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WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

# Integrated Medium Term Plan

## 2017/18 – 2019/20

*Status: Final: March 2017*



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## EXECUTIVE SUMMARY

The Aneurin Bevan University Health Board's IMTP has been refreshed following extensive engagement within the organisation and builds upon the Health Board's approved plans over the last two years. The structure of the Plan has been revised to reflect both changes within the Health Board and revised Welsh Government guidance.

The Health Board 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 model is predicated on delivering more care closer to home within a primary and community care setting to improve the patient experience and whilst creating a sustainable system of care.

*"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 IMTP 2015/16**

It is our vision that everyone is able to live longer healthier lives at home and will receive the majority of their care either at home or in their local community, where it is safe, effective and efficient to do so. This will be achieved through our work on Keeping People Well, Sustainable Primary Care, and Integrated Health and Social Care. Our Care Closer to Home Strategy is an integrated plan for strengthening our communities outside of hospital settings, based on a number of integrated working themes including person centred, workforce sustainability, shared resources/pooled budgets, community resilience and early intervention & prevention. This Strategy is being delivered through our 12 Neighbourhood Care Networks, and forms the foundation of our future service model.

The approval of the Specialist and Critical Care Centre (SCCC) provides a key enabler for strengthening our acute services and our focus will be on developing transition plans leading to the opening of the SCCC, including the essential contribution of Primary and Community Services and in refreshing our Programme Business Case, in particular, the supporting hospital network in the context of strengthened regional planning.

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, of which demand management is a key element.

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 described and being continually developed to ensure delivery of the strategy and supports the strengthening of the Health Board 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 Health Board ambitions. A greater focus on efficiency opportunities and prioritisation based on potential benefits are key areas of increased focus as we go into 2017/18.

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. The Health Board's plan identifies opportunities to bring forward the implementation of some of its plans and accelerate the development of some services in delivering national and local priorities within available resources. Specifically, this includes the following:

- The development and delivery of sustainable service and workforce models that ensure optimum performance delivery on a recurrent basis.
- Support the Health Boards population health challenges.
- Supporting the transitional elements of the Health Boards plans in developing future sustainable services as part of its Clinical Futures Strategy.

The Health Board plan demonstrates the organisation's commitment to delivering service, workforce and financial sustainability through delivery of its Clinical Futures Strategy. A growing programme of work that supports the priority of prevention and improving the population health and inequalities that exist across the communities, a strong focus on primary and community services with Neighbourhood Care Networks becoming the bedrock of providing care closer to home and ensuring a hospital network that provides the highest quality services when people require hospital treatment with the SCCC a critical enabler of delivering that objective.

The organisation is embracing and embedding the principles of value based healthcare across the whole system and are continuing to strengthen the involvement of the public and the voice of the citizen in the planning of our services.

## 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 £1.1 billion.

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 2016/17 – 2018/19 for the Health Board was approved by Welsh Government on 29<sup>th</sup> June 2016 and therefore this document provides an overview of the refreshed plan for 2017/18 to 2019/20, reflecting on the progress made in over the past 12 months, current challenges and the updated outlook for the next three years.

This report is divided into four 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 achievements that have been delivered in 2016/17, summarises opportunities and challenges faced by the Health Board and describes the significant service change agenda that will be addressed over the life of this plan.

**Section Three** sets out the key components of the Three Year Plan, reflecting on the achievements of 2016/17 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 Four** summarises the key outcomes anticipated over the three years and the governance framework that will support delivery of the plans.

This plan is supported by a detailed set of appendices which complies with the Welsh Government planning guidance and provides greater detail and depth to the key areas covered in this overarching narrative.

## SECTION ONE – STRATEGIC OVERVIEW & CONTEXT

### 1.1 Health Board Vision & Values

Aneurin Bevan Health Board was established in October 2009 and achieved 'University' status in December 2013. It serves an estimated population of over 639,000, representing approximately 20% of the total Welsh population. With a budget of £1.1 billion it delivers healthcare services to people in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.



The Board is chaired by David Jenkins, OBE and the Executive Team is led by Judith Paget, Chief Executive Officer.

Aneurin Bevan University Health Board has a longstanding, approved Clinical Strategy, which has been tested, validated and adapted to meet new challenges and provides the blueprint for innovative and redesigned services to meet future demands of the populations we serve. The Clinical Futures Strategy continues to form the platform for service planning from 2017 – 2021.

The Strategy sets out our vision for modernising clinical services for the population of Gwent and South Powys. At its heart, the strategy seeks to rebalance the provision of healthcare, enabling citizens to play a more active role in their health and well being, providing more services within the community using Neighbourhood Care Networks to drive and deliver change at local level. In keeping with the outcomes of the South Wales Programme, it reshapes our hospital services in order to centralise specialist and critical care services in a single purpose build hospital, whilst maintaining a network of local hospitals to meet routine care needs.

The welcomed approval by Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport, of the Full Business Case for the Specialist and Critical Care Centre has ensured that a key component of infrastructure to deliver our Clinical Strategy will be in place by 2021. This provides a clear focus for the Health Board to develop and implement detailed transitional plans for our clinical services in the run up to the opening of the Specialist Critical Care Centre (SCCC).

Figure 1.1 – Health Board's Vision and Values

Our vision for Aneurin Bevan University Health Board is to work with our communities for a healthier future, to care for patients when they need us and for our staff and services to aim for excellence in all that we do.

Everyone who works within Aneurin Bevan University Health Board share four core values that guide the approach we take to work, how we do things, how we treat others and how we expect to be treated.



During 2016/17, we continued to take forward our vision, through delivering the next steps in our Clinical Futures Strategy and achieving the following:

- Improving public health and reducing health inequalities by working with our partners to promote healthy lifestyles and ensure there is access to preventative services, particularly for those in areas of greatest need.
- Providing and commissioning services that focus on the needs of the patient, in their homes, communities and where necessary hospital settings.
- Ensuring safety, excellence and quality in all our services at all times.
- Improving the efficiency and effectiveness of our services.
- Actively engaging patients, carers and communities and building strong partnerships to ensure services focus on need.

- Focusing on prudent and value based healthcare to ensure we improve clinical value and value for money.
- Driving excellence through innovation and research which is embedded in practice.
- Trusting and supporting our staff to make the right decisions for patients and to improve care

## 1.2 Strategic Context

The last few years have been significant in terms of the development of national strategies and new legislation in Wales, with the enacting of the “Well-being of Future Generations (Wales) Act 2015” and the “Social Services and Wellbeing (Wales) Act 2014. **The Well-being of Future Generations (Wales) Act 2015** places a well-being duty on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales, in a way that accords with the principle of sustainable development.

Across the Health Board, work is progressing at pace on developing our Well Being Statement and Well Being Objectives in readiness for April 2017. The approach adopted locally has centred on a “bottom-up” approach to the development of Well Being Objectives, which reflect citizen and service driven priorities for improvement.

The citizen voice has been sought through regular and informal engagement across the region. Key themes that have emerged include GP access, care closer to home, urgent care, communication, mental health, dental services and illness prevention. In asking citizens about things that contribute to their well being, other themes have emerged including family and friends, access to outdoors, sleep, relaxation, helping others and volunteering. Thus, in developing its Well Being Objectives, the Health Board has included reference to work being undertaken by the five Public Service Boards (PSBs) across the region on the Well Being Plans that reflect the outcomes of the population needs assessment and wider well being themes. Work with the PSBs will enable further refinement of the Health Board Well Being Objectives.

Figure1.2- Well being of Future Generations Framework



Having regard to the Sustainable Development Principle, the Health Board is in the process of assessing all Corporate, Divisional and related functions to ensure that the development, delivery and improvement of our services reflects the ‘long term’, ‘prevention’, ‘integration’ ‘collaboration’ and ‘involvement’ ways of working. Implementation of the Clinical Futures Strategy and next stage construction of the Specialist and Critical Care Centre (SCCC) offer key opportunities to demonstrate application of the Sustainable Development Principle and five ways of working.

### Well-being Statement

The Health Board has developed 10 Well-being Objectives that signal our initial priorities for improving the economic, social, environmental and cultural well-being of Gwent. It is our intention that these Well-being Objectives will be subject to further testing and refinement to take into account the publication of the 5 Gwent Public Service Boards (PSB) and the other Public bodies Well-being Objectives and Plans later in 2017. Through this process we will become much clearer about how we can truly maximise our contribution towards the seven national Well-being Goals.

### Well-being objectives

The Health Board, in collaboration with our partners, will:

**Objective 1**

Support every parent expecting a child and give every child in Gwent support to ensure the best start in life.

**Objective 2**

Support adults and children in Gwent to live healthily and to age well, so that they can retain independence and enjoy a high quality of life in to old age.

**Objective 3**

Promote mental well-being as a foundation for health, building personal and community resilience.

**Objective 4**

Encourage involvement of people who use our services and those they support, in jointly owned decisions regarding their own health and care plans, and in wider service planning and evaluation so that we, with our partners, deliver outcomes that matter most to people.

**Objective 5**

Ensure we maximise the effective use of NHS resources in achieving planned outcomes for services and patients, by excellent communication, monitoring and tracking systems in all clinical areas.

**Objective 6**

Promote a diverse workforce able to express their cultural heritage, with opportunities to learn and use Welsh in the workplace.

**Objective 7**

Develop our staff to be the best that they can be with high levels of employee well-being and, as the largest employer in Gwent, promote NHS careers and provide volunteering and work experience opportunities.

**Objective 8**

Reduce our negative environmental impact through a responsible capital building programme and a sustainable approach to the provision of building services including; carbon and waste management, undertaking procurement on a whole life-cycle cost basis and supportive of local sourcing, promoting sustainable and active travel and, advocating improvements in environmental health.

**Objective 9**

Plan and secure sustainable and accessible healthcare services ranging from prevention through to treatment, rehabilitation and recovery that meet current and future needs and address health inequities and differing levels of need across our communities.

**Objective 10**

Continue to integrate our actions with wider public, independent and voluntary sector partners with the aim of developing streamlined, whole system services for people who use our services and those they support.

**The Five ways of Working (Figure 1.2)**

The application of the five ways of working identified in the Act is how public bodies are able to maximise their contribution to the seven Well-being Goals. We recognise that the first step towards embedding the five ways of working into our day to day business is to understand how these principles are currently being applied to our corporate functions. Carrying out an audit of the five ways of working against Health Board corporate functions will be our immediate next step.

We have taken the opportunity to work with the Wales Audit Office, as a pilot site for developing the new approach to audit for the Well-being of Future Generations Act. This work will focus upon our Well-being Objectives and the application of the sustainable development principle to the Health Board's Clinical Futures Strategy and the plans for the Specialist Critical Care Centre (SCCC).

Delivery against our initial Well-being Objectives will be via our Service Change Plans and this will be monitored by the WBFGA Steering Group and reported to the Public Partnerships and Well-being Committee on an annual basis. Mid-way through 2017 we anticipate that the 5 Gwent PSB Well-being Plans and Objectives will be available which will further inform our initial Well-being Objectives. Each Objective will contribute to all, or a number of goals and through our Service Change Plans and governance processes we will endeavour to ensure that we maximise our contribution towards each of the seven national Well-being Goals.

**The Social Services and Well-being (Wales) Act 2014** provides the framework for improving the well-being of people who need care and support, carers, and for transforming social services in Wales. The Act requires Local Authorities and their partners to consider the integration of care with health services where this would benefit the wellbeing of children, adults and carers; prevent or delay the need for care; and improve the quality of care and support.

The Health Board, through the regional Greater Gwent Health, Social Care and Well Being Partnership (GGP), continues to work closely with its partner agencies in taking forward collaborative work programmes aimed at more effectively responding to the needs of our catchment population. The Regional Development Plan has provided a framework and enabled the Partnership to develop and agreed a Joint Statement of Intent for each of the partnership priorities, which set out service gaps and areas for collaboration. These include:

**Table 1.1**

<p><b>Carers</b></p> <ul style="list-style-type: none"> <li>▪ Improving provision of information, advice and assistance.</li> <li>▪ Addressing the advocacy needs of carers.</li> <li>▪ Improving services for young adult carers and addressing transition issues.</li> <li>▪ Mental health and well being of carers.</li> <li>▪ Sustaining staff training and awareness raising</li> </ul>	<p><b>Children with Complex Needs</b></p> <ul style="list-style-type: none"> <li>▪ Addressing the emotional well being and mental health for children and young people, including individuals with neuro-developmental needs such as Autism Spectrum Disorder (ASD)/ Attention Deficit Hyperactivity Disorder (ADHD).</li> <li>▪ Supporting children with disabilities and complex health needs through a hub and spoke model of service delivery.</li> <li>▪ Preventing escalation of complex need and enhanced therapeutic provision – reviewing existing provision and areas for improvement.</li> <li>▪ Research the development of accommodation and support for care leavers with complex needs (16 years of age plus).</li> </ul>
<p><b>Older People with Complex Needs</b></p> <ul style="list-style-type: none"> <li>▪ Initiatives that address loneliness and isolation.</li> <li>▪ Development of integrated place based teams with a focus on ‘care closer to home’.</li> <li>▪ Domiciliary care that is planned and developed with providers on a place based approach.</li> <li>▪ Take forward a ‘better life’ programme to support care homes in giving sustainable, high quality and consistent care.</li> <li>▪ Extend and improve the range of housing solutions that enable older people to live independently but not in isolation.</li> </ul>	

The structure for delivery includes key reporting mechanisms into the Partnership Board comprising a Regional Leadership Group, Provider Forum, Joint Commissioning Group, Citizens Panel and Communications Group.

In agreeing and implementing necessary governance arrangements, the GGP has recognised the benefits of enabling direct reporting arrangements from relevant existing multiagency forums that will lead progress on the partnership priorities, linked to the agreed Statements of Intent. The GGP also has direct oversight of the Intermediate Care Fund (ICF) and is thus able to effectively link the allocation of ICF funding to the achievement of partnership priorities.

The reporting forums include the Greater Gwent Carers Programme Board and Regional Children’s services forum. The Chairs of these forums will provide regular progress updates and seek further

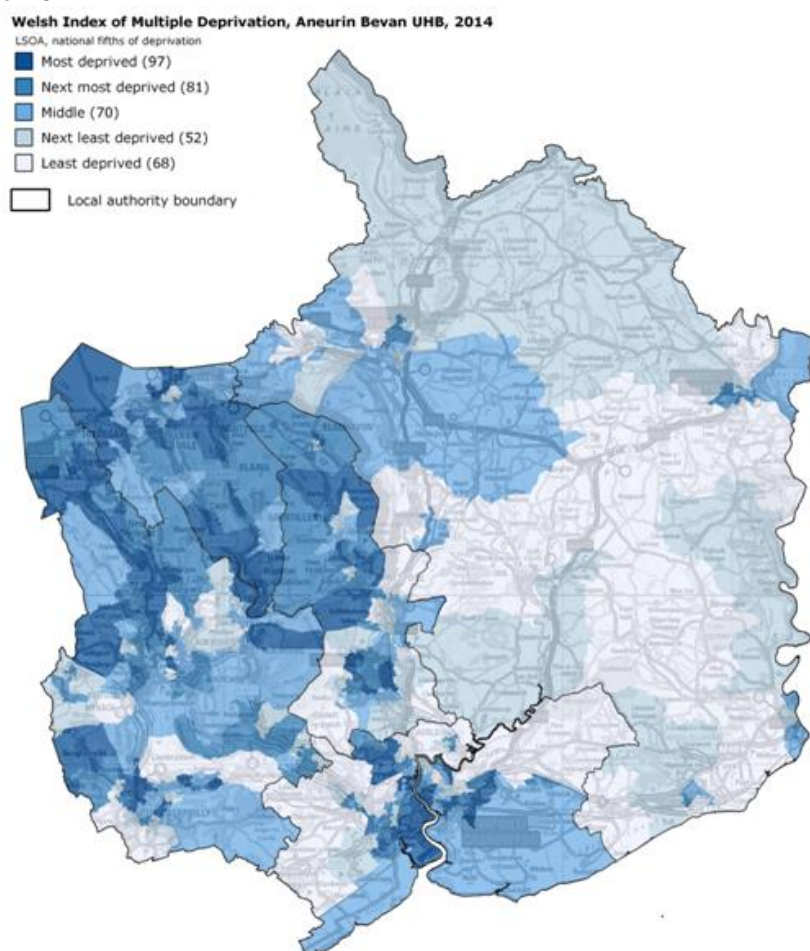
advice as members of the GGP. In addition, the Police and Crime Commissioner Strategic Commissioning Group is establishing links with the GGP to enable effective sharing of relevant work programme progress. The Partnership Board also receives updates on progress with the development of our **Care Closer to Home Strategy** which is the key vehicle for delivering the **Welsh Government Primary Care Plan**.

