR overview sessions to GP practice staff</td><td>Q4 2015/16</td></tr>
<tr><td colspan="3">Commission Phase 1 service</td><td>Q1 2016/17</td></tr>
<tr><td colspan="3">Develop option appraisal for delivering to patients whose GP practice do not want to provide</td><td>Q2 2016/17</td></tr>
<tr><td colspan="3">Secure approval for preferred option and progress to implementation of Phase 2</td><td>Q3/2016/17</td></tr>
<tr><td colspan="3">Commission Phase 2 (full repatriation from secondary to primary care)</td><td>Q4 2016/17</td></tr>
<tr><td rowspan="6">Funding</td><td></td><td>£’000s
2016/17</td><td>£’000s
2017/18</td><td>£’000s
2018/19</td></tr>
<tr><td>Pay</td><td>42</td><td>0</td><td>0</td></tr>
<tr><td>Non-Pay</td><td>1,379</td><td>1,521</td><td>1,521</td></tr>
<tr><td>Total Spend</td><td>1,421</td><td>1,521</td><td>1,521</td></tr>
<tr><td>Funding Secured:
WG funding
Core UHB Budgets</td><td>1,421
663
758</td><td>1,521
763
758</td><td>1,521
763
758</td></tr>
<tr><td>Cost pressure:</td><td></td><td></td><td></td></tr>
<tr><td>Workforce</td><td colspan="4">The new service will be delivered by GP practices and their staff.

In year one additional capacity in the secondary care INR nursing team (backfill) has been agreed to allow the most experienced nurses to come out to primary care to deliver training and support to GP practices for the first 6 months.

It is anticipated that as vacancies have been held within the hospital based INR nurse led clinics, when all INR management is repatriated to primary care the existing secondary care nurse capacity released will support the new model of care but also existing secondary care services such as DVT clinics which are currently under resourced.</td></tr>
</table>

7.4.2 Outline Schemes

The following programmes are those which have been agreed in principle to progress and outline programmes scoped.

The IMTP, as part of its annual refresh will include detailed templates as and when programmes are approved and commissioned.

Community DVT Service (4.8)
This service is aligned to the Anticoagulation transformation programme and would involve the implementation of a community DVT diagnostic service via Community Teams (CRT). It is anticipated that this service would:

- reduce waiting times for Ultra Sound scans;
- lead to earlier diagnosis and fast track those patients who require hospital services
- reduce the number of avoidable (suspected" DVTs to hospital services. Reduces number of "suspected" DVTs transferred to hospital.

Children's Community Abdominal pain/Continence Service (4.9)
This project forms part of the UHBs over-arching paediatric outpatient transformation project and seeks to develop community based paediatric abdominal pain/continence clinics to support families and provide GPs with an alternative to acute referral when symptoms can be better managed closer to home. It is anticipated that this service will:

- reduce waiting times for this cohort of patients to be assessed and receive support;
- release capacity across the whole paediatric outpatient pathway as these referrals will no longer be made to the acute service.

Community Cardiology Service (4.10)
Demand for cardiological assessment has increased significantly over the last decade with new primary care referrals increasing at a rate of approximately 6% per annum, driven at least in part by the National Service Framework, NICE Guidelines and QOF. Whilst this has forced significant improvements in patient care, waiting times remain too long, particularly for urgent patients who are at risk of adverse events. The proposed 16 week pathway for cardiology will further pressurise the system.

A significant proportion of patients simply require diagnostic assessment and reassurance or advice on a management plan rather than formal review by a Consultant Cardiologist. At present all such referrals are managed by Consultant Cardiologists with secondary care investigations, some patients having to travel considerable distances to hospital, on more than one occasion for assessment. A recent audit of e referral outcomes at the Royal Gwent Hospital showed that 17% of referrals were management with advice or diagnostics and advice without the need for formal clinic review.

There is increasing interest in Community Cardiology Services. Such services are able to provide basic diagnostics and assessment closer to home in primary care premises with triage for these tests and reporting by General Practitioners with a Special Interest in Cardiology (GPwSI) supported by local Consultant Cardiologists. Such an approach would facilitate direct feedback and education in primary care and also allow secondary care teams to concentrate on patients with more serious pathology. The development of Community Cardiology services is in line with national priorities in "Together for Health – a Heart Disease Delivery Plan", providing timely care closer to the patient's home.

The development of a community cardiology services would enable patients, referred by GPs, to be seen outside the secondary care setting, thus providing a new model of service which could provide the following benefits:

It is anticipated that this service will**:**

- Improve access to diagnostics and shorter waiting times across the whole system;
- Deliver care closer to home;
- Allow more focus on complex cases managed by consultant specialists.

Funding has been secured to progress this scheme via the All Wales Heart Disease Implementation Group.

Understanding demand programme – GP referrals (4.11)
The UHBs Outpatient Transformation Programme identifies the programmes of work required to transform the way we deliver our outpatient service. It recognises that a critical element to delivering this change is understanding our demand.

This scheme focuses specifically on understanding GP referrals and over a three year period will use benchmarking data to focus on understanding why:

- The UHB is an outlier compared to other HBs in relation to GP referrals at a sub specialty level.
- There is variation amongst GP practices within the UHB.

The first stage is thus identifying variation in GP referrals. Variations in healthcare exist for many reasons, Populations and individuals have distinct needs, and some of the variation which has been observed is a reflection of the responsiveness of the service to, meeting particular needs. Unwarranted variation is:

"Variation that cannot be explained on the basis of illness, medical evidence, or patient's preference" (John Wennberg).

Understanding demand and indentifying unwarranted variation is an essential step in driving change. As a result of this work it is anticipated that individual pathway redesign and new services will be developed.

Ambulatory Care Sensitive Conditions (4.12)
ACSCs are conditions for which effective management and treatment should prevent admission to hospital. They can be classified as: chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness (Ham *et al* 2010).

The NHS Institute for Innovation and Improvement identifies 19 ACSCs which are discussed in The Kings Fund briefing "Emergency hospital admissions for ambulatory care-sensitive conditions; identifying the potential for reduction" which concluded that:

"high levels of admissions for ACSCs often indicate poor co-ordination between the different elements of the health care system, in particular between primary and secondary care. An emergency admission for an ACSC is a sign of the poor overall quality of care, even if the ACSC episode itself is managed well. The wide variation of emergency hospital admissions for ACSCs implies that they, and the associated costs for commissioners, can be reduced."

The report goes onto state that:

"In order to realise the potential reduction, in the short to medium term better management of ACSCs in primary care is needed to reduce emergency hospital admissions (i.e., secondary prevention). In the longer term, commissioners need to tackle the underlying causes of ACSCs (i.e., primary prevention), for example, reducing prevalence of chronic diseases, such as diabetes, through public health and preventive measures. A good start would be for clinical commissioning groups to use data on variations in emergency admissions from ACSCs by constituent practices to understand variations in the quality of general practice as one of the causes."

It is apparent, as set out in other areas of the IMTP that significant progress has been made in some of the 19 ACSC areas, and further that there is a strong emphasis on primary prevention.

This programme of work will thus commence with a multi-disciplinary review of the 19 identified

ACSCs and confirmation of where work has/is being undertaken and thus recognising those areas which not need to be targets using a systematic approach.

7.4.3 - Schemes to be Scoped

Primary Care – Cancer Diagnosis Programme (4.13)
A priority area for the UHB is primary care diagnosis of cancer, especially in lung and Upper GI cancer to aim to support GPs to diagnose cancer early and better integrate cancer care.

This programme of work will be directly aligned to the Macmillan Framework for Cancer in Primary Care programme and will support by UHB staff and the newly appointed clinical leads.

Integrated ENT Services (4.14)
This programme will seek to deliver more care in a community setting and is directly aligned to the Wales National ENT Implementation Plan.

Integrated Audiology Services (4.15)
Audiology services are an excellent example of services which could be more prudently delivered in a primary care and community setting.

This programme will seek to develop integrated audiology services which will be aligned to the “All Wales integrated health and social care action plan” to be published by Welsh Government in early 2016 for consultation.

SCP 5 – Chronic Conditions Management

Aim
The evidence demonstrates that there is a strong link between deprivation and the numbers of people with poor health including those associated with chronic health conditions, e.g. the incidence of Diabetes in Wales is almost doubled in areas of high deprivation compared to the least deprived areas. Chronic conditions management is therefore a key priority for the UHB and its partners reflected through the Single Integrated Plans agreed by the Local Service Boards in Gwent and across the divisional service change plans. The key chronic conditions identified as priorities for management within this SCP are those which are also reflected in our Local Delivery Plans, namely:

- Diabetes;
- Chronic respiratory disease;
- Neurological conditions;
- Stroke;
- Heart disease;
- Liver disease.

Key changes from the 2015/16 IMTP
- Anti-coagulation plan – now part of the work programme for SCP4.
- Osteo-arthritis of the knee- also in SCP 4.
- Medicines management is now managed as a cross-cutting work programme in its own right and is also a key enabler within the work programme for SCP 3.
- Patient and community education and support approaches are embedded in all the LDPs.

5.1 Approach

The aim of these plans is based on the principles of prudent healthcare by tackling the root causes of ill health, improving early detection and management of chronic conditions and offering optimal treatment and continuity of care across the care continuum. It is also aimed at supporting people to self-manage their chronic conditions.

A key aim of this SCP is to improve the overall coordination and management of the LDP process to ensure that there is a consistent approach to the development of plans with the full engagement of services across the whole care pathway and key stakeholder groups. A proposal is being prepared by the Planning Directorate with Divisional colleagues to establish an overarching Delivery Board and executive lead that will oversee the publication, submission and delivery processes of LDPs for chronic conditions.

For example, the managerial and clinical leads for each chronic condition LDP (Divisional Directors or Directorate Managers/Clinical Directors) work with their colleagues across the Divisions and Directorates where appropriate and their communities to develop the priorities to improve patient outcomes and reduce inequalities. They also work with the Directors of Public Health and Primary Care to consider the population needs and how they relate to UHB priorities. Most of the clinical leads are members of the National Implementation Groups and feed back to their relevant teams locally.

In addition, the UHB has two websites which allow staff across the organisation to see progress and monitor timescales. The first is on the UHB intranet and is for cascading information from Welsh Government, Implementation and Delivery Groups and local LDP Teams. The other is on the UHB internet site and publishes the approved Local Delivery Plans, the latest Annual Reports and Action Plans available for the public.

http://www.wales.nhs.uk/sitesplus/866/page/77350

The intranet site has enabled more collaboration across Divisions and Directorates in order to link with the Planning Directorate/Chief Operating Officer's Directorate to pull together cross cutting themes as part of future strategies and corporate plans. There have also been better links with the Finance Directorate to discover whether the priorities in the LDPs are aligning with business cases and capital funds.

Detailed below are refreshed plans for Diabetes and Respiratory. Summaries on the status of the other LDPs are also provided but will be expanded in the final draft IMTP.

5.2 Adult Diabetes Mellitus

Baseline Position
The prevalence of Type 2 diabetes in Gwent is 27% higher than the UK national average according to the latest National Diabetes Audit. The UHB is currently caring for 37,311 patients with a diagnosis of diabetes mellitus of which over 85% are managed in primary care. Some 90% have Type 2 Diabetes. The numbers of people who develop Type 2 diabetes is expected to rise sharply over the next ten years. Public Health Wales have predicted 48,638 patients by 2020 and 55,887 by 2030. Recently published estimates suggest that up to 30% of the adult population are at significant risk of developing the condition.

Prevalence of diabetes varies across Gwent with Blaenau Gwent having the highest proportion of people with diabetes overall, whilst practice prevalence ranges from 4.4% in a practice in South Monmouthshire and 9.8% in a practice in Newport West. These figures only represent the known burden of disease and are likely to be an underestimate of the true prevalence. The *"Living Well, Living Longer"* health inequality programme is anticipated to increase detection rates in the five most deprived NCN areas. There is also marked variation between the eighty seven primary care practices in the UHB area, e.g. "poor glycaemic control" varies from around 5% up to 25%.

Podiatry and Orthotic services are provided as part of an integrated service model, delivering specialist detection, treatment, mobilisation and advice on managing the long term complications of the diabetic foot following national guidance. Services are delivered within community clinics, at the patient's home, rapid access clinics, inpatient and MDT Complex Diabetic Foot Care Clinics. Specialist and Advanced Podiatry practitioners work across the integrated model, providing direct care programmes and as part of multi-disciplinary support alongside primary care teams, residential care, community and hospital settings. Patients access the service through a single point of contact, with a centralised booking system that facilitates rapid response to urgent diabetic foot care irrespective of the care setting.

At present the majority of GPs refer patients needing injectable therapy including **insulin therapy and GLP-1 receptor agonist therapy** to secondary care. These patients are seen by a physician to assess the suitability for these treatments, before seeing a clinical nurse specialist to receive instruction on injection technique. All Diabetes Specialist Nurses (DSNs) have historically been based in hospitals. Any support that the current DSN workforce offers outside hospital is at the expense of capacity for dealing with inpatients that have diabetes and the support they provide to hospital based specialist diabetic clinics.

There is evidence that NICE guidance is not being followed when diabetes medication is being initiated and maintained thus prudent healthcare principles are not being followed, leading to potential waste, harm and unnecessary variation.

Patient activation and learning to self-manage their condition has not been promoted as extensively as it needs to be, leading to a dependency relationship with health services. Although engagement with and delivery of *X-Pert* structured patient education is the highest in Wales, the absolute levels of uptake by patients with Type 2 are still very low.

Data collection and performance in **specialist care** is not adequate to support an integrated

service, as all diabetes outpatient referrals are counted with all endocrine referrals and there is no differentiation between the different types of patient being referred. The inability to distinguish patients who have one of the 'Super Six' conditions [i.e. Type 1 DM, Renal Dialysis, Very Complex Type 2, Antenatal, Insulin Pump, Foot Complications] from those who do not, means that planning transformed services is severely hampered.

Many patients experience long waits for specialist care. As at 16th January 2015, there were 893 patients waiting for a first new outpatient appointment with the Diabetes & Endocrinology specialist team. Of these it is estimated, around 460 patients were for diabetes appointments. The maximum waiting time is 25 weeks, with urgent referrals seen more rapidly – the service aims to reduce maximum waiting times to 12 weeks for all referrals.

1686 patients are on the waiting list for follow-up appointments at the Royal Gwent Hospital (excluding nurse led clinics). 1140 of these patients have missed their due by dates with the over half of these missed in the last 5 months of 2014 alone. This has resulted, at least in part, from a 25% reduction in consultant capacity over the last 18 months (12 month maternity leave and a retirement, despite best efforts the Health Board was unable to secure cover). The Diabetes Directorate's plan to address waiting times and backlogs includes extra clinics, implementing an integrated diabetes service to improve skill levels in primary care and reduce demand for secondary care to provide routine diabetes care and secure commitment for a full-time substantive consultant replacement (business case) to ensure service sustainability.

Key findings of National Diabetes Audit in Primary Care

- A far higher participation rate of practices in Gwent than in England or Wales.
- Disease burden in Gwent is the top quartile of prevalence in the UK.
- Over 70% of patients with Type 2 Diabetes have completed Annual Type 2 Diabetes reviews, putting Gwent in the top quartile of performers in England and Wales.
- Achievement of treatment to target for modifiable cardiovascular risk factors is at the national average.

Desired Future State

Diabetes services in the UHB will be developed using co-production principles, incorporating the major changes described below. There will be especial emphasis on promoting self-care and self-management, with personal goal setting.

To deliver the highest possible level of care for increasing numbers of patients we need to move from the current two stream service to one where we have a fully integrated team. Such systems have already been implemented in several areas across the UK, notably Portsmouth, Wakefield and Northampton.

There should be a single directorate of Diabetes, spanning all services in primary care and specialist services, encompassing inpatient, outpatient and primary care support teams.

The community and inpatient nursing teams will be integrated and lead by a single Band 8A nurse, using an in-reach model for inpatient and outpatient care.

The aim of the **Primary Care Diabetes Nurse Specialist Nurses** (PCDSNs) will be to ensure that patients have better controlled HbA1Cs and rational use of diabetes medication in keeping with prudent healthcare principles. These PCDSNs will provide the following services for patients:

- Offer direct patient care for patients that practice teams struggle with, e.g. initiating insulin close to home, including care homes.
- Offer indirect patient care by up-skilling practice teams to sustainably deliver more complex and better quality care close to the patient's home, including care homes.
- Patient and carer education in venues close to home.
- Research and audit of services.

DSNs in **secondary care** will continue to provide inpatient diabetes care (20% of hospitalised patients have diabetes) and will support the delivery of "Super Six" working with consultants in Diabetes and Endocrinology. Podiatrists will continue to roll out the "Foot in the Bed" assessment tool, facilitating the screening of those patients with diabetes with at risk foot status and enabling referral to foot protection programmes.

The current specialist Diabetologists will exclusively deliver care to those patients with 'Super Six' Diabetic Conditions, as well as inpatient support. The venues for delivery of care to 'Super-Six' patients will be determined by prudent health care principles, with an assumption that care can be delivered closer to home, rather than be hospital-based. The development of non medical prescribing for podiatrists with advanced scope of practice will enable the provision of supplementary prescribing (antibiotic therapy, pain relief, referrals for imaging). This will enhance quality care, delivered in a timely manner which will aid efficient use of resource, improve flow and ensure seamless care across the diabetes pathway.

The most immediate and significant change in care will be that the initiation of injectable therapy will transfer from a hospital based services to primary care. This will be achieved with consultant support and an expanded team of diabetes specialist nurses based in NCN areas and working in GP practices. The UHB is currently awaiting the outcome of negotiations between WG and GPC Wales on this issue. Following integration, we expect to see a significant reduction in the volume of consultant referrals. Bench-marking data suggest referral rates could fall by as much as 90% (Portsmouth). We would expect that there would be a significant change in the prescribing pattern of the types of injectable treatments, to more closely matching NICE guidance, with growth in human insulins from 13% to NICE recommended 28% of injectables. This is in keeping with prudent healthcare as it is likely to release savings to be recycled elsewhere in the diabetes programme.

Consultants and DSN's will be increasingly available to provide advice to primary care teams on how to care for particular patients, and thus knowledge will transfer into primary care and especially into the practice nursing teams. Diabetes consultants will visit practices on a regular schedule, at least twice a year, to provide virtual outpatient clinics, a model already used in Portsmouth.

Patient reference/participation/support groups will be set up in each locality (or NCN where there is demand). These important fora will help further co-production of services.

Patient learning and activation (along with their carers) will be enhanced through a significant increase in the delivery of proven evidence-based *X-Pert* programmes. More patients, and their carers, will complete courses, as there will be more sessions delivered, at more venues by more trained educators.

The UHB will support the formation and development of local Diabetes Peer Review Groups in NCNs, where GPs and practice nurses will be able to share data (e.g. referrals, outcomes etc. etc) and constructively discuss care using continuous quality improvement methodology.

Evidence from community integrated teams in Wakefield show that when specialist staff interact with primary care teams, unmet need is identified and prescribing costs will increase. Thus the integrated service will concentrate on the quality of prescribing not cost reduction and ensure prudent healthcare principles are followed. Furthermore, evidence from the Portsmouth integrated model shows that at a population level, an increase in the proportion of patients who are well-controlled does not appear in the first three years. However, admissions for short terms effects of poor control do reduce. Consequently, the integrated service will concentrate on reducing unplanned emergency admissions for reversible diabetes complications e.g. hypoglycaemia, hyperglycaemia.

Care homes will provide a significant focus for Diabetes Care, through the increased intervention of

the Community Clinical Nurse Specialists, creation of Personal Management Plans, Advanced Care Plans and unplanned emergency admission avoidance work.

Diabetes is an area where the UHB will explore costed care pathways. It will then consider the establishment of a 'whole system budget', whereby the entire indicative budget for diabetes care for the UHB is delegated to NCNs. These NCNs would then work with their local Patient Reference Groups, through co-production methodology, to determine the development of patient–focussed services, utilising the resources of the entire community to prevent, detect and manage diabetes. However, more work is needed to provide baseline data and agree metrics for analysis to support such a budgeting approach. This would form part of a greater programme of works to improve outcomes of chronic conditions.

Key Milestones for Delivery

Table 7.5.1

Diabetes Pathway Transformation	
Establish diabetes referral data collection and analysis in secondary care	Q4 2015/16
Ensure 4x community based CNS in post to work independently with primary care teams	Q4 2015/16
Establish Operational Policy for CNS and primary care teams	Q4 2015/16
Recruit 1 diabetes specialist education team leader	Q4 2015/16
Review patient education service	Q4 2015/16
Agree clinical governance framework for CNS operation	Q4 2015/16
Engage ABCi mathematical modellers to devise models to describe how consultant time will be released to provide support to CNS and primary care, whilst maintaining Super-Six care delivery	Q4 2015/16
Promotion of e-mail advice line for GPs & practice nurses	Q4 2015/16
Establish mechanism for safe transfer of non-Super Six patients from outpatients to CNS/Primary Care	Q4 2015/16
Establish learning needs assessment for primary care teams	Q4 2015/16
Devise and agree terms of and funding for insulin initiation and supervision enhanced service	Q4 2015/16
Diabetes enhanced service is reviewed and rewritten to incorporate changed model	Q4 2015/16
Establish Patient Participation Groups in each locality or NCN	Q4 2015/16
Adopt new NICE guidance [to be published April 2015] on management of Type 2 Diabetes Mellitus	Q4 2015/16
Incorporate prudent healthcare principles in all service developments, e.g. medicines management	Q4 2015/16
Review how the diabetes programme relates to other Chronic Conditions Programmes	Q4 2015/16
Reduce unplanned emergency admissions for reversible diabetes complications by 5% [e.g. Hypoglycaemia & Hyperglycaemia]	Q4 2016/17
Review funding mechanism for Diabetes pathways	Q4 2016/17
Establish co-production of local diabetes service modelling, using local diabetes patient reference groups	Q4 2016/17
Deliver increased x-Pert patient education programmes	Q4 2016/17
Patient experience surveys in every NCN show 10% improvement in satisfaction with care provided	Q4 2016/17
Reduce unplanned emergency admissions for reversible diabetes complications by 25%	Q4 2017/18
Ensure consequences of co-production in previous years are readily apparent in service delivery and patient and carer experience	Q4 2017/18
Patient experience survey in every NCN conducted shows 20% improvement in satisfaction with care provided	Q4 2017/18

Governance
The pathway development is led by the Chair of the Diabetes Transformation Group and supported by members of the Group. It reports into the Primary Care and Network Development Board, Unscheduled Care Transformation Board and Families and Therapies Division.

Desired Outcomes and Quantifiable Benefits

Table 7.5.2

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
Quality	Improved clinical governance		Clinical Governance process agreed and approved.	Q4 2015/16
	Patient experience		Patient/carer experience surveys conducted in every NCN	Q4 2015/16
			10% improvement in satisfaction with care provided.	Q4 2016/17
			20% improvement	Q4 2017/18
	Improved clinical outcomes		No increase in proportion of patients in PC with poorly controlled diabetes.	Q4 2016/17
			5% increase in proportion of patients meeting all 4 targets in NDA bundle of 4.	Q4 2016/17
			10% increase in proportion of patients meeting all 4 targets in NDA bundle of 4.	Q4 2017/18
			10% reduction in operations for diabetes related amputations.	Q4 2017/18
			5% reduction in operations for diabetes related eye diseases.	Q4 2017/18
Workforce	Increased capacity to work independently with PC teams.		5 community based PCDSNs recruited	Q4 2015/16
	Increased capacity to provide specialist diabetes education		An additional PCDSN was recruited (one of the 5 above). Each PCDSN gives one day a week to specialist diabetes education, nullifying the need for a specialist educator role.	Q4 2015/16
	Improved support of patients with diabetes from		PCDSN Teams established in 4 NCNs	Q4 2015/16

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
	integrated teams for PC workforce.			
Performance	Improved consultant mentoring and advice provided in PC settings. NHH inpatient diabetes MDT and DNSs implemented at all hospital sites.		15% decrease in specialist activity. Support rolled out in 4 NCNs. 30% decrease and roll out to 8 NCNs. 50% decrease and roll out to 12 NCNs.	Q4 2015/16 Q4 2016/17 Q4 2017/18
	Reduced referrals to outpatient specialist services		20%	Q4 2015/16
	(1) Insulin initiation and (2) supervision enhanced services rolled out Currently awaiting outcome of discussions between WG and GPC Wales.		At least 4 NCN areas. At least 8 NCNs. All 12 NCNs.	Q4 2015/16 Q4 2016/17 Q4 2017/18
	Reduced injectable therapy sessions provided in specialist services.		10% 40% 90%	Q4 2015/16 Q4 2016/17 Q4 2017/18
	Reduced unplanned and emergency admissions for reversible diabetes complications.		5% 25%	Q4 2016/17 Q4 2017/18
	More completed x-Pert patient education programmes delivered.		20%	Q4 2016/17
Finance	TBA			

Other benefits:

- Improved dedicated diabetes care will result in reduce emergency admissions and shorter duration of stays in hospital.
- Although drug costs are unlikely to reduce in absolute terms, prudent healthcare principles will result in greater efficiencies.
- Whole system budgeting will provide a model for the design and delivery of other chronic conditions services.
- Established mechanism for safe transfer of non-Super Six patients from Outpatients to CNS/Primary Care
- Established Operational Policy for CNS and Primary care Teams.
- Ensure consequences of co-production in previous years are readily apparent in service delivery and patient and carer experience.
- CEPP scheme incorporates GLP1 audit, with repeat Gliptin audit.

Interdependencies

Primary Care & Networks division, Diabetes directorate, Unscheduled Care Division, Children & Young People directorate, Dietetics directorate, Podiatry directorate, Medicines and pharmacy directorate, LMC, Communities Services division, Ophthalmology directorate, Scheduled Care

division, Patient Panels/Patient Participation Groups, Carer's Networks, Diabetes Cymru UK.

Table 7.5.3 - Resource Implications

Description	Band	WTE	Cost (£)
Funding for insulin initiation and supervision			
Funding to sustain DNS service post-March 2015			224, 774
Diabetes Nurse Specialist operational manager	7	1	49, 086
Diabetes specialist nurses		5	210,430
Diabetes specialist education team leader		0	0
Blackberry devices x 6			1, 716
Laptops x 6			5, 040
Total			**715,0790**

Key Risks and Mitigation

- Lack of quality data on secondary care performance hampers ability to undertake robust modelling and analysis.
- Access to reliable and robust clinical information systems within community service environment
- If there is variance in diabetes care/management across primary care then patients will not be receiving equitable services.
- Increasing number of referrals to hospital based services from rising demographics.
- Failure to fund and support patient education
- Risks to improving in-patient care for patients with diabetes and co-morbidities
- Failure to meet objectives set out in the UHB Diabetes Delivery plan
- Numbers of diabetes DNSs retiring in the next few years is a risk to sustaining the workforce.
- Recruitment challenge for specialist and advanced Allied Health Professionals including Podiatry, Orthotics and Dieticians
- Optimisation of medicines management may not occur.
- Harm from patients waiting long periods for assessment and treatment in outpatients
- Ability to recruit to primary care diabetes specialist nurses as specialised area – mitigation is to consider job sharing to attract primary care practices nurses into roles.
- Securing funding for post March 2015 – application for funding currently with the UHB Strategic Change Fund
- Lack of engagement by patient in sustainable patient participation groups
- Lack of engagement by primary care physicians if they do not perceive support from secondary care clinicians as quality education.
- Uncertainty of recruitment of DM Consultant following retirement.
- No permanent ante natal services cover by Consultants.

5.3 Respiratory

Baseline Position

Improving the respiratory health of the population is a major challenge for the Health Board and provides a key opportunity to improve the lives of patients and their families.

Health Statistics Wales 2013 states that one in seven adults (14%) in Wales reports being treated for a respiratory condition and respiratory diseases cause one in seven (15%) of all deaths in Wales. The total cost of prescribing for respiratory medicine in NHS Wales primary care from July 2013 – June 2014 was £85,430,162. Most patients with asthma and COPD are managed in the community.

Disease prevention

The Health Board is committed to ensuring that the population it serves are encouraged to value good lung health, to be aware of the dangers of smoking and, take personal responsibility for their lifestyle choices to reduce the risk of acquiring a respiratory condition and maximise the benefit of any treatment. In some parts of Gwent, smoking prevalence is still at 28% with little evidence of reduction in the past few years. It is accepted that in order to improve the quit rate we must

develop smoking cessation services to provide a range of services that better meet the varying needs of the population. In order to do this, the Primary Care and Network (PC&N) division has worked with Public Health Wales to develop and publicise these services, creating ease of access to help with smoking cessation in a number of different ways:

- Highlighting smoking cessation as a key priority across all Neighbourhood Care Network Plans.
- Smoking cessation pathway developed with Public Health/SSW at NCN level for implementation to meet Tier 1 target.
- Brief intervention training offered to NCNs across the UHB area.
- Pharmacy Level 3 smoking cessation service established.
- Health bus promoted smoking cessation and lung health across 4 locations in Gwent over a 2 week period in July 2013.

This work remains a key priority in the Neighbourhood Network plans, but to improve effectiveness we must integrate the above actions further with secondary care, reviewing current inpatient and outpatient facilities to ensure that we are taking every opportunity to offer smokers help to quit.

Smoking prevalence in the UHB is 22%. The percentage of adults who smoke daily or occasionally has dropped from 27% in 2003 however there is still much work to be undertaken to substantially reduce this and the UHB still has the second highest prevalence of regular smokers in Wales.

In 2014/15 out of 1425 people offered treatment to give up smoking 38% of them made a quit attempt validated at 4 weeks, this is relatively low in comparison to the many other Health Boards. However, The UHB implemented a smoke free environment policy in 2012 which was developed and supported by the Tobacco Control Group. There has been an expansion of the level 2 smoking cessation services within the UHB, with 23 pharmacies participating. This scheme is targeting services in Blaenau Gwent, Caerphilly and Monmouthshire. Further extension of 5 level 3 cessation services provided by community pharmacies is complete with a further 25 pharmacies identified for the scheme in year 1 and a further 20 pharmacies in year 2.

The UHB has also recruited two smoking cessation counsellors who are managed jointly by the respiratory physicians and Public Health Wales. Their role continues to support existing services and patients during their inpatient stay and after discharge. The UHB is also piloting the maternal smoking cessation support model to increase the number of pregnant women who smoke to engage with smoking cessation service and go on to quit.

Immunisation against influenza is an important preventive measure in patients with respiratory disease. Through the neighbourhood care networks we have improved our performance in the area but there is still work to be done to encourage higher immunisation rates in groups that are traditionally harder to reach such as younger asthmatics. There is an opportunity to enhance partnership working with community pharmacy in this area. The 2013/14 data demonstrates that The UHB achieved a vaccination rate of 70.4% for at risk over 65s and 55.3% for at risk under 65s. Both of these are higher than the all Wales average but it would be fair to say that further improvements would be beneficial to our high risk groups and to achieve a target of 75% take up.

Improved awareness campaigns across the Health Board and primary care and a targeted approach in respiratory clinics and wards to continue to improve take up for our high risk respiratory patients.

In addition, the UHB has an active campaign to encourage staff working in high risk areas to take up the flu vaccination programme.

Detecting disease quickly

When problems with lung health do occur, we aim to ensure that individuals can expect early and accurate diagnosis and effective treatment to reduce morbidity and mortality and improve quality of life. In order to do this it is necessary for patients with suspected asthma or COPD to have good

access to health care professionals able to carry out diagnostic tests such as spirometry and interpret those tests to ensure accurate diagnosis and appropriate treatment. For suspected interstitial lung disease, bronchiectasis and sleep disordered breathing, timely access to specialist opinion and radiological tests are essential. Therefore, education and support for primary care nursing and GPs is paramount and there is an opportunity to provide this through initiatives currently being developed within the Division.

Delivering fast, effective care
Evidence tells us that non-drug interventions such as smoking cessation, flu immunisation and pulmonary rehabilitation are much more effective at reducing morbidity from COPD than inhaled drug treatment. However, there is currently a mismatch in emphasis between these interventions suggesting that we are not achieving the best outcomes that we can for patients and could better target our resources. An "Invest to Save" initiative involving a specialist respiratory nurse supporting asthma and COPD reviews in primary care has already saved in excess of £100K and there is much more that could be done with further integration of primary care and specialist nursing. If savings were reinvested in pulmonary rehabilitation we would achieve better outcomes and therefore value for both patients and the Health Board – an example of prudent healthcare.

Further work done includes:

- Guidance produced and disseminated to primary care relating to the optimisation of respiratory medicines management in asthma and COPD.
- Optimisation of inhaled therapy training rolled out with associated guidance.
- GSK prep training provided to primary care practitioners.
- Review of the domiciliary oxygen service in the UHB undertaken.

Waiting times for respiratory outpatient clinics are between 26 and 36 weeks long and we must seek new ways for primary care to obtain timely advice from chest physicians. The previously established respiratory helpline did not achieve the intended benefits – we must explore the reasons for this and find alternative solutions to enable timely and effective care closer to home.

The number of GP referrals into secondary care averages at approximately 400 per month. All referrals are seen within 36 weeks however in the last 12 months 12 % of patients are waiting to be seen over 26 weeks and it is the expectation that no patients will wait longer than 26 weeks to be seen and treated. In the last 12 months 86.5% of referred patients have been treated in less than 26 weeks. There have been some periods when due to diagnostic delays 1.3% of referrals were treated over 36 weeks.

There has also been concern within the Directorate relating to timeliness of urgent (non cancer) appointments and as a result a change in clinic description and template has taken place to provide urgent clinic slots, which are currently being monitored. All referrals are reviewed and prioritised and where it is felt that a referral could be managed within primary care, advice letters suggesting treatment and action are dictated back to GP. The Directorate has also set up an email advice line to provide information to GPs who need expert advice but do not necessarily want to refer a patient into secondary care. The Directorate has developed a chronic cough proforma for GPs which has been approved by the Medicines Management Committee.

Improving information
We currently have a range of metrics which help us to assess our performance against the key objectives already described. For example, those relating to COPD care have been incorporated into a dashboard that allows a comparison of disease prevalence with a view to reducing variation against performance. Further refinement of outcome measures is needed so that we can assess whole system performance.

5.4 Palliative Care

It is the case that many patients with advanced respiratory disease end their life in hospital when this may not be their preferred place of care. There are many reasons for this, not least the ability to provide an accurate prognosis. However, it is possible to identify those patients who may not benefit from further hospital admissions and by working closely with secondary care colleagues we can seek to explore the wishes of this patient group and manage them so that we are affording them dignity and control over their illness as they approach the end of their life. Much work has already been done in this area led by our GP Macmillan facilitators including:

- Guidance developed for the management of breathlessness.
- Work undertaken between primary and secondary care and out of hours on the development of a register of patients who frequently exacerbate.
- Dissemination of prognostic indicators and advice on the development of palliative care registers to include patients with non-malignant disease.

Desired Future State
Patients will access fully integrated respiratory services, where most care is provided in or close to their homes.

Priorities for Improvement
Smoking cessation support will be further enhanced, optimising management in primary and community care settings and working with our NCN partners to promote and maximise uptake of smoking cessation support and resources, expanding community smoking cessation services and delivering smoking cessation educational programme to staff.

The COPD Dashboard will be reviewed on a quarterly basis to identify variation in prescribing and measure the effectiveness of our strategies to optimise medicines.

For a number of years we have had COPD homecare operating successfully in some areas and long term condition (LTC) specialist nursing in the community. Respiratory patients experience many transitions and crisis points in the course of their illness whether that is an acute exacerbation requiring emergency care or advance care planning as the disease process advances. It is recognised that if we are to ensure truly seamless care for patients that is close to home and manages each transition in the best possible way, specialist care must be fully integrated into the extended primary care team.

This will facilitate integrated and timely management for patients with acute exacerbations of COPD at home; help avoid unnecessary admission; support early discharge from hospital, liaise and refer into pulmonary rehabilitation programmes; provide education / support / advice to healthcare professionals regarding the management of patients with COPD in the community including medicines optimisation and provide anticipatory care e.g. prevention advice, education and support to carers, working in partnership with GPs, district nurses, palliative care and other partners.

The Community Pulmonary Rehabilitation service is not uniform and there is insufficient capacity in service across the UHB area. A review of the service is to be undertaken including improving interface with Third sector to better manage pulmonary rehabilitation support; making available accessible community venues and developing a unified referral process. We will reduce inappropriate referrals and seek to provide support to patients who do not meet the criteria for formal PR, but would benefit from additional support including peer support to help manage their illness. The work undertaken in primary care will dovetail with the requirements of the UHB Respiratory Action Plan and the Respiratory Directorate and be co-ordinated through the Respiratory Planning and Delivery Group.

Outcomes for patients:
- Improved quality of life through greater support in the community.

- Reduced risk of admission to hospital, increased self management.
- Improved access to pulmonary rehabilitation.
- More deaths occurring in preferred place of care.
- Increase in uptake of Flu vaccination, specifically for high risk patients and those with a respiratory condition.
- Increased efficiency, timeliness and effectiveness of services delivered.
- Consistent and robust performance management system to evidence practice and identify gaps.
- Resource directed to where it adds greatest value for patients.
- Reduction in the number of emergency bed days used by COPD and asthma patients.
- Increase in early discharges from hospital.

Key Milestones for Delivery

Table 7.5.4

Respiratory	
Refine and implement model for community based respiratory nursing	Q2 2015/16
Recruit Community based Respiratory Nursing Team (Band 7, Band 6 Nurse and Band 4 Administrative Officer	Q2 2015/16
Accelerate the ongoing work to optimise drug treatment in respiratory disease	Q1 2015/16
Establish working group associated with the Respiratory Planning and Delivery Group	Q1 2015/16
Integrate Neighbourhood smoking cessation strategy with secondary care outpatient and inpatient care and monitor the effect of the smoking cessation counsellors within secondary care	Q2 2015/16
Deliver consistent model for Pulmonary Rehabilitation, decrease inappropriate referrals and improve access	Q4 2015/16
Develop a co-productive strategy for involvement of Third sector in providing patients with additional support to manage their condition and to enable the Health Board to engage patients in providing meaningful information relating to their patient experience	Q2 2015/16
Analysis of GP referrals to secondary care to scope alternative ways of managing patients in the community e.g. chronic cough pathway	Q3 2015/16
Evaluate the lessons from the 2014 EOLC audit, highlighting themes related to EOLC for respiratory conditions in relation to end of life planning and develop solutions to improve respiratory end of life care with secondary care	Q4 2015/16
To engage in the All Wales MDT for patients suffering from ILD and who may be prescribed high cost medication to manage their symptoms (perfenidone)	Q4 2015/16
Inclusion of respiratory module in practice nurse foundation course	Q1 2016/17
Ensure all staff involved in respiratory care have had access to inhaler technique training	Q2 2016/17
To develop a collaborative communication strategy to provide advice, information and education to health care professional and carers and patients	Q2 2015/16
Implement the solutions developed through the 15/16 milestones for respiratory palliative care	Q 4 2016/17
Explore the most effective way the primary care to access consultant advice.	Q 4 2016/17

Governance

This scheme is led by the Primary Care Clinical Director supported by the Clinical Director for Respiratory Medicine. It reports to the Respiratory Planning and Delivery Group and Respiratory Directorate.

Desired Outcomes and Quantifiable Benefits

Table 7.5.5

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
Quality	Decrease in poorly controlled COPD patients		The high strength ICS prescribing (items per 1000 PU's) for smokers This measure gives an indication of the proportion of smokers being treated with high strength prescriptions for a lung related condition Prevalence of Asthma, COPD in the UHB and Wales and percentage of adults smoking daily and in deprived areas	Q2 2016/17 Q4 2015/16
	Medicines management and COPD admissions data		GP referrals for patients with respiratory conditions Number of all respiratory admissions and emergency admissions in the UHB Average length of stay for admissions and emergency admissions for all respiratory conditions	Q3 2015/16
	All patients with a diagnosis of Asthma and COPD have an annual review		Percentage of patients with asthma and COPD, on a GP register, who have had an asthma review in the preceding 15 months	Q4 2016/17
Workforce	Establishment of Community Respiratory Nursing Team Scoping of specialist nursing requirements to be integrated with practice and district nursing		Full establishment of respiratory nursing resources, base and WTE reviewed with job plans and integrated management structure	Q2 2016/17
Performance	Further savings from a reduction in inappropriate high dose inhaled corticosteroids		The high strength ICS prescribing (items per 1000 PU's) for smokers Number of patients aged 15	Q4 2015/16

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
	Increased number of people accessing smoking cessation services Increased uptake of flu vaccination for high risk patients		or over in Wales who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months Percentage of smokers making a quit attempt and CO validated at 4 weeks Percentage of patients in Wales aged 65+ and those below 65 in high risk groups who received influenza immunisation	
	Reduced waiting times for pulmonary rehabilitation		Percentage of patients assessed in the UHB and Wales referred for pulmonary rehabilitation at time of discharge	Q2 2016/17
Finance	TBA			

Interdependencies
Pharmacy Lead, GPs, LTC Nurse Team, Respiratory Specialist Clinicians, Third Sector, Community Division/Frailty Service and Neighbourhood Care Networks

5.5 Neurological Conditions

Baseline Position
Together for Health – a Neurological Conditions Delivery Plan for NHS Wales and its Partners was published by Welsh Government in April 2014. The UHB's Local Delivery Plan for Neurological Conditions up to 2017 was published in December 2014. The plan identifies the following objectives as its key themes:

- Raising awareness of neurological conditions – Increased awareness of neurological conditions and their symptoms.
- Timely diagnosis of neurological conditions – Neurological conditions are detected quickly, allowing timely progress to care and treatment.
- Fast and effective care – People with a neurological conditions should receive fast, effective care and treatment.
- Living with a neurological condition – Whether in the community or in hospital, people are placed at the centre of care with their individual needs identified and met so they feel well supported and informed and able to manage the effects of their neurological condition.
- Children and young people – Children and young people with neurological conditions receive appropriate care.
- Improving information – Information systems to support high-quality care, clinical audit and to drive service improvement.
- Targeting research – A commitment to research, delivering improved diagnosis, management, treatment options and outcomes (Oct 2014).

The LDP's executive lead is the Director for Therapies and Health Sciences. Clinical and

managerial leads are also assigned. Governance for delivery of the LDP is currently with the Unscheduled Care Division.

National Priorities for 2016/17
Guidance from WG has indicated that in 2016/17, priorities for Stroke delivery are the following:

- Developing a co-productive approach to increasing awareness of neurological conditions.
- Delivering clear consistent patient information.
- Delivering access to neurology services, for patients of all ages, consistently throughout Wales.
- Developing consistent and coherent neuro-rehabilitation services, for patients of all ages.
- Developing and responding to patient experience and outcome measures.

Key Milestones
The extension of the community neuro-rehabilitation service to include support for patients with acquired brain injury.

5.6 Stroke Services

Aim
To improve and maintain the improvement in stroke services in line with the UHB Local Delivery Plan, Welsh Government Stroke Delivery Plan and Royal College of Physicians Stroke Standards.

Baseline Position
In 2013, driven by the desire to provide consistent and equitable high quality stroke care, as measured against the evidence-based, national clinical standards set by the Royal College of Physicians (RCP) and the Welsh Government Tier One targets, the UHB recognised the need to re-design its stroke services.

The UHB published its Stroke Local Delivery Plan in July 2013, which clearly described the aim of enabling high quality stroke services to be delivered for the people of Gwent that equalled 'best-in-class' and aspired to world class standards. In line with the milestones specified in the Welsh Government's National Stroke Delivery Plan (2012) the UHB's Local Delivery Plan has remained a live document and has been refreshed on an annual basis to take into account progress made and focus on developments for each coming year. The UHB submitted its annual Stroke Local Delivery Plan report to Welsh Government and this is published at the following link: ABUHB Local Delivery Plans

The Stroke Services Re-design Programme (SSRP)
The UHB's Clinical Futures Programme defined the template of a single hyper-acute stroke unit (HASU), at the new SCCC supported by a number of enhanced local general hospitals, community hospitals and community services. However, it was accepted that a re-designed pathway for stroke was required prior to the SCCC being opened in 2019 in order to consistently meet the Royal College of Physicians Stroke Sentinel National Audit Programme (SSNAP) standards and the new Quality Improvement Measures

In 2013 the UHB's Stroke Board developed a vision for stroke services and a clinical model for change that encompassed the entire stroke pathway from prevention to life after stroke, and this pathway was used to guide the physical reconfiguration of stroke services across the UHB. The resulting re-designed pathway is fully aligned to the national priorities for stroke care and was fully implemented on 25th January 2016.

Historically, in-patient stroke care was provided across seven different hospital sites, including two hyper-acute emergency admission sites. The new model since implementation of the SSRP focuses the UHB's resources, and the skills and expertise of its staff, by concentrating services on fewer sites through the development of a sustainable service model with centres of excellence.

Inpatient stroke rehabilitation is now condensed into three sites at St Woolos Hospital (SWH), YYF

and NHH, supported by the development of a Community Neuro-rehabilitation Service (CNRS) which enables Early Supported Discharge (ESD) for stroke patients to be rehabilitated at home where it is appropriate and safe to do so. Once the SCCC is operational, hyper-acute stroke care will transfer from RGH to the SCCC, with acute and rehabilitative stroke care continuing as per the interim solution.

Desired Future State
By Q4 2017 the UHB will be consistently maintaining stroke services in line with or exceeding 'Best in Class' across Wales.

By 2019 the UHB will be consistently maintaining stroke services in line with its Clinical Futures model and meeting or exceeding 'Best in Class' across the United Kingdom

The ABUHB Stroke Delivery Plan
The UHB submitted its annual Stroke Local Delivery Plan report to Welsh Government and this is published at the following link: ABUHB Local Delivery Plans

ABUHB Stroke Performance
The UHB is committed to sustained improvement in performance for stroke care. We have continued to actively participate in the Sentinel Stroke National Audit Programme (SSNAP) and monitor our performance against these clinical standards in addition to the Welsh Government targets for stroke. The UHB's stroke performance is reported monthly to the NHS Wales Delivery Unit and annually in the UHB's Stroke Local Delivery Plan Report found at: ABUHB Local Delivery Plans

Quality Improvement Measures
In October 2015 the Welsh Government replaced the Tier One Bundles with new Quality Improvement Measures, which are more challenging but represent specific elements of the SSNAP audit. From the end of January 2016 the Royal Gwent Hospital (RGH) will be the only admitting site for stroke across the UHB and the only site measured against the Quality Improvement Measures.

The Quality Improvement Measures are more challenging than the previous Tier One Targets, with the 4 hour target comprising direct access to the stroke ward and a swallow screen; the 12 hour target comprising access to CT scan; the 24 hour target comprising assessment by stroke consultant, stroke nurse and one of occupational therapist (OT), physiotherapist (PT) or speech and language therapist (SLT); and the 72 hour target comprising assessment by OT and PT and a formal swallow screen by SLT. With the introduction of a stroke consultant at the front door from December 2015 and introduction of the new stroke pathway in January 2016 our performance in January 2016 was:

Table 7.5.6

Quality Improvement Measure	January 2016 Performance
4 hour	45.1%
12 hour	96.1%
24 hour	64.7%
72 hour	94.1%

Our performance was above the All Wales average for measures 1, 2 and 4. Going forward we would expect to see sustained and significant improvement.

Sentinel Stroke National Audit Programme (SSNAP)
Our SSNAP clinical audit performance has showed improvement over time against a number of domains, however, performance can be affected significantly by issues such as staffing levels as shown over recent quarters in relation to therapy support for stroke patients. Although modest improvements were made across Wales over the past two years, most organisations, including the UHB achieved an overall level D for July-September 2015, with only two sites achieving a level C

score.

Although the UHB is not performance measured against SSNAP by the Welsh Government, this data is now available in the public domain at: Stroke Sentinel National Audit Project (SSNAP)

With the implementation of the UHB's Stroke Re-design Programme, we anticipate significant improvements across all SSNAP domains. From December 2015, we introduced a phased implementation of consultant support to the front door at RGH, which should result in improved performance against the scanning, stroke unit and thrombolysis domains. The final element of the re-design programme, the opening of the HASU at RGH and associated re-aligned bed model is planned for the end of January 2016. As a result we would envisage significant and sustained improvement in performance from the final quarter of 2015-16 and beyond.

We have also reviewed our performance against the SSNAP Acute Organisational Audit in 2014 and predict a significant improvement in the next audit due in 2016, where we anticipate moving from Bands D and E to a Band B across the acute pathway.

In addition to sustained improvement in performance against clinical and national standards, the UHB will be introducing Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to measure and monitor meaningful outcomes for patients via the adoption of The International Consortium for Health Outcomes Measures (ICHOM) Stroke Standard Set of measures.

The UHB has recently commenced a programme of work to develop Patient Level Information Costings for the new stroke pathway, which will enable clinicians to examine variation in cost in a meaningful way. Future developments include linking patient level pathway costs to patient level outcomes in order to measure value.

On an ongoing basis, performance against both the Quality Improvement Measures and the SSNAP audits will continue to be reported to the Quality and Patient Safety Committee and the Board to provide assurance regarding the quality and safety of care provided to stroke patients and to demonstrate the investment of time and resource to this service change was justified and provides value for money.

In addition performance and achievement of national priorities going forward will be monitored on a national basis via the Stroke Implementation Group.

Priority Focus for the Next 12 Months
The priority over the coming year will be to realise the benefits of the re-designed pathway and to implement Patient Recorded Outcomes Measures (PROMs) and Patient Recorded Experiential Measures (PREMs)

Desired Future State
In developing our local Stroke Delivery Plan the UHB recognised the need to reconfigure services in order to deliver high quality consistent care for stroke patients. To achieve this it has embarked on a challenging programme of service re-design, which encompasses the whole pathway from prevention to life after stroke.

The Re-design Programme aims to enable stroke services to consistently meet the clinical standards and optimal outcomes for stroke care and encompasses both the 'where' and the 'how' services will be delivered in the future. The re-design was clinically led and has engaged with patients, staff and partners across the whole pathway of stroke care to identify, agree and implement the most appropriate, cost effective and sustainable solutions for the future.

The final elements of the Stroke Services Re-design Programme - opening of the HASU and re-alignment of stroke beds across the UHB were completed on 25 January 2016.

However, service improvement will not cease after this time and the team will continue its drive to improve services for our stroke patients. The longer term vision is to develop 7 day services across the whole pathway starting with rehabilitation services to further improve the standards of care for stroke patients.

Table 7.5.7

Stroke Services	
	Timescale
Stroke Services Re-design Programme	
Realise anticipated programme benefits of the Stroke Services Re-design Programme	Q4 2017
Stroke Delivery Plan	
Preventing Stroke	
Continue to roll out and embed prevention strategies such as Living Well Living Longer and access to smoking cessation, Adult Weight Management Service and National Exercise Referral Scheme (NERS)	Q4 2017
Identify, implement and audit clearly stated performance measures and targets for stroke prevention	Q4 2018
Embed participation in national audits and action on outcomes	Q4 2018
Detecting Stroke Quickly	
Identify further actions needed to improve detection, calls for help and reduction in detection to needle time	Q4 2017
Delivering Fast Effective Care	
Evaluate the performance and delivery of the re-designed pathway	Q4 2017
Improve and maintain performance against Welsh Government Quality Improvement Measures and the SSNAP standards	Q4 2017
Consider the provision of seven day acute services	Q4 2018
Supporting Life after Stroke	
Realise the benefits of CNRS in terms of patient and carer satisfaction and outcomes	Q4 2017
Expand the CNRS to support patients with acquired brain injury (ABI)	Q4 2017
Consider the provision of seven day rehabilitative services	Q4 2017
Further develop the detection and treatment of post-stroke psychological problems	Q4 2017
Engage with stroke survivors, their families and carers, involving them in all aspects of stroke services	Q4 2017
Improving Information	
Develop a meaningful and informative Stroke Performance Dashboard	Q4 2017
Develop stroke specific public facing webpage	Q4 2017
Refresh identification and recording of information needs	Q4 2018
Implement PROMs and PREMs	Q4 2017
Establish systems for routine review of performance against Welsh Government Quality Improvement Measures, SSNAP and mortality data to inform practice and further service re-design	Q4 2017
Develop Patient Level Information Costings for the entire stroke pathway	Q4 2017
Targeting Research	
Stroke Research Group to maximise local research opportunities and inclusion of patients in large scale multi-centre trials	Q4 2017
Report research activity to the Health Board	Q4 2017
Realise the benefits of Health Outcomes Measurement to provide robust and meaningful data for stroke research and evaluation	Q4 2019

Governance

The Service Change Plan is led by Alison Shakeshaft, Executive Director of Therapies and Chair of the UHB Stroke Board and supported by members of the Group. The Stroke Board reports

assurance to the UHB's Quality and Patient Safety Committee.

Desired Outcomes and Quantifiable Benefits

Table 7.5.8

Service Change Plan	Outcome	Baseline Measure Dec 2015	Target Measure	Timescale
Improved Hyperacute Stroke Care				
Quality (Measures for HASU only)	**Achievement of 4 hour Quality Improvement Measures**	30%	95% within 4 hrs of attendance	**Q4 2016**
	Access to stroke ward in 4 hours	38%	95%% within 4 hrs of attendance	Q4 2016
	Swallow screen within 4 hours of attendance	42%	95%	Q4 2016
	Patients assessed by stroke specialist consultant within 24 hours	95%	95%	Q4 2016
	Patients assessed by a nurse trained in stroke management within 24 hours	87%	95%	Q4 2016
	Patients assessed by one of Physiotherapist, Occupational Therapist or Speech and Language Therapist within 24 hours	87%	95%	Q4 2016
	Achievement of 12 hour Quality Improvement Measure	87%	95%	Q4 2016
	Brain imaging within 12 hours of attendance	87%	95%	Q4 2016
	Achievement of 24 hour Quality Improvement Measures	77%	95%	Q4 2016
	Patients assessed by stroke specialist consultant within 24 hours	95%	95%	Q4 2016
	Patients assessed by a nurse trained in stroke management within 24 hours	87%	95%	Q4 2016
	Patients assessed by one of Physiotherapist, Occupational Therapist or Speech and Language Therapist within 24 hours	87%	95%	Q4 2016
	Achievement of 72 hour Quality Improvement Measures	83%	95%	Q4 2016
	Patients assessed by physiotherapist within 72 hours	93%	95%	Q4 2016
	Patients assessed by OT within 72 hours	91%	95%	Q4 2016
	Patients assessed by SLT within 72 hours	76%	95%	Q4 2016
	Patients receiving formal swallow	74%	95%	Q4 2016

Service Change Plan	Outcome	Baseline Measure Dec 2015	Target Measure	Timescale
	assessment within 72 hours Patients discharged early through ESD across all in-patient sites	20%	30%	Q4 2016
Improved Stroke Thrombolysis Performance				
	Eligible patients thrombolysed	71%	100%	Q4 2016
	Thrombolysed patients with door to needle time ≤ 30 min	0%	50%	Q4 2016
	Thrombolysed patients with door to needle time ≤ 45 mins	20%	90%	Q4 2016
	Thrombolysed patients with pre and post thrombolysis NIHSS score	60%	100%	Q4 2016
Improved Outcomes for Stroke Patients	ICHOM Stroke Standard Set (PROMS data collection in development)	To be determined	To be determined	Q4 2017
Increased patient/ carer satisfaction	PREMS in development	To be determined	To be determined	Q4 2017
Workforce	Capability to provide 7 day rehabilitation services for stroke patients	Staffing levels post SSRP	Option B of the SSRP Business Case therapies staffing (full RCP standards plus 7 day services all therapies, all stages of the pathway)	Q4 2018
Performance	Average acute stroke LoS reduced to 7 days	To be determined	7 days	Q4 2017
	Average provider super-spell LOS reduced to 20 days	To be determined	20 days	Q4 2017
	Beds used by stroke patients reduced to 73	83	73	Q4 2017
	Reduced readmission rates	To be determined	To be determined	Q4 2017

Interdependencies

Unscheduled Care Division; Family & Therapies Division; Therapy Services; Therapies professional groups; Community Services; CNRS; Community Resource Teams; Neighbourhood Care Networks; The Stroke Association; Community Health Councils; Local Authority Adult Services; Local Authority Scrutiny Committees; Town and Community Councils; Stroke Board; the UHB's governance committees; Finance Division; the UHB's Workforce and Organisational Development; Planning and Performance Division

Table 7.5.9 - Resource Implications

Description	Band	WTE	Cost (£)
The Stroke Services Re-design Programme was resourced in line with Option A in the programme business case as approved by the Board in April 2015. Further resource implications associated with any further development e.g. full 7 day services across the stroke pathway will need to be costed.			

Key Risks, Mitigation and Opportunities
Risks identified within the Stroke Services Re-design Programme are mitigated and managed as they arise and as new risks and issues are identified throughout implementation they will be added to the risk register and managed appropriately.

Risks associated with further implementation of Stroke Delivery Plan priorities will be identified and managed appropriately.

5.7 Heart Disease

Baseline Position
"Together for Health – a Heart Disease Delivery Plan" was published by the Welsh Government in 2013. The UHB's *Together for health: Heart disease delivery plan up to 2016 for the UHB and its Partners* was submitted and published in February 2014. The first Annual Report was published in December 2014 and additional progress reports were published in April 2014 and April 2015. The plan identifies the following objectives as its key themes:

- Promotion of healthy hearts;
- Timely detection of heart disease;
- Fast and effective care;
- Living with heart disease;
- Improving Information;
- Targeting research (April 2014).

Clinical and managerial leads are assigned. Governance for delivery of the LDP is currently with Unscheduled Care Division. Some elements are part of the Living Well, Living Longer programme are managed under SCP 2. The Plan is due to be refreshed as the original timeframe to 2016 is now complete.

Progress against Local Priorities in 2015/16
There has been good progress on implementation of the LDP in its final year. Some key examples include:

- Cardiovascular risk health assessments successfully rolled out as part of the Living Well, Living Longer programme in Blaenau Gwent West Neighbourhood Care Network (NCN) area and now rolling out in Caerphilly North and Blaenau Gwent East NCNs (see SCP 2).
- Partnership Childhood Obesity Strategy and Action Plan developed along with a family-based childhood weight management service (Level 2 and 3) business case (see SCP 2).
- Rolled out Smoke Free Support Service to further hospital inpatients, fully integrated with Community Pharmacy enhanced services to support patients following discharge from hospital (see SCP 2).
- Working with other health boards, trusts and private providers to commission a phased increase in access to cardiac MRI over the next 5 years to improve diagnostic and prognostic information.

National Priorities for 2016/17
Guidance from WG has indicated that in 2016/17, priorities for heart disease delivery are the

following:

- Roll out and implementation of a consistent model for the delivery of cardiovascular risk assessment.
- Improve pathways offering consistent and timely access to cardiac diagnostic tests and treatments.
- Improve outcomes by increasing participation and case ascertainment in national clinical audit with regular feedback to clinical leads.
- Drive measurable service improvement in Cardiac Rehabilitation services to meet national standards by delivering services consistently and equitably.
- Improve the capacity, recruitment and retention of the cardiac physiologist workforce and support the development of educational programmes for advanced and extended roles to support delivery of improved pathways.
- Implement the Out of Hospital Cardiac Arrest Strategy for Wales.

Key Milestones

Table 7.5.10

Liver	
Replace Royal Gwent Hospital cardiac catheter laboratory (capital programme).	Q2 2016/17
Reduce follow up waiting times.	
Explore development of a local Complex device therapy services (ICD) from 2016/17 to reduce inpatient waiting time currently provided at UHW.	Q4 2016/17
Address current shortfalls and geographical inequalities in Heart Failure nursing.	Q4 2016/17
Explore GPwSI and Community Cardiologist model to deliver non complex cardiology consultation.	Q4 2016/17
Streamline management of urgent patients with serious clinical pathologies for priority booking.	Q4 2016/17
Develop plans to drive down waiting times for the full range of cardiac diagnostic tests and measuring progress against WG's pilot 8 week component waiting time reporting.	Q4 2016/17
Published cardiac diagnostic test results e.g. echocardiogram results on Clinical Workstation to speed treatment planning.	Q4 2016/17
Introduce High Sensitivity Troponin I blood test to improve the detection of cardiac events in women in particular, and to facilitate earlier hospital discharge for those with negative results.	Q4 2016/17

5.8 Liver Disease

Baseline Position

The UHB's Local Delivery Plan in response to the *Together for health: liver disease delivery plan for NHS Wales and its partners to 2020 May 2015* was submitted to WG in August 2015. The plan identifies the following objectives as its key themes:

- Preventing liver disease and promoting liver health.
- Timely detection of liver disease.
- Fast and effective care.
- Living with liver disease.
- Improving information.
- Targeting research.

The executive lead for the LDP is the Director of Public Health. Clinical and managerial leads are also assigned. Governance for delivery of the LDP is currently with Unscheduled Care Division with key elements aligned to SCP 2.

Progress against Local Priorities in 2015/16

There has been good progress on implementation of the LDP since its approval in August. Some

key examples include:

- Maximised UHB's role as a Responsible Authority under the Licensing Act. UHB has successfully made 3 representations as a Responsible Authority.
- Gwent Drug and Alcohol service launched.
- An Integrated Alcohol Treatment Pathway developed and business case for Alcohol Care Team in RGH, NHH and YYF approved in anticipation of funding being available by the All Wales Liver Disease Delivery Group.
- Childhood Obesity Strategy has been developed and is being taken through the 5 LSBs for agreement.
- Project plan for the AST/ALT ratio risk assessment pilot being developed.

National Priorities for 2016/17
The first Annual Report on progress against the LDP is due in April 2016. Guidance from WG has indicated that in 2016/17, its priorities for the delivery plan are the following:

- Awareness raising of risk factors and lifestyle changes to prevent liver disease.
- Transforming early diagnosis through better awareness, training, resources, access to testing.
- Redesign the pathway and the development and implementation of standards.
- Make an impact on alcohol-related hospital admissions through alcohol care teams in each Health Board.
- Development of specialised services, such as liver transplantation and HCC provision.

Key Milestones

Table 7.5.11

Liver	
Design and deliver a targeted testing system for Hep B and Hep C among those at risk of BBVs	Q4 2015/16
Introduction of data sharing agreement and protocol for alcohol misuse statistics.	Q4 2015/16
Produce a business case for dedicated dietetic support and recruitment of dietician as part of the multi-disciplinary team Liver Disease Delivery Plan approved and submitted to WG to tackle increase in mortality rates in under 65s due to liver disease in Wales.	Q4 2015/16
Design and deliver a targeted community testing for Hep B and Hep C in Newport for those born in countries with high prevalence by March 2016	Q4 2015/16
Advocate for the inclusion of alcohol misuse as an NCN priority for 2016/17	Q4 2015/16
Develop and design an appropriate intervention to address alcohol misuse in the 50+ age group by March 2016	Q4 2015/16
Develop Alcohol Care Team as part of an integrated alcohol pathway by April 2016	Q1 2016/17
Work with clinical biochemistry to introduce AST/ALT ratio risk assessment pilot by April 2016	Q1 2016/17
Introduce Child Weight Management Service by April 2016	Q1 2016/17
Identify and introduce evidence-based alcohol misuse prevention programmes in schools by September 2016	Q2 2016/17
Explore potential for extending Nalemefene prescribing for harmful drinking and mildly dependent drinkers by September 2016	Q2 2016/17
Put in place a protocol to improve the quality of alcohol misuse data collection in A&E	Q3 2016/17

SCP 6 - Continuing Healthcare (CHC)

Aim
The aim of this Service Change Plan is to redesign services funded through NHS Continuing Health Care (CHC) in order to deliver high quality, person-centred, CHC services in Gwent in a financially sustainable way.

The SCP is described in 3 sections reflecting the delivery arrangements within the UHB:

- Adult Complex Health Care.
- Mental Health and Learning Disabilities Complex Healthcare (see **SCP 8**).
- Children's Continuing Care under the care of Specialist Child and Adolescent Mental Health Services (S-CAMHS), Child and Adolescent Learning Disability Services (CALDS) and the Children's Community Nursing Service (CCNS).

6.1 Adult Complex CHC

Why is it important?
Continuing Health Care (CHC) is a complete package of ongoing care arranged and funded solely by the NHS, for people who have been assessed as having a primary health need. This considers four key areas:

- Nature – this describes the type of needs, their effect and type of help needed to manage these needs.
- Intensity – this describes the severity of needs which require a degree of ongoing care.
- Complexity – is how symptoms interact, making them difficult to manage and requiring skills to monitor, treat and manage the care.
- Unpredictability – this is the degree to which someone's needs fluctuate and how difficult those needs are to manage.

CHC is just one part of a continuum of services that local authorities and NHS bodies need to have in place to support people with health and social care needs and is one aspect of care which people may need as the result of disability, accident or illness to address both physical and mental health needs. This care can be provided in any setting and there are many patients receiving 24 hour packages of care in their own homes.

These packages may be long term for example for people with profound disabilities where the care may commence in early childhood or for people with specific needs such as home ventilation. Some patients with complex needs may need intense support for shorter periods and may have their care provided and funded through CHC for these periods. In these instances every effort is made to ensure continuity of care for the patient and their families.

There is a fast track process for patients requiring urgent placements or packages as a result of there being patient safety or safeguarding concerns. There is also a fast track process for patients at the end of their lives who require a package of care to enable them to remain at home, if that is their choice. In these circumstances often our Hospices are involved.

LHBs have the lead responsibility for CHC in their local area but work in partnership with Local Authorities, other NHS organisations and independent / voluntary sector partners to ensure effective operation of the National Framework for Implementation 2014. Within the UHB the majority of cases are managed by Complex care, with the Mental Health and Learning Disability Division managing the service for their patients and Family and Therapies Division managing the service for children.

The Continuing Healthcare (CHC) Service Change Plan for 2015/16 highlighted the fact that CHC was fast becoming the most significant cost pressure facing the UHB in that year and indeed throughout the three-year timeframe of the IMTP. This was largely predicated on the actual level of net growth experienced in 2014/15 (£6.3m) with little indication that this would subside in 2015/16 and beyond unless there was a transformative approach to service delivery.

The resultant financial forecast included in the Plan is replicated in the following table:

Table 7.6.1

3 Year Forecast	2015/16 £000s	2016/17 £000s	2017/18 £000s
Forecast overspend position	16,030	17,668	24,949
of which:			
Non-recurrent growth (Phase 3 IRPs)	4,401	0	0
Recurrent growth	6,557	7,796	9,269

The UHB subsequently recognised the challenge in managing such a significant level of cost pressure and agreed to provide an additional £12m of recurrent funding in 2015/16, with an expectation that the remaining £4m shortfall would be met by service transformation and efficiencies.

Desired Outcomes and Measurable Benefits

6.2 Priorities for Improvement

Building on last year's plan, the key desired outcomes can be summarised as follows:

- Assurance on clinical quality and safety.
- More timely and robust clinical assessments for CHC.
- Skilled, supported and sustainable workforce.
- Reduced reliance on high cost agency nursing and agency spend overall.
- Financial savings with associated reductions in costs and volume growth.

Examples of how these will be delivered and their impacts measured are outlined in the table below.