In addition to the framework outlined above, the **Joint Commissioning Group** is leading a number of work streams aimed at facilitating a regional approach to the commissioning of key services including Care Homes, domiciliary care services and Third Sector services. Work is underway to scope work programmes and gather evidence on current commissioned provision across the region. This joint work provides opportunities to review current service specifications and to identify preferred regional service models which reflect the outcomes of the population needs assessment and address identified service gaps.

### 1.3 Local Context

The local population covers diverse geographical areas with a mix of rural, urban and valley communities. The valley areas experience high levels of economic deprivation, including low incomes, poor housing stock and high unemployment resulting in many challenges.

Figure 1.3



Produced by Public Health Wales Observatory, using WIMD 2014 (WG), released August 2015  
© Crown Copyright and database right 2015, Ordnance Survey 100044810

- Smoking is a major risk factor for heart disease and remains a significant public health concern with 22% of the adult population being active smokers.
- 26% of adults are obese (BMI  $\geq 30$ ) with rates in Blaenau Gwent, Torfaen and Caerphilly significantly higher than the Wales average.
- Low participation of local residents undertaking physical exercise on a regular basis.

- Poor dietary habits illustrated with a survey in 2009/10 demonstrating the proportion of adults in the Health Board who had consumed at least five portions of fruit and vegetable in the previous day was 31%.
- High levels of alcohol misuse with around 42% of adults reported drinking above recommended limits in the previous week. In relation to patterns of alcohol misuse around 131,118 residents report binge drinking.
- Deprivation is higher than the Welsh average, ill health more prevalent and life expectancy is 9 years lower for men and 7 years lower for women resident in the most deprived areas of Gwent then in the least deprived areas.
- There is an 18 year difference in healthy life expectancy at birth between people living in the least and most economically deprived areas.
- In four of the Local Authority areas, a high percentage of children are living in poverty and children living in a deprived area in Gwent are less likely to be breast fed and more likely to have dental caries which is an indicator of a poor diet.
- Gwent has the highest prevalence of Type 2 Diabetes across Wales, which consumes significant resource across the health system.
- Adults in the Gwent area have generally poorer mental health and well-being than the rest of Wales (Welsh Health Survey), poor mental well being is strongly associated with unhealthy behaviours.
- Health inequalities are particularly evident in cancer survival rates, whilst all our residents have seen an improvement in cancer survival rates since 1999-2003, there is a large discrepancy between our least deprived (62%) and most deprived (44.9%) communities.

Our primary care and community infrastructure has developed significantly in recent years with the adoption of our primary care led Neighbourhood Care Networks (NCNs). These networks focus on planning integrated care with key partner organisations for their communities. However we continue to face the challenge of a general practitioner workforce in declining numbers as clinicians reach retirement.

Our hospital network has benefited from two new modern hospitals at Ysbyty Aneurin Bevan (2010) and Ysbyty Ystrad Fawr (2011). Our hospital infrastructure is based largely on the 1960s District General Hospital model. Much of the estate is no longer fit for purpose, offering poor patient environments, fragmentation and duplication of scarce clinical services across the Nevill Hall and Royal Gwent Hospitals. The approval of the SCCC provides a clear way forward for the Health Board and will require the updating of the detailed plans for the SCCC and its supporting hospital network and the transition arrangements leading up to the opening of the SCCC.

There are a number of significant challenges for the existing workforce both in terms of increasing demand, recruitment shortages and compliance with Deanery standards including:

- Skills shortages, recruitment challenges.
- The ageing workforce profile.
- Deanery rota and training standards compliance.
- Provision of 7 day and extended services for a number of professional groups.
- Specialist skills spread too thinly on existing hospital site configuration.
- Increasing demand across the healthcare system.

The Health Board has been proactive in developing new non-medical roles to support service delivery, such as practice based pharmacists and enhanced nurse practitioners as part of a programme of workforce modernisation and developing a prudent workforce to support service sustainability going forward.

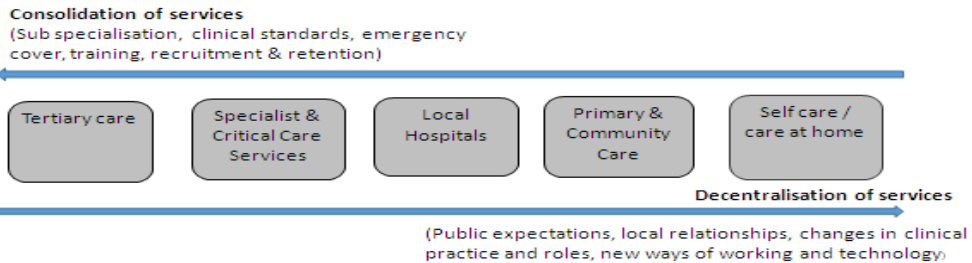
#### **1.4 Clinical Futures Strategy**

The **Clinical Futures Strategy** sets out the strategic direction for modernising clinical services. Clinical Futures is a clinically owned and led programme that seeks to rebalance the provision of care in Gwent, enabling citizens to play a more active role in their well-being, providing more services in a community setting and uses our Neighbourhood Care Networks as the foundation for this and ensuring world class hospital services for people when they need them.

It delivers a new differentiated, acuity based model of care to improve access. It is consistent with the national policy context outlined in section 1.2 together with “Working Together for Health”, the South Wales Programme and the South Wales Health Collaborative medical and surgical clinical models.

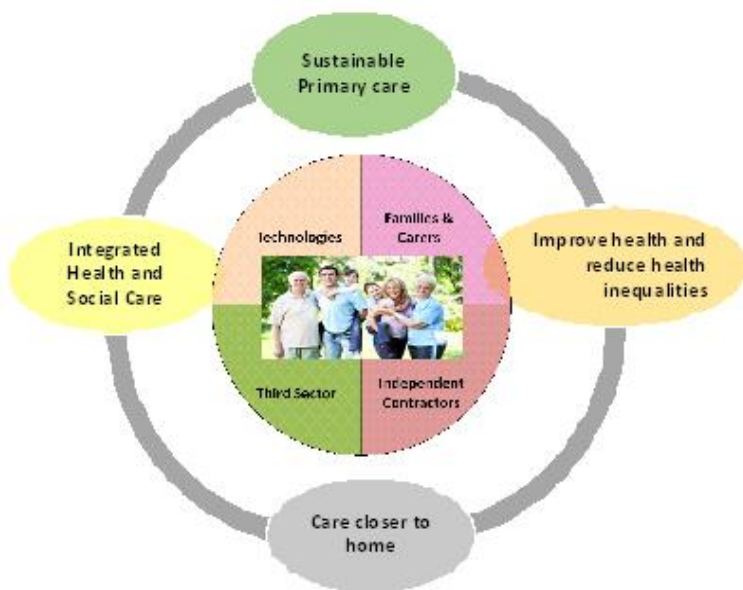
Figure 1.4

### The Model:



Primary and community services are at the heart of the model and central to developing a new relationship with patients as co-producers in preserving, maintaining and improving their own health and well being. Primary, community and social care services are strengthened and integrated to create the capacity to support and treat patients in their homes and communities.

Figure 1.5



Enhanced access to primary and community care services over seven days is a key component of the model. Importantly, the Strategy shows the quantum shift required to realise most care being delivered closer to home.

NCNs will be supported through a 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 SCCC.

The SCCC plays a critical role in the strategy, improving the provision of services and clinical outcomes; sustaining fragile services through consolidation in a single site that is

geographically accessible to the population served; addressing workforce recruitment/retention challenges and improving flow and system performance. Additionally, it will improve patient experience and provide modern facilities for the delivery of care.

Figure 1.6



The welcomed approval of the Full Business Case for the SCCC is the next step in the implementation of our Clinical Futures Strategy. By 2021, when the new facility is commissioned we will:

- Care for our sickest patients on one site.
- Concentrate our Emergency Departments onto a single site, and have a single centre for cardiology, gastroenterology, trauma, emergency and high acuity surgery.
- Provide consistent services across 7 days.
- Improve access to comprehensive diagnostics across 7 days.
- Consolidate smaller fragile specialties.
- Improve patient safety by providing consultant led service across 7 days.
- Maximise ambulatory care models.
- Separate routine/planned care from emergency care.

For a number of services, and as a result of significant recruitment and retention difficulties, there will be challenges in maintaining the current configuration of services in the interim. These are described within the **Service Sustainability Service Change Plan** and set out where interim measures may be necessary as a transition to the Clinical Futures model for services such as inpatient paediatric and obstetric services.

Although initially developed in 2004 by the Gwent Health Community, the Strategy has remained both relevant and resilient, receiving universal support across the community through extensive consultation. It responds to the local health challenges of the Gwent population, provides an enabler for regional change and supports a modernisation agenda that is consistent with national strategies and Royal College reports and recommendations. The Health Board will be strengthening the programme structure and resources required to deliver its' Clinical Futures Strategy. This will commence with the review of the model of care for medical specialties and this will inform subsequent organisational capacity planning (flows, hospitals, activity, and length of stay, workforce, finance and scheduling). It is likely that this will require external expertise. This will underpin the refreshing of the Clinical Futures Programme Business Case and confirm the scope and acuity of care provided by the hospital network supporting the SCCC and enable the development of a comprehensive transition plan between now and the opening of the SCCC.

## 1.5 Our Ways of Working

The Health Board delivers services based on a number of golden threads that are the principles that underpin the service and its plans and is at the heart of everything we do (summary at section 1.1)

### 1.5.1 Reducing Health Inequalities

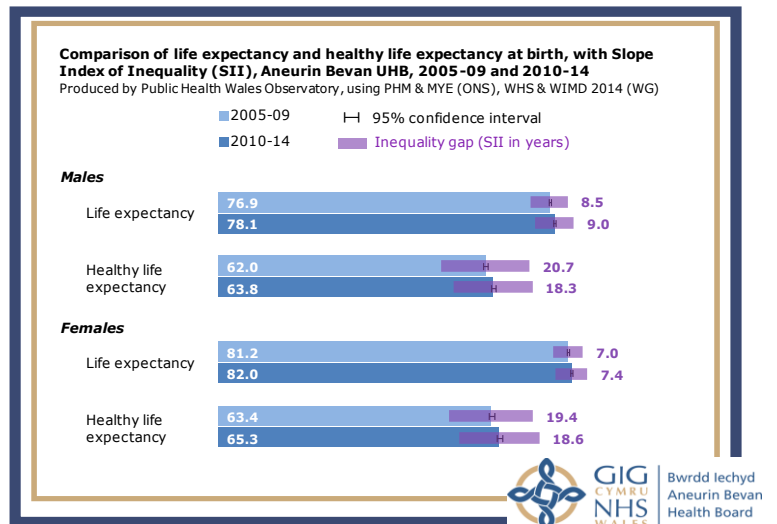
Reducing health inequalities is a strategic priority for the University Health Board and is a fundamental component of our longer term plan to reduce demand for healthcare through systematic, population scale interventions that target the underlying causes of poor health, such as lifestyle choices and socio-economic deprivation, and the uptake of screening to improve early detection and optimum treatment of disease.

Within Gwent there is an 18 year difference in healthy life expectancy at birth between people living in the least and most economically deprived areas within the Health Board area, and a 9 year difference in life expectancy between men and a 7 year difference between women [Graph 1.1]. For men, these figures highlight the difference between living in good health past retirement age to 72 years or developing health problems at age 56 years that may make it difficult to continue to work, particularly in manual jobs. People living in economically disadvantaged areas are therefore doubly affected. As well as the burden of ill health and economic costs for individuals, the costs of healthcare treatment, loss of productivity, lost taxes and higher welfare payments are an economic burden on society as a whole.

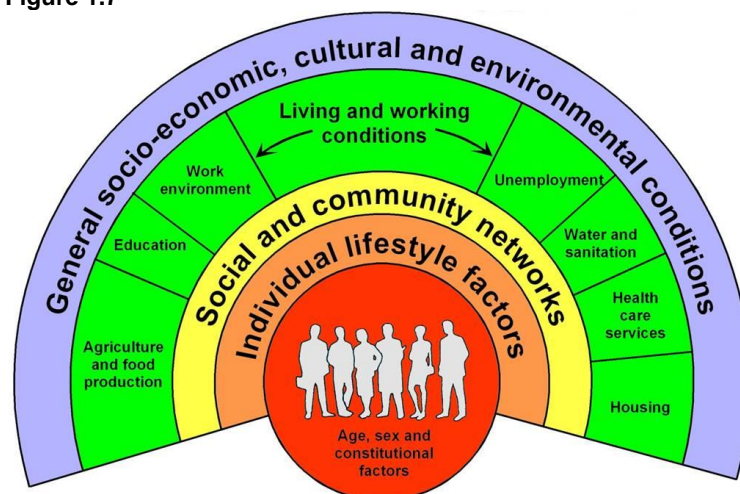
As elsewhere, much of the inequality in health across the Health Board's area is due to heart disease, stroke, cancer, diabetes, respiratory conditions and liver disease. Health inequalities from these diseases are largely attributable to higher rates of lifestyle risk factors leading to disease, compounded by presentation and diagnosis at a later stage of the disease when there is less likelihood of optimal treatment. Reducing the current rate of these diseases for the most deprived fifth of the population to nearer the rate for the least deprived fifth would make a significant contribution towards the Health Board's ability to achieve sustainability and meet forecast demand increases from demographic changes.

This reflects the social determinants of health across the communities we service, including the difference in social and community networks, local living and working conditions and general socio-economic, cultural and environmental conditions (Figure 1.7).

**Graph 1.1 Life expectancy and healthy life expectancy at birth.**



**Figure 1.7**



Source: Dahlgren and Whitehead, 1991

The World Health Organisation (WHO) Ottawa Charter (1986)<sup>1</sup> provides a framework for the organisation of partnership actions to address the social determinants of health. 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.

This framework underpins our approach to reducing health inequalities and improving the health of our population and provides a platform for delivering our responsibility under the Well Being of Future Generations Act.

**The best start in life** - the burden of ill health accumulates over the life course starting in the womb with a child's physical and emotional development over the first 1000 days of life setting the foundation for their future adult health. The 'Welsh Adverse Childhood Experiences Study (Public Health Wales 2015) provides compelling evidence of the association between exposure to Adverse Childhood Experiences (**ACE**) in childhood and health-harming behaviours in adult life.

The findings of the study are adults who were exposed to 4 or more Adverse Childhood Experiences were:

- 4 times more likely to be a high-risk drinker;
- 6 times more likely to have had or caused unintended teenage pregnancy;
- 6 times more likely to smoke e-cigarettes or tobacco;
- 6 times more likely to have had sex under the age of 16 years;
- 11 times more likely to have smoked cannabis;
- 14 times more likely to have been a victim of violence and 15 times more likely to have committed violence against another person over the last 12 months;
- 16 times more likely to have used crack cocaine or heroin;
- 20 times more likely to have been incarcerated at any point in their lifetime.

Adults who have experienced ACEs in their own childhood often end up raising their own children in households where ACEs are more common. Such a cycle of childhood adversity can lock successive generations of families into poor health and antisocial behaviour. Preventing ACEs in a single generation, or reducing their impacts, would benefit not only the current generation of children but future generations.

We are awaiting the publication of Public Health Wales follow up report to the 'Welsh Adverse Childhood Experiences Study' which will set out effective interventions to reduce the frequency and impact of Adverse Childhood Experiences and will take full consideration of these in refining local plans.

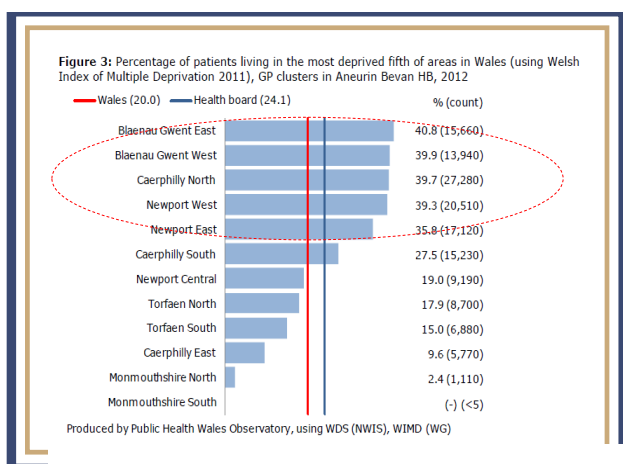
**The Living Well Living Longer Programme** - our award winning, innovative Living Well Living Longer programme is being rolled out in the areas of highest deprivation in the Health Board's area (Graph 1.2). The programme is a systematic, population scale approach to increasing the proportion of people at risk of heart disease, stroke and diabetes who are benefitting from proven, effective

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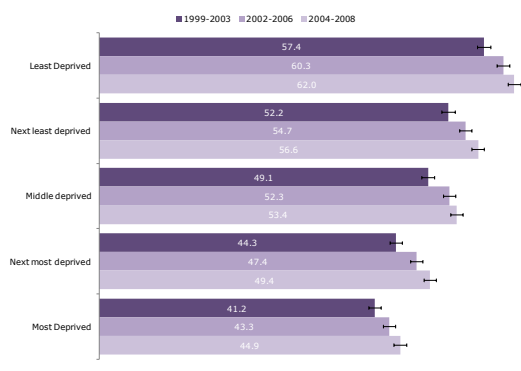
<sup>1</sup> World Health Organisation (2015) The Ottawa Charter for Health Promotion [Online] Geneva: WHO. Available at: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html> [Accessed 9 January 2015]

interventions to reduce their level of risk. The programme invites eligible adults age 40-60 to have a Health Check, and supports those that attend to set personal goals and access support to reduce their lifestyle risk factors as well as to access appropriate treatment for high blood pressure, high blood lipids or diabetes.

Graph 1.2



Cancer 5 year survival in Wales: percentage by deprivation quintile



The programme is addressing the Inverse Care law by providing additional capacity in the primary care system where the need is highest. The programme is being planned and implemented through the Neighbourhood Care Networks (NCNs) covering the most deprived areas within the Health Board area. The NCNs are the footprint for the development of a sustainable, social model of primary care to support people to reduce their risk of heart disease, stroke, diabetes, cancer, respiratory and liver disease.

Graph 1.3

**Improving cancer survival rates in disadvantaged areas** - health inequalities are particularly evident in cancer survival rates (Graph 1.3) which have greatest impact in older age because age is the biggest risk factor for developing cancer with two thirds of all cases of cancer in the UK being diagnosed in people over 65 years. The main preventable risk factors for cancer are:

- Smoking;
- Being overweight or obese;
- Eating an unhealthy diet;
- Physical inactivity;
- Excess alcohol consumption;
- Exposure to too much sun.

Other factors contributing to lower cancer survival rates in the most deprived areas are:

- Lower uptake of screening programmes;
- Not recognising symptoms of cancer;
- Delay in acting on symptoms of cancer;
- Less ability to access and navigate available healthcare services.

**Reducing inequality in uptake of immunisation programmes across NCN areas** - variation in uptake of all immunisations is another form of health inequality across the Health Board's area. Influenza vaccination is an effective intervention to protect older people and those with chronic diseases yet uptake is lowest in the most deprived NCN areas, where rates of chronic disease are highest. Work continues to improve uptake of routine childhood immunisations and ensure all children across all NCN areas are protected by their 4<sup>th</sup> birthday.

Our plans to reduce health inequalities are set out within the **Reducing Health Inequalities and Improving Population Health Service Change Plan (SCP 1)**.

### 1.5.2 Population Health and Commissioning

The Health Board is responsible for commissioning the health and well being of its population and we are continuing to develop a more structured and rigorous 'commissioning' approach to planning and delivery of services. This approach is informed by the 'Value Based Healthcare' principles set out

below to ensure the development of a commissioning system that prioritises resources to drive performance improvement in healthcare outcomes for patients and residents.

- **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 influence decision making and challenge current practice.
- **Ethical frameworks**, prioritisation methodology and other governance frameworks supporting 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 Health Board and to ensure the important aspects of an investment or disinvestment decision is highlighted and evaluated.
- **Business intelligence** to support decision making - In order to support informed decision making within the Health Board, 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.

The above elements require the commissioning 'system' to act as an enabler, with business intelligence and clinical evidence, along with transparency in decision making and prioritisation being the critical tools to success. Delivery of the commissioning intentions falls to both internal divisions and external providers, with robust monitoring of delivery to ensure best value is being delivered.

The Health Board continues to adopt a collaborative approach to commissioning developing partnerships with neighbouring Health Boards, Local Authorities, third sector partners, the Police & Crime Commissioner and others as necessary to ensure the needs of the population are met.

### 1.5.3 Quality and Patient Safety

Quality and patient safety is at the centre of our work in seeking to achieve excellence. We always aim to put the patient first, so that every person that uses our services, whether at home, in their community, or in hospital, has a good experience. To do this, the quality and safety of our care and services is a core focus throughout all our plans, from small changes in one service to the driving force for Clinical Futures.




Our Approach to Quality Improvement is that all staff have two roles: to continuously improve in their job and see 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 staff to be able to do this we have worked hard to make the Improving Quality Together training available to everyone, encouraging teams to undertake training together so that they all have an understanding of improvement methodology and share the same "common language" to support innovation and delivery of change. Our focus is to empower staff to deliver significant improvement of patient flow across the healthcare system.

Historically, the main focus for quality and safety in the health service has been on hospital services. The Health Board is actively seeking to cover the whole scope of its services from the patient's home, through community services to hospital care. Where we recognise that improvements are needed, the Health Board looks right across the healthcare system to make sure that changes are made that work together to ensure the best possible outcomes and experience for the greatest number of people (examples illustrated in Table 1.2). We also increasingly work closely with partners in social care, the independent sector and the third sector to deliver improvements in quality. For example, the Dementia Board spans Health, Social Care and the 3<sup>rd</sup> sector, jointly setting and delivering a strategy for ensuring that people and their carers can live well with dementia, working together to increase the numbers of dementia friendly communities and ensuring acute hospital wards have the skills and resources to provide effective and compassionate care for people with dementia.

The 22 Health and Care Standards are the quality framework against which all our healthcare services are assessed. They have been designed to fit with the 7 quality themes identified in the NHS Outcomes and Delivery Framework and we continue to prioritise areas that reduce avoidable harm to patients, specifically:

- Avoidance, early identification and management of sepsis, healthcare associated infections, hospital acquired thrombosis, falls and pressure damage.
- Compliance with fundamental aspects of Trusted to Care including dementia, nutrition, hydration, medicines and continence care.
- Adopting prudent healthcare principles, ensuring that patients are equal partners and fully engaged in our improvement events.
- Embed identification and treatment of dementia across all areas.
- Reducing mortality and sustain this reduction to decrease variation across our hospital sites.
- Improving the quality improvement skills of our staff.

**Table 1.2 - Quality Improvements across the whole healthcare system**

	 Home	 GP/Community	 Hospital
<b>Recognising Deteriorating Patient/Sepsis: NEWS as a common language</b>	District Nurses recording baseline physiological observations, determining what is normal for the person. Out of Hours Service also using NEWS	GPs report patient's observations/parameters when contacting hospital to admit. Nursing Homes have received training on NEWS	NEWS used across all acute and community hospitals to recognise deterioration ABC Sepsis using trigger tool to recognise and respond to sepsis at front door and whole of YF
<b>Reducing C. diff</b>	Infection control links with Nursing Homes	Antibiotic prescribing practice information and data for GPs Significant Event review of cases	Antibiotic prescribing practice Cleaning/deep cleaning Hand washing Review of each C. diff case
<b>Reducing Pressure Damage</b>	Reporting of pressure damage of people on District Nurse case loads	Reporting of pressure damage in Nursing Homes Training on preventing pressure damage in Nursing Homes	Training on preventing pressure damage. Revised reporting of pressure damage. Improved supply of mattresses.

The Board monitors quality across the Health Board through a number of mechanisms. Independent Members are involved directly through championing specific issues and areas of service, providing challenge and support. They also consider a performance report on quality at every Quality and Patient Safety Committee and Board meeting, which monitors quality outcome measures, many of which are reflected in the quality improvements in this plan. Increasingly the measures reflect quality across the whole patient pathway. The reporting arrangements enable them to monitor against milestones that have been set, to ensure we are moving towards each outcome.

Further assurance is provided through comprehensive surveillance and review, starting with the patient voice by triangulating concerns, patient experience information, mortality reviews, national clinical audits, incident reporting (including serious incidents), complaints and Ombudsmen reports.

Details of our overarching approach and specific plans for quality assurance and improvement for this planning cycle are set out in an extended Appendix 1.

#### 1.5.4 Patient Experience

**Figure 1.8 - Approach to embedding patient experience at heart of quality**

Understanding the experience of what it feels like to use the services of the Health Board is fundamental to being a learning organisation that is person centred in the design and delivery of services. Patient experience is at the heart of quality in healthcare and it needs to be embedded across the organisation with visible leadership (figure opposite). In order to achieve this, we need to be able to see the experience of care through the patient, family and carers' eyes. This means that the patient voice needs to be heard at all levels of the organisation, and that the patient is involved and listened to as an equal partner in their care, and in the processes of designing and delivering care.



The Health Board Framework for Patient and Family Experience has been refreshed in 2016/17. A workshop was held in December 2016 with a wide range of key stakeholders to assess current position and develop priorities.

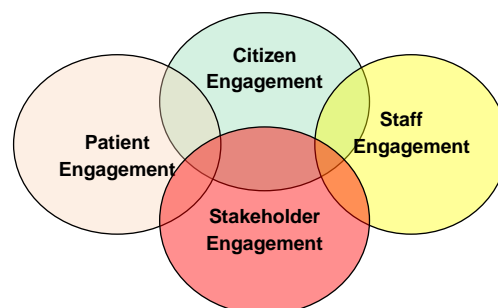
Listening and learning to improve the experience of care is fundamental and the framework is implemented within a context of integration with the Organisational Development strategy, the Citizen Engagement strategy, the improvement and value based health care work, the development of Patient Reported Experience Measures and is underpinned by the values of the organisation. The key priorities for 2017/18 include:

- First impressions and enhancing first contact with the Health Board.
- Further development of patient feedback mechanisms and learning from feedback.
- Develop the PREMs approach to International Consortium for Health Outcomes Measures (ICHOM) Values Based Health Care.
- Focus on Trusted to Care and care of older people in hospital.
- Implementation of the Dementia strategy.
- Continue to develop the implementation of All Wales Standards for Accessible Communication and Information for People with Sensory Loss.
- Refresh the Volunteering strategy and further enhance the contribution of volunteers.
- Continue the implementation of the Carers Strategy.

### 1.5.5 Patient Engagement and Partnerships

Our commitment to improving service quality, patient safety and experience and the delivery of timely services for patients, not only focuses on delivery of key targets but also ensuring that we are engaging effectively with communities and partner organisations to reduce the impact of health inequalities, promote people to take more responsibility for their own health and ensuring our communities are aware of and able to be involved in the planning and delivery of local services (Figure 1.9).

**Figure 1.9**



The Health Board's approach encompasses 4 distinct areas of engagement:

An on-going and continuous dialogue with the public is enabled through the citizen engagement work-stream, known locally as 'Talk Health: ABUHB Engages'. Our approach uses a range of methods to engage with people.

- **Engage4Change** (street level engagement) - weekly presence in neutral areas of high footfall (i.e. supermarkets, market halls, one stop shops and leisure centres) in one of the five Local Authority areas, 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.

- **Better 2gether** - We are not the only organisation seeking to engage more strongly with our communities at this time, we work with other public and third sector organisations to share and join with planned engagement opportunities.
- **Community Connects** - enables us to reach into particular communities (either of common interest or geographically specific) i.e. Lansbury Park Deep Place study, Pontypool Deep Place Study, Mosques in Newport, Markham Winter Soup event, Communities First activities, 50+ fora.
- **A Peoples Network** – has also been established to ensure an on-going dialogue and will form the basis in the coming year of our Talk Health locality based public fora which will be key to the transition towards the opening of the SCCC.

We are building our organisational and community capacity using engagement activities to get a perspective on what local people think about NHS services. We are making significant strides to demonstrate that when we listen, we also act. We have spoken with over 11,000 people since the establishment of our engagement team in the Autumn of 2015.

On the 17<sup>th</sup> February 2017, the Health Board arranged a dedicated 'Talk Health' Public event to consider the draft IMTP with the public. 172 people were engaged in the day and discussed each of the Strategic Change Plans of the IMTP. The following offers an overview of the key themes and which plans have been impacted as a result:

Table 1.3

<b>What is important</b>	<b>Where is this being addressed</b>
Investment in early years (in all areas of Gwent) Alcohol Obesity Mental Health Smoking	<b>Improving Population Health (SCP 1)</b>
Waiting times for GP appointments Introduction of new roles into general practice Support for the introduction of traditionally hospital based services into Community Settings Customer care at reception Stronger use of voluntary sector	<b>Care Closer to Home (SCP 2)</b>
Focus on young people with diabetes Focus on prevention and delaying development of Type 2 diabetes Targeting schools and educational establishments for diabetes prevention Raising awareness of neurological conditions in the community Measuring quality as well as quantity of services and patients 'test-driving' services in development (Patient Recorded Outcomes Measures) Keeping people at home if possible Asking people about the ways in which they want to receive information and recording this in their records Prioritising where most improvement is needed	<b>Major Health Conditions (SCP 3)</b>
Importance of communities understanding mental health Crisis Education and training Mental Health support and advice Peer support	<b>Mental Health &amp; Learning Disability (SCP 4)</b>
A&E Waiting Times Introduction of 111 Falls Lack of knowledge on alternatives to A&E Minor Injuries Making arrangements for discharge	<b>Urgent and Emergency Care (SCP 5)</b>

What is important	Where is this being addressed
<p><b>Out-Patients</b>  Speed of out-patients appointments  Usefulness of text reminder service (Dr Dr)  Want local accessibility as much as possible  Choice of closest (near to me) rather than earliest appointments  Use of technology</p> <p><b>Cancer Services</b>  Access to quick diagnosis and results  Need for psychological support  Need for family support  Having a choice in treatment  Increased public awareness (particularly for screening)</p>	<p><b>Planned Care (SCP 6)</b></p>
<p>Knowing what's there now, and what will be there in the future  Needing to let people know in advance about any changes  We don't mind travelling particularly if we can park  Importance of infection control</p>	<p><b>Transition and Service Sustainability (SCP 7)</b></p>
<p><b>Therapies</b>  Timely access to therapies  Availability of equipment/advice to support weight management, blood pressure monitoring  Increased communication between professionals</p> <p><b>Children &amp; Adolescent Mental Health Services</b>  Need to more strongly engage children &amp; young people.  Difficulty being referred and then being diagnosed  Need for more holistic planning with people like housing  Transition  Availability of service at weekends and evenings</p>	<p><b>Family &amp; Therapies Plan</b></p> <p><b>Family and Therapies Plan (Section 3.9)</b></p>

As an underpinning principle of the way we do our business, there was also specific discussion on Value in Healthcare and the outcome of this session will be picked up through the entirety of the IMTP.