Table 7.6.2

Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
Revise the staffing structures and accountability framework in conjunction with the Trade Unions.	Q1 16/17	Structure fit for purpose. Clear accountability framework.	Agency spend	Evidence staff-side and TU support for changes. Improved recruitment and retention. Reduced agency spend CHC team involvement in packages prior to MDTs for complex cases	Q2 16/17

Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
Implement sustainable model of care for high dependency patients requiring home ventilation.	Q2 16/17	Patients requiring home ventilation receive safe, effective care that meets their clinical needs. Reduced spend on Agency nursing.	Service Costs Agency use Patient delays	Cost savings (yet to be determined) Less reliance on agency staff Reduced delays in patients being discharged	Q4 16/17
Band 4 HCSW roles developed to support care of high dependency patients receiving home ventilation.	Q3 16/17				Q4 16/17
Agree fast track end of life care process	Q1 16/17	Patients receive timely decisions regarding their care packages. Care packages appropriate to the changing needs of the patient and their families	Time from application to package being delivered.	Package delivered within 24 hours	Q1 16/17
Ensure all patients receiving CHC packages of care at home undergo timely reviews for their eligibility so that their care is appropriate to their needs.	Q3 16/17	All receive timely reviews to ensure their needs are met.	Current compliance with 3 month assessment as in NHS Wales Framework.	Improved compliance with 3 month assessments or earlier if specified at previous assessment.	Q4 16/17

Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
Review fee rates (including CHC premium) to incorporate national living wage and increased acuity of patients.	Q1 16/17	Equalisation of fee rates, aligned to LA fee increases.	Current fee rates	Fee rate comparisons at LA level.	Q1 16/17
High cost placement reviews.	Q4 16/17	Prudent healthcare principles based on clinical need.	Baseline costs	Cost savings	TBC
Review of psychology input by C&VUHB for patients with Acquired Brain Injury.	Q4 16/17				TBC
Manage IRPs investigations for Phases 1 - 5	Q4 16/17	Investigations completed in a timely manner.	No of requests	Complete investigations within 12 months of receipt.	Q4 16/17
Maximise all opportunities to work across the health and social care system to improve outcomes for patients and their families.	Q4 16/17	Examples of more integrated working. Improved pathway for patients receiving care under Section 117. Develop pooled budgets		Section 117 guidance followed. No of pooled budgets.	Q4 16/17
Transition Board to oversee transition from children's services to adult services for young people with complex needs.	Q2 16/17	Transition Board established. Seamless transfer of services.	Current service provided	No of young people. Involvement of young person and family in care planning. Satisfaction with service.	Q4 1617
Access to equipment for patients with complex needs (including bariatric	Q3 16/17	Timely access to equipment. Clarity regarding equipment	Current waiting times. No of DTOCs due to	No DTocs due to delays in accessing equipment. Clarity regarding	Q3 16/17

Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
patients).		supplied through GWICES. Improved access to bariatric equipment	equipment access.	equipment responsibility.	

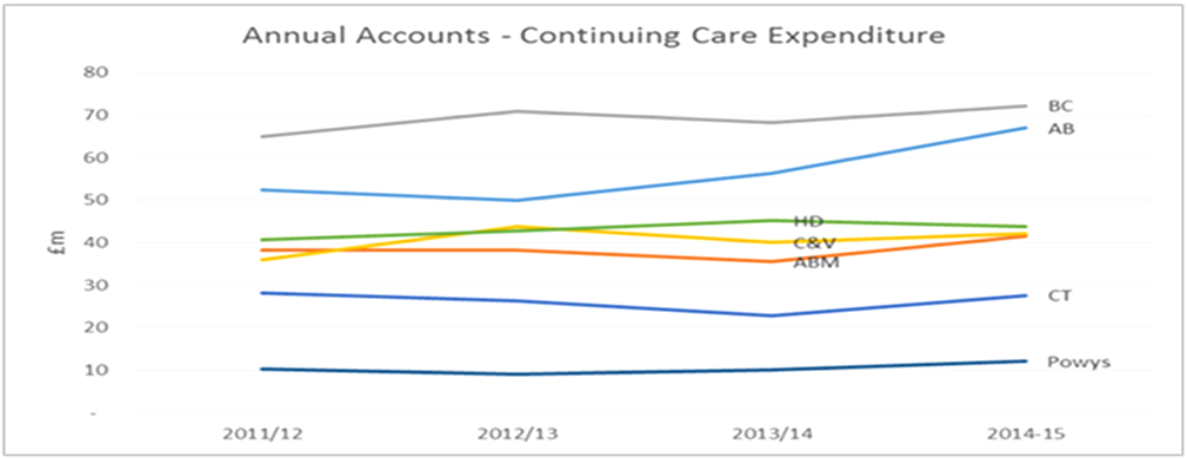
Baseline Position

Benchmarking across Wales

ABUHB had been identified as an outlier with regard to both annual expenditure and rate of growth on CHC provision, particularly over the previous two financial years. There has been significant work by the Finance Team to clarify the position across Wales.

The following graph illustrates the divergence in costs and growth reported in the last four financial years:

Graph 7.6.1



Furthermore, cost per case analyses highlighted the following:

- The UHB has had the highest average cost per case for CHC placements in Wales for the last two years.
- The UHB would need to reduce total CHC expenditure by between £10.331m (20%) and £14.245m (28%) per annum, compared to 2014/15 outturn, to meet the all-Wales average.

Consequently, a multi-faceted approach to reviewing the all-Wales position was undertaken in an attempt to identify the key drivers to the difference.

Within the limitations and accuracy of data provided, the findings from the review indicate:

- All approaches to the data analyses confirmed ABUHB as a cost outlier.
- EMI expenditure in total and relative terms has been determined as the most material factor in the outlier position.
- The baseline for “standard” nursing home fees in Gwent is driven by Local Authority rates plus a premium in recognition of the added complexity of a CHC patient over and above that of NHS Funded Nursing Care (FNC). This premium is in the order of £50 to £60 per week per placement and accounts for approximately £1.8m of annual CHC expenditure. Not all Health

Boards recognise this differential in their CHC fee levels.
- The inclusion of hospital provision for >65 year olds in health care does not explain the material difference on CHC spend.
- Volume and bed capacity differences provided only a marginal contribution to the cost difference.
- Differences in relative demographic forecasts were not a significant factor.

This information has proved invaluable in understanding the baseline position for the UHB and the need to revisit both the governance around assessment and decision making and service delivery models.

Key Achievements in 2015/16
During the year there were changes in the management arrangements for complex care in order to give a specific focus on developing a sustainable service and ensure rigour in decision making to maximise core service provision and deliver effective appropriate care for patients going forward. Subsequently a new governance structure was put in place.

There was also a 12 point plan developed in year to address some of the issues facing the service. This included:

- Review of all high cost packages and those where one to one care is funded. This resulted in a financial improvement of £781,287 during 2015/16.
- Reducing the reliance on nursing agencies for two packages of care, with the aim of transferring care delivery to the UHB's Care at Home Team.
- Reducing agency spend overall.
- Agree care home fees for 2015/16.
- Review hospital MDT facilitator role.
- To develop Band 4 Health Care Support Worker roles to support high dependency patients receiving home ventilation.
- Reviewing the palliative care fast track process.
- Reviewing the procurement for domiciliary care.
- Manage the IRP process in a timely manner, ensuring robust assessment and review.
- Reviewing current structures and communication, specifically with the Local Authorities.
- Timely response to CSSIW reports and the Older People Commissioners report 'A Place to Call Home' to ensure patients receive safe care.
- Review psychology input for Acquired Brain Injury Patients.

Having a focused plan has resulted in:

- Improvements in patient care through ensuring that patients needs are central to any decision making relating to packages of care. The processes to manage patients, ensuring more timely decision making and identification of where delays are occurring has also been a focus of work. A CHC tracker has been developed and is currently being tested in County Hospital, in order to reduce any delays due to assessment and CHC processes and ensure all patients are being cared for in the right setting.
- Staff agreeing the priority areas to be addressed and being supported to address some difficult issues. Some of the family dynamics are complex and challenging due to the difficult situations families are facing on a daily basis.
- Clear reporting arrangements to the monthly Deep Dive with the Executive Team. The Complex Care Team have found these invaluable in being to raise difficult issues and being supported by the Executive Team.

Workforce Issues
An additional Senior Nurse has been appointed to enable more of a Locality focus in order to enhance relationships between the UHB, Local Authority and Care Home staff. This is important to manage safeguarding and care home governance concerns, timely assessments and to ensure appropriate packages of care are put in place, in conjunction with patients and their carers.

A second MDT Facilitator has been appointed for Nevill Hall Hospital. This post holder will support wards to manage the assessment process in line with the 2014 National Framework and liaise with patients and their carers to ensure that they are involved and supported through assessments and any decision making.

There has been a specific focus on managing sickness and increasing PADR compliance.

Clinical Issues
The palliative care fast track process for patients at the end of their lives has been reviewed with the UHB's End of Life Care Board, this includes St David's Hospice Care and Hospice of the Valleys. The aim is to ensure this is a speedy process in respect of decision making so that patients and families are cared for in the place of their choice.

All patients with high cost packages or receiving additional one to one care have been reviewed and will now be reviewed according to need but six monthly as a minimum.

Two patients who have had their care delivered by nursing agencies are being transitioned to the Care at Home Team.

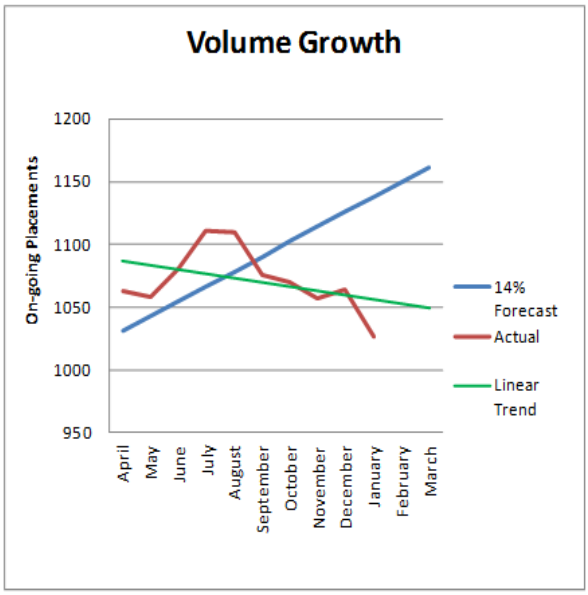
Independent Review Panels
Dedicated management support has been identified to review the position and manage the process.

Care Home Fees
The UHB agreed a maximum fee increase. The UHB is working with the five Local Authorities to agree fee increases for 2016/17 and revise the care home contracts to ensure consistency for the care homes.

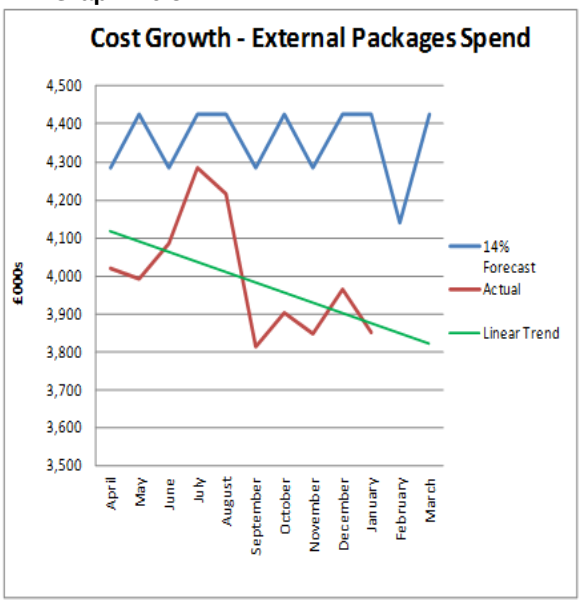
Financial Impact
Focus on and prioritisation of service change opportunities has clearly had a positive impact on the financial position in 2015/16. The Division are reporting a £1.268m underspend on CHC to 31st January 2016, and a forecast underspend of £2.154m (having also returned £4.1m of the £12m additional funding provided by the Board). There is however, a corresponding £462k forecast increase on FNC, but this would still leave the budget with an overall underspend position at year-end.

Growth is showing a remarkable downturn in comparison to that experienced in 2014/15 and the early part of 2015/16, as the following graphs clearly illustrate:

Graph 7.6.2



Graph 7.6.3



CHC placements had shown a marked increase from 1,019 to 1,111 in the first four months of 2015/16, which at over 9% suggested that even the 14% predicted in the IMTP could be exceeded. However, placement numbers have shown a steady decline in the subsequent months, reducing to 1,027 as at 31st January 2016. Cumulative volume growth to date is then just 8 patients (0.8%), suggesting an overall increase of less than 2% by year-end.

However, cumulative cost growth to date is 3.9% (£1.5m), suggesting that new placements are on average higher than those they are replacing. This is an overall improvement of £3.8m compared to the original IMTP forecast.

6.3 Workforce

Historically, CHC has been subject to high levels of sickness. Since July 2015 priority has been given to managing sickness absence and safely staffing packages of care with a high number of vacancies resulting in improved sickness rates below the target of 6.80% since August 2015. PADR compliance within CHC is however currently at 55.33% as during this period of recovery, the teams have not had the capacity to carry out meaningful PADR's.

Recruitment and Retention

CHC has a high number of Registered Nurse vacancies and due to a national shortage is having difficultly filling these positions. This alongside long term sickness absence of registered nursing staff is having an impact on the workload for existing staff and rates of retention. Staff are experiencing challenging working conditions and increased demands. A series of resilience training sessions has been arranged to take place in January 2016 for all staff.

To ensure safe staffing levels and quality of care these vacancies are currently being covered by on and off contract agency nurses which has a financial impact on the service.

Off-Contract Agency and Transition

The Complex Care Care at Home Team (CAHT) delivers care to patients living in the community with significant healthcare needs. For the majority of patients the level of physical healthcare needs can be provided by Band 3 Healthcare Support Workers (HCSW), under the supervision of a Registered Nurse. There are however, a number of patients requiring care from staff who have Intensive Care/High Dependency Care skills (ITU/HDU).

Whilst the CAHT has a small number of Registered Nurses with ITU/HDU skills, there is a significant reliance on Thornbury Nursing Service (TNS) and MPS to cover the shifts. With the

current directive to cease contracting with TNS, the capacity in appropriately trained staff to continue to provide care to existing patients is a risk. In addition, there are a number of patients in hospital who require staff with ITU/HDU skills to support their return home.

Across England and Wales there are increasing numbers of health care services contracting with healthcare agencies for healthcare support workers, specifically trained to deliver care to patients who have needs such as:

- Spinal injuries;
- Tracheostomies;
- Invasive ventilation;
- End tracheal suctioning;
- Cough assist.

The UHB is pursuing this model of service delivery, and has commenced a tendering process for such an agency to deliver care to existing and new patients with these related care needs. The timescale for awarding the contract is 9th March 2016.

Development of a Band 4 Role
Significant work has been undertaken to plan and develop a career pathway and role for Band 4 assistant practitioners who will replace the need for registered nurses to care for those individuals with mechanical ventilation needs who are otherwise stable in a community environment. A number of staff are currently undertaking level 4 education programmes to support these plans. Over 12 staff already have these qualifications and will provide a cohort of individuals who will be eligible to apply for these roles once advertised.

Response – Delivery Plan
Opportunities 2016/17 and beyond

Strategic and Partnership
The Social Services and Wellbeing Act gives some real opportunities to ensure effective, appropriate care packages are delivered to patients. Key work to date includes integrated assessment, the development of an integrated commissioning group and care home governance.

Part 9 of the Act outlines cooperation and integration and gives a framework for the development of integrated health and social care teams to provide care to patients in the community. There is the potential to deliver this through the Neighbourhood Care Network structure, with the potential for pooled budgets. An early area being explored is the delivery of end of life care packages with the two voluntary hospices.

It is anticipated that for 2016/17 the UHB will agree care home fees with the respective Local Authorities. The UHB will also review the current CHC premium that is paid to care homes.

There is some specific work with Third Sector Organisations to maintain independence and deliver patient advocacy, an example of this is in Newport based in a GP practice.

There are also opportunities being explored to work with Housing Associations to implement the In One Place model, where appropriate. This has been successfully implemented for patients requiring support following discharge from low secure units.

The increased Welsh Government funding for Intermediate Care during 2016/17 may also give opportunities, although the UHB has not yet received any guidance from Welsh Government in relation to this.

Workforce Issues
There have been major difficulties in recruiting to and retaining Registered Nurses and there is currently a specific recruitment drive to attract Registered Nurses for the Care at Home Team. This

includes involvement in overseas recruitment.

There is an opportunity to deliver a more whole system approach to safe long term care, this will require a slightly reconfigured team and additional investment. The aim of this will be to provide more timely assessments in appropriate settings, working with patients and their families.

Reducing reliance on agency staff is a further priority and whilst agency usage has reduced it remains higher than desirable. Developing the Band 4 role will help address this, this is not a short term solution and is restricted by the number of courses available.

There has been additional HR support to manage the high sickness levels, which has resulted in a reduction but as with the use of agency staff the current levels are above the UHB target.

Clinical Issues
There is a backlog of patients receiving packages of care at home, who are not receiving timely reviews of their need for a CHC funded package of care. There are capacity issues within the District Nursing Service to undertake these reviews and a more sustainable solution is being discussed. Whilst any solution may require additional funding, it is anticipated that this will be an invest to save scheme.

Current Risks for 2016/17:

- **Outcome of the NHS Funded Nursing Care Judicial Review and Appeal.** This may have both a service and a financial impact for the UHB. ABUHB has already provided a total of £452k for 2014/15 and 2015/16 for the agreed element of the review.
- **Fragility of the Sector.** The implementation of the Living Wage will have a significant impact on the care home and domiciliary care sectors. These services are already under pressure and there are real concerns for the sustainability of some of these services.
- **Demographic Impact.** Whilst in year for 2015/16 there has been a reduction in the growth of patients being identified as having a primary health need, there is at present insufficient evidence of confidence that this will be sustained in the longer term.
- **Workforce Recruitment and Retention.** While there are opportunities to improve recruitment and retention, there are real risks that the difficulties with Registered Nurses may continue. Whilst part of the solution will be the development of Band 4 nurses, the real impact of this will not be until 2017/18.
- **Legislation.** The Cheshire West Judgement has increased the number of patients being referred to the Court of Protection. This is specifically related to patients with acquired brain injury and has a significant impact on the workload of a very small team of two nurses.

Financial Position 2016/17 to 2018/19
The refreshed financial plan for CHC & FNC submitted in November 2015, identified the following forecast variances:

Table 7.6.3

	CHC £000s	FNC £000s	Total £000s
2016/17	1,010	947	1,957
2017/18	(1,350)	1,250	(100)
2018/19	403	1,575	1,978

The £1.957m net overspending in 2016/17 is largely as a result of the Division expecting to re-provide for the Phase 3 IRPs (£4.1m) deferred from 2015/16 in addition to managing new growth. Thereafter there is a predicted underlying deficit in the order of £2m arising from annual cost and volume growth predictions.

With the implementation of the new living wage threshold from April 2016, nursing home providers are expected to be seeking fee increases of at least 5.6% in each of the next three years. To

break even, this would need to be capped at 2% with overall growth maintained within a 3.5% envelope. Efforts are now being made to determine how this might be achieved on a recurring basis.

Subsequent to the submission of the financial plan, there has been a sustained reduction in CHC cost & volume growth, which supports the baseline position from which future year forecasts have been derived. However, FNC numbers have continued to increase beyond original expectations which is sustained to year-end will materially impact on the 2016/17 FNC baseline (and overall deficit).

It is also unclear at this time as to whether any of the £4.1m provision for the Phase 3 IRPs will need to be re-provided into 2015/16. If so, then clearly this will improve the 2016/17 position correspondingly, albeit the burden would then fall against the 2015/16 budget that had been returned to Central reserves.

Actions 2016/17 – 2018/19
Whilst the priority for 2016/17 will be to complete the actions in the 12-point plan, other priorities agreed are as follows:

- Implement the revised End of Life Care fast track process to ensure patients receive their care in the place of their choice in a timely manner.
- Implement sustainable model of care for the high dependency patients requiring home ventilation to ensure they have safe and effective care.
- Ensure all patients receiving CHC packages of care at home receive timely reviews for eligibility so that their care is appropriate to their needs.
- Manage the IRP funding requests and reduce the number of families waiting for decisions.
- Work with the Local Authorities to agree fee rates for 2016/17.
- Review the provision of the CHC premium.
- Ensure that any opportunities to work across the health and social care system to reduce the need for long term care are explored and use of additional Intermediate Care Funding is maximised.
- Improve the transition process between children and adult services, especially for children with profound learning disability services.
- Access to equipment is an issue and previously much equipment has been funded by CHC for patients without a primary health need. This needs to be addressed with the Local Authorities and GWICES.
- Revise the staffing structures and accountabilities within Complex Care, in conjunction with the Trade Unions, to ensure fit for purpose and ensure the delivery of high quality care.
- Review of Section 117 arrangements in line with guidance to ensure patients receive appropriate care.
- There is also an opportunity to review the senior management arrangements for the total service and consider the development of a corporate commissioning unit.

6.4 Children and Young People's Continuing Care

Why is it important?
Children and Young People's Continuing Care are managed by the following services within the Families and Therapies Division:

- Child and Adolescent Learning Disability Service (CALDS);
- Child and Adolescent Mental Health Services (CAMHS);
- Children and Young Peoples Continuing Care (CYPCC).

The CALDS and CAMHS are responsible for the assessment and placement of young people eligible for Continuing Care (CC) funding. The service commissions and provides for young people requiring placement funded through Continuing Care, or WHSSC commissioned services, young people with complex Learning Disabilities and associated co-morbidities, and it manages transition

arrangements for young people with late presentation developing serious mental health issues.

The UHB's plan for 2015/16 focused on a number of important issues such as resolving poor communications between adult and young people's services within health, and problems receiving timely notification of potential transition cases between agencies, particularly in relation to young people placed out of county by education/social services. The lack of alternative forms of accommodation has also been a limiting factor for early engagement with local health (CAMHS/CALDS) services on alternative options for managing CC cases in the future.

Desired Outcomes and Measurable Benefits
The development of Young Peoples services requires a multi-agency approach to developing a range of alternative community based service provision including more therapeutic community placements as an alternative to secure care and also as a step down from secure placement.

Sufficient staff to meet establishment levels need to be recruited and retained to reduce reliance on high cost nursing agencies for CYPCC.

Baseline Position
The Community Childrens Nursing (CCN) service is responsible for delivering a range of complex care packages within the community. The service has experienced steadily increasing demand with a major challenge around recruitment of registered nurses.

Progress to date has achieved:

- Recruitment drive for children's nurses was successful in recruiting Band 5 staff and 7 student nurses starting Oct 2015. However, significant Registered Nursing recruitment issues remain and will be a continuing focus for the foreseeable future.
- A specialised Continuing Care placement team was established for children and young people.
- Proposal for an integrated play scheme in Serennu.

Current demand for CC placement for CALDS/CAMHS placements is stable at present with an average of two new cases per annum.

Progress to date has achieved:

- CALDS capacity has been increased by 1 wte nurse and a part-time Clinical Psychologist. Recruitment of a Band 7 Team Leader is also planned.
- New WG monies for improving CAMHS were invested in more comprehensive services across the tiers. Details are provided in SCP 7 – Sustainable Services for CAMHS.
- Service modelling audits were completed to analyse certain case presentations resulting in specialised placements. The Partnership Board is using these to develop more local specialist services. Representation from the 'In One Place' programme has been invited to help resolve the accommodation options.
- A local multi-agency protocol to improve transition arrangements and communications between agencies has been agreed. It will be evaluated in 2016/17.

Financial Position 2016/17 to 2018/19
The refreshed financial plan for Children's Continuing Care identifies the following forecast variances:

Table 7.6.4

	2016/17	2017/18	2018/19
£000s	263	241	243

The projected outturns include in-house and outsourced care provision and savings schemes as set out in the Delivery Plan below.

Response – Delivery Plan
Key deliverables are:

- Development of a strategy for alternative community based service provision for CALDS and CAMHS.
- Develop plan for sustainable short stay respite service for CYPCC. One 3 bedded respite facility in operation two weekends per month on ward 2/3 NHH. Continue to explore options for second respite facility in the South of Gwent.
- Review of the local multi-agency transition protocol.

Our plans for improving Specialist CAMHS are set out in **SCP 7** – Sustainable Services.

SCP 7 – Service Sustainability

7.1 Introduction

As described in the UHB's Clinical Futures Strategy, the sustainability of a number of acute specialties will ultimately be achieved through their consolidation on to a single site, the SCCC, which is planned to open in 2019, subject to the approval of the relevant Business Cases post Welsh Government scrutiny. The strategy is consistent with the outcome of the South Wales Programme and the work of the South Wales Health Collaboration on the clinical models and future configuration of medical and surgical specialties.

The SCCC case describes how specialist services will be centralised as a means of providing critical mass and delivering both improved outcomes and Deanery expectations to improve medical training. It is however recognised that there will be a challenge in sustaining services prior to the advent of the SCCC and this section describes how the UHB will address the sustainability of a number of services, with particular regard to the timetable for achieving medical educational contracts.

In the last year, the UHB has successfully centralised its hyper acute stroke services at the Royal Gwent Hospital, delivering the plan described in its last IMTP. This builds upon the centralised models in place for a number of specialties, including urology, ENT and maxillofacial. Due to the interdependencies of clinical services, the UHB however lacks the physical capacity to centralise all services prior to the opening of the SCCC, compounded by the quality of the existing infrastructure of our two acute hospitals in Abergavenny and Newport.

This SCP therefore identifies how the UHB will sustain its services prior to the planned opening of the SCCC. This encompasses both a review of the actions to sustain paediatric, obstetric and neonatal services following the implementation of a new service model to sustain services at Nevill Hall Hospital. For surgical specialties it describes how a plan will be developed to respond to the August 2016 Deanery timetable for improving training and for other specialties in August 2017.

The potential adoption of a new workforce model for neonatal services is also described, though this is complicated at the time of drafting by uncertainty regarding the identity of which of the three neonatal units in South Wales will need to adopt this new model.

Finally, the SCP describes how Specialist CAMHS services will be improved and sustained. Whilst not described in this section, the UHB is working with other Health Boards on the sustainability of a number of services such as major trauma, radiology and SARC. This is described in **Sections 3.3 and 3.1**

7.2 Paediatrics, Obstetrics and Neonatal Services

Aim
This SCP seeks to provide a more sustainable model for paediatric, obstetric and neonatal services within the UHB prior to the anticipated opening of the SCCC in 2019.

Baseline Position
In 2015/16, the UHB implemented new workforce models to sustain paediatric, obstetric and neonatal services at the Nevill Hall and Royal Gwent Hospitals to achieve Deanery requirements to centralise medical training at the Royal Gwent Hospital and enable improved quality of medical training. This has required the appointment of hybrid consultants, Clinical Fellows and specialist nursing posts, with gaps filled by agency staff. These plans were described in the previous IMTP and have a further full year effect cost of £1.2m in 2016/17. While the new workforce model has been implemented, it has not proven possible to recruit to substantive roles for all posts, notably Clinical Fellows and it is therefore over reliant upon medical agency staff to cover posts and

remains fragile. This was illustrated over the Christmas period where extraordinary contingency measures were undertaken to maintain service continuity, including the transfer of <35 week births from Nevill Hall Hospital to Royal Gwent Hospital for a limited period.

The above is compounded by the calibre of some agency doctors which has resulted in their early release and national recruitment difficulties, exacerbated by maternity leave and sickness.

Desired Future State
It has previously been demonstrated that the UHB does not have the capacity to centralise inpatient paediatric, obstetric births and neonatal services at the Royal Gwent Hospital without very significant capital expenditure, which would have a long lead in period and would be superceded by the creation of the SCCC. In order to sustain services prior to the opening of the SCCC it is necessary to review the current workforce model to determine whether through additional actions this can be staffed with greater assurance or whether an alternative clinical model is feasible, which may have a bearing on the configuration of inpatient paediatric, neonatal and obstetric services.

This will require the interdependencies between inpatient paediatrics, neonatal services and obstetric care to be carefully appraised. The obstetric service has to be co-located with neonatal, anaesthetic and critical care services due to clinical interdependencies, with more complex and severe cases already consolidated at the Royal Gwent Hospital.

Work Programme Overview
To support the above the following milestones have been identified:

Table 7.7.1

1.	To develop and implement contingency plans which manage acute pressures over the Christmas (December 2015) and New Year period, and in the event of further pressures.	Dec 2015 + ongoing
2.	To reappraise the current workforce model and the supporting recruitment and retention plan.	Jan 2016
3.	To map current out of hours activity at Nevill Hall Hospital by specialty and staff group.	Jan 2016
4.	To reconsider the clinical model for inpatient paediatric, obstetric and neonatal services to determine whether the services can, in whole or part, and informed by interdependencies, be reconfigured prior to the opening of the SCCC.	Mar 2016
5.	To report to Executives the outputs of review and agree direction of travel.	
6.	To engage with the Aneurin Bevan Community Health Council on emerging themes and seek feedback on potential changes.	
7.	To determine the potential impact of changes on patient flows, including any impact on neighbouring Health Boards.	Mar 2016
8.	To undertake a detailed feasibility of potential changes, such as centralisation, including infrastructure requirements and their ability to meet demand.	Mar 2016
9.	To report to the Board on the outcome of the feasibility and agree action plan to take forward.	
10.	Through Acute Care Alliance structures, to ensure that neighbouring Health Boards are apprised of UHB plans and their potential impacts.	

Interdependencies
This SCP is linked with the SCP for neonatal services and other service sustainability SCPs, notably for surgery and anaesthetics. That for neonatal services is particularly relevant as it has the potential to significantly exacerbate recruitment and retention difficulties.

Governance
This SCP is clinically led by the Divisional Director for Family & Therapy services, supported by the

Division's General Manager; Performance & Improvement Manager; the Assistant Director of Planning; and a Multi Disciplinary Group. This group reports to the UHB's Service Sustainability Steering Group and the Board's Planning & Strategic Change Committee.

7.3 Neonatal Services

Aim
This SCP seeks to ensure that the UHB safely sustains Level 3 neonatal services within Gwent and improves the quality of medical training.

Baseline Position
The UHB provides Level 3 Neonatal Intensive Care Units at the Royal Gwent Hospital. Although neonatal services were within the scope of the South Wales Programme, they were excluded from public consultation as the Neonatal Clinical Reference Group (CRG) recommended that three units be retained at Cardiff, Morriston and Newport, prior to the planned opening of the SCCC.

The Deanery has subsequently identified a requirement to both reduce the number of neonatal trainees (9 posts over 2 years) and to centralise training to sites with a minimum of 4 trainees. This in effect requires medical training in neonatology to be centralised onto two sites. This has been reviewed by the Neonatal CRG and they have reaffirmed the need for three neonatal units to be retained in South Wales. It is therefore proposed that the future neonatal service configuration be two training units and a non training unit. This has been subject to a detailed consideration by the CRG, though a detailed feasibility risk assessment has yet to be completed and reconciled with the Deanery timetable. WHSCC have been tasked with taking forward the process by which the non-training unit will be identified and the feasibility and contingency planning undertaken.

While no decision has been made, there is therefore the potential that the UHB may become a non-training unit and their SCP seeks to address this potential eventuality.

Desired Future State
If it is the case that the UHB's Neonatal Intensive Care Unit were to become a non-training unit then a new clinical workforce will be required to safely sustain neonatal services within Gwent.

Work Programme Overview
To support the above aim the following milestones have been identified:

Table 7.7.2

1.	To create a multidisciplinary group to plan potential service change and workforce challenges.	Sept 2015
2.	To identify workforce gaps in the event of the UHB being a non-training unit.	Sept 2015
3.	To appraise the Board of the potential for change in service configuration.	Oct 2015
4.	To support the Neonatal CRG and Neonatal Network in their work in appraising future service configuration.	Q3 2015/16
5.	To support WHSCC and the Neonatal Network in the development of a feasibility plan, risk assessment and contingency plan.	Q4 2015/16
6.	To contribute to the process by which the non-training site is identified.	Q4 2015/16
7.	If appropriate, to commence recruitment to new workforce model: ▪ Tier 1 – April 2016; ▪ Tier 2 – January 2017.	
8.	To develop an implementation plan for the safe provision of the new workforce model.	Q1 2016/17

Interdependencies
There is a notable interdependency with the paediatric, obstetric and neonatal SCP, which is being undertaken in response to difficulties in sustaining current services due to recruitment and

retention pressures, which will be exacerbated by the potential requirement to recruit further Clinical Fellows and hybrid consultants.

The Deanery's timescale for the proposed changes (Tier 1 by August 2016, Tier 2 by 2017) is very challenging and the delivery of a new workforce model may not be achievable to this deadline. The UHB will work with the Deanery, Welsh Government, the Neonatal Network and other Health Boards in the development of contingency plans to address this.

Governance
This SCP is clinically led by the Divisional Director for Family & Therapy services, supported by the Division's General Manager, Performance & Improvement Manager, the Assistant Director of Planning and a Multi Disciplinary Group. This group reports to the UHB's Service Sustainability Steering Group and the Board's Planning & Strategic Change Committee.

Risks

- There are currently a high number of vacancies for existing medical posts in both paediatrics and neonatology with significant risks to meeting the introduction of the Deanery timetable. The number of training posts vacant is equivalent to the number of posts that will be decommissioned at tier 1. At tier 2 the number of posts that will be decommissioned is less than the number of training post vacancies at tier 2.There is a long lead in period to Tier 1 alternative posts and it is unlikely that a new model could be safely established by September 2017.

- Based on the number of posts required, it is not possible to fully meet the requirements for Tier 2 posts based on medical workforce alone and there are significant risks in recruiting either Clinical Fellows or hybrid consultants to the volume required.

- The additional risk on the affected UHBs is the financial costs of the new service model.

7.4 Surgical Specialties

Aim
This SCP seeks to ensure that the UHB safely sustains the provision of surgical services and improves the quality of medical training.

Baseline Position
In July 2015, the Deanery notified Health Boards of the intention that Education Contracts would be adopted for all specialties by August 2017, with the expectation that this be achieved for paediatrics, obstetrics and gynaecology and surgical specialties by August 2016. The UHB's plans to achieve this for paediatrics, obstetrics and gynaecology were described in the last IMTP and were implemented in 2015/16. This is further work to be undertaken with these specialties and this is described in Section 7.2.

One of the key determinants in agreeing Education Contracts is the frequency of the residential out of hours commitment, with a 1:11 rota the expectation hitherto. Whilst the UHB's Clinical Futures workforce plans are based on this expectation enabled by service centralisation, the current configuration of service presents a significant challenge in delivering the Education Contract as the current infrastructure mitigates against the centralisation of services.

The UHB has in previous years invested in additional medical workforce (Clinical Fellows) to sustain emergency surgical services at Nevill Hall Hospital following a reduction in the number of medical trainees. This has resulted in the following current arrangements for resident out of hours cover:

Table 7.7.3

Royal Gwent Hospital	
Consultant	1:8
Tier 3 (SpR equivalent)	1:11
Tier 2 (CT equivalent)	1:9
Tier 1 (F1)	1:12
Nevill Hall Hospital	
Consultant	1:6
Tier 3/2	1:8
Tier 1 (F1)	1:8

The above demonstrates that the Tier 2 rota at the Royal Gwent Hospital and the combined rota at Nevill Hall Hospital do not meet the 1:11 expectation on which Education Contracts are based.

Whilst there are non-resident SpRs for other surgical specialties, there will be issues in achieving the educational contract in other surgical specialties for the Tier 2 rotas (CT equivalent).

Desired Future State
It is desired that the UHB agree an Education Contract with the Deanery whilst sustaining high quality surgical services within the UHB.

Work Programme Overview
To support the above, the following milestones have been identified:

Table 7.7.4

1.	To participate in the Deanery workshop on the extension of Education Contracts within Wales.	Dec 2015
2.	To create a multi-disciplinary group to oversee the development of plans to achieve the Education Contract in surgical specialties.	Mar 2016
3.	To complete a baseline assessment of the current surgical rotas and identify 'at risk' rotas.	Apr 2016
4.	To undertake an assessment of 'at risk' rotas to identify shortfalls in fulfilling the Education Contract.	Apr 2016
5.	To identify options for bridging the gaps, whether through workforce redesign, additional appointments or service reconfiguration.	Apr 2016
6.	To approve deliverability of options, including the management of key interdependencies.	May 2016
7.	To develop an implementation plan, including a risk assessment of deliverability to the August 2016 deadline.	May 2016
8.	To develop contingency plans in the event of inability to achieve the August 2016 deadline, including work with neighbouring Health Boards via ACA structures.	May 2016
9.	To engage the Deanery in the feasibility of delivering change to the August 2016 deadline	May 2016

Interdependencies
There are a number of key interdependencies between emergency general surgery and other clinical services. These include obstetrics, emergency medicine, an undifferentiated acute medical take and trauma services. These have a significant impact on the potential reconfiguration of emergency general surgery services prior to the opening of the SCCC.

Governance
This SCP is clinically led by the Director of Planning & Performance, with support from the Assistant Director of Planning. This group reports to the UHB's Service Sustainability Steering Group and the Board's Planning & Strategic Change Committee.

Risks

- Whilst the UHB's Clinical Futures plans enable the centralisation of emergency surgery in each specialty, it will not be possible to achieve this within the current configuration of hospital services in Gwent due to the associated interdependencies.
- It has previously been assumed that the Education Contract requires a resident 1:11 rota and this will be thoroughly tested, internally and with the Deanery.
- The UHB does not currently comply with a number of clinical standards and will be unable to do so until the centralisation of services at the SCCC.
- The likely lack of an internal contingency plan to safely manage activity within Gwent may impact on other specialties.
- The delivery of the above work programme will be challenging in the light of the Deanery deadline of August 2016.
- Whilst provision has been made for the additional costs of achieving compliance, this will need to be validated in light of the agreed implementation plan.

7.5 Medical and Anaesthetics

Aim
This SCP seeks to ensure that the UHB safely sustains the provision of medical and anaesthetic services and improves the quality of medical training.

Baseline Position
In July 2015, the Deanery notified Health Boards of the intention that Education Contracts would be adopted for medical and anaesthetic specialties by August 2017, with the expectation that this be achieved for paediatrics, obstetrics and gynaecology and surgical specialties by August 2016.

One of the key determinants in agreeing Education Contracts is the frequency of the residential out of hours commitment, with a 1:11 rota the expectation hitherto. Whilst the UHB's Clinical Futures workforce plans are based on this expectation enabled by service centralisation, the current configuration of service presents a significant challenge in delivering the Education Contract as the current infrastructure mitigates against the centralisation of services.

The UHB has in previous years invested in additional medical workforce (Clinical Fellows) to sustain medical services at Ysbyty Ystrad Fawr following the centralisation of trainees at the Royal Gwent Hospital.

Neither medical nor anaesthetic specialties have 1:11 rotas at both the Royal Gwent and Nevill Hall Hospitals, compounded by the number of rotas and tiers for SpR and CT equivalents.

Desired Future State
It is desired that the UHB agree an Education Contract with the Deanery whilst sustaining high quality medical and anaesthetic services within the UHB.

Work Programme Overview
To support the above, the following milestones have been identified:

Table 7.7.5

1.	To participate in the Deanery workshop on the extension of Education Contracts within Wales.	Dec 2015
2.	To create a multi-disciplinary group to oversee the development of plans to achieve the Education Contract in surgical specialties.	Jun 2016
3.	To complete a baseline assessment of the current surgical rotas and identify 'at risk' rotas.	Jul 2016
4.	To undertake an assessment of 'at risk' rotas to identify shortfalls in fulfilling the Education Contract.	Jul 2016
5.	To identify options for bridging the gaps, whether through workforce redesign,	Aug 2016

	additional appointments or service reconfiguration.	
6.	To approve deliverability of options, including the management of key interdependencies.	Aug 2016
7.	To develop an implementation plan, including a risk assessment of deliverability to the August 2016 deadline.	Sept 2016
8.	To develop contingency plans in the event of inability to achieve the August 2016 deadline, including work with neighbouring Health Boards via ACA structures.	Sept 2016
9.	To engage the Deanery in the feasibility of delivering change to the August 2016 deadline	Oct 2016

Interdependencies
There are a number of key interdependencies between medical and anaesthetics services and other clinical services, notably surgical specialties. These include obstetrics, emergency surgery and trauma services. These have a significant impact on the potential reconfiguration of medical and anaesthetics services prior to the opening of the SCCC.

Governance
This SCP is clinically led by the Director of Planning & Performance, with support from the Assistant Director of Planning. This group reports to the UHB's Service Sustainability Steering Group and the Board's Planning & Strategic Change Committee.

Risks
- Whilst the UHB's Clinical Futures plans enable the centralisation of an undifferentiated medical take, it will not be possible to achieve this within the current configuration of hospital services in Gwent.
- It has previously been assumed that the Education Contract requires a resident 1:11 rota and this will be thoroughly tested, internally and with the Deanery.
- The UHB does not currently comply with a number of clinical standards and will be unable to do so until the centralisation of services at the SCCC.
- The likely lack of an internal contingency plan to safely manage activity within Gwent may impact on other specialties.
- The delivery of the above work programme will be challenging in the light of the Deanery deadline of August 2017.
- Potential additional costs will need to be considered in the UHB's 2017/18 Financial Plan.

7.6 Vascular Service Sustainability

Aim
This SCP seeks to deliver sustainable vascular services for the UHB in the context of a strengthened South East Wales Vascular Network.

Baseline
The UHB is part of the South East Wales Vascular Network, with emergency out of hours aneurysm surgery undertaken at the University Hospital of Wales, supported by vascular surgeons from the UHB, Cardiff & Vale UHB and Cwm Taf UHB. Currently, there is no 24/7 interventional radiology service in South East Wales. A detailed baseline assessment of the current service provision has been undertaken through the South East Wales Vascular Services Group and they have identified that the current services do not meet Vascular Society guidelines.

Desired Future State
An option appraisal has been undertaken which concluded that aortic surgery, both emergency and elective, together with above ankle amputations should be centralised, with the future hub being the University Hospital of Wales.

The clinical model supporting this has been developed and largely agreed, encompassing both vascular surgery and interventional radiology and is described in a supporting business case which has been considered by the Chief Executives of the three UHBs, who have asked for further work to be undertaken in the development of an enabling implementation plan and associated financial plan.

Work Programme Overview
The work programme of the shortly to be convened Vascular Group, under the leadership of the Director of Cwm Taf UHB has yet to be determined and subsequent versions of the IMTP will be updated to reflect this. As is anticipated, the costing phase of work will be completed by the end of April 2016 with the implementation plan developed subsequently.

Interdependencies
There are a number of interdependencies, in particular the role of interventional radiology in the support of non vascular services. There will be a parallel need to consider the rehabilitation pathway for vascular patients which is sub-optimal.

Governance
The shortly to be convened Vascular Group will have representation from the UHB and will report to the UHB's Service Sustainability Group and the Board's Planning & Strategic Change Committee.

Risks
- Ability to release capacity and resource for activity proposed to transfer to the hub.
- The current level of interventional radiology consultant vacancies across the South East region, with vacant posts in the UHB and Cwm Taf UHB.
- The need to reconcile proposed changes to the agreed interventional radiology model that potentially widen the scope of activity changes.
- The availability of capital to support the creation of a hybrid theatre at UHW.
- The Ability to create capacity (beds and theatres) at the hub to support additional activity.
- The current excess costs of the proposed transfers and service developments.

7.7 Specialist Child and Adolescent Mental Health Service (S-CAMHS, Division of Family & Therapies)

Specialist Child and Adolescent services across Wales have for some time struggled to keep up with demand. The publication of the Welsh CAMHS strategy "Everybody's Business" was published in 2001 and following this a number of reports from the Children Commissioner, Welsh Audit Office, Welsh Government Public Accounts Committee and The Children & Young people's Committee, highlighted shortcomings in the provision of services to children and adolescents across Wales.

Specialist Child and Adolescent Mental Health Services (S-CAMHS) have also experienced a rapid, exponential increase in demand. Demand has doubled over the period 2011-15.

During this time there has also been an increase in the complexity of referrals. The service has seen a fourfold increase in urgent referrals, and an increase in self harm referrals. Additionally, ward admissions have also doubled and with an increasing demand and expectation for diagnostic services to be provided, such as Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder, responding to the increase of the more urgent and complex children and young people has meant that the S-CAMHS ability to manage routine waiting times for children and young people has been compromised leading to unacceptable waiting times in both routine and neurodevelopmental referrals.

Deliberate self harm referral trends to S-CAMHS over the last five years have also seen a fourfold increase. Self harming behaviour is now intrinsic to some youth cultures. There is little evidence that the number of children with severe suicidal intent or indeed those completing suicide is

increasing significantly, however there are many children who appear to be unconcerned regarding the outcome of their behaviour.

Children and young people displaying extreme behaviour in the community are increasingly likely to be labelled as a mental disorder by Local Authority and Police services requiring urgent assessment.

Evidence from Cardiff University suggests that some of the most common problems in childhood, e.g. ADHD, Conduct Disorder are decreasing but the threshold for coping by teachers and parents has also decreased. Unfortunately, outside of S-CAMHS professionals, teachers and social workers no longer receive child development training as part of their core training and GPs may only receive 1 day in their medical school career. To compound the issue, children increasingly present with more overtly risky behaviours as part of any upset. Over referral to S-CAMHS has been shown to have negative consequences for children and young people leading to dissatisfaction and increased waiting times for those requiring an S-CAMHS response.

A recent report undertaken by service users highlighted that S-CAMHS should support the much smaller numbers of children and young people with the greatest need many of the referrals that these services receive are not appropriate and lead to:

- Frustration for those children and young people and their families who learn that they have been sent down a route which cannot meet their needs.
- Frustration for S-CAMHS staff who spend time and resources on assessments which need not have happened.
- Harm for those young people who really do need the mental health expertise of a S-CAMHS service but find their way to that service delayed by so many others who turn out to not have needed it.

The solution lies in a Prudent Healthcare approach but more specifically:

- maximum diversion;
- minimum intervention;
- systems management.

The UHB's S-CAMHS service has recently introduced a number of initiatives to address the issues described above. It has introduced a demand capacity model of care designed to provide the patient with greater choice whilst improving the patient flow. It has revised its referral criteria to ensure that those in need of S-CAMHS response are accepted on to the waiting lists. It has invested in additional nursing staff to ensure that the urgent response is delivered effectively and in a timely manner. It has invested in a crisis outreach team to improve outcomes and manage the most serious and complex patients closer to home, preventing admission and expediting discharge. It has and is delivering a waiting list initiative to reduce the unacceptable waiting times for both the routine waiting list and also the neurodevelopmental waiting list.

Waiting List Progress

The service has three strands to its waiting lists management. The urgent case management, the routine case management and the ND case management. Across Wales the responsibility for the ND services lies with its paediatricians and therefore operates within a 26 week RTT. The division of Family and Therapies is addressing this by developing an integrated multidisciplinary children's service which will include ND and S- CAMHS will work in collaboration with its paediatric colleagues to deliver a seamless service. Additional investment has been received for this, this new model will free up S-CAMHS clinicians to manage those referrals requiring a specialist response and therefore it anticipates a positive outcome for reaching the new WG targets of 48 hours for an urgent referral, four weeks for a routine referral.

Aim
The current pressures on public service resources coupled with rising demand, rising expectation and increasing public concern mean that the role of NHS specialist services in meeting the emotional and mental health needs of the population in Wales needs to be reviewed. Health boards need to provide transparent planning mechanisms that enable service users and staff to have clear expectations of the service; in terms of what is provided, the quantity and quality outputs it expects to see, for the resource committed.

Baseline Position
This SCP describes what a sustainable and functioning secondary CAMHS service in the UHB will be developed. It reflects on the changing demand and presentation of mental health difficulties and suggests models by which the services could be provided. It assumes that the University Health Board will provide consultation, early intervention and assessment services for children and young people as part of the Local Primary Mental Health Support Services (LPMHCSS) developments.

NHS Specialist CAMHS (Tier 2/3 or secondary services)
The service provides assessment and treatment for all children under 18 years old, with moderate to severe mental disorder or illness. The service ensures equity of access through its referral criteria and the provision of services across Gwent. It has specific, tailored access and input, to ensure equity of access, for children and young people who misuse substances, are in the youth justice system, are looked after by local authority and may have a sensory impairment (such as Deafness) and Learning Disabled children. An increasing number of children have a formal Care & Treatment Plan (CTP) and fall within the criteria of the mental health measure, or statutory social care or education requirements.

Involvement of social care staff in the care programme is a key component of service. The model of care provides a range of services promoting continuity of involvement ranging from evidence based specialist consultation through to intensive direct therapy. Service performance measures are based on clear expectations of capacity and activity and also based on benchmarking data and resource allocated. The service primarily focuses on achievement of patient outcomes valuing patient feedback and the audit of performance such as DNA rates, risk assessments, complaints, compliments, staff wellbeing, training and development.

Together for Children & Young People:
Is a service improvement programme for Welsh NHS CAMHS (with a focus on wider remit CAMHS as well as S_CAMHS and three pieces of work are informing the programme. Public Health Wales has carried out a large baseline audit of the 5 CAMHS services across Wales. A Needs assessment for the population & an evidence-based review of what works has also been undertaken. Four work-streams (from wide remit CAMHS to S-CAMHS) are taking the agenda forward within key areas:

- Resilience & Well-being.
- Enhanced Support & Early-intervention.
- Neurodevelopmental & Learning Disability.
- S-CAMHS.

Making Sense: A report by young people on their well-being and mental health (a response to the 'Together for Children & Young People' Programme :

This important document was published in January 2016. It is a powerful document that was written by young people and supported by the Children's Commissioner for Wales Professor Sally Holland. S-CAMHS are using this document to inform the shape of its services.

The following S-CAMHS developments are being implemented during 2016/17:

Neurodevelopmental Service: The in-hours secondary level assessment pathway has now been operational for over a year. The Choice and Partnership Approach regarding the organization of the clinics has promoted equity of access and an increased reliability with of the standards of assessment process.

The Enhanced Secondary Service: This enhanced service reflects S-CAMHS commitment to moving towards an integrated pathway including SALT & Paediatrics. S-CAMHS vision is for an all-age, single point of entry, sharing an informatics system. A three sector hub model will be rolled out to the three children's centres across Gwent to become fully operational by October 2016. Providing an integrated service for children and young people with Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder..

Eating Disorder Service: The increase in numbers of clinical staff will allow the current virtual service to consolidate into a dedicated team. Access will be improved for Initiatives like the multi-family Maudsley model of therapy and pathways to an urgent eating disorder clinic for cases presenting at tier 2 will be clearer.

Crisis Outreach Team (COT): The COT works with YP & families during crisis periods for 6 weeks. The COT team has made a positive impact on the management of children and young people in crisis since it was first implemented in April 2015. Recent audits have shown that prior to the team being in place the average stay in hospital was **9 months** at the time of the last audit the average stay was **6 weeks.** The new funding will enable S-CAMHS to double the number of staff in the Cot team to enable the implementation of an out of hour's response.

Enhanced Emergency Liaison Team: Driven by the increase in emergency demand S-CAMHS developed a nurse liaison service in August 2016 utilising existing resources. The 2 liaison nurses have almost totally replaced the previous post overdose (POD) and deliberate self harm (DSH) rota which has created increased capacity of the tier 2 clinicians to focus on multi disciplinary team (MDT) work. In addition the liaison team are creating pathways to care and are facilitating greater understanding of crisis presentations throughout the paediatric wards, A&E's and social service departments which they come into contact with.

As a result of additional funding by June 2017 the team will double and will then extend its provision to out of hours. A recent audit showed that the external feedback for the team was extremely positive.

Dialectical Behavioural Therapy Service: Additional funding has also allowed S-CAMHS to develop two Dialectical Behavioural Therapists (DBT) which will offer a pure to model therapy for about 14-16 cases per year. This will involve regular intense individual therapy, telephone coaching, access to a 6 month DBT skills group programme and a consult group for the therapists to attend. There are also going to be at least 2 DBT group skills programmes running at any one time. Further expansions will be planned, implemented and evaluated and the DBT Special Interest Group (SIG) will be providing the momentum for this.

Enhanced Child Psychotherapy Resource: Three additional sessions of child psychotherapy will be provided for existing resources. The resource will sit at a tier 3 levels.

Renovation of Isca/Augustus: The increase in demand has led to difficulties in providing additional suitable spaces for children and young people on an outpatient basis. As a result of a successful Capital funding bid S-CAMHS will be proving some of the new space for outpatient activity in the Augustus Isca building. Structural work is underway. A co-production event is planned to ensure that children and young people are the key stakeholder influencing the shape of its outpatient services including the décor of the inside of the building.

New Waiting List Targets:
Historically the government waiting list targets have been **4 weeks** for *'urgent'* cases and **16**

weeks for *'routine'* cases. Welsh Government announced new targets in October 2015) which required '*urgent'* cases to be seen within **2 days** and *'routine'* cases to be seen within **4 weeks.** The *'urgent'* target' has been consistently achieved since October 2015. The '*routine'* target has will be operational until April 2016. The Clinical Directors group alongside the Welsh CAMHS advisor and the CAMHS Lead for the Government have negotiated new definitions for urgent/emergency cases. There are three types of cases eligible for being considered urgent/emergency in line with Prudent Healthcare principles:

- Severe Depression with high risk of suicide.
- Life-Threatening Anorexia.
- Psychotic Disorder.

Waiting List Management:
It is well recognised that the exponential increase in demand for S-CAMS referrals has outstripped the services capacity to deliver its service to children and young people within the target time. The service has made significant improvements to its waiting times since the announcement of new funding from WG. It will continue to offer additional clinics until the waiting time is within the 4 week target which is due to be set in April 2016 whilst the additionally funded posts recruitment process is completed.

Outcome Measures:
In order to assess if the S-CAMHS service meets the needs of the population. A National group has been looking at outcome measures for S-CAMHS and concluded that S-CAMHS across Wales should be implementing the following 3 measures:

- The Clinician rated Child Global Assessment Scale (C-GAS)
- The young person completed Goal Based Outcome (GBO).
- The Parent/Carer & Young Person Versions of the **Commission for Health Improvement: Experience of Service Questionnaire (CHI-ESQ)** as a measure of satisfaction.

The S-CAMHS Senior Management Team (SMT) are committed to supporting the use of outcome measures for evaluating the quality of the service and have recently invested in IT equipment to place evaluation module within the newly planned outpatient environment utilising app based technology to collect services user evaluations electronically.

Mental health Measure, Care and Treatment Planning and WARRN:
The implementation of the care and treatment planning (CTP) and Warrn assessment process continue to be used across the service. Regular audits take place to provide assurance that the standard is maintained as per the Mental Health measure for Wales.

Desired Future State
The structural arrangement of the core specialist CAMHS services are being reviewed to provide a pan Gwent service delivered by two multidisciplinary teams (MDT). The consultation period will commence during the summer of 2016. The services tier three teams currently offer intense assessments and appropriate interventions, however further integration of tier three forensics, substance misuse and learning disabilities and continuing care into the MDTs is underway.

The Crisis Outreach Team (COT) is being expanded to manage the out of hours referrals. They are and will expand their capacity to work with emergency presentations and link closely with the Nationally commissioned South Wales inpatient unit, in order to minimise length of admission and improve clinical outcomes.

A sector hub model of integrated care for the Family and Therapies children's centre has been supported by the Executive Team in the UHB. The model will further build on the enhancement of the Neurodevelopmental Service providing a single pathway to young people accessing services with an ASD or ADHD referral for assessment. The business case for additional staff has been

supported. The Division expect the embryonic model to be in place by October 20

Quality
Additional resource will ensure effective professional supervision and support to CAMHS professionals in Local Primary Mental Health Support Services (LPMHCSS) where these are not provided by the CAMHS service. It is important to ensure services models are integrated to ensure consistency of care across the spectrum of mental health needs and smooth patient focussed transitions between services mild to moderate.

Prudent health care would indicate that some of the most cost effective interventions are sessions into Infant mental health. This would be provided as part of a team with health visiting, Social work and midwifery primarily through supervision and consultation. Access to Adult MH services may also be necessary for parents needs.

Sessions into services for young people with severe mental illness, complex deliberate self harm, eating disorders, emerging personality disorders etc. This service could be integrated with Adult Mental health services. They could serve an age range of e.g. 15-30 with a service model that is built on Early Onset Psychosis service models. It should provide 24 hour services combining assertive outreach, In Patient, Crisis teams, CITT etc. All will require a CTP.

Cost Effectiveness
Implementation of the new crisis and emergency teams to improve the crisis response has already seen significant impacts. Further expansion in the teams will ensure that through the management of young people at a secondary care level as opposed to a tertiary/ WHSSC level, I is a more cost effective prudent approach and will result in a cost containment against the WHSSC profile.

Workforce
Prudent health care would suggest that this provision should be accessible to professionals from Education and Social Care services particularly those working with the most vulnerable groups, such as looked after children, families first and flying start project.

Finance
Containment of costs against the WHSSC Budget.

Resources Necessary to Implement Solution
In the UHB significant work is needed to develop the neurodevelopmental assessment service to match level of demand. Involvement of local education services is key as well as clear planning of services to ensure clarity of capacity.

There is a training requirement for CAMHS staff to deal with severe MH and for Adult MH to deal with younger age group if youth services are developed. The current gaps in transition, historical and service culture differences, and impasse that occur, is often as a direct result of behaviour created by the anxiety felt by staff groups due to these skill gaps.

Work Programme

Table 7.7.6

	Key milestone for delivery of the next three years
2016/17	▪ Continue to undertake review of referrals to identify inappropriate demand. ▪ Model & cost alternative pathway for those referrals that fall outside referral criteria. ▪ Staffing expansion of CAMHs Liaison Service April 2016 ▪ Integration and expansion of Neurodevelopmental Team ▪ Refurbishment Augustus/ Isca . ▪ Implementation of enhanced services for Crisis Outreach, Eating Disorder, Emergency Liaison, DBT services utilising funding from WG ▪ Full implementation of Choice and Partnership Approach (CAPA) model for

	Key milestone for delivery of the next three years
	managing demand ▪ Monitor progress and evaluate Specialist CAMHS Crisis Outreach Team (COT) ▪ Monitor progress and evaluate Neurodevelopmental Service ▪ Monitor progress and evaluate service model for children with emotional and behavioural problems not appropriate for specialist CAMHS ▪ Monitor progress and evaluate transition policy and protocol ▪ Monitor progress and evaluate the Tier 3 service and the current interventions (Intervention programme and other specific interventions) ▪ Demonstrable evidence of clinical improvements
2017/18	▪ Monitor progress and evaluate Specialist CAMHS Crisis Outreach Team (COT) ▪ Monitor progress and evaluate Neurodevelopmental Service ▪ Monitor progress and evaluate service model for children with emotional and behavioural problems not appropriate for specialist CAMHS ▪ Monitor progress and evaluate transition policy and protocol ▪ Monitor progress and evaluate the Tier 3 service and the current interventions ▪ Intervention programme and other specific interventions) ▪ Demonstrable evidence of clinical improvements ▪ Work with education, local authority and Primary Care to implement alternative pathway for referrals falling outside scope of CAMHS service.
2018/2019	▪ Review effectiveness of alternative pathway for activity that falls outside scope of service.

Workforce

Recruiting to S-CAMHS can be problematic. This is compounded by the need to recruit across Wales to similar posts at the same time during 2016 with the aim to increase access and reduce waiting times for children and young people referred to S-CAMHS.

Table 7.7.7

Service	Band	Staffing required	WTE
Neurodevelopmental Service		Consultant Community Paediatrician	0.5
		CAMHS Consultant	0.2
	7	Advanced Nurse Practitioners	1.0
	6	Nurse	1.0
	6	Nurse	1.0
	6	Occupational Therapist	1.0
	6	Speech & Language Therapist	0.4
	8C	Consultant Psychologist	0.4
	5	Administrative Coordinator	1.0
	4	Administration	1.0
Psychological Therapies	8b	Clinical Psychologist and Team Lead	**0.8**
	8a	Clinical Psychologist	**0.6**
	7	Clinical Psychologist	**1.0**
	5	Graduate Psychologist	**1.5**
	3	Administrator	**0.6**
Early Intervention Psychosis	**6**	Young Persons Recovery Worker	1.0
	6	Young Persons Support Worker	0.5
		Psychiatry Speciality Doctor	1.0
	1.0	Young Person's Support Worker	3.5
Enhance PCMHSS	**6**	RMN	**1.0**
	4	Support and Recovery Worker	**1.0**
	8a	Psychologist	**0.5**
	7	Systemic Therapist	**1.0**
Enhanced Crisis Outreach	**6**	Therapeutic Practitioners	**1.0**
	6	Therapeutic Practitioners	**1.0**
	6	Occupational Therapist	**1.0**

Service	Band	Staffing required	WTE
	4	Support Worker	**1.0**
	4	Support Worker	**1.0**
Eating Disorders		CAMHS Consultant Psychiatrist	**0.2**
	7	Advanced Nurse Practitioner	**1.0**
	6	Dietician	**1.0**
	3	Administrator	**1.0**
Emergency Liaison	**6**	Nurse	**1.0**
	6	Nurse	**1.0**
	4	Administrator	**1.0**
DBT	**7**	DBT Therapist	**1.0**
	7	DBT Therapist	**1.0**

Interdependencies

- Such a deliberate focus of emphasis will entail a significant shift of cases currently seen by some NHS CAMHS to the LPMHCSS and require multiagency resource increases.
- The specialist CAMHS staff remain committed to providing training and consultation to our partners.
- Significant collaboration and partnership working is required from AMH (for the severe mental health service), and Child Health, and community nursing (for neurodevelopmental and infant mental health services) to develop the necessary service models. It is hoped that the increased quality and decreased duplication of effort from these cases that currently impinge at some point on all services would offset some of the demand in due course.
- On a National level, consideration must be given to the critical mass of services. Not all services in Wales will be able to deliver the full range of services within their own health board boundaries. There is a need to develop a clinical network or reconfigure services, across Wales, to ensure equitable delivery of services, manage demand to equalise waiting times and maximise training, development and supervision opportunities.

Consequences if this solution is not implemented:

- Growth in WHSSC activity at Tier 3 level.
- Inequality in terms of access to services.
- Increased demand with no capacity.
- A lack of an integrated approach to service delivery.

Other benefits

Identify key risks/mitigation within each component.

Risks & mitigation

Identify key risks/mitigation within each component:

- Ability to manage demand is not entirely within the direct control of Specialist
- The capacity demand plan relies on a range of factors aligning, for example a small service and workforce is potentially fragile in relation to staff sickness and vacancies which then potentially impacts on delivery.
- Aging and deteriorating estate presents potential risk to service continuity. The organisation has made capital funding available to refurbish Augustus Isca in St Cadocs to improve the process flow of the OPD based at Ty Bryn in St Cadocs. This work is anticipated to be completed by June 2016.
- Given that the whole of Wales will be recruiting to posts following significant increase in CAMHS funding the possibility of failure to recruit to the clinical posts is a risk that is being monitored closely.

Governance

Project Lead	Janine Jones, Directorate Manager Wendy Clarke, Senior Nurse
Clinical Lead	Mark Griffiths, Clinical Director
Project Structure	Local implementation groups overseen by the Directorate and the Division
Reporting arrangements	Mental Health and Learning Disability Committee
Plan status	Agree
Monitoring Arrangements	Through internal IMTP meetings and tracker

SCP 8 – Strengthening Mental Health and Learning Disabilities Services

Aim
The aim of this Service Change Plan is to strengthen the provision of Mental Health and Learning Disabilities services in order to deliver the aspirations of these strategies, which are:

8.1.1 Mental Health
To enable all people facing a mental illness or poor psychological well-being living within Gwent and South Powys to lead fulfilling lives and have the same opportunities as others in society.

Individuals with a mental health problem and their carers will be able to access services that support their daily living needs such as housing and employment and have access to the full range of health and social care services, provided by a mix of professionals according to their need.

8.1.2 Learning Disabilities
To enable adults with a learning disability living within Gwent to lead fulfilling lives and have the same opportunities as other people in society. Adults with a learning disability and their carers should have access to the full range of public services and receive support from specialist services when required.

8.2 Why is it important?

Mental Health is everybody's business which therefore requires close working across the UHB and externally with 3rd Sector partners and other statutory organisations such as the police and local authorities. The aim is to deliver services at the right time, to the right people by skilled staff using evidence based practice.

The context for public services in Wales is set out in 'Making the Connections' and 'Beyond Boundaries'. Within this framework the strategic direction for health is set through 'Designed for Life': A Strategy for the NHS in Wales' and 'Together for Health' (2011*)* which placed an emphasis upon:

- Working across organisations for the most effective use of public monies.
- Improving health as well as sickness.
- Developing one system to enable integrated care.
- Pursuit of excellence in all areas.
- Transparency on performance.
- New partnerships with the public and staff.

For Mental Health specifically, there are also many requirements, which are communicated through the Mental Health Act, the Mental Health Strategy for Wales: Together for Mental Health, the Mental Health Measure Wales, and the intelligent targets published for dementia, depression, first episode psychosis and eating disorders.

Our approach to MH/LD is set out in two local integrated strategies which were launched in 2012. They are '*Together for Mental Health in Gwent and South Powys'* and our *Learning Disabilities Strategy 2012-17*.

In addition to the two strategies outlined above, in line with Welsh Government recommendations and in support of national and local strategic direction, the Gwent Forensic Psychiatry Service has developed a local strategy, "Working Together for a Safer Future". This will guide and support services by adopting the values and principles of Aneurin Bevan University Health Board's (ABUHB's) Local Integrated Mental Health Strategy - "Together for Mental Health in Gwent and South Powys" and Welsh Government's strategy – "Together for Mental Health'' – a Cross-Government Strategy for Mental Health and Wellbeing in Wales 2012.

Welsh Government is currently consulting on a new draft Delivery Plan for *'Together for Mental Health 2016-19'*. The MH/LD IMTP will be reviewed against the Delivery Plan when it is formally launched to ensure ongoing alignment.

In collaboration with service users and other local partners, the Health Board developed a mental health Annual Report in October 2015. The report outlined areas of progress in the last year and also identified some key priorities moving forward. Several of these key priorities are included in the Divisional opportunities for change. In addition, in December 2015, Welsh Government launched a Mental Health Crisis Care Concordat and the Health Board will be working with partners within 2016/17 to implement a multi-agency action plan to address the key principles outlined within the Concordat.

8.3 Desired Outcomes and Measurable Benefits

In order to achieve our vision and meet future demands in a sustainable way, the MH&LD division has reconciled a number of opportunities for change against the following key principles:

- Supporting primary/community teams to manage patients closer to home.
- Reducing health inequalities and delivery of key public health priorities.
- Improving access to services and the quality of care to patients.
- Applying prudent healthcare principles to our services and clinical pathways.
- Fulfilling our ambition of achieving Best in Class across the organisation.
- Directly supporting the wider Clinical Futures model and any interim stages that must be progressed in advance of the opening of the Specialist and Critical Care centre. This would need to also include interim models that may be required as a result of Deanery requirements or wider Clinical Network or South Wales Collaborative proposals.
- Managing within existing resources and minimising any cost growth.