### 1.5.6 Prudence and Value Based Healthcare

The Health Board has made a commitment to make prudent and value based healthcare an active movement for change within and outside the organisation, including demand management. It is a vehicle to deliver new ways of working within a clinical value based framework and enables 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 stopping treatment(s) which have no or limited evidence base and tests which may lead to over diagnosis and over treatment with the associated harms, as part of the Health Board's approach to demand management.

An engagement programme is being 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 feature across all divisions in secondary, primary and community care and require the support and engagement from key stakeholders and patients.

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 intervention;
- Choose Wisely;
- Patient information/material;
- Commitment to outcome measures and co-production;
- Formation of a strategic partnership with the International Consortium for Health Outcomes 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).

Whilst the Clinical Effectiveness Group continues to build upon the earlier work streams, in the 2017/18 the focus will be on prudence in clinical teams, looking to see how we can generate activity that will bridge prudent into the value based domain and change the existing cultural behaviour. The relationship between finance and clinicians is also developing at pace and liberating further prudent innovation. This will ensure we are providing the right care for our population and systematically capturing outcomes that matter to our patients.

The work we have initiated provides us with a vehicle to integrate systems between health and social care, and unite us in our common goal to transform services in accordance with the prudent healthcare principles and improve the lives of our patient population. In addition, during 2017/18 we will:

- Focus our efforts to work with urgent care to see if we can look at prudent in an MAU setting.
- Set up a prudent healthcare education and training programme aimed at new consultants, junior doctors and clinicians.
- Set up a bi-monthly rolling programme of work across all divisions on the prudent healthcare agenda.
- Arrange an event on value and values aimed at clinicians and finance representatives to help bridge the professional gap.

The scope of the Health Board's Value Based Healthcare programme: Assessing the Value and Measuring What Matters is included at Appendix 2.

### **1.5.7 Innovation and Research**

Our philosophy is to foster a strong culture of learning, research and innovation which feeds into practice. We believe that research activity will grow in quantity and quality where it is viewed as a core activity, offered to patients as part of their routine clinical care.

As a University Health Board, we seek to demonstrate the value that this status has brought across the whole organisation from the Board to the Ward or Practice, and how our behaviours in embracing clinical and non-clinical research, disseminating research and innovation, embedding service evaluation and developing strong partnerships with Universities, in and outside of Wales, have changed. This will be overseen by the Health Board's Academic Partnership Board.

Through our "Putting Things Right" arrangements, audit, staff recognition and awards processes we advocate learning from errors and sharing good practice.

The Aneurin Bevan Continuous Improvement (ABCi) service provides the Health Board with a systematic approach to innovation, service improvement and leadership. The service supports the culture that enables its employees to be curious, courageous and creative providing opportunity to seek different ways to provide healthcare and to improve and innovate services. Achieving improvements in the patient experience, outcome and financial efficiency requires rigorous

methodology that is rooted in the Science of Improvement. By embedding this methodology at the frontline the capability to test, measure, implement and sustain improvement increases drastically.

In the past 12 months, ABCi has introduced the IHI Breakthrough Series methodology to build, support and deliver on large scale improvement programmes. This methodology is used globally, and has delivered improvements across many complex healthcare issues within primary and secondary care, improving safety and operational efficiency.

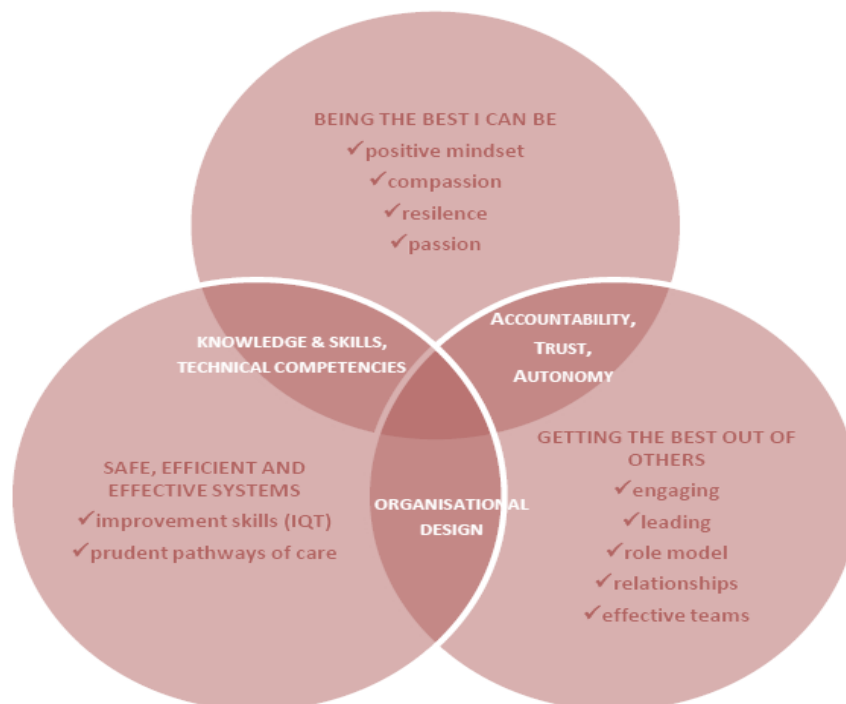
### 1.5.8 Staff Empowerment and Organisational Development

Whilst the challenges facing the University Health Board are significant the opportunities available to make positive changes to the way we work are even greater. 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 golden thread throughout the IMTP and is a shared responsibility. It is essential to ensure we make the most of the strengths, opportunities and challenges presented to us. We are focused on:

- Developing leadership and management potential.
- Improving staff experience and engagement.
- Bringing our organisational values to life.
- Facilitating talent management and succession planning at all levels.
- Supporting the delivery of the Service Change Plans.
- Supporting Primary care transition and integration.
- Preparing our staff for and supporting them with service and workforce redesign leading up to the opening of the SCCC.
- Enhancing and protecting the well-being and health of staff.
- Building reciprocal relationships with the community we serve.

Figure 1.10 - Staff Empowerment and Organisational Development Framework



Our commitment is to equip our staff with the knowledge, skills, experience, competencies and confidence they require. We have worked hard to make the Improving Quality Together training available to everyone. More than 4,200 staff have completed this training, 240 have also completed

silver level IQT. Over the coming year, ABCi will develop a Gold IQT programme, honing the skills of the silver alumni, building a collaborative to support improvements at scale that is aligned to corporate strategic objectives. The key focus, in the first instance, is to deliver significant improvement of patient flow across the healthcare system.

We continue to build and consolidate 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.

In summary, the Health Board faces the same **national challenges** that have been well described within public sector bodies; an ageing population in declining health with ever increasing complex needs; increasing patient acuity and a disproportionate number of our adult population live with one or more chronic conditions. We alone cannot address these challenges and welcome the opportunities that the Wellbeing of Future Generations Act provide to strengthen joint ownership of priorities and shared responsibility for solutions across public sector organisations.

Realising our Clinical Futures Strategy, we will continue to focus on ensuring that people are supported in their home or community environment and transition plans are developed and implemented in readiness for the opening of the SCCC in 2021. We will reshape hospital based services, ensuring that the hospital network provides our citizens and our primary and community services with appropriate, accessible and timely care.

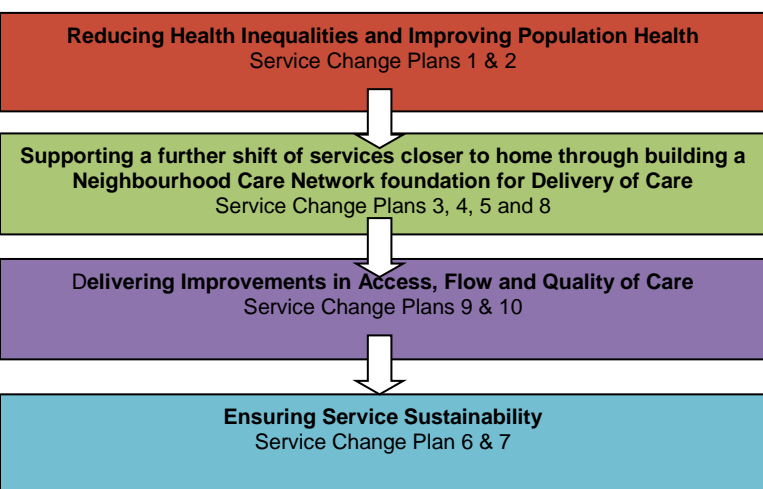
At all times, in every part of our healthcare system, we will strive to be “best in class” – pushing the boundaries to reduce health inequalities and to provide efficient, effective and proportional interventions in accordance with value based, prudent healthcare.

## SECTION TWO – ACHIEVEMENTS IN 2016/17, OPPORTUNITIES/ CHALLENGES AND SIGNIFICANT SERVICE CHANGE

### 2.1 Progress in Delivering the 2016/17 – 2019/20 IMTP

As we refresh our approved three year plan, it is important to reflect back on 2016/17 and capture the key achievements and lessons learned over the past 12 months. The 2016/19 IMTP was organised into ten Service Change Plans (SCPs) aligned to the Health Board's priority areas. These work programme areas were derived from our organisational clinical service strategies including Clinical Futures, our Divisional IMTPs and national programmes and priorities.

Figure 2.1 - 2016/17- Service Change Plan Overview



An executive led delivery framework has continued to oversee implementation of the SCPs and ensure that further opportunities to improve services and realise benefits are 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.

Significant progress has been made on many issues within our SCPs during the past twelve months. Some of the key achievements are set out below with further detail at Appendix 3.

#### Reducing Health Inequalities and Improving Population Health (SCPs 1 & 2)

- Living Well Living Longer health checks rolled out across 3 Neighbourhood Care Networks in Gwent.
- Prison Healthcare service implemented smoking cessation services to both local prisons which have become the first Smoke Free Prisons in Wales; the highest proportion of prisoners being tested for Blood Borne Viruses and the introduction of risk assessment for Cardiovascular Disease mirroring the Living Well Living Longer programme available to our most deprived populations.
- Bowel screening pilot undertaken to follow-up patients who had failed to return their bowel screening kits (50% of non-responders, predominantly resident in our most deprived communities) and supported to participate fully in this important screening programme.
- Gwent Child Obesity Strategy "Fit for Future Generations" has been adopted by the five Public Service Boards and now developing a multi-agency response to develop and deliver Child Obesity Action Plans.
- 3,000 people have attended group psycho-educational sessions as part of the Mental Wellbeing Foundation Service.
- 1,300 staff have received training in Making Every Contact Count, with a commitment that 10% of our frontline staff will receive this training each year.
- 2.8% of the estimated Health Board's smoking population were treated by NHS Smoking Cessation Services with 38% validated as successful.

### **Supporting a further shift of services closer to home through building a Neighbourhood Care Network foundation for Delivery of Care (SCP 3, 4, 5, and 8)**

- Practice Based pharmacists are now embedded in GP practices, in the quarter April to June 2016 they delivered 2,819 hours undertaking work that would normally be undertaken by a GP. Further initiatives have commenced during the past year including practice based social workers and social prescribers and direct access physiotherapy each designed to reduce the need for patients to access services through a consultation with their GP.
- Primary Care Operations Support team is well established and supporting vulnerable practices with clinical and leadership resources. Implementing our 5 year plan to redesign Out of Hours primary care through the increase of skill mix and introduction of new roles including pharmacy and advanced paramedics. This has resulted in a sharp decrease in the numbers of unfilled sessions allowing the service to maintain the capacity to address patient demand.
- Primary Care Diabetes Services are helping patients to control their HbA1Cs through adopting prudent healthcare principles. A rational approach to the use of diabetic medications has seen a reduction of costs of needles by £30,000/quarter.
- The Older Person's Pathway is now available across Newport, leading to person centred stay healthy plans, anticipatory care plans and risk stratification for each GP practice population.
- Achieving a 19% reduction in the incidence of unplanned emergency admissions for reversible diabetes complications, an overachievement against a 5% target reduction
- 3rd Sector Mental Health Foundation Tier Commissioning process completed with awards announced in October 2016. New service delivery models for Advocacy, Information, Advice and Assistance, Counselling and Community Well Being, Skills and Training commenced in December 2016.
- Remodelled Mental Health Out of Hours crisis response services, with extended hours for CHRT, liaison psychiatry team and a resident shift system for junior doctors.
- Waiting lists for psychological therapies have been reduced and a number of new developments introduced following investment from Welsh Government.
- Peri-natal Mental Health services have been established for pregnant or post-natal women at risk of developing or being affected by mental illness.

### **Delivering Improvements in Access, Flow and Quality of Care (SCPs 9 & 10)**

- The redesigned stroke pathway including centralisation of hyper acute stroke services has delivered highest SSNAP standard achievement in Wales.
- Expanding integrated models for diabetes, respiratory, and cardiology which have resulted in 100% achievement against Tier 1 targets for 36 and 26 weeks.
- The Emergency Frailty Unit at the Royal Gwent Hospital is delivering improved outcomes for elderly patients and reducing average length of stay for patients accessing the unit from 9 to 4 days.
- The SAFER bundle has been implemented on two medical wards and is supporting the pro-active delivery of care management plans; discharge processes and improving flow (impact to be quantified in next iteration).
- Ambulatory Care Services have been established in NHH and RGH focusing on senior clinical decision makers as the first point of contact for all ambulant patients referred by their GP for emergency medical assessments.
- All theatre sessions at Ysbyty Ystrad Fawr now fully utilised Best in class with regards percentage reduction in > 36 week RTT breaches in Wales.
- Forecast delivery of 80% compliance with the Adult Mental Health Primary Care Access target for assessment and intervention
- The Health Board will improve elective access by reducing the number of patients waiting over 36 weeks from >2,500 at the end of March 2016 to 1,200 by the end of March 2017, subject to the management of risk, with no post year end RTT "bounce back".
- There has been a shift of resources and activity to Primary Care in both minor oral surgery and ophthalmology. 2,300 patients have received their minor oral surgery treatment in a primary care dental surgery, 3,000 patients have received their Glaucoma follow up assessment and 7,000 slots are available in primary care opticians for Wet AMD.

- The Health Board will have reduced the number of patients waiting for CT and MRI within year, though challenges remain in endoscopy.
- There is an active programme for applying prudent healthcare principles for osteoarthritis in knees and the expansion of the musculoskeletal service.
- Reductions in the number of cases of *C. difficile* within the Health Board are on target to achieve the 28 cases per 100,000 population target. The Health Board has the lowest rate of *S.aureus* bacteraemia in Wales.
- The establishment of the Falls Scrutiny Panel which reviews every in-patient fall that results in a fracture. Our focus on the prevention of falls in hospital has ensured that our staff have a thorough understanding of the risk factors for falls and actions to prevent them are at the forefront of patient care plans. The Falls Response Unit, a joint initiative with WAST, continues to stream patients with non-fracture falls into appropriate community based care
- An improvement in the recognition of and response to patients presenting in ED with sepsis through the successful implementation of the Sepsis 6 Bundle.
- The Welsh Risk Pool annual review of the management of complaints, claims and incidents demonstrate the Health Board's well established and maturing process for actively learning from concerns. Furthermore, our redress arrangements are held up as an exemplar of good practice in Wales.
- The Health Board leading work with partners in the community to determine how people who experience social isolation and loneliness are best signposted to existing services.
- Access to GP practices compare well, achieving first or second place to the rest of Wales against the 3 main indicators of access.
- The Health Board now has the shortest average length of stay for emergency medical admissions for chronic conditions when compared with all other Welsh regions and as a result also experiences the lowest number of occupied bed days per 10,000/population over 18 years of age. This year has seen a small increase in number of admissions (1.4%) however the number of bed days utilised for this patient cohort decreased by 2.3% in the same period.
- Made substantial progress in implementing its community hospital bed plan with patients now staying in hospital for 5 days fewer than was the case in 2014/15.
- Delayed Transfers of Care (DToc) performance in Gwent over the 11 month period of December 2015 to October 2016 compares well with the rest of Wales when weighted by the total population over the age of 75.