The Division has also mapped its identified opportunities for change to the revised Health and Care Standards published in April 2015.

8.4.1 Mental Health

In 2014/15, the Division identified a number of opportunities for change and developed a range of service change plans. The key delivery themes for the service model are:

- Prevention and early intervention via the enhancement of Foundation and Primary care services.
- Acute, crisis and inpatient services.
- Improving access to evidence based interventions.
- Accommodation and supported living.
- Supporting those with complex needs by the development of pathways of care.

8.4.2 Learning Disabilities

The aim of this Directorate is the development of local alternative service provision to meet the needs of people with a Learning Disability and complex needs. The Directorate will work in conjunction with the Divisional Continuing Healthcare team, local housing associations (In One Place) and local service providers to develop local capacity to support service users close to home. The needs of service users will be considered on an individual basis and local solutions developed to meet their needs. The outcomes to be achieved are:

- Individuals will be offered the opportunity to return to their home area, where appropriate.
- Individuals will be offered a range of housing and support options based on the principle that everyone is entitled to their own home.
- Individuals' connections with family and friends will be improved, respecting the wishes of individuals.
- Support the development of a skilled local workforce.

- Individuals receiving packages of care within county will be offered an opportunity for service re-design.
- Provision of a cost effective and improved quality of service.
- Reinvestment of funding presently spent on CHC to develop and improve local services.
- Development of a more flexible approach to contracting thus ensuring more individualised packages.
- Ensure quality and effectiveness remains a key principle in the development of services.
- Creation of outcomes focused service models.

Child and Adolescent Mental Health Service (CAMHS)
Our plans for improving CAMHS are set out in SCP 7 – Sustainable Services.

8.5 Baseline Position

Population Needs Assessment
Evidence published in *Together for Mental Health: a Cross-Government Strategy for Mental Health and Wellbeing in Wales* shows that:

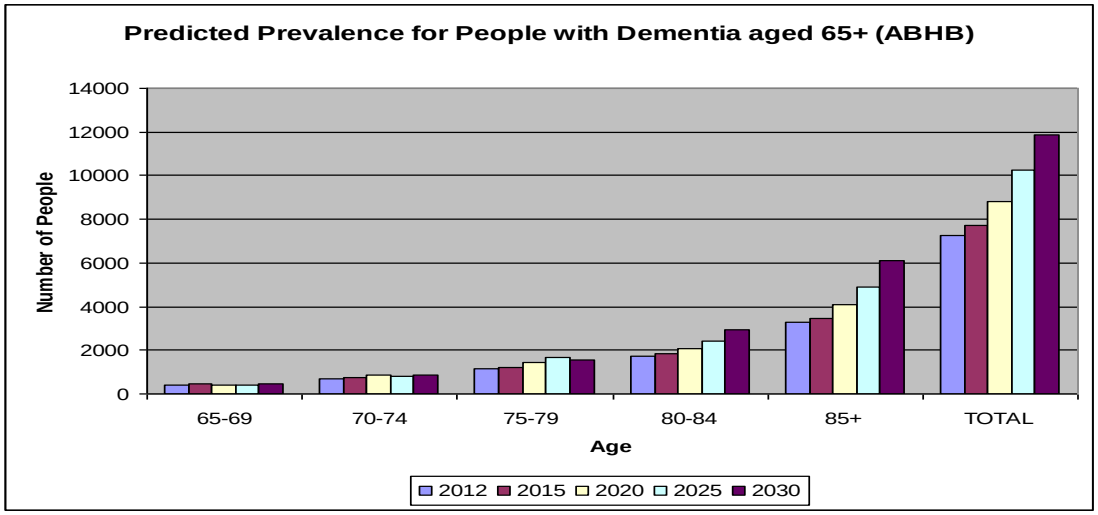
- 1 in 4 adults experiences mental health problems or illness at some point during their lifetime.
- 1 in 6 of us will be experiencing symptoms at any one time. At a time of recession, when levels of stress and anxiety inevitably rise, more people will be affected.
- 1 in 10 children between the ages of 5 and 16 have a mental health problem and many more have behavioural issues. There is evidence this is increasing.
- Approximately 50% of people with enduring mental health problems will have symptoms by the time they are 14 and many at a much younger age, demonstrating that mental illness can affect people across the course of their lives.
- In Gwent this equates to around 100,000 people experiencing mental health symptoms at any one time. Of the c.240,000 0-14 year-olds in Gwent, some 24,000 will have a mental health or behavioural problem, and many of these will go on to experience mental health problems in adulthood.

Mental Well-being and Mental Illness
The main source of data offering a perspective on mental health and illness in the area is the Welsh Health Survey.

The Welsh Health Survey 2012 and 2013 revealed that 13% of people in the ABUHB area report being treated for a mental illness. It is likely that there are a greater proportion of people experiencing a common mental illness but not seeking treatment. Overall the data indicates that adults in the ABUHB area have generally poorer mental health and wellbeing than the rest of Wales, and this is correlated with deprivation in common with many other health indicators.

Dementia
Within Wales, the number of people with dementia is projected to increase by 39% *(National Dementia Vision for Wales; Welsh Government/Alzheimer's Society, 2011).* This increase in the numbers of older people will inevitably place more demands on our health and social care system. The graph below shows a predicted 27% increase in the older adult population in ABUHB over the next 17 years with a predicted 39% increase in the number of people with dementia aged 65 years and above. This will not only place demand on mental health older adult services but on health services in general with increased demand on primary care, unscheduled and scheduled care.

Graph 7.8.1

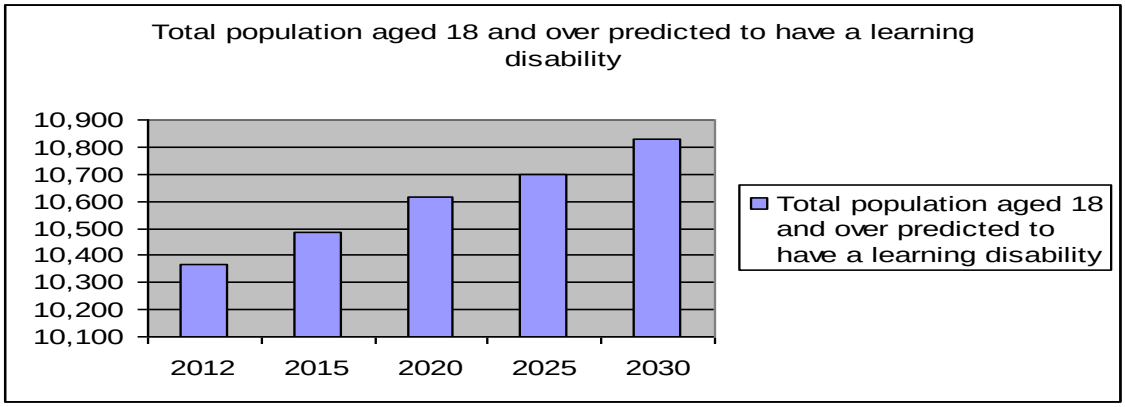


(Source: www.daffodilcymru.org.uk)

Learning Disabilities

The data shown below shows the prevalence for people with a learning disability in the ABUHB area is predicted to increase by 2.3% from 2012 to 2020. This will impact on the capacity of our learning disability services to cope and due to the complexity and severity of the physical and learning disability predicted, this will also have an effect on the Continuing Healthcare budget. It will also have an impact on other services provided by ABUHB such as children's services, district nursing, acute and secondary care and older adult services. Rising demand means that we will need to adapt and change how we deliver mental health and learning disability care if we are to meet our population needs in a sustainable way.

Graph 7.8.2



8.6 Benchmarking

Core services

For the 2nd year, the UHB has contributed to the NHS Benchmarking Network – Mental Health Benchmarking. The information below provides a high level summary of the key observations from the benchmarking report for 2015.

Acute Adult Mental Health

- **Beds per 100,000 population** – We are close to the mean with 20.3 (mean is 20.5).
- **Bed Occupancy** – We are at 76.6% bed occupancy which is a slight increase from 75% last year but we are still in the lowest quartile and only 4th from the bottom of the graph of all participants. Only one Welsh LHB has lower bed occupancy.
- **Admissions per 100,000 population** – At 373 we (have increased 25 from 348 and) are third from the top of the graph (a similar position to the 2014 exercise). We are the highest Welsh LHB.

- **Mean length of stay (excl. leave)** at 13 days which would make us one of the lowest LOS of all participants.
- **Delayed transfer of Care** – We are just below average (mean) with 4.3%, a slight increase from 4.1% in the 2014 exercise. We have the lowest value compared to the other LHB's.
- **Emergency Readmissions within 30 days**– We are at the top of the chart with 16%, an increase from 12.7% last year. The average of all participants' is 8.7%

Older Adult Mental Health

- **Beds per 100,000 population** – We are in the upper quartile at 81 beds per 100k population. There are 8 participants with higher number of beds including 3 of the other Welsh LHB's.
- **Bed Occupancy** – Our bed occupancy is 78.6%. We are just above the lower quartile and is a reduction from the 2014 level of 81%.
- **Admissions per 100,000 population** –We have a high level of admissions at 394 when the mean is 230. This is very similar to last year's level of 396. There were 4 participants with higher admission rates of which 2 were Welsh LHB's.
- **Mean length of stay excl. leave -** We are unchanged from last year when we were 62 days and we are just above the lower quartile mark of 58 days.
- **Delayed Transfer of Care** – At 10% we are above the mean of 8.1% (showing a slight reduction from 11% in 2014). We have the shortest time of all the LHB's
- **Emergency Readmissions within 30 days**– at 11.4% we are the second highest participant and highest of all of the Welsh LHB's.

Overarching Quality Factors

- **Staff satisfaction** score of 88%. We are second highest of all respondents.
- **Serious incidents** (per 100,000 occupied bed day and face to face contacts) are 13 when the mean is 26. We have the lowest value of the health boards
- **Number of complaints** we are 47 when the mean is 65. We are the lowest of the health boards.
- **Ligature incidents** per 100,000 occupied bed days – We appear to be 2nd highest.
- Incidents of **physical violence to staff** (per 100,000 occupied bed days (excluding leave) and face to face contacts) is 261 which is just above the upper quartile line while violence to patients is lower at 72 (per 100,000 occupied bed days (excluding leave) and face to face contacts) which is just above lower quartile.

The Division only received the final benchmarking report in December 2015 and further work is now required in order to reflect on the key issues that are emerging from the benchmarking report and to triangulate this data with other service information in order to fully understand what this may mean for future service delivery. Workshops are planned for February 2016.

8.7 Continuing Healthcare

Continuing NHS healthcare (CHC) refers to services that are arranged and funded solely by the NHS for those who have been assessed as having a primary health need. CHC can be provided in any setting including a person's home, care home or in some cases, for those detained under the Mental Health Act, their care may be provided within a secure setting.

Currently 30% of the overall budget for the MH and LD division is spent on CHC, predicted to rise to over 50% of the budget being allocated to services outside of the NHS. During 2015, benchmarking was undertaken with three other Welsh Health Boards which identified the following issues:

- ABUHB is the only Health Board in the cohort to spend more on externally commissioned CHC beds than on internally provided adult mental health beds.
- When considering the total adult mental health spend (ABUHB community and inpatient services and CHC provision) the Health Board had the lowest spend per 1,000 registered population compared to the other three health Boards.
- Similarly, spend in adult learning disabilities on externally commissioned CHC beds was higher

that on internally provided beds.
- Adult learning disabilities services have seen increasing levels of expenditure on CHC beds on a yearly basis since 2013/14.

Data sources: MH Benchmarking 2013/14, LD Benchmarking 2013/14, All Wales Data Capture Exercise for CHC.

8.8 Performance

There is a high level of compliance across a number of key performance measures for MH and LD including crisis intervention targets, S136 safety arrangements, All Wales Care Metrics and complaints.

Against the Mental Health (Wales) Measure, the service has improved its compliance against Part 1 of the Measure for assessments within 28 days throughout 2015/16. It is currently at 80.8 %. The therapeutic target of 56 days is currently at 72.2% and the service has assessed its ability to meet the new target for 28 days from April 2016 and is expecting to be able to balance capacity and demand for treatment. There are good standards of compliance across Parts 2 and 3 of the Measure.

8.9 Key Divisional Achievements in 2015/2016

Following the development of the first Integrated Medium Term Plan (IMTP) in 2013, the MH and LD Division has worked on the priorities identified with key achievements outlined below. Some of the priority areas will roll over to this IMTP.

Table 7.8.1

Key Priority	Progress
Foundation Tier	▪ 3rd Sector Commissioning review moving to implementation in Q3 2016/17. ▪ Roads to Wellbeing programme has been established throughout all boroughs. This includes C-CBT (Computerised Cognitive Behavioural Therapy) kiosks, Stress Control and ACT-ivate your Life groups across all boroughs. Initial data shows that for people attending *ACT-ivate your Life* classes, 71% of people showed clinically significant change in depression symptoms and 75% for anxiety symptoms. For *Stress Control* classes, 88% of people showed clinically significant change for both depression and anxiety.
Tier 1 Services	▪ Learning Disability Residential Service Review - significant progress has been made with all the service user assessment and person-centred planning workshops completed. Service specifications are to be developed for each individual with a view to developing a service model. ▪ Recurring additional funding secured which has supported a sustained and significant improvement in PCMHSS target performance. ▪ Victims Hub - the ABUHB CPN is the only designated nurse in Wales working directly with victims who have mental health conditions. They offer advice and take referrals from any agency within the Hub, which includes self referrals.
Tier 2 Services	▪ Meeting Tier 1 Care and Treatment Plan targets across all service areas. ▪ Listen, Engage, Act and Participate (LEAP) initiative in Caerphilly borough expanded with a further development within Torfaen being planned. ▪ Recurring funding secured to embed the Rapid Assessment Interface and Discharge (RAID) model within the Newport Hospitals and extend across ABUHB following a successful evaluation. ▪ Better Outcomes in Learning Disabilities (BOLD) - A pilot initiative is currently being undertaken in conjunction with Local Authority colleagues using the Vanguard methodology to test new ways of working. The pilot initiative commenced in July 2015 and will run for a 9 month period following

Key Priority	Progress
	which it will be evaluated and recommendations in relation to next steps considered. ▪ Redesign of Intensive Support packages services for 2 individuals who are now supported by independent providers. ▪ Agreement obtained to proceed with an Engagement Plan to consider the future configuration of Older Adult MH inpatient services. Events to be held in early 2015 with public, stakeholders and staff. ▪ In One Place scheme established in Monmouthshire for people with complex needs.
Tier 3 Services	▪ The remit of Low Secure Unit proposal has been expanded to scope the need for a High Dependency Unit (HDU) and an extended Psychiatric Intensive Care Unit (PICU).
Service User Involvement	▪ Mental Health Annual Report was once again co-produced with service users. ▪ Pan Gwent Service User and Carer Forums are in place and meet quarterly. In September 2015, service users and carers from across Gwent met in Bedwelty House, Tredegar to discuss "how are we doing, and is there anything we are doing particularly well" in Mental Health over the past year, and "what could we do better as we move forwards". ▪ Recovery symposium facilitated by Mental Health & Learning Disabilities Partnership Board and the International Mental Health Collaborating Network (IMHCN) was held in November 2015 for service users, carers, statutory and Third Sector representatives. ▪ MAS Carers survey - workshop being held in December 2015 to enable clinicians, LA and 3rd Sector partners to consider the feedback and reflect on practice. A report will be developed summarising the outcomes and improvement actions to be taken which will be communicated to MAS patients and their carers. ▪ Learning Disabilities Strategy Planners group meets regularly. They have been introduced to the Better Outcomes in Learning Disabilities (BOLD) team and discussed the systems thinking project going forward. ▪ Co-production event held in South Powys with Public Health Wales for service users in relation to improving access to psychological therapies.
Workforce Development/ Management	▪ Psychological therapies training Dialectical Behaviour Therapy (DBT) and Eye Movement De-sensitisation and Reprocessing (EMDR) training is complete, Special Interest group and Supervision group are in place to support practice. Acceptance and Commitment training has also been delivered. ▪ The 3rd Mental Health and Learning Disabilities Showcase has been held. ▪ Advanced Nurse Practitioner Pilot in YYF has been very successful and the postholder recently won the Royal College of Nursing (RCN) in Wales Improving Individual and Population Health award. ▪ Two other staff were also successful in the recent RCN in Wales awards, namely the Humanitarian Nursing award and the Health Care Support Worker award. ▪ Robust management of sickness absence has seen a reduction in this absence rate. ▪ Significant improvement in numbers of staff within the Division who have a PADR with 76.7% compliance for week commencing 19th December.
Benchmarking	▪ Fully participated in National benchmarking project for the 2nd year. ▪ Some benchmarking undertaken to compare CHC and generic service spend with several other HB's in Wales.
Research	▪ Pilot of Health Equalities Framework has been completed and will be rolled out within the Learning Disability Directorate. ▪ Learning Disabilities Service user involvement and participatory research -

Key Priority	Progress
	topics and research questions have been set by service users and the Directorate are working with the University of South Wales to obtain further funding to take this forward.

Response – Delivery Plan

8.10 Service Plans - Priorities for Improvement

The Mental Health Annual Report for 2015/16 has been submitted to WG and this identifies key priorities for the future and these priorities are reflected within the IMTP.

Examples of the Division's plans for partnership working during the next year are summarised below:

- Reviewing service provision to children and young people to maximise the accessibility and effectiveness of PCMHSS provision to children and young people.
- Strengthening the integration of the PCMHSS and existing primary care services, including through engagement with the developing NCN management structure, with the aim of enhancing mental health care provision across primary care.
- To provide more timely feedback following the forums and develop the Service User and Carer Stakeholder Reference Group.
- Ensure regional views are represented at the National Service User Forum.
- Build better links with the Nursing and Residential Care Homes Sector.
- Provide some step down services where patients leaving Gwylfa/ Bellevue can practice and develop their community living skills with support systems in place.
- Gwent Police along with ABUHB are looking at the development of a new working structure where a Mental Health Practitioner will be based in Gwent Police Force Control Room to be able to support the response to persons in mental health crisis who often contact police as the first port of call.
- Improve how we work with key stakeholders including housing and social care providers
- To be part of the development of more comprehensive liaison between police and mental health services and to provide a learning environment and offer development opportunities for students and staff to observe multi-agency working.

Over the next three years, the Division intends to focus its resources on the opportunities listed in the table below, which span all tiers of the service model and the themes described above. In addition to these there will be other objectives within individual service areas/ Directorates that will be progressed.

Table 7.8.2

Theme	Identified Opportunities for Change	Level of Change Involved
Prevention and early intervention via the enhancement of Foundation and Primary care services.	▪ Commissioning new service model from 3rd sector and development of foundation tier services ▪ PCMHSS and meeting of Tier 1 targets	▪ Strategic ▪ Tactical
Acute, crisis and inpatient services.	▪ Review of Adult Inpatient provision ▪ Older Adult Mental Health inpatient reconfiguration ▪ Out -of-hours service re-modelling	▪ Strategic ▪ Strategic ▪ Tactical
Improving access to evidence based interventions.	▪ LEAP (Vanguard methodology) ▪ Neuro-developmental Pathway ▪ Improving access to psychological therapies ▪ Older Adult Mental Health community service review	▪ Tactical ▪ Tactical ▪ Tactical ▪ Strategic

Theme	Identified Opportunities for Change	Level of Change Involved
	▪ Older Adult Mental Health Liaison & RAID ▪ Learning Disabilities community & specialist services review	▪ Tactical ▪ Strategic
Accommodation and supported living.	▪ Learning Disabilities residential services review ▪ Learning Disabilities ISP residential services review ▪ In One Place Project	▪ Strategic ▪ Strategic ▪ Strategic
Supporting those with complex needs by the development of pathways of care.	▪ Inpatient substance misuse detoxification and stabilisation provision ▪ Development of a pathway for females with complex mental health issues ▪ Development of a pathway for males with complex mental health issues ▪ Development of a local low secure unit, HDU & extended PICU	▪ Strategic ▪ Strategic ▪ Strategic ▪ Strategic

Building on last year's plan, the timetable for these schemes is outlined in the following table.

Table 7.8.3

2015/16 Apr 15 - Mar 16	2016/17 Apr 16 - Mar 17	2017/18 Apr 17 - Mar 18	2018/19 Apr 18 - Mar 19
1. Prevention and early intervention via the enhancement of Foundation and Primary Care Services			
Commissioning new service model from 3rd sector			
Development of PCMHSS & meeting associated Tier 1 targets			
2. Acute, Crisis & Inpatient Services			
OAMH inpatient reconfiguration			
	Review of Adult MH inpatient provision		
Out of Hours (OOH) service re-modelling			
3. Improving access to evidence based interventions			
LEAP			
Neuro-developmental Pathway			
	OAMH community services review		
OAMH Liaison & RAID			
LD community & specialist services review			
Improving access to Psychological Therapies			

2015/16 Apr 15 - Mar 16	2016/17 Apr 16 - Mar 17	2017/18 Apr 17 - Mar 18	2018/19 Apr 18 - Mar 19
4. Accommodation and supported living			
LD Residential Services review			
LD Review of ISP Residential Service			
In One Place Project			
5. Supporting people with complex needs through the development of pathways of care			
Inpatient substance misuse detoxification & stabilisation provision			
Development of a local Low Secure Unit/High Dependency Unit/Extended Psychiatric Intensive Unit			
Development of pathway for females with complex mental health issues			
	Development of pathway for males with complex mental health issues		

Examples of how the service change plans above link to desired outcomes and measureable benefits are outlined below.

Table 7.8.4

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
LEAP (Vanguard)	Integrated care in Gwent where citizens have a person-centred/directed response and services coordinated to support good mental health and achieve personalised outcomes.	Variation in level of co-location /integration of mental health services across Gwent	Progression of schedule of learning/testing different ways of service delivery and design (through Vanguard). Progressive expansion of test conditions (population, skill mix and geographical location)	▪ LEAP Phase I – concluded 2014/15 ▪ Phase 2 Q3-Q4 2015/16 ▪ Phase 3 Q3-Q4 2015/16 ▪ Onward roll-out across Gwent determined by evaluation outcomes – Q4 2015/16 onwards – to be determined by partnership board by Feb 2016

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
Third Sector Commissioning	Equitable access to services across Gwent Our Commissioning intent better supports recovery and community resilience consistently across Gwent	▪ No commissioning plan in situ ▪ Distribution of resources not aligned to need across Gwent ▪ Variable and multiple funding agreements with 3rd Sector across Gwent ▪ Commissioning of current services not aligned to need	▪ Pan-Gwent commissioning plan and timescales agreed ▪ Resources are aligned with need in Gwent ▪ Collaborative procurement of services across Gwent ▪ Development of Outcome Framework ▪ Recovery and Community Resilience integrated into service specifications.	▪Q2 2016/17 ▪Q2 2016/17 Q2 2016/17 ▪Q2 2016/17 ▪Q2 2016/17
Primary Care Mental Health Support Service	PCMHSS Measure compliance = shorter waiting time for patients and care closer to home.	▪ Waiting time of referrals ▪ Number of complaints received	▪ 80% referrals to PCMHSS will receive assessment within 28d from referral. ▪ 90% referrals to PCMHSS who require an intervention will receive the intervention within 56d of assessment. ▪ Fewer complaints received regarding PCMHSS	▪Q3 2016/17 ▪Q3 2016/17 ▪Q3 2016/17
Rapid Assessment, Interface & Discharge (RAID)	Reduced lengths of stay (LOS) at RGH and NHH to improve patient flow and capacity. Better clinical outcomes and patient experience. More care closer to home.	LOS at RGH & NHH Number of avoidable admissions in DGHs.	▪ Reduce LOS at RGH & NHH ▪ Increase in patients discharged back to usual place of residence ▪ Reduce n. adms for acute IP care.	▪Q1 2016/17 ▪Q1 2016/17 ▪Q1 2016/17
Learning Disabilities residential services review	Preferred service model will deliver a more efficient service with associated cost savings. Service users have equity of access to a wider range of services and opportunities which will result in improved independence, skills, QOL within 12 months.	Current levels of service available to users	£277,000 cost saving Evidence of wider range and more equitable access to services across Gwent.	2016/17 non-recurrent
Older Adults Inpatient	The development of inpatient services for	▪ Number of wards and beds	▪ Better quality of care packages	▪Q4 2015/16 Engage with

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
Reconfiguration	older people with organic memory problems/dementia or functional mental health issues such as anxiety, manic depression or schizophrenia. Co-location of dementia services with physical health care & diagnostic services in DGH settings to enable joint working to reduce the need for patients to be transferred to other sites for physical health needs. ▪More targeted services for specific and different needs. Development of highly skilled expert teams, Specialist teams, 'Centres of Excellence', for older people with frailty needs. Reduced length of stay and improved care planning.	▪ Number of service users required to travel to different sites for treatments ▪ Waiting times for treatments	▪ Reduced number of patients required to travel to different sites for various treatments ▪ Reduction in LOS	Staff and Public to obtain their views on current arrangements and future service provision ▪Q1 2016/17 build a service model based on engagement results ▪Q2 - Q3 2016/17 consult with Service users on staff on proposal of changes
Improving Access to Psychological Therapies	▪ Improved access to psychological therapies for adults, older adults and people with LD ▪ High levels of service user satisfaction with psychological therapies ▪ Increase service user choice	▪ Current waiting times ▪ range of treatments available	▪ Reduction in waiting times for treatments ▪ Increased usage of available treatments ▪ Feedback from service users	▪ Q3 2015/16 pilot approaches ▪ Q3 2016/17 review of waiting lists
Out of Hours Service	▪ Service available 24 hours a day for any one in crisis ▪ Allow admission to the patient's home ward ▪ Improved patient experience i.e. shorter waiting times and less travelling between sites.	▪ Waiting times in A & E ▪ Number of assessments ▪ Patients required to travel to various sites	▪ 24 hour service ▪ Reduce waiting times	▪ Q3 2016/17

Service Change Plan	Outcome	Baseline Measure	Target Measure	Timescale
Continuing Health Care for MH & LD	Fewer delays for people eligible for CHC through more collaborative working between the CMHTs and CHC. Improved sustainability and resilience to meet demand through the reconfiguration of in-house assets and services. More care provided closer to home (In One Place Projects).	▪ DTOCs ▪ CHC framework targets	▪ Reduced DTOCs ▪ Timescale compliance improved by 35% ▪ Min 90% compliance with standards p.a. ▪ Reduce out of County placements by 15% ▪ T.S. House Blaina ▪ Ty Penallta, Caerphilly	Q4 2016/17 Q3 2016/17

Priorities for Continuing Health Care
As highlighted above, benchmarking has indicated that the current predicted growth in Continuing Healthcare is not sustainable and ABUHB does not have all the services required to deliver the whole pathway and service model necessary for those with the most complex and challenging needs. Initial scoping work suggests that ABUHB is missing essential components of the model such as a Low Secure Unit (LSU) and High Dependency Rehabilitation Unit (HDU). A key priority is therefore to develop and implement new pathways of care and associated service models. This will require the development of a new 'graduated whole system' service model supported by a new build facility which will be subject to a full business case. In the interim, the plan is to develop a scheme for an HDU and extended Psychiatric Intensive Care Unit (PICU) to better respond to clinical need and co-morbidity across the population of Gwent and also to reverse the trend of increasing year on year overspend on CHC.

8.11 Workforce

A detailed workforce plan has been developed for each of the directorates in line with their SCPs. A key theme through all the directorate workforce plans are the challenges the division faces in the recruitment of RMN / RNLD nurses and junior and mid grade doctors.

Qualified Nurses
Due to the national shortage of qualified nurses throughout the UK, it is increasingly difficult to recruit to RMN vacancies as applicants are being sought from the same pool. There is therefore increased competition throughout South Wales, with a high number choosing to take up employment in the Cardiff area. The Division is currently carrying 41.68 WTE vacancies, 17.22 WTE appointed but not started and 21 students offered positions when they qualify in March and July 2016, however we expect a proportion of these to drop off. The drop off rate from the intake in May 2015 was 43% therefore in future we would anticipate a similar drop off rate. There are 32.17 WTE identified so far due to retire over the next 3 years, 21 of whom are due to retire in 2016.

The majority of the nurses on inpatient wards are band 5. Many inpatient based nurses are seeking and securing Community Posts which are at a band 6, which causes an on-going recruitment issue on all inpatient wards. A review of bands on units needs to be undertaken as part of the future workforce plans. In addition to these issues, the Health Board is also facing competition from private providers. Private mental health providers in the Gwent and the wider South Wales area are in abundance and are offering significantly higher starting salaries than the Health Board can offer.

Reduced training numbers over previous years has resulted in a shortage of nurses throughout the UK. That mixed with a high retirement trajectory is resulting in high vacancies which cannot be recruited into. Although Nursing Principles does not apply to Mental Health, Safer Staffing Levels is an objective that would like to be achieved which increases the numbers required. Nursing training numbers have been increased from 2015 however the increase is unlikely to be seen in practice for the next five to ten years. This is due to the reduced training pipeline from previous years' low commissioned numbers, together with the ageing workforce who are approaching retirement age.

Unfortunately the division has not been able to benefit from the overseas recruitment strategy that other divisions are part of. This is due to the fact that European trained nurses are unable to achieve their RMN / RNLD status from the NMC in order to work in this field in the UK.

In terms of the recruitment of nurses the Division's plan includes the following actions:

- Commencement of a recruitment wheel via the Bank for RMN/RNLD vacancies.
- Continue to run recruitment Nursing Fairs for newly qualified nurses. Past experience shows there has been a drop out factor, with applicants initially accepting posts then taking up posts elsewhere. Location seems to be a key factor for successful recruitment.
- The introduction of the Accelerated Nurse Development Program from September 2015.
- Rotational working across Older Adult and Adult.
- A specific Older Adult University Campaign – early discussions with the Lead Nurse.
- Scoping of new roles such as Band 4 Assistant Practitioner roles to work within the nursing structure as well as further development of existing roles such as Advanced Nurse Practitioner, Nurse Practitioner and Nurse Prescriber.

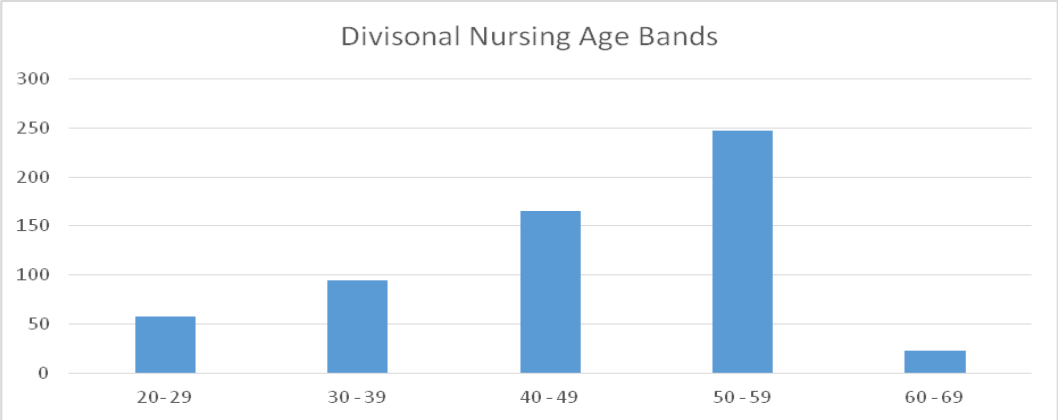
Medical Workforce
The division is currently experiencing difficulties in the recruitment of its medical workforce, specifically Junior and Mid Grade Doctors.

The division has been carrying vacant slots at Core Training (CT) levels for several years, the cumulative vacancies therefore will result in significantly low Junior Doctor coverage by day and out of hours from August 2016. This is a nationwide issue with a reduced training pipeline across the UK but is particularly prevalent in Wales. A critical issue affecting the Health Board is trainees selecting places in Cardiff as their preferred location for training rotations, resulting in more rural areas struggling to attract the required number of medics. A recent GMC survey found trainees in Wales are the most dissatisfied trainees in the UK. Findings were based on trainees in Wales working more hours than rest of UK, hospitals being too far away from training schools, lack of supervision and lack of technology, with Wales still operating on a paper based system whereas some English trusts have moved to a paperless system, thus reducing time spent on paperwork.

Workshops led by the Divisional Director and Clinical Directors are planned. These are to look at the recruitment challenges, new models and ways of working, in order to develop a Medical Workforce Strategy with the consultant workforce.

Age Profile
The Division has an ageing workforce. The graph below shows that the majority of the nursing workforce are above the age of 45, with 367 employees above 45 years of age and 219 below the age of 46. Many staff hold Mental Health Officer Status which allows them to retire at the age of 55 although many choose to retire and return to work on a flexible working application, usually on reduced hours. There is a need for clear succession planning.

Graph 7.8.3



Variable Pay

Throughout 2015/16 variable pay levels increased for both registered and unregistered staff on inpatient units. Agency spend has increased overall since the start of the financial year.

The high levels of variable pay and agency spend have been directly linked to the increasing number of nursing vacancies throughout the directorate. Sickness has also had impact on variable pay, again as a consequence of the vacancy factor.

Sickness Absence

There has been a significant decrease in sickness absence since January 2015, the target of 5.2% being achieved in the latter few months of 2015/16. Sickness/absence is being actively managed across all areas in line with All Wales Policy.

Stress and anxiety are the top reasons for sickness absence in the Division so there are plans to look at initiatives that could address issues raised as part of the staff survey and focus groups including interventions such as stress control courses, resilience training and 'Activate Your Life'.

8.12 Medium Term Financial Plan Update

The Mental Health and Learning Disability Division is forecast to overspend by £1,420k for 2015/16 at the time of pulling together the medium term financial plan based on month 8 information. The target is reaching a ceiling of £1,000k overspend at year end.

The medium term Financial Plan position across the Division is shown on the table below with a £6,620k overspend forecast for 2016/17:

Table 7.8.5

Forecast Variance mth 7 Over/ (under) 2015/16 £000's	Directorate	Budget Total 2016/17 £000's	Plan Variance Over/ (under) 2016/17 £000's	Plan Variance Over/ (under) 2017/18 £000's	Plan Variance Over/ (under) 2018/19 £000's	Plan Variance Over/ (under) 2019/20 £000's
(185)	N585 - Community MH Central Services	4,722	(99)	(99)	(99)	(99)
(300)	N850 – Older Adult MH Service	15,577	(338)	(338)	(338)	(338)
600	N860 – Adult MH Service	17,359	653	653	653	653
0	N862 –	3,122	(0)	(0)	(0)	(0)

Forecast Variance mth 7 Over/ (under) 2015/16 £000's	Directorate	Budget Total 2016/17 £000's	Plan Variance Over/ (under) 2016/17 £000's	Plan Variance Over/ (under) 2017/18 £000's	Plan Variance Over/ (under) 2018/19 £000's	Plan Variance Over/ (under) 2019/20 £000's
	Primary Care Measure					
0	N889 – Local MH Grant Scheme	426	0	0	0	0
(24)	N890 – Service Level Agreements	945	(0)	(0)	(0)	(0)
307	N888 – Learning Disabilities Business MNG	8,365	306	29	29	29
94	N891 – Forensic Service	3,499	95	95	95	95
46	N892 – Gwent Specialist Substance	1,271	46	46	46	46
(141)	N894 – Other Specialist MH Services	1,148	(141)	(141)	(141)	(141)
	FS&P Modelling Pay award and terms changes	1,192	53	104	140	172
398	**Division Total excluding CHC**	**57,626**	**576**	**350**	**386**	**418**
1,387	N877 – MH&LD Continuing Healthcare	21,783	6,044	10,828	15,612	20,396
1,785	**Division Total including CHC**	**79,409**	**6,620**	**11,178**	**15,998**	**20,814**

The Division is anticipating receiving full year recurrent funding in 2016/17 for investing in new services through Mental Health funds announced by Welsh Government. These are for psychological therapies £357k, psychiatric liaison £761k, Older Adult occupational therapy £90k, and perinatal services of £282k.

There is also investment from new Welsh Government funds from Primary Care funds, with £420k anticipated for Primary Care Measure teams.

CAMHS funding allocated by Welsh Government has also been approved for new investment in

the Early Intervention Service of £156k, and for CAMHS workers in the Primary Care Measure teams of £157k.

The Division faces significant financial challenges particularly with the forecast growth on Continuing Healthcare, with rising numbers of patients and costs, most notably for Learning Disability clients and low secure adult Mental Health placements.

Overall the forecast variance for 2016/17 is a £6.62m overspend, due mainly to the full year effect of new CHC patients approved in the current year of £2,473k, and of new growth in 16/17 of £3,884k. The CHC team have a savings target of £1,600k, which is being developed and will mitigate some of the rise, but the CHC overspend is forecast to be £6.044k which is 91% of the overall overspend.

The potential pay award costs have been included and funding has been assumed for this in line with central financial planning advice. The cost of medical pay awards and commitment awards are not assumed to be funded, and there is a £53k cost pressure included for this for 2016/17.

There are several streams of work in progress which are looking at improving the future financial position, but until these are worked through in more detail, and in some cases capital secured, it is not possible to include these with any certainty in the Financial Plan.

It is anticipated that whilst big service changes including low secure provision, older adult service reorganisation, and Learning Disability residential service review are taken forward, the Division will do everything it can to mitigate the forecast cost growth.

8.13 Capital Requirements

A number of the plans identified will have capital requirements, the extent of this requirement will only be clarified as detailed planning and costing work is completed. The known significant elements at this time are:

- Development of new local services such as a local LSU, HDU and extended PICU and a potential inpatient substance misuse detoxification facility.

- Alterations to and/or reconfiguration of current inpatient environments to ensure that they are configured to support the desired service models and that the environments are fit for purpose and meet security, safety and patient needs. This would include the OAMH inpatient reconfiguration; Adult MH inpatient reconfiguration; the pathway for both females and males with complex mental health needs as well as the transfer of the Forensic CMHT base to St. Cadoc's Hospital so that they are located on the same site as their main inpatient unit and can work more closely to move individuals through the care pathway.

The Division also has extensive capital requirements to maintain and improve environmental standards within our inpatient care settings across the Division. All have these have been submitted as part of the capital funding process; they are risk rated and are included within our Directorate and Divisional risk registers. The scarcity of capital funding available for such works is a great concern for the Division.

SCP 9 – Urgent and Emergency Care

Aim

The aim of this Service Change Plan is to redesign urgent and unscheduled care services to better meet the increasing needs of the population, establish further integration across the complexities of the system and meet national quality and access expectations. The vision is simple:

- Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families

- Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

- Thirdly, effective streaming of patients who present at all points in the system to the most appropriate point of care, reducing the number of admissions in acute hospitals, minimising length of stay and maximising the use of the right care settings.

Figure 7.9.1

The SCP is described in 6 sections which align with the priorities of the Wales Unscheduled Care Board and is consistent with the EASC Commissioning Framework.

- Care Closer to Home
- Agreed Care Pathways
- Clinical Process Excellence
- Hospital Site Management
- Well Managed Wards
- Effective Transfer of Care

The Health Board established an Urgent Care Board in August 2015 with membership from all areas of the unscheduled care system to oversee the plans outlined in this Service Change Plan and assure the Health Board of the progress made to achieving the aims and priorities of the IMTP.

Why is it important?
Over the last few years there has been increasing concern within the Health Board that demands placed on emergency services exceed capacity. An indication of this problem is an increase in attendances to ED departments within the Health Board of 10.5% between January/February 2015 and 2016, the most striking increase in activity over recent winters. This has resulted in many patients waiting for excessive periods; the University Health Board performance is frequently below the national standard of 95% of patients being seen, treated and discharged/admitted in less than 4 hours.

The pressures evident at the front door are replicated in primary care settings. Demand for urgent appointments exceeds capacity, our engagement activities with local communities shows that the public are most exercised by the difficulties they face securing an appointment with their GP.

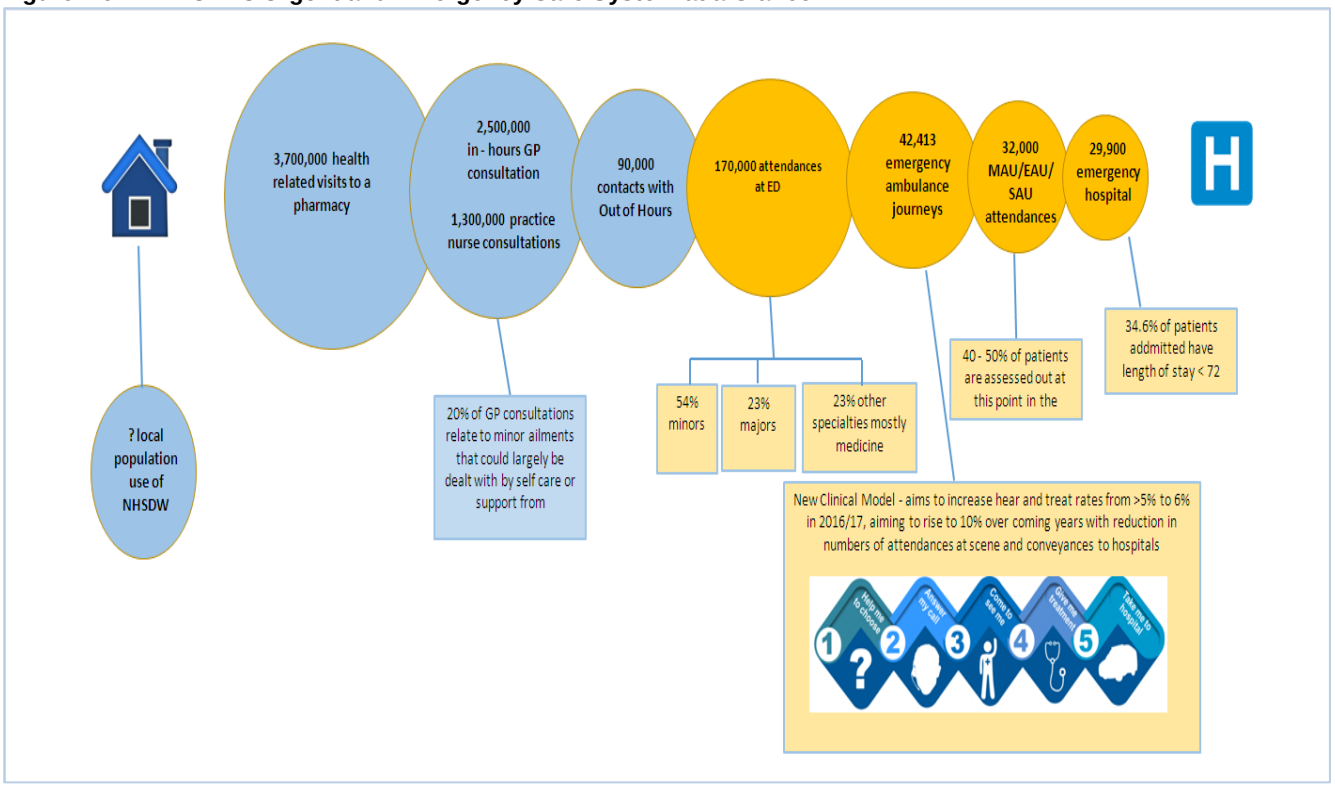
Since 2012/13 the number of GP emergency assessments admitted to MAUs has increased by 32% (5,500 patients), and emergency admissions have risen by 13.4% (3,320 patients) over the same period. The reasons for the growing pressures on urgent and emergency care services are experiencing have been well rehearsed. Two things in particular are cited. Firstly, an ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care across the system. Secondly, many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided in and outside of hospital, and default to ED. What is clear is that demand will continue to rise, and the current system of care is not sustainable.

Figure 7.9.2 illustrates the volume of urgent and emergency care activity generated across the system during 2015. It also shows that opportunities exist for meeting peoples' urgent and emergency care needs closer to home, specifically

- 20% of GP consultations relate to minor ailments which could be managed through self care or community pharmacy services
- **Less than 5% of emergency calls are currently resolved and closed on the phone (WAST aim to achieve 6% during first 6 months of 2016/17, aspiring to 10% over the next 3 years)54% of ED attendances are for minor injuries/illness, a proportion of which should be managed through primary care and community services
- 23% of ED attendances relate to other specialties, predominantly medicine
- 40-50% of patients attending medical assessment units are assessed out (i.e. do not require a hospital admission)
- Almost 35% of patients admitted have a length of stay less than 72 hours

***Through the EASC Commissioning Framework the benefits of the new clinical model for WAST should impact positively on patient flows to acute hospital settings, with more patients managed via hear and treat, or in receipt of care from paramedics in the community.*

Figure 7.9.2 - ABUHBs Urgent and Emergency Care System at a Glance



Capitalizing on these opportunities is the basis of this Service Change Plan, specifically:

1. To avoid people choosing to queue in ED, or being taken to hospital unnecessarily to receive the treatment they need, the service outside of hospital must be improved and enhanced.

2. To ensure that people have timely access the most appropriate urgent and emergency care service within hospital settings, a single point of entry, that contribute to urgent and emergency care into a single Emergency Floor model is proposed for each of the acute hospital sites, namely the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH).

3. To maximize patient flow with standardization of patient pathways and ward operational procedures that integrate the input of all care practitioners (medics, nurses, therapists, and social services) must be adopted across the all hospital wards.

9.1 Care Closer to Home

The importance of general practice as the first port of call for patients with immediate and potentially urgent needs is recognised by the Department of Health, BMA, RCGP and Welsh Audit Office. Where primary care respond to immediate and potentially urgent needs as early as possible in the patient's journey, the workload and cost for the rest of the NHS can be reduced. Better management of urgent requests can lead to a substantial reduction in attendances at A&E and emergency hospital admissions (EMAs).

Priorities for Improvement
The key desired outcomes can be summarised as follows:

- Optimising Access in General Practice for urgent care – same day consultation (face-to-face; telephone or home visit)
- Sustainable General Practice infrastructure to support care closer to home (2015/16 number of practices reduced from 89 to 84, anticipated that a further 4 practices will close during 2016/17)

- Skilled, supported and sustainable workforce, including pharmacists in primary care practices.
- Sustainable OOH service model

Examples of how these will be delivered and their impacts measured are outlined in the table below.

Table 7.9.1

	Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
Primary Care Urgent and Emergency Access	Define and agree reasonable standards of access to urgent, soon and planned care in conjunction with LMC and ABCHC	Q1 16/17	Desired access standards consistently understood and provides basis of delivering improvement Clear accountability framework.	62*/84 practices with 5 "A" is for access standard	Evidence LMC, ABCHC and GP support for access standards. Number of practices completing diagnostic of demand/capacity to deliver new access standards	Q4 16/17
	Implement phase 1 or Access Quality Improvement Scheme - Pacesetter	Q2 16/17	Diagnostic of practice accessibility. Robust improvement plans to improve access	Number of same day appointments by participating practices.	Reduction in rate of attendance at ED for practice population. 50% of practices will participate in scheme in 2016/17 (anticipated that 36/62* practices to implement in 2016/17)	Q4 16/17
	Sustainable primary care workforce – primary care operational support team (see SCP 3)		Core and enhanced access for patients to urgent and emergency primary care services			
Stay Well and Advanced Care Planning	2,000 older people (frailty scale 3-7 band) in Newport City on Stay Well Plans	Q1 16/17	Risks identified, wellness plans and support in place to maintain independent living	No of ED attendances and no of emergency admissions for patient cohort.	215 fewer ED attendances 30 fewer admissions for patient cohort.	Q4 16/17
	Nursing team to support care homes, through training programmes, to improve and enhance clinical practice including: a) embedding Advance Care Planning b) up-skilling the workforce CDM and deteriorating	Q4 16/17	By Jan 2016 verification of death policy will be in place in the independent sector. The training needs analysis completed & training strategy will be in place for independent nurses. Reduced variation in standard and range of care	Number of anticipated deaths in Nursing homes previously GP verified compared to Number of deaths in Nursing homes verified by ACP Accredited foundation	No GP call outs for anticipated deaths No of nursing home residents with ACPs in place. Number of registered nurses undertaken ACP training Number of HSW undertaken Communications training Number of nurses	Q1 16/17 Q4 16/17

	Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
	conditions c) Verification of death policy for anticipated deaths d) NMC revalidation requirements met		provided in nursing home.	course for new independent nurses – nos of new nurses completing course. Emergency admissions 2014/15 – 613 (ALOS – 7.4 range 1 – 24 weeks) 2015/16 – 510 (ALOS – 7.4 range 1 – 18 weeks)	undertaken Foundation training Numbers of emergency admissions for nursing home patients to acute settings	Q4 16/17
Gwent Out of Hours Urgent and Emergency Primary Care Service	Attracting GP workforce	Shifts robust Capacity aligned with Demand Compliance with All Wales OOH targets	Shift filled rates over previous 12 months	Number of unfilled shifts Performance against the targets 2016/17 fill rate 80%	Fill rate 90%	Q4 2016/17
	ACPP editor - local call handing algorithms	Skilled and knowledgeable workforce	Pharmacy repeat prescribing direct to community pharmacy		30% of medication requests redirected to community pharmacy @ call handling stage	Q2 2016/17
	Skill mix for clinical triage	Nurse – single or uncomplicated calls Doctor – complex needs CPS – patients with mental health needs	Disposal rates Triage Call time Redirection of patients to and from ED		37% advice rate % directed to other services, by service	

Access

General Medical Services (in-hours) are currently provided through 84 General Practices, with 586,672 patients registered as of January 2016, as set out below. These patients generate 2.5 million contacts with General Practitioners and a further 1.3 million contacts with practice nurses each year.

Table 7.9.2

	Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen	Total
Practices	13	25	13	20	13	**84**
Registered Patients	72,683	182,758	86,068	150,681	94,428	**586,672**

Optimising access in General Practice through the Pacesetter improvement scheme will be a key mechanism to further improve core and enhanced access for local communities.

Improvement Plan
The Health Board launched a new Access Quality Improvement Scheme in January 2016 what has two discrete phases. Phase 1 focuses on effective capacity and demand modelling leading to the development of robust access improvement plans, critically this phase will include patient and staff surveys. The second phase is designed to support practices to implement plans to improve access that were identified in phase 1. It is anticipated that 50% of GP practices will participate in this scheme in 2015/16. Funding this transformation programme is through the Primary Care Fund monies received in 2015, with practices participating in phase 1 receiving the sum of £1,000 plus 30p for each registered patient and paid on completion of phase 1.

Out of Hours Urgent and Emergency Primary Care service operates between the hours of 6.30pm and 8am Mon-Fri and all day Saturdays, Sundays and Bank Holidays. The service has the following responsibilities:

- To identify immediate life threatening conditions
- Identify patients who need urgent in-patient care
- To identify those whose treatment cannot wait
- Defer those who can wait to see their own GP/ self care
- Communicate effectively with patients and other healthcare professionals
- To refer to Out of Hospital services to maintain and support patients at or as near to home as practicable

These are delivered through three discrete service domains:

1. Call handling & triage (in future this element is likely to go to 111 Wales Phone First with limited repeat triage and no call handling)
2. GP & Nurse consultations in Primary Care Centres (PCCs)
3. Home visiting By GPs and Nurse Practitioner and Nurses

Staffing Levels
The service is provided has an annual budget of £5.67m, the staffing skill mix and number are illustrated in Table 7.9.3, they provide cover from 18.30 to 8.00 each week day and weekend and bank holiday cover from Friday 18.30 to 8.00 the next normal working day.

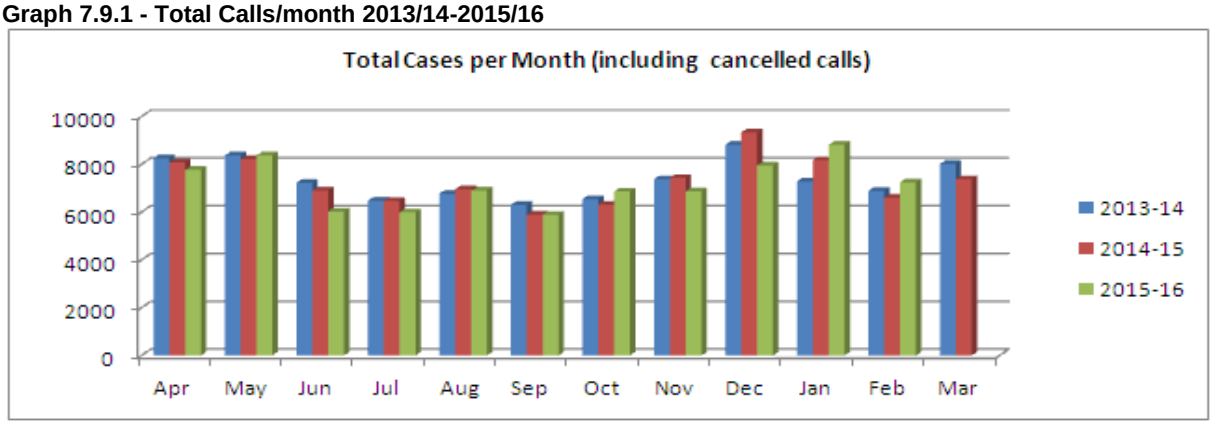
The service has difficulties filling shifts to match service demand, particularly in order to cope with the predictable peaks in triage calls in the mornings of weekends and bank holidays, and in recruiting sufficient ANPs and GPs to ensure all shifts are filled.

Table 7.9.3- Staffing Establishment OOH Service

	Staff in Post	Establishment
	(Whole time equivalents)	
General Practitioners (13 part-time salaried/ 65 sessional)	4.8	17.89
Nurses	11.24	12.57
Call-handlers	20.12	22.45
Drivers	11.39	13.73
Shift Co-ordinators	2.72	2.81
Manager	2.8	2.8
Administration	5.49	6.07
Total	**71.49**	**77.86**

Service Activity
Call volumes have remained broadly similar over the past three years with an average of 240 calls each day. During the first two months of 2016, the peak in activity noted across the urgent and emergency care system was evident, though not as marked, in the Out of Hours Service with a 7% and 5.5% increase in call volumes in January and February respectively.

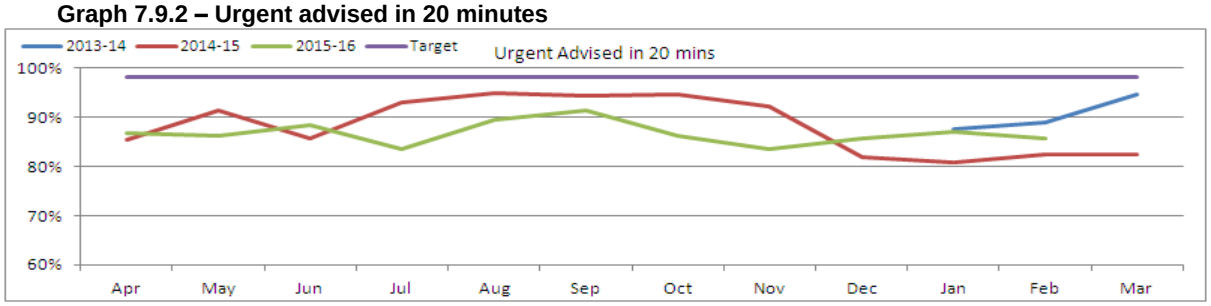
Graph 7.9.1 - Total Calls/month 2013/14-2015/16



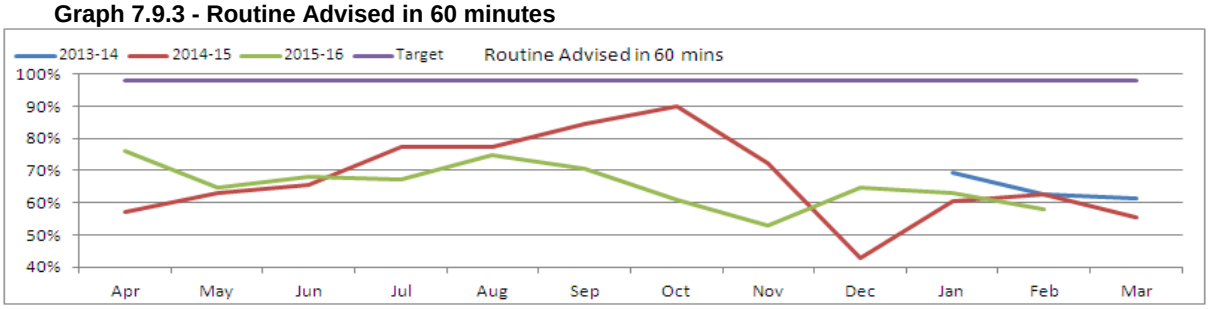
Triage Performance

ABUHB are early adopters of the more stringent All Wales standards where 98% of urgent calls are dealt with within 20 minutes and 98% of routine calls within 60 minutes. These National Targets will be implemented across NHS Wales by 2017. Current performance is illustrated in figure 9.4 and 9.5. The service is facing challenges achieving these new standards consistently. It is important to note that whilst the designated service is “urgent Primary Care “there is increasing evidence that a large percentage are in fact non urgent and many of these patients claim access issues for the in hours periods”. There has also been an increase in medics who practice a higher level of risk aversion following some NICE Guidelines and Significant Events. Whilst these incidences are extremely low the increase aversion to risk would appear to be disproportionate. Out of Hours standards are under review.

Graph 7.9.2 – Urgent advised in 20 minutes



Graph 7.9.3 - Routine Advised in 60 minutes

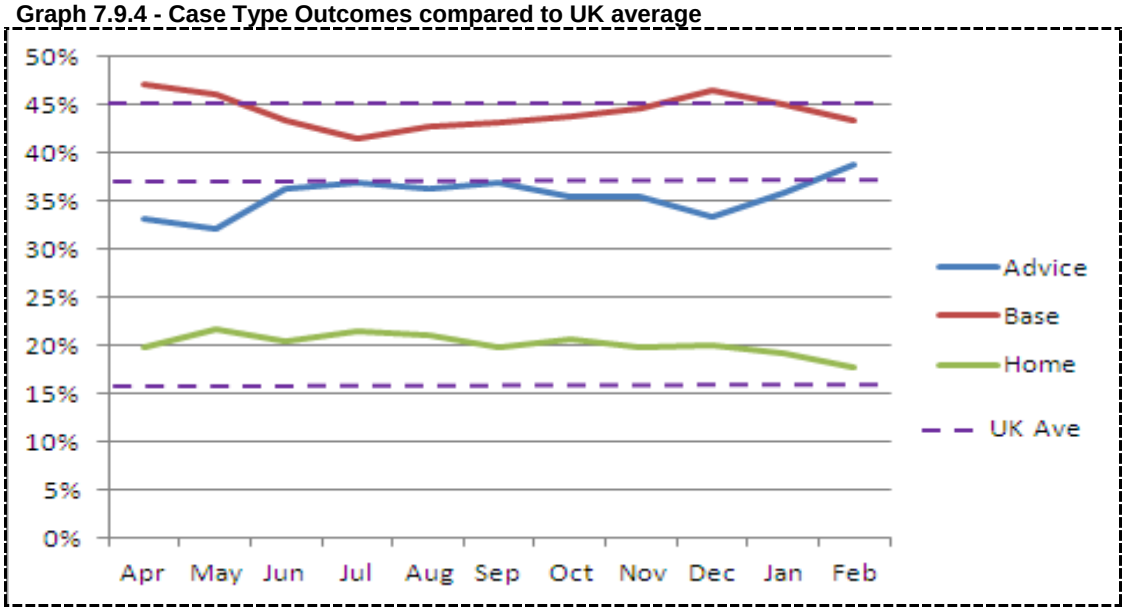


Impact of ABUHB OOH’s on Emergency Departments and Acute Hospital Services

Referrals for assessment/advice - the GPOOH’s service aims to minimise or reduce the flow of primary care patients accessing care via front-line services such as ED or MAU by appropriately caring for patients at home. The outcomes of calls to the service compared with the UK average are shown in figure 9.6 below.

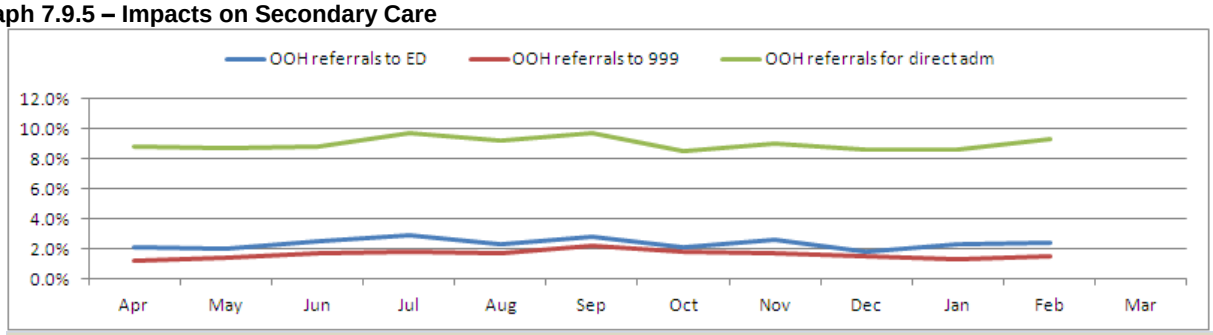
Calls from patients given telephone advice (39% compared to UK average 46%) generally result in self care or a deferral to be seen by in-hours primary care service. The remainder are triaged to receive face to face assessment in a Primary Care Centre (43% compared to UK average of 38%) or where necessary at home (18% compared to UK average of 16%).

Graph 7.9.4 - Case Type Outcomes compared to UK average



The percentage of calls resulting in acute admissions to hospital is a reliable measure for ABUHB OOH's effectiveness in preventing primary care patients accessing services via secondary care. 85% of calls to the service remain in the community. The proportion of patients seen that are referred to ED average at 2.4% of all contacts and direct admissions is 9%.

Graph 7.9.5 – Impacts on Secondary Care



Impact on Secondary Care 2015-16

Actual numbers	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Avg
OOH referrals to ED	165	168	149	175	163	163	142	180	142	208	175	166
OOH referrals to 999	98	120	105	108	116	128	127	116	118	115	107	114
OOH referrals for direct adm	689	728	535	586	635	575	584	621	686	762	675	643
OOH referrals to WAST	140	144	131	130	156	160	157	145	143	157	130	145

Challenges

Demand for the service has remained relatively static over the past three years with highly predictable peaks and troughs. However the increasing number of the frail elderly and those with complex disease, as well as the changing expectations of clinician behaviour and documentation means the average consultation is taking longer.

As the service is only resourced to ""to ensure individuals with urgent primary care needs, which cannot wait until the next available in-hours surgery, are met and that other patients accessing the service are given appropriate advice and information"." (Wales Quality & Monitoring Standards for the Delivery of Out-of-Hours Services, 2014) this mismatch between patient expectations and service capacity presents an increasing challenge in meeting the needs of those patients who are really sick.

The current service delivery is also in breach of the Welsh government standards for Out of Hours care in a number of areas. Experience from other services is that when Out of Hours GP services

are not meeting patient need in a timely fashion, the burden on Emergency Department and the Ambulance Service increases. Due to the risk adverse nature of both services a higher percentage of patients then end up in secondary care. When the service is under pressure a significant percentage of this pressure is absorbed internally, resulting in increased stress for staff, quicker consultations with the possibility that important clinical features are missed and fewer staff being willing to work within the service.

There are six key problem areas impacting on effective delivery of Urgent and Emergency Out-of-Hours Primary Care, which are summarised in Table 7.9.4. The most significant being that demand is outstripped by available resources as the service is currently designed.

Table 7.9.4 - Areas for Improvement OOH Service

Issue	Impact
Sufficient clinical cover to meet current demand	Escalation when unable to capacity falls short of demand is to refer patients to acute secondary care services or back to in-hours General Practice resulting in more admissions to hospital Staff experience higher levels of stress which has negative effect on recruitment and retention, and risks to patient safety Reduction in number of operational Primary Care Centres making service less accessible to patients
Optimising Skill mix – nurse capacity	Nursing and independent prescriber numbers are the highest in Wales but service faces significant challenges recruiting sufficient numbers of nurses to provide a robust, sustainable service Lead time for additional skills and competencies training is 12 months, numbers of training places needs to be increased
Increasing demand and public expectation	Increasing numbers of people access service for routine care that could wait until in-hours and/or pharmacy services are available Difficult to dissuade expectations from wants to an "urgent need". This is a dichotomy that despite education and communication seems to have had little influence on behaviour Non-urgent demand creates queuing, bottlenecks and delays for those with genuine urgent care needs
Prescribing requests and dispensing demand out of hours	Access to Community pharmacies is not equitable across the patch and lead to patient being seen outside of priority in order to meeting opening times. Repeat prescriptions are an issue particularly where patients have not accessed their own GP Many conditions presenting to OOH could be treated by a pharmacist
Availability and responsiveness of other services need for onward referral	Timely referral and handover to alternative services is essential, not only to improve experience and outcomes for individual patients but to avoid queuing and bottlenecks
Impact and alignment of Phone First (111)	Working toward the introduction of 111 within the Health Board area by 2017

Key Achievements 2015/16

- Improved performance in comparison with previous years with consistent improvement across all targets since December 2015
- Continual improvement in filling GP shifts with consistent fill rate of 80%
- Programme initiated on nursing workforce redesign aligned to demand/capacity profile for service
- Working with USC Division to improve re-direction rates from ED to OOH
- Home Triage working guidance and pilot in place
- Introduced Pharmacy repeat prescribing service
- Implemented new telephony infrastructure to improve performance
- Development of new clinical pathways for non-clinical staff to appropriately direct callers to right part of the system or give advice on self care

Improvement Plan

Desired Future State
The UHB seeks to redesign Primary Care Out-of-Hours service to:

- Reduce non-urgent demand.
- Recruit and retain a skilled and sustainable multidisciplinary workforce.
- Ensure a responsive, efficient equitable service.
- Deliver the agreed All Wales OOH performance standards.
- Ensure the service is integrated within the local urgent and emergency care system.
- Deliver a high quality service is delivered across ABUHB.
- Prepare for the roll-out of 111 by 2017.

A service redesign plan for the Urgent Primary Care Out Of Hours Service has been developed, with changes for the service which will alter its shape and direction over the next 3 to 5 years. Changes include:

- Staffing skill mix and the roles of the professionals within the team, including proposed new roles. Such changes will incur some savings but others will create additional costs and the report attempts to estimate the anticipated resource implications. These need to be phased over a number of years, as there will need to be time to provide training programmes and development opportunities. The key drivers to cost increase are the rates proposed for sessional GPs, the development of community pharmacy services and increased nursing posts whilst costs can be reduced in the level of GPs required for the service.
- Process improvement which can be implemented with minimal costs and in a relatively short time frame.
- Development and revision of clinical assessment tools and thresholds which can be implemented with minimal cost implication.

The proposed changes, summarised in Table 7.9.5 are necessary to provide a safe, sustainable service in a context of reduced GP availability and the aim of the report and its proposals is to suggest a service model which will stabilise and develop the service to improve patients' experience and to ensure that quality standards are delivered. The revised service will also be better placed and prepared for the introduction of the 111 service. It is anticipated that by providing a high quality, well planned service with an active programme of staff support and organisational development, we will more proactively attract staff to work in the service. The revised model is developing as part of the wider unscheduled care system and co-ordinated to work with all 24/7 service provision.

Table 7.9.5 - Components of the 3-5 year OOH modernisation plan

Key Actions with Resource Implications		Actions with Minimal Resource Implications	
1.	Increase Sessional GP rates to £80 per hour for weekday evening and £90 per hour for weekend and overnight. Bank Holiday pay to be increased to £120 per hour for the daytime and £130 per hour for overnight.	1.	Develop ACPPs for a wider range of conditions.
2.	Commission extended pharmacy opening hours throughout the Aneurin Bevan area.	2.	Promote the "Do I Need A Doctor" application through the Health Board Communications Team.
3.	Introduce the pharmacy LES throughout the OOH period.	3.	Explore online registration in conjunction with the 111 Team.
4.	Investment in an Adastra-Symphony Bridge.	4.	Provide refreshments.
5.	A Mental Health Nurse to be available during peak periods in the call centre.	5.	Change Performance Management System.
6.	Create a Band 8a Operations Manager role.	6.	Roster changes to ensure 1 GP triaging between 18.30hrs-22.00hrs weekdays and extra GP input at weekend.
7.	Create a Band 7 Aneurin Bevan Project	7.	Development of consensus statements and a

Key Actions with Resource Implications		Actions with Minimal Resource Implications	
	Coordinator role to lead transition to 111.		supportive management environment to facilitate clinicians to manage risk appropriately.
8.	Provide additional nurses to triage in the call centres at peak times with GPs available by phone in the bases.	8.	Telephone triaging to be addressed at Pan Gwent CPD sessions.
9.	Gradually replace GP evening visiting shifts with Nurse Practitioners.	9.	Introduction of Skype consultations and an inbox for pictures (ABCi funding).
10.	Introduce APPs into the service to provide home visiting capacity at peak periods.	10.	Introduction of home triage.
11.	Consider commissioning non emergency ambulances to bring housebound non palliative patients to base during peak periods.	11.	Develop PGDs to cover the full OOH formulary in conjunction with WAST.
12.	Continue provision of emergency supply through Community Pharmacies.	12.	Invest in the education of Community Nurses.
13.	Extend Torfaen Minor Ailments scheme to the rest of Gwent.	13.	Develop ACPPs, for Minor Illness directly to pharmacies and nurses.
14.	Work to establishing pharmacy hubs.	14.	Develop ACPP, for female UTI.
15.	Employ HCAs to do initial observations and support clinicians.	15.	Electronic transmission of scripts.
16.	Appoint Band 2 Administration Coordinator at VPH.	16.	New system for sourcing of unusual drugs.
17.	Appoint APP and substitute 12hrs of GP time at weekend.	17.	Virtual support from OOH for pharmacies.
18.	Training and Development of triage staff.	18.	Adopt simulated surgeries.
19.	Appoint Band 5 trainee nurses to be trained to Band 6/7 NP/ANP.	19.	Work with WAST to develop their SOP for administration of palliative care drugs.
20.	Purchase Clinical Guardian Software.	20.	Liaise and link with the on-going work and training in Care Homes, including Anticipatory Care Planning.

Key Milestones 2016/17

Table 7.9.6

Service Change	Outcome	Baseline measure	Target Measure	Timescale
Attracting GP workforce	Robust rotas Capacity aligned with demand Compliance with All Wales targets	Shifts filled v last 12 months	Number of unfilled shifts Compliance with targets	Q4 2016/17
ACPP editor – local call handling algorithms	Consistency in call handling, skilled, knowledgeable and confident workforce		30% of medication requests redirected to community pharmacy @ call handling stage Handover calls to appropriate triage agent	Q2 2016/17
Skill mix for clinical triage	Nurse – single or uncomplicated calls Doctors – complex need CPS – mental health needs	Disposal rates Triage call times Advice rate 39% (v UK average 46%)	Advice rate improvement Y1 40% Y2 41% Y3 42%	 Q4 2016/17 Q4 2017/18 Q4 2018/19
Pharmacy LES throughout OOH period			30% of medication requests managed by community pharmacy	Q2 2016/17

Plans are interconnected and should be read in conjunction with **SCP 3** primary and community care services.

9.2. Agreed Care Pathways

The establishment and maturation of Neighbourhood Care Networks within the Health Board has facilitated the development and expansion of services within the community aimed at maintaining independence and reducing reliance on hospital based care.

Interagency Winter Planning has also contributed significantly to the development of integrated care pathways for Falls focusing on creating WAST led community orientated rapid response vehicles to provide assessment and intervention to people in their homes and avoiding unnecessary conveyances to hospital.

Desired Outcomes and Measurable Benefits

Priorities for Improvement
The key desired outcomes can be summarised as follows:

- Consolidate Newport Older Person Pathway "Stay Well Plans"
- Consolidate and strengthen links between 24 hour Community Nursing (including CRT/frailty services) and OOH service
- Advanced Care Planning in Nursing Homes – recognising and managing deteriorating patient in situ
- Strengthen Chronic Conditions Management pathways
- Ambulatory Care Capacity and Pathway
- Integrated Falls Pathways

Examples of how these will be delivered and their impacts measured are outlined in the table below.

Table 7.9.7

	Key Milestone	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
Primary and Community Care Pathways	Stay Well Plans (Older Persons Pathway)	▪ Improved access to social networks and reducing social isolation ▪ Improved access to benefits ▪ Referrals to the wider primary care team, including OT, Frailty, Long Term Conditions nurses. ▪	▪ No. of people on stay well plans and their admission to long term care or in receipt of packages of care ▪ No. of people on stay well plans and their unplanned admission to hospital ▪ No. of people on stay well plans who are assessed out following attendance at emergency assessment unit.	▪ Reduction in no. of people on stay well plans and their admission to long term care or in receipt of packages of care ▪ Reduction in no. of people on stay well plans and their unplanned admission to hospital ▪ Reduction in no. of people on stay well plans who are assessed out following attendance at emergency assessment unit.	Q4 16/17

	Key Milestone	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
	24 hour community nursing service	▪ Increased number of specific scheduled duties calls to Primary Care OOHs undertaken by HCSWs; ▪ DN teams operate consistent hours across 5 boroughs; ▪ DN input 24/7 providing unscheduled response ▪ .	▪ Emergency admissions to secondary care ▪ GP OOH Demand ▪ A&E Attendances	▪ Reduction in unplanned hospital admissions ▪ Reduction in palliative/end of life unplanned hospital admissions ▪ Reduction in demand on GP OOHs service ▪ Reduction in demand on A&E ▪ Improvement in quality of care and continuity of care as care provided closer to home ▪ Equity of access for patients across the UHB	Q4 16/17
	Advanced Care Planning (Nursing Homes)	▪ More anticipatory plans in place Less unplanned hospital admissions ▪ Improved and targeted referrals to other services ▪ A safer, better quality service.	▪ Number of anticipatory care plans ▪ Reduction in unplanned hospital admissions from care homes ▪ Improved & targeted referrals to other services ▪ Improved skill set of Care Home staff ▪ Release of GP time from unnecessary care home visits	▪ Increase in number of anticipatory care plans ▪ Decrease in unplanned hospital admissions from care homes ▪ Improved & targeted referrals to other services ▪ Improved skill set of Care Home staff ▪ Release of GP time from unnecessary care home visits	Q4 16/17
Ambulatory Care Pathway	Establish Business Case and implementation plan for Ambulatory Care Unit at NHH	Dedicated Ambulatory Care Unit assessing all medical patients presenting to the Front Door (7 days), Which includes GP call handling capacity	▪ Current assessed out rates @ front door ▪ Emergency medical presentations and admissions	▪ Assessed out rates ▪ Numbers of emergency medical presentations diverted to “planned”/scheduled slots ▪ Numbers of GP calls diverted to planned”/scheduled slots ▪ Number of GP calls diverted to community based care	Q3 2016/17
	Establish Business Case and implementation plan for Ambulatory Care Unit at RGH				Q3 2016/17
	Maximise wasted outpatient capacity at acute sites	▪ increase ambulatory care clinic capacity for same day or next day	Cancellation rates in OP by specialty	Number of hot clinic slots created by specialty Number of hot clinic slots used – same day/next day	Q2 2016/17
Integrated Care Pathways	Falls Pathway	Falls assessment (non fracture) in community setting supported by CRT and community services to manage patient safely at home	Number of patients conveyed to hospital following a Fall	▪ Increase the number of patients assessed and managed in community settings following a fall ▪ Reduce the number of people conveyed to hospital following a fall	Q4 2016/17
	Chronic Conditions Management	Reduced unplanned and emergency admissions for	No of patients in PC with poorly controlled diabetes	25% reduction in unplanned and emergency admissions 30% decrease in specialist	Q4 2016/17

	Key Milestone	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
		reversible diabetes complications.	admitted to hospital 2015/16.	diabetes activity	
		Medicines management and COPD admissions data	No of patients in PC with poorly controlled COPD admitted to hospital 2015/16.	▪ Number of all respiratory admissions and emergency admissions in the UHB ▪ Average length of stay for admissions and emergency admissions for all respiratory conditions	Q3 2016/17

Plans for Stay Well, 24 hour community nursing and Advanced Care are interconnected and should be read in conjunction with **SCP 3** primary and community care services. Plans for strengthening Chronic Conditions Management are shown in **SCP 5.**

Ambulatory Care services have been introduced to the Health Board over the past three years through the establishment of an Acute Care Physician Model at the Royal Gwent, Nevill Hall and Ysbyty Ystrad Fawr Hospitals. Increasingly ACPs and ANPs are playing a crucial role at the front door providing assessment, diagnosis, intervention and discharge on an ambulatory basis within ED in addition to managing patients in the Medical Assessment Units. 33% of patient seen by the ACP service are assessed out at the front door. However, when ACP cover was extended to 10pm daily during a four week pilot (2014/15) assessed out rates increased to 40%.

As part of the Winter Plan, ACPs have provided a consultant led GP Call Handling Service providing support and advice that facilitated a planned element to patient assessment for 28% of calls, enabling improved management of patient flow at the front door.

Challenges
The Ambulatory Care service faces a number of challenges most significantly capacity is restricted in relation to workforce and consequently the level of senior clinician cover is not consistent across 7 days. There are also infrastructure is constraints with no dedicated Ambulatory Care Unit on any of the acute hospital sites, and the current estate does not lend itself to streaming patients once they attend ED.

Securing additional capacity to better match capacity and demand is a further challenge; ACPs are from a restricted workforce pool. The Health Board is critically reviewing the current Front Door system, its' workforce; infrastructure and processes with a view to optimising the resources available to the system with a focus on creating sufficient ambulatory care capacity to meet local urgent and emergency care needs.

Desired Future State
The UHB seeks to redesign Ambulatory Care services to ensure that:

- Emergency medical patients, attending either MAU or ED will be triaged & assessed by a senior clinical decision maker, and treatment plan agreed with 3 hours of the time of arrival, 7 days a week.
- Consultant led GP call handling service which impacts on the number of patients needing emergency assessment and the time of day they are seen.
- Robust ambulatory care clinic capacity is available to facilitate redirection from front door into speciality clinic as appropriate
- Ambulatory Care will be the default, unnecessary admissions to a hospital bed will be minimised

Key Milestones 2016/17

Table 7.9.8

Milestone	Outcome	Baseline measure	Target Measure	Timescale
Analysis of front door case mix to model demand for ambulatory care by acute hospital site	Model demand and patient flow to inform capacity requirements for comprehensive ambulatory care service		Improve patient experience by admission avoidance, right care, right place, right time. Increase in ambulatory volumes with reciprocal reduction in MAU trolley demand Triage & rapid ACP clinic access as an alternative to MAU admission Increased assessed-out rates, standardised approach 7 day working	Q1 2016/17
Critical review of existing front door and specialty services clinical resources to identify opportunities to expand Ambulatory Care capacity at the front door at each acute hospital site	Clear understanding of existing capacity to deliver service model – to include ACPs, ANPs A&E Consultants, outpatient capacity for ambulatory care clinics.			Q1 2016/17
Review of estate – to identity opportunities to create optimal environments to provide ambulatory care at the front door at each hospital site	Clarity in respect of critical adjacencies and estate requirements to operationalise ambulatory care service model			Q1 2016/17
Develop business case for implementing ambulatory care service model	Detailed business case for consideration by Urgent Care Board.			Q2 2016/17

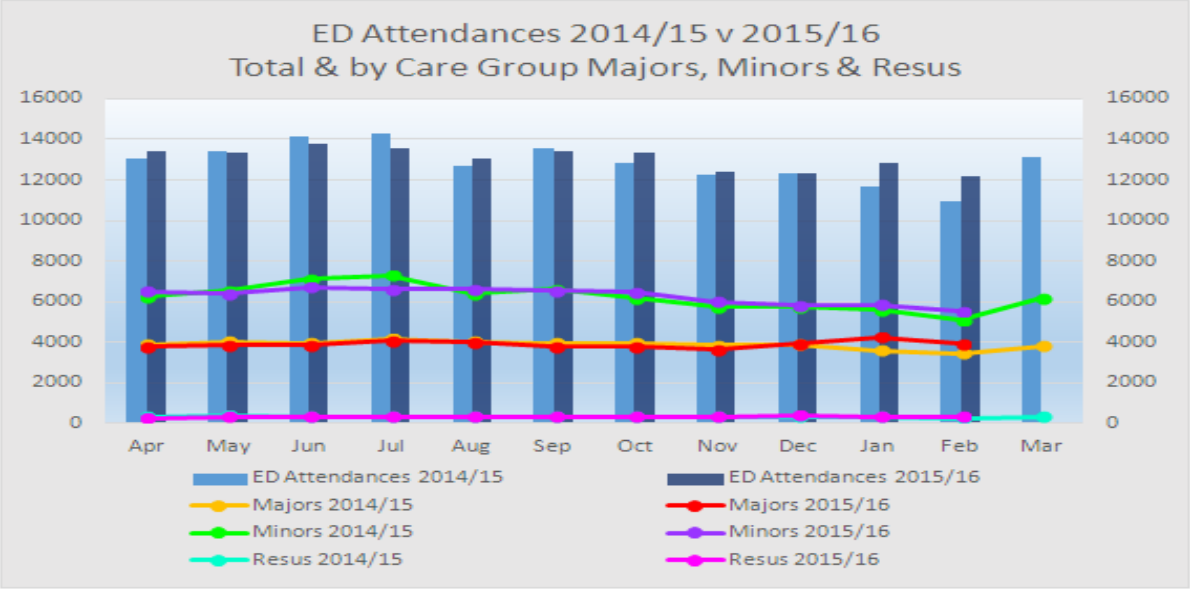
9.3 Clinical Process Excellence

The ideal patient journey should be ***"assess once, investigate once and decide once"*** however the physical layout and the geographical separation of ED and medical and surgical assessment areas prevents the efficient assessment and streaming of patients attending acute hospital sites into the most appropriate stream. Currently there is duplication of booking in and triage/assessment leading to a fragmented patient journey, resulting in a delayed and poor patient experience.

In response to a consistent underachievement of the 4 hour target and limited progress in reducing and eliminating 12 hour waits in ED, new clinical roles (including Acute Care Physicians, Advanced Nurse Practitioners and Emergency Nurse Practitioners) and services (ambulatory care, clinical decision units, ACP call handling, nurse led minor injury service) have been introduced over recent years.

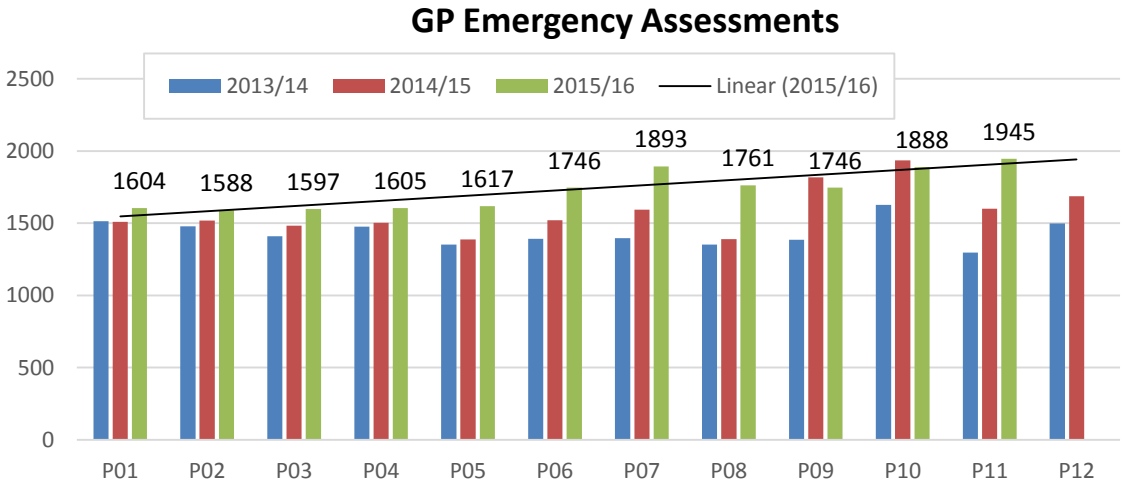
Annual attendances for both major and minor patients across **Emergency Departments** have been static for several years with the exception of January and February 2016 where there was an overall increase of 10.5% compared to the same period last year as shown in Graph 7.9.6 this increase was across all care areas and sites.

Graph 7.9.6 - ED Attendances 2014/15 and 2015/16



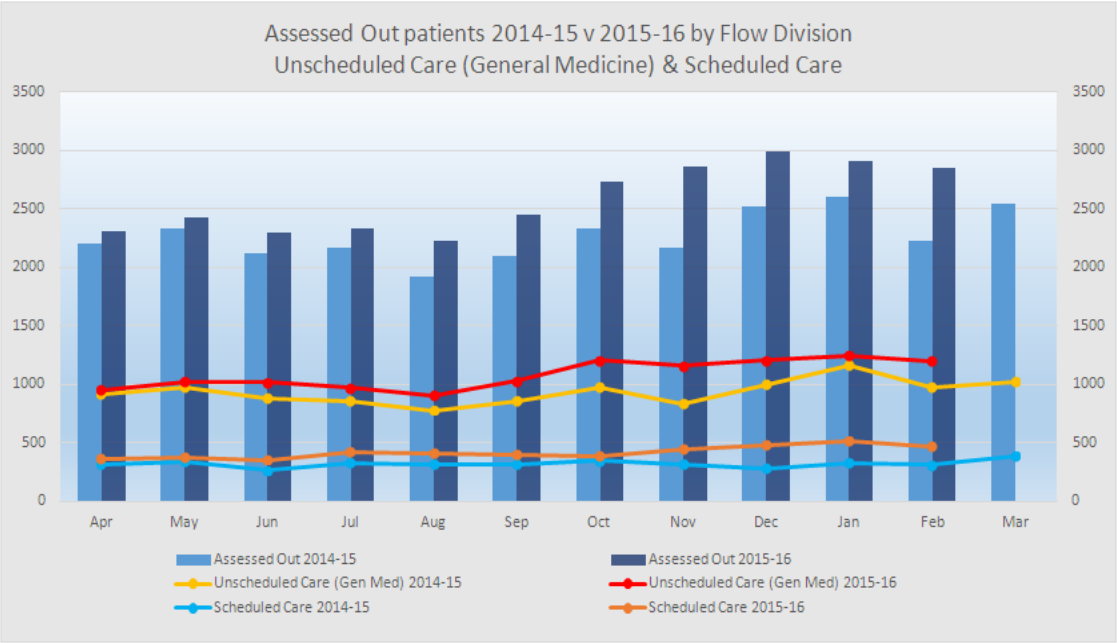
There has also been an increase in GP referrals to the assessment units with a rise of 20% compared to last year. This pattern of increasing referrals for emergency assessment is consistent across the past 3 years, it may reflect the ageing demographic and increased levels of acuity, declining numbers of GPs, variation in the distribution of community based alternatives and/or the need to develop ACP led GP call handling to better support primary care to manage patients in their own homes.

Graph 7.9.7 - GP Emergency Assessments



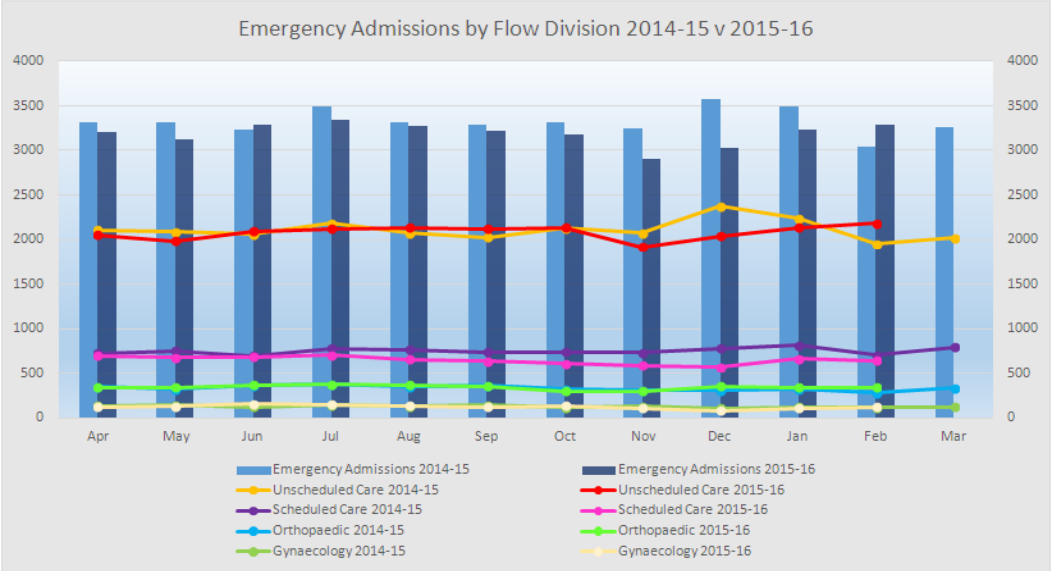
Assessed out rates have increased by over 4% compared to the same period last year reflecting the efforts made by the organisation to increase senior clinical decision maker capacity at the front door.

Graph 7.9.8 - Assessed out rates 2014/15 and 2015/16



Emergency admissions have similarly fallen by 4% compared to the same period last year with an increase in admissions in February 2016 corresponding to the sharp increase in ED attendances.

Graph 7.9.9 - EMAs comparison 2014/15 and 2015/16

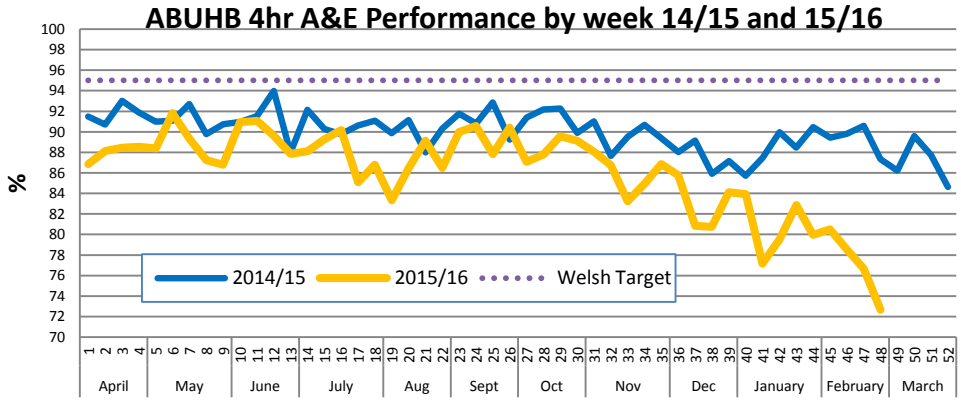


This analysis indicates that the Health Board has made significant progress over the past year to minimise emergency admissions and increase assessed out rates in the context of significant and complex demand. This is evident through increased emergency admissions for older people on both acute hospital sites. At NHH, there was an 8% increase in those aged 75-84 years and a 9% increase in those aged 85+. At RGH, there was an 8% increase in those aged 85+. To respond to this change a new pathway for Frail Older People introduced in January 2016 at the Royal Gwent Hospital, a full review of its impact will be undertaken in May 2016.

However, following a number of challenging months of activity (with ED attendances 10% higher and emergency admissions 17% higher in the final quarter of 2016/17 compared to the same period last year) achievement of the 4 and 12 hour target deteriorated (February 2016 and first three week in March 2016 it was 63.9% and 68.9% respectively at the Royal Gwent Hospital and 82% and 78.4% respectively at Nevill Hall Hospital. During February 2016 a total of 433 and 184 patients at RGH and NHH respectively breached 12 hour target.

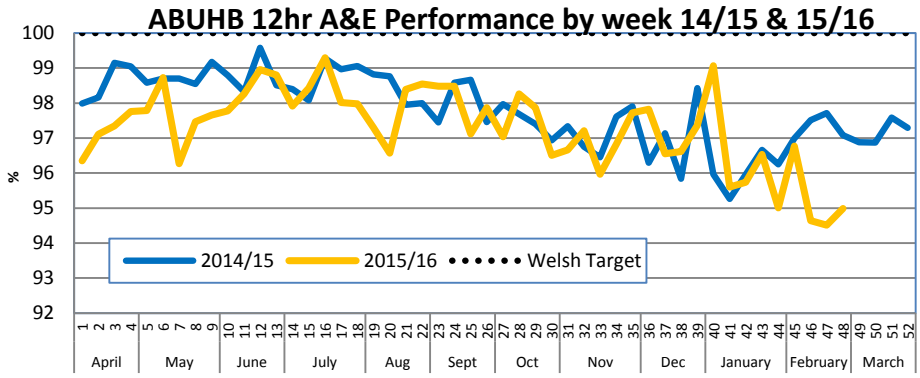
The performance against the **4 hour target** remains challenging, with a declining trend since October 2015.

Graph 7.9.10



The **12 hour performance** showed an improvement in performance throughout December 2015. However, in response to the challenging demand at the front door, performance against the twelve hour target has dipped to 95% at the end of February 2016, with performance in the last three weeks in February being the lowest reported this financial year.

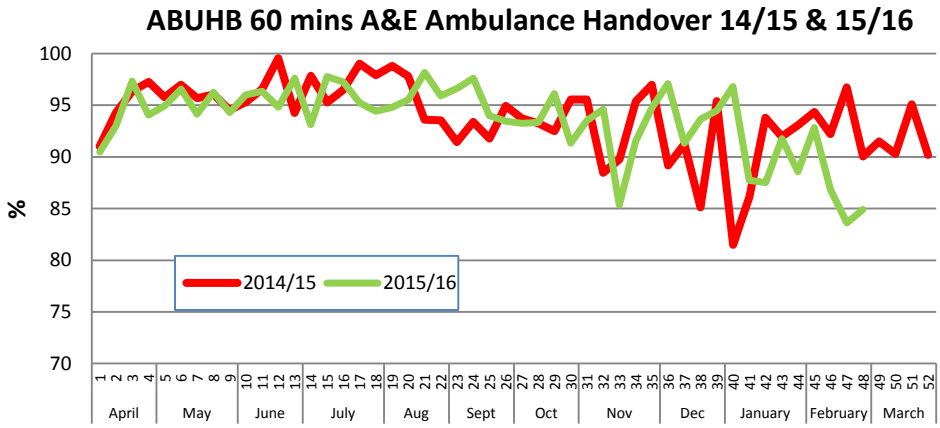
Graph 7.9.11



Ambulance Handover Target

Year to date performance against the 15 and 60 minute handover targets has improved with increases in performance for both target areas over the first three quarters of the year. However, the 60 minute handover ambulance performance has declined from the end of December and has dropped below the performance levels achieved over the majority of the January and February periods compared to last year.

Graph 7.9.12



Over January and February 2016, the number of ambulance attendances at Emergency Departments increased by 5.2% in comparison to the same period in 2015. This equates to an increase of 293 additional ambulances attending ED in the first two months of this year in comparison to last year.

The culmination of the work of the Urgent Care Board has resulted in a recommendation to develop an Emergency (Assessment) Floor at each of the acute hospital sites. The Board recognises the individual contributions of the acute service elements that contribute to the urgent and unscheduled care pathway together with the impact of the various initiative that have been put in place to meet rising demand and improve streaming of patients to the most appropriate pathway. However it also recognises that the current system is fragmented, inefficient and poorly designed to deliver an ideal patient journey.

Developing a single floor Emergency and Medical Assessment Department that incorporates key adjacencies and presence of diagnostics and medical assessment services on the same floor is required. The Health Board, through this aspect of the Urgent and Emergency Care SCP, is embarking on the process of clarifying the Emergency Floor model of care, capacity and infrastructure required to deliver the model on both acute hospital sites, demand and capacity and patient flows, and the workforce plan necessary to deliver it.

Priorities for Improvement

- Improve compliance with waiting time targets for minors stream by ring fencing ENP capacity to meet patterns of demand for patients with minor injury or illness presenting to ED.
- Improve compliance with ambulance handover targets/response to immediate release.
- Develop an Emergency Floor model that consolidates existing emergency care and medical assessment services creating a single front door for the acutely unwell, together with mapping physical layout of the department, capacity requirements (admitting the patient to another part of the hospital builds a further level of delay), key adjacencies, and workforce requirements to deliver the model.
- Contingency surge capacity planning following review of effectiveness of the winter plan for 2015/16.
- Skilled, supported and sustainable workforce, continuing with Nurse Recruitment Strategy, strengthening the medical workforce and maximising the contribution of the allied health professional workforce.

Examples of how these will be delivered and their impacts measured are outlined in the table below.

Table 7.9.9

	Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
Protect Minors Stream	Agreed workforce plan for ENP capacity Secure resource to implement workforce plan Capital scheme progressing – will separate patient stream from majors	Q2 16/17 ? ?	Physically separate patient streams to avoid congestion and delays. Protect staffing (ENP) levels in Minors department to ensure compliance with 4 hour target Improved recruitment and retention of nursing staff Development of department triggers to ensure staff directed to minors when needed to prevent 4hr breach	45 – 50% of patients presenting to ED are minors - circa 80,000/ annum	Improve patients experience, reduce trolley waits, avoid ambulance delays 95% of minors stream will be admitted, discharged or treated within 4 hours of arrival at ED No ENPs recruited and retained each year	Q4 16/17
Emergency Floor	Develop Service Model	Q1 16/17	Single front door for acutely unwell patients Senior clinical initial assessment at point of entry Streaming (within emergency floor – minors, majors, ambulatory care, short stay EFU/MAU/SAU) Minimal patient moves Minimal steps in processes/hand offs	Compliance with tier 1 targets Time taken from arrival at ED to assessment/ admission /discharge	Evidence of clinical support for service model	Q1 16/17
	Workforce plan to support clinical model				Skill-mix and number of workforce to meet projected case mix and workload	Q1 16/17
	Modelling patient flows				Capacity requirements and sizing of clinical elements of Emergency Floor to deliver safe/efficient service robust	Q1 16/17
	Estates infrastructure/ Adjacencies/ logistics to implement model at RGH and NHH				Adjacencies matrix and zones within the Emergency Floor mapped	Q2 16/17
	Implementation plan including clinical operational policies	Q2 16/17				Q2 16/17
Surge Capacity	Lessons learned from winter plan 2015/16	Q1 16/17	Impacts of actions taken to improve flow including EFU	Outcomes of initiatives undertaken as part of winter plan	% improvement on outcomes for schemes that will be retained	
	Surge Demand profiling					
	Surge Capacity modelling					
	Winter plan 2016/17	Q2 16/17				Q4 16/17
	Escalation triggers	Q1 2016/17	(TEDT) Daily performance board (specialty response time; quality		Patient transfer to ward within 15 minutes of notification of	

	Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
			indicators, redirection figures, patients and performance monitoring in each area Escalation status follow agreed descriptors and associated action cards Dedicated transfer team Escalation action cards in place		available bed.	

Key Achievements 2015/16

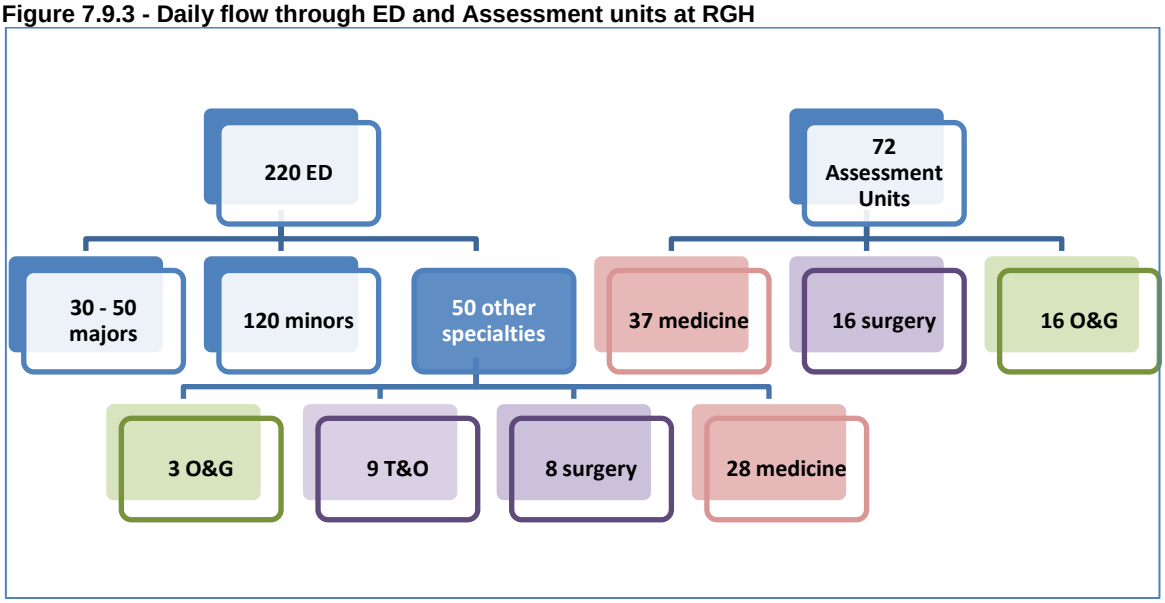
- Phase 1 of the Elderly Frail Unit (11 beds) has been established at RGH, the service is designed to enable frail older people with "acute" presentations to benefit from targeted, intensive and older person centric care that enables them to flow through the acute care system within 72 hours or less.
- Hyper-acute Stroke Unit is now operational at RGH this service opened on 25th January 2016.
- Successfully implemented phase 1 and 2 of the overseas recruitment strategy – the full benefits of this will be seen in 2016/17 when new recruits are fully registered to practice in the UK.

Opportunities 2016/17 and beyond

Over recent years the Health Board has invested in a number of new services to meet rising demand in ED including.

- Ambulatory Care Services ensuring that emergency medical patients attending either Medical Assessment Units or ED are triaged, and assessed by senior clinical decision makers as early in the pathway as practicable with treatment plans in place within hours of presentation. This has resulted in high rates of "assessed out" during the hours when ACPs are present. Pilots have shown assessed out rates and/or diversion to same or next day ambulatory care increase when GPs calls are taken by ACPs (up to 31% of GP calls lead to a scheduled or planned element to patient assessment enabling improved management of patient flow at the front door and improved patient experience).
- An Elderly Frailty Unit, designed to cater for older people who require a short hospital stay for investigation, diagnosis and treatment of an acute presentation but because of frailty issues will need focused and consistent attention to facilitate discharge within 72 hours. The service opened in January 2016 and is now being reviewed to determine its impact on patient care and flow.
- Flow management through the clinical hub has adopted a more systematic, objective and analytical approach to improve understanding of the issues and factors that impede patient flow through the system. This informs decision making and ensuring that actions taken are impacting positively on patient flow. On average 220 people attend ED at the RGH daily and a further 72 attend medical or surgical assessment unit as shown in Figure 9.14 below.

Figure 7.9.3 - Daily flow through ED and Assessment units at RGH



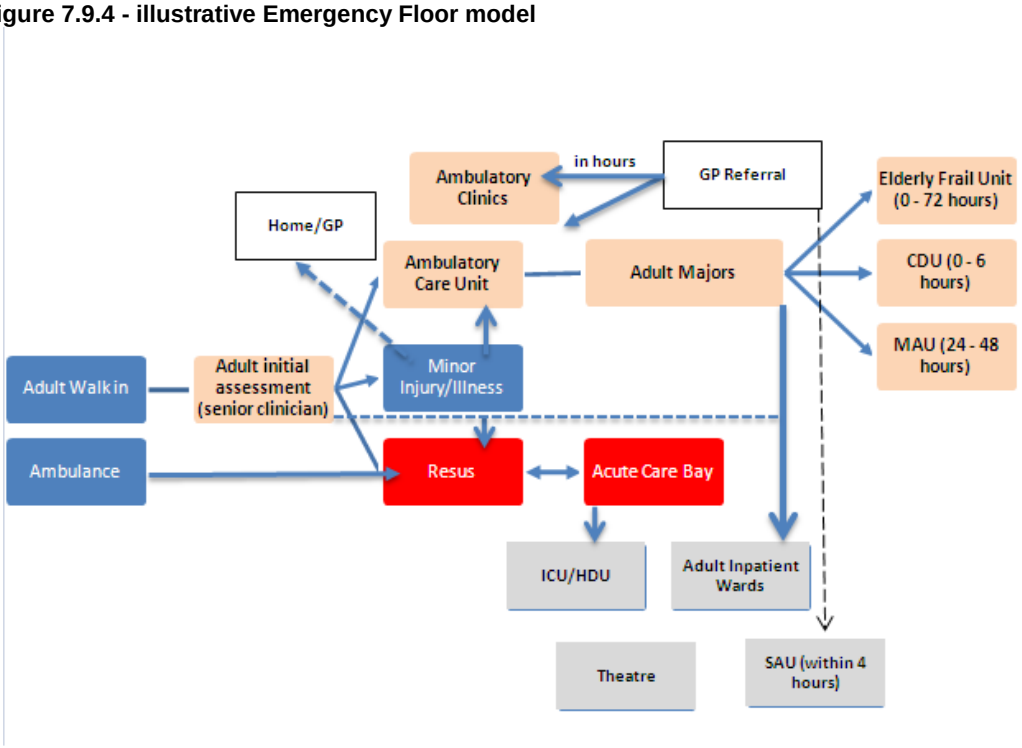
Challenges

The current configuration of the urgent and emergency system presents a number of key challenges that are set out below

- Access to senior clinical opinion from the earliest point in the emergency medicine patient pathway i.e. at initial assessment stage is variable (ACP capacity is finite and recruitment pool is contracting)
- Effective streaming of patients to the most appropriate point of care is not optimal
- Emergency assessment functions and zones are located on different floor within the hospitals, adding steps to the process/hand-offs and delay
- Design of ED departments and capacity within zones of the department constrains patient flow – there is no dedicated facility to provide Ambulatory Care Services at the Front Door
- Opportunities to increase Ambulatory Care Clinic Capacity through active management of wasted appointment slots in medical and surgical Out-patients services have not been exploited
- New ways of working including using the skills and expertise of professional staff flexibly is limited – due in large part to resources being inadequate to meet projected case mix and workload

To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices the development of an Emergency Floor with adequate infrastructure and capacity is being progressed by the Health Board. An illustration of the emerging model is shown in Figure 7.9.4.

Figure 7.9.4 - illustrative Emergency Floor model



The objectives underpinning the development of this model are to:

- provide the Health Board with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.
- Ensure early access to senior clinical decision maker
- increase the productivity of the emergency care pathway including maximising ambulatory care capacity
- improve the clinical effectiveness and safety of urgent and emergency care service
- improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.
- ensure the appropriate supply and skill mix to consistently deliver the 95% ED target, and a number of individual key performance indicators within different components of the Emergency Floor
- ensure the right staffing levels are available in all components of the floor to ensure the correct 'gearing' to achieve the identified standards and manage surges in activity

.

The Urgent Care Board has commissioned clinicians working within Emergency and Medical Assessment Service at both acute hospital sites to develop plans to introduce the Emergency Floor model at RGH and NHH.

The principles of initial assessment by a senior clinician, integration of all emergency assessment functions into the Emergency Floor, understanding demand and flow to inform re-design of current capacity (including workforce and, estate configuration options), underlying principles of no-wait, minimal patient moves, minimal steps in process and possible constraints (workforce, affordability, design) are understood.

The Emergency Floor model will be developed by April 2016 with the SCP being updated to reflect key milestones and benefits delivery trajectory in Quarter 1.

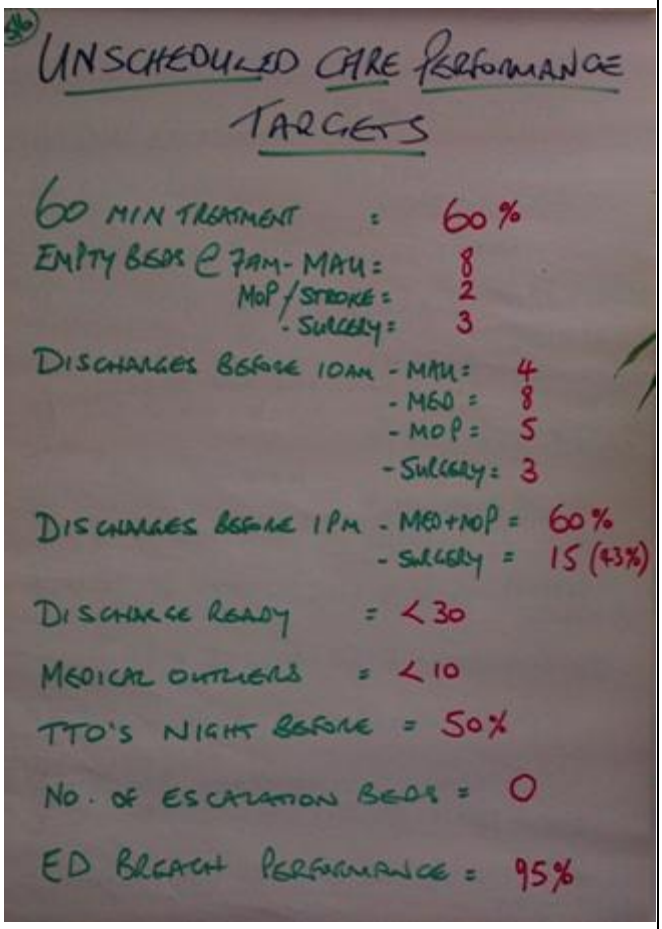
9.4. Hospital Site Management

Optimising patient flow is a critical objective for the Health Board and a programme for improvement has commenced in 2015 which aims to improve overall flow performance and impact on the key access and quality measures.

Building on the progress made in 2015/16 to tighten and systematise site management processes and systems. The plan aims to use information to drive decisions based on previous patterns and trends. Understanding real time data to ensure demand and capacity is understood and the divisions have clarity of the capacity required to meet demand.

The Clinical Hub co-ordinates structured site meeting throughout the day and there is a daily organisational conference that brings together all acute sites, community and GP OOH to understand the current position and the actions required to improve performance. The process is summarised below.

Daily @ 8.30am	Reviews performance from the previous day: ▪ ED – first 60 minutes and timely decision making ▪ MAU – demand on base beds daily by time of day ▪ Feeds this data into daily discharge goal and trigger (including targets for transfers of care) ▪ Ward by ward discharges ▪ Empty spaces on MAU at 8pm ▪ Green to go daily number ▪ Numbers of patients on Complex list
4 x Daily @ 8.30am Noon 4.15pm 9pm	Understands whole system requirement for today ▪ ED performance at start of day ▪ Patients waiting beds in ED ▪ Empty spaces on MAU ▪ Predicted early day discharges by ward ▪ Discharge goals for system (number of transfers to CRT/community services) ▪ Responsibilities for actions ▪ Escalation triggers
12.30pm	Organisational Conference Call – 3 sites, community services and OOH



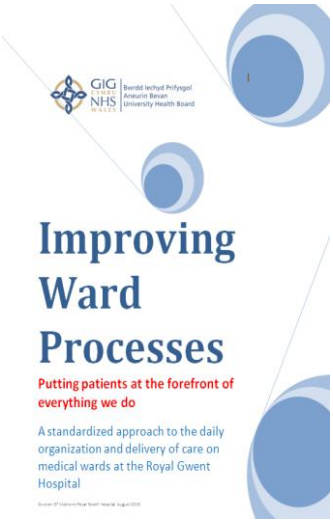
There are structured meetings throughout the day for site teams and there is a daily organisational conference call that brings together all acute sites, community and GP OOH to understand current position and the actions required to improve performance – this process will be consolidated and further developed throughout the life of the IMTP.

The **Escalation Plan** has been reviewed and refreshed to support the safe and timely management of patients accessing health care services within the Health Board. The plan identifies actions to be initiated at each stage of escalation to support the mitigation of pressures and promote patient flow. Critically the Escalation Plan is an integrated system wide response.

The Health Boards' Escalation plan and full capacity protocol was approved by the Executive Team in February 2016. The plan was completed following a series of escalation exercises both

tabletop and live to test the robustness of the plan. Action cards for each department and/or service are being revised. The plan predominantly affects the Royal Gwent and Neville Hall Hospitals, but includes actions involving all sites including community hospitals and partner organizations.

9.5. Well Managed Wards



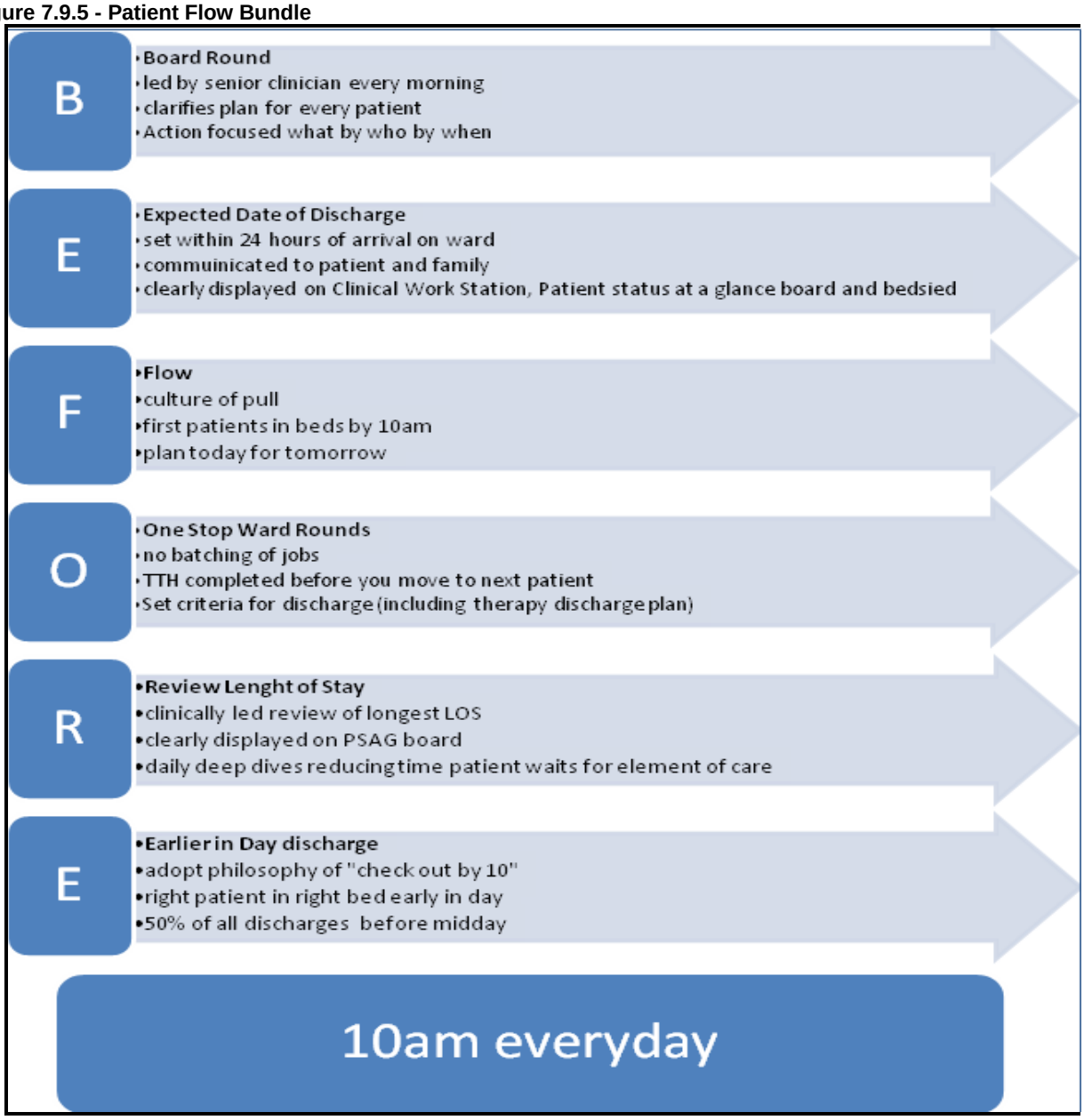
Improving quality of care through effective patient flow is everyone's responsibility. It is paramount that patients are treated safely and effectively with care and compassion in a system they can trust. The concept of using flow to improve care is gaining momentum. Most delays and inefficiencies in the health care system are as a result of a mismatch between when capacity is available and when demand presents to the service. The Health Board has adopted a standardised approach, based on best practice to optimise flow, reduce bed occupancy and improve patient experience. A Patient Flow Bundle and checklist has been developed and trialled on 4 wards during 2015/16. Figure 7.9.5 illustrates the patient flow bundle.

The Programme to implement the "Model Ward" across medical and surgical wards on all acute hospital sites forms the basis of the well managed ward component of this plan. The Health Board recognises that there are significant opportunities to improve performance and efficiency in respect of length of stay in hospital beds. However the primary driver is to move from a system where discharges follow pressure from would be admissions to one where beds are available before demand builds up as this offers the greatest benefit in terms of patient and staff experience.

Table 9.7.10

Key Milestone	Timescale	Desired Outcomes	Baseline Benefit Measures	Target Benefit Measures	Benefit Timescale
Model Ward Agree and timetabled implementation plan – minimum of 4 wards/each quarter	Q4 16/17 (all wards)	Standardisation of inpatient process Consistent use of admissions process and clinical decision making Standardised daily board rounds Improved discharge planning and timeliness of actions Reliable discharge predictions across 7 days Weekly audit	Current discharge rates by ward	No patient breaching 12 hour wait for medical bed 100% patients with EDD (within 24 hrs) Decrease occupied bed days Increase in weekend discharges 30% discharges before noon	Q1 16/17 Cumulative impact across Q2 – Q4

Figure 7.9.5 - Patient Flow Bundle



The criteria/steps to be met for the Model ward have been agreed as follows:-

- Timely and appropriate diagnosis documented along with an appropriate reason for admission.
- Implementation of Best practice LOS by case types to support a defined and evidenced based EDD, All patients will have a documented EDD.
- Discharge planning is commenced on admission and needs to occur in a thoughtful manner, anticipated and planned prior to its happening on every ward for every patient.
- Care will be guided by best evidence when available, and through guiding principles that put patients safety as a central point at all times.
- Effective communication is essential to safe clinical care and needs to be within the MDT and with patients/caress/families.
- To standardise the admission documentation and other documents used by the MDT for use across all wards , including rounding tools,
- There will be a parallel Structure for Therapies and Nursing.
- Daily consultants ward round, which in addition include a Friday pm round to plan and set goals for discharges over the weekend (including nurse led discharge).
- Clearly defined and standardised White board for use on all wards.
- Full involvement of the MDT preventing delays in any aspect of patients care and progression of

care ,

- Discharge letter is drafted and available 24 hours in advance of discharge.
- TTO's are available and ready on the ward 24 hours in advance of EDD.
- All patient safety measures and metrics are met and achieved and in time exceeded.

The Health Board has focused on supporting the development of standardisation to support clinical decision making which includes a rounding tool to support systematic daily board rounds:

The aim of introducing the model ward is to reduce LOS while improving patient safety, experience and quality of care.

Figure 7.9.6

ROUNDING TOOL

- **Clear Diagnosis**
- **Clear Management Plan**
- **Discharge planning**
- **Why is patient in hospital**
- **Ceiling of care appropriate**
- **I V switch to oral**
- **DNR**
- **Communication to pt**
- **Therapy discharge plan**
- **On appropriate ward?**
- **Last seen by consultant**
- **TTOs complete?**

Key Milestones 2016/17

Table 9.7.11

Milestone	Target Measure	Timescale
• implementation plan to be instigated to all clinical personal to facilitate the compliance of documentation of the EDD, as part of the evidenced based pathways • Initially for the medical wards, and possibly one surgical rolling out during the project to all wards at RGH and then across sites • Design and Implementation of a rounding tool in conjunction with the medical staff to bring a standard approach to patient management and documentation • Rounding tool agreement on format and aim to pilot on model wards in November • Review over 2 weeks and then look to implement and audit compliance • Communication with medical staff involved to ensure the approach and completion is understood • Develop and implement the Ward dashboard, which needs to include LOS , number of admissions , and discharges and audit form compliance with documentation.	• 100% of patients will have an EDD reflecting admitting diagnosis/co morbidities prior to transfer to wards • Admitting doctor will be responsible for the documentation of the EDD • Consultant on ward to review daily and evidence that review , this will impact on the PDD • EDD will remain constant and the PDD will vary depending on the patients response to treatment (PDD may be shorter than the EDD) • To start Model wards then roll out to all other medical wards with full implementation. • 100% utilisation of rounding tool all consultants 2 weeks after launch on their wards • Plans for any areas that fail to reach 100% of compliance of the rounding tools • Ward sisters to ensure that the rounding tool is in notes daily prior to round	Q4 2016/17
Model Ward roll out • Criteria for completion of Board rounds to be developed and implemented • White boards to be the same format with EDD PDD LOS • Review the current board to include areas such as LOS <u>Rounding tool documentation</u> Consultant contact with patient and involvement is clearly documented with timely decision making, supported by evidenced based pathways and agreed bets	• Ward sisters will audit 20 notes a week ensuring that the correct paperwork is being utilised and will feedback to ward consultant any doctors that are not compliant • Senior nurses s and ward sisters to ensure that 100% of staff to understand model ward concept • Ward sisters to take responsibility for auditing rounding tool usage weekly spot checking 20 notes • Senior nurses and ward sisters to take 100% responsibility of compliance and auditing of all safety matrixes for EDD Compliance	Q4 2016/17

Milestone	Target Measure	Timescale
practice LOS by diagnosis Specialist medical Clinics for discharge can the VIP process be developed? • Introduce ambulatory specialist medical clinic to support discharge and for diagnostic evaluations • Publish the criteria for patient types to be booked, to give a clear process to all staff • Implement mechanism to ensure staff have easy access to appointment times • Clear communication of available slots audit clinics to ensure effective utilisation, one clinic per week for weeks and review	• Rounding tool completion of each pre-defined section • LOS by ward • Board round compliance • 5 day a week consultant rounds • Discharge summary compliance • TTO ordering • Current 28 day re admission rate and report weekly working	
High quality patient care and improved Patient safety daily metrics • As Part of providing high quality care each site will conform to the national and local quality targets and patient Safety targets highlighted in the base line audits • Patient safety daily metrics to be introduced (catheter days, IV Antibiotics days) to be collated weekly- • Patient satisfaction by Ward, CAUTI rate(CAUTI Catheter acquired Urinary tract infection), Falls, VTE, pressure ulcers data to be collected weekly Clearly defined targets for improvement will be set using the baseline audit as a string point and activities monitored against, each of the targets(which have been identified above) on a monthly basis <u>Base line audits needed in</u> • catheter days, • IV Antibiotics days to be collated weekly • CAUTI rate, (PT thermometer) • Falls,(PT Thermometer) • VTE,?? • pressure ulcers (PT Thermometer) • Dementia Screening – best practice for over 75yrs • Frail elderly	• The improvements set are as follows • 50% reduction in catheter usage by ward • 100% of patients to have a rationale for antibiotic usage • 75% reduction in hospital acquired pressure ulcers and to be sustained • 100% of I.V antibiotics monitored daily and documented reason for staying on • Reduction in patients developing Cdif in hospitals to reduce to the required level- need to check GWH number allowed and look to improve on this	Q4 2016/17

Managing a patients' hospital stay safely and efficiently requires the systematic implementation of good practice, consistency amongst clinicians and strong leadership by ward managers and senior medics.

The number of beds needed to deliver inpatient care drives the number of nursing staff and associated costs of securing them for the Division. In recent years (pattern similar across the NHS) the Division has struggled to recruit enough qualified nurses to the core establishment to cover the ward rotas, there is a heavy reliance on bank and agency which has implications for the reliability of services, quality of care and cost.

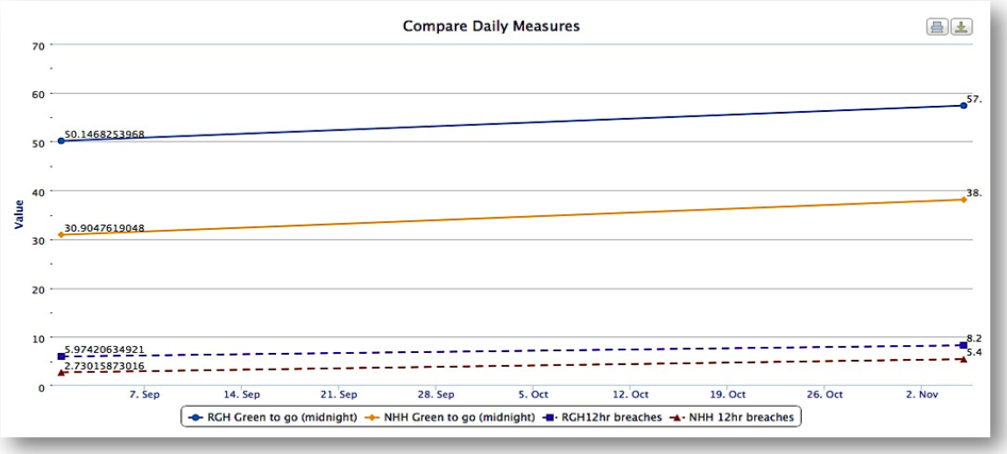
In 2015/16 variable pay remains one of the most significant financial challenges for the Division the additional cost to the service running at £6M/annum. The workforce plans to improve recruitment (including recruiting from overseas), retention, and maintain/improve the health and wellbeing of staff are shown in **section 5.**

9.6. Effective Transfer of Care

The vast majority of cases admitted to hospital result in simple discharges. Those patient identified with complex needs are currently managed via “medically fit” and “green” lists. The Health Board has a solid track record of working jointly with Local Authority partners to expedite discharge for patients who are deemed by their consultant to be medically fit/clinically stable but who still occupy an acute hospital bed.

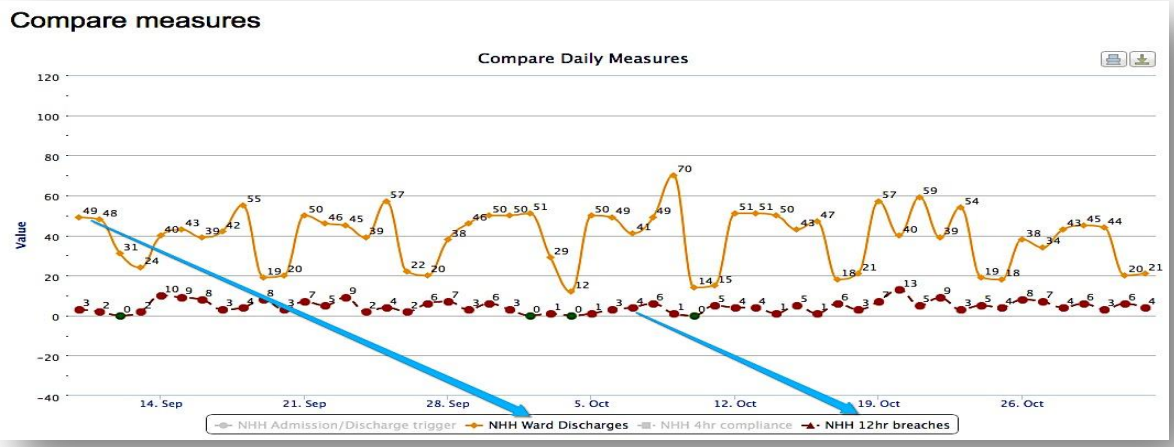
The overall number of medical beds occupied by complex patients i.e. patients who have a complex discharge requirement as they require multi-agencies or multi-disciplines to facilitate their discharge, remains high. The complex list at the Royal Gwent Hospital shows that as at 19th November 2015, 80 out of 284 medical patients at the Royal Gwent Hospital were complex patients, constituting 29%. The complex list at NHH shows that, as at 2nd November 2014, 52 out of 156 medical patients were complex patients, constituting 33%. The historical range of complex patients defined to medicine is between 30-32%. The impact of high numbers of people remaining in hospital is illustrated in the graph below. It suggests a relationship between low discharge rates and 12 hour breaches in the Emergency Department at Nevill Hall Hospital.

Graph 7.9.13 - Daily measures



This is further demonstrated in the graph below, it shows the number of patients who are designated “Green to Go” (**G2G**)or medically fit for discharge at midnight (the Royal Gwent and Nevill Hall Hospitals) as the numbers of G2G patients in hospital beds rise there is a mirror effect in the numbers of 12 hour breaches.

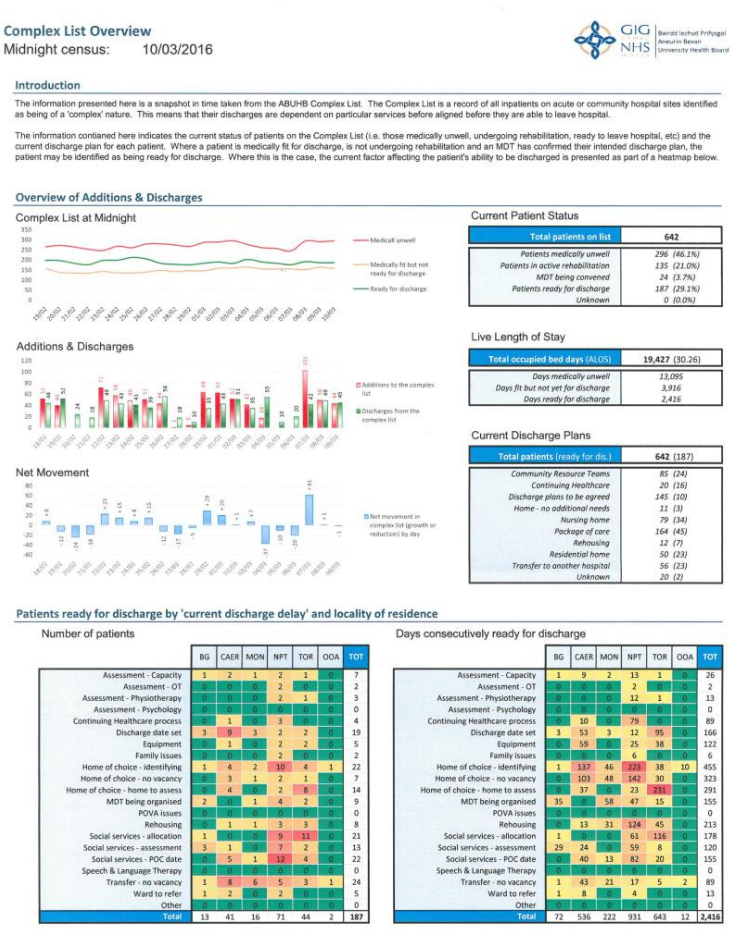
Graph 7.9.14 - Daily Measures (2)



Ideally no patient should be waiting in an acute hospital bed once they are medically fit for

discharge, but it is not a position that is deliverable in the short to medium term. Further diagnostics are being undertaken within the Division to identify the number of G2G patients that can be in the system at any one point in time without impacting significantly on system flow. In the first year of this plan the Division, working with others, aims to reduce G2G patients to less than 55 at the Royal Gwent Hospital and less than 30 at NHH.

Figure 7.9.7



In November 2015 the Delayed Transfer of Care Action Group was established, chaired by the Deputy Chief Operating Officer and includes Assistant Directors of Social Services and Heads of Services from the five Local Authorities whose services are co-terminus with those of the Health Board. Its function to remove barriers to expeditious discharge for patients with complex health and social care needs.

Daily reporting form the "Complex List" are downloaded each day at midnight giving a summary position of admission and discharge over the previous days and the aggregated position by Local Authority, example is shown opposite.

In addition to the daily management of patients and discharge planning by health and social care teams, the Health Board employs "deep dives" at Local Authority level to discuss patients on the complex list to identify any blockages that need resolution at individual or organisational level. This has identified reasons for delay ranging from access to specialist equipment, specifically for bariatric patients through to difficulties with families not wishing to engage in their relatives discharge and delays in arranging MDT meetings in a timely manner. The Health Board has used £450,000 of the Intermediate Care Fund to action specific issues identified through deep dives that impact on delays in transfer of care and range from social worker capacity, through telecare, bariatric equipment and the third sector including the Lighthouse Project.

Discharge Liaison Nursing service has also been subject to review and a clear need identified to re-define this service moving from a uni-professional co-ordinator to a multi-professional case management service for complex cases. The Health Board, together with Newport City Council have agreed to establish a pilot for an 8 week period, with a dedicated social worker and two DLNs functioning as case managers. The outcome of this pilot will inform the model of service that will be progressed.

The Health Board has also established a "Green to Go" ward at the Royal Gwent Hospital to consolidate Care for medically fit patients on Advanced Nurse Practitioner led ward with dedicated therapeutic input to ensure that patients can maintain and improve their level of functioning while the ward team focus on addressing issues that have resulted in their extended stay in an acute

hospital. Early indications of impact suggest that LOS has been reduced by 15% for this patient cohort, a formal evaluation of the G2G ward will be undertaken in May 2016. The focus of this plan is, subject to the outcome of the review, extend this model to support flow at Nevill Hall Hospital.

Sustainable Nursing Workforce the Welsh Government has supported the implementation of Nursing Principles to improve patient quality and safety. This has resulted in an increase in nurse to patient ratio both by day and night. Consequently for some areas this has meant a change in skill mix which has increased registered nursing posts and a decrease in Health Care Support Workers (the latter particularly affected NHH wards with HCSW were higher). Recruitment to additional registered nursing posts commenced last year without much success due to a limited nursing pool and the competition across South East Wales to fill the increased vacancies is high.

At the start of the financial year there were 722.08 wte registered nurses employed by Unscheduled Care Division, which has reduced to 716.43 wte at December 2014. During this time there have been 36 new starters, but unfortunately 52 leavers across all the Directorates service resulting in a turnover rate of 8.93%.

Staff sickness and the prevailing registered nurse vacancy situation are driving up the use of variable pay, which represents poor value for money and increases the challenge of maintaining continuity of patient care. Concerted efforts are being made to manage down sickness levels in key 'hotspots'. However, recruitment to existing vacancies, keeping ahead of turnover combined with reducing sickness absence should result in a reduction in variable pay, improved staffing levels and greater continuity of care for patients. Whilst a 3 year plan will inevitably take a longer term strategic and corporate view of how to address registered nurse staffing shortfalls, the following actions indicate our key priorities to address the immediate challenges for the next 12 months.