### Ensuring Service Sustainability (SCPs 6 & 7)

- There is agreement from both Aneurin Bevan and Powys Community Health Councils to proceed to develop capital plans to centralise breast services at Ysbyty Ystrad Fawr.
- The inpatient paediatric and obstetric services have been sustained at Nevill Hall Hospital throughout 2016/17 without loss of service continuity. A clinically identified transition plan is being developed and will be taken forward in the next year.
- The Health Board has implemented a revised workforce model to sustain neonatal services at the Royal Gwent Hospital following the loss of Tier 2 Deanery posts and is on track to extend this to cover the loss of Tier 1 posts in March 2017.
- Surgical specialties have achieved compliance with the new Education Contract and sustained acute services in their current configuration, albeit with a current over-reliance on agency staff.

In addition to the achievements outlined above, the Health Board has also:

- Sustained its policy for no "off-contract" agency usage since April 2016 on all Hospital Sites
- Won the Welsh HPMA Award for Partnership & Engagement - Living the Values Project and this was presented at the National Clinical Care Conference in November 2016
- Improved our ranking in the Stonewall Workplace Equality Index by 71 places from 188 out of 397 organisations in 2015 to 117<sup>th</sup> in 2016
- Improved our Bank shifts fill rate from 86% to the current rate of 92% through successfully increasing our HCSW bank capacity
- Offered 36 placements under the LIFT scheme since January 2016.

- Continued to introduce new roles to improve the resilience of our services and workforce.
- Improved performance against National Prescribing Indicators, specifically in the prescribing of low strength inhaled corticosteroids and the use of non steroidal anti inflammatory drugs.

## 2.2 Opportunities and Challenges

The environment in which the Health Board operates has become increasingly complex and dynamic. These include the ageing population, increasing demand for health and social care, significant workforce challenges and increased public expectation, at a time of sustained austerity in public sector finances.

The Clinical Futures Strategy sets out the strategic direction for modernising clinical services for the population of Gwent and South Powys. Clinical Futures is a clinically owned and led programme that seeks to rebalance the provision of healthcare in Gwent. This enables citizens to play a more active role in their health and wellbeing, providing more services within the community using Neighbourhood Care Networks to drive and deliver change at a local level and reshaping our hospital services in order to centralise them at the Specialist & Critical Care Centre (SCCC), whilst maintaining a network of local hospitals.

The welcomed approval of the SCCC provides a clear focus for the Health Board to develop detailed transition plans for its clinical services in the run up to the opening of the SCCC in 2021. For a number of services, and as a result of significant recruitment and retention difficulties, there will be challenges in maintaining the current configuration of services prior to the advent of the SCCC and these are described within the Health Board's Service Sustainability Service Change Plan (SCP), where interim steps may be necessary as a transition to the Clinical Futures model for services such as inpatient paediatric services.

This will require closer collaboration and partnership working with other Health Boards. Whilst there has been effective joint planning of a number of services on a regional context, the scale, scope, and momentum of regional planning will increase and this is described in greater detail in the subsequent significant service change section.

The Health Board strives to continuously improve its efficiency and productivity and has responded by creating a new Productivity and Efficiency Board in 2016/17. This will lead targeted improvements in performance against a number of indicators, and aligned to enabling improvements in urgent and emergency and elective access. The Health Board has undertaken a significant piece of work which scopes the wide range of opportunities within each Division and has used the Divisional planning process to ensure that Divisional Plans address the key opportunities.

Whilst the Health Board delivered on a range of issues and plans in 2016/17 there are a number of key lessons and challenges that have been considered in the refresh process. These primarily include:

- The scale of ambition versus what is realistically achievable over a 12 month period such as RTT and access to diagnostic plans.
- The assessment of demand growth and acuity especially around the urgent and emergency care service during the winter months with 20% growth above the same period 2016 (October to December).
- Further strengthening of partnership working with Local Authorities and the Third Sector, within the context of the Well Being and Future Generations Act.
- The workforce pressures due to the national recruitment issues and additional funding that resulted in increased posts and over reliance on agency staff, often at premium rates.
- The need to reform the Health Board's Clinical Futures Programme Business Case, building on the welcomed approval of the SCCC and within the context of strengthening regional planning.
- In the light of workforce pressures, there is a need to develop transition plans for acute specialties, initially commencing with paediatric and obstetric services.
- The need for greater efficiency and productivity to achieve financial sustainability.

General reflections also include the pace and scale of change required to support the strategic ambitions of the Board alongside the need for strengthening the performance management and delivery framework that supports delivery of the plan.

### **2.3 Significant Service Change (Service Sustainability) and Transition to the Specialist Critical Care Centre**

In accordance with both the Health Board's Clinical Futures Strategy and the South Wales Programme & work of the South Wales Collaborative on medical and surgical specialities, the sustainability of a number of acute specialties will ultimately be achieved through their centralisation at the SCCC, which is planned to open in 2021. This includes inpatient care for high acuity elective and emergency surgery, paediatrics, obstetrics, neonatology, cardiology and gastroenterology. The SCCC provides the enabling infrastructure and critical mass for such services, with the objective of 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 the transition plans the Health Board will develop to sustain a number of services in the light of current and anticipated workforce challenges. As a result of capacity constraints and interdependent services the Health Board will seek, as far as is practical, to retain the existing configuration of acute services until the opening of the SCCC in 2021, though it will seek to standardise practice and introduce new models of care in advance wherever possible.

In the last year, the Health Board has successfully centralised its hyper acute stroke services at the Royal Gwent Hospital, established early supported discharge and rationalised stroke rehabilitation with a marked improvement in outcomes and quality of care. This has built upon the centralised models in place for a number of specialties, including urology, ENT, ophthalmology and maxillofacial surgery. In response to the requirement to centralise paediatric and obstetric trainees at the Royal Gwent Hospital, inpatient paediatrics and obstetrics services has been sustained at Nevill Hall Hospital by the implementation of a new workforce model. Despite intensive focus and world-wide recruitment, this has not however proven sustainable and the Health Board has been appraising transition options for these services prior to the opening of the SCCC as part of its 2016/17 Plan and below describes how this will be taken forward in partnership with Cwm Taf and Powys UHBs in 2017/18, as part of the Health Board's regional planning work programme.

In September 2016, the Health Board implemented a new workforce model for its neonatal services following the redistribution of Tier 1 & 2 trainees between Singleton and Royal Gwent Hospitals. In October 2016, the Joint Committee of the Welsh Health Specialist Services Committee accepted the recommendation of an independent expert panel that neonatal Denary trainees in South Wales would be based at Singleton and the University of Wales, with agreement that an alternative workforce model be established from March 2017 to sustain neonatal services within the Health Board as part of the South Wales Neonatal Network. The section below describes how this will be delivered as part of enhanced collaborative arrangements with Cardiff and Vale and Abertawe Bro Morgannwg UHBs, and the Neonatal Network.

There are similar challenges emerging for surgical and medical specialties. Whilst the Health Board has successfully implemented actions to deliver the revised educational contract in surgical specialties, these are over-reliant on Clinical Fellows, with the Health Board experiencing recruitment and retention pressures previously described for Paediatrics. The Health Board will therefore seek to develop transition plans for its surgical and medical specialties in 2017/18, carefully appraising the feasibility of further centralising services prior to the advent of the SCCC in the light of both clinical interdependencies and available infrastructure.

Our plans to address these major service change areas are set out within **the Service Sustainability Service Change Plan (SCP 7)**.

Recognising the scale of the challenge for the Health Board in delivering organisation wide change required to support the Clinical Futures model and the opening of the SCCC, the Health Board will be strengthening its planning infrastructure, including strong clinical leadership across the system to ensure that its service and capital planning resources are fit for purpose, and that there is a supporting

organisation development programme.

Whilst the SCP 7 describes the development of transition plans for a number of acute services, it is recognised that the scope of the Health Board's transition plans will need to extend to Primary and Community services and the redevelopment and resubmission of the Clinical Futures Programme Business Case. There is also likely to be additional capital funding during the transitional period to support the physical infrastructure required to meet the increasing demands and performance improvement expectations over the next four years. The Health Board has commenced a review of priority clinical models to inform the refresh of plans for the SCCC and the supporting hospital network, and this will inform the transition plans for the enhanced Local General Hospitals

### **Strengthening Regional Planning**

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 Health Board 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 Health Board, 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. The approval of this case in October 2016 provides additional impetus to strengthen regional planning in South East Wales.

The Health Board has played an active role within the South Central ACA structures and has a full role in the detailed planning of service change, particularly in the development of contingency plans for paediatric and neonatal services, and in the successful capital cases to strengthen neonatal services in South East Wales. More widely it is playing an integral role in considering the optimal future configuration of a number of services, including vascular surgery, major trauma, SARC and pathology services.

Whilst the detail of how Regional Planning and Centres of Excellence will be taken forward is being considered by Chief Executives via the NHS Collaborative, there is agreement that a number of initiatives will be undertaken to strengthen regional planning in South East Wales, which includes work with:

- Cwm Taf and Powys Health Boards on the provision of services to the population of the Heads of the Valleys and South Powys, with an initial focus on paediatric, obstetric and neonatal services.
- Cwm Taf and Cardiff Health Boards in considering the future configuration of acute services, and in particular taking forward the configuration of medical and surgical specialities.
- Cwm Taf and Cardiff Health Boards on radiology and endoscopy services with short term actions focussed on the elimination of backlogs in 2017/18 and a long term focus on sustainability.
- Powys Health Board on the local provision of sustainable Mental Health Services within Powys
- Public Health Wales and Cwm Taf Health Boards on the future model for microbiology services in South East Wales.
- Velindre NHS Trust is taking forward the Transforming Cancer Service Programme, including the potential creation of a satellite Radiotherapy Unit at Nevill Hall Hospital.

## SECTION THREE – DELIVERING OUR PLANS

The IMTP demonstrates how the organisation aims to meet the needs of the population, deliver sustainability, service change and service improvement and make progress in the delivery of the overarching strategic direction in the context of its Clinical Services Strategy. The Clinical Futures Strategy is an essential underpinning of the IMTP, and the IMTP is the mechanism that seeks to provide the bridge to the opening of the SCCC in early 2021, an important enabler of the Clinical Futures Strategy. The Health Board’s Clinical Futures Strategy and key objectives have been reviewed by the Board and these were used as the basis for detailed internal planning guidelines for both Divisional and Corporate Service Change Plans. The key objectives over the next three years include:

- Reducing health inequalities and improving population health.
- Supporting the further shift of services closer to home through building a strong Neighbourhood Care Network foundation for delivery of care.
- Delivering improvements in access, flow and quality of care to patients.
- Ensuring service sustainability in key services
- Fulfilling our ambition of achieving “best in class” across the organisation.
- Managing within existing resources and minimising any cost growth.

### Approach to Planning in 2017/18

As part of the IMTP refresh process, the updated plan continues to be developed using the three levels of planning (Operational, Tactical and Strategic) 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. These 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.

Figure 3.1 - ABUHB Planning Framework



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

### Operational Planning - Improving Operational Efficiency

The Health Board 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 the context of unprecedented challenges facing the NHS it is crucial that we ensure we maximise our efficiency and productivity across the system. The Lord Carter Review of “Operational Efficiency across the NHS” published in 2015 sets out the requirement and opportunity for efficiency and productivity across the service in England, and Wales is no different with Welsh Government also setting out a greater expectation around this issue. The Health Board has delivered programmes of efficiency and productivity on an

annual basis and has strengthened its information intelligence to support the identification of opportunities.

However, the Health Board plans to strengthen the programme and processes to drive a greater delivery of efficiency and productivity across the organisation to support the service, workforce and financial challenges over the next three years and beyond. During 2016/17 the Health Board has established the Efficiency Board to oversee key areas of work and drive productivity improvements at pace.

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 Health Board in support of the 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 implementation of 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 48 beds with a key component relating to long stay patients.
- **GP Referral Rates** – benchmarking of referral rates across the Health Board sets out the potential opportunity by specialty and demonstrates that across 11 specialties there is an excess of over 29,000 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 2017/18. 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 cross cutting 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 and is fundamental to the delivery of financial and service sustainability (Section 4.1).

### **Tactical Planning - Service Change Plans**

The Health Board has continued to develop its Service Change Plans as the mechanism by which it progresses changes that span the tactical and strategic levels of planning. These primarily relate to cross cutting work-streams, and corporate priorities that support delivery of key objectives.

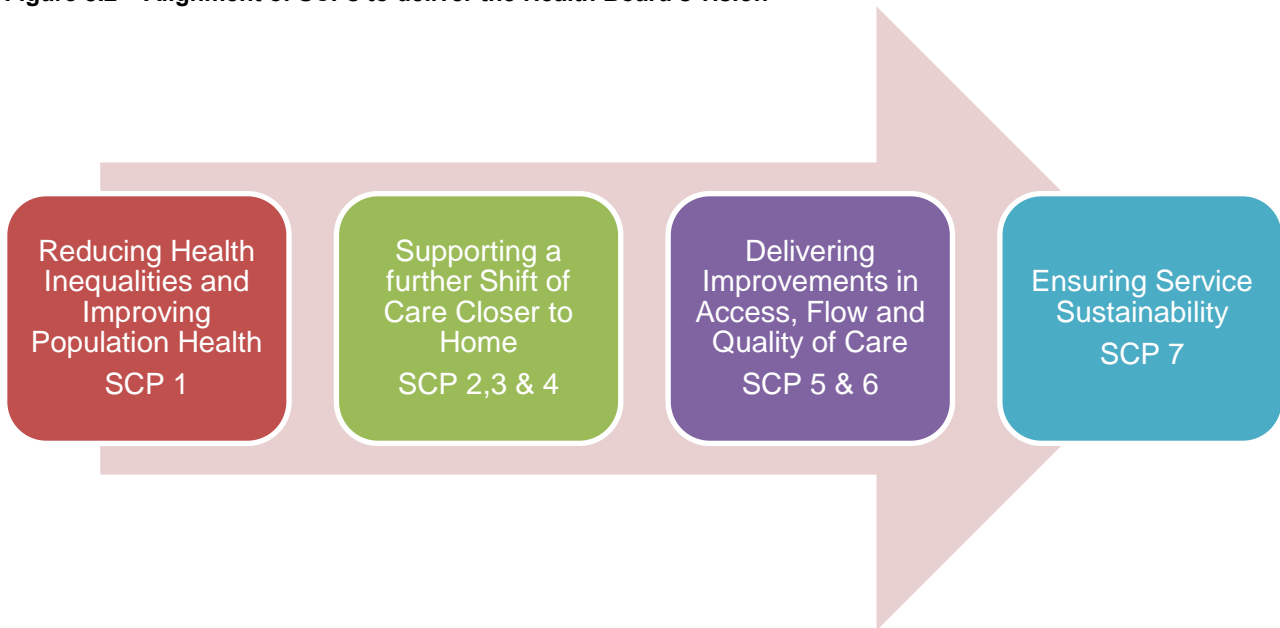
With a vision of integration and improvement, we continue to concentrate our change efforts into the delivery of preventative activities with Neighbourhood Care Networks as the primary mechanism for delivering care, access to the right service, flow through the system and service sustainability. Our

priority plans have been streamlined from the 10 SCPs set out in last year’s IMTP to 7 which are set out in Table 3.1. This reflects the growing maturity of our Neighbourhood Care Networks who are leading the delivering Care Closer to Home and progress in delivering work programmes related to improving population health and wellbeing.