Table 7.9.12

Vision	**To ensure that the right number of staff, with the right skills are in employed by the service to provide high quality care to meet patients needs**
Desired Outcome and Benefits	Wards staffed to All Wales Nursing Principle levels Robust staffing levels reducing reliance on bank and agency Delivery of high quality care maximised flow through the acute hospital component of the system
Measurement	Numbers of nurses recruited Turnover intervals Sickness and absence levels Compliance with fundamentals of care Completed episodes of care, including LoS Complaints and complements Untoward incidents
Milestones	Q1- Q2 2016/17 – Recruitment Drive and Overseas Recruitment Strategy Q1 –Q4 2016/17 – alternative workforce plan (HCSW (enhanced skill mix), physicians assistants, enhanced clinical roles, speciality clinical roles) Q1 – Q4 2016/17 – Retention Drive and Strategy (including developing leaders for the future)
Workforce Implications	30.02 wte Registered Nurses 19.71 wte Health Care Support Workers
Financial Implications	Current expenditure to date (month 11) on nurse agency £2.8 million

Profile for Improvement in key metrics associated with urgent and emergency care is summarised below, with further details in Annex 3.

Table 7.9.13

Metric	March 2016	March 2017	March 2018	March 2019
4 hr A&E compliance	80%	92%	93.5%	95%
12 hr A&E compliance	600	200	100	0
% 8 min Cat A response	62%	65%	67.5%	70%
No of >1 hr handover	458	100	50	0
MH DTOC/10,000 population	2.0	1.6	1.5	1.4
Non-MH DTOC/10,000 population	16.7	13	12.1	11

Delivering these targets will be a culmination of the outcomes and impacts of the actions the Health Board is taking as described in the body of this service change plan.

SCP 10 - Planned Care

10.1 Introduction

In February 2016, the UHB established a Planned Care Board under the leadership of the Chief Operating Officer to develop and implement a transformation programme that aligns with the UHB's Clinical Futures Strategy and the National Programme for Planned Care, and delivers improvements in efficiency and productivity that in combination with prudent healthcare will deliver high quality, affordable and sustainable services.

The aims and objectives of the Board are to lead:

- Health Board specific work-streams:
  - Demand and Capacity;
  - Modernisation/transformation;
  - Informatics;
  - Efficiency/productivity;
  - Workforce.

- The Health Board's contribution to the work of the National Planned Care Programme:
  - ENT;
  - Ophthalmology;
  - Urology;
  - Trauma and Orthopaedics.

- The development of annual plans to improve elective access, delivering sustainable services that meet recurrent demand.

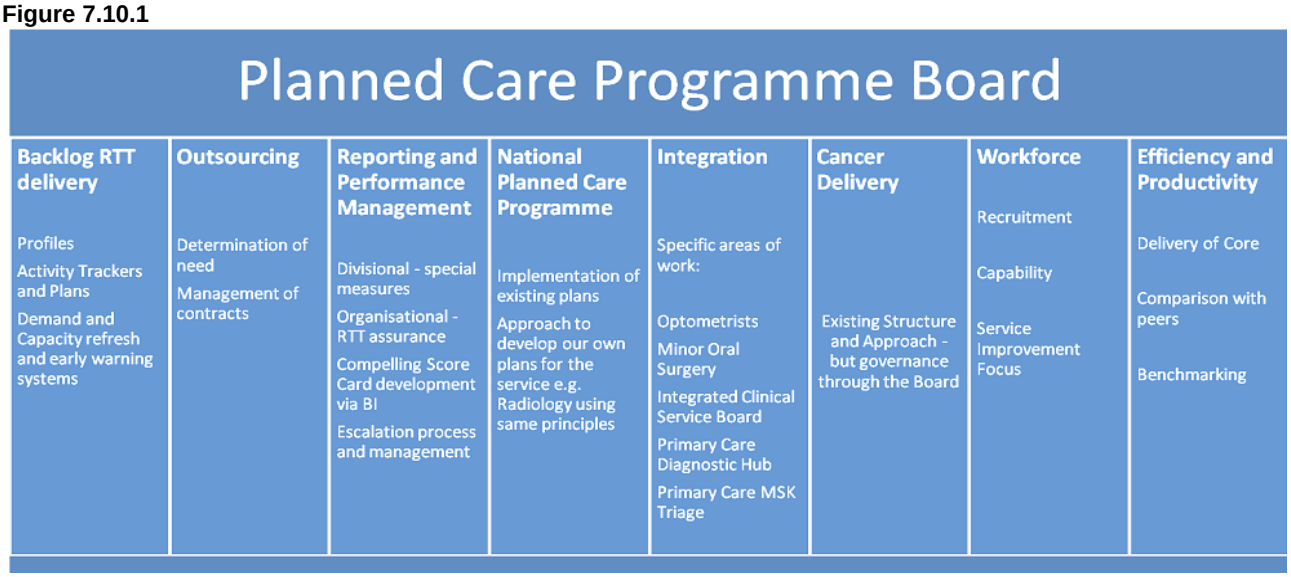
- A clear framework for elective demand and capacity that underpins local delivery plans, including those to eliminate backlogs.

- Provides a link to Care Closer to Home Health Board work-streams, which seeks to shift activity and resources from secondary to primary care where clinically and financially appropriate.

- A focus for the implementation of prudent healthcare initiatives in Planned Care as a means of optimising demand and delivering services.

The scope of the Board is described below:

Figure 7.10.1



The Board is multidisciplinary and extends from primary to secondary care. There are a number of supporting sub-groups, including:

- Demand Sub-group;
- Capacity Sub-group;
- RTT In Year Delivery Sub-group;
- National Programme Specialty Sub-groups;
- Outpatients Transformation Programme;
- Theatres Programme.

By way of illustration, the remit of the Demand and Capacity Sub-groups is summarised below:

Demand

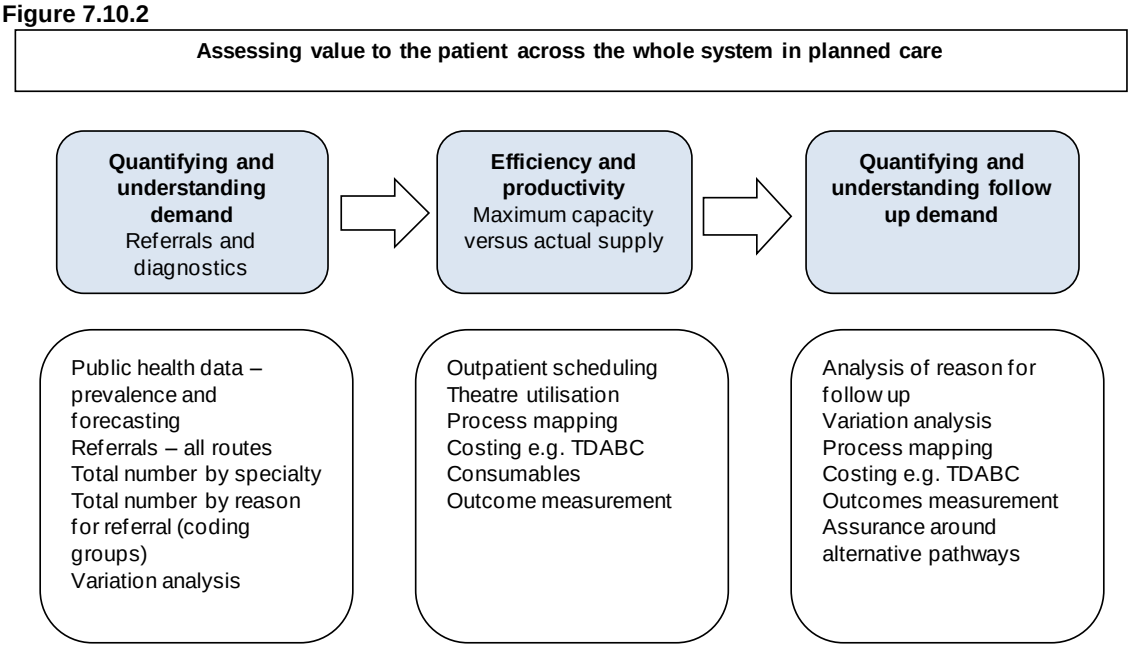
- Understand the current methods of assessing demand and sharing good practice.
- Identifying generic and condition/service specific opportunities for improvement through improved analysis/benchmarking etc.
- Understanding and sharing what work is already going on and the potential impact.
- Identify new opportunities to influence elective demand.
- Understand what processes are currently in place to manage demand and consider further options for managing elective demand in the future.
- Review information requirements for effectively managing demand in the future.
- Identifying the gaps and recommending priority areas of work to be taken forward through the IMTP.
- Ensure forward look of impact of changing demographics on elective care in the future is understood and built in to future plans.

Capacity

- Reviewing current practice in building up elective capacity and identifying and sharing good practice.
- Identify what the current system (i.e. the 'status quo' is likely to deliver us Next year & future years.
- Identify areas of opportunity for improvement through internal and external benchmarking and analysis.
- Prioritise areas of potential quick wins.

A detailed programme plan for 2016/17 is being drafted but the attached forms and illustration of the approach being undertaken:

Figure 7.10.2



This SCP describes how the UHB will improve elective performance and is structured as follows:

- RTT delivery;
- orthopaedic sustainability;
- diagnostic waiting times;
- cancer services
- outpatient transformation.

10.2 Referral to Treatment Time

Baseline Position
The UHB has faced significant challenges in achieving improvements in elective access in 2015/16, with between 2500 and 2600 patients forecast to be waiting over 36 weeks for treatment at the end of March 2016 (subject to validation at year end).

Desired Future State
The UHB seeks to deliver Best in Class Planned Care by improving elective access to deliver RTT targets through the following:

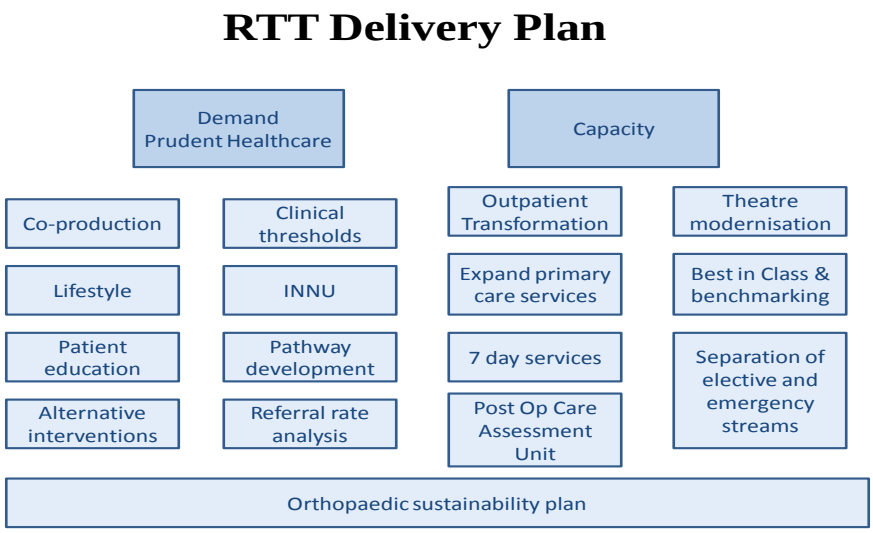
- Managing demand through prudent healthcare.
- Optimising capacity, improving productivity and efficiency.
- Rebalancing activity between secondary and primary care.
- Eliminating backlogs and providing sustainable services.

Demand/Capacity Assessment
The demand and capacity assessment for key specialities has been completed with the recurrent demand/capacity gap providing the basis of the sustainability challenge, with the treatment backlogs the estimated year end position and OP backlogs the number of patients waiting over 16 weeks on a surgical pathway. Orthopaedics is subject to the same principles and subject to a separate sustainability plan described in this Chapter at 10.3.

Whilst high level analysis has been undertaken for all specialties, more detailed subspecialty analysis has been undertaken for General Surgery, Orthopaedics, Ophthalmology and Maxillo-facial surgery.

Plan for delivery
The UHB's RTT delivery plan is illustrated below:

Figure 7.10.3



The UHB has developed delivery plans for each specialty, including contributions from efficiency, increased capacity and prudent healthcare in eliminating recurrent and non-recurrent gaps. The indicative solutions and key milestones are recorded below:

Table 7.10.1

Speciality	Closing the treatment gap to achieve a maximum wait of 35 weeks	March 2017
General Surgery	Addressed through internal schemes.	0
ENT	Addressed through internal schemes.	0
Maxillo Facial	Addressed through internal schemes.	0
Ophthalmology	Addressed through a combination of internal schemes and externally commissioned capacity.	0
Urology	Addressed through internal schemes.	0
Dermatology	Addressed through internal schemes.	0
Gynaecology	Addressed through internal schemes.	0

There has been a comprehensive review of specialty demand/capacity assessments that have included increased emphasis on efficiency and productivity, together with a focus on prudent healthcare. Specialty specific plans fully reflect the operational, workforce and financial implications of delivery. The use of external capacity for ophthalmology and orthopaedics is again included in 2016/17 and is fully reflected in the UHB's Financial Plan.

Profile for delivery

Based upon detailed plans, the UHB's profile for improvement is included at **Annex 3 and it is anticipated that by the end of Quarter 1 the total 36 week breach volume will be less than 2284.**

The following table summarises the profile for improvement over the next three years.

Table 7.10.2

	March 2016	March 2017	March 2018	March 2019
26 week compliance	88.5	90%	92%	95%
Breaches* of 36 weeks	2600	2700	500	0

Breaches confined to orthopaedics

Governance Arrangements

Project Lead	Chief Operating Officer
Project Support	Divisional Managers and Assistant Directors of Performance and Planning
Project Structure	UHB RTT Delivery Group
Reporting arrangements	Finance and Performance Committee and Planned Care Board
Plan status	Plan finalised

The UHB has detailed profiles for improvement with accountability for the delivery of RTT targets lying with the Chief Operating Officer, and the Directorates and Divisions with regular reporting through the Finance and Performance Committee and the Planned Care Board. Additionally this is supported by Access Groups within Divisions.

Workforce and Financial Impact
As demonstrated above, the UHB is seeking to deliver recurrent demand through core budgets by improved efficiency, alternative pathways and application of prudent healthcare principles wherever possible with a focus on reducing reliance on additional activity. The workforce and financial impacts of the RTT delivery plan will be included within the UHB's overall workforce and financial plans and will be subject to further scrutiny.

10.3 Orthopaedic Sustainability Plan

Baseline Position
It is forecast that there will be 1576 patients waiting for orthopaedic surgery at the end of March 2016, of whom 300 will have been waiting over 52 weeks, with the delivery of improvement a UHB priority for 2016/17 and beyond. The UHB has been over-reliant on non-recurrent capacity to deliver recurrent demand, and this plan describes how through a combination of prudent healthcare, service redesign, internal efficiency improvements, externally commissioned capacity and recurrent investment the UHB will in time deliver sustainable orthopaedic services.

Desired Future State
The UHB seeks to deliver Best in Class orthopaedic services by improving elective access to deliver RTT targets through the following:

- managing demand through prudent healthcare;
- optimising capacity;
- rebalancing activity between secondary and primary care;
- eliminating backlogs and providing sustainable services.

Demand/Capacity Assessment
The outputs of detailed recurrent demand/capacity assessment are described in the following tables:

A detailed demand capacity reconciliation has been undertaken with the UHB anticipating reducing the number of 36 week breaches to 1,200 by March 2017, and further reductions to 500 in 2017/18 and their elimination in 2018/19.

This is based on a subspecialty assessment and includes the benefits of a prudent approach (OA knee, spinal injections) together with productivity improvements and the use of external capacity.

UHB actions to bridge the demand/capacity gap, though these are currently being risk assessed in terms of their deliverability.

Detailed delivery profiles have been developed and included at **Annex 3.**

The table below summarises the profile for improvement in 36 week breach volume over the next three years.

Table 7.10.3

	March 2016	March 2017	March 2018	March 2019
36 week breaches	1494	1200	500	0

Governance arrangements

Project Lead	Chief Operating Officer
Project Support	Divisional Manager
Project Structure	UHB Access Group
Reporting arrangements	Finance and Performance Committee
Plan status	Plan to be drafted

Workforce and Financial Impact

As demonstrated above, the UHB is seeking to deliver recurrent demand through core budgets by improved efficiency, alternative pathways and application of prudent healthcare principles wherever possible with a focus on reducing reliance on additional activity. The workforce and financial impacts of the RTT delivery plan are included within the UHB's overall workforce and financial plans, and will be subject to further review.

10.4 Diagnostic Waiting Times

Baseline Assessment

At the start of 2015/16, the UHB was performing relatively poorly in comparative to the position across the rest of Wales, with the main pressure points were in non-obstetric ultrasound and MRI.

Improvements have been made within year and the following outturn is anticipated:

Table 7.10.4

Modality	March
CT	319
MR	4
US	1437
Nuclear Medicine (MIBI)	5
Echo	206
Stress	36
Vascular US	120
Urodynamics	0
Endoscopies (all)	900
Total	**3027**

Desired Future State

The UHB seeks to deliver Best in Class diagnostic services through the following:

- Managing demand through prudent healthcare.
- Optimising capacity.
- Rebalancing activity between secondary and primary care.
- Eliminating backlogs and providing sustainable services.

Plan for delivery

The UHB's Planned Care work programme is illustrated below for key modalities.

Table 7.10.5

Modality	D/C Gap	Solution
MRI	4,453	Mobile for 22 weeks
CT	1,312	Commission internal capacity
US	3,603	Outsource external capacity

Profile for delivery
Based upon outline plans, the UHB's profile for improvement is described below, with the planned maintenance of diagnostic waiting times, working towards a maximum of 8 weeks. It is anticipated that the 8 week breach volume will have fallen to 1929 by the end of Quarter 1.

Further work is being undertaken on the endoscopy delivery plan.

Detailed profiles are included in the supporting appendices.

The table below summarises the profile for improvement in eight month diagnostic performance over the next three years.

Table 7.10.6

	March 2016	March 2017	March 2018	March 2019
% 8 month compliance	79%	85%	92%	100%

Governance arrangements

Project Lead	Chief Operating Officer
Project Support	Divisional Managers and Assistant Directors of Performance & Planning
Project Structure	UHB Access Group
Reporting arrangements	Finance and Performance Committee
Plan status	Plan drafted but not yet approved

The UHB has developed detailed profiles for improvement with accountability for the delivery of RTT targets lying with the Chief Operating Officer, Directorates and Divisions with regular reporting through the Finance and Performance Committee and Executive Team. Additionally, this is supported by Access Groups within Divisions.

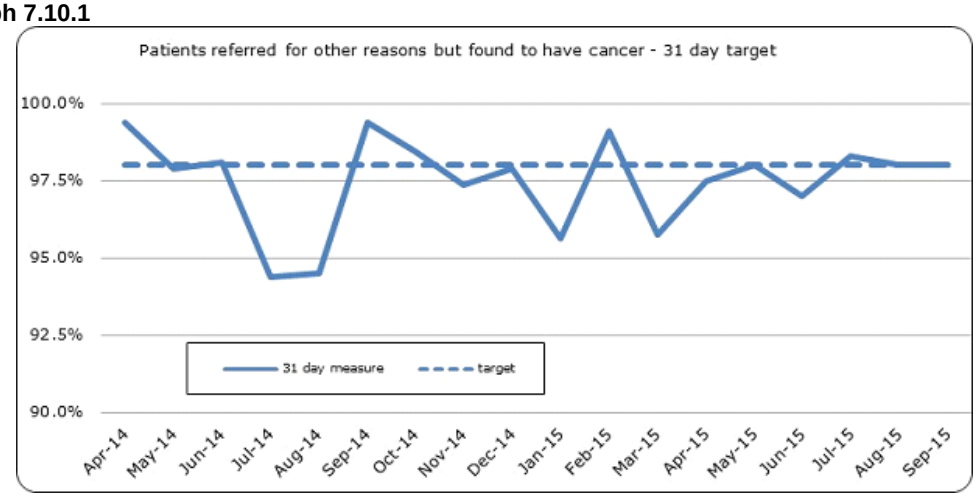
Workforce and Financial Impact
As demonstrated above, the UHB is seeking to deliver recurrent demand through core budgets by improved efficiency, alternative pathways and application of prudent healthcare principles wherever possible with a focus on reducing reliance on additional activity. The workforce and financial impacts of the diagnostic delivery plan have been included within the UHB's overall workforce and financial plans.

10.5 Cancer Services

Baseline Assessment
Over the last 12 months, the UHB has shown continued commitment for cancer care. Despite a series of difficult and challenging operational pressures in delivering cancer services, there has been continued progress and a number of marked improvements in the delivery and sustainability of the UHB's Cancer Delivery Plan. These are described in the UHB's Annual Cancer Services Report, approved at the September 2015 Board.

The UHB has always maintained a strong commitment to the care of cancer patients, historically leading in Wales regarding compliance with the Cancer Access Tier 1 Targets. In the first half of 2015/16, there has been variable performance against these targets and a challenging period for the UHB and the teams managing care for patients with cancer. There has been an increasing demand for initial outpatient appointments of approximately 22% along with some difficult staffing issues in some key areas that support cancer delivery such as radiology and pathology.

Graph 7.10.1



The UHB has achieved compliance with the 31 day target since July 2015 and is seeking for this to be sustained following the strengthening of operational processes. Whilst there has been a parallel improvement in compliance with the 62 day target, performance has yet to achieve the 95% target and this has been the focus of improvement in the second half of the year and into 2016/17.

The UHB has delivered a number of improvements in 2015/16, including:

- Improved waiting times for the Breast service.
- Continued excellent feedback from Peer Reviews.
- Submission of "100" day plan for improved performance with the 62 day USC cohort by December 2015 to the Welsh Government.
- Active monitoring of urology first appointments.
- Changes to the urology referral criteria line with NICE guidance supported by GP advice flier.
- Appointment of administration support to implement Tracker 7.
- Thoracic CNS appointment.
- USS biopsy waits identified and flagged with radiology.
- Establishment of fortnightly Radiology workshop meeting.
- Executive attendance at Cancer Improvement Group.
- Breast service Network Action plan in-conjunction 100 day plan.
- Development of the UHB Cancer Guide.
- Delivery of cancer waiting times targets.
- Developing a long term Cancer Strategy for the Health Board in conjunction with Velindre Cancer Centre.
- Sustaining performance against the Cancer Time to Treatment targets against a backdrop of increasing demand and challenging workforce shortages.
- Working with Velindre Cancer Centre to develop facilities to deliver more Chemotherapy.
- Ensuring all patients receive formal written care plans.
- Engaging more fully with Primary Care to improve care pathways and deliver timely access to patient services.
- Develop further Cancer Rehabilitation services in partnership with Primary Care - National Cancer Survivorship Initiative (NCSI).

Desired Future State

The UHB seeks to deliver exemplary cancer services through the delivery of its cancer plan and the sustained delivery of access waiting times.

Profile for Improvement

The UHB will deliver the urgent suspect cancer (USC) and non-urgent suspect cancer (Non-USC) care targets by the end of March 2015 and will subsequently sustain them.

Table 7.10.7

Parameter	2015/16	2016/17	2017/18	2018/19
Non USC	98%	98%	98%	98%
Urgent Suspect Cancer	95%	95%	95%	95%
10 day OP target	100%	100%	100%	100%

Demand and Capacity
There is evidence that the UHB has higher than expected referrals for a number of common cancer sites but that this level of outpatient demand is not reflected in higher treatment rates than compared to the rest of Wales. This therefore suggests that there is scope to reduce demand in areas such as breast. Aligned to the changing demands, further demand and capacity work will be undertaken in a number of areas including head and neck, breast, respiratory and cancer services so that capacity is responsive to increasing demand.

Service Delivery Plans and Milestones
The UHB has developed a Cancer Delivery Plan for each tumour site that covers both compliance with Cancer standards and delivery of cancer treatment times. These, together with the UHB's Annual Cancer Report, can be accessed at (hyperlink). Through its Cancer Implementation Group, the UHB will focus on five key priorities over the next 12 months:

- Organisation of cancer support services to ensure improved.
- Services, delivery, planning and performance.
- Primary care oncology.
- Develop single urgent cancer pathway.
- Patient experience.
- Lung cancer.

A large part of work in delivering these key priorities has already begun within the UHB. Acting on feedback and concerns raised during the peer review processes, the UHB seeks to ensure the robust and timely implementation of the tumour site action plans. The Cancer Delivery Plan remains very much a key priority for the UHB in order to optimise and improve the quality of service we provide to Gwent and South Powys residents in cancer care. This is also important in order for the UHB to retain its excellent reputation for cancer service delivery with our patients, Welsh Government and key stakeholders.

Working together to Transform Cancer Services in South East Wales
The number of patients presenting with cancer in Wales is rising and although survival rates are improving, they still lag behind most other European and similarly developed Western countries. The UHB recognises that its cancer services need to change in order to accommodate the projected demands on our cancer services, to meet our patient's needs and improve patient experience and cancer related outcomes. The way in which services are organised will need to change to meet this increasing demand. Services will therefore need to evolve, recognising that specialist non-surgical cancer treatment is only part of a strategic development concerning the wider context of cancer care.

The UHB is working with Velindre Cancer Centre and other stakeholders in order to:

- Better understand the challenges and opportunities from the perspective of a whole range of stakeholders.
- Build a shared consensus for a new service model of cancer care in South East Wales and how it integrates with Local Health Boards.
- Further strengthen existing partnerships to deliver this new service model, together with an impetus to drive continuous service improvement with the rest of Wales.

Together for Health: Cancer Delivery Plan 2012-2016 highlighted the need for collaborative working between and across primary, secondary, tertiary care and the third sector and the

opportunity to think differently, placing the patient at the heart of the entire system. Considering the entire systems and by working together, Velindre Cancer Centres have led the development of a vision for the future where the system of cancer care is better than the sum of its parts, and built on the following principles:

- Patient experience and outcomes at the centre of everything they do regarding service design and delivery.
- Patients taking responsibility for their own health, by providing them with the information support and skills they require to manage their own needs effectively.
- Equalising relationships between patients, families, carers, clinicians and professionals.
- Patient safety is paramount and fundamental standards of care will always be met.
- Services provided as close to home as possible, where safe and appropriate.

To support the delivery of the above principles, the UHB will work with Velindre Cancer Centre in the development of a new clinical service model, seeing the patient as the "hub" of the process wherever they are within the healthcare system. The intention is to provide everything the patient needs in order to allow them to achieve their goals in their preferred environment, whether that is where they live or in one of the four formal treatment settings (spokes).

These "spokes" are described as being an evolution of Velindre Cancer Centres current outreach services which creates an opportunity to consider and develop radical changes in the provision of cancer related care within UHB's current service models. The Cancer Village and Radiotherapy Village are both seen as outreach services that are fully integrated into local communities and sit alongside the wide range of public services available to patients and their carers. This vision would allow patients to receive their full package of treatment without ever needing to attend the Cancer Centre, which will only be required by patients with complex clinical needs or for patients participating in complex cancer trials. This would impact upon the UHB's future cancer service provision and in order to meet our patient's needs, the UHB will work closely with the Transforming Cancer Services SE Wales programme team in developing the detail of the proposed restructure and service provision within the "Cancer Villages".

Workforce and Financial Impact
Through its increased focus on job planning, the UHB will seek to ensure that recurrent demand is delivered through substantive budgets and that the cost of non-recurrent activity is minimized through improved efficiency wherever possible.

Delivery and Risk Management Arrangements

Project Lead	UHB Cancer Lead
Project Support	Divisional Managers and Cancer Managers
Project Structure	Cancer Board
Reporting arrangements	Finance and Performance Committee
Plan status	Cancer Local Delivery Plan approved

Via the Chief Operating Officer, Directorates and Divisions are accountable for the delivery of both cancer standards and treatments targets, with progress overseen by the Cancer Services Committee, chaired by the UHB Cancer Lead with regular reporting through the Executive Board, and the Access Group.

Outpatient Services Transformation Plan

Aim
To develop a new business format to deliver consistent planned care applying Prudent Healthcare principles.

Baseline Position
While much elective care is based on broad clinical agreement, delivery of care is rarely planned and monitored according to those agreed methods of working. Hence, most outpatient care, in

common with planned care in general, is not delivered and managed according to agreed pathways. Hence, improvements (including those against performance measures) are often achieved through expediting which is time consuming, one-off, inefficient and may have unintended consequences. On the other hand, real innovations, of which there are many, may not be embedded or spread.

Desired Future State

All elective outpatient care will be delivered and managed according to agreed clinical pathways and incorporate the principles of prudent healthcare. The priority is to develop this model within one division (ophthalmology) and then to coordinate the stepwise spread of the required business system across other divisions. In addition, all outpatient services will be delivered and managed according to standards which are co-produced with the public and patients of Aneurin Bevan UHB and which are consistent with national performance measures.

Work Programme Overview

Table 7.10.8

Scheme	Affected divisions	Planned outcome	2015/16	2016/17	2017/18	2018/19	Status
Abdominal pain pathway	Paediatrics	Reduced referrals		✓			
Prudent pathway development	Ophthalmology	Capacity and demand in balance by June 2016	✓	✓			
	Orthopaedics	Agreed care pathway for hip replacement incorporating prudent principles	✓	✓			
	TBC (two divisions per year)	Agreed care pathway for at least one care group incorporating prudent principles		✓	✓	✓	
Bespoke support	ENT, Orthopaedics, Cardiology, Paediatrics, Diabetes	Support delivery of divisional objectives	✓				
	General Surgery, Urology, Dermatology, Neurology, Obstetrics			✓			
	TBC				✓	✓	
Consultation process to establish patient-led agreement standards for outpatient services	All	Standards and measurement system established		✓			

Dependence

All changes to clinical activity levels are the responsibility of the relevant division. This programme will deliver corporate level change. ABCi will also support individual divisions if required through

agreed service plans. Requests for such support within individual years will be met according to the priority given to divisions in the schedule set out in the 2015/6 IMTP:

Table 7.10.9

Year	Specialities
2015/16	ENT, Oral Surgery, Orthopaedics, Ophthalmology, Respiratory, Cardiology, Paediatrics and Gynaecology), workforce development and other associated processes and systems.
2016/17	General Surgery, Urology, Dermatology, Neurology, Obstetrics in addition to infrastructure development (clinical, booking, information), workforce development and other associated processes and systems.
2017/18	Specialties for the Year 3 Plan will be prioritised against the following parameters: ▪ Recurrent capacity and demand gap with no sustainable plan in place. ▪ Increased expenditure on additional clinics. ▪ Increased use of Bank/Agency to cover core clinics, high sickness levels and wider recruitment/ workforce issues with no sustainable plan in place. ▪ Outlier in terms of benchmarking against quality, performance and financial parameters. ▪ Potential to integrate with Primary Care and alignment with Clinical Futures.

Governance

The programme originally described in the IMTP did not start and its governance arrangements have been dismantled. The succeeding Outpatient Transformation programme started in September 2015. It is managed as an improvement programme by ABCi and overseen by a steering group which includes leaders from each affected division, from the executive team, finance and informatics. ABCi reports this work to its steering group which is chaired by the CEO.

Key Risks

Table 7.10

Risks	Mitigating actions
Slippage of National Informatics Programme	Mitigating actions currently are lobbying by Head of Informatics to keep reconfiguration plans prioritised.
Lack of clinical buy in and impact on delivery of changes proposed	Ensure approach embedded in programme is clinically led. This will require the diagnostic in-put of Executive Director of ABC*i*.
Workforce and sickness pressures within clinical teams may mean planned initiatives are delayed	No mitigating actions
Lack of funding for rollout of pilot initiatives and wider work programme	No mitigating actions in place. Resources required to be identified through IMTP planning framework
Projected impact of initiatives identified for 2015/2016.	Liaising closely with Directorates to ensure their modelling and projections are robust and deliverable. These will be monitored through the Outpatient Dashboard and through corporate led capacity and demand forecasting.
Risks underpinning follow up action plan relates to ongoing resources to support validation, validation expertise and ability to embed new ways of working to reduce future demand.	Ongoing monitoring through steering group and escalation through Executive Director of ABC*i*
Lack of integrated/ pathway approach and internal flow/ commissioning challenges resulting in difficulties in developing an ambulatory model that proposes localisation of services and more out of	Mitigating actions will be to take a pathway approach and ensure early involvement of clinicians within Primary and Secondary Care

Risks	Mitigating actions
hospital care.	
Capacity both at an operational and corporate level to support service improvement and change.	Highlight risks. Additional capacity has been highlighted within this document.
Benefits achieved do not meet IMTP criteria.	IMTP criteria will be paramount in selecting change options. Highlight through monthly reporting.

Alignment of Plans with Workforce, Finance and Capital

Each of the above Service Change Plans have been aligned to the finance, workforce and capital plans recognising there is further work ongoing to finalise priorities for investment as business cases are developed to demonstrate benefit and impact, identifying workforce solutions to support plans and the identification of further opportunities for improved efficiency and productivity. The following tables sets out the links to the finance, workforce and capital at a high level across the four themes.

Table 7.11

Key Theme	Finance	Workforce	Capital
Reducing health Inequalities and improving population health	Funding implications have either been secured through national funding sources or included in the service investments within the financial plan. Funding for Childhood Obesity been agreed as per Executive recommendations in 2015	Additional workforce is required to support these schemes with most posts recruited to.	No capital implications
Supporting shift of care from secondary to primary through the NCN foundation for delivery of care	Financial implications of these work programmes have been secured through specific WG funding for primary care, integration and to support local delivery plans. Further local plans have been agreed for some projects in 2015 such as the Liver disease plan and these are included within the financial plan.	Additional staff recruited to support the primary care, Intermediate Care Fund and Mental Health schemes in 2015/16.	Primary Care opportunities are being pursued with Welsh government. Mental Health low secure plans also being developed during 2016/17.
Delivering Improvements in access and quality of care to patients	The indicative financial implications of the Planned Care and Urgent and Emergency Care plans are included in baseline budgets or have been identified as priority areas. These primarily relate to the solutions to deliver RTT, cancer, diagnostics, Out of Hours, the front door model and community beds and will need to be finalised in the context of the overall plan and efficiency opportunities.	Additional workforce required to support Urgent & Emergency Care Plan including pharmacist, ENPs. New workforce models are considered as part of the overall workforce plan. Better use of our resources is a key component of planned care with a focus on improving productivity.	Capital plans include potential schemes to support A&E plans at Nevill Hall, potential improvement in breast services, and additional diagnostic equipment.
Delivering Service	The financial implications and	Additional medical	Awaiting WG

Key Theme	Finance	Workforce	Capital
Sustainability	opportunities relating to CHC are included within the financial plan. The additional costs associated with the key service sustainability issues including medical staff issues, vascular services transfer are also included within the financial plan.	posts required to support the service sustainability issues with new workforce models being considered and adopted.	approval for funding of NICU scheme at RGH. Replacement equipment to sustain service been secured for Cardiology Cath Lab and potentially WG to support replacement diagnostic equipment.

10.4 Service Planning - Strategic Work Programmes

Significant progress is being made through the Service Change Plans (SCPs) to support progress towards the delivery of the Clinical Futures Strategy and the overarching objectives of the UHB. However, as part of the maturity stages of our planning process and as part of the refresh exercise, the Board recognises the need to strengthen the focus and pace with which the organisation achieves some of the more strategic change and system shifts required in the future, above and beyond what is being delivered through the SCPs.

Through detailed review and reflection of organisation achievements and challenges, the Board intends to develop three Strategic Work Programmes that will be developed during 2016/17 that will build on the work of the service change plans and support greater strategic change and system shifts to deliver the overarching ambitions of the UHB. These include:

Figure 7.10.4

These Strategic Work Programmes will be developed and progressed through the existing structures where possible and builds on the progress already being made through the Service Change Plans and will represent an ambition and change programme that will span a longer time period but with key milestones on the journey to measure success of the programme.

Supporting our workforce and investing in organisational development and culture shift to support these programmes of work is a key enabler and requirement to delivering the system shifts and

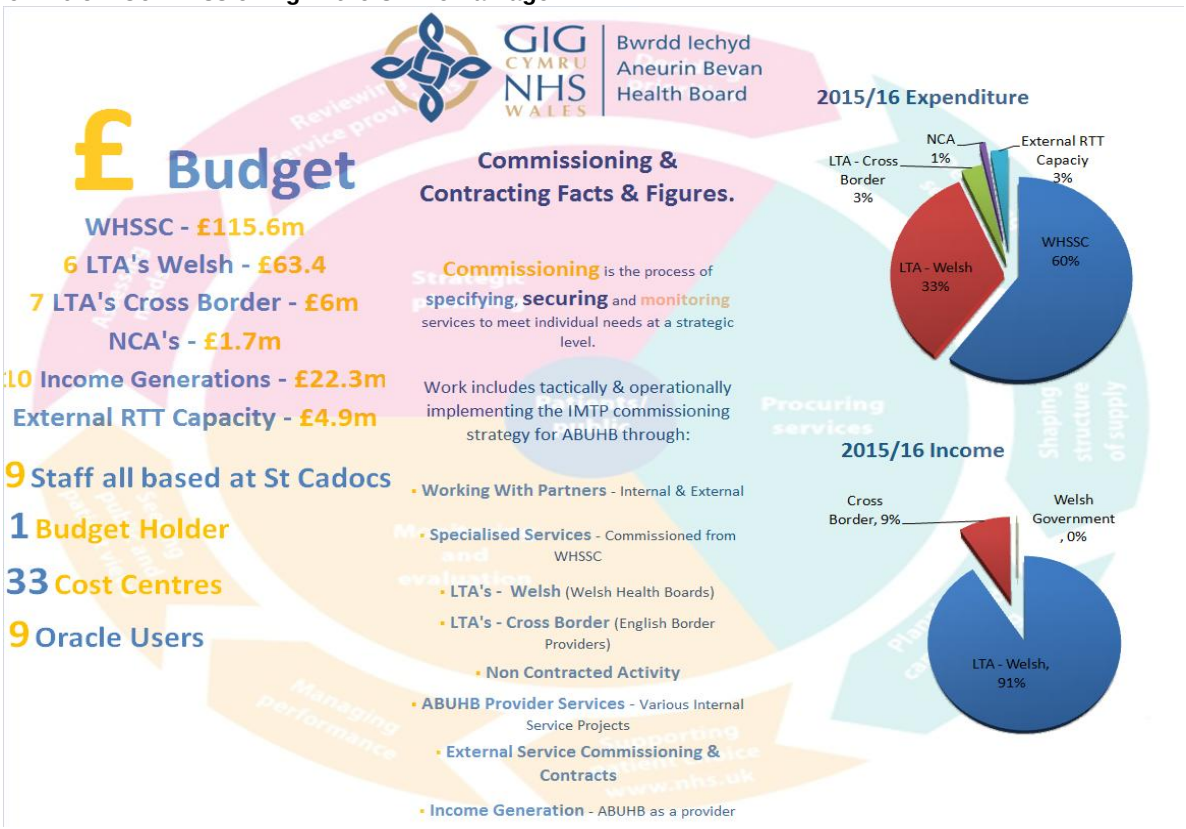
new ways of working that will need to underpin strategic change to the scale required.

This work is due to be developed during the first six months of 2016/17.

10.5 External Commissioning

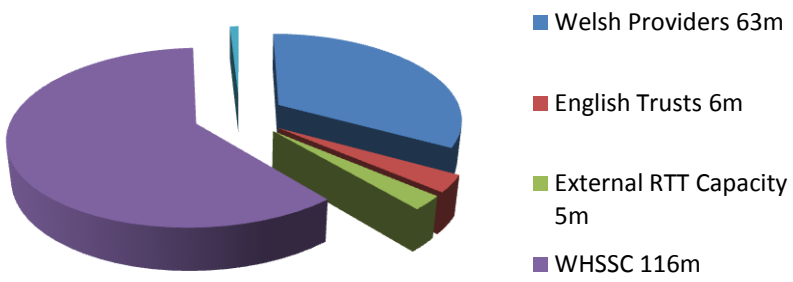
Specific Work Programme for the Annual Commissioning Delivery Plan
The UHB Commissioning and Contracting team have established three areas of responsibility for which an Annual Commissioning Delivery Plan will be agreed as part of the UHB's Integrated Delivery Plan. These are external contracting, UHB commissioning and specialised services commissioning. These specific responsibilities include contract management of a portfolio of health service agreements including financial and activity analysis and performance management, development of outcome based indicators, supporting the programme outlined above including prioritisation process development, referral management for key initiatives and management of cross border commissioning issues. Specialised services commissioning is also a key programme of work to progress along with WHSSC partners and through other collaborative arrangements.

Figure 7.10.5 – Commissioning in the UHB on a Page



The UHB delivers the majority of routine care to our resident population within Gwent (on average 88% of hospital and community based care). We commission a broad range of services at an annual cost of approximately £190 million secured through a complex portfolio of contracts and contracting arrangements with English and Welsh Providers. Around £75m relates to hospital provided care at a secondary care level and £115m to tertiary services commissioned through Welsh Health Specialised Services Committee (WHSSC).

Graph 7.10.2 - LTA Budgets by providers



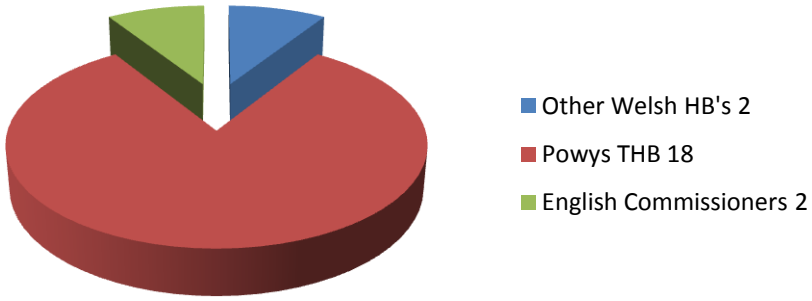
1.1 Commissioning & Contracting Plan

The strategic work programme for commissioning will include:

- Developing intelligent commissioning & contracting.
- Improving service portfolio intelligence (SPI).
- Developing and supporting value based commissioning.
- Improving the value added benefits from the specialised commissioning opportunities.
- Leading on the Cross Border policy.

Provider Income Maximisation
Whilst this is a small element of UHB service provision it is important that costs incurred either within an LTA or on an ad hoc basis are recovered appropriately to ensure the UHB are not cross subsidising other areas patient care. We provide services to Welsh and English commissioners, a total of £22m income is received annually.

Graph 7.10.3 – Income Sources as a provider



Specific Work Programme for 2016/17
Four elements of work will be prioritised:

- External Commissioning – LTA/Contracts.
- Cross Border Commissioning – Policy and operational changes.
- Specialised Services – working alongside WHSSC.
- Internal Commissioning – Internal Demand & Capacity Assessment.

External Commissioning
The current agreement with Care UK rolls through 2016/17 and ends August 2017/18. Ongoing management of this agreement for orthopaedics and ophthalmology will be a key area of work and it's effective management of how the capacity is used will have significant bearing on the financial plan given the potential for variability for example in terms of specialty usage and casemix. Casemix and forecasts will need to be carefully monitored to ensure procurement arrangements are not breeched whilst the opportunity of additional capacity is maximised. Further specialities are being considered for external commissioning to support RTT. These include radiography ultra

sound, gynaecology and breast surgery.

Powys Mental Health Management Transfer
Following the postponement of the planned transfer date of December 1st 2015, due to concerns around the level of clinical risk associated with the proposed Powys model, the Finance C&C team will continue to heavily support the Division manage the transition of the LTA. Much work has already been undertaken in progressing a revised LTA to cover the ongoing service provision required by Powys. This will need to be refined and finalised alongside the Transition Board that will now deliver the transfer and resolve the risk issues. From there the Finance C&C team will provide the ongoing reporting and LTA management function for the agreement.

Wales/England Cross Border
The Finance C&C team are facilitating key work supporting the review of current protocol arrangements necessitated by the Department of Health. Effective engagement across a range of internal, all Wales and UK work streams continues to progress at pace. As well as informing the policy decision, the team will also work with local Divisions, English Trusts and CCGs to facilitate the effective transfer of responsibility for commissioning patient care if a revised protocol arrangement is confirmed. The potential financial risk will also be monitored; the team are liaising closely with Welsh Government and NHS England colleagues to understand these implications.
The outcome of this agenda will likely influence the review of the UHB Policy for Out of Area Referrals to Secondary Care which is due in 2016.

Long Term Agreements (LTAs)
The core work of the team to deliver LTA management for the UHB continues. Effective management of LTAs is supporting robust negotiation of agreements, to ensure appropriate service delivery and value for money. Activity trends have become less predictable and these are being carefully assessed to understand where the opportunities lie for future years. This workstream also includes supporting the Regional/All Wales collaborative work underway with regards centralised service proposals, for example Vascular Surgery and a Major Trauma Centre.
Effective engagement with UHB Divisions to support any service delivery changes, external procurement requirements and potential repatriation opportunities also continues.

Specialised Services
The Welsh Health Specialised Services Committee (WHSSC) Integrated Commissioning Plan (ICP) is currently being finalised jointly with Health Boards in accordance with the Framework of National Planning Requirements with particular focus on the requirements of prudent healthcare, quality and safety and addressing health inequalities. The key elements being considered in the development of the plan include:

- Clear Specialised Services Commissioning Intentions agreed by all Health Boards – these have been circulated at all providers and only new schemes which comply with this intentions will be considered for inclusion. These include:

    - proposals to achieve Tier 1 targets;
    - proposals relating to national priority areas of Maternal and Child Health, Cancer, Mental Health and National Delivery Plans;
    - proposals to address clinical risk and patient safety in specialised services;
    - opportunities for repatriation and savings.

- Horizon Scanning – This is focused on compiling and assessing a list of new drugs, interventions and technologies expected in 2016-19. The total anticipated costs for the initial horizon scan have been estimated at £18.7M in 2016/17 (All Wales impact FYE). New NICE pronouncements are driving a significant element of the service & investment plan.

- Prioritisation – a process has been developed which outlines a clear, rational approach and a fair, transparent process to ensure that evidence-based health gain for the local population and value for money are maximised in health service planning and delivery. Current areas of focus

include:

- Ventricular Assist Devices;
- Proton Beam Therapy;
- Hand transplantation;
- Pancreatectomy and Islet Cell Transplantation.

- Prudent Health Care & Wider Economic Benefit - changes in technology have been considered which is likely to benefit other elements of the care pathway and reduce unnecessary interventions including:

  - Cardiac Ablation;
  - Genetic Testing Stratified Medicine.

- Baseline Review – A financial review is ongoing of each contract and service baseline within the WHSSC portfolio to identify recurrent service pressures and underspends.

- Impact of Developments in 2015-16 – As part of the IMTP process in 2015-16, a significant number of developments have been approved in 2015-16, including:

  - Bone Marrow Transplant Phase 1 and Phase 2;
  - Enzyme Replacement Therapy;
  - Cardiac Surgery;
  - Cerebral Metasases.

A number of these developments have had a significant 'lead' time with the recruitment of consultants/staff and the development of the required infrastructure. This has resulted in some significant financial slippage being recognised in the 2015-16 WHSSC financial position. However, the FYE of these developments will represent a significant challenge in the overall WHSSC financial position in 2016-17.

A number of further schemes which strongly comply with Prudent Healthcare principles around avoiding un-necessary treatment have been identified for consideration in 2015-16 with a significant FYE effect impact in 2016-17. These include potential developments around Interstitial Lung Disease and scope of the PET-CT policy.

This section has identified both the strategic and tactical approach to Commissioning and contracting for the UHB. It is supported by a more detailed operational plan and monitoring framework.

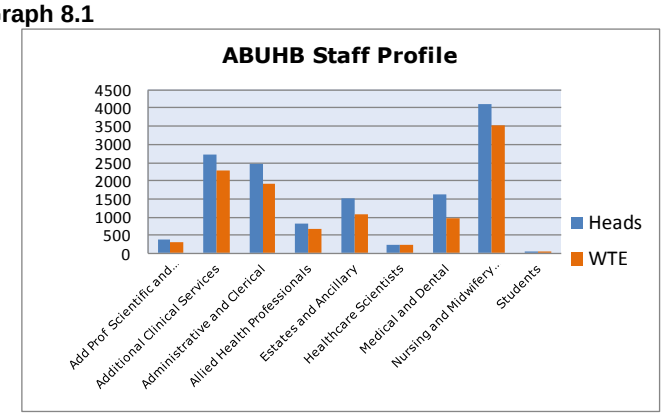
Chapter 8 - Organisational Development and Workforce

The performance of our healthcare system is directly related to the people who provide care and services to the individuals, families and communities we serve. It is vital that we use the talents and experience of our whole workforce to provide services that improve health and improve care together, whilst creating future workforce sustainability. Achieving this balance needs a different mix of skills, competency and capabilities to the current ones. Our Clinical Futures Workforce Strategy is one of the key building blocks to delivering these changes.

1. Our Workforce Profile

As of October 2015 ABUHB employs 13,869 staff (10,967 WTE) and is the largest employer in Gwent. Within the workforce nursing and midwifery and additional clinical services there are 6185 WTE staff contracted and this makes up 50% of the overall workforce. The medical workforce make up to 9% of the workforce and 21% of the total spend. The staff profile is this is shown in graph 7.1.

Graph 8.1



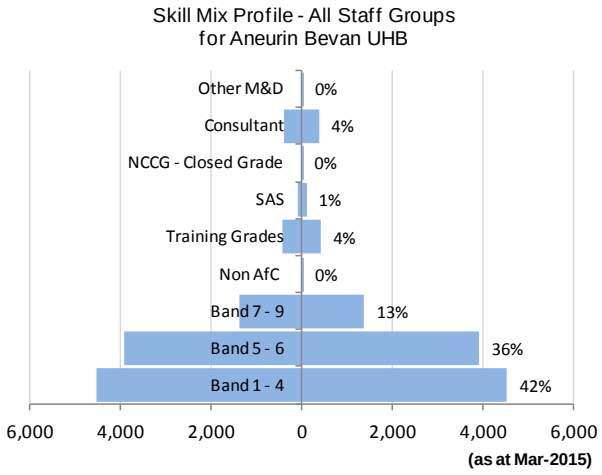
Whilst the staffing group profile has not changed significantly since October 2014, the number of contracted staff in post has increased by 272 WTE staff and over the same period variable pay has increased by 15 WTE. The largest increase in staff has been within additional clinical services and administrative and clerical with marginal increases observed in Nursing.

The primary reasons for the increase in staff and detailed in 2015/2016 IMTP plan are due to:

- Increased number of managed GP practices – increased administration, nursing and medical workforce
- Recruitment to meet nursing principles
- A number of Primary Care schemes and an increase in non medical roles e.g., Pharmacists and nursing to support GP sustainability and delivering Care Closer to home.
- Local Delivery Plans – stroke (AHP and nursing)

The current Profile and banding of the workforce is shown id figure 7.2. Within the profile bands 1-4 constitute for 42% of the workforce with 13% of the workforce in the higher agenda for change bands 7-9. Benchmarking against other Welsh Health Boards indicates that ABUHB has a higher number of staff in bands 1-4 than the average of the other six health boards and also is lower in bands 7-9 than the average of the health boards demonstrating an improved use of skill mix. ABUHB is comparable with -the all Wales average for staff in bands 7-9.

Graph 8.2

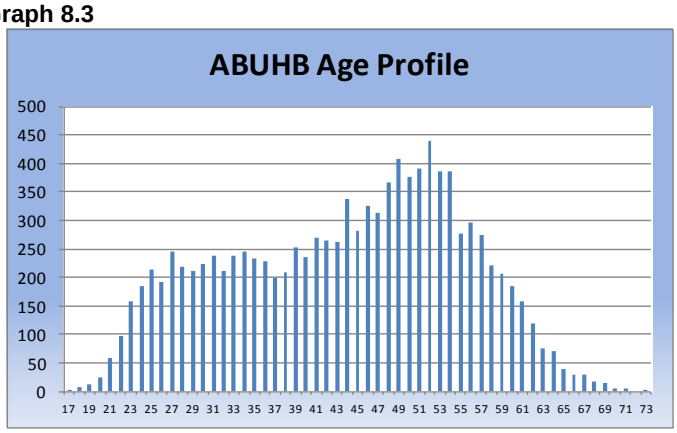


1.1 Age of ABUHB workforce

One of the biggest challenges facing the organisation is the ageing workforce and managing the ageing workforce as retirement ages increase in line with pension changes. Graph 8.3 shows the current age profile of the UHB workforce. There are variances between staff groups and these will need to be considered within the workforce plans and when assessing numbers for educational commissioning and addressed through succession planning.

Whilst 31% of the Nursing and Midwifery workforce are 51 years and over, there are also variations within this staff group in particular, community hospitals have a higher age profile than that of the acute hospitals. The largest non clinical staff groups affected by the ageing workforce include estates and ancillary workforce which has 48% of its workforce over the age of 51 years and administration and clerical with 40% of the workforce.

Graph 8.3



In terms of the age profile of the medical and dental workforce There are high numbers in SAS and doctors in COTE and Anaesthetics, over the age of 55 years.

1.2 Primary Care Workforce

The Primary Care General Practitioner workforce is made up of 471 Medical posts, of which 320 are GP Partners and 81 are salaried GPs, 38 medical registrar posts and 25 posts filled by locum staff. The age profile for the GP, salaried and locum workforce is shown in Table 8.1 (excluding registrar and retainer posts). This shows that 21% of the workforce is over 56 years of age which given the average age of retirement as 60 years, would mean that 88 could leave the service in the next 4 years. This is an increase of 2% since last year's assessment.

The ABUHB Medium Term Plans last year highlighted risks attached to a significant cohort of GPs

at or approaching retirement age and one Health Board has stated a need for 1.5 new GPs to replace each of its retiring GP due to issues such as different working patterns and feminisation of the workforce amongst GPs, where female make up 56% of the workforce and 50% of the overall worked sessions by the GP workforce.

Table 8.1

Age Bands	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71 & above	no age given	Total
Female	6	48	45	41	32	22	16	2	4	2	1	219
Male	4	18	23	27	35	30	28	19	12	5	0	201
Total	**10**	**66**	**68**	**68**	**67**	**52**	**44**	**21**	**16**	**7**	**1**	**420**

Information gathered as part of a GMS practice survey undertaken in September has been used to prepare the ABUHB Practice Nursing profile (figure 7.6). The data shows that there are 158 WTE practice nurses in including advanced specialist nurses. In addition there are 112 WTE non-registered nurse support staff of which includes HCA's and Phlebotomists.

Table 8.2

Role	WTE
Advanced Nurses	22.8
Practice Nurses	135.9
Direct patient care/HCSW	112.2
Administration and Clerical	603.7
Other	22.3
Total	896.9

Additionally, from recent census information, 50% of registered nursing staff in primary care are aged 44 – 55, with a further 20% aged 56 years and above. The remaining posts include administration roles which account for 67% of the workforce.

2. Workforce Challenges

There are a number of signficant challenges for the existing workforce both in terms of increasing demand, recruitment shortages and compliance with deanery standards. The following section outlines existing challenges facing the various staff groups throughout ABUHB.

The significant challenges facing the workforce across the spectrum of healthcare in Gwent have been highlighted throughout the IMTP and are summarised below and included in Template (C22. Recruitment Challenges):

- Skills shortages, recruitment challenges
- The ageing workforce profile
- Deanery rota compliance and training standards
- Provision of 7 day and extended services for a number of professional groups
- Specialist skills spread too thinly on existing site configuration
- Increasing demand across the healthcare system
- Recruitment and Retention of staff in fragmented unsustainable services in outdated poor estate in the absence of SCCC approval.

Without the SCCC the medical workforce specifically will not be sustainable. To ensure that rotas are sustainable in the current service configuration would require the recruitment of a significant number of junior doctors. Since many of the junior doctor gaps are at SPR level, due to insufficient training numbers at this level and extreme challenges of recruitment, hybrid consultants would be the only solution to filling these gaps.

Maintaining services on the existing two sites is therefore not a sustainable workforce option, as

this would require a level of medical cover that is not available in the labour market now or in the future. This presents a serious risk to patient care and safety.

New non medical roles are being developed to support the medical model. However, these roles cannot be medical replacements in terms of supervision of junior doctors or undertake tasks that only medical staff can do. The SCCC will be a primary enabler in delivering workforce sustainability, supported by a programme of workforce modernisation that will reduce the reliance on the medical workforce.

Medical and Consultant Dental Staff
Medical training is undergoing a significant review across the UK and there are substantial areas of shortage and risk which are a feature of the majority of NHS Wales plans. It is noted that the supply and risk issues facing the medical workforce provide opportunities to and drive development of other professions and staff groups.

The impact of 1:11 rota deanery standards, changes to medical trainees allocation and shortages of speciality specific junior doctors are creating challenges. To date the following have been identified as areas of significant challenge and the organisation is exploring a variety of options to ensure service continuity:

2.1 Obstetrics
Whilst the UHB continues to maintain obstetric services on our two District General Hospital sites, we face significant challenges in achieving a 1:11 rota and recruitment to middle grade medical positions and consequently rely on the use of locums to fill gaps, which compromises continuity and quality of care and are poor value for money. To address these weaknesses a solution has been identified based upon additional hybrid consultants (8), specialty doctors (4) and advanced maternity practitioners (5).

2.2 Paediatrics
Similarly, the requirement to achieve a 1:11 rota for paediatric trainees has prompted an appraisal of options to maintain service sustainability, with a capital based approach discounted on grounds of practicability. Additional hybrid consultants have therefore been required as a non-recurrent solution prior to the SCCC.

2.3 Neonates
In our current configuration, neonatal services are delivered on a pan-Gwent basis, with staff rotating across both the Royal Gwent and Nevill Hall Hospital sites. Over recent years it has become increasingly difficult to provide and equivalent level of service at both sites due to limited availability of specialist staff, this reflects experiences elsewhere in the UK. In the future, neonatal services in Gwent will be consolidated at the SCCC but in the interim three additional consultant posts have been recruited to provide service sustainability.

2.4 Emergency Medicine
Ongoing difficulties in both the allocation and recruitment of middle grade junior doctor rotas to sustain existing services on two sites and provide any extended consultant cover. Clinical Futures Strategy and centralisation of the services at the SCCC will assist with delivering extended coverage of the existing medical workforce and will reduce the number of rotas required and therefore improve the junior doctor cover and 1:11 deanery compliance. In anticipation of the existing challenges UHB has developed non medical roles to support the ED service model such as nurse led minor injury units, however these cannot be a replacement for the need for senior medical decision makers. There will be ongoing development of these roles and new non medical roles to sustain the medical model in the short and longer term.

Development of non medical roles to support lower tier junior doctors include:

- Emergency Nurse Practitioners
- Physicians Associates

- Advanced nurse practitioners
- Development of the pharmacy input into admissions process including A&E;

2.5 Mental Health

Mental Health is having significant difficulties with sustaining junior doctor rotas, in light of the number of allocated junior doctors and significant challenges in recruiting of non training grade posts. There are also difficulties recruiting to consultant posts in a number of geographical areas.

In light of the difficulties facing the medical workforce, as well as the increasing demand on services and the objectives set out in the Together for Mental Health Strategy and the Mental Health Measure, the division is reviewing its Medical Workforce Strategy to ensure a sustainable and appropriate medical workforce going forward. The division is currently in the process of engaging with all Consultants within the division to obtain their feedback on what the current challenges are, what the main medical priorities are going forward specifically looking at what activities could be undertaken by other roles, and finally what the short-term and long-term options are to ensure a sustainable and appropriate service and workforce.

At this stage no decisions have been made and the division cannot provide an agreed plan on its medical workforce until the engagement process has concluded, however we aim to have agreed short term options in place from August 2016. Some key themes within the workforce strategy include the reduction in site provision which will reduce the number of rotas, on call rotas for medical staff:

Short Term:

- Development of one admission site which reduces demand on current on call provision
- Local units supported by GP's
- CRHTT based at admission unit overnight with SHO with local HTT at local units until 10pm
- Extend liaison / HTT provision
- Centralisation of acute services
- Recruitment of Clinical Fellows
- Clinical Fellows for short term contracts
- Ongoing integrated planning with Primary care
- New roles to support the medical model through prudent workforce planning approaches.
- Integrated CMHTs with inpatient units

Longer Term:

- Centralised inpatient unit
- Crisis house – may reduce demand on medical and nursing time
- Single admission unit for acute presentation (short stay, typically up to 7 days)
- Inpatient unit on same site for up to 10 weeks stay
- Development of rehab units, detox units with appropriate workforce model to support
- Development of a Low secure unit
- Co-location of older adult with medical wards where possible to allow improved cross cover.
- Development of advanced practitioners and the role of the Physician Associate is being explored.
- Exploring training and research post with Cardiff University

2.6 Surgery and Anaesthetics

Further difficulties are anticipated in meeting recent Deanery announcements of requirement for junior doctor compliance within General Surgery in 2016 and Anaesthetics in 2018. Plans are being developed to address a workforce solution in the absence of a practical site reconfiguration.

To address the junior grade doctor difficulties a number of prudent healthcare schemes are being developed and training has commenced to increase the non medical workforce to support the junior doctor roles. The key programmes of development include:

- Development of surgical care practitioners to support lower tier medical doctors (2016 onwards)
- Alternative approaches to recruitment of higher tier junior doctors through collaborative working with Edinburgh University and short term Clinical Fellow contracts (2016)
- Development of Advanced Critical Care Practitioners – (commenced 2015 with onward training programme until 2018)
- Development of Physician Associates in Anaesthetics in trauma and orthopaedic surgery to assist with spinal and regional blocks will assist with reducing the anaesthetic resource for these procedures.

2.7 Other Medical Specialities

In addition the above there are a number of local and national recruitment difficulties in a number of consultant medical workforce professions including General Practitioners and secondary care services including Radiology, Psychiatry and Histopathology, obstetrics, paediatrics, neonates, female urology consultants at both consultant and clinical fellow level in most of these specialities.

Whilst short term solutions have been developed through the recruitment of additional Clinical Fellow posts and hybrid consultant posts, recent work undertaken by the CFWI indicates that the future supply of consultants in these key areas is not likely to increase and only sufficient to match anticipated turnover of existing consultant posts. Therefore, there is the potential that consultants working in a "hybrid" role could leave to take up substantive posts as they become vacant. Additionally, workforce plans are being developed to support the implementation of physician's associates along with re-alignment of existing advanced practitioners and nurse specialists to deliver the service model

2.8 Nursing and Midwifery

Similar to other organisations across Wales, ABUHB has not been able to recruit sufficient numbers of nursing resource to fill its current number of vacancies and meet the Safe Staffing Levels of care proposed within Nursing Principles. The long lead in times for training and the forecast graduate numbers to meet demand is unlikely to change in the next 2 years, despite the introduction of accelerated graduate training numbers and an increase in training numbers for 2015. The current vacancies are 242 WTE and these gaps are currently being met through on average 229 WTE variable pay of which 71 WTE is agency. An overseas recruitment campaign will assist has recruited 120 wte new nurses and this will incrementally reduce the reliance on variable pay until June 2016. A recruitment campaign to the Philippines has also secured an additional 61 WTE nurses who have been offered posts and should commence their employment in December 2016 until March 2017 following the necessary immigration processes.

Within Primary Care, through securing WG funding the UHB has been working colloboratively with GP practices that would support practice nurse development under the criteria of up-skilling staff. Consultation with practice nurses indicated the need to develop an accredited foundation course for nurses new to general practice.

In the absence of an accredited programme, ABuHB has developed a draft 'Foundation in Practice Nursing' course which has been based on the RCGP Competency Framework for Practice Nurses. Meetings have been held with Cardiff University who have confirmed that ABuHB's proposed 'Foundation in Practice Nursing' course could be accredited by the University by October 2015.
Ongoing work and training has been developed for practice nurses in relation to minor injuries, immunisations, CPD and re – validation.

A recent survey undertaken collaboratively with nursing homes indicates that they are facing similar difficulties in terms of nurse recruitment. In the last year, ABUHB only recruited 69 wte new welsh trained graduates as apposed to Cardiff and Vale and ABM who secured 179 wte new nurses each. The reason for the poor uptake of new Welsh trained nurses is of concern and is possibly attributed to the location of the two Welsh university providers in Cardiff and Swansea. ABUHB is seeking to improve on this position through collaborative working with these University providers in addition to ensuring an equitable number of placements are offered within ABUHB and

promotion of the ABUHB for new graduates.

2.9 Allied Health Professional

In the last year there has been an increasing challenge in recruiting to a number of AHP professions and specialist roles within these. Recruitment challenges in a number of specialist roles within therapies**.** All therapy services are reporting a reduction in the number, and suitability of applicants for recruitment to bands 5, 6 and 7. Recruitment strategies being developed skill mix changes (roll out of additional Band 4 roles,) extending scope and development support for senior grades to increase retention. There is ongoing engagement with a wider number of UK universities and HEI e.g. Strathclyde University and the placement for Orthotist students.

In addition to focus upon Out of Hospital care models, increased emphasis upon development of Acute Hospital Flow and supporting roll of therapists is creating additional staffing demands. This demand is currently being met by locum cover. However, all areas are reporting difficulty in obtaining locum therapists, which is different from previous years. Service redesign and patient flow models will be heavily influenced by potential availability of numbers of graduate and experienced staff, thus requiring more creative solutions to recruitment and retention of graduate staff and shift in focus to develop further Band 4 multi professional roles such as Therapy Assistant Practitioners. A pilot project is underway in CNRS to employ Band 4 Therapy assistant Practitioners with view to wider roll out following evaluation of the role.

2.10 HealthCare Scientists/Additional Professional Technical

It is predicted that there will be increase in the number of patients on home life schemes. This will increase the Pharmacy department's workload. Implementing the recommendations of the AWMSG and RPS guidance will have a major impact on the department in terms of pharmacist and pharmacy technician workload. During 2015, mainly due to the welcome development of many new and extended clinical pharmacist roles including those in GP clusters, the service has an unprecedented level of pharmacist and pharmacy technician.

The outcomes of Modernising Pharmacy Careers work streams are beginning to materialise but over the next year there needs to be clarity on the programmes and how the placements impact on the departments. This is likely to have a major impact on the infrastructure required to support trainees. This will be most acute during the transition period whilst maintaining the current programme whilst implementing the new programme. There is a need for clear communication and engagement between the service and the programme board to ensure that the needs of the service are considered when implementing the new programme. The Health board at present have concerns about the impact that the new programme has on service delivery.

2.11 Staff retention and turnover

Retention and management of the health and well being of older staff is a key issue in developing the ABUHB workforce strategy, with the need to focus on the parts of the workforce with an older profile and to understand the implications of working longer. Areas of nursing such as Mental Health and Health Care scientists are showing a higher than normal age distribution. Equally, there is evidence that some staff are choosing to work longer past normal retirement age of 60 and this poses challenges in terms of role adaption and the environment, to accommodate the multifaceted changes of age in terms of sensory, physical and psychological aspects.

Our turnover has decreased marginally from last year and currently is projected at 6.78%, and is comparable to other Health Boards. The organisation has actively managed to ensure ongoing recruitment in areas such as Nursing and HCSW to ensure it minimises its vacancies at any one time.

Retention of staff will be a key priority for the next year and improving organisational awareness of areas of retention concerns through staff engagement and surveys, to ensure that UHB remains and employer of choice. Within the medical workforce the following actions are being progressed:
With the worsening position filling Junior Doctors rotations across Wales, ABUHB are looking into the following to try and improve recruitment into these posts. The Health board is constantly

reviewing its ability to fill vacancies and develop a varied approach to recruitment and its process.

- Vacancies are advertised continually on NHS Jobs and via the relevant journals to encourage applications from the UK and overseas.
- Skype interview are and will continue to be conducted for shortlisted candidates from overseas.
- The Health Board is currently pursuing the use of HCL for support with overseas recruitment.
- A generic advert has been developed by the Health Board to encourage recruitment of junior grades. This advert allows expression of interest for junior grades so they can be put forward as a candidate in the relevant specialities reducing the requirement of multiple applications. These posts could also be utilised in a rotational capacity so that doctors may work within another speciality until their preferred choice is available. This would reduce variable pay where gaps are being covered by Ad Hoc Locums.
- Advertisement of post in different journals such as the Irish Times, GPOne, etc, are being utilised to provide wider scope of potential candidates.

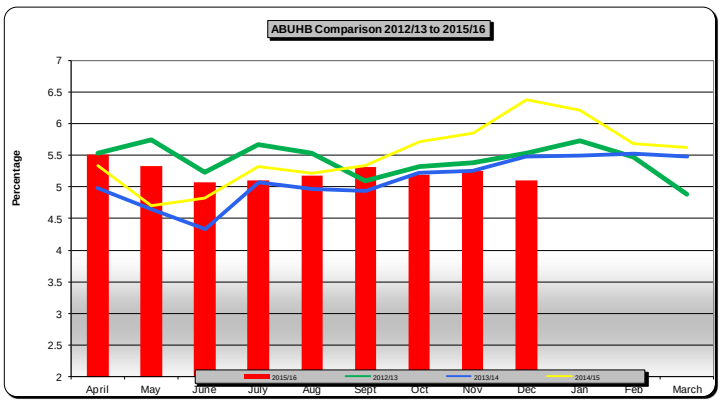
Within Primary Care further evaluation of the medical workforce is being undertaken to improve the recruitment and retention challenges within GP practices. The health board is working collaboratively with Primary Care GP independent contractors in the development of:

- Provision of flexible working
- Facilities for home triage – pilot commencing 2016
- Targeting potential GP retires to return to mentorship roles, training roles and undertaken minor surgery

2.12 Sickness

The average run rate for the UHB according to All Wales data shows that ABUHB have reduced their sickness rate from the last submission from 5.3% to 5.19% below the Wales average of 5.4%. (Graph 8.4) Sickness continues to be highest amongst Additional Clinical Services, Estates and Ancillary and Nursing and Midwifery staff groups.

Graph 8.4



Whilst sickness still remains a target area of workforce, this has not increased from the same period in previous years and at December; the sickness was at it lowest for the same period in the last 4 years. There continues to a focus on identifying hot spot areas and develop HR strategies to assist with reducing sickness in these areas. Sickness continues to be highest amongst Additional Clinical Services, Estates and Ancillary and Nursing and Midwifery staff groups. The impacts of sickness absence contribute to the increase in variable pay and agency expenditure equates to approximately 600 WTE lost.

2.13 Variable Pay

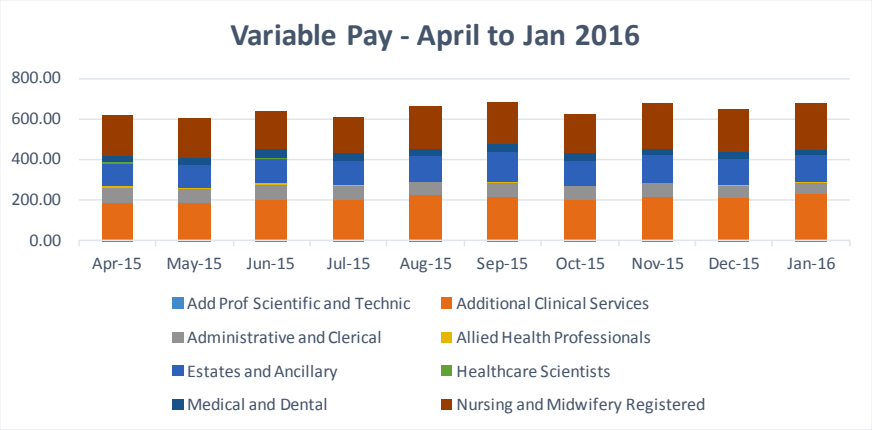
The impact of sickness absence, temporary increases in demand, recruitment difficulties and special ling patients with additional needs presents challenges in relation to continuity and quality of care, and is costly to the NHS. The variable pay hours worked is currently equates to an additional 667 WTE worked above core hours. Whilst the organisation understands that an

element of variable is acceptable to meet short term changes in demand, the variable pay bill is neither sustainable in the medium term or affordable in the short term, and the organisational target to reduce high cost areas such as agency and locum costs continues to be a priority.

The largest use of agency usage is within nursing and midwifery and the table below shows the expenditure on agency usage. In September 2015 the Board agreed that Healthcare Support Worker agency staff would no longer be used with effect from 1st October 2015. An agreed protocol setting out actions to avoid using HCSW agency is in place and any usage is investigated and escalated to the Directors' of Nursing and Workforce. Improved processes and controls have also been introduced in addition to the recruitment of overseas nurses to reduce off contract nursing agency by end of March 2016.

The graph below shows the additional WTE worked for variable pay. The variable pay used within Estates and Ancillary is not high cost agency and offer a cost effective way to managing fluctuations in service needs.

Graph 8.5



2.14 Managing increasing demand - There is an increasing demand for health services and the difficulties of managing this within the existing resources, recruitment difficulties in some specialities and financial constraints. Various approaches are identified in terms of additional resources and an increased focus on role substitution and maximising skill mix through adoption of prudent healthcare principles.

2.15 The impact on Co-Production - will mean that skills and knowledge to manage changing expectations about care need to be built into training and in particular leadership development, including cross sector training and development of social care.

3. Workforce – Key Themes to Deliver Clinical Strategy

"Working Differently, Working Together" Focuses on four workforce and organisational development objectives which set out the high level components of what needs to be delivered and the key enabling actions to support Together for Health. The four objectives focus on improvements in engagement of the workforce, a sustainable and skill workforce focused on prevention and well being of the people of Wales, a redesigned workforce and a workforce that aims at excellence within available resources

Whilst the medium term plans will focus on the next 1- 3 years, we will ensure that these align with those underpinning our Clinical Futures plan which has given a strong vision and focus on workforce planning for the longer term. A large number of workforce plans have been developed to support the development of the Critical Care Centre, and these will be used to ensure alignment with 1- 3 year workforce plans.

3.1 Prudent Health Care and Workforce

The drive for efficiency and improvement, which underpins all the prudent healthcare principles, means that in a system with limited resources health professionals have a duty to establish not only that they are doing well, but that they are doing better than anything else that could be done with the same resources. The concept of 'only do what only you can do' remains a fundamental tenant of a prudent health and social care workforce. In essence this means that we should continue to use this concept and ensure that no professional should routinely be providing a service, which does not require their level of clinical ability or expertise.

The Health Board has developed a good track record of applying prudent workforce principles. For many years midwifery nurse assistants have been supporting midwives in the delivery of care; assistant practitioners in radiology support routine plain film x rays; healthcare support workers within therapies delivering care and educational packages; nurse led clinics for sexual and reproductive clinics delivering care to Young Persons.

During 2015 the Health Board made further progress. Some of the schemes already developed and currently being developed will also assist with meeting the junior doctor challenge and meeting deanery 1:11 rota compliance. Key areas where prudent health care principles have been implemented during 2015 include:

Within Secondary Care

- Pharmacy technicians are being used within medicines management, thus releasing pharmacists to undertake more appropriate skilled tasks – commenced 2015/16 and ongoing
- The numbers of pharmacy independent prescribers within secondary care has increased to support decision making.
- New technologies such as Digitisation of Health Record are assisting with the prudent healthcare agenda and the programme is in the second year of a longer term implementation plan. The new technology will enable a significant reduction in labour intensive tasks, whilst improving accessibility of health records across the health board, and reducing cancelled appointments in outpatients because of the non availability of the health record.
- Building on the Government 'best guess' that £11 is saved in social care and health associated care for every £1 spent on contraception, the integrated sexual health midwife (ISH) was introduced in 2014. As a result the numbers of teenagers taking long acting reversible contraception increased post pregnancy or termination to prevent and avoiding another pregnancy in teenage years. There are plans to extend this service and build an outreach team around the ISH Midwife utilising staff currently sub-contracted to partnership organisations to support all vulnerable people.

Within Primary Care

In order to address the Primary Care & Community priorities which are:

- Keeping people well and Independent at home
- Sustainable and accessible primary care
- Rebalancing care from secondary to primary care
- Integration of services for older people

This will require a different workforce profile to the one which currently exists. This will be guided by the prudent healthcare principles incorporating core features that the primary care workforce are expected to exhibit. New models which will demand that traditional primary care professionals play new roles which bridge over the divide between medicine and public health.

Table 8.3

Priority	Workforce Impact	Timescales
Keeping people well and Independent at home	**1.** Will require 24/7 nursing care **2.** More resource to manage chronic conditions in primary care such as nursing **3.** Development of new roles such as practiced based pharmacists, social workers, therapy staff, HCSW role as well as Advanced Nurse Practitioners, Pharmacists and Paramedic Practitioners within Urgent Out of Hours Services and increased roles for the 3rd Sector as well as the development of Physician Associates and Practice Managers to improve anticipatory care planning and medicine management support. Development of integrated teams supporting continuing health care	2016 2015 onwards 2015 onwards
Sustainable and accessible primary care	**1.** Managing aging profile and sustainability of primary care workforce due to changes in population demographics which require different workforce profile and different skills. This will require service that is provided by a multi-disciplinary integrated teams which include medical, therapies, pharmaceutical, dieticians, physicians associate, Nurse Practitioners, social Workers supporting NCN Network. **2.** Development of Primary Care Support Team to encourage service improvements within existing practices **3.** Out of Hours Urgent Primary Care Services requiring sustainable model including different workforce model, mobilising wider primary care practitioners, less dependent on GP provided model of care. This includes both new ways of working and new workforce models such as Home Triage, Paramedics, pharmacists, advanced practitioners, healthcare assistants, **4.** Establishment of a primary care staff bank to ensure primary care services are sustained and appropriately developed for future with clear direction and plan aligned with the Clinical Futures Strategy **5.** Improve retention of existing resource through the adoption of family friendly policies, flexible working and new ways of working such as home/telephone triage. Developing new roles for the aging workforce such as mentoring, training roles to maximise their experience and skills for the training and development of new GP entrants and new roles.	2016 onwards 2016 onwards 2015 onwards 2016 onwards 2016 onwards 2016 onwards
Rebalancing care from secondary to primary care	**1.** 24/7 community nursing teams to support carer breakdown, palliative care, catheter care **2.** Community phlebotomy services to release community nursing time ensuring local access for patient population **3.** Maximising independent contractors such as dentists, ophthalmology, minor oral surgery **4.** GP practices treating minor illnesses via practice based nurses **5.** Development of workforce plan to support the release of resources to sustain the care pathway from secondary to primary care. This will be part of the care closer to home strategy which is currently in development for all schemes identified in SCP4.	2015 onwards 2016/2017 onwards 2016 onwards 2016 onwards 2016/2017

Priority	Workforce Impact	Timescales
	6. Healthcare support workers are assisting in the delivery of the Community Neuro-rehabilitation Service.	
Integration of services for older people	**1.** Maximising the use of voluntary sector in the wellbeing of older people. This will potentially reduce the need for hospital admission. **2.** Development of graduated and green wards in community hospitals through the effective streaming and classification of patients according to acuity will result in a revised community hospital workforce profile – such as development of re-ablement workers and band 4 **3.** End of Life and Palliative Care plan will also impact on workforce. This will clearer through 2016 **4.** Nursing and pharmacy support for Nursing Homes and GP Practices to improve care planning and avoid hospital admissions	2016 2016/2017 2016/2017 2016 onwards 2015 onwards
General	**1.** All of the above will be developed via NCN and Community Hospital strategy and underpinned by appropriate OD interventions **2.** Workforce planning around population needs requires further development **3.** Divisional restructure for the Primary Care and Community Division **4.** Cultural change to team based care, system of primary care 'v' speciality care	2015 onwards 2015 onwards 2016 2016

The following are schemes are examples of key areas for workforce development for 2016 and beyond:

Within Secondary Care

A number of prudent workforce modernisation is proposed throughout 2016 with training plans aligned to both providing sustainability of the existing workforce but new roles to assist with increased demand and skills shortages**.** These are shown below:

Table 8.4

Priority	Workforce Impact	Timescales
Compliance with Deanery 1:11 Surgery	▪ Development of non medical roles to support lower tier medical doctors – surgical care practitioners	2016
Medical Sustainability secondary care - Medicine	▪ Development of non medical roles to support lower tiers- PA, ANP and pharmacists	2016/2017
Medical sustainability - Anaesthetics	▪ Advanced critical care practitioners are being developed to support junior grade doctor rotas.	Commenced 2014 and ongoing until 2019
Medical sustainability Mental Health	▪ Medical strategy and service strategy to be finalised April 2016 (see point 7.2.5) and use of non medical roles	From April 2016
Medical sustainability Obstetrics/Gynaecology	▪ Coloposcopy nurses and hysteroscopy nurses ▪ Senior Midwifery Clinicians are supporting the junior doctor rota within obstetrics	2014 started with rolling programme of development
Nursing	▪ Development of graduated care	2016 – first ward

Priority	Workforce Impact	Timescales
	models and green to ensure care is based on patient acuity and alignment of skills to meet the patient acuity. ▪ Development of band 4 in Community services ▪ Development of advanced practice and realignment of existing resources to new care pathways ▪ Ophthalmology Nurse Practitioners will be undertaking injecting, and this will release medical capacity	implemented December 2015 2016 in conjunction with All Wales work 2016
Diagnostics and therapies	▪ Radiographers are reporting plain film images in radiology, thus releasing scare radiologist resource. ▪ Development of band 4 role in Community Neuro Service ▪ Development of monographers ▪ Extended roles of Therapists	2015 onwards 2016
Health Care scientists and additional professional staff	▪ Assistant practitioners in audiology to undertake hearing aid assessments ▪ Increase in numbers of pharmacy Independent prescribers to support medical model ▪ Extended roles of pharmacy technicians	2015 and ongoing

4. Nursing

Nurse Revalidation
ABUHB was the Welsh pilot site for the NMC revalidation of nurses and midwives with 813 registrants completing the whole process equating for >38% of the entire UK revalidation pilot population and nearly a quarter of the ABUHB nursing and midwifery workforce. ABUHB have worked with the WG and the NMC demonstrating that revalidation is achievable and are putting together a comprehensive action plan to take revalidation forward over the next 3 years to support all nurses and midwives undertaking this process.

In addition, the health board has worked with the NMC and RCN to produce films and resource materials to support this work and has presented at numerous national conferences. ABUHB was recognised as runner up in the RCN Wales CNO award and has received high acclaim for its implementation of the revalidation process.

The key nursing priorities going forward include:

- Implementation and review of the recruitment strategy
- Reduce agency expenditure through sustainable workforce solutions – recruitment, green wards, graduated ward.
- Continue with development of Advanced Nurse Practitioner, specialist nurse training programme to support the challenges maintaining the junior doctor rotas and support the medical model.

5. Therapy Services

To ensure therapy services continue to deliver services that achieve maximum potential in enabling patients to self manage their conditions and live fulfilling lives, there will be a need to continue to develop new ways of working across organisational boundaries. In addition to this a focus on integration and rebalance care to support prudent health care. The key strategic changes going forward include:

- Develop an operational and financial model that creates greater integration between therapy services.
- Therapy seven day service in OT and Physio.
- Align therapy services to NCNs. - this work has already been completed within the Community Nutrition Support Service, and Community Podiatry Services are restructuring community clinical teams to align with NCN. Other therapy services are evaluating options as to how best to realign service delivery models.
- Re-valuate the CNRS to support early supported discharge to stroke patients.
- Continue and develop the Obesity Management Service (adult and child). Adult Obesity Service is fully operational and has reported its first 12 month outcome paper to Exec Board. Children and Young Persons weight Management Service paper has been presented to Execs and was well received. Within Divisional IMPT to identify funding.
- Implement plans for extended and advance practitioner roles.

Meet waiting times standards in all therapy services. All therapy services are within profiled waiting times trajectory and all are reporting positive movement month on month. For larger services e.g. OT and S&LT Malcolnmess Care aims training has been instrumental in reducing waiting times. Physiotherapy Services are presenting Divisional paper to address recruitment options with view to improving capacity to address waiting times in Musculoskeletal services.

6. Better integration between health, social care and support organisations

There will be a requirement to workforce plan across sectors including the focus the where care is delivered, the design of jobs and the skills needed. As the largest employee of registered health professionals the organisation has engaged with providers of care within Gwent including, Primary nursing homes, CHC Mental health providers with the focus of gaining appreciation of workforce demand and capacity to inform educational commissioning numbers and to avoid competitive labour markets for roles in the future.

Below are a number of examples of services that have integrated workforce plans with local authorities or third sector providers and new schemes that demonstrate ongoing integrated planning both within and external to the UHB.

Table 8.5

Integrated Teams	Integrated with Local Authority or Third Sector or other
Mental Health LEAP and BOLD in learning disabilities	Integrated Partnership approach with GP practices, and local authorities to delivering a multi disciplinary care. Ongoing review of pilot sites and potential roll out further in 2016
Early Intervention	Hafal Third Sector involvement in Newport
RAID – Rapid assessment, interface and discharge	Social workers working in multi disciplinary teams supporting secondary care teams in the assessment of patients with mental health needs. Extended the services to N Hall in 2015
CMHTs (OAMH)	Integrated teams across all boroughs with local authorities and third sector links for carers and welfare
Caerphilly PCMHSS	Integrated with Caerphilly local authority
Road to Wellbeing Classes	Jointly delivered with Communities first in Caerphilly and with

Integrated Teams	Integrated with Local Authority or Third Sector or other
	Mind in the remaining boroughs
Memory Assessment Service (MAS)	Alzheimer's Dementia Support Workers
CPN within police control room	Partnership working with Gwent Police – pilot in 2016
Frailty (CRT)	Integrated teams with local authorities providing care across all boroughs have been in existence for over 4 years. During 2016 and onwards there will be further development of CRT and integration of CRT teams with community nursing and with NCN's
Older Persons Pathway	Development of Older Persons pathway is being modelled through workforce planning, using mathematical models which will commence with integrated approach between Health and Social Care. –2016-2017
Primary Care	Integrated multi disciplinary teams aligned with NCN networks Integrated workforce planning with Primary Care and the provision of care closer to home.

7. Volunteers

In planning and developing the workforce ABUHB recognises the totality of the workforce assets including directly employed staff, directly contracted staff and the voluntary sector. This is an exciting time when volunteering within the NHS is expanding and evolving. Our vision, as stated in our Volunteering Strategy which was developed collaboratively with our third sector partners is:

> *"to ensure that all volunteering services within ABUHB complement the work of paid staff and are safe, of high quality and add value to the experience of patients and families and to the lives of volunteers."*

Successful delivery of the strategy will mean that volunteering activity takes place in every division across the Health Board and provides demonstrable benefit to patient and family experience.

Key aims of our volunteering strategy include:

- Improving the experience of patients
- Providing worthwhile volunteering opportunities that will benefit patients and their families, volunteers, the community and services
- Establishing and maintaining a resilient framework for the recruitment, induction, placement, support and supervision of volunteers within the Health Board.
- Expanding the range of roles and activities undertaken by volunteers in all clinical and public areas.
- Raising the profile of volunteering within the Health Board and the wider community
- Working in partnership with other Health Boards to share good practice, developing a coordinated approach to volunteering across Wales.
- Working in partnership with GAVO, TVA, third sector organisations and support groups to promote volunteering opportunities.
- Developing and maintaining volunteer schemes in partnership with third sector organisations ensuring formal written commitment to the principles contained in this strategy and the ABUHB Volunteer Policy.

- That the contribution of volunteers is fully and formally recognised by the Health Board.

There are currently a wide range of volunteering schemes within ABUHB, involving many partnerships and over a thousand volunteers including:

- A number of volunteering schemes at Serennu Children's Centre, in partnership with the Sparkle charity
- Ward based schemes including Age Cymru Gwent Red Robins located at St Woolos and Royal Gwent Hospitals and GAVO's Sunflower Project at Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan, both schemes also involve hairdressing students from a variety of local colleges
- Condition specific schemes including Cardiac Rehabilitation and Aftercare Charities, Breast Cancer and Prostate Cancer Support Groups
- The multi-award winning CHAaT Scheme (Care Home Ask and Talk)
- Pets as Therapy
- Caudwell Children Out Patients Play Activities
- Blood Bikes
- Hear to Help, in partnership with Action on Hearing Loss
- Educating Patients Programme
- Welcoming Services
- Cafés, shops, snack/newspaper trolleys, library trolleys
- Chaplaincy Volunteers
- 'Chill out in the chapel' where volunteers help provide complimentary back, neck, foot and hand massages for staff

It is recognised that there are significant pockets where expansion is needed and in seeking to meet this need for expansion, there has been a significant shift towards working much more closely with our third sector partners. This collaborative multi-partner approach, involving the two local County Voluntary Councils, a wide range of 3rd Sector partners and the Community Health Council will focus on planning and submitting consortium bids for financial support. Links are also being established with workforce planning for future provision with opportunities for membership of the group. Significant progress has been achieved towards determining priorities for volunteering expansion through discussion with service managers and feedback from patients, which will precede the preparation of bids.

The profile of volunteering within the Health Board has increased significantly following the first Volunteer Recognition Event held in June 2015. The Health Board has publicly committed to holding annual events to formally thank volunteers, through a variety of awards and long service recognition, and through the publication of an annual 'Volunteering news' newsletter.

8. Alternative Employment Schemes (AES)

The organisation developed alternative employment schemes with over 60 trainee Health Care Support Worker placements identified to support the wards. In partnership with Educ8, the UHB submitted an application for further placements/funding of Jobs Growth Wales to the Welsh Government though to date funding for only an additional 10 placements has been agreed.

The Caerphilly Passport Scheme is on hold pending agreement of future funding. However, the LIFT programme has been successful rolled out and 8 week placements are being offered for individuals unemployed for 6+ months living in non working households and from deprived areas.
The Health Board has a target of delivering 125 placements by March 2017. The coordination of these placements will be dependent on the capacity within divisions to support such placements. The numbers of placements offered and completed will be completed for the next iteration of this plan.

9. Improving Workforce Productivity and Efficiency

The pressure to control workforce costs, and at the same time deliver good quality, safe and clinically effective services requires detailed integrated service, workforce and financial planning. Achieving this presents a demanding workforce change programme for this year and the foreseeable future. To meet the in-year challenges of minimising workforce costs while ensuring the workforce is engaged and motivated staff, the Health Board will continue taking a planned approach to both delivering services differently and making sure the existing workforce is deployed as efficiently as possible using the management of change principles and framework where necessary.

Good practice identifies two basic strategies that the Health Board has adopted to identify ways in which workforce costs can be reduced by maximising workforce efficiency whilst "right-sizing" the workforce (aligned with different models of care), these strategies are not mutually exclusive. Delivering the benefits of these approaches will hinge on how effectively change can be managed. Creating capacity for change, at all levels of the organisation, is central to the Health Boards' Organisational Development Programme.

The Healthcare systems' ability to provide safe, high quality, effective, and patient centred services depends on sufficient, well motivated and appropriately skilled workforce operating within service delivery models that optimise their performance. Changing service models is the preferred approach and the service models that underpin the Health Board's Clinical Futures Strategy are designed to transform local services, optimise performance and deliver a sustainable system of care.

9.1 Reducing Variable Pay and high cost agency spend

A strategy has been developed to reduce off contract agency by March 2017 through improved planning, processes and controls, interventions to sustain the use of off contract agency will need to be sustained through 2016/2017.

In parallel, while the Health Board continues to progress service change, attention will also focus on maximising workforce efficiency with the expressed intention of reducing the variable pay bill, as outlined in the table below.

Table 8.6

Area	Action	Impact	Outcome
Managing sickness and absence	Effective sickness management by equipping organisation with appropriate skills, competencies and tools: ▪ Ongoing training and support for managers ▪ Hot spot areas identified/analysed/action plans made and implemented ▪ Education/awareness for all staff on impact of absence and resources available to support staff wellbeing ▪ Improved, timely access to Occupational Health ▪ Highlight reports and Divisional Management Teams held to account for compliance with targets ▪ Sickness deep dives to understand and support improvements	**600** whole time equivalents out of system at any one time	1% reduction by 2016/17 to 5% **(WG Target 4.49%)**
Recruitment and Retention	▪ Nursing recruitment strategy developed for 2016/2017 Overseas recruitment to Europe and Philippines recruited an additional 175	Reduce off contract agency spend	Reduce off contract agency spend

Area	Action	Impact	Outcome
	pending commencement in post ▪ Slick recruitment methods have been developed to minimise the timeline for recruitment, together with developing options that can best mitigate unwanted shortages or surpluses of different health workers. ▪ Continue to explore local recruitment campaigns and ensure flexi retirement is considered as part of workforce sustainability. ▪ Medical Recruitment strategy development ongoing in line with sustainability plans and CF strategy. ▪ Therapy recruitment strategy ongoing	Provide safe staffing levels Reduce agency spend and sustainability of services	by April 2016 and beyond
E-rostering	117 wards/units have implemented Health Roster – the focus now is to realise the full potential if this system including Payroll, Absence Management and Bank. This will ensure: ▪ Accurate record of actual hours worked ▪ Auditable record of changes made to staffing ▪ Real time sickness/absence records ▪ Accurate record of temporary staff usage ▪ Available staffing across ward/floor to facilitate gaps in rota within the team In parallel, ensuring good financial controls on workforce variable costs and reducing medical and locum expenditure	↓overpayments ↓ need for bank and agency	

In summary, the Health Board has adopted a multi dimensional approach to reducing the variable pay bill. Delivery of performance against these is monitored through the Workforce IMTP group, which is chaired by the Workforce and OD director and reports are provided to the Workforce and OD Committee, which is a sub committee of the board and also through the Corporate Planning delivery frameworks.

9.2 Aligning the Workforce to Changing Service Models

In addition to the additional resources required to ensure medical workforce sustainability, through the integrated planning process each division has identified a range of service changes designed to optimise workforce utilisation in addition to workforce changes required to support service sustainability. These plans are cognisant of, and complementary to the configuration of the workforce required for Clinical Futures. They include:

- Delivering care closer to home through the development of workforce models to support the various schemes which underpin the strategy as detailed in previous section
- Reduction in resources and or changes to skill mix as a result of new technologies, such as digitisation of health records and LIMS within pathology services and e-requesting.
- Modernisation and alignment of the workforce through ongoing assessment of service demands and needs.
- A range of plans to increase workforce skills to meet changing needs and models of service delivery, for example dementia, information technology, leadership, prescribing, team working, and workforce planning skills.

In some areas the organisation appreciates that there will need to be investment in services.

Table 8.7 outlines additional workforce investment schemes that have been identified as part of our three year plans a number of which are linked with external funding:

Table 8.7

Workforce Investments	WTE changes contracted WTE
Additional Clinical Services	34.51
Additional Professional Technical	4.3
Administration and Clerical	22.5
AHP	3.5
Estates and ancillary	2
Health Care Scientists	5
Medical and Dental	28.07
Nursing	54.91
Grand Total	**154.79**

Workforce investment opportunities identified within the plan include:

- Development of 24 hour district nursing
- Development of Community Phlebotomy service
- Additional Clinical Fellows to meet deanery rota compliance
- Development of a Primary Care Resource Team
- Development of the Elderly Frail Unit and right sizing the Medical Assessment Unit
- Additional non medical roles to support service sustainability
- Development of CAMHS services
- Core workforce to meet RTT and reduce reliance on variable pay

9.3 Consultant Contract – Job Planning

Effective job planning underpins the majority of the amendments to the regulation of the Consultant Contract in Wales. The current contract ensures individual consultants and their employer agree on the content, scheduling and outcome of activities based on patient and services need and forms the contractual commitment. Job planning reviews are required on an annual basis to ensure contractual compliance. Effective job planning is a key mechanism to support delivery of the Health Board's objectives.

Annual Job plan reviews provide an opportunity to focus on current service delivery expectations. The job plan should include planned progression towards the clinical futures model of service delivery.

Although effective job planning can deliver some efficiency leading to cost savings, the main benefits are in optimising the contribution of the non training Medical & Dental Workforce, by active engagement in leading the modernisation agenda for NHS Wales particularly the service changes required to meet the clinical futures model.

The benefits of effective job planning ensure active engagement of a key component of the workforce and enables workforce financial costs to be clearly identified. Table 8.8 shows the progress made in 2015/16 and the key actions during 2016/2017.

Table 8.8

Progress made 2015/16	Key actions 2016/17
100% of Consultants and SAS doctors have Job Plans	Increase focus on SAS Doctor job planning.
	Improve compliance with targeted support for areas of poor annual review compliance.
Health Board guidance to support the allocation of SPAs has been developed and approved.	Maintain the work programme, agreed by the Job Planning and Revalidation Group to deliver on the job planning agenda.
	Review TOR for Job planning and revalidation group to realign to strategic objectives.
64% of Job plans have been reviewed within the 15 month period.	Continue to provide proactive support to directorates in targeted job planning training sessions.
Two cohorts have completed the enhanced clinical leadership programme and the third has commenced.	Establish a Job Planning peer support Group.
	Review, develop and continue to rollout internal training.
Internal job planning training sessions have been delivered.	Explore the appropriateness of available E-Job planning packages to ABUHB.
	Continue contribution to All Wales E-Learning package
Bespoke training sessions have been delivered within unscheduled care to support required change in service delivery.	Contribute to further development of ESR data capture and reporting.
	Support the development of divisional outcomes for DCC activity.

The plans associated with the above will be monitored by the Job Planning and Revalidation Steering Group and reported to the Workforce and OD Committee.

9.4 Contracting Specialist Expertise

Contracting of specialist expertise is a feature of delivering our services in areas where is has proved difficult to recruit. Examples of this are ophthalmology, information technology and radiology reporting.
The UHB will continue to work with its independent contractors to provide seamless services for its population.

9.5 Reducing Workforce Costs

There are other opportunities to reduce workforce costs including the use of salary sacrifice including purchase of annual leave, cycle to work, child care vouchers. In 2014 the organisation introduced the car lease scheme and in the autumn of 2015 year it introduced the Computer/IT scheme. The number of staff taking up the opportunity to participate has been in excess of 1100 staff and with cost savings generated of £535K, improving on previous year's uptake and performance. The benefits not only assist with cost reductions but are mutually beneficial to staff too and improve.

Ensuring alignment and maximising the use of both National terms and conditions for Agenda for Change staff and reviewing medical payments and allowances to ensure these are in line with national terms and conditions remains a key priority with the UHB.

9.6 Projected Workforce Cost savings (in development)

Table 8.9 shows the anticipated financial impacts on workforce savings. Further work is required to determine the savings associated with a number of schemes where additional workforce capacity

will negate the requirements of variable pay. Workforce savings identified and aligned to the financial plan include:

- The Health Board has made a decision to eradicate off-contract agency usage with effect from 31 March 2016. Expenditure on off-contract agency usage is circa £800k per month. Plans and guidance have developed to ensure that the Health Board maintains its public duty to continuously provide a safe service. The short term strategy to deliver this objective is to increase bank usage and cover any shortfall through on-contact agency usage, the medium to long term strategy is to recruit to nursing vacancies through active local recruitment strategies and overseas recruitment campaign
- Local and Corporate plans to maximise attendance in work are in the process of being refreshed with a strong focus on performance management of the escalation stages within the policy.
- Efficient E-Rostering is an enabling strategy to ensure that the workforce are rostered efficiently to avoid any unnecessary variable pay. Plans are being developed to look at all options to ensure that efficient rostering maintains a key priority for the Health Board and that the efficiencies are delivered.
- Improved productivity and efficiencies through demand and capacity modelling will reduce the costs associated with WLI and premium payments
- Delivering significant savings against high cost nursing agency through the appointment of overseas nursing, local recruitment drives and improved controls and processes.
- Existing and new Salary Sacrifice schemes continue to give year on year improved workforce savings (£750K)
- Reducing the reliance on administration variable pay through service reconfiguration within the Referral and Booking function and ongoing roll out of Digitisation of Health Records.

Table 8.9

Scheme (savings identified)	**£**
Reductions in Variable Pay, reduction in high cost agency and ongoing workforce modernisation	£7.8m
Salary Sacrifice Schemes	£0.7m
Local Service/Workforce Plans	£2.5m

9.7 Opportunities for further workforce efficiencies

The Health Board is exploring the potential impact of the following:

- **Maximise the use of Benchmarking** and available benchmarking tools such as skill mix analyser, I view, BI tool and embedding these as of the process to support workforce planning.
- **Voluntary Early Release**.
- ***Associated impacts of service reconfiguration*** on other services, for example reconfiguration of beds may offer further opportunities for workforce savings within non clinical support services which are currently aligned to providing services to the inpatient wards, such as Facilities.
- Integrated service and workforce planning of patient pathways and ***aligning staff to patient pathways*** where applicable, this approach has already commenced within Stroke services and identified opportunities of improved workforce efficiencies and alignment of resources.
- Maximising the use of ***information technology*** and deliver efficiencies through improved ways of working and networking throughout the organisation.
- ***Office Strategy*** project which scopes administration resources and how these could work more efficiently through the maximising of technologies and potentially centrally locating resources, thus reducing duplication and introducing more effective ways of working.
- ***Annualised contracts*** where there are possible to meet seasonal variations in demand.
- ***Management of incremental progression*** *linked with PADR.*

10. Educational Commissioning

The organisational future workforce requirements are supported through the annual educational commissioning process and are documented in the attached appendices (to follow). The figures for graduate commissioning numbers are calculated through an assessment of future demand and current supply of workforce based on age profiles and turnover of staff within the relevant professions. The organisation also engages with the primary care sector and also Nursing Homes and Community Providers to ensure that the commissioning figures meet the needs of ABUHB and the local economy.

The educational commissioning figures in Template C23 "Educational Commissioning are a response to the changing service needs:

- Emergency Nurse Practitioners in emergency departments providing 24/7 cover
- Physician associates in anaesthetics
- Physician associates in acute medicine and primary care
- Advanced Nurse Practitioner roles in neonates, gynaecology and paediatrics and other specialties for medical sustainability
- Extended scope of practice for therapy services diagnostics
- Increase in therapists with independent prescribing
- Surgical Care practitioners providing assistant with theatre medical cover
- Health Care support worker development and programmes required to develop assistant practitioner workforce (band 4)
- Increase in Mental Health nursing graduate numbers to meet the ageing workforce profile
- Nursing educational figures reflect turnover, age and the Safe Staffing Bill
- New educational requirements to meet changing service models.
- In order to fill the current vacancies in Pharmacy and to ensure that the service can meet the anticipated increase in workforce required to meet the service developments listed in the document and the Clinical futures model, ABUHB aims to increase its trainee numbers. This includes both Pre-registration trainee pharmacists and Diploma band 6 pharmacists.
- In line with Clinical futures and workforce planning to inform the SCCC, the ongoing increasing demand for radiology services, will require an adequate number of radiographer's graduates and extended skills within the existing workforce and this reflected in the commissioning figures.

The educational graduate commissioning figures and those to support extended practice and master's level of training requirements have been by the Nurse and Therapy Director and have been aligned to service changes predicted for the medium and longer term.

11. Strategic Workforce Priorities

A summary of strategic workforce priorities is provided below and will be updated to reflect the plan priorites in . The workforce plan will be updated as the Health Board's plans are strengthened to delivery safe, sustainable services within available resources once there is a clear understanding of any residual financial gap. Delivery of the key workforce priorites will be reported via updates received against the delivery framework. Additional Workforce governance frameworks include:

- Workforce and OD Committtee
- Clinical Futures Programme Board
- Clinical Futures Workforce and OD group
- IMTP Workforce group
- Relevant service change plans
- Nursing Principles group
- Therapy Modernisation group

Table 8.10 - Strategic Workforce Priorities(in development)

What	How	Why
Maximising resources	▪ Implement Recruitment Strategy ▪ E-rostering and roll out of enhanced functionality ▪ Job planning ▪ PADR ▪ Management of sickness through health and well being strategies and implementation of policies ▪ Benchmarking ▪ Succession planning – develop systems to identify and grow talent within the organisation.	▪ Reduce/eliminate vacancies (right number of staff to optimise outcomes and experience). Reduction in variable pay and no off contract agency ▪ Matching resource to patient need/acuity ▪ 65% with job plan within a 15 month period ▪ Align organisational and personal goals (85% of staff) ▪ Cost of system is unsustainable ▪ Continuity and quality of care for patient, motivated, content and well workforce ½% year on year reduction in sickness rates ▪ To identify opportunities to do better
Changing service models	▪ 7 days services ▪ Reconfiguration of beds – skills, redeployments ▪ Graduated Care Model and skills to manage complex needs ▪ Local delivery plans e.g. stroke ▪ Digitisation of Health Records ▪ Outpatient transformation ▪ Technology – e health, virtual health ▪ Primary Care new models and Care Closer to home strategy ▪ Living well Living Longer an integrated approach with local authority.	▪ To meet patient needs, where possible in their homes, reduce hospital attendances and where an admission is required – minimise the length of time spent in hospital settings ▪ Realise the benefits of new ways of working on staff number and skill mix, where relevant the transfer/re-deployment of health workers across the system. ▪ Integrated workforce planning centred on patient needs. ▪
New and Extended Roles	▪ Advanced Practitioner Framework and new roles (e.g. physicians associate, practice based pharmacists, Rehabilitation HCSW, Band 4 workers in community) ▪ Integrated working with primary care to develop and enhance skills. ▪ Multi-disciplinary/multi-agency working ▪ Regionalisation of Pathology Services ▪ Development of skills to manage complex cases in the community ▪ New workforce models to support emergency medicine.	▪ To support recruitment difficulties with primary and secondary care medical roles and improve recruitment and retention of skilled AHPs and nurses ▪ To deliver a prudent workforce, ensuring that health workers “do only what they can do”, in terms of skills and expertise ▪ To create capacity to meet the healthcare needs of most citizens, in a timely fashion, close to home, including: □ Pharmacists in general practice □ Integrated, community led, Diabetes Nurse Specialists □ Integration of community resources (CRTs, District Nurses, Therapies) into Network Teams focused on our 12 NCN communities □ RAID – multidisciplinary team
Organisational Development	▪ In partnership with staff to ensure the Organisational Development Strategy is fit for purpose ▪ Prioritise areas for action	• To create the capacity to become a primary care led NHS, with services predominantly delivered through NCNs, supported by a network of local hospitals and a single SCCC.

What	How	Why
	aligned to service priorities ▪ Improve workforce planning knowledge within the organisation and use of benchmarking tools	
Delivering Clinical Futures	▪ In partnership with staff to finalise a workforce strategy to deliver the clinical futures aligned with the emergent service models for: more care delivered through local Neighbourhood Care Networks; network of local hospital services delivering routine care; and the SCCC where specialist and critical care services are consolidated in a single centre	▪ Traditional workforce numbers, skill mix and deployment reflect a system dominated by hospital based care ▪ Implementation of Clinical Futures will need a workforce with enhanced skills to provide more care in the community, deliver robust assessment, diagnostic and treatment services over 7 days and for some services over 24 hours. ▪ A balanced specialist/generic workforce where scope of practice is optimised across a range of professional groups is required to ensure a sustainable healthcare system for Gwent

Chapter 9 – Finance

1. Setting the Context

1.1 Introduction

The key objective of the Board is to improve the Health of the population, prevent ill health and to provide safe and clinically effective integrated health care **within available resources**. This is based on a strategy of both commissioning and providing a range of services to meet the populations needs that are underpinned by the principles of prudent healthcare, and are both sustainable and cost effective in line with the key priority of treating people closer to home through strengthened primary care and community services.

It is recognised that substantial service change is required over the medium term to meet these organisational objectives and priorities in the context of a changing population demographic, and increasing demand and workforce pressures which need to be managed within the resources available to the organisation.

It is also acknowledged that this is within a context whereby the UHB's underlying financial position in key areas has deteriorated within 2015/16, and progress in delivering improvement in its financial position in overall terms has been on a non-recurrent basis. The UHB therefore has a challenge to address in terms of the recurrent financial sustainability of its plans.

The Welsh Government's draft budget for 2016/17 prioritises and allocates an additional £260m of resources to Health, of which £30m is an increase to the NHS Wales Intermediate Care Fund, and £30m to support older people and mental health services. £200m is therefore anticipated to be allocated to Health Boards on a 'fair shares' funding basis.

This chapter considers both the national and local context for the UHB's financial outlook over the next three years, and describes the modelled changes to the UHB's cost base and development of the UHB's service and workforce plans in order to meet its statutory financial obligations during this period.

1.2 Long-Term Strategic Financial Outlook

It is widely recognised that the changing economic climate associated with austerity has had a significant impact on the portfolio of Public Sector funding, and subsequently the allocation of Healthcare funding within the United Kingdom over the last 5 years. This coincides with an evidence base that there is a growing elderly population with increasing healthcare needs, medical and technological advances, changing public expectation, all resulting in a significant increase in the demand on services. This combination of factors results in a highly variable environment within which to project the prospective long-term income and expenditure outlook for the NHS in Wales.

In recognition of this, Welsh Government commissioned a Nuffield Trust report which was published in June 2014 which outlines a 10 year financial outlook for the NHS in Wales. The review indicates a potential shortfall of between £1.2bn and £3.6bn for the NHS in Wales by 2025/26 based on a series of assumptions. The report identifies that whilst funding is falling for the Welsh NHS, the demand pressures for NHS services continue to rise. *"The NHS in Wales is now required to meet a growing demand for services with less money, while sustaining high-quality care. These pressures largely arise from a growing and ageing population. But there has also been a rising trend in the proportion of people living with long-term chronic conditions, which places an additional burden on the NHS, above that due to the changing population alone. Alongside the rising pressures due to additional population demands, over the history of the NHS the unit costs of delivering services have also risen in real terms, not least due to wage pressures, with staff pay accounting for over half of all NHS spending."*

In October 2015, the UHB submitted to Welsh Government its Programme Business Case for its Clinical Futures Strategy and Full Business Case for the development of its Specialist Critical Care Centre (SCCC). As part of this process the UHB undertook an assessment of its 10 year Income & Expenditure outlook as an organisation. In undertaking this assessment, the UHB was reliant on the Nuffield report as the major evidence base in this area. The assessment for the Nuffield report was undertaken on a national basis, and there is further work required by the UHB prospectively to undertake a similar detailed assessment on UHB specific basis which is being developed.

This summarised national position was considered in two ways to inform an UHB perspective:

- Applying ABUHB's fair share allocation basis to the national indications to identify an indicative shortfall.
- Applying indicative values for GDP Deflation and the National Spend Index, to the UHB allocation.

This high-level assessment based on the Nuffield Trust's analysis indicates that the UHB's shortfall by 2025/26 in real terms will be between **£310m** (on a fair shares basis) and **£350m** (on applying national values to the ABUHB allocation).

Applying the principles of the Nuffield Trust assessment to the UHB's 10 year financial outlook and underlying 2015/16 IMTP outlined a challenge over the ten year period of **£194m.**

It is acknowledged that as part of the 2016/17 budget Welsh Government recognises this outlook and has increased the allocation available to the NHS in Wales by £260m. It is also assumed that fair shares of funding made available in 2017/18 and 2018/19 in relation to the Nuffield assessment will support the UHB in bridging this gap.

It is assumed within the wider economic context and Barnett consequential position of NHS England that over a medium-term basis this is a front-loaded settlement and the UHB needs to maximise this opportunity to achieve a sustainable financial position and prioritise the strategic shift in resources which would support recurrent sustainability.

Therefore in summary the UHB's long-term projections indicate a significant financial shortfall based on the national evidence available and which needs to be addressed in line with the available evidence base. Whilst funding is anticipated in recognition of this gap, from a UHB perspective this shortfall can only be addressed by continuing the development of a medium term value based agenda maximising utilisation of resources and supporting strategic shifts in resources enabling future sustainability. Focus is therefore required in the short-term on improving operational efficiency and effectiveness, and cost containment, to improve the sustainability of the UHB's underlying position.

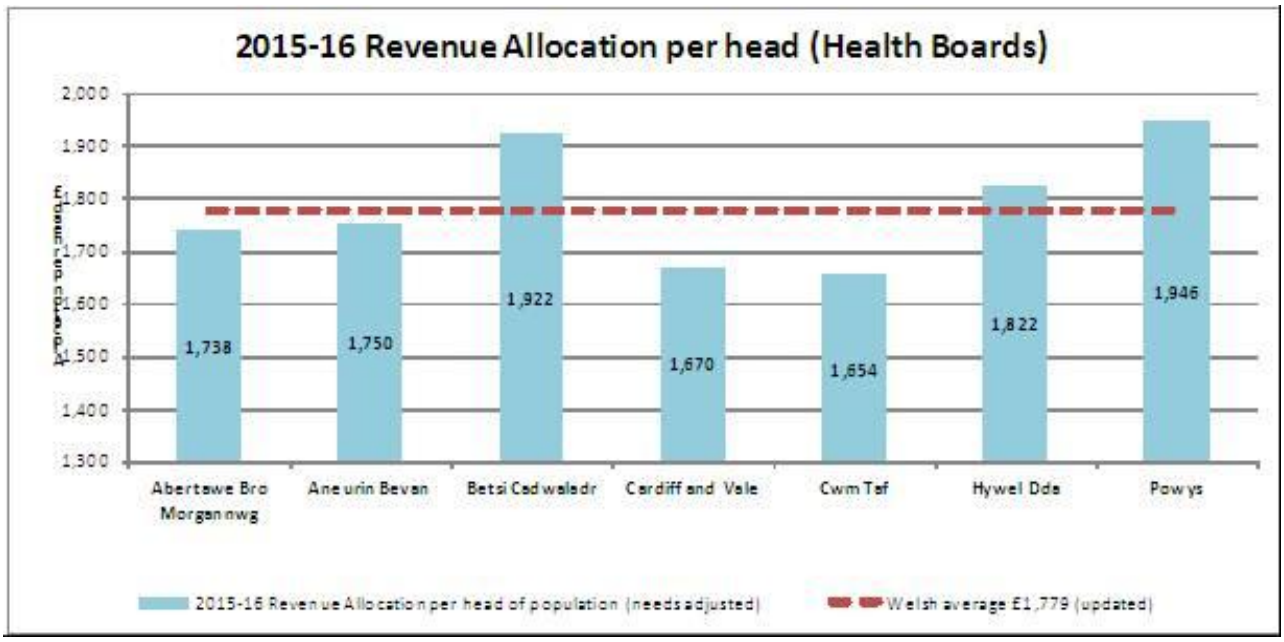
1.3 Local Health Board Context

1.3.1 Population Funding

From an ABUHB perspective, the population of Gwent represents one fifth of the total Welsh population and is recognised as a diverse and ageing population with poor health associated with multiple deprivation and high and increasing levels of chronic conditions, all consistent with the findings of the Nuffield report.

When health needs are taken into account, the UHB has a lower level of funding per head of population than the Welsh average. Furthermore, South Wales Health Boards together have a materially lower level of funding per head of population than North Wales. The Townsend formula uses "direct" health needs data as its basis of distribution with no significant adjustment for age, which mainly favours South Wales Health Boards with the health needs associated with their industrial heritage. Historically, the distribution of funding has materially disadvantaged the UHB as funding for the service has been distributed using more ad-hoc measures.

Table 9.1



This historic position therefore provides a greater challenge to the organisation in attempting to address the needs of the population with less than its fair share of funding. Using the needs based formula ABUHB would receive in the region of £15m additional funding to be in line with the average revenue allocation per head.

However, positively for the UHB the increasing use of a fair shares approach to the allocation of new funding by Welsh Government is beginning to address this historic shortfall, and a continuation of a fair shares approach to future growth will ensure that the UHB's funding level equates to a fair share of the total NHS Wales allocation.

One of the key messages from this analysis is that the baseline starting position for the UHB is not a strong one with funding already below both needs and the Welsh average. This however is beginning to be addressed with the allocation of growth funding on a fair shares basis, the continuation of which will ensure the UHB has a fair share of total NHS Wales funding in time. A medium term approach to maximise the value and use of resources which are allocated on a fair shares basis, within an integrated service, workforce, and financial planning approach is key to future sustainability.

1.3.2 Developing Financial Strategy

In response to the 10 year outlook, the UHB is developing its Financial Strategy for the longer term to develop the tools, approaches, and intelligence required to meet this long-term financial challenge described above. This is a development programme with an aspiration to position and allow the UHB to deliver on this challenging agenda over the longer-term, and continue its excellent delivery record of sustaining financial balance. Whilst this work will not fully inform this plan, it represents the framework within the UHB is developing its work to inform future financial planning.

Strategic Purpose

The UHB has a number of strategic aspirations which inform the financial strategy and framework within which plans are developed, which include:

- Achieving 'Best in Class' with no limits to ambition.
- Creating a Centre of Excellence for Financial Management, Strategy & Research, with a strong evidence base informing our plans.
- Work collaboratively with other health organisations, sectors, and nations.

- Have a clear focus on improving Value and achieving Value Based Healthcare.
- Maximise the opportunities of working within a planned, integrated, system.
- Continue to maximise the potential in the Prudent Healthcare agenda.
- Measure and track benefits of planned changes in a clear business planning process.
- Ensure the resource utilisation agenda enables organisational priorities such as improving quality, and facilitates change in line with the UHB's strategic aims.
- Enable professional development through up-skilling the workforce and increasing capability in modern and innovative techniques.
- Meet the needs of the UHB and Wales, being unique and bespoke to the Welsh framework and agenda.

Whilst an ambitious strategy, the developing work programme outlines how this will be achieved through developing an increased focus on resource utilisation and positioning, and a structured framework to support the development of value through considering both the macro and micro resource agenda.

Strategic Positioning
Maximising the use of resources available to the UHB requires a clear understanding of the appropriateness of those resources to meet the demands on services; ensuring resources are deployed to meet the needs of the population, and a clear understanding of available evidence in how resources are deployed to inform opportunities for improvement.

In particular, it is imperative for the UHB within the context outlined above that this development is an iterative assessment whereby modelling assumptions are consistently revised and improved as the evidence base becomes more mature and this can be compared to actual reality.

From a Strategic Positioning perspective, the UHB is embarking on its continued development of:

- A clear view of the prospective resource outlook, aligned with the UHB's population and demographic projections, assessing the likely ongoing resource requirement in comparison to resource available.

- A clear view of all available evidence bases to inform the UHB's ongoing strategy and plans, to include (but not limited to) the work of the Nuffield Trust, the Carter Review, the Commonwealth Report, Townsend allocation and all other relevant evidence bases.

- Utilise relevant tools to align the UHB's resource utilisation to the needs of the population, aligning resource information to public health information to assess the relative allocation of resources. Having established a clear view of utilisation, the UHB will use available tools such as STAR (Health Foundation) to explore incremental change in resource availability and the impact on population health to inform prospective choices.

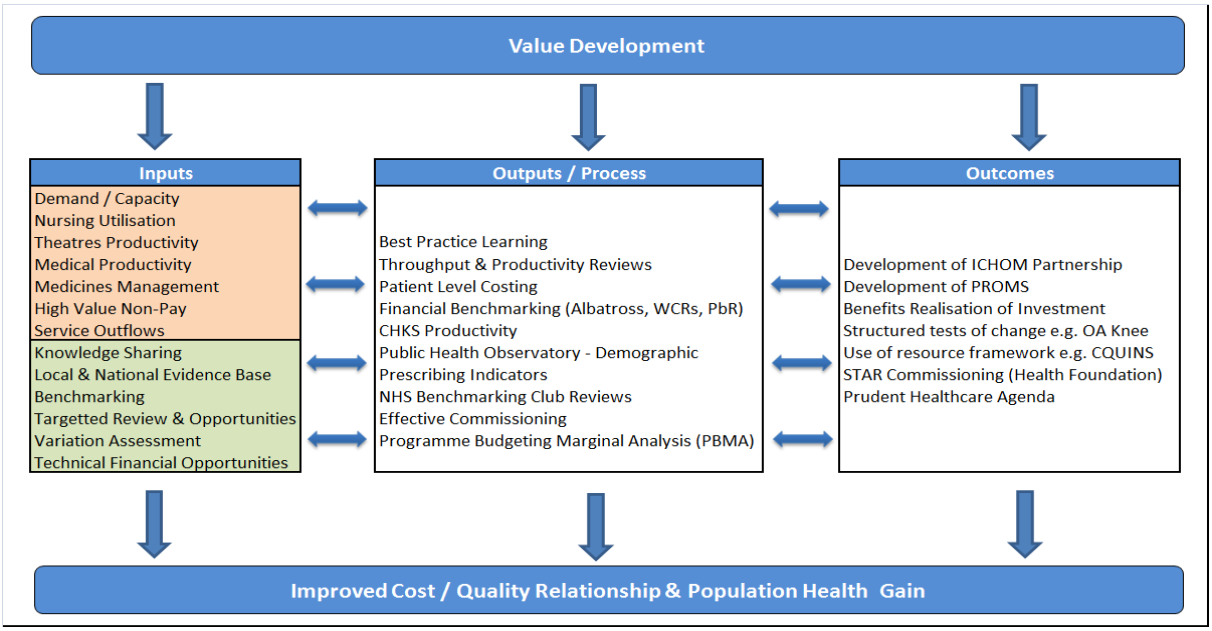
- Ensuring a clear view of the appropriateness of the resource allocation available to the UHB relative to the demands on its services from the population it serves, and informing the development of a system which would recognise the UHB's fair share of available funding.

Strategic Delivery
Irrespective of the level of resources available to the UHB, the equity of its allocation and how this meets the needs of its residents, the UHB has a statutory duty to manage its services within available resources which it needs to deliver. The UHB is continuing to develop its approach to Value Based Healthcare, and looking to ensure it delivers maximum Value to its residents through improving outcomes and ensuring a continual improvement in its cost/quality relationship. This includes ensuring that the organisations resource allocation framework supports and incentivises the delivery of best Value.

As such, in order to progress the Value agenda the UHB is developing its strategic approach to maximising its delivery of value through its component parts from an input, output / process, and

outcomes perspective. This is looking to be developed through a structured framework which is looking to capture and progress all opportunities to improve the cost / quality / outcome relationship in order to ensure an improvement in value. The key work streams are outlined below:

Figure 9.1



It is recognised that the maturity of each component of Value and the information supporting each of these is at a variable stage of development on a local level, which is consistent with the picture both nationally and internationally. This naturally informs the UHB's approach with more information readily available at input and output level, with significant work in progress in developing our outcome data.

From an **input** perspective, the UHB will be developing its approach at both a macro level of key areas that consume a significant amount of resource (e.g. bed capacity, medical staff, theatres etc), and at a more granular micro level. For the former, the UHB will be developing a clear strategy financially for the management of the small number of areas which consume a significant level of resource with a focus on developing an improvement in Value. For the latter, the opportunities for improvement can be identified in a number of ways for example through learning from other Health Boards and Foundation Trust plans, reviewing local evidence bases such as audit reports, ABCi reviews, national evidence bases such as NICE, opportunities presenting through the Prudent agenda, or a range of variation assessments in our current practice as a Health Board. The focus of the UHB will be at both a macro, and micro level, ensuring that opportunities for cost improvement in an informed evidence based manner are identified and pursued on a UHB wide basis.

From an **output** perspective, the UHB will be continuing its review of all available information that supports its outputs both financially and non-financially in order to inform the opportunity for improvement. This will enable the Board to identify all opportunities for further productivity and efficiency in order to support its objectives prospectively from both a cost reduction and cost avoidance perspective.

From an **outcomes** perspective, the UHB has developed an ambitious programme to develop its outcome data and develop its Value based approach. This includes the development of a strategic partnership with ICHOM with a structured work-plan with standard data-sets beginning with Parkinson's services with further developments in Cataracts, Hip & Knee pathway, Low Back Pain, and Stroke over the IMTP period. The UHB is also developing its use of PROMS, and leading on both local and national pathway work associated with Ophthalmology and Orthopaedics services. In addition, the UHB will be developing its approach to support benefits realisation to ensure that

any new investment supporting local and national priorities support an improvement in Value and achieve the intended objectives. Likewise, in developing its resource allocation framework, the UHB will be considering approaches to incentivise delivery and optimising Value through its resource allocation process including exploring developments such as CQUINS, STAR Commissioning (Health Foundation), and align to local development plans such as Living Well, Living Longer.

The work programme outlined above represents a direction of travel and continuous programme of work that structures how the UHB will be addressing the challenges it faces in both this three year outlook and over a wider ten year period.

1.3.3 Financial Delivery & Baseline Financial Challenge

In 2015/16, the UHB had its 3-year IMTP approved, which was approved with an associated financial shortfall of £19.7m in year one, with actions being set in place in 2015/16 to ensure that this financial shortfall is addressed on a sustainable basis. In doing so, the UHB acknowledged its accountability to achieve a balanced service, workforce and financial plan and to continue to develop plans to address this identified shortfall. This is concurrent with a commitment from Welsh Government to recognise previous funding shortfalls to the Board and to deliver a funding settlement this year based on a minimum of "fair shares" funding and a further opportunity to discuss financial support for identified priorities within the plan.

Within this financial year, the UHB has been tracking to a forecast position in excess of £19.7m in its position. This has been reducing in recent months and the UHB is now forecasting a break-even position for the year-end. This however is due to non-recurrent funding from Welsh Government and non-recurrent opportunities available to the UHB. The underlying deficit of the UHB needs to be addressed as a priority in order to achieve a sustainable financial basis going forward. Key to this is addressing the unsustainable service and workforce models which are driving the UHB's cost base, and taking the necessary actions to bend the cost curve prospectively.

Key issues driving the UHB's underlying position are:

- Nursing and Medical workforce costs, with workforce pressures in-year being greater than planned. The UHB has been an outlier in its use of off-contract agency in 2015/16, and actions are being taken to address this both locally and regionally from the 1st of April, and this is a key issue to resolve from a financial sustainability perspective.

- Demand and Capacity pressures across the Unscheduled Care system are driving workforce costs as above and capacity solutions which are not financial sustainable and require greater focus on a holistic demand / capacity plan across the UHB.

- CHC growth, in both community and Mental Health services have been a key pressure area for the Board with the UHB an outlier to the rest of Wales in terms of its CHC position from a 2015/16 plan perspective. Positively, in-year actions have begun to bring the UHB in line with peers from a community CHC perspective and this position needs to be sustained prospectively and address the same challenge within Mental Health and Learning Disability services.

- Further cost increases in medicines from both a primary and secondary care perspective present a sustained financial challenge to the UHB to manage.

- Higher elective care requirements to support Tier 1 delivery are driving increased costs both internally to the UHB and its outsourcing requirements to achieve the required level of performance delivery

- Additional costs of Specialised Services and the new Emergency Ambulance Services Committee (EASC) are reflected in the UHB's position and have materially contributed to the underlying position. As a recurrent growth area the UHB needs to continue its management of this position prospectively.

In summary, the UHB has an underlying financial position which is unsustainable and has deteriorated in-year on a recurrent basis. The UHB's plans therefore are focussing on developing and ensuring a more sustainable financial footing through maximising productivity, efficiency, cash releasing savings, and cost control to bend the cost curve. It is expected that similar to the principles of the outlook for NHS England, increased funding confirmed for 2016/17 and planned for the next two years represent a front-loaded settlement, with an increasing expectation of what is managed from within these resources. It is critical therefore that the UHB delivers the required actions to ensure a more sustainable financial footing which this plan seeks to address.

1.3.4 Clinical Futures Strategy

In October 2015 the UHB submitted its Programme Business Case for its Clinical Futures Strategy and Full Business Case for the development of the Specialist Critical Care Centre (SCCC). As outlined in that case the development is crucial to securing the future sustainability of services in Aneurin Bevan and is a key component of the UHB's strategy in managing demand growth and cost mitigation prospectively. The key assumptions within the business case are reflected within these plans, as are the wider principles of the Clinical Futures Strategy in developing and managing services closer to home and through the development of its Neighbourhood Care Networks (NCNs).

2. Financial Outlook 2016/17 – 2018/19

The UHB has undertaken an assessment of its three year financial outlook based on the underlying position described above, and modelled the future cost outlook of known pressures and increases in service costs which have emerged from the planning process alongside an assessment of funding available.

This section clearly outlines the UHB's assumptions in terms of anticipated funding levels, current service plans, and known or potential cost increases.

2.1 Funding Assumptions

An assessment has been made of the anticipated Revenue Allocation from Welsh Government alongside other anticipated income across the next three years. The UHB has based its starting assumption from the Allocation Letter for the recurrent baseline of 2016/17 and developed a set of planning assumptions for further funding increases across the three year period based on the known central funding, experience from previous years, and principles shared and agreed by All Wales Directors of Finance in discussion with Welsh Government in February 2016.

The Welsh Government Allocation letter for 2016/17 confirms that £200m revenue funding, equal to 3.2% growth on Health Budgets, to meet on going demand and other increases as set out in the 2014 Nuffield Trust report. The funding, however, is not built into the allocation document but confirms that UHBs can plan on receiving a share largely based on its population shares.

The allocation letter also confirms that the £70m investment in 2015/16 allocated for Primary Care, National Delivery Plans, Intermediate Care Fund and Efficiency through Technology has not been included but will continue to be allocated in year, until 2015/16 projects have been reviewed and recurrent plans are agreed. Currently therefore the UHB is making its best assessment of anticipated allocations to support known agreed plans, and expects this to be updated as recurrent plans are confirmed including those being progressed on a regional and all-Wales basis. The UHB is expecting through this process to receive its fair shares of the recurrent resources allocated for recurrent 2015/16 plans.

The UHB is making the following key assumptions in relation to funding:

- The UHB will receive fair shares of £200m additional funding available to Health which equates to approximately £38.2m.

- In line with all Wales Directors of Finance principles the UHB is assuming fair shares of funding of £160m in 2017/18 and £170m in 2018/19 respectively.

- As per principles shared with Directors of Finance, the UHB is assuming that the following pressures are funded from its fair shares of the £200m made available in 2016/17 (and on a recurrent basis):

    - National pay pressures equating to 1% wage award, the impact of living wage moving to £8.25 per hour, and the loss of NI rebate on NHS Pensions.
    - Hepatitis C and Eculizumab.
    - Non Pay Inflation.
    - 1% uplift on Long Term Agreements with other NHS providers as agreed by All Wales Directors of Finance.
    - Primary Care Contractors estimated uplift for GMS Services (equivalent to 0.98% per annum) and General Dental services (equivalent to 1.44% per annum).
    - Apprenticeship Levy to employers from 2017/18 onwards.
    - This assessment excludes any impact of a Direct Enhanced Service for Warfarin which remains under development.

- The UHB is assuming additional allocations in line with Capital plans and full funding of capital charges.

- In line with allocation guidance, the UHB is assuming it will receive its fair shares of funding associated with 2015/16 plans including primary care, National Delivery Plans, Intermediate Care Fund, and Efficiency Through Technology Fund (ETTF). Allocations are anticipated for known and confirmed schemes but not for those schemes which are yet to be confirmed. The UHB assumes that the confirmed position will reflect a fair shares distribution to the UHB. It is assumed that this funding will be received in 2016/17 on a recurrent basis.

- It is assumed that there is no payback liability or impact of any under-spend associated with National Delivery Plans in 2015/16.

- Welsh Government will continue to hold the budget for the difference between the cost of prescribing and the cost of dispensing and that any risk associated with this will be borne centrally.

- The UHB is assuming Phase 3 retrospective CHC claims and any associated provision required in 2016/17 will be matched by WG AME funding, and that this will be reflected when this position is confirmed.

- The UHB is assuming that any decision to allocate centrally held funding for hospital prescriptions dispensed in the community (WP10 (HP)) will be cost neutral to the UHB.

- The UHB is assuming the continuation of specific funding streams which are historically treated as in-year allocations as listed within the anticipated allocations schedule.

- The UHB recognises that a further £60m has been allocated on a national level to support an increase in the Intermediate Care Fund (£30m) and older people and mental health services (£30m). Whilst the process supporting accessing this funding is yet to be confirmed the UHB is not assuming its fair shares of this funding. However, the UHB's plan assumes that accessing this funding to support delivery of its plans will enable delivery of its actions to mitigate costs as outlined later in this chapter.

The anticipated allocation over the next three years therefore is as follows:

Table 9.2

Allocation Assumptions	2016/17 £m	2017/18 £m	2018/19 £m
Health Board Allocations	1,044.68	1,085.42	1,116.66
16/17 Anticipated Health Board Allocations	3.28	3.28	3.28
Pay and Pensions Funding	11.51	6.83	6.90
Additional General Growth Funding (Popn Shares)	26.69	24.33	26.21
Sub- Total Allocation Increase	**1,086.16**	**1,119.86**	**1,153.05**
Anticipated In Year Funding			
Revenue	13.09	9.50	9.77
Sub-Total	**13.09**	**9.50**	**9.77**
TOTAL WG Allocation	**1,099.25**	**1,129.36**	**1,162.82**

The UHB also receives an additional £62m income though a range of other sources, primarily from other UHBs for patients flows, education and training and Local Authorities, which supports the UHB's total funding envelope as follows:

Table 9.3

Total Income	2016/17 £m	2017/18 £m	2018/19 £m
Income (estimated)	74.3	74.3	74.3
WG Allocation	1,099.2	1,129.4	1,162.8
Total Funding	**1,173.6**	**1,203.7**	**1,237.1**

While no assumptions are made at this stage of the plan on any material changes to these income levels, the UHB needs to identify all opportunities to generate additional income outside of its allocation. In particular University status is expected to generate further academic related income in terms of receiving a fairer share of Welsh Government SIFT and Research and Development over the medium term and should be considered as the plan is further developed.

2.2 Underlying Deficit Position

Within this financial year, the UHB has been tracking to a forecast position in excess of £19.7m in its position. This has been reducing in recent months and the UHB is now forecasting a break-even position for the year-end. This however is due to non-recurrent funding from Welsh Government and non-recurrent opportunities available to the UHB.

The assessment of the UHB's underlying position for 2016/17 as modelled as part of this planning process is a deficit of **£26m**. This represents an increase of **£6.3m** above the outlined IMTP position of **£19.7m**.

This increase in the underlying position is due to:

- Full-year effect of service sustainability issues of continuing to run services in the way they are currently configured including those with sustainability challenges at a junior doctor level in particular.