**Table 3.1**

SCP	Title	SCP	Title
1	Improving Population Health and Wellbeing	5	Urgent and Emergency Care
2	Care Closer to Home	6	Planned Care
3	Management of Major Health Conditions	7	Service Sustainability
4	Mental Health and Learning Disability		

**Figure 3.2 – Alignment of SCPs to deliver the Health Board’s vision**



This section also sets out the component of the plans that relate specifically to older people and maternal and child health to provide a population focus. Significant enabling plans relating to finance, workforce, capital and informatics are being developed and aligned with the priorities and outcome targets identified in each of the Service Change Plans.

Each of these four themes is described below setting out the core components of the Service Change Plans.

# Reducing Health Inequalities and Improving Population Health

**3.1 SCP 1 - Improving Population Health and Well Being**  
This SCP seeks to improve the health and wellbeing of the Health Board’s population, reduce health inequalities and benefit individuals and ensure the sustainability of our healthcare system

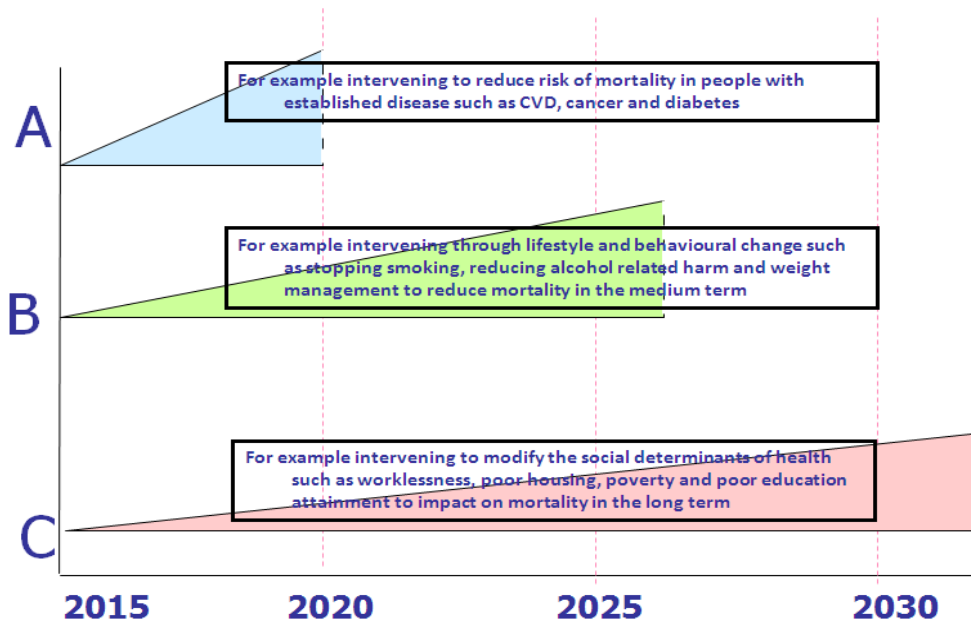
Increasing the proportion of the population who do not smoke, who are a healthy weight, who eat a healthy diet, are physically active and do not exceed guidelines on alcohol consumption would have population impact on rates of heart disease, stroke, diabetes, cancer and liver disease. As well as reducing the burden of preventable disease for the individuals, preventable diseases due to lifestyle factors are putting current 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.

We want 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. The long term aspirations are:

- 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.

Achieving these aspirations will require a range of actions some of which will have impact on population health 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 (Graph 3.1.1) [Bentley].

Graph 3.1.1



There are 8 key programmes of work that are in place to support this objective.

### 3.1.1 Reducing childhood obesity and preventing Type 2 Diabetes

The Gwent Childhood Obesity Strategy 'Fit for Future Generations' has been adopted by all five Public Service Boards in the Health Board's area. The strategy provides analysis of the increasing problem of childhood obesity including local data analysis and the compelling case for coordinated multiagency action to implement the evidenced based actions described in the strategy [Fit for Future Generations 2015].

The 'Fit for Future Generations' strategy complements the chapter on Diabetes in the 2015 Aneurin Bevan University Health Board Director of Public Health report which sets out the case for action to halt the rise in obesity to prevent the increase in Type 2 diabetes because 85% of Type 2 diabetes is attributable to obesity. In line with the predicted rise in diabetes in adults across Wales, diabetes in adults in Gwent is predicted to rise to 10.7% in 2020 and 11.9% in 2013 (ABUHB DPH Report 2015).

As elsewhere, the proportion of both the child and adult population who are overweight or obese is highest in the most deprived parts of the Health Board's area and lowest in the least deprived areas.

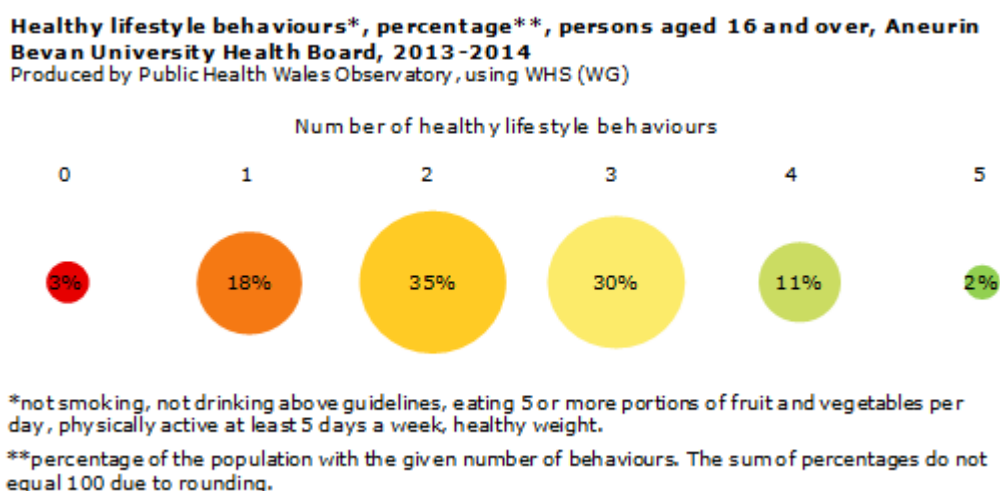
#### To reduce childhood obesity and prevent Type 2 Diabetes the Health Board will:

- Implement a tier 3 weight management service for children and families with severe obesity by December 2017 (subject to funding).
- Advocate for reducing childhood obesity to be adopted as a Wellbeing Objective by all five Public Service Boards (PSBs) in the Health Board's area by March 2018.
- Evaluate and review adult weight management services by March 2019, including service provision for specific risk groups such as pregnant women and pre-diabetics.
- Develop a range of services to promote physical activity and healthy weight in conjunction with community partners across NCN areas by March 2020.

### 3.1.2 Making Every Contact Count

Currently (Figure 3.1.1) only 2% of the people living in the Health Board's area are achieving all five healthy lifestyle behaviours with 3% achieving none, 35% only two and 30% three.

Figure 3.1.1



Historically policy and services have tended to focus on individual lifestyle risk factors but increasingly the importance of multiple lifestyle risk factors is being recognised. A study of adults age 45-79 in Norfolk found that over a ten year period, 95% of those with no unhealthy lifestyle risk factors were still alive in contrast to only 75% who smoked, had a low consumption of fruit and vegetables, were physically inactive and consumed alcohol above guidelines. Importantly, this association was graded with 92% of those with one unhealthy lifestyle risk factor still alive, 88% of those with two and 85% with three. [Khaw et al 2008].

The Health Board's Making Every Contact Count (MECC) strategy addresses multiple rather than individual lifestyle behaviours. The Health Board is committed to give MECC training to 10% of their frontline staff each year to ensure that opportunities to help our population to address their lifestyle risk factors are optimised.

**To Make Every Contact Count, the Health Board will:**

- by March 2018 provide MECC training for 10% of frontline staff;
- by March 2019 provide MECC training for an additional 10% of frontline staff;
- by March 2020 provide MECC training for an additional 10% of frontline staff.

### 3.1.3 Disease prevention through population scale services to support lifestyle changes

To achieve impact on preventable heart disease, stroke, diabetes, cancer, respiratory and liver disease at a population scale will necessitate reaching thousands of adults living in the Health Board 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 Health Board's adult population, approximately:

- 22% of adults are smoking, which is 105,500 people<sup>2</sup>.
- 26% of adults are obese, which is 121,100 people<sup>3</sup>.
- 42% of adults are drinking 'above guidelines', which is 195,600 people<sup>4</sup>.
- At least 1 in 6 adults in Gwent experiencing poor mental health, which 95,741 adults.

In addition to the weight management service plans in the section on obesity (above), the Health Board has plans for scaling up smoking cessation and alcohol treatment services and will:

**To scale up smoking cessation and alcohol treatment services, the Health Board will:**

- Implement action plans in conjunction with specialist national services led by PHW to increase uptake of smoking cessation services to 5% of smokers per year, with ambition for at least 2.8% of these treated in community pharmacy by March 2019.
- Implement plans to extend the Alcohol Care Team to seven days a week and introduce an outreach service by March 2019 (subject to funding).
- Support implementation of the "More People, More Active, More Often" LSC physical activity programme.

### 3.1.4 Large Scale Change Physical Activity Programmes

The 'More People, More Active, More Often' programme is a Large Scale Change (LSC) physical activity programme targeting inactive women (aged 14 – 40) resident in communities of high multiple deprivation in the Gwent Heads of the Valleys. The 'Fit for Future Generations' programme is an LSC physical activity programme in Newport. People in Wales are still overwhelmingly inactive, particularly in more deprived communities where people are up to twice as likely to be physically leading to significant health inequalities. Young women are more likely to drop out of sport and activity earlier than boys and are less likely to remain physically active in adulthood.

**The LSC programmes are aiming to:**

- 'Mobilise people' with a strong narrative, strong brand and use of 21st century media.

<sup>2</sup> Data from Public Health Wales Observatory, using Welsh Health Survey 2012-13; 95% confidence intervals for adult smokers are (21% - 24%) and (99,800 – 111,200 people)

<sup>3</sup> 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)

<sup>4</sup> 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)

- 'Mobilise communities' using community development approaches to create 'community hubs.'
- 'Mobilise leaders of change' by engaging and inspiring senior professionals to be champions for physical activity and by knowledge transfer through Large Scale Change Academy sessions involving a wide range of system leaders.

The success of the programmes will be measured through: visibly active communities; more young women hooked on sport; more active adults; less sedentary adults; more opportunities created and used by our target communities to be active.

### 3.1.5 Improving Wellbeing Services, Health Literacy, Self Care and Mental Health

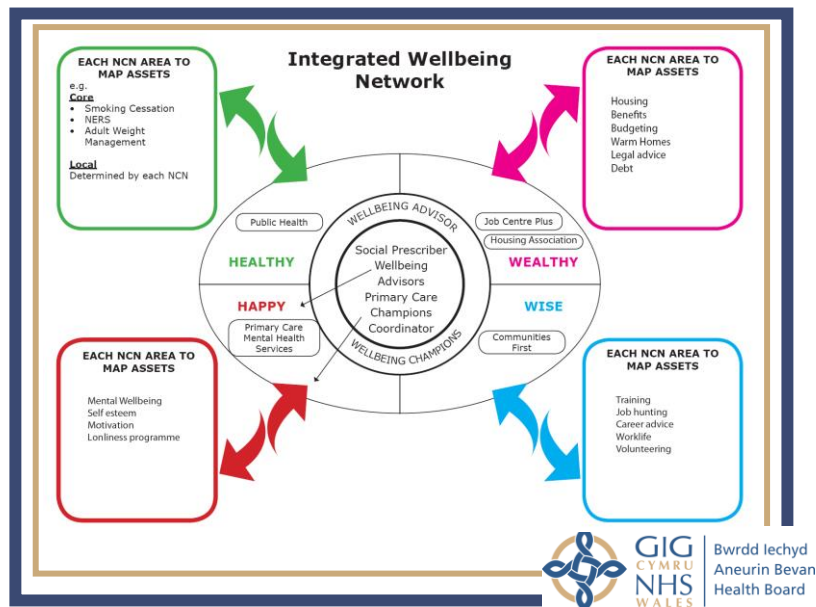
Poor mental wellbeing is strongly associated with unhealthy behaviours. Improving mental wellbeing is a necessary first step towards making lifestyle changes for many people, particularly in the most disadvantaged communities and amongst vulnerable groups. In 2016, the Mental Wellbeing Foundation Tier across the Health Board's area has been enhanced by the roll out of the Road to Wellbeing group psycho-education classes. Further development of the Mental Wellbeing Foundation Tier will be focussed on the most disadvantaged communities and vulnerable groups in conjunction with the Living Well Living longer programme.

**To further develop the Mental Wellbeing Foundation Tier and progress Wellbeing services including health literacy and self care the Health Board will:**

- Implement a mental wellbeing pathway as part of the Living Well Living Longer programme.
- Working with community partners through NCNs, implement an Integrated Wellbeing Network as part of the Living Well Living Longer programme (Figure 3.1.2).
- Working with community partners through NCNs, test social prescribing service models to address social causes of poor mental wellbeing.

Supporting our citizens to improve their mental well-being will enable individuals to take more responsibility for their physical health and well-being, ultimately our aim is to support them to be more self reliant, aware and informed about the choices they make.

Figure 3.1.2



### 3.1.6 Population Immunisation Programmes

In 2016 the Health Board successfully implemented a new service model for providing the routine childhood immunisation programme in response to provide greater service capacity to deliver the extensions to the programme in recent years. Childhood immunisation is a highly effective population

health measure.

Influenza vaccination is a highly effective population health measure to prevent older people, those with a chronic condition, pregnant women and children becoming ill with flu and developing serious complications. The Health Board has some of the highest community flu vaccination uptake rates in Wales and in 2016 has implemented a focussed programme to improve uptake by Health Board staff.

**To maintain and improve uptake of population immunisation programmes the Health Board will:**

- Work with partners in NCNs to improve uptake of primary childhood immunisations in the most disadvantaged areas of the Health Board in order to meet the 95% uptake required to achieve population herd immunity.
- Build on the 2016 programme to achieve the 50% target and increase influenza uptake by Health Board front line staff.
- Maintain position as leading Welsh Health Board performance on influenza immunisation for over 65 year olds and those in at risk groups, with increasing performance on uptake by pregnant women.

### **3.1.7 Reducing health inequalities through Living Well Living Longer Programme**

The innovative Living Well Living Longer programme is being rolled out in the areas of highest deprivation in the Health Board's area, inviting eligible adults age 40-60 to have a Health Check, and supports those that attend to set personal goals and access support to reduce their lifestyle risk factors as well as to access appropriate treatment for high blood pressure, high blood lipids or diabetes.

To reduce rates of disease in the most deprived NCN areas, the Health Board will:

- By March 2018, complete the roll out of the Living Well Living Longer Programme in Torfaen North, Newport East and Newport West NCNs.
- By March 2018, implement a sustainable, social model of primary care to support people to reduce their risk of heart disease, stroke, diabetes, cancer, respiratory and liver disease in Blaenau Gwent West, Blaenau Gwent East and Caerphilly North NCNs.
- By March 2019, implement a sustainable, social model of primary care to support people to reduce their risk of heart disease, stroke, diabetes, cancer, respiratory and liver disease in Torfaen North, Newport East and Newport West NCNs.

### **3.1.8 Reducing inequalities in the incidence and rates of survival from cancer**

Health inequalities are particularly evident in cancer survival rates which have greatest impact in older age because the biggest risk factor for developing cancer with two thirds of all cases of cancer in the UK being diagnosed in people over 65 years. Improving cancer survival rates in disadvantaged areas is one of the key planks of our strategy to reduce health inequalities.

**To improve Cancer Survival Rates the Health Board will:**

- Support people to reduce their preventable risk factors for cancer through the Living Well Living Longer Programme (as set out above).
- Work with Public Health Wales to implement the lessons from the successful pilot project to increase uptake of bowel screening through NCNs (subject to funding).
- By September 2017, through NCNs, identify and disseminate the common themes from the 2016 GP Practice audit of new cases of cancer.

The following table sets out the links to key enablers including finance, workforce and capital at a high level.

**Table 3.1.1**

Key Theme	Reducing health Inequalities and improving population health
Finance	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 included within the financial plan for 2016/17
Workforce	Additional workforce to support Childhood Obesity programme have been recruited to. Ongoing development of integrated workforce for Living Well Living Longer Programme
Capital	No capital implications

## Supporting a further shift of services closer to home through building a NCN foundation for delivery of care (SCPs 2, 3, & 4)

In terms of Primary and Community Care and Mental Health Services, our ability to deliver the necessary shift in service emphasis from acute 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, multi-agency workforce which makes full use of the wider primary care team. In this regard, there are clear links between this Plan and all other Service Change Plans.

In the context of strengthening the primary care element of the Clinical Futures Strategy, work is underway to finalise our **'Care Closer to Home Strategy'** that articulates how a shift of focus from hospitals and illness to health and well being in an integrated health and social care system, will build capacity in out of hospital services, and thus improve patient experience and outcomes. The Strategy includes all services delivered in Primary and Community Care and will be underpinned by a five year delivery programme.

### 3.2 SCP 2 - Care Closer to Home

This SCP seeks to facilitate the development and sustainability of service improvement models that support the delivery of care closer to home.

In the context of an emerging model for Primary Care across Wales and implementation of the requirements of the Social Services and Well Being (Wales) Act and Well Being of Future Generations Act, this SCP has been developed with full engagement of all partners (with citizens, public, independent and third sector partners). Neighbourhood Care Network (NCN) Plans and the Care Closer to Home Strategy have been aligned in order that the overall strategic aims can be delivered consistently across Gwent.

As a key enabler of the overarching Health Board Clinical Futures Strategy, the Care Closer to Home Strategy sets out an integrated plan for interventions required by our communities outside of hospital settings, based on a number of integrated working themes including person centred, workforce sustainability, shared resources/pooled budgets, community resilience and early intervention & prevention. In the context of an evaluation of current integrated ways of working and the evidence base, successful implementation of the principles of care closer to home will enable the necessary transition from traditional, secondary care focused service delivery, to integrated service provision, across the patient journey that enables bespoke solutions to address the needs of our population.

With particular reference to the Well Being of Future Generations Act, this SCP contributes to a number of the seven Well-being Goals. Examples are:

- **'A Healthier Wales'** - preventative work with populations in areas such as smoking cessation, obesity and mental wellbeing provide examples of actual and planned progress in this regard.
- **'A Prosperous Wales'**- in the context of ill health being a limiting factor to social mobility and financial wellbeing, risk stratification of the target population and anticipatory care planning are key actions and include the Newport Older Persons Pathway Project.
- **'A More Equal Wales'** - work being undertaken at a borough level to address inequalities in health illustrates a response to the identified diverse needs of our population which include different rates of deprivation, ill health, morbidity and mortality across our five boroughs.
- **'A Wales of Cohesive Communities'** - the twelve multiagency Neighbourhood Care Networks (NCNs) across the region are well placed to actively and effectively engage with our communities in the planning and delivery of services.

Previously, SCPs 3 and 4 described the key service change priorities across primary care and

community services. This year, SCP 2 encapsulates our “Care Closer to Home” priorities with further detail on supporting actions and priorities set out in plans which are in place at a Divisional level.

There are clear links with SCP 1, ‘Prevention and Improving Population Health’ and SCP 3, ‘Management of Major Health Conditions’. In addition, continued progress in implementing the Clinical Futures Strategy, including construction of the SCCC, provides further focus on the necessary shift of emphasis within a patient’s care journey from hospital to primary care and the community, based on an integrated health and social care system. Increasingly, closer working with our housing colleagues forms a key foundation to this approach.

Our vision for the development of service models that enable care closer to home is based on the following Health Foundation statement which confirms the vital role played by community based activities that encompass a range of supportive actions and agencies:

***“Person and community-centred approaches for health and wellbeing include a wide and diverse range of activities, interventions and approaches. These range from collaborative consultations with health and care professionals that focus on what is most important to people, to community dance classes in the local hall. They happen in formal health and care settings, people’s own homes and in the wider community.”***

<sup>5</sup>

## Key Challenges

### Workforce

We are experiencing significant challenges in recruiting and retaining GPs, which is consistent with other areas of Wales. Of the 81 GP Practices across Gwent, 17 Practices are single/two GP based Practices which, in the absence of Practice mergers, are deemed to be unsustainable in the long term.

The following additional challenges have been identified:

- As GPs are independent contractors, it is more difficult to influence necessary changes in working practices and introduce new ways of working aimed at optimising care closer to home for patients. This challenge will be a key focus of Neighbourhood Care Network Plans and associated work with individual GP Practices.
- It is not possible to use a ‘one size fits all’ approach to workforce models at a Practice level as we need to recognise the individuality of Practices and different patient demographics. The process for development and implementation of the Care Closer to Home Strategy will enable a bespoke approach to workforce models linked to identified local needs.
- Newly qualified GPs are reluctant to enter into lease agreements with GP partners noting potential liability issues when their Practice partners retire.
- Current Contract of Employment terms are less attractive for a salaried GP - Locum contract terms of remuneration are better.
- While non-medical workforce models in GP Practices offer an alternative solution to GP recruitment challenges, workforce supply issues are affecting other professions too e.g. nursing.

In relation to the nurse workforce, the Nursing Plan for the next 5 years forms part of the workforce skill mix development plan. This includes recruitment of Paramedics, Pharmacists, Therapists, Public Health Educators, and Paediatric and Mental Health staff to address the GP and nursing workforce shortfall and enable a more flexible approach to implementation of new primary care and community service models in line with the Care Closer to Home Strategy.

### Resources

Key resource issues that inform the financial position include:

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<sup>5</sup> At the Heart of Health: Realising the Value of People and Communities (The Health Foundation)

- Staff shortages which continue to pose a significant projected risk. Alternative staffing models must now be considered based on learning from the Quality Improvement Access work stream and mathematical modelling of workforce retirement.
- The challenge of sustaining services should national Primary Care funding cease - we are developing response scenarios as part of forward planning.
- How to plan and fund Community Pharmacy developments as part of the sustainability of primary care services.
- Medicines management poses a continued challenge, particularly in the context of the disease prevalence in Gwent. We have a sustained focus on identifying savings and efficiencies, 'horizon scanning' to learn from others and collaborative working with other Divisions. The unit price continues to be difficult to predict.

### **Plans for Change**

Our 2017-2020 Change Plans and underpinning work streams are focussed across three priority areas in driving forward our ambition to deliver more care closer to home, namely:

- Access and sustainability.
- Care pathways and shifting the focus of care from secondary care to primary and community care.
- Reducing health inequalities and improving population health.

Across these priority areas the underpinning work streams, which are set out below, are focussed on delivery of the Care Closer to Home Strategy objectives:

### **Priority 1 - Access and Sustainability**

#### **3.2.1 Making services more accessible and sustainable**

It is recognised that as the population changes the traditional models of primary care and community services no longer meets the evolving needs of our population and services must adjust their skill mix to ensure that the necessary skills and expertise are available to support patients when they need them most. Our plans involve changing the skill mix within primary care and community services to make more prudent use of scarce GP and other staff resources, utilising professionals with the most appropriate skills / expertise based on patients' needs. This approach includes the use of other healthcare professionals including Paramedics, Pharmacists and Mental Health workers to enable a more flexible approach to workforce model development and implementation across primary care and community services.

In order to improve access to GP services, we will continue the Access QI programme for a further year and will continue to consolidate the Primary Care Operational Support Team (PCOST) to support Practice sustainability. If agreed, we will then re-invest the Welsh Government funds into further tests of service change. Key measures of success include a reduction in the number of 'at risk' Practices within Gwent and improved access to GP services.

We will also continue to develop innovative recruitment initiatives, linked to the All Wales Primary Care Workforce Plan and recruitment of a range of care professionals including social workers, and further the development of the Urgent Primary Care Out of Hours workforce and service model.

#### **3.2.2 Delivering effective medicines management**

The Carter Report indicates that the NHS needs to focus on workforce in order to drive optimal value and outcomes from the money that is spent on medicines. However, benchmarking exercises indicate that Pharmacy Services in the Health Board are significantly below the national average in terms of workforce size per bed capacity. This impinges upon the service's ability to react quickly to optimise patient outcomes, prevent admissions and support discharges from hospital.

Our medicines management programme includes interventions to reduce potentially harmful and wasteful practices such as inappropriate prescribing of antibiotics and an urgent requirement to continue the management of poly pharmacy. The Divisional Plan sets out further detail on this work stream including invest to save proposals

### 3.2.3 Developing a skilled local workforce

There is a requirement for the workforce to work across both health and social care boundaries in a more generalised way and staff development needs to support and focus on this approach. This will reduce the number of handoffs between the professions and result in patients having more timely interventions. It is therefore imperative that both existing and new staff receive the necessary training and support in order to ensure consistent delivery of new ways of working, across Gwent, and that best practice is reinforced in order to make the most of the resources available. It is also recognised that there is still a need to develop specialists in a number of our services to undertake specific clinical roles, e.g. community dentistry, thus the planned approach will include links to national training programmes as well as the development of local skills training mechanisms (further detail on dental services is set out in the Divisional Plan including the Local Oral Healthcare Action Plan).

The key milestones and timetable for delivery of this priority area are set out below:

Table 3.2.1

Desired Outcome/Impact	Measure	Plan	Time Frame
<b>Making services more accessible and sustainable</b>			
<ul style="list-style-type: none"> <li>▪ Accessible and sustainable services</li> <li>▪ GP hours released through intervention of practice-based pharmacists and social workers</li> <li>▪ Increase number of patients using direct-access physiotherapy, thereby reducing demand for GP for initial referral</li> <li>▪ Improved access to GP and dental services – reduced waiting times</li> <li>▪ Reduction in the number of ‘at risk’ practices within Gwent</li> <li>▪ District Nursing hours released through re-allocation of demand to Community Phlebotomy Team</li> <li>▪ Increase number of nurses trained to undertake complex wound management</li> <li>▪ Improved fill rate for Medical Out of Hours Primary Care Service</li> <li>▪ Reduction in the number of frequent attenders to OOH Primary Care and WAST Services</li> <li>▪ More effective use of resources, resulting in improved productivity and better patient outcomes</li> <li>▪ Reduced spend on GP locums &amp; nurse bank/agency</li> </ul>	<ul style="list-style-type: none"> <li>▪ % reduction in GP vacancies and increased retention of senior GPs from 16/17 baseline</li> <li>▪ Reduction in number of patients (from 16/17 baseline) attending EDs for conditions which could be managed in primary care</li> <li>▪ Increase in compliance with OOHs response targets against 16/17 baseline</li> </ul>	<ul style="list-style-type: none"> <li>▪ Appoint Prog Mgr</li> <li>▪ Develop NCN Plans</li> <li>▪ Complete demand/ capacity audit and report findings</li> <li>▪ Implement senior retainer and GP Fellow schemes</li> <li>▪ Implement agreed OOHs base changes</li> <li>▪ Implement ‘whole system model’ in pilot NCN area</li> <li>▪ Evaluate progress on all areas to inform plans for 18/19</li> </ul>	Q1 2017/18
			Q2 2017/18
			Q3 2017/18
			Q4 2017/18
<b>Delivering effective medicines management</b>			
<i>Effective Medicines Management</i> <ul style="list-style-type: none"> <li>▪ Improved antimicrobial stewardship and the longer term development of</li> </ul>	<ul style="list-style-type: none"> <li>▪ Common ailments managed more appropriately by a pharmacist (measure to be agreed).</li> <li>▪ Change in patient behaviour</li> </ul>	<ul style="list-style-type: none"> <li>▪ Implement Medicines Management Plan. Prescribing advisors to meet with all GP Practices</li> <li>▪ Scope model for CRT</li> </ul>	Q1 2017/18

Desired Outcome/Impact	Measure	Plan	Time Frame
<p>microbiological resistance.</p> <ul style="list-style-type: none"> <li>8-to 8pm 7 day service to identify medication related admissions and quicker response to support emergency discharges.</li> <li>Better use of medicines resulting in improved patient outcomes.</li> <li>Electronic prescribing and medicines administration will improve patient safety</li> <li>Robotic automation ensures an efficient pharmacy service with a focus on ward based clinical care.</li> <li>Increase in polypharmacy reviews contributing to admission avoidance.</li> <li>Common ailments managed more appropriately by a pharmacist.</li> <li>Increased number of patients with a respiratory review and improved asthma control.</li> <li>Reduction in prescribing costs through better repeat prescribing processes.</li> <li>Increased number of non-medical prescribers.</li> </ul>	<p>monitored through number of registrations and medicines supplied</p> <ul style="list-style-type: none"> <li>Achievement of WG Tier 1 target for number of Treated Smokers against 16/17 baseline</li> <li>Improved compliance with national prescribing indicators</li> </ul>	<ul style="list-style-type: none"> <li>Respiratory review pilot implemented</li> <li>Submit robotics plan to WG</li> <li>Implement repeat prescribing model roll out</li> <li>Common ailments scheme implemented at 43 sites</li> <li>Progress approved business cases</li> <li>Roll out stoma services model</li> <li>RGH Aseptic Unit installed (subject to agreed funding)</li> <li>Roll out of 'Choose Pharmacy' to remaining sites (NWIS dependent)</li> <li>Installation of robot (subject to funding)</li> </ul>	<p>Q2 2017/18</p> <p>Q3 2017/18</p> <p>Q4 2017/18</p>
<b>Developing a skilled local workforce</b>			
<ul style="list-style-type: none"> <li>Service users will receive high quality, timely and effective services from a trained and flexible nursing workforce with an understanding of the full patient pathway.</li> <li>Provision of targeted skills training and introduction of new roles to deliver an integrated community service model.</li> <li>Increased number of ACP's in place</li> <li>Implemented Training Strategy</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in unplanned admissions from care homes against 16/17 baseline</li> <li>Reduction in GP call outs to verify death against 16/17 baseline</li> <li>Increased number of ACP's in place against 16/17 baseline</li> </ul>	<ul style="list-style-type: none"> <li>Sign off professional Ed and Development Strategy</li> <li>Implement 'My Home My Care' service in NHH</li> <li>Develop recruitment and retention Strategy</li> <li>Develop new training programme for ANPs</li> <li>Deliver ANP development programme</li> </ul>	<p>Q1 2017/18</p> <p>Q2 2017/18</p> <p>Q3 2017/18</p> <p>Q4 2017/18</p>

**Priority 2 - Care pathways and shifting the focus of care from secondary care to primary and community care**

**3.2.4 Rebalancing secondary and primary care**

There is potential to shift more care from secondary care into a primary care setting and we have a number of examples where this has already been effective, e.g. the Ophthalmic Diagnostic and

Treatment Centres for glaucoma and macular degeneration. Divisional Delivery Plans provide further detail on activity to enable a continued shift of clinical activity from hospital to primary care for those with a major health condition including diabetes and respiratory disease. As a key mechanism for driving integrated service development and improvement across primary care and secondary care, we will establish a cross-divisional Clinical Reference Group to scope and agree future opportunities and the development of new service models which offer referrers primary care service alternatives for advice and diagnostics. This will include the development of associated workforce plans to ensure the right staff are in the right place at the right time linked to needs driven capacity plans. This work programme will also progress the work with early diagnosis of lung cancer and development of community and primary care located diagnostics. Key to this approach will be an openness to learning from both within the Health Board, e.g. PREMS and PROMs project for stroke and neurological conditions, and across Wales e.g. ICHOM and the adoption of best practice.

Health Board wide Implementation of the 111 service will also contribute to a reduction in demand on hospital based urgent care services linked to provision of, and access to, more appropriate community based services and provides significant opportunities for delivery of our Clinical Futures Strategy.

### **3.2.5 Integrating services to provide more effective support for people with complex needs**

A significant number of individuals with complex needs are still cared for in their home environment and often have a number of different agencies involved in their care; from health, local authority and the third sector. If admitted to hospital, discharge planning often requires a multi-disciplinary and multi-agency approach to ensure that the patient's care is transferred to the most appropriate setting with the most appropriate level of support. However, organisational boundaries can inhibit timely discharges, causing patients to remain in hospital unnecessarily and increase risk of further infection and dependency. Health and social care services must work closely together with the third sector in order to support this group of patients and NCNs are ideally placed to ensure that care reflects the core needs of the local community and avoids inequalities in care.

In support of this agenda and the need to organise more services at NCN level, we will work together with our partners to agree the development of Community Hubs and Urgent Care Hubs and we will design clear pathways for community hospital activity.

### **3.2.6 Supporting patients to stay well and independent at home**

Secondary care services are under increasing pressure to cope with the demands placed on them by the growing elderly population. This is having an impact on hospital bed capacity, with rising numbers of patients referred to emergency assessment units and admitted to hospital under Care of the Elderly specialists, which in turn causes congestion in hospital that affects the ability of the Emergency Department to meet the national 4 hour target. However, it is acknowledged that there are opportunities to prevent admissions to hospital in the first instance, by risk stratification, stay well health plans, surveillance and rapid response in times of crisis or to facilitate earlier discharges in a number of cases, thereby preventing patients from becoming unnecessarily dependent on healthcare services.

Building on current markers of success, our plans are to evaluate the impact of the Older Persons Pathway in Newport, particularly in relation to patient experience, resilience and reliance on traditional services (health and social care) and to consider the roll out of this service model in line with the Care Closer to Home Strategy and linked to local population needs. We will also consolidate new care pathways and service models across all the major health conditions, building on work already undertaken for citizens with diabetic and respiratory conditions.

The key milestones and timetable for delivery of this priority area are set out below:

**Table 3.2.2**

<b>Desired Outcome/Impact</b>	<b>Measure</b>	<b>Plan</b>	<b>Time Frame</b>
<b>Rebalancing secondary and primary care</b>			

Desired Outcome/Impact	Measure	Plan	Time Frame
<ul style="list-style-type: none"> <li>▪ Rebalancing care across secondary and primary care</li> <li>▪ Reduction in GP referrals to Endocrinology &amp; Diabetes specialty to any Welsh Provider</li> <li>▪ Reduction in A&amp;E New Attendances – Hypoglycaemia (E162)</li> <li>▪ Reduction in occupied bed days and average length of stay for patients admitted due to their diabetes.</li> <li>▪ Improved access to pulmonary rehabilitation</li> <li>▪ Increased number of care plans for patients with respiratory conditions</li> <li>▪ Increased number of respiratory patients who have had their medicines reviewed and a reduction in those not attending for annual review</li> <li>▪ Eradication of delayed follow ups for Glaucoma</li> <li>▪ Managed annual growth in referrals to hospital dental services</li> <li>▪ Reduction in annual referrals to hospital dental services</li> <li>▪ Reduction in new and follow up outpatient demand for dermatology</li> <li>▪ Reduction in dermatology RTT breaches</li> <li>▪ Roll out OA knee patient activation groups to all 12 NCNs</li> <li>▪ Reduction in hospital admissions for patients with INRs &gt;5</li> </ul>	<ul style="list-style-type: none"> <li>▪ 5% reduction in high dose inhaled cortico-steroid prescribing against 16/17 baseline</li> <li>▪ % and actual number change from the 16/17 baseline across all areas cited</li> <li>▪ Repatriation of circa 5,700 patients from secondary care INR clinics to primary care</li> <li>▪ Reduction in pathology activity circa 103,000 tests per annum</li> </ul>	<ul style="list-style-type: none"> <li>▪ First meeting of Clinical Ref Group</li> <li>▪ Commence 3 new ODC contracts</li> <li>▪ Commence INR pilot for house-bound in Torfaen</li> <li>▪ Complete and submit pulmonary rehab BC</li> <li>▪ Deliver respiratory skills training to PC &amp; Comm nurses</li> <li>▪ Evaluate overall performance in 17/18 and develop plans for 18/19</li> </ul>	<p>Q1 2017/18</p> <p>Q2 2017/18</p> <p>Q3 2017/18</p> <p>Q4 2017/18</p>
<b>Integrating services to provide more effective support for people with complex needs</b>			
<ul style="list-style-type: none"> <li>▪ Fewer handoffs between agencies, resulting in fewer delays / quicker response time for patients at the point of need</li> <li>▪ Improved patient experience and reduction in repetitive assessment due to improved information sharing</li> <li>▪ Reduced incidence of harm to staff in the community due to improved sharing of risk assessments / information between agencies</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reduction in the number of delayed transfers of care (DTCs) against 16/17 baseline</li> <li>▪ Reduction in the average length of stay of patients in community hospitals against 16/17 baseline</li> </ul>	<ul style="list-style-type: none"> <li>▪ Implement agreed action plan following Frailty Services review</li> <li>▪ Evaluate MOWIC project</li> <li>▪ Scoping of IT equip and networks for WCCIS</li> <li>▪ Org and development &amp; asset plan across all sectors</li> <li>▪ Future alignment plan for community services</li> <li>▪ Develop training programme for MOWIC</li> <li>▪ Commence WCCIS testing and staff training programme (WCCIS go live in 18/19)</li> </ul>	<p>Q1 2017/18</p> <p>Q2 2017/18</p> <p>Q3 2017/18</p> <p>Q4 2017/18</p>
<b>Supporting patients to stay well and independent at home</b>			

Desired Outcome/Impact	Measure	Plan	Time Frame
<ul style="list-style-type: none"> <li>▪ Increase number of OOH nurses trained to support patients with complex needs</li> <li>▪ Increased number of people with Stay Well plan in place</li> <li>▪ Reduction in the number of A&amp;E attendances, MAU referrals and unplanned admissions to hospital following Stay Well Plan in place</li> <li>▪ Reduction in the number of emergency medical admissions from nursing homes</li> <li>▪ Increase in patients referred to Newport Frailty from OOH Primary Care</li> <li>▪ Reduction in Newport patients referred from OOH Primary Care to secondary care services</li> <li>▪ Increase number of patients discharged / assessed out from Emergency Assessment Unit with corresponding referral accepted by Blaenau Gwent Frailty Services</li> </ul>	<ul style="list-style-type: none"> <li>▪ % increase in nursing scheduled care response in Out of Hours Primary Care against 16/17 baseline</li> <li>▪ % increase in nursing unscheduled care response in Out of Hours Primary Care against 16/17 baseline</li> <li>▪ % increase in patients with long term conditions being supported by DNs overnight against 16/17 baseline</li> <li>▪ 50% reduction in the number of patients conveyed to hospital when visited by FaRS Service against 16/17 baseline</li> <li>▪ % and actual number change from the 16/17 baseline across all areas cited</li> </ul>	<ul style="list-style-type: none"> <li>▪ Agree, post evaluation, roll out plan for Newport Older Persons pathway</li> <li>▪ Consider, post evaluation, year round roll out of falls referrals service</li> </ul>	Q1 2017/18

### ***Priority 3 - Addressing Inequalities in Health and improving population health***

In common with other communities in the UK, there are inequities in the health and well-being of the Gwent population, demonstrated in part by the variation in life expectancy between boroughs, such as in Blaenau Gwent and Monmouthshire. We have an opportunity to ensure that interventions such as screening and early detection are targeted appropriately, with particular focus on areas of lower uptake (bowel screening, breast screening, childhood immunisation and smoking cessation) and to ensure that uptake is improved over the coming years.

There are clear links between this priority area and SCP 1, 'Prevention and Improving Population Health' with the opportunity to place greater emphasis on community based interventions within this SCP. Each NCN has the autonomy to direct local service provision based on local need and it is incumbent on the Division, through the NCNs, to ensure that monies are used effectively to provide appropriate levels of care in the areas of greatest need and that this is reflected through the NCN plans. There are examples of inequity in medication provision approaches, for example unnecessary prescribing of antibiotics and effective management of poly pharmacy that highlight opportunities to improve outcomes for patients alongside more effective use of resources.

The 12 NCN local plans describe the issues that affect their local population and therefore provide a plan for improvement, working in partnership with all cluster members including the local authority, Public Health Wales and third sector partners. The NCNs have identified key areas requiring change / improvement including:

- Greater uptake of smoking cessation services.
- Improved diagnosis, care and support for those with dementia and their families, including roll out of the dementia road map.

- Improved compliance with delivery of childhood immunisations at 5 years of age.
- Closer working with Public Health Wales to delivery screening and prevention objectives, with particular focus on improved screening for breast cancer, bowel cancer, diabetes, cardiovascular disease and stroke.
- Prevention of obesity and support for weight loss.
- Annual health check for patients with a learning disability.
- Patients on 6 or more medications are reviewed as part of the poly pharmacy process which will ultimately prevent admission.
- Reduction of Clostridium Difficile in primary care.
- Further roll out of the Living Well, Living Longer programme and participation in the all Wales Programme.
- Reduction in the number of children receiving dental general anaesthetic.

The key milestones and timetable for delivery of this priority area are set out below:

**Table 3.2.3**

Desired Outcome/Impact	Measure	Plan	Time Frame
<b>Reducing inequalities in the health and well being of our population</b>			
<p><i>NCN priority areas:</i></p> <ul style="list-style-type: none"> <li>▪ Increased compliance with childhood immunisations at 5 years of age</li> <li>▪ Increased compliance with breast and bowel screening services</li> <li>▪ Increase uptake of Learning Disability enhanced service annual reviews - 90% of all eligible</li> <li>▪ Reduction of c. diff rates in primary care</li> <li>▪ Reduce number of children receiving dental general anaesthetic</li> <li>▪ Earlier diagnosis of lung cancer</li> </ul> <p><i>Palliative Care / End of Life Care:</i></p> <ul style="list-style-type: none"> <li>▪ Increased percentage of patients on palliative care register</li> <li>▪ Increase percentage of patients with an ACP &lt; 90 days old at time of death</li> <li>▪ Increase patients dying in their preferred place of death</li> </ul> <p><i>Community Services priority areas:</i></p> <ul style="list-style-type: none"> <li>▪ Reduction in the prevalence of patients on a District Nursing caseload with a pressure ulcer</li> </ul>	<ul style="list-style-type: none"> <li>▪ % and actual number change from the 16/17 baseline across all areas cited</li> </ul>	<ul style="list-style-type: none"> <li>▪ Development Plans for Practices completed and those for NCNs commenced</li> <li>▪ Engage stakeholders in agreeing service model for new hospice</li> <li>▪ NCN Plans completed and submitted</li> <li>▪ Implement e-learning module for Care Decisions tool</li> <li>▪ NCN Plans agreed and funding allocated</li> <li>▪ Evaluate and review Palliative Care Strategy in preparation for refreshed national objectives</li> </ul>	<p>Q1 17/18</p> <p>Q2 17/18</p> <p>Q3 17/18</p> <p>Q4</p>

## Enablers

### Neighbourhood Care Network Development and Plans

A major enabler for the effective delivery of the plans will involve understanding the impact of innovative service models that have been tested in different parts of our NCN system, and agreeing those that will be adopted systematically across the primary and community care system. Early

adopters will be NCN areas that have the biggest potential impacts on improving patient flow (planned and unplanned) through our two major acute hospitals. The development of our NCN structures, plans and service delivery are therefore key to achieving this. Further detail on the NCN Plans, including delivery timeframes, is set out in the Divisional Plan.

Particular examples of how NCNs will support delivery are:

- NCNs are at the forefront of our Care Closer to Home Strategy development and continue to lead the development of local plans, ensuring they are embedded in the Integrated Medium Term Plan.
- NCN Leads (and other NCN members) have been trained in leadership, finance and regularly participate in a number of Wales Cluster events.
- NCNs manage the funds allocated directly to clusters by Welsh Government and are leading changes in service delivery, such as the Older Persons Pathway in Newport. NCNs will continue to invest in new and innovative roles including pharmacists, social workers, social prescribers, physiotherapists, etc.
- Following implementation of the new Divisional structure for Primary Care and Community in 2017/18, NCN Leads will form part of the “triumvirate” team which will manage services within a Borough as well as managing the NCN collaborative machinery. This will strengthen NCN influence on core service deployment.
- NCN Leads are proactively discussing with GPs the future model for Primary Care and how Practices can merge and support each other to meet demands at a time of national recruitment difficulties. Fit for purpose estate solutions are a pivotal element of future service models.

### **Information Development and Sharing**

Accurate and timely information plays a pivotal role in delivering safe and effective services. We are committed to establishing a Performance Assurance Framework which ensures that information is available to pro-actively inform decision making, to highlight good practice and to identify areas requiring support, in order to drive improvement.

As the Health Board prepares for the implementation of the Welsh Community Care Information System (WCCIS), we recognise the significant opportunity this brings to improve sharing of information between professionals, to strengthen our commitment to more integrated working and to aid the provision of safe and effective patient care. In addition, information which allows robust evaluation of new services is essential if we are to ensure effective implementation of service improvements that benefit patients.

The Primary and Community Services Workforce Plan cites the development of roles to support General Practice and Primary Care and facilitate service sustainability. A Divisional website has been developed for primary care and a promotional video has been developed to attract new staff to our community hospitals.

### **Integration and Partnership Working**

The development and delivery of improved services will continue to be underpinned by effective integration and partnership working as evidenced by:

- The development of the Care Closer to Home Strategy.
- The alignment of adult social care with each of the 12 NCNs which indicates the strength of partnership working and the shared goal of delivering integrated services.
- In Monmouthshire there are integrated teams, facilitated through a Section 33 Agreement – there are plans to develop this arrangement further to include Chepstow Hospital and to outline an approach which can be replicated across other boroughs.
- The Frailty service is an example of a successful Section 33 based integrated service.
- Other examples of integrated services include the Newport Older Persons Pathway, social prescribing and practice based social workers, Community Connectors and discharge in-reach teams.

The Greater Gwent Health, Social Care and Well Being Partnership Forum and its sub-structures is steering the development of the joint Care Closer to Home Strategy and the regional Transformation Team is supporting the Strategy implementation.

### **Investment**

A number of our service plans will require some additional investment. Business cases are being developed and matched to potential funding sources as appropriate.

### **Governance and Corporate Support**

The Executive lead for this SCP is the Chief Operating Officer, supported by the Associate Director for Integration and Innovation and members of the corporate planning team. The implementation leads are identified within the detailed Divisional Plan against specific work streams and milestones from the Divisional teams. The Primary Care, Community and Mental Health/Learning Disabilities Transformation Board is the delivery Board overseeing refinement of the plans, implementation and risk management. It is accountable to the Executive Team.

Additional corporate support will be provided for ongoing demand and capacity analysis and review of flow opportunities, Business Case development and engagement and consultation activities.

### **Key Risks**

A risk register and risk management plan is in place and is a standing agenda item on the monthly Division Assurance meetings. An assessment and identification of interdependences has been undertaken for the key risks which include:

- **Staff recruitment** – includes inability to recruit GPs and sustain General Practice. Recruitment of nurses, pharmacists, paramedics and therapists is also a challenge to service continuity and sustainability.
- **Cessation of dedicated funding** – should Welsh Government Primary Care funding cease there would be a major impact on the continuity and sustainability of a range of primary care based service improvements across the region.
- **Resource transfer** - Primary Care services may be able to provide more timely and cost effective care for activities that were previously undertaken in secondary care and the Health Board will develop a framework