- Reinstating the effects of non-recurrent opportunities and savings realised in-year supporting the 2015/16 position.
- Full-year effect of expenditure increases in 2015/16 in relation to Mental Health and Children's CHC packages of care, and service priorities.
- The recurrent impact of key areas which has driven the UHB's position off-plan in-year in particular in relation to workforce pressures and challenges such as the increased use of off-contract agency nursing.

As outlined above, the UHB's underlying deficit position has deteriorated in year, and is assessed at £26m in 2016/17 for the reasons outlined above. This position is not sustainable and it is essential that the UHB takes the action required to address this and ensure a more sustainable financial footing going forward.

2.3 Assessment of Inflation & Demand Pressures

As set out in the Nuffield report, costs are expected to rise in the region of 4% per annum across the next ten years. The UHB has undertaken its own detailed assessment in conjunction with national modelling work to identify the key areas where costs are anticipated to increase across the system at both a national and local level. Costs are rising as a result of general inflation, workforce costs, increasing demographics and demand, changing clinical standards and medical advancements.

Increases to the current cost base have been assessed across the three year period, with a greater clarity on year one at this stage. This assessment identifies inflation and service demand pressures in the region of 4% each year.

The following table summarises the total cost growth for the three year period:

Table 9.4

Increased Demand and Inflation Costs (gross, ie not reduced for funding assumptions)	**2016/17 £m**	**2017/18 £m**	**2018/19 £m**
Pay (Inc Pension / NI)	12.7	10.0	7.7
Non-Pay	2.2	1.3	1.3
Prescribing	3.4	1.2	3.2
Primary Care (Contracts & Other)	7.4	1.3	2.5
NICE	6.6	5.6	5.8
CHC	6.7	7.7	7.8
WHSSC	3.4	4.2	3.2
Externally Commissioned Services	1.7	0.2	0.3
Total Net Costs	**44.1**	**31.6**	**31.7**

It is worth noting that of the cost growth outlined above, approximately £5.6m relates to items and services which are assumed to be funded by in-year allocations in year 1 (and recurrently thereafter), in particular relation to primary care contracts and other services.

2.3.1 National Pay Increases

Pay represents a significant element of the UHB budget and is a key driver of cost in future years without changes in the way the workforce is both structured and in supporting changing service models.

The UHB has assumed national pay increases in line with the All Wales modelling group assumptions, including a 1% wage award uplift in each of the financial years for Agenda for Change and Medical and Dental staff, alongside an increase in the Living Wage moving to £8.25 per hour. It has recently been announced by the Minister that this position has been confirmed. As

outlined above this is assumed to be funded from the UHB's fair shares allocation for 2016/17, and future years.

Other incremental pay costs modelled as part of this plan assessment include:

- Medical Staff costs associated with SAS Junior Doctors increments and the impact of Distinction Award increases associated with medical staff are also included as identified on an all Wales basis.
- The impact of an Apprenticeship Levy as confirmed by the UK Government Spending Review and Autumn Statement 2015 which comes into effect from 1st April 2017.
- This assessment does not include any further external drivers around specific pressures associated with medical and nursing staff costs.

2.3.2 Pension Cost Increases

In addition to national pay pressures there are also planned changes to NHS pensions which are expected to occur within the next financial year. These are:

- The cessation of contracting out arrangements seeing the end of the National Insurance rebate both for employers and employees starting in 2016/17. Currently the 14% employer's contribution is abated by 3.4%. This will cost the UHB approximately £6.9m.
- Auto enrolment of staff on to the Pension scheme whereby staff have to actively opt-out rather than opt in.

In line with national pay pressures it is assumed that the impact of these changes is managed through the UHB's fair shares of the additional £200m revenue made available across NHS Wales.

2.3.3 Non-Pay Inflation

An assessment has been made to establish the potential impact on local non-pay costs for national inflationary pressures across the three years. This assessment has been undertaken working in conjunction with the national modelling group using HCSI and procurement advice in parallel with local issues at divisional level. Inflationary cost increases are anticipated in particular in relation to medical and surgical purchases, provisions, and increases in Section 33 pooled costs.

2.3.4 Primary Care

Primary Care prescribing has been estimated utilising the most recently available PAR data and adjusted for the increase or decrease in the number of prescribing days in each year alongside an estimate of item growth.

The rate of prescription items dispensed in the community in Wales has risen by an average of 3.2% a year between 2008 and 2015. The prescribing growth forecast for the UHB for 2016/17 takes account of these national growth assumptions and the increase in the number of prescribing days during the financial year. This growth in total is assessed at £3.2m.

It is intended through the continued delegation of prescribing budgets to Neighbourhood Care Networks (NCNs), the use of incentive schemes and ongoing support of the medicines management team that in-year cost growth is managed through off-setting savings.

In addition, the UHB's plans include the full year effect and recurrent impact of the Primary Care investment in 2015/16, and an uplift for GMS and Dental Services contracts based on the historic trend.

2.3.5 NICE

The UHB commissions a range of services, both internally and externally, which include the implementation of guidance issued by NICE and recommendations from AWMSG. This includes the costs of new high cost drugs. An assessment has been made to identify the cost impact of NICE/ AWMSG and continues to be a cost pressure across the three years, due to full year impact of technologies introduced in 2015/16 as well as new appraisals being published.

The UHB's assessment includes a material provision in relation to the use of Hepatitis C drugs costs of £3m, and NICE growth with external providers of £2m of which £1.7m relates to Velindre NHS Trust. This assessment excludes Eculizumab which is reflected within the Specialised Services position.

In line with planning principles shared with All Wales DoFs it is assumed that the costs of Hepatitis C are to be funded from the UHB's fair shares funding allocation.

It is intended that the implementation of new and existing NICE/AWMSG guidance is considered as part of reviewing each relevant care pathway, to identify where and how any potential cost increases can be managed within existing resources.

2.3.6 CHC/FNC

The effective management of complex care needs is a key partnership challenge for both the NHS and local government. The predicted growth in the older people's population of 33% by 2020 and the increasing numbers of children and young people with complex needs following serious illness or injury, coupled with the current challenging resource environment faced by statutory organisations, makes the need to ensure resources are used appropriately and effectively even more essential.

At the outset of 2015/16, continuing the trend of previous years, the UHB was an outlier to the rest of Wales in its activity element of CHC growth in particular. In year significant progress has been made in stabilising the complex care position and ensuring the UHB position is more in line with that of other Health Boards. The complex care plan currently assumes 5.6% growth to reflect demographic increases plus fee increases commensurate with the anticipated effect of the introduction of the National Living Wage from April 2016.

Significantly, the UHB's current plan indicates a significant increase in the growth assessment of Mental Health and LD CHC, which is being driven by:

- Increasing low secure placements as a result of step down from medium secure units, prison referrals and existing client acuity.
- Patients transitioning from child services to adult services, primarily learning disability patients.
- Eligibility of patients.

It is essential that the UHB continues to focus on delivering the necessary change in service models that will address this unsustainable growth position. Failure to change the current pattern of service delivery will be a material financial risk to the three year plan.

2.3.7 Externally Commissioned Services

The UHB commission a broad range of services at an annual cost of approximately £190m secured through a complex portfolio of contracts and contracting arrangements with English and Welsh Providers. Around £75m relates to hospital provided care at a secondary care level and £115m to tertiary services commissioned through Welsh Health Specialised Services Committee (WHSSC). As per the principles recently agreed at all Wales Directors of Finance, the UHB's plans assume that 1% net growth will be reflected on LTA's with Welsh providers with a value of approximately £1.2m. This includes Velindre NHS Trust, where the UHB's plan assumes 1% will be the net contribution in total to Velindre also.

Specialised Services – In 2015/16 growth in specialised services and the UHB's contribution to the Emergency Ambulances Services Committee (EASC) presented a pressure to the Board of approximately £4m which is contributing towards the UHB's total underlying position as outlined above. The UHB's assumptions for 2016/17 and recurrently in relation to EASC assume that the £1.4m allocated recurrently in 2015/16 is the total funding requirement for EASC in 2016/17 excluding the 1% uplift to LTA's as described above.

The UHB's assumptions in relation to the overall WHSSC plan reflect the plan which is being submitted to Joint Committee. The UHB has a provision of £3.4m in relation to the WHSSC plan which reflects 'Black', 'Red', and unavoidable 'Amber' schemes. This assessment excludes the lowest priority 'Amber' schemes at a value of £0.929m, and also excludes 'Green' rated schemes as they have been considered very low risk as part of the IMTP Commissioning process. It is anticipated that as part of the planning process a final plan will be approved by Joint Committee which will consider affordability and outline choices to manage specialist services within a minimised resource envelope. The UHB's provision includes a provision for Eculizumab of £0.346m. The UHB's three year plan reflects the three year plan which is being put forward to Joint Committee in line with the assumptions above.

The UHB's plan assumes that there is no impact in relation to any changes to the Cross Border Protocol between NHS Wales and NHS England, based on advice from Welsh Government officials.

External Contracts
The UHB spends approximately £75m per annum with other hospital providers across England and Wales for secondary care services. In addition to the 1% net LTA growth assumption, and NICE assessments described above, the UHB has made an assessment of LTA growth in activity in line with projected demographic growth and demand risk, and specific UHB priorities such as Cardiac MRI.

A comprehensive commissioning and contracting development agenda is set out in the plan to develop value based commissioning which should provide opportunities to potentially mitigate some of the additional cost increases that have been identified.

2.3.8 Other Key Assumptions
In addition to the detail assessments outlined above, the following assumptions are worthy of note in the context of the UHB's financial plan:

- This plan excludes any impact of the development of a Direct Enhanced Service in relation to Warfarin which remains in development with the cost and benefit of this development to be finalised and confirmed.
- The UHB's recurrent position includes a £1.5m provision to support the UHB's share of the Welsh Risk Pool position over and above the baseline position of £75m on an all Wales basis. This position will be reviewed in line with the latest assessments as shared by NWSSP.

2.4 Investment in Tier 1 delivery, Service Change & Sustainability

Given population needs, increasing demand, the requirement to secure progress towards the delivery of tier 1 targets, and various service sustainability issues associated with continuing to run services in the way they are currently configured, it is inevitable that local cost pressures and investment choices emerge, which will require careful consideration by the UHB in the context of the overall plan.

Therefore, in addition to the key inflation and service demand pressures described above, a local assessment of potential further costs has been identified through the current planning process and can be categorised under the following headings:

- Further increases in planned medical and nursing expenditure in particular in relation to local sustainability issues.
- Additional investment to make progress towards delivering Tier 1 targets including with external providers.
- Continuation of escalated capacity to support unscheduled care flow, and proposed increases in capacity across the unscheduled care system to support improvement in flow.
- Increases in workforce to support the transition in service models towards the development of SCCC as outlined in the business case.

- Regional and national developments including Sexual Assault Referral Centre (SARC), Vascular Centralisation, and national Informatics developments. There is no provision within the UHB's plan for any changes in relation to Neonates services or changes associated with the Diagnostic Imaging Academy.
- National policy changes and standards.
- Recurrent impact and full-year effect of 2015/16 investments specifically in relation to Primary Care, Mental Health, and CAMHS services.

Plans to date have indicated approximately £26.2m investment could be required for 2016/17 with further work ongoing to ensure all potential costs are considered and tested against potential benefits and outcomes. Of this, approximately £8.6m relates to the recurrent effect of 2015/16 investment and investment supported by direct funding allocations, therefore this potential investment is £17.6m excluding these directly funded items.

Plans for 2017/18 and 2018/19, include an assessment of known specific pressures within each financial year (e.g. service sustainability requirements as outlined in the SCCC FBC within each financial year, and Phase 3 retrospective claims becoming a revenue pressure in 2018/19), and an assessed general requirement of £7.5m per annum whilst more detailed service and workforce plans are developed. It is important all known service issues are identified and considered at this planning stage to enable the Board to make the right choices when considering the expected benefits and outcomes of each investment.

The UHB's plan assumes that there is a rigorous approach and assessment of any assessed increased in cost enabling cost mitigation in support of its position, and ensuring any increased use of resources delivers expected outcomes and benefits, and meets the strategic objectives of the Board.

3. Responding to the Financial Challenge

3.1 Progress to Date

The scale of the financial challenge identified above, demonstrates that the current level of service provision and the workforce required to support those services is unaffordable in the medium term from within the assumed resources available from Welsh Government. Financial sustainability will only be achieved through a combination of delivering improved operational efficiency, mitigating potential cost growth, and robust outcome based plans. Changing and matching the level and method of service delivery, with supporting workforce changes, within available and allocated resources is the key requirement of this plan to achieve a balanced financial position over the three years.

The plans to date have identified opportunities to the value of £21.5m which are summarised as follows:

Table 9.5

Savings Identified to date	2016/17 £m	2017/18 £m	2018/19 £m
CHC Savings	4.7	3.3	3.0
Commissioned Services	0.2	- 0.0	0.1
Medicines Management	2.9	2.8	3.3
Workforce Savings	2.5	4.1	0.0
Non-Pay	1.2	0.2	0.0
Further Planned Savings	10.0	-	-
Total Net Costs	**21.5**	**10.4**	**6.3**

The UHB's plans assume that 2% cash releasing savings will be delivered through a combination of plans already in place and further opportunities with plans in development. Planned savings in place include:

- Savings associated with CHC and Medicines management reflecting savings delivered through the delivery mechanisms put in place over the course of 2015/16 and new year schemes.
- Workforce savings primarily relating to reductions in medical and nursing variable pay, and reconfiguration of capacity in particular with relation to community and stroke services.
- Non-pay savings relate to procurement opportunities in core clinical services.

The UHB's plan assumes that further savings will be delivered to a level which means cash releasing savings are the equivalent of 2% in total. These will be developed and delivered through maximising the opportunities associated with:

- Delivering on plans to cease the use of off-contract nurse agencies from the 1st of April and fully reflecting these within divisional plans
- Increased procurement savings
- Reductions in premium payments to Medical staff
- Increased productivity and efficiency resulting in consequential cash releasing gain
- Improved workforce management including absence management, effective rostering, and improved productivity through job planning

Planned savings outlined above represents approximately 2% of the UHB's turnover, in relation to anticipated cash releasing savings. Savings plans are in differential stages of maturity and development and are a key focus area of the Board to develop further robust divisional delivery plans to ensure that this level of saving materialises in line with plan.

3.2 Improving Operational Efficiency & Effectiveness

The UHB has a clear ambition to maximise the use of its resources through achievement of delivering Best in Class performance in its efficiency and effectiveness in addition to and increasing emphasis on a Value based approach.

As outlined above the UHB is continuing to develop its strategic approach to maximising value through focussing on the key component parts of value, in addition to recognising that there are clear opportunities for the UHB to improve its underlying productivity and efficiency position. For the next iteration of UHB plans focus is being placed on identifying and maximising available and known opportunities with a focus on:

- Developing modernised workforce solutions to address underlying challenges in managing existing service models and developing integrated solutions.
- Improved length of stay on a system wide basis.
- Outpatient transformation and management.
- Maximising non-pay value and procurement.
- External provider efficiency and cost avoidance.
- Maximising utilisation of capacity, e.g. Theatre productivity and throughput.
- Optimisation of Medicines.
- Decommissioning interventions of limited value and maximising the benefits of the prudent agenda.
- Use of capital and technological enablers to facilitate the necessary improvements in efficiency and effectiveness.
- Maximising the benefits associated with investment in 2015/16 to support integration and new service models.

As part of the UHB's continued development of its plan process these areas are being continuously targeted and reviewed to maximise both cash releasing savings and recognising that a number of opportunities relate to improved productivity and efficiency,

supporting the organisations approach to cost mitigation and avoidance.

3.3 Further Cost Mitigation & Actions

As outlined above, the UHB's current plans describe annual demand and inflation pressures and a range of service pressures and demands which translate to a significant increase in the UHB's cost base.

Further cost mitigation assumed within the UHB's plan of £10.5m in year 1 and £5m per annum in 2017/18 and 2018/19. This cost mitigation is in specific relation to:

- Management of CHC growth, in particular that associated with Mental Health & LD.
- Increased productivity and efficiency as outlined above.
- Management of Prescribing growth and effective management of medicines pathways
- Effective management and minimise where possible the impact of assessed cost increases in relation to non pay.
- Management of any developments and commitments in relation to externally commissioned services.
- Rigorous and detailed consideration of any service change and sustainability priority, with a clear view of minimising any commitment without a clear benefit in terms of outcome, health gain, value.
- Maximising the impact of 2015/16 recurrent service developments.
- Maximising the impact of services implemented through the additional funding allocated on an all Wales basis to support Intermediate Care Fund and Older People & Mental Health Services.

The UHB recognises that all steps to mitigate cost growth without a clear outcome and value gain are required in order to improve its sustainable position and will be a key focus of the UHB's plan.

3.4 Investment to support Integration, ICF, Older People & Mental Health Services

It is recognised that within the outline budget for 2016/17 Welsh Government there is an allocation for increasing the Intermediate Care Fund by £30m, with an increase in funding to support older people and Mental Health services by £30m with details of how these resources will be accessed and on what criteria to be confirmed. At this point therefore the UHB is not assuming 'fair shares' of this funding whilst this process is being confirmed. The UHB's plan does however assume that developing service solutions to meet the criteria associated with this funding will support the organisations plan and cost mitigation requirement.

4. Key Risks to the Financial Plan

The assessment provided in this plan is based on the best information available known at this stage and a number of upside risk assumptions which improve the financial outlook. Therefore, it should be recognised that there are a number of key issues and risks within the UHB's plan for the three year period from 2016/17 – 2018/19. The key risks are outlined as follows:

- Funding growth is assumed for years 2 and 3 to the equivalent of fair shares of £160m and £170m respectively. Whilst it is acknowledged that this is a reasonable assumption and the Welsh Government has indicated support of the Nuffield model and assessment, the funding available in future years will be dependent on Barnett consequential of UK Government settlements and the Welsh Government Comprehensive Spending Review.

- Part of planned savings relate to capacity reductions which are dependent on the successful management of demand in alternative ways and delivery of productivity and efficiency assumptions. Should these not materialise these savings would be at risk.

- Planned savings include the development and delivery of further cash releasing savings plans to an equivalent of 2% in total. This is dependent on the delivery of key issues such as ceasing the use of off-contract agency nursing. Should this not be delivered these plans will be at risk.

- Whilst it is acknowledged that increased funding was made available to Health in the outline WG budget there is also a reduction in funding available to partner organisations such as third sector and local authorities. This plan assumes no change in partner organisation service provision which will have a consequential impact on the UHBs service provision and demand.

- This plan assumes a clear level of increased pay costs as a result of modelling assumptions in relation to wage award, and pensions. This excludes any assessment of further external drivers around specific pressures including medical and nursing costs.

- An assessment is included for the potential increase in relation to the cost of specialised services and it is anticipated that the affordability of the WHSSC plan is considered as a key criteria of the planning process via Management Group and Joint Committee. There is no provision for any changes over and above the current WHSSC three year plan and assumptions outlined in this chapter.

- This plan assumes a level of cost mitigation in key areas in relation to specific actions, the ability to deliver these will have a material impact to this plan.

- The costs assumed within this plan to improve upon delivering Tier 1 targets have been estimated based on the latest demand and capacity assumptions. These costs may be increased as plans are further developed and risk assessed with further alignment required of service, workforce, and financial plans.

- The ability to develop and implement modernised workforce plans to deliver a more sustainable service solution with improved efficiency and reduce reliance on temporary and premium cost of staff. There is a risk that there will be continued reliance on high cost agency expenditure due to the demand for staff groups, especially nursing, continuing to exceed supply.

- The UHB has not assumed any general contingency in the current plan.

The risk range associated with each year of the financial plan is outlined below, with key risks relating to the level of funding assumed, delivery of planned levels of cash releasing savings and cost mitigation, and management of demographic growth across secondary and tertiary services. The UHB will be ensuring that all risks in the delivery of this plan are minimised and continually assessed as this plan continues to develop.

Table 9.6

Description of Risk	Downside Risk Range		
	16/17 £m	17/18 £m	18/19 £m
General Funding Allocation not available Years 2 and 3	-	31	33
Risk to capacity related planned savings	1	1	1
Risk to delivery of planned cash releasing savings to 2% (including use of off contract nursing) and including recurrent effect on underlying deficit position	10	10	10
Ability to mitigate costs in line with current assumptions	5	3	3
Demand growth and excess capacity above current plan assumptions	1	2	2
Specialist Services Demand Growth in Excess of Plan	1	2	2
Further medical workforce sustainability challenges above plan	2	2	2
Increased Costs of Supporting Tier 1 Target delivery and service sustainability	2	4	4
TOTAL RISK RANGE	**0 - 22**	**0 - 55**	**0 - 57**

5. Summary of the Revenue Financial Plan and Next Steps

This chapter outlines the UHB's revenue financial plan for 2016/17, the three year period from 2016/17 – 2018/19, and the financial outlook on a wider long-term basis.

The outline position based on the UHB's current plan is as follows:

Table 9.7

	2016/17 £m	2017/18 £m	2018/19 £m
Additional General Growth Allocation Funding	38.2	31.2	33.1
Anticipated Allocation Adjustments	13.1	-1.0	0.4
Additional Funding Expected	**51.3**	**30.1**	**33.5**
Underlying Deficit	25.8	12.8	14.0
Service Demand and Inflation	44.1	31.6	31.7
Service Change and Sustainability	26.2	15.1	14.2
Planned Savings	-21.5	-10.4	-6.3
Cost Avoidance & Mitigation	-10.5	-5.0	-5.0
Total Net Costs	**64.1**	**44.1**	**48.6**
(Surplus) / Deficit	**12.8**	**14.0**	**15.1**

This assessment indicates that in order to achieve a balanced financial plan for 2016/17 the UHB needs to identify a further £12.8m of actions to reduce its indicated deficit based on the assumptions within the current plan through a combination of further efficiencies, cost mitigation, and developed workforce and service models which are sustainable through the Board's Service Change Plans.

Furthermore this position includes some upside risk assumptions which the UHB needs to manage to secure the delivery of this position and plan. The range of risk is up to £22m in 2016/17 over and above the position described.

Within the context of an anticipated front-loaded financial settlement, increasingly the key requirement of the UHB is to deliver a sustainable underlying position, with years 2 and 3 being largely driven by the carry forward position of the preceding year. It is essential therefore that in 2016/17 the UHB takes the necessary actions to manage its cost base to bend the cost curve on a recurrent basis.

In summary, as outlined in this paper the UHB recognises that in order to live within its resources on a recurrent basis the continued development of a value based approach and significant changes to workforce and service models are required over the medium term. However, in the short-term the UHB has an increased and unsustainable underlying deficit which requires an increased level of productivity, efficiency, and cash releasing savings to ensure this is addressed. Within this context, ensuring cost mitigation actions are also key alongside the expectation that any new cost is rigorously assessed in terms of outcome gain and benefit to enable the Board to make the required choices.

6. Capital Plans

6.1 Introduction

This section outlines the UHB's Capital Programme and priorities together with an overview of our

estate. The Capital Programme not only funds estates projects but also statutory requirements, equipment and ICT replacement and developments. The capital allocation process is primarily based on a detailed risk based assessment of Divisional and Directorate priorities together with a corporate overview of investment needs resulting from individual IMTP plans, spend to save initiatives and proposals that specifically impact on efficiency, quality and performance.

6.2 The ABUHB Estate

As a direct result of our Clinical Futures Programme more and more services are being provided in the community and in ways which differ from the traditional models of care focused on acute hospitals. However there is a continued reliance upon a range of healthcare premises to ensure appropriate care is provided safely as close to the patient as possible.

The UHB has a large estate portfolio exceeding 50 premises (hospitals and clinics). The UHB also has a number of commercial leases in place to provide accommodation for various staff groups and services. This size of estate does not fully portray the scale of the estate when the spread of specific sites and the number of premises contained within a site are also considered. The UHB therefore has a large number of premises, of varying ages, state and utilisation to manage in a way that supports service delivery.

Managing the estate implications of the service plans is led by a Strategic Estate Group (SEG) and underpinned by the Accommodation & Space Utilisation Group, to facilitate the operational management and changes of space, and the Land & Property Group to handles acquisitions and disposals. The work of the SEG will also look to reflect the emerging service strategies that reflect the changing service models and move towards Community and primary based services, and the changes to the Clinical Futures model.

In addition to the SEG, the UHB has in place a Primary Cares Estate Group that is committed to strengthening Primary and Community facilities in support of the Clinical Futures ethos of local and appropriate services. Integration and NCN Development are a key principle of our Clinical Futures plan. A central theme in delivering primary and community services is the creation of “networks” that bring care as close to the patient as possible through progressive working practices within NCNs. Twelve NCNs were established in 2011, each comprising of primary care, health and social care, housing and third sector community providers operating within the boundaries of the neighbourhood. The original role was facilitative and enabling, responding to local need and national priorities across health and social care and has resulted in increased uptake of influenza immunisations, smoking cessation and the development of the Living Well, Living Longer programme. This includes community service re-provision at County and Chepstow Hospitals (following the NCN lead), and reinforcing the principle of care closer to home. The UHB is also committed to the creation of Primary Care Resource Centres that enable a multi-disciplinary approach and support delivery of the Clinical Futures Programme.

This work will be led by the Primary Care Plan for Wales and the following factors will need to be taken into account:

- The shortages of GPs and the need to provide sustainable services using a practice skill mix which will include pharmacists, advanced nurses, therapists, social workers et al.
- The need to minimise the number of GP surgeries due to staffing issues and so there is likely to be fewer but larger provisions, e.g. resource centres, possible federations of practices, etc.
- The need to transfer more services currently provided in secondary care into the community.

6.3 Capital

The following section and table set out the currently forecast UHB capital funding expected to form the basis of the CRL over the next 5 years together with a summary of the projects seeking funding from the All Wales Capital Programme.

6.4 All Wales Capital Programme

The IMTP process and corresponding work to identify and address service, estate and equipment risk has identified a number of priorities for capital investment which cannot be accommodated from the UHB's available discretionary capital funding. These are therefore put forward for potential funding from the Welsh Government Strategic Capital Programme. These schemes are outlined in the table below:

Table 9.8

	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
All Wales Capital Programme Funding					
Approved Schemes:					
RGH A&E Scheme	2,902				
Business Cases Submitted to WG for funding					
Clinical Futures					
SCCC (excluding inflation, based on FBC submission)	26,686	84,892	77,930	79,939	5,394
Newport ELGH (excluding inflation, based on PBC)	100	904	2,226	2,766	3,205
NHH ELGH (excluding inflation, based on PBC)	100	527	1,090	1,557	3,763
Sub Total Clinical Futures	26,886	86,323	81,246	84,262	12,362
Cardiac Cath Lab	1,774				
Neonatal Sustainability	2,016				
Sub Total Other Submitted Cases	3,790				
Total Business Cases Submitted to WG for Funding	**30,676**	**86,323**	**81,246**	**84,262**	**12,362**
Funding Submissions to National Programmes					
Radiology Equipment Replacement	5,110	4,250	4,060	3,520	3,610
RGH Endoscopy Decontamination (JAG Compliance)	350		1,400		
Strategic Laundry Equipment Replacement Programme	635	500	350	350	
IT -Strategic Schemes -Patient Flow	1,682				
IT -Strategic Schemes including WCIS	850	1,070	500	500	500
Sub Total National Programmes	8,627	5,820	6,310	4,370	4,110
Strategic Projects & Investments (in priority order)					
Provision for RGH Car parking	1,000				
Upgrade RGH Pharmacy Aseptic Suite		800	1,200		
Investment in 4th MRI	1,600				
Centralisation of Breast Service	300	1,000			
Mental Health Strategy		200	1,000	2,500	3,000
Estate Infrastructure Risk		500	1,000	1,000	1,000
ABUHB Ward Upgrade Programme		1,000	1,000	1,000	1,000
Refurbishment of NHH A&E		1,500	2,000	500	
Sub Total Priority Developments	2,900	5,000	6,200	5,000	5,000
Primary Care Investment					
East Newport Health and Social Care Centre RC	50	1,000	3,000	950	
Abertridwr/Penyrheol/Senghenydd (Aber Valley)		250	750	3,000	1,000
Ebbw Vale Resource Centre		50	450	1,500	2,000
Tredegar Resource Centre			250	1,250	2,500
Sub Total Primary Care Investment	50	1,300	4,450	6,700	5,500
Sub Total AWCP Unfunded Requirements	**42,253**	**98,443**	**98,206**	**100,332**	**26,972**
Total AWCP Requirements	**45,155**	**98,443**	**98,206**	**100,332**	**26,972**

Brief information relating to schemes submitted or proposed for possible All Wales Capital Funding is given below:

Specialist and Critical Care Centre (SCCC)
The Clinical Futures Programme Business Case (PBC) and the Full Business Case (FBC) for the SCCC were formally submitted to Welsh Government on 14th October 2015. The programme submitted with the FBC assumed that Welsh Government approval would be received in January 2016 to allow a start on site in May 2016, completion in May 2019 and commissioning by August 2019.This programme is now not going to be achieved as the FBC/PBC scrutiny process with Welsh Government is not yet completed.

It should be noted at this point that the ongoing uncertainty regarding the SCCC is creating significant difficulties with regard to the planning of developments and estate infrastructure improvements on a number of sites, particularly Nevill Hall (NHH), Royal Gwent (RGH) and St Woolos (SWH) Hospitals. This is because of the significant effect that the SCCC will have on the functional content of these sites and the fact that large areas of accommodation will not be required.

Local General Hospitals - Redevelopment of RGH/SWH/NHH Post SCCC
The Newport (RGH) and Abergavenny (NHH) Local General Hospitals will be a fundamental part of the future hospital network for Gwent following the opening of the Specialist and Critical Care Centre at Llanfrechfa Grange in 2019 and will be a key part of delivering the Benefits identified in the Clinical Futures Programme. They will deliver a broad range of hospital services to the local population and provide the majority of hospital care whether planned or unscheduled. They will work in co-operation with the Specialist and Critical Care Centre by streaming the general and routine services away from the major emergencies and complex cases and along with the existing hospital at Ysbyty Ystrad Fawr they will have a key role in achieving the rigorous performance and efficiency targets set for the Clinical Futures programme.

Following the transfer of certain services and departments to the Specialist and Critical Care Centre (SCCC) in 2019 the two existing District General Hospitals (Royal Gwent Hospital in Newport and Nevill Hall Hospital in Abergavenny) will each undergo a change of role to that of an extended Local General Hospital (eLGH) as the remaining services are rationalised and reconfigured.

In 2012 the Specialist and Critical Care Centre Outline Business Case submitted to the Welsh Government was accompanied by a paper about the proposed Local General Hospitals. The paper was predicated on the assumption that limited All Wales Capital funding would be available for investment in the changes required to deliver viable eLGH sites in Newport and Abergavenny post-SCCC. It provided the information listed below:

- A background to the development of the eLGH model within the context of the Clinical Futures Programme.
- A description of the proposed service model and high level functional content of the proposed eLGHs at RGH and NHH.
- High level capital costs for the proposed development of RGH and NHH post construction of the SCCC and associated capital programmes, cost profiles and site plans.

During 2014-2015 this work was reviewed in order to support the submission of the SCCC Full Business Case (FBC) and Clinical Futures Programme Business Case (PBC). A process was undertaken to check assumptions made in 2012 about activity, clinical models, cost etc. and where possible to link to the IMTP and CF Programme. The outputs from the process included:

- An initial review by Directorates of the previous assumptions.
- High level site and service configurations that informed workforce plans and revenue assumptions.
- Meaningful plans to inform prioritisation of interim investment on the sites.

- What the facilities requirement will be – this will have three stages:

1. What services are where on Day 1 when the SCCC is completely open.
2. The layout once the UHB "consolidates" existing services into existing facilities immediately certain functions have moved to the SCCC.
3. The layout following any capital investment and site re-configuration rationalisation and demolitions resulting from the Business Cases for the eLGHs – this may be a long phased process given the possible difficulties of working on operational hospital sites.

Early in 2014, all Divisions and/or Directorates were requested to complete a comprehensive proforma and in most case 1:1 meetings took place between Directorates and the Capital Planning Team. The aim was to have as complete a picture as possible about individual services despite the long lead time until the development of LGHs commences.

In 2012, the SCCC OBC assumed that the majority of services on the SWH site would be relocated to the RGH site, including community / rehabilitation services. It assumed that in terms of beds only Mental Health services would remain on the SWH site in the Casnewydd Unit. These assumptions were tested in more detail in 2014 as the current service model for Mental Health requires co-location of dementia beds with a number of other clinical services.

Bed modelling based on the CF Bed Model has been undertaken and bed requirements test-fitted into the wards identified to be retained at the two principal sites. This threw up a number of issues about previous site rationalisation assumptions particularly at NHH. This information was used to develop high level schedules of accommodation which then informed a costing exercise based on three scenarios:

- Do Nothing - New build SCCC, no redevelopment of LGHs.
- Do Minimum – New build SCCC, Minimal redevelopment of LGHs.
- Redevelopment - New build SCCC, Major redevelopment of LGHs.

Cost forms were completed for all 3 scenarios and submitted as part of the PBC process

The working assumption at PBC stage is that the "Do Minimum" will be the preferred way forward. This will be fully tested in individual Outline Business Case (OBC) documents for the two Local General Hospitals following approval of the CF PBC.

The detailed output of this work in the form of Capital Costs has prepared for the RGH, SWH and NHH sites based on a categorisation of the areas or services on each current hospital that will:

- be reused with no investment;
- require minor refurbishment;
- require major upgrade;
- require a new build.

The calculation of the profiles has assumed that:

- Capital costs will be funded by Welsh Government but subject to separate business cases, i.e. OBCs and FBC following submission of the Programme Business Case to the Welsh Government in October 2015.
- Physical alterations /start on site post SCCC completion i.e. late 2019.
- A 4 to 5 year "construction" period.
- All sites are developed in tandem.

Cardiac Cath Lab Replacement, RGH
2016-2017 is now the scheduled replacement for the imaging element of the Cardiac Cath Equipment at RGH. Phase 1 which consists of supporting systems was funded in 2014-2015, the cost of phase 2 is £1.5m.

If funding cannot be provided by the All-Wales Capital Programme this equipment is assumed to be a high priority within the UHB's Discretionary Capital Programme impacting on investment in other areas and the UHB's capacity to undertake development and environmental capital schemes.

Neonatal Sustainability and Neonatal Intensive Care Unit, RGH
A Business Justification for capital investment of £2.05m for the reconfiguration of the current Neonatal Unit located on B5 North at the Royal Gwent Hospital has been submitted as part of an overall Neonatal Network. This is in order to support the current service whilst addressing important environmental and compliance risks. This is an interim arrangement until the replacement unit is commissioned at the SCCC in 2019 to ensure service sustainability can be maintained.

Although the case for change is primarily driven by the UHB's requirement to deliver compliance with environmental standards the solution will also provide a potential interim solution to meeting requirements of the All Wales Neonatal Standards and to continue to sustain neonatal services within the context of Clinical Futures Programme. The following investment objectives have established:

- To address the current environmental risks in the existing Royal Gwent Hospital NICU which fails to meet basic environment standards relating to a significant infection control risk as laid out in the national guidance.
- To address the current environmental risks in the existing Royal Gwent Hospital NICU which fail to meet functional and spatial layout in accordance with HBN 09-03 Cot space capacity recommendations.
- Providing further potential capacity to increase cot numbers in line with the All Wales Neonatal Standards recommendations, to provide 6 extra cots.

The preferred option is to maintain the existing service at the current location at RGH, with investment to increase space between cots and increase capacity to create space for an additional 6 cots.

6.5 Potential National Programmes

It is understood that Welsh Government will be sponsoring certain National Programmes in 2016/17 and possibly beyond. These may include:

- Radiology Equipment Replacement;
- Endoscopy/Decontamination;
- Strategic Laundry Equipment Replacement;
- IT Strategic Schemes.

The UHB's outline requirements under each programme are noted in Table 9.8 above and summarised below:

Imaging Equipment Replacement - The UHB has a recurring annual requirement for approximately £3-4m of imaging and other high value equipment. Included within this figure is a requirement to replace at least one major piece of equipment such as an MRI, CT or Gamma Camera each year. In 2016-2017 the total requirement is particularly significant as it is in excess of £5.0m including replacement of one MRI and Mammography equipment.

Endoscopy Decontamination - As a result of a JAG inspection of the Endoscopy Unit at RGH the need for improved decontamination facilities has been identified as a high risk. Subject to the outcome of an HSDU modelling exercise being undertaken as part of SCCC planning it is proposed to release space on Level 1 adjacent to the current RGH HSDU by relocating an Operational Estate Workshop. The space released will be able to be developed subsequently to address some of the other risk issues in the existing RGH department.

The 2015-2016 Facilities IMTP stated that it seemed likely that a new build HSDU would be the preferred way of meeting emerging instrument processing requirements. Since that time the potential for the facility at the RGH to remain the main processing centre for surgical instrumentation has been revisited.

The UHB is currently undertaking a modelling exercise with the support of ABCi and Cardiff University to determine the optimum equipment configuration and capacity and staffing pattern required to enable used instrumentation to be processed and available for re-use within 24 hours.

A separate exercise will examine the logistics requirement for transport of instrumentation between sites that minimises that time delay between end of surgery and receipt at HSDU. This work will enable an informed decision to be made regarding whether to refurbish RGH (can it accommodate the necessary equipment and staff) or if a new build is required. Whichever solution is preferred the new arrangements will need to be in place to support the operation of the SCCC from 2019. Any investment proposal will need to be aligned to the recently issued revised guidance on decontamination of medical device – WHC/2015/50 and the most up to date Welsh Government recommendations.

Strategic Laundry Equipment -The Green Vale laundry located at Llanfrechfa Grange is now 25 years old and equipment replacement is a high priority. Green Vale processes over 10m pieces of linen per annum for the UHB as well as Cardiff & Vale, Powys, WAST and Velindre. A number of small English PCT's are also customers.

The extensive investment (c£2.0m) required in the next 4 years and the strategic reliance of Health Boards in SE Wales on Green Vale laundry are strong indicators that central funding may be appropriate to ensure continued services and the avoidance of a transfer of activity to commercial providers. The current condition of the laundry in ABMU, and the limited capacity in Cwm Taf and Hywel Dda, further support the case for a strategic approach to funding capital replacements.

Strategic Informatics and Capability - There is a significant requirement for investment in informatics including:

- ICT Infrastructure including:

    1. Software and Hardware Life cycle management covering Server, Network, Telecommunications, Storage and the Desktop Estate.
    2. Fulfil capacity and availability management service needs. E.g. Digital storage growth, improved security
    3. Improved mobility to provide the organisation with a more flexible service delivery model

- Clinical information systems replacement:

    1. Theatres system
    2. Mental Health System (from ePEX to the Welsh Community Care information System (WCCIS)

- Mobile devices to support the implementation of the WCCIS.

- Paperless wards using electronic Patient Flow Management to deliver bedside computing to support Early Warning systems.

- Improved access to IT systems within hospital settings including but not limited to mobile tablets (e.g. electronic Intensive Care Unit systems, Infection control monitoring systems etc).

Many of these projects will rely on capital and revenue availability, may be part funded from National programmes and may well require the delivery of cash releasing benefits or cost

avoidance benefits before gaining acceptance.

6.6 Priority Developments

In addition to the possible National Programmes the UHB is also developing a number of further potential capital projects set out below in priority order:

Car Parking RGH
The RGH site is under considerable pressure from the volume of traffic and lack of car parking. This is further compounded by possible changes in the availability of space on the Whiteheads site where the UHB currently occupies about 300 spaces. Consideration is currently being given to interim measures to improve the situation between now and 2019 when a significant volume of services are planned to transfer to the SCCC at Llanfrechfa Grange.

Pharmacy Aseptic Suite RGH
An All-Wales audit of Aseptic Suites has highlighted the need for this facility to be upgraded and re-equipped during the period covered by this plan. This work needs to be completed by the opening of the SCCC in 2019 and will future proof the units for potential service developments and changing legislation.

MRI
A Business Case for an additional (4th) MRI scanner is being prepared. An additional MRI is required to keep pace with demand for Diagnostic investigations which until now has been addressed through rented capacity. This additional facility could be located at YAB.

Breast Centralisation
The unification of breast services and the development of a centre of excellence is currently being considered as part of delivering improvements to the delivery of cancer services within the UHB
The development of a unified centre of excellence will mean that all patients referred for breast specialist care of any sort will be seen at one site.

Mental Health Low Secure Unit and other Specialist Facilities
Patients requiring care within a Low Secure environment currently have to be placed out of the Gwent area in private provider organisations. This is both inappropriate from the clinical perspective, prolongs length of stay and is costly. The aim is to provide a locally managed NHS low secure service for individuals aged 18 years and above who require this level of security. These individuals generally have a severe and enduring mental disorder and require protracted admission in conditions of higher security than a generic acute psychiatric ward can offer. Providing care and treatment for this group of individuals will aim to achieve the following objectives:

- To improve the quality of care and range of interventions provided, ensuring that the individuals' needs are met.
- To improve the patient and family/carer experience.
- To improve care co-ordination and care management by facilitating increased knowledge and understanding of individuals by clinicians.
- To develop a skilled and expert workforce in this specialty within the UHB area.
- To provide benchmarking data that enables the service to demonstrate a reduction in the length of stay.
- To reduce the number of UHB residents that are placed in specialist placements, out of county/Wales.
- To introduce low secure NHS facilities with a view to reducing the reliance on the independent sector.
- To reduce the revenue spend on low secure specialist placements.

This proposal forms part of the Mental Health and Learning Disability Clinical Futures model. The Mental Health and Learning Disability Division acknowledges the need to develop its services

particularly for development of a service model and pathway required to provide specialist in-patient services for the most complex service users in the Adult and Learning Disabilities Directorates.

Following an initial and positive scoping meeting with Welsh Government the Division is now establishing whether the scheme should form part of a more co-ordinated regional proposal. The project is now extended to reflect a requirement for an integrated Learning Disabilities and Mental Health service for those with complex needs and the scope has now broadened to include both PICU/HDU. A timetable and governance structure for taking the project forward is currently being developed with a view to a further scoping meeting with WG

Estate Infrastructure and Estate Risk / Ward Upgrade Programme
Almost half of the UHB estate is over 40 years and around a third over 50 years. Serious condition problems are manifesting across a number of sites:

- roofing;
- water distribution;
- windows;
- local power distribution (age, capacity, accessibility);
- ventilation and heating systems and controls;
- general fabric;
- ward environment.

As stated above under the SCCC the ongoing uncertainty regarding the funding of that project is creating difficulties with regard to the planning of developments and estate infrastructure improvements on a number of sites, particularly Nevill Hall, Royal Gwent and St Woolos Hospitals. This is because of the significant effect that the SCCC will have on the functional content of these sites and the fact that large areas of accommodation will not be required.

The Facilities Division maintains a risk register and reports annually to Welsh Government on backlog maintenance requirements. In July 2014 the risk adjusted backlog maintenance cost reported to the UHB was £11.7m with a total backlog value of £37.7m. The need for estate infrastructure investment has been an ongoing priority for the UHB. The issue was recognised by the Welsh Government in 2010 when All Wales Capital Funding totalling circa. £8m was awarded to address the most significant estate risks and critical systems such as primary power supplies and core distribution systems.

Although the highest priorities were addressed and some additional AWCP funding has also been used to address estate risks the original submission to the Welsh Government requested £16m and there remains an ongoing requirement for investment on the two major hospital sites not only in the short term but particularly as they are now clearly identified as the preferred way forward as the Local General Hospitals for Newport and Abergavenny following commissioning of the Specialist Critical Care Centre in 2019. Estate Infrastructure failures continue to have a potentially significant impact on service delivery and could compromise patient safety.

There have been no planned substantive ward refurbishments at the UHB's main sites for at least 5 years. When designing and building healthcare facilities it is assumed that major refurbishments (including infrastructure such as local power, ventilation, fire detection etc.) will take place on a 15 year cycle, structural fabric on a 20-25 year cycle and roofing every 60 years.

This is illustrated by the situation at the RGH where all wards in D block would normally have been expected to have been refurbished at least once since construction, those in C block twice and those in B block at least three times. The routine refurbishment of accommodation is essential to ensure facilities remain fit for purpose, e.g. provision of adequate low voltage power supplies, replacement of flooring surfaces, window replacement, energy efficient lighting, heating and ventilation controls, medical gas provision, redecoration, fire detection replacement, sanitary and bathroom facilities.

A typical full refurbishment of a ward requires 6 months and will cost in excess of £1m. The UHB should consider a plan that includes a ward refurbishment each year at both RGH and NHH (ideally 2 per annum at RGH) and 1 per year in community hospitals to ensure that wards are maintained in reasonable condition. Such a plan would take account of provisional plans for the reconfigurations of both RGH and NHH to become Local General Hospitals post SCCC commissioning.

It is therefore estimated that as a minimum an annual recurring capital allocation of circa £1m is required to enable a long term programme to be developed that will include some limited ward facility refurbishment and wider estate condition maintenance.

If AWCP funding is not available the UHB will continue to address the highest estate risks from the funds available within Discretionary Capital but this will be at a much lower level of expenditure and estate infrastructure failures could have a potentially significant impact on service delivery and patient safety.

Any investment will be directed to areas of highest risk but in the case of RGH and NHH also prioritised to those areas currently planned to be retained in the emerging plans for the future role of these hospital as Local General Hospitals.

Emergency Department, NHH
The Emergency Department at NHH currently faces significant challenges relating to capacity, flow and environment. Any investment will be carried in such a way that any resulting changes will be consistent with the future role of the department post-SCCC when the site will be configured as a Local General Hospital.

6.7 Primary Care Developments

The UHB continues to review its Primary Care Estate Strategy to ensure that planned changes support the development of the Clinical Futures model of care and the developing role of the Neighbourhood Care Networks and also to reflect the recent Welsh Government funding changes.

In order to identify schemes for consideration in 2015-2016 the UHB followed the agreed process to prepare for the prioritisation exercise. This included:

- Identifying those schemes included in 2014-2015 prioritisation exercise and not yet progressed or completed.
- A review of practice development plans (PDPs) and Neighbourhood Care Network (NCN) plans;
- Discussions with NCN leads of priorities in their areas.
- The Health Board writing to all practices asking them to submit expressions of interest in relation to new major or minor improvement grants.

On completion of the full list, a two stage process was undertaken:

Stage 1 – Internal multi-disciplinary officer evaluation of all schemes identified against the Welsh Government published “Critical Success Factors”. This review resulted in a draft prioritisation list being developed.

Stage 2 – Primary Care Estates Panel**.** This panel included representation from the Health Board (including non-officer member), Aneurin Bevan Community Health Council, Gwent Local Medical Committee and Shared Services Partnership. The panel reviewed the prioritisation list from stage 1 in detail, along with the rational for development. It was recognised by the panel that the development of primary care estates plans is a variable process affected by a number of factors, mostly being out of the control of the Health Board. This means that the prioritisation and phasing of schemes are subject to change annually. Consequently, the panel agreed that, unlike the 2014-20/15 exercise, the 2015-2016 schemes would not be listed in priority order but rather those to be

progressed as either new developments or as major improvement grants as phase 1 and phase 2.

The outcome of the 2015-2016 Primary Care Prioritisation exercise is set out below. It should be noted that the Llanbradach development is not included below as this is being progressed. Interviews have taken place to appoint the 3PD.

The priority and phasing of these potential schemes is being regularly reviewed by the UHB. It is proposed that these schemes are progressed as a priority.

New Developments

Phase 1
- Abertridwr, Penyrheol & Senghenydd Surgeries
- East Newport Health Centre
- Ebbw Vale Resource Centre
- Risca Surgery, Castell Clinic Cwmfelinfach (This has been addressed via capital funding)
- Tredegar Resource Centre

Phase 2
- Abersychan Primary Care Centre
- Bellevue Branch Surgery at Bettws
- Bryngwyn & Central Surgeries
- Caldicot Group Practice, Magor Surgery
- Greenmeadow Surgery

Minor Improvement Grants submitted in 2015-2016. It should be noted that these schemes would be prioritised and subject to available funding:

- Glan Rhyd Surgery – Blaenau Gwent
- Tonyfelin Surgery – Caerphilly
- Dixton Surgery – Monmouthshire
- Mount Pleasant Surgery, Portskewett Branch Surgery – Monmouthshire
- Eveswell Surgery – Newport
- St Paul's Clinic – Newport
- Central Surgery – Newport
- Lliswerry Medical Centre – Newport

Chapelwood Surgery has also submitted a request to extend their current premises. Although this is not an improvement grant, the building is owned by a third party, there is additional revenue costs associated with this.

In addition, the following UHB premises have also been included with the prioritisation exercise for improvement grants in 2015-2016:

- Blaen –Y-Cwm Surgery
- Pen- Y- Cae Surgery
- Bryntirion Surgery
- Gaer Medical Centre
- Alway Surgery

Further schemes that were identified but not progressed in 2015-2016 will be considered in 2016-2017.

Four major improvement grants have been identified as part of the 2015-2016 prioritisation exercise:

- Caldicot Group Practice- Monmouthshire;

- Chippenham Surgery – Monmouthshire;
- Tudor Gate Surgery – Monmouthshire;
- The Usk Surgery – Monmouthshire.

The UHB will work with these practices to progress their plans and applications, but dependent on available funding, not all of these would realistically be delivered in 2015-2016 and more likely to be in 2016-2017 or 2017-20/18. A further £200k of investment will be required to deliver all of these schemes.

Welsh Government is pursuing opportunities for gaining EU investment to fund major projects for Primary Care Estates. The UHB has submitted 2 schemes:

- East Newport Health Centre;
- Abertriwdr/Penyrhoel& Sengenydd (Aber Valley).

If AWCP funding is not available consideration can be given to potential revenue funding streams but these do not provide good value for money and are unlikely to be affordable in the context of ongoing revenue constraints. It is difficult to see how the proposed strategic shift of services from Acute to Community and Primary Care can be supported from the perspective of the Estate without investment in new facilities.

6.8 Developing the Discretionary Capital Programme

As there is evidently a significant shortfall between the capital funding available and the demand for capital the UHB operates a system to ensure that the limited capital funds are used appropriately. This consists of a comprehensive Divisional Capital Prioritisation exercise covering risk assessment, impact and mitigation for every individual capital requirement. The detailed outcome is validated with Divisions prior to it being used to inform decisions made about capital expenditure in Discretionary Capital Programme.

It is clear that not only is there a significant requirement for capital to sustain service delivery and development but the UHB cannot meet all its other capital demands including:

- Fire Safety;
- Estate Risk and Backlog;
- Fully depreciated theatre, diagnostic and general equipment replacement including ultrasound and major scanners and non-clinical requirements;
- ICT infrastructure;
- Other Corporate development priorities such as Digital Health Records;
- Environment issues.

In summary, it is estimated that the organisation's demand for Capital is estimated to be in excess of £60m over the period 2016-2017 to 2020-2021 with Discretionary Capital funding anticipated to be normally circa £7.2m per annum. It is also assumed that in most areas there will be further unforeseen capital requirements and a contingency will therefore be retained for this purpose. The overall outlook is set out below in the following table:

Table 9.9

	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
Funding					
Total Discretionary in CRL	7,209	7,209	7,209	7,209	7,209
Non Recurrent Uplift to Discretionary	3,605				
Add Forecast NBV of Disposed Properties	50	100	100	100	100
Restorative Dentistry Funding Adjustment	-61				
Total Discretionary Funding	10,803	7,309	7,309	7,309	7,309
Applications:					
Direct Service Allocations:					
Statutory Maintenance	700	350	350	350	350
H&S Fire Safety allocation	150	75	75	75	75
Imaging - X Ray Tube Replacement	50	50	50	50	50
Total Direct Service Allocations	**900**	**475**	**475**	**475**	**475**
Priority Schemes					
Sustainability CAU & OPD		850			
Women's Health Unit, B7		650			
RGH screening Room Completion	950				
Relocation of Specialist CAMHS OPD	272				
NHH Asceptic Suite Upgrade	350				
15/16 Commitments B/ forward	527				
Total Priority Schemes	**2,099**	**1,500**	**0**	**0**	**0**
2016/17 Opportunities					
Imaging Equipment Replacement	339				
Replacement Dental Vans for Community Service	190	190			
Environmental Upgrade Programme	300				
Rollout of automated Stock Control Systems	500	500			
Catering Programme	300	145			
Total 2016/17 Opportunities	**1,629**	**835**	**0**	**0**	**0**
Balance of Available Funding	**6,175**	**4,499**	**6,834**	**6,834**	**6,834**
Unfunded Demand Against Available Capital					
Divisional Capital Requirements					
Risk Scored 20-25	6,070	8,339	10,553	15,734	19,234
Balance of Available Funding	105	-3,840	-3,719	-8,900	-12,400
Risk Scored 15-19	5,801	10,503	16,658	20,158	23,658
Balance of Available Funding	-5,696	-14,343	-20,377	-29,058	-36,058
Risk Scored 10-14	2,704	3,935	6,827	7,469	11,089
Balance of Available Funding	-8,400	-18,278	-27,204	-36,527	-47,147
Risk Scored <10	2,573	4,680	7,128	9,414	12,514
Balance of Available Funding	**-10,974**	**-22,957**	**-34,332**	**-45,941**	**-59,661**

Chapter 10 - Informatics and Technology

1. Informatics and Technology

High quality healthcare services depend on high quality information; the right person having the right information at the right time can make the difference to the clinical outcome and experiences of a patient, service user or carer. High quality information enables healthcare professionals to make the process of care safer, more effective and efficient. The role of Informatics is to be a key enabler in the delivery of patient care and which recognises the value and need to make information accessible and available in managing the patient journey. As part of its role its objectives are to:

- Deliver pathway modernisation and benefits through the application of technology.
- Ensure that the technology acquired and deployed both nationally and locally meets operational requirements and enables delivery of clinical requirements.
- Take responsibility for Clinical and Business Change design, implementation and benefits realisation in terms of strategic benefits delivery.
- Underpin clear plans emerging from the UHB's Divisions and 'enable' the achievement of their objectives.
- Provide the local dimensions into any National Business Case and ensure that such cases reflect local strategy and the UHB's IMTP.
- Ensure the Strategic and Operational plans for informatics are integrated fully into the UHB's IMTP and Delivery Plans.
- Inform national informatics priorities, providing clinical engagement and supporting clinical horizon scanning.

In line with the previous IMTP the Informatics teams delivered the following in 2015/16:

- Readiness for the transition from the local A & E system to the Welsh Emergency Department System [WEDS];
- Major steps in modernising the desktop infrastructure (Windows 7);
- Lead the UHB in developing the case for electronic Patient Flow Management (ePFM);
- Increasing the volume of conversion of paper records to electronic format with over 100,000 patients records now digitised;
- Procurement and implementation of a text reminder service (DrDoctor) to facilitate the reduction of 'Did Not Attends' by over 30%;
- Improvements in clinical communications between primary and secondary care with 8,000 discharge notifications, 10,000 referrals and 7,000 clinical letters now delivered electronically per month;
- Extended use of digital dictation in additional specialties;
- Additional functionality for the UHB's MedSecs clinical correspondence system;
- Developed technologies and supported piloting of ICHOM data collection;
- Extended piloting locations for Welsh Clinical Portal Electronic Pathology Test Requesting;
- Completion of a major data cleansing programme for Mental Health & Learning Disabilities electronic records;
- Initial development of online training resources for Myrddin and the Mental Health System (ePEX);
- Continued planning and readiness activities for completion of the LIMS programme (Cytology, Histology & Blood Transfusion);
- Developed and implemented the award winning Information Governance Stewardship programme;
- Improved patient experience through implementation of public Wi-Fi in the UHB's large general hospitals.
- Restructured the Information Department to establish dedicated teams to support the work and development of UHB Divisions.
- Further developed a Business Intelligence approach to support the delivery of corporate and

Divisional Service Change Plans [SCP's] and initiatives.

Current Programme

The UHB has a 3-year IM&T plan in place, which sets out the programme of work to support the implementation of its Clinical Futures strategy and to enable service improvement. As part of the UHB's full IMTP, the Informatics Plan takes into account the various national and local strategies and standards including the "Informed Health and Care – A Digital Health and Social Care Strategy for Wales", the Clinical Futures Strategy and the Strategic Outline Plan and provides a commitment to progress the implementation of national programmes jointly with NWIS, other Health Boards and care delivery partners as well as ensuring that it can continue to deliver current services to the patient, the clinician and other UHB staff. The Informatics programme of work reflects its role as a key enabler within this strategy and plans to deliver the technology to further support Clinical Futures (including telehealth) and the Specialist Critical Care Centre. Specific projects to support service change at a Divisional and Directorate level included in the UHB's IMTP are also included within the Informatics programme.

The overarching priorities for the next three years are centred on the themes of:

- Core Capacity, Capability and Sustainability: ensuring that the UHB can continue to function.
- Digital Health and Integrating Systems: supporting the Once for Wales national programme and local system development.
- Information: promoting and supporting service improvement.

Within these themes there are sub-themes which will help identify the requirements and plans from a resource, technical and tactical perspective. Highlights from this plan include proposals to improve:

- patient safety with the introduction of electronic pathology and radiology notifications and sign-off and electronic prescribing;
- patient flow through its services and reduce delays by implementing the Welsh Emergency Department System [WEDS] into A&E and Assessment Units and an electronic Patient Flow Management system into in-patient and community bed areas;
- multi-disciplinary and multi-agency working by implementing the Welsh Clinical Community Information System [WCCIS];
- workforce mobility by implementing technology to support 'deskless' staff;
- the patient experience and outcomes by introducing systems which record these experiences and outcomes [using ICHOM data sets];
- the quality of care and gain efficiencies via information systems to support business analytics and clinical audit;
- cross boundary co-production through increased accessibility to clinical information (CWS to WCP convergence) and increased patient participation and access to care records (MHOL)

This programme of work, whilst prioritising delivery of needs, is flexible to allow for the changing circumstances throughout its lifespan and the availability of national and local resources, including capital and revenue funding.

Core Capacity, Capability and Sustainability: ensuring that the UHB can continue to function

To ensure that the current ICT technical infrastructure remains 'healthy' and fit for purpose for the current and future services, an annual investment plan will be developed. This plan will:

- Consolidate and manage the software and hardware life cycles of server, network, telecommunications, storage and the desktop estate to effectively support access to information systems.
- Attempt to identify demand led requirements from agreed strategic, IMPT, division and other service based and funded projects (as evidenced by the 43% growth in desktop and mobile

devices over the past 3 years).
- Identify trends and developments in technology to determine new opportunities and enablers to support new ways of working and sustainability, such as, changes in mobile working.
- Ensure that the security arrangements are maintained to the high standard expected. "Cybersecurity" is an increasing threat and will remain high on the Informatics and UHB risk registers. The investment will include requirements to maintain high level security at an affordable level.

These areas require continuing investment to continue the good work of the ICT department to "keep the lights on"; it must be remembered that investment in ICT is similar to investment in the estate, in that, it is now seen as a necessity to effective clinical services.

Resource Outlook

Financial

Informatics does not have a permanent ring fenced allocation of capital funds each year. The current process is based around bidding for capital funding against the requirements of the entire UHB, and using risk scoring to prioritise each bid. Informatics has been reasonably successful in acquiring capital funds for ICT projects, either from discretionary capital or through national Welsh government bids. The capital investment in ICT only over the last few years is shown in Table 10.1.

Table 10.1: Investment within Informatics programmes over the last 6 years.

Year	2010	2011	2012	2013	2014	2015
Investment (£000)	£847	£1,938	£2,698	£1,314	£3,338	£1,113

The ability of Informatics to purchase capital based equipment with short lead times e.g. software and off the shelf hardware, such as, pcs, has allowed Informatics to address some key ICT risk areas such as desktop, server and network equipment and security around operating systems; investment needs to continue in these areas.

Staffing:

Over the last 3 years there has been no staff head count increases and the overall budget has shrunk since 2013 as shown in Table 10.2. During this period we have successfully managed our support costs effectively and have reduced costs to the UHB through improved procurement. Please note that NON-PAY cost also includes a proportion of service payment costs to NWIS as specific services transition within the Once for Wales strategy which is envisaged to grow over the next few years.

Table 10.2: Revenue Breakdown

Year	2012/13	2013/14	2014/15
PAY (£000)	£3,387	£3,007	£3,173
Non Pay (£000)	£1,961	£1,974	£1,889

The last 3 years has resulted in a 43% growth in PCs and Laptops to service clinical need to implement the digital strategy, providing access to clinical, administrative and workforce information systems. Whilst the benefits of additional computing resources for staff have allowed greater service efficiencies it has placed additional strain on the service to ensure integrity and security are maintained. Added to this is the demand being placed on the service by NWIS for the implementation and support of new national systems and as a result call requests to the informatics service desks have increased by 22%. Implementation and training resources are fully consumed resulting in negative comment in WAO report regarding inadequate training being provided. Whilst customer service and feedback on the services remains excellent the existing establishment has struggled to maintain service levels resulting in increased response times, dropped calls to users and inability to meet to core programme implementation and training support. Similarly calls to the Switchboards from the public have increased from **0.77m pa to 1.2m**

pa which represents a **37%** increase as the UHB further strengthens engagement with the public.

It is recognised that the current funding level is sufficient to manage the current state and any future developments will require additional resource as noted in the detailed Informatics IMTP. The total level of UHB spend on Informatics is lower than the recommended 2% of total revenue expenditure at 0.73% and lower than the all-Wales average of 0.83% [WAO Diagnostic Review of Capacity and Resources – Nov 2015]. With several significant further changes e.g. the new SCCC, adoption of WCCIS and WCP convergence, investment is paramount to ensure successful implementation and realisation of the benefits.

As an indication of the potential investment required for the comprehensive and successful implementation of a complex project, the early scoping of the resource requirements for the WCCIS, suggests a requirement of an additional 21 WTE staff to the present complement. These will include project managers, product specialists and trainers, information specialists, ICT technicians, service desk support, and clinical and business change resources. The number of additional devices and users is currently scoped for our services at circa 4,000.

It should be noted that ICT marketing and procurement models are increasingly moving toward regular revenue streams, in particular for software and cloud services. These will reduce capital reliance for some items but will negatively impact upon the UHB's revenue expenditure.

Digital Health and Integrating Systems: supporting the Once for Wales national programme and local system development

Clinical Portals at the centre of care delivery
One of the key aims for both National and Local informatics services is to underpin clinical care with a digitised patient record, ensuring that clinicians and others can view and update that holistic record from a portal wherever the patient presents and so support safe care and improved decision making.

The UHB has a well-established Clinical Portal (CWS) developed in house which has been in situ for 20 years and currently has over 8,500 users both in secondary care, primary care and is also available in some other Welsh locations outside Gwent. It is rich in functionality both in terms of presenting data from many other systems (including documents and results); provide various notifications and alerts; and support many workflows which were developed to improve patient safety, gain clinical and administrative efficiencies, and deliver organisational compliance and meet quality standards. CWS remains highly popular with its clinical user base particularly with Junior Doctors rotating into the UHB with experience of comparable systems elsewhere.

NWIS has developed the Welsh Clinical Portal (WCP) as a national NHS Wales solution for Health Boards and Trusts and whilst the product currently comprises limited functionality in comparison to CWS, the emerging strategies which include the delivery of the Welsh Care Records Service (WCRS), seeks to support cross boundary information flow and deliver other benefits available from within the WCP and by integration with other national systems.

The Health Minister requires all Health Boards to fully utilise the WCP and the UHB are committed to a plan, in which, the functionality of CWS and WCP converges to a point that enables the use of WCP in place of CWS. This plan is to be delivered in the next few years with minimal cost and disruption to current services. Failure to converge systems or move to a point where WCP is the primary means of obtaining information could mean that the UHB will be unable to underpin the delivery of National specialist services and associated cross boundary patient flow and out patients will be disadvantaged.

e:Clinical Records Development & Implementation: supporting the Service Change Plans

Digitising Health Records
Over 25% of the 400,000 acute patient records held by the UHB are now digitised with every new

acute patient record digitally created. This ensures that clinicians are able to instantly view the record wherever the patient presents at acute services and supports improved decision making. Paper records are scanned and made available alongside electronic records and work continues to reduce the paper notes at source whilst continuing to scan the legacy records. Within the next three years it is anticipated that the UHB's Digital Health Record [DHR] Project will reach the point whereby it can say that the majority of its acute patient records are digitised (hopefully, this will also be the case nationally) and once the initial investment is repaid, deliver savings estimated at £1M per annum.

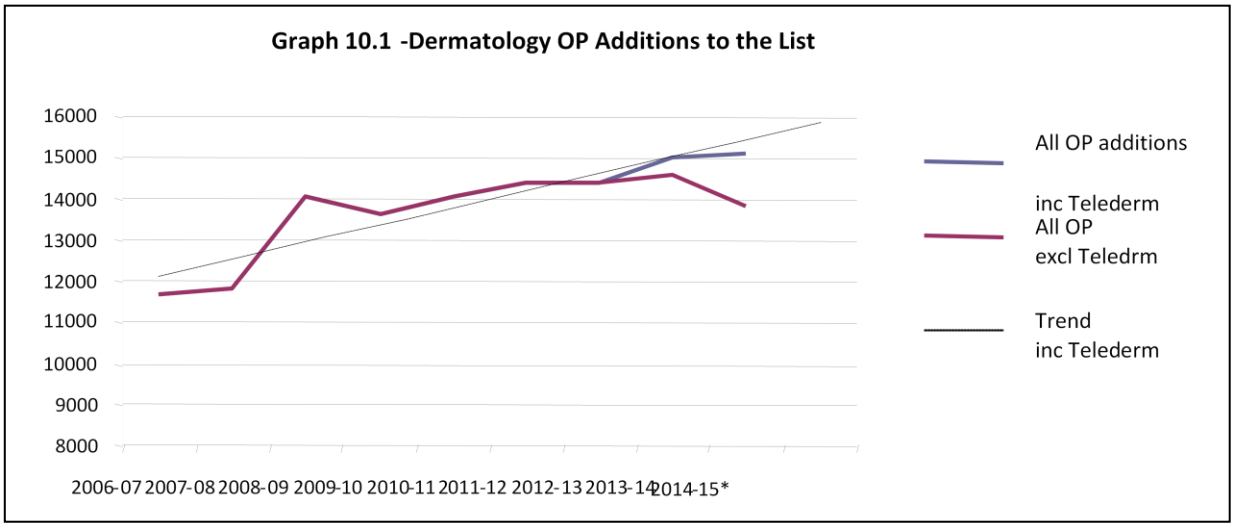
The importance of this project cannot be underestimated in terms of improving patient safety, service efficiency and clinical efficacy but also to support the delivery of the Wales NHS strategic aim of a single national patient electronic record where primary care, secondary care and community care information is available via the Welsh Clinical Portal.

Scheduled Care

Electronic test requesting has been slow in gaining traction with only a few pilots in place. The Division aims to focus on improving take up over the next year both in secondary care and primary care to ensure services such as Pathology and Radiology can streamline current manual services. Theatre systems are currently under National review and the UHB plans to move from the existing system to a 'made in Wales' system in 2016/17 due to the savings this would realise and support to the 'Once for Wales' strategy.

The National procurement of a Point of Care Testing (POCT) solution in 2016 will enable the UHB to develop a case for interfacing existing devices to this and also improving on device availability. Plans are to implement this in 2017 which will reduce the turnaround time between tests and results in busy areas such as A&E and reduce current pressures on our main pathology departments.

One solution which has proved its worth and is ready for scaling up across the UHB services is the model used by the Tele-Dermatology Service, which seeks to radically reduce the wait for patients receiving a consultation from our consultant dermatologists by introducing a medical photography clinic soon after the referral and followed by a virtual review by the consultants. This has resulted in a reduction of demand on our face to face consultations which has bucked the trend of increasing waiting times.

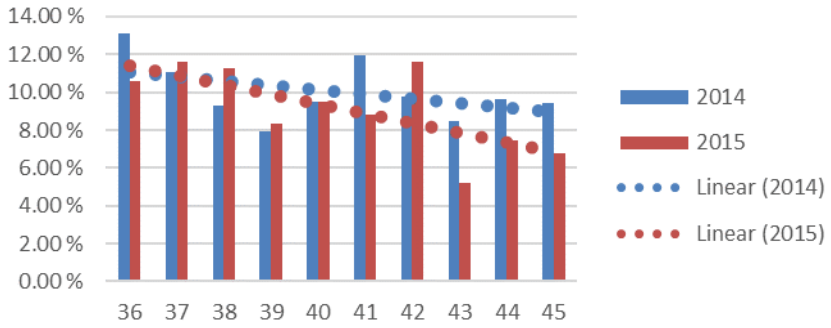


Outpatient transformation – Over the next 3 years this service will be expanded across Gwent with both dermatology and other services such as ENT taking advantage of this method of working. Ophthalmology will continue to be supported as they develop the Ophthalmology Diagnostic and Treatment Centres (ODTC) and other diagnostic services to capture detailed images locally which can be reviewed by consultants back at base. Informatics will continue to support the service in developing virtual clinics and non-face2face consultations with a mix of National and Local

integrated systems. The development to support T&O and reduce fracture clinic follow-up attendances last year has demonstrated the benefits and should be scaled up over the next 3 years.

Increasing capacity – 2015 saw a focus on targeting a reduction in DNA rates. A text reminder service called Dr Doctor has recently been piloted across two specialties with reductions in DNA rates gained. The service was launched in 2 specialties in week 42 with a significant impact as can be seen in the following graph.

Graph 10.2



This service will continue to be rolled out for all specialties in 2016/17.

Unscheduled Care

Front Door – replacement of our local Symphony system with the National version is planned for 16/17 and will be an opportunity to further reduce paper generated in the department and also implement the system within our 7 assessment units. This will provide the service with valuable performance based information to support real-time workflow and monitor process re-engineering as well as capturing clinical information for the digital patient record. Redesign of RGH minor injury unit will be supported by improvements in the IT infrastructure increasing access to these systems.
Patient flow - Introduction of a real-time electronic Patient Flow Management systems in 2016/17 will provide the service with a visualisation of the patient journey and help identify bottlenecks, variation and waste. The teams can then manage change using a variety of dashboards and business intelligence as a by-product of data collection in support of their objective of reducing Length of Stay (LOS) and Delayed Transfers of Care (DTOC).

Planned Services – to support the service in gaining further increases in productivity, effectiveness and efficiencies, particularly for outpatients and diagnostics, solutions recently implemented have included text reminders to reduce DNA rates, replacement of our old endoscopy system and the early development of Patient Reported Outcome Measures (PROMS). Intensive care units are struggling to manage with maintaining an adequate specialist resource across Wales. eICU is a system which can link to life sign monitoring and provide remote support for the patient from clinical hubs. Over the next year, plans to test this out will commence in two Health Boards (Hywel Dda and Cwm Taff), and if proven to be successful, will then be scaled up across Wales.

Families and Therapies

Implementation of Welsh Community Care Information System (WCCIS) over the next few years will seek to deliver an integrated health and social care record and as a result, reduce duplication of effort whilst improving communications between staff over the whole care spectrum. This National system has the facility to improve scheduling by matching demand to resource, a long awaited solution for the division. However, IT infrastructure is poor in many community bases and IT devices are inadequate. With the introduction of the (WCCIS) it will become imperative that this infrastructure is improved and that the staff are equipped with mobile devices to support their workflow.

The introduction of a new Maternity information system sets an environment for the collection of valuable data to support the development of advanced and specialist nursing and midwifery roles.

The system requires further development to provide a suite of standardised information which can influence sustainable and consistent models of care.

Progress on refining and improving our business intelligence systems supports the Division in analysis of referrals, case mix and outcome measurement facilitating future workforce and service model plans.

Improvements with the flow of information between, primary, community and secondary care is essential to support the clinical futures model when more reliance is placed on step up and down transfers underpinned by improved pathways. To this end, the patient flow management system must also be implemented at a virtual level in the community resource teams and 3rd sector to ensure whole service capacity dashboards in real-time are maintained.

Mental Health and Learning Disabilities
Introduction of the WCCIS is fundamental to the division's plans to integrate patient information within multiagency teams. Whilst the timeline for transition to the new system remains unclear the data migration process from our existing system to the National one will need to be robust to ensure integrity of data is maintained and the transfer achieved in a timely manner to reduce / prevent disruption to the clinical service provision.

Similar to bases found in the Family and Therapies Division, the existing infrastructure both in terms of network capacity at some MH and LD sites and IT equipment across the boroughs is inadequate and requires investment and upgrading to assure appropriate communications are in place to support access to essential systems.

Primary Care
All informatics services to primary care are provided by the National Welsh Informatics Service (NWIS). All 86 practices in Gwent have now migrated to one of the two National systems and the Welsh Clinical Communications Gateway is the messaging fabric which links this system to our secondary care systems. The UHB will continue to take full advantage of this and already are well ahead of other Health Boards in the number of e discharges sent back to primary care, whilst a pilot with NWIS in 9 practices are managing all clinical correspondence electronically. This pilot will be reported back to the National programme in early 2016 and all other practices are planned to take this approach during 16/17 leading to significant savings by removing paper and transportation costs.

Clinical futures and exploiting new technology trends
It is anticipated that patients will increasingly move between different service providers and different sites. In this respect, then it is natural that clinical and support staff will also move to meet patients at the sites, including at home and in the community. Where these sites are community based then there will be greater emphasis on mobile technology to obtain that information. Informatics will move its service delivery model to allow the staff (users) to be able to access the information and systems and applications they need from a variety of devices. To ensure that the UHB can support and maintain this diverse model of delivery then it will need to continue to invest in the desktop estate to ensure it is kept up to date and fit for purpose. In addition Informatics will work with NWIS to develop and implement a national cloud strategy which will support mobile working and to create an identification and authentication service such as single sign on to enable a consistent look and feel for staff.

Information: promoting and supporting service improvement

Information – Business Intelligence
Over the next 2 to 3 years, the development of UHB Information Services and the provision of information to clinicians and managers will utilise a Business Intelligence approach. It is essential to note that the focus of this work will not be "business" in the sense of commercial activities, transactions and finance but rather the true business of the UHB, maintaining and improving the health of the citizens that we serve.

The key people who will benefit from this approach are the clinicians and operational managers who have responsibility for the delivery of services to citizens and patients. Business Intelligence will help them to better understand the way that their services operate, the impact of their services and the way that their services could be improved. The approach will include the development of easier and more intuitive access to information for staff that provides a comprehensive and rounded view of performance against process and outcome measures. Proposed areas of development include:

- A focus on patient pathways, enabling the analysis of activity and events in more meaningful ways than is allowed by the existing silos of Emergency Department Data Set (EDDS), Admitted Patient Care (APC), Out-Patient Department (OPD), Community Services, primary care, etc.
- Achieving comprehensive access to primary care data, a crucial component in understanding and promoting the shift in focus from acute to primary and community care services that is at the heart of Clinical Futures.
- An increased concentration on patient experiences and outcomes, especially those reported by patients, rather than counts of activity and the monitoring of processes.
- Driving work at a national level to achieve a better match between submitted information and developing clinical and operational practices.

A Business Intelligence approach will also be taken in the provision of information to the people who use or are interested in the services we provide. They will be provided with access to comprehensive and detailed information about our services that is understandable and useful. Although, as stated above, developments will be focused on understanding and improving the direct delivery and planning of care, we will also strive to maintain and improve the provision of information for Finance, Planning, Workforce and other corporate departments. This will support the better targeting and use of resources to ensure that the future delivery of services to our patients and citizens remains robust and sustainable.

Clinical Classification – Coding

A crucial component of much of the information we produce and use is the accurate and timely classification or coding of the problem, diagnosis and treatment of each individual patient. To achieve this requires skilled and experienced staff. The recruitment and retention of staff is a persistent challenge and, over the next 2 to 3 years, departmental structures and working practices will be reviewed and changed to increase the resilience of the Department. For example, home working and the limited outsourcing of specific areas of coding (e.g. endoscopies) will be explored. As well as increased resilience, an additional objective will be to minimise and potentially end the use of contract coders because they are expensive and require additional staff time to audit their work to ensure quality is maintained.

The national targets for coding are solely focused on the timeliness of coding and do not provide any indication of the quality of clinical coding. The pursuit of target compliance will be maintained but will be balanced by increasing the emphasis on the quality of coding.

Outreach work by the Coding Department, the development of the portal to capture clinical terms with the future implementation of SNOMED and other related technologies will support and guide clinicians in contributing to the coding process by clarifying some of the key aspects of the care of individual patients (such as primary and secondary diagnosis) to provide a starting point for clinical coding. However, classification and coding will require the input and expertise of experienced clinical coders for the foreseeable future.

Resource

Capital investment

Informatics does not have a permanent ring fenced allocation of capital funds each year. This is true of both Local and National infrastructure. The current funding process is based around bidding for capital funding against the requirements of the entire UHB, and using risk scoring to

prioritise each bid. Informatics has been reasonably successful in acquiring capital funds for ICT projects, either from discretionary capital or through national Welsh government bids. The capital investment from local discretionary for ICT over the last six years is shown in the table below.

Table 10.3 - Investment within Informatics programmes over the last 6 years

Year	2010	2011	2012	2013	2014	2015
Investment (£000)	£847	£1,938	£2,698	£1,314	£3,338	£1,113

The ability of Informatics to purchase capital based equipment with short lead times e.g. software and off the shelf hardware, such as PCs, has allowed informatics to address some key ICT risk areas in relation to desktop, server and network equipment and security around operating systems; investment must to continue in these areas to support business continuity and defend against cyber-attacks.

Revenue investment:
Over the last 3 years there has been no staff head count increases and the overall budget has shrunk since 2013 as shown in the table below. During this period we have successfully managed our support costs effectively and have reduced costs to the UHB through improved procurement. Please note that NON-PAY cost also includes a proportion of service payment costs to NWIS as specific services transition from local to National under the 'Once for Wales' principle which is envisaged to grow over the next few years.

Table 10.4 - Revenue Breakdown

Year	2012/13	2013/14	2014/15
PAY (£000)	£3,387	£3,007	£3,173
Non Pay (£000)	£1,961	£1,974	£1,889

The last 3 years has resulted in a 43% growth in PCs and Laptops to service clinical need to implement the digital strategy, providing access to clinical, administrative and workforce information systems. Whilst the benefits of additional computing resources for staff have allowed greater service efficiencies it has placed additional strain on the service to ensure integrity and security are maintained. Added to this is the demand being placed on the service by NWIS for the implementation and support of new national systems and as a result call requests to the informatics service desks have increased by 22%. Implementation and training resources are fully consumed resulting in negative comment in WAO report regarding inadequate training being provided. Whilst customer service and feedback on the services remains excellent the existing establishment has struggled to maintain service levels resulting in increased response times, dropped calls to users and inability to meet to core programme implementation and training support. Similarly calls to the switchboards from the public have increased from **0.77m pa to 1.2m pa** which represents a **37%** increase as the UHB further strengthens engagement with the public.

Future requirement:
It is recognised that the current funding level is sufficient to manage the current state and any future developments will require additional resource as noted in the detailed Informatics IMTP. The total level of UHB spend on Informatics is lower than the recommended 2% of total revenue expenditure at 0.73% and lower than the all-Wales average of 0.83% [WAO Diagnostic Review of Capacity and Resources – Nov 2015]. With several significant further changes e.g. the new SCCC, adoption of WCCIS and WCP convergence, investment is paramount to ensure successful implementation and realisation of the benefits.

As an indication of the potential investment required for the comprehensive and successful implementation of a complex project, the early scoping of the resource requirements for the WCCIS suggests a requirement of an additional 21 WTE staff to the present complement. These will include project managers, product specialists and trainers, information specialists, ICT technicians, service desk support, and clinical and business change resources. The number of additional devices and users is currently scoped for our services at circa 4,000.

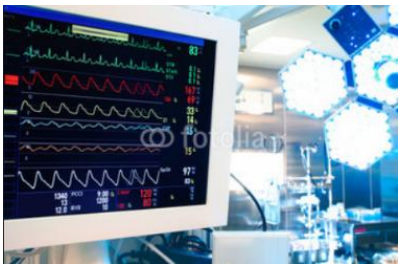
It should be noted that ICT marketing and procurement models are increasingly moving toward regular revenue streams, in particular for software and cloud services. These will reduce capital reliance for some items but will negatively impact upon the UHB's revenue expenditure.

Conclusion
The UHB will ensure that it continues to take advantage of systems and processes that puts patients at the centre of care following them through all phases of their care at hospital, in primary and community care settings and with care partners with seamless transfers of care (clinical flow). In addition, it will be moving to a position where it will be offering staff and patient's access to systems and resources outside of the UHB environs in order to provide clinical and support services. Patients will be provided with access to their record over the internet – allowing them to monitor their own care and to ensure that their details are accurate. It will enable services which allow the clinician and patient to interact and have consultations using the computer – the patient at home and the clinician in the surgery (a virtual consultation). This will enable a quicker response and reduce waiting times. It is clear however, that to support the organisation, implement new technology, and maintain current infrastructure, further investment is required [WAO Diagnostic Review of Capacity and Resources – Nov 2015].

2. Systems for Technology Adoption

Whilst there are many technical advances with diagnostic instrumentation the following focuses on equipment which is agnostic of specialty.

Systems which support patient level care through life sign monitoring devices are now easier to interface with patient information system sat the bedside.



The Health Boards in Wales have collaborated to gain funding for an electronic patient flow management system plus improvements in bedside care and are seeking to interface these monitors with Early Warning Score modules which in turn will alert a team of outreach clinicians immediately should there be a significant change in a patient's recordings. This is considered best practice in managing sepsis.

Furthermore, the developing eICU bid to Welsh Government seeks to link intensive care patient monitoring systems complete with video link to central clinical hubs to ensure expert advice is on hand from any hub in Wales to any ICU bed leading to improved outcomes for patients. This is proposed to commence in two Health Boards in Wales in 2016 and if the benefits are proven, will then be subject to an All Wales roll out including the ICU beds in both NHH and RGH.

Finally, plans to procure a central Point of Care Test system by NWIS in 2016 will enable further expansion of POCT local devices which can remove delays from test to result and potentially reduce the wait/LOS for patients. Business cases for additional devices will be required to support this expansion.

3. Technological and Informatics Opportunities

Rapid advances in Technology ensure the marketplace is full of solutions which support clinicians and Health organisations in care delivery. There is however a caveat to the take-up of innovations in that the costs should at least equate to the quality and/or financial benefits gained as a result. We have many existing solutions which could be enhanced with new technology but the costs

outweigh the additional benefit gained. It is important that benefit delivery associated with technical implementations are tested by prototype prior to further investment for scaling up, and that scarce resource is focussed on delivering solutions with proven benefit rather than those with minimal gain.

The UHB has spent much of the last decade focussing on delivering information to the clinicians but more emphasis is now planned on data gathering through technology such as e-forms and wizards. There is an opportunity to develop intelligent question sets rather than just replace the paper forms with an electronic copy, and this excites many clinicians as this detailed information will better reflect their clinical activity and the patient's presentation. The key aim is to replace paper-based notes and associated free text with structured data which is able to be re-presented in other documents and correspondence. This structured data will also support interrogation to improve clinical outcome and organisational efficiency.

Collecting data as part of clinical workflow from a number of systems has enabled the UHB to collate this within a data warehouse and to start to provide detailed business intelligence for the organisation. This data has been essential in providing information to both baseline and monitor changes in our move towards the clinical futures model.

Implementing the new SNOMED Clinical Terms coding structure provides an opportunity to take 'decision support' to the next level. A collation of clinical terms gathered on referral/admissions has the potential to:

- automatically trigger bundles of care;
- break into tasks which are handed over between disciplines and shifts;
- provide an estimated date of discharge based on previous data;
- be analysed alongside outcome measurement to set new standards of care where indicated;
- provide detailed clinical documentation, clinical coding and correspondence as a by-product;
- add detail to support patient level costing.

This will reduce variation and harm, standardise and promote quality and excellence for patient benefit. This would also support efficiency gains to the organisation.

Microsoft office 365 and Skype for business are amongst a number of technological advances which is rapidly improving to support mobile staff and patient communications through increased availability of person to person video. Secure connections also help us to share clinical records between the UHB and local service providers enabling some services to be contracted out.

The growth in web based secure technology alongside the increase in patients who have access to the World Wide Web brings us closer to supporting patient access to their own record. My Health Online currently enables patient access to appointments and repeat prescription and the next few years is likely to deliver access to key elements of clinical information, facilitate monitoring alongside Point of Care devices and provides specific health related educational support to facilitate a shift in patients taking responsibility for their own health and well-being.

And finally, recent technical advances have enabled the UHB to securely share the internal Wi-Fi and to offer public access to Wi-Fi in our large hospital sites with plans to expand this within St Woolos and County hospitals over the next year.

Section 3

Chapter 11 - Stewardship & Governance

1. Corporate Governance (IG)

The UHB continues to focus on ensuring that the organisation has clear strategies and plans designed and delivered with patient interests at their centre. There is complete support for the Francis Report principles and requirements for a patient focused culture, clear focus on fundamental standards, openness and transparency, candour to patients, strong cultural leadership, and caring and compassionate nursing. The organisation seeks to ensure that the services we deliver are of the highest safety and quality and meet required standards and that our staff play key roles in shaping and delivering them.

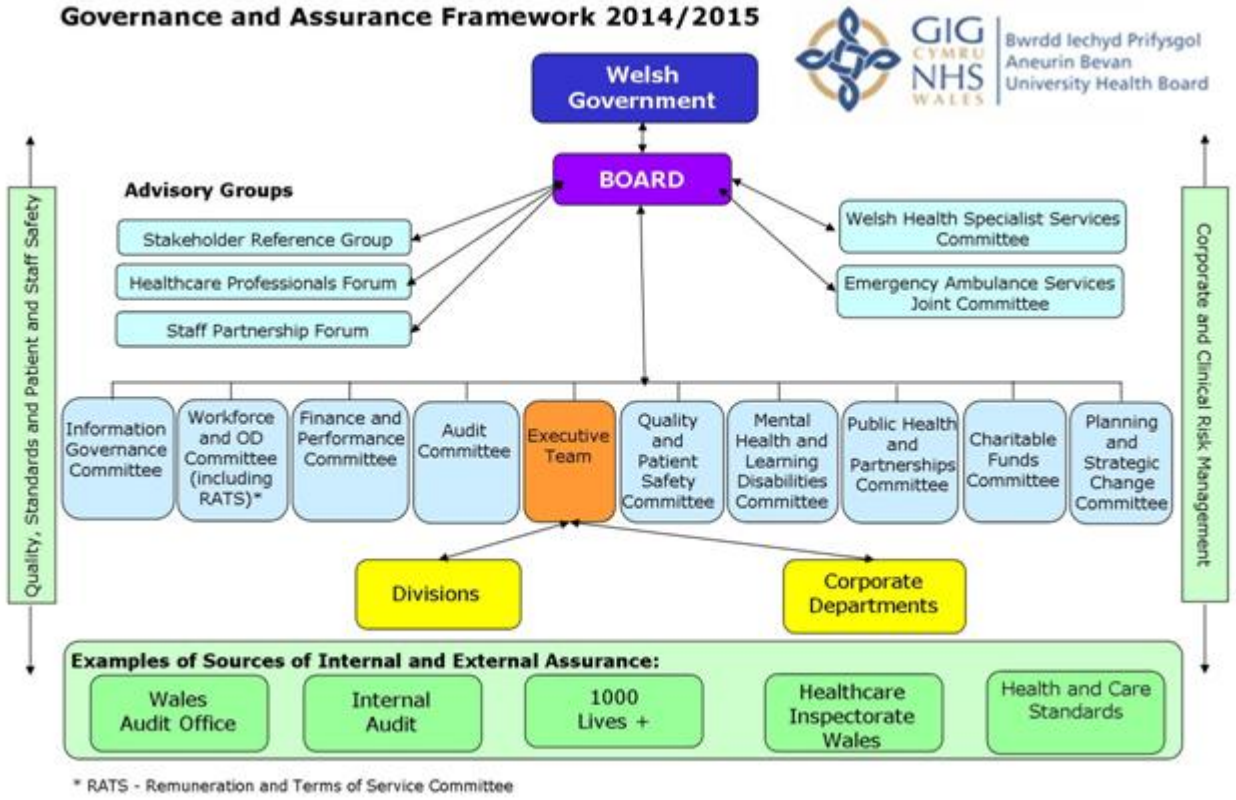
We have a clear organisational commitment to good governance, which includes having a clear vision and a strong focus on public service values, as well as being a learning and developing organisation. These values have been borne out in our own and independent assessments over recent years. However, the UHB as an organisation is not complacent and is aware that there is continuing work that has to be undertaken to further develop, especially to realise the opportunities and requirements of our status as a University Health Board.

Our Board is accountable for governance and internal control in the organisation, with the Chief Executive (as Accountable Officer) responsible for maintaining appropriate governance structures and procedures. This responsibility includes a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst also safeguarding the public funds and the organisation's assets (in accordance with the responsibilities assigned by the Accounting Officer of NHS Wales).

The UHB has continued to develop its framework and systems of governance and assurance. The Board sits at the top of the organisation's governance and assurance framework and systems and sets strategic objectives, monitors progress, agrees actions to achieve these objectives and ensures appropriate controls are in place and are working properly throughout the organisation. To do this the Board also takes assurance from its Committees and also its assessments against the Health and Care Standards in Wales and other professional standards and regulatory frameworks. The UHB and its committees are also seeking to use the key themes of the IMTP and progress against key actions to inform the development of Board and committee agenda and also through this to actively track progress against actions and particularly progress against agreed outcomes to ensure that the intended benefits and improvements have been realised.

The UHB's governance and assurance arrangements have been established in accordance with our Standing Orders and Standing Financial Instructions. The UHB's agreed objectives also seek to ensure we meet national and locally determined priorities and professional standards throughout the conduct of our business. Reporting and monitoring against these objectives, and the risks associated with their delivery and achievement, are received by the UHB and its Committees. Further information on Governance framework and arrangements is included in the UHB's Annual Governance Statement, Annual Report and the Annual Quality Statement, which are available via the UHB's web pages. The UHB's governance and assurance arrangements are outlined in the diagram opposite:

Figure 11.1



In recent years the publication of the Francis Report, the Keogh Report and the report on Betsi Cadwaladr University Health Board and the assurance letter submitted to Welsh Government and annual Wales Audit Office Structured Assessments (please see below) which have focused on governance matters along with our own internal evaluations has provided the UHB with further opportunities to reflect on our organisational position in relation to our approach and to identify key areas for further development.

The UHB also uses the Welsh Government's **Citizen Centred Governance principles** to guide our work of obtaining assurance from within the organisation and also giving assurance externally to others in order to demonstrate that the UHB is achieving its objectives and meeting our responsibilities. The extent to which UHB with our partners is able to demonstrate its alignment with these principles and also how we plan for and deliver our responsibilities for citizens are important aspects of the ways in which we are organised, manage our business and perform.

The **Wales Audit Office Structured Assessment Report** for 2014 highlighted that the organisation's governance arrangements have continued to mature and develop to meet our stated goals and also identified that the key areas identified in last year's structured assessment have also improved because our structures and frameworks continue to develop and mature effectively. This external assessment of the UHB's continuing development was encouraging, but the UHB recognises that there is further improvement work required to respond to our stated ambitions as an organisation to provide the best services for local people. The UHB has in place a programme of actions to respond to the areas of further development identified in the Structured Assessment.

The key assessment and conclusion from Wales Audit Office was as follows:

Wales Audit Office Structured Assessment Overall Conclusion:

'The UHB has arrangements to support good governance and a strong performance and improvement focus, but more needs to be done to ensure the healthcare model is modernised and financially sustainable to meet the need of future generations:
The UHB's financial management arrangements ensured that it met its target to break even for 2013/14, but it does not yet have effective sustainable financial planning as part of an integrated medium term plan. The UHB's governance arrangements are continuing to improve from a broadly sound base, but the organisation needs to strengthen planning to ensure it meets its future longer term financial challenges and population health demands. The UHB needs to further develop its approach to the design and management of change and to strengthen workforce planning'.
(WAO, 2014)

The UHB has committed to a range of actions in response to the Structured Assessment to be delivered during 2015/2016 and these include:

- Building on the UHB's current approach by developing longer term savings plans, but also exploring the potential for income generation as an organisation and in partnership.
- As part of the development and implementation of the Integrated Medium Term Plan (Three Year Plan) the UHB is reviewing its planning capacity and the resources made available to take forward the implementation of the plan.
- Further enhancing the UHB's approach to clinical engagement as part of our programmes of change and patient pathway design.
- Building on existing good quality and patient safety committee arrangements by the development of a quality assurance framework.
- Reviewing the information taken to the Board to ensure that this includes more information on clear patient outcomes, clarity on risk appetite and consistency of risk reporting.
- Developing a clear change management framework and develop a programme of delivery and monitoring.

Progress against these key actions is being taken forward via the Executive Team and is being monitored by the Audit Committee through tracking reports with a focus on assessing outcomes and realising intended benefits.

2. Risk Management

The UHB has continued to develop and embed its approaches to risk management to ensure risk systems continue to be streamlined and interconnected and that our understanding of risks actively informs the UHB's key priorities and actions and its overall approach to risk governance in the delivery of its Annual and Three Year Plans.

During 2015, the UHB has made further developments to its approach to risk management. Changes have been made to the format and presentation of the UHB's Corporate Risk Register to reflect the risks of the non-delivery of the UHB's Integrated Medium Term Plan. This has resulted in the Corporate Risk Register now being separated into key themes of the Plan to enable the Board to track progress.

The UHB's Public Health Team has also been undertaking development work on a bespoke public health and partnerships risk register, which reflects the medium to longer term nature of these programmes of work and these risks have also been reflected in the UHB's overall corporate risk register.

In October 2015 the UHB undertook further development activity in partnership with the UHB's Risk Managers' Network. As a result a further programme of development work has been agreed.

This work will be further developed over coming weeks and months to rework the UHB's Risk Management Strategy, particularly focusing on the areas of key risks vis-à-vis key issues currently being managed, how the wording of risks become more patient and public focused, that reporting mechanisms are further clarified and also the risk appetite of the organisation is further understood building of the work undertaken by the Board during 2015 on risk appetite.

Therefore, the UHB clearly sees active and integrated risk management as key elements of all aspects of our functions and responsibilities especially in order to support the successful delivery of our business and our plans. This assists in ensuring high quality and safe heath care is provided to local people, that we contribute to improving the health and well being of our population and that a safe and supportive working environment is provided for our staff.

The Chief Executive has overall responsibility for the management of risk for the UHB. The Executive Lead for clinical risk management is the Nurse Director and has delegated responsibility for ensuring that arrangements are in place to effectively assess and manage clinical risks across the organisation. The Board Secretary along with the Nurse Director work together to design systems and processes for risk management with the Board Secretary having responsibility for maintaining and co-ordinating a corporate risk register and the corporate reporting of risks. The UHB and its Committees identify and monitor risks within the organisation. Specifically, the Executive Team meetings present an opportunity for the executive function to consider and address risk and actively engage with and report to the Board and its Committees on the organisation's risk profile and the risks of non delivery of its agreed Annual and Three Year Plans.

The risk profile of the UHB is continually changing, but the key risks that emerge and can impact upon the UHB's achievement of its objectives its Annual and Three Year Plans include strategic; operational, financial and compliance risks. There were 32 risks on the UHB's Corporate Risk Register at December 2015 (as summarised below).

Table 11.1

Category of Risk	Number of Risks at December 2015
Strategic Risks	**10**
Financial Risks	**1**
Operational/Business Risks	**11**
Compliance Risks	**7**
Public Health Risks	**3**

2.1 Top Risks and Sensitivity Analysis

As part of our wider governance and quality strategy, the UHB is committed to ensuring that risk management is an integral part of our practice and essential for the safety of our patients and to maintain the highest possible standards of care. The governance framework for this is described in the UHB's Risk Management Strategy, with the Corporate Risk Register underpinned by detailed risk assessments maintained by each Directorate, Division and Neighbourhood Care Network.

Corporate risk priorities are also reported to our Board at each of its meetings and are in the public domain. For information, we have provided an abridged version of the more detailed corporate risk register as at January 2016, listing the critical high risk areas for this organisation (over the medium term) which will need to actively managed and mitigate against over the next 1-3 years. This risk framework has now aligned to the Health Board's Service Change Plans.

Table 11.2

Description of risk	RAG rating	Mitigating Actions	Risk Owner / Reporting Arrangements.
Theme: **Overarching and Enabler Risks (1)** **Unscheduled Care (2)** **Referral to Treatment Time Targets and Access to Services (3)** **Primary Care (4)** **Workforce Sustainability (5)** **Continuing Healthcare (6)** **Public Health and Health Protection (7)**			
Planning (1) Failure of the Health Board to effectively and efficiently provide services to meet the needs of the population we serve, without a clear and agreed IMTP	20	IMTP agreed by Board in March 2015, and by the Welsh Government in June 2015. The IMTP is in the process of being refreshed and will identify risk areas and focus on key priorities.	Director of Finance and Interim Director of Planning and Performance reporting to the Board (with delivery aspects monitored through all Committees of the Board).
Emergency Care (2) Failure of the Health Board's Emergency Care provision to meet the needs of local people Failure of the Health Board to meet the target that no patients would wait longer than 12 hours or 4 hours in our emergency departments.	**20**	Health Community Action Plan agreed. Patient Flow Improvement Programme established. The new WAST Clinical model has been implemented and is monitored through fortnightly meetings with WAST leads. Escalation of 12 hour breaches to Chief Operating Officer. Winter Plan approved and being actioned.	Chief Operating Officer reporting to the Finance and Performance Committee and the Unscheduled Care Board
Referral to Treatment Times (3) Failure of the Health Board to meet Referral to Treatment Time Targets resulting inpatients not receiving their treatment in a timely way.	**20**	Additional service provision being commissioned to support the Health Board's achievement of the agreed position. Outsourcing plans in place for orthopaedics and ophthalmology.	Chief Executive and Interim Director of Planning and Performance and Chief Operating Officer reporting to the Finance and Performance Committee and Board
Patient Experience (3) Failure of the Health Board to meet the public and patient quality of care, positive experience and dignity of care expectations of local people.	**20**	Clear action plans with active monitoring in place. Evidence and feedback shows that implementation will mitigate the current risks.	Director of Nursing, reporting to the Quality and Patient Safety Committee.
Primary Care Services (4) Failure of the Health Board to deliver a sustainable model f primary care services (especially GP Services)	**20**	Sustainability Framework being developed. Work being undertaken with Neighbourhood Care Networks with regard to sustainable models	Chief Operating Officer reporting to Quality and Patient Safety Committee.

Description of risk	RAG rating	Mitigating Actions	Risk Owner / Reporting Arrangements.
leading to patients being unable to access primary care services			
Workforce Sustainability (5) Inability to provide sustainable patient care as a result of needing to meet the Deanery requirements. Failure to plan for, recruit and retain staff with the right skills to deliver high quality care for patients.	**20**	Discussions ongoing with deanery and clinical teams in relation to projected trainees allocated for next year to identified specialities in order to mitigate an adverse patient impact. Recruitment and retention plan in place and regularly reviewed.	Medical Director/Director of Workforce and OD/Nurse Director reporting to Workforce and OD Committee
Continuing Healthcare (6) Failure to develop an effective strategic plan to manage the forecast growth in the requirement and costs for Continuing Healthcare for local people	**20**	CHC Management Board oversees the strategic direction and operational delivery of the plan.	Chief Operating Officer reporting to Finance and Performance Committee
Engagement (1) Failure of the Health Board to clearly understand the needs of citizens if it did not engage with stakeholders and partners in a timely ways on strategies and service plans and proposals	**16**	Positive working relationships with key stakeholders and CHC. Engagement Strategy approved by the Board and new Engagement Team in place.	Interim Director of Planning and Performance and Board Secretary reporting to the Board and Planning and Strategic Change Committee
Care Home provision (3) Failure to meet the care needs of local people as the right care is not in place in local care homes in terms of quality, safety and also capacity of the local care home sector	**16**	Ongoing engagement with care homes to reinforce key requirements to mitigate risks.	Chief Operating Officer reporting to Quality and Patient Safety Committee
Public Health Failure to support citizens to maintain and improve their health, wellbeing and independence.	**16**	Public Health Team working with Divisions, community based groups and third sector bodies. Living Well Living Linger programme commenced and wider patient education programmes in place. Further investment required to	Director of Public Health reporting to Public Health and Partnerships Committee

Description of risk	RAG rating	Mitigating Actions	Risk Owner / Reporting Arrangements.
		support community based and longer term programmes.	

2.2 The Risk and Control Framework

The UHB's approach to risk management provides a framework and structured process for the identification and management of risk across the organisation to better inform decision making and the delivery of the Annual and Three Year Plans. The UHB's systems and processes allow for the Board and staff to implement necessary actions to respond to risks at all organisational levels. They also facilitate the reporting of risks throughout the organisation, escalating to senior levels of management, where required, and to the UHB and its Committees via the Executive Team, or vice versa, to further inform corporate decisions and delivery of corporate plans.

The UHB recognises that through these processes it is not possible to eliminate or avoid all risks and that in some instances the Board, the wider organisation and with our partners we might have to take informed risks to further our stated aims and objectives and delivery of Annual and Three Year Plans. However, as risks are recognised and identified, actions to understand and respond to these risks are undertaken and implemented. If after all necessary steps have been taken and the risk remains, the UHB may decide to accept the risk and continue to actively manage it recognising its potential impact on the delivery of our plans.

The Board's risk appetite and its decisions to accept and actively manage risks might be different for the range of its responsibilities. The Board through information and intelligence from within and outside the organisation will determine the level of risk it is willing to accept for each area of its plans and business. This is determined by the Board at its meetings and informed by the work of its committees and strategic and operational planning activities.

The UHB links closely with public service partners, such as Local Authorities and other bodies and organisations to assess and manage risk and to understand key issues and risk that could impact upon the UHB and affect the effective and efficient delivery of its services and functions to support patient care.

3. Financial Controls, Reporting and Audit Arrangements

The organisation's financial control framework is set out within the Standing Financial Instructions of the organisation. SFI's set out the regulation of financial proceedings and business and are designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business. They translate statutory and Assembly Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a scheme of decisions reserved to the Board and a scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the UHB.

In addition to Standing Orders and Standing Financial Instructions there are a series of Financial Control Procedures that cover core financial systems of the UHB, including a budgetary control policy that sets out the accountability framework for budgets and processes that are to be followed when budget variances arise.

There are many other control systems within the UHB that contribute to good financial control. The Audit Committee provides assurance to the board that the organisation's systems of internal control are effective. In seeking assurance as to their effectiveness the Audit Committee approve a programme of internal audit of systems and processes to seek assurance and to drive

improvement. The UHB has invested in additional internal audit resource over recent years as part of its strategy of improving internal control systems and compliance. Internal Audit is provided by NWSSP Audit and Assurance. Further assurance is also gained from external audit work provided by Wales Audit Office in relation to their role in providing an opinion on the organisation's statutory accounts and their work on structured assessment and performance reviews.

Financial reporting for the organisation follows a firm monthly cycle. The financial position is reported to WG on working day five of the month end and is followed immediately by a flash report to the organisation on the financial position. A full and a comprehensive financial report for the Board is produced monthly and presented to the Board (bi-monthly) or the Finance and Performance Committee of the Board (monthly).

Delivery of the work streams within the UHB's financial plan for the year are monitored through Challenge and Support meetings via the executive team. There are also two board sub committees that support financial governance arrangements. The Finance and Performance Committee's role is to focus on in year delivery together whilst the Planning and Strategic Change Committee role is to focus on longer term strategic planning on behalf of the Board.

At a divisional level, Divisional Management Teams, including Business Partner Accountants, meet to discuss the current financial position of the Division and the organisation and discuss the financial agenda, forecasts and plans. This occurs on a regular basis and at a minimum on a monthly basis.'

4. Information Governance

Information Governance is one of the essential regulatory components that facilitate the effective and efficient delivery of services. Good Information Governance provides patients, families, partners, service users and staff with the confidence that the UHB is creating, collecting, storing and using information correctly and within the law.

The Information Governance Unit will work closely with all divisions and services to assist with the delivery of information systems; facilitating the use of Privacy impact Assessments before any new information system is implemented [this is likely to become a statutory regulation in the next two years].

As partnership working increases we will be ensuring that our staff and patients are well-informed about the work we do with our partners, such a, social services. We will ensure that the framework for sharing information – the Wales Accord on the Sharing of Personal information [WASPI] and its associated information Sharing Protocols [ISP's] – is used to deliver effective and efficient services between our partners. It is important to link this with the patient care pathway to ensure that all partners [third sector, private or public] are identified and included. We will develop a WASPI: South-East Wales Partnership forum by way of ensuring and assuring that ISP's developed are appropriate and implemented correctly. This will be a vital requirement once the transition within local government is finalised.

The next few years will also see a major change in the confidentiality and privacy laws with a new European Union Data Protection Regulation to be issued, followed with changes to UK law. We will attempt to anticipate the changes and put processes in place enabling the UHB to respond quickly and positively to any (new) requirements.

Staff are much more aware of IG and its requirements than three years ago but we will continue to build on the theme of personal ownership and accountability where IG is "part and parcel" of everyday work for all staff – we will look to expand the excellent work of the Information Governance Stewards to additional community services and secondary care services.

We will review the UHB's IG training delivery programme to improve staff knowledge and work with our partners in health and others to ensure a consistent approach and content across NHS Wales. The delivery of training and monitoring compliance to mitigate the risk of reputational damage and financial sanction and to ensure that policies and training are effectively and efficiently communicated will require the procurement of delivery software to explore the UHB's compliance culture, improve staff awareness and be more efficient in the way it can deliver policies and training across the UHB.

Over the next few years there will be increasing scrutiny around the public sector compliance with IG standards and legislation and we will be ensuring that the UHB meets the standards required.

Chapter 12 – Outcomes and Delivery

1. Our Outcomes and Delivery Framework

Our approach will be based on effective delivery and assurance principles by promoting effective leadership, positive culture, mutual support, strong governance and accountability and robust performance management. This will be achieved by:

- Empowering leaders to deliver change at all levels within the Health Board.
- Providing support to enable leaders to understand, model and address complex, systemic challenges to delivery of our objectives.
- Being explicit about how staff are expected to contribute to change from their role in optimising their department's performance to wider organisational challenges.
- Having meaningful (not multiple) matrices that allow progress to be measured.
- Ensuring that there are clear structures and accountabilities for deliver change and integrated structures to monitor their delivery.

The Governance and Assurance Framework for the organisation is attached as Appendix 1 and is the structure that will be used to support the delivery framework.

This framework will assist in the monitoring of progress against achievement of key priorities and ascertaining they are having the appropriate impact and outcomes. This monitoring will measure progress of key deliverables both in terms of actions and against agreed profiles. There will be reporting arrangements to ensure escalation where appropriate and support to effect remedial actions. This approach will be underpinned by having strong focus on the delivery of Service Change Plans which will have clarity on delivery arrangements including:

- Clinical and managerial leads.
- Status of detailed plans.
- Key milestones and timescales.
- Integrated outputs (quality, operational, efficiency, workforce and finance), that form the basis of tracking of plan delivery.
- Risks and mitigation plans.

To ensure that the Health Board's strategic priorities are being delivered an integrated planning tracker will be developed for each Service Change Plan and incprorated into the perofmrnace maangement framework, providing the means by which progress would be measured quarterly and includes the following:

- Progress against key project milestones within the quarter.
- Delivery against performance milestones.
- Delivery of planned workforce changes.
- Delivery of financial benefits.
- Realisation of quality, patient experience and performance outcomes.
- Key risks and mitigating actions.
- Enabling support required.

There is clarity on priorities, action and key deliverables for 2016/17 but less granularity for 2017/18 and 2018/19. The delivery framework and governance structure continue to be reviewed and will be strengthened as required as we progress through the planning and delivery process.

Figure 12.1

The framework is based on seven domains, identified through extensive public and stakeholder engagement.

The new Performance Management Framework will also encompass local delivery plans and programmes of work and will consider and include:

- Progress and Outcomes of Service Change Plans & Strategic Work Programmes
- Productivity & Efficiency Indicators
- Primary Care & NCN Performance Indicators
- Progress around patient outcomes eg, PROMS, PREMS, ISCHOM.

This will be an iterative process as the information available across these areas is improved. A stronger focus on quarterly monitoring is also being introduced to support the delivery process.

The table below sets out the key metrics that are included as part of the National Outcomes & Delivery Framework and the planned performance over the next three years.

Table 12.1

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure			**Target**				**Profile**		
				Mar-14	**Mar-15**	**Mar-16**	**Mar-17**	**Mar-18**	**Mar-19**
Monthly	% of patients waiting less than 26 weeks for treatment – all specialties		95%	91.5%	88.4%	88.5%	90.0%	92.0%	95.0%
	Number of 36 week breaches – all specialities		0	891	2,329	2,550	1,200	500	0
	% of patients waiting less than 8 weeks for diagnostics		100.0%	59.5%	85.4%	77.0%	85.0%	92.0%	100.0%
	% of new patients spend no longer than 4 hours in A&E		95%	92.1%	91.8%	80.0%	92%	93.50%	95%
	Number of patients spending 12 hours or more in A&E		0	154	230	600	200	100	0
	% of Cat A Ambulance responses within 8 minutes		65.0%	49.9%	50.6%	62.0%	65.0%	67.5%	70.0%
	Number of over 1 hour handovers		0	1	1	458	100	50	0
	% of patients referred as non-urgent suspected cancer seen within 31 days		98.0%	98.3%	99.4%	98.0%	98.0%	98.0%	98.0%
	% of patients referred as urgent suspected cancer seen within 62 days		95.0%	96.2%	95.1%	92.2%	95.0%	95.0%	95.0%
	% compliance with acute stroke QIMs:	stroke care 4 hours rgh compliance	95%		11.4%	59.2%	95.0%	95.0%	95.0%
		stroke care 12 hours rgh compliance	95%		65.5%	97.4%	95.0%	95.0%	95.0%
		stroke care 24 hours rgh compliance	95%		44.2%	80.3%	95.0%	95.0%	95.0%
		stroke care 72 hours rgh compliance	95%		77.0%	94.7%	95.0%	95.0%	95.0%
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities									
Measure			**Target**				**Profile**		
				Mar-14	**Mar-15**	**Mar-16**	**Mar-17**	**Mar-18**	**Mar-19**
Monthly	% of assessments by the LPMHSS undertaken within 28 days from the date of referral		80%	41.3%	23.4%	80.0%	90.0%	90.0%	90.0%
	% of therapeutic interventions started within 28 days following assessment by LPMHSS		80%	73.3%	78.2%	60.0%	80.0%	80.0%	80.0%
	% of LHB residents (all ages) to have a valid CTP completed at the end of each month		90%	88.5%	92.2%	90.0%	90.0%	90.0%	90.0%
	% LHB residents sent their outcome assessment report 10 working days after assess		100%			TBC	100.0%	100.0%	100.0%
6 monthly assessment	% of hospitals with arrangements to ensure advocacy available to qualifying patients		100%			100.0%	100.0%	100.0%	100.0%

SAFE CARE - I am protected from harm & protect myself from known harm									
Measure			Target				Profile		
				Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Monthly	DToC delivery per 10,000 LHB population - mental health		Reduction (rolling 12 months)	3.3	2.9	2.04	1.6	1.5	1.4
	DToC delivery per 10,000 LHB population - non mental health			21.7	20.3	16.7	13.0	12	11
	Number of cases of C Difficile per 100,000 of the population		28 per 100,000			33.5	28.0	28.0	28.0
	Number of cases of MRSA per 100,000 of the population		1.5 per 100,000			2.1	1.5	1.5	1.5
STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health									
Measure			**Target**				**Profile**		
				Mar-14	**Mar-15**	**Mar-16**	**Mar-17**	**Mar-18**	**Mar-19**
Quarterly assessment	% estimated LHB smoking population treated by NHS smoking cessation services		5% (end of fin year)	1.1%	1.3%	2.0%	3.3% (1.9% AB) (1.4% SSW)	4% (1.9% AB) (2.1% SSW)	5% (2.2% AB) (2.8% SSW)
	% smokers treated by NHS smoking cessation services who are CO- validated as successful		40% (end of fin year)		38.3%	40.0%	40.0%	40.0%	40.0%
Monthly	Number of emergency admissions for basket of 8 chronic conditions per 100,000 of population		Reduction (12 months trend)	1284	1286	1287	1200	1140	1083
	Number of emergency readmissions for basket of 8 chronic conditions per 100,000 of population			260	277	252	240	228	217
Annual assessment	% uptake of the influenza vaccine in the following groups:	Over 65's	75%	70%	70%	67.0%	67.0%	70%	70%
		Under 65's in at risk groups		55%	53%	48.0%	48.0%	50%	55%
		Pregnant women		47%	45%	75.0%	75.0%	75%	75%
		Healthcare workers	50%	39%	40%	41.0%	50.0%	50%	50%
Quarterly assessment	% uptake of childhood scheduled vaccines up to the age of 4:	5 in1 age 1	95%	97%	98%	95.0%	95.0%	95%	95%
		MenC age 1		97.50%	98.50%	95.0%	95.0%	95%	95%
		MMR1 age 2		97.10%	96.50%	95.0%	95.0%	95%	95%
		PCV age 2		96.70%	96.60%	95.0%	95.0%	95%	95%
		HibMenC Booster age 2		95.90%	95.70%	95.0%	95.0%	95%	95%
Annual assessment	% of reception class children (aged 4/5) classified as overweight or obese		Annual reduction			25.1%	24.6%	24.6%	24.0%
Quarterly assessment	Number of contacts to the mental health C.A.L.L.		Quarterly improvement			3714	3,890	4,085	4,289
	Number of contacts to the Wales Dementia helpline					76	84	92	102
	Number of contacts to the DAN 24/7 helpline					868	911	957	1004
Monthly	Of those practices set up to use MHOL, % who are offering appointment bookings		Improvement (12 month trend)			71.8%	80%	85%	90%
	Of those practices set up to use MHOL, % who are offering repeat prescriptions					63.5%	75%	80%	85%
EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful									
Measure			**Target**				**Profile**		
				Mar-14	**Mar-15**	**Mar-16**	**Mar-17**	**Mar-18**	**Mar-19**
Monthly	% Crude Mortality		Reduction (12 month trend)	1.86%	1.75%	1.71%	1.60%	1.55%	1.50%
	RAMI 2015			115	113	109	100	98	96
	% valid principle diagnosis code 3 months after		95%	93%	99%	95.0%	95.0%	95%	95%
	% valid principle diagnosis code 3 months after		98%	98%	98%	98.0%	98.0%	98%	98%
Annual assessment	Number of Health & Care Research Wales Clinical Research Portfolio Studies and Commercially		Annual improvement			75	82	90	99
	Number of patients recruited into Health & Care Research Wales Clinical Research Portfolio Studies					4,462	4,908	5,153	5,411
Annual assessment	Number of Audits the organisation is participating in against the national clinical Audit Programme		Annual improvement			36	36	37	38
Annual assessment	% people aged 50+ who have a GP record of blood pressure measurement in the last 5 yrs.		Annual improvement			92.9%	94.0%	95%	96%
TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care									
Measure			**Target**				**Profile**		
				Mar-14	**Mar-15**	**Mar-16**	**Mar-17**	**Mar-18**	**Mar-19**
Annual assessment	% GP practices offering appointments between 17:00 and 18:30 at least 2 days a week		Annual improvement	99%	100%	99.0%	99.0%	99%	99%
	% of GP practices open during daily core hours or within 1 hour of the daily care hours			75%	92%	96.0%	97.0%	98%	99%
Quarterly assessment	Patients treated by an NHS dentist in the last 24 months as % of population		Improvement (12 month trend)	56.4%	56.5%	57.0%	59.0%	61%	63%
Monthly	Number of follow-up appointments delayed past their target date (booked & not booked)		Reduction (12 month trend)	80,969	33,977	24,000	18,000	12,000	6,000

INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities								
Measure		Target				Profile		
			Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Annual assessment	% of over 65 registered as having dementia with their GP practice	Annual improvement			3.2%	3.4%	3.60%	3.80%
DIGNIFIED CARE - I am treated with dignity & respect & treat others the same								
Measure		Target				Profile		
			Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Monthly	% procedures postponed on >1 occasion, had procedure <=14 days/earliest convenience	Improvement (12 month trend)	50.0%	38.2%	36.5%	50%	55%	60%
SAFE CARE - I am protected from harm & protect myself from known harm								
Measure		Target				Profile		
			Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Monthly	Number of healthcare acquired pressure sores in a hospital setting	Reduction (12 month trend)	44	12	29	22	20	18
Quarterly assessment	% compliance with National Patient Safety Agency Alerts issued prior to Apr-14	100%	100%	100%	100%	100.0%	100%	100%
	% compliance with National Patient Safety Agency Rapid Response Reports issued prior to Apr-14		100%	100%	100.0%	100.0%	100%	100%
	% compliance with Patient Safety Solutions Wales Alerts issued after Apr-14				100.0%	100.0%	100%	100%
	% compliance with Patient Safety Solutions Wales Notices issued after Apr-14				87.5%	100.0%	100%	100%
Monthly	Of the Serious Incidents due for assurance within the month, % which assured in agreed timescale	90%			80.0%	90.0%	90%	90%
	Number of new Never Events	0			3	2	1	0
OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful use of them								
Measure		Target				Profile		
			Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Monthly	% staff absence due to sickness	Reduction (12 month trend)	5.5%	5.4%	5.5%	5.0%	4.90%	4.80%
	New OP DNA rates for selected specialties (E&P	Reduction (12 months trend)	9.6%	8.0%	7.3%	7.0%	6.80%	6.50%
	Follow up OP DNA rates for selected specialties		9.9%	9.2%	8.5%	8.2%	8.00%	7.50%
Annual assessment	% of total medical staff undertaking performance	Annual improvement		80.0%	88.0%	90.0%	92%	94%
	% of total non medical staff undertaking		60.6%	61.0%	74.4%	85.0%	87%	89%

In addition to the above at a high level the following tables set out what the organisation is planned to achieve at the end of each year included in the refreshed plan that will form the basis of the new performance management framework.

At the end of Year 1 we hope to achieve:

- Improved uptake of childhood immunisations by age 4 to 95%.
- Improved uptake of smoking cessation to 3.3% population.
- Improved uptake of flu vacs by staff to 50%.
- Completed roll out of Living Well, Living Longer to North Caerphilly and BG West.
- Introduced 24/7 community nursing services.
- Introduced community phlebotomy services.
- Transferred more specialist hospital services to PC settings to bring care closer to home.
- Refreshed chronic condition delivery plans such as Cardiology and introduced community cardiology service.
- Produced strategic outline case for MH/LD complex care services and business cases for interim HDU and extended PICU.
- Sustained clinical services under pressure from medical staff shortages e.g. in paediatric and neonatal services.
- Achieved financial balance.
- Reduced emerging admissions to acute hospitals by approximately 7%.
- Reduced delayed transfers of care by 20%.
- Improved operational efficiency and effectiveness.
- More care provided by integrated teams.
- More care planned and delivered around NCN communities.
- Started building the SCCC.
- Reduced the number of 36 week breach patients by 50% to 1,200.
- Further reduce the incidence of C.difficile and Staph aureus infection to deliver population

denominated targets (equivalent of 20%).
- Agreement of an implementation plan for the further centralisation of vascular services in South East Wales.
- With neighbouring Health Boards, commenced phased introduction of the Imaging Academy for Wales.
- Established a new service model for Sexual Assault Referral Services in South Wales.
- Redeveloped the Neonatal Unit at the Royal Gwent Hospital to address infection control risks and increase network resilience.
- Reduced sickness absence by 5%.
- Eliminated >8 week waits for diagnostic tests.
- Improved the RAMI (2015) performance from 109 to 100.
- Improved 4 hour performance to deliver 92% compliance, with parallel improvements in 12 hour and WAST performance.
- Developed and implemented a new performance management framework
- Defined the work programme and delivery structure to support the new strategic programmes.
- Removed the use of off-contract agency

Divisional Outcome and Delivery Framework
To ensure that our plans are based on strong foundations, they are built up from detailed Divisional Plans. These are based upon the planning model described above, aligning demand with capacity, productivity improvements and clinical outcomes, and mapping their impact on workforce, supporting infrastructure, finance and other outcomes.

Through performance management arrangements, Divisions are held to account for delivery of their plans and performance via monthly integrated reviews by the Chief Operating Officer. These reviews are based upon a standard agenda and tracking an agreed range of metrics (quality, operational, financial), including the Delivery and Outcomes Frameworks. Progress in the delivery of the Divisional Plan is formally reviewed quarterly, with the same principles applied to corporate departments. Divisions in turn operate a mirror system of reviews with their directorates to ensure that accountabilities are cascaded through the organisation, and the delivery of plans embedded within operational business. The progress in each SCP is reviewed by the appropriate UHB Committee and regular overviews to the UHB particularly highlighting areas which may be challenging.

Corporate SCP Outcome and Delivery Framework
Each Service Change Plan has defined the following to support delivery:

- Executive Sponsor;
- Clinical and managerial leads;
- Status of detailed plans;
- Key milestones and timescales.
- Integrated outputs (quality, operational, efficiency, workforce and finance), that form the basis of tracking of plan delivery.
- Risks and mitigation plans.

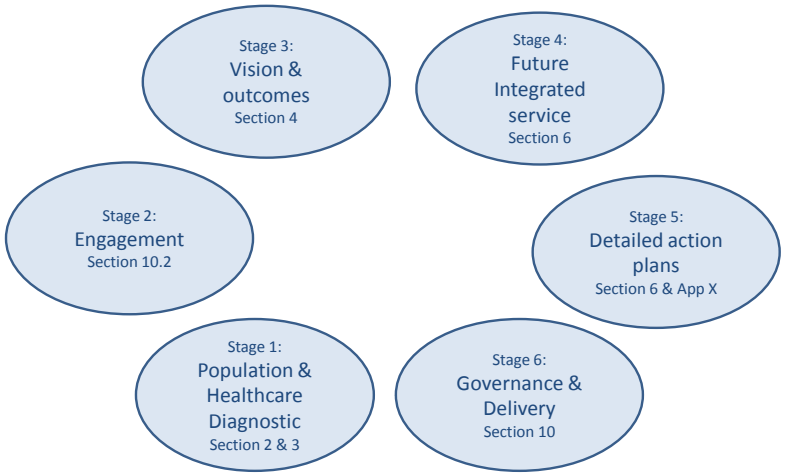
To ensure that the UHB's strategic priorities are being delivered an integrated planning tracker will be developed for each Service Change Plan, providing the means by which progress would be measured quarterly and includes the following:

- Progress against key project milestones within the quarter.
- Delivery against performance milestones.
- Delivery of planned workforce changes.
- Delivery of financial benefits.
- Realisation of quality, patient experience and performance outcomes.
- Key risks and mitigating actions.
- Enabling support required.

2. Operating Model – Planning Model and Cycle

The UHB has used the 6 stage overall planning process, adapted for use within the UHB (Figure 12.1). As such, the plan seeks to demonstrate how the UHBs Clinical Futures Strategy will over the next three years deliver a sustainable healthcare system for Gwent and South Powys, which enables the UHB to deliver its vision within available resources.

Figure 12.2 - UHB Planning Cycle



The UHB has a well defined Clinical Services Strategy (*Clinical Futures*) and this is an essential underpinning of our IMTP, and this IMTP seeks to provide the bridge to the proposed opening of the SCCC in spring 2019. The UHB's Clinical Futures Strategy and objectives have been reviewed by the Board and Executives and these were used as the basis for detailed internal planning guidelines for both Divisional and Corporate Service Change Plans:

- Supporting the further shift of services from secondary to primary care
- Reducing health inequalities and how they support key public health priorities.
- Delivering improvements in access and quality of care to patients.
- Applying prudent healthcare principles and values to services and clinical pathways.
- Fulfilling our ambition of achieving Best in Class across the organisation.
- Managing within existing resources and minimise any cost growth.

The resultant Service Change Plan framework is described in **Chapter 7**.

Divisional Plans

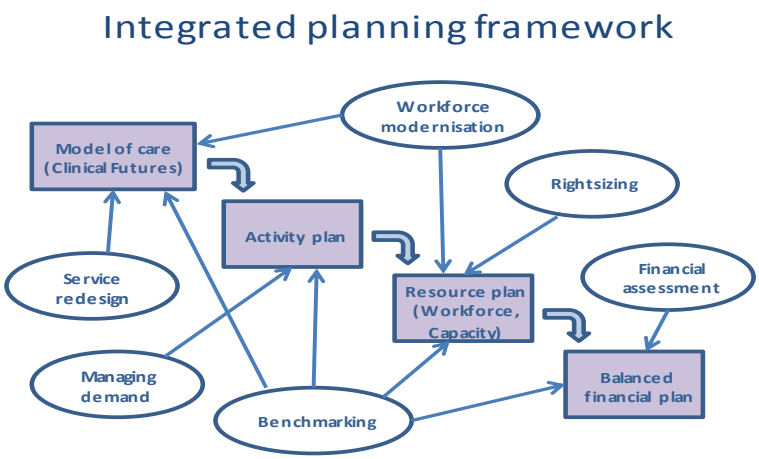
To ensure that the IMTP encompasses the entire scope of the UHB, it is underpinned by detailed Divisional Plans, informed by Directorate Plans. In developing this plan, greater emphasis has been placed upon the identification of the timetabled outcomes of proposed changes, be they quality, workforce, financial and efficiency. Qualitative and quantitative management information has been made available to inform the diagnostic phase of the planning process, with support provided by relevant Corporate Teams thereby seeking to provide capacity and capability across the organization. Progress in the delivery of 2015/16 Divisional Plans has been formally reviewed by Executives, with the process used to identify opportunities and priorities for change in updated Divisional Plans.

The UHB continues to use the Integrated Planning framework (Figure 12.3), which provides

connectivity between the key components of the plan (Quality and Safety, Demand and Capacity Assessment, Delivery of Standards Efficiency and Effectiveness, Workforce and Finance). The four step process allows each of the elements to be modified, tested and challenged if the proposed changes do not deliver safe and sustainable services within the available financial envelope.

There is good evidence that a systematic approach to planning is becoming engrained in the core work of Divisions, with examples of excellent practice. The consistent achievement of this across all Divisions will be a priority for 2016/17.

Figure 12.3



Corporate Service Change Plans

Where there are cross-cutting issues, these have been scoped and form the basis of Corporate Service Change Plans, with identified Executive, Clinical and Planning Leads. The UHB has retained its framework of 10 over arching Service Change Plans, supported by a number of cross cutting themes, including prudent healthcare. The diagnostic and engagement stages of the planning model have been used to determine the focus of the UHB's key change priorities. The detail of Corporate Service Change Plans is included in Section 6.

Summary

In summary, the UHB's IMTP for 2016/17-2018/19 starts with year two of the approved plan and has been refreshed based on the reflections of year one and a look ahead for a further year into 2018/19 and is consistent with the Welsh Government process to maintain approval status.

The UHB has a strong overarching strategy in Clinical Futures which is consistent with the national strategies and legislation and responds to the significant challenges facing the health system at both a national and local level.

The patient and citizen is at the heart of our plan and quality and patient safety remains at the centre of our work with a greater focus on patient experience and engagement with co-production and the prudent agenda driving the ambition for value based care.

The approach to planning is being developed to differentiate between the programmes of work that support improving operational efficiency, service change and improvement and wider system change. A comprehensive work programme is established and being continually developed to ensure delivery of the strategy and supports the strengthening of the UHB plans as part of an iterative process which embeds planning across the organisation at all levels.

The key enablers to delivering the service plans are also set out with continued challenges facing the organisation in relation to resource availability especially in terms of workforce availability, revenue and capital and IT capacity to deliver the UHB's ambitions. A greater focus on efficiency opportunities and prioritisation based on potential benefits are key areas of increased focus as we

go into 2016/16.

The outcomes and delivery framework is also a fundamental component of ensuring delivery of the plans. The key outcomes of the service plans and performance against national targets are set out with a greater focus on quarterly reporting as we commence 2016/17.

Further detailed information on all components of this plan can be found in the supporting technical document.

3. Future State – What does Success Look Like in Three Years?

By 2019/20 it is our vision that everyone is able to live longer healthier lives at home, or in a homely setting. We will have an integrated health and social care system built around our Neighbourhood Care Networks, a focus on prevention, anticipation and supported self management. We aim to deliver a systematic reduction in health inequalities in our most deprived communities, and reduce premature deaths in conditions such as cancers, heart attacks and stroke.

In partnership with Local Authorities and the third sector, cohesive services for children, older and vulnerable people will be available to all the distinct communities we serve. We will have in place an up-to-date, agreed suite of care pathways that assist both healthcare staff and patients understand and achieve the best approaches for care which is safe, citizen centred, clinically and cost effective.

We will have sustainable 24/7 primary care services to ensure that urgent and planned primary care is locally accessible to enable patients to receive their care close to home. This includes our citizens who have diverse cultural and language needs; people with physical and learning disabilities; people with sensory loss, people with low health literacy and frail older people. There will also be a focus on reaching out to those citizens who seldom seek help.

We will have established a more equal relationship between patients and professionals, based on openness and sharing information to ensure that the intensity of testing and treatment is consistent with the seriousness of the illness and the individual patient goals.

We will shift the balance of our services to primary care by increasing the number of specialist services currently provided in our hospitals will be delivered in a primary care setting and there will be seamless collaboration between practitioners across the whole system. This will necessitate some of our services working very differently to focus on supporting patients in a primary care setting; through direct patient contact, indirect support to practice teams and remote monitoring of patients.

Technological opportunities will be maximised, with an integrated electronic health and social care record system that allows clinicians and social care practitioners to share information about patients that enables new workflows (for example virtual clinics, booking systems, advice lines) across the health and social care system, which will also enable patients and carers to access appropriate, timely and relevant information. All our independent contractors will be part of the NHS network so that patients will have a single record that will facilitate shared care and patient management across all settings.

All local services will be configured within the 12 Neighbourhood Care Networks and designed to meet the health and social care needs of their communities. This will require a professional and managerial accountability structure to ensure the delivery of safe, effective, efficient services to meet the health and social care needs of the communities they serve.

When hospital treatment is required, and cannot be provided in a community setting, day case and

ambulatory care treatment will be the norm. There will be 24/7 access to consultant led hyper-acute and specialist care, facilitated by consolidating these service in the newly opened Specialist and Critical Care Centre at Llanfrechfa Grange in 2019.

Whatever the setting, care will be provided to the highest standards of quality and safety, with the citizen at the centre of all decisions. At all times, in every part of the system, we will strive to be "best in class", pushing the boundaries of efficiency, effectiveness and proportional interventions in accordance with prudent healthcare. There will be a focus on ensuring that people are supported in their home or community environment as soon as appropriate.

The health service in the UHB will be regarded as a caring and improving health system built on a model where integration, partnership working, prudence and public participation are all paramount.

By the end of Year 3 we hope to achieve:

- Everyone able to live longer healthier lives at home, or in a homely setting.
- Health inequalities in our most deprived communities will be reduced, and there will be fewer premature deaths due to conditions such as cancers, heart attacks and stroke.
- Services will be delivered in an integrated health and social care system built around our 12 Neighbourhood Care Networks.
- Services will be more focused on prevention, anticipation and supported self management.
- In partnership with Local Authorities and the third sector, cohesive services for children, older and vulnerable people will be available to all. We will have in place an up-to-date, agreed suite of care pathways that assist both healthcare staff and patients understand and achieve the best approaches for care which are safe, citizen centred, clinically and cost effective.
- We will have sustainable 24/7 primary care services to ensure that urgent and planned primary care is locally accessible.
- We will have established a more equal relationship between patients and professionals, based on openness and sharing information.
- We will shift the balance of our services by increasing the number of specialist services, currently provided in our hospitals, being delivered in a primary care setting with collaboration between practitioners across the whole system.
- Technological opportunities will be maximised, to enable clinicians and social care practitioners to share information about patients, and which will also enable patients and carers to access appropriate, timely and relevant information.
- When hospital treatment is required, and cannot be provided in a community setting, day case and ambulatory care treatment will be the norm.
- There will be 24/7 access to consultant led hyper-acute and specialist care, facilitated by consolidating these service in the newly opened Specialist and Critical Care Centre at Llanfrechfa Grange in 2019.
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the citizen at the centre of all decisions. At all times, in every part of the system, we will strive to be "best in class", pushing the boundaries of efficiency, effectiveness and proportional interventions in accordance with prudent healthcare.
- The health service in ABUHB will be regarded as a caring and improving health system built on a model where integration, partnership working, prudence and public participation are all paramount.
- Eliminated 36 week breaches and delivered 95% 26 week compliance.
- Achieved 95% 4 hour compliance in the Emergency Department, eliminating 12 hour trolley waits.

Chapter 13 – Summary

In summary, the Aneurin Bevan University Health Board's IMTP for 2016/17-2018/19 starts with year two of the approved plan and has been refreshed based on the reflections of year one and a look ahead for a further year into 2018/19 and is consistent with the Welsh Government process to maintain approval status.

The UHB has a strong overarching strategy in Clinical Futures which is consistent with the national strategies and legislation and responds to the significant challenges facing the health system at both a national and local level.

The patient and citizen is at the heart of our plan and quality and patient safety remains at the centre of our work with a greater focus on patient experience and engagement with co-production and the prudent agenda driving the ambition for value based care.

The approach to planning is being developed to differentiate between the programmes of work that support improving operational efficiency, service change and improvement and wider system change. A comprehensive work programme is established and being continually developed to ensure delivery of the strategy and supports the strengthening of the UHB plans as part of an iterative process which embeds planning across the organisation at all levels.

The key enablers to delivering the service plans are also set out with continued challenges facing the organisation in relation to resource availability especially in terms of workforce availability, revenue and capital and IT capacity to deliver the UHB's ambitions. A greater focus on efficiency opportunities and prioritisation based on potential benefits are key areas of increased focus as we go into 2016/17.

The outcomes and delivery framework is also a fundamental component of ensuring delivery of the plans. The key outcomes of the service plans and performance against national targets are set out with a greater focus on quarterly reporting as we commence 2016/17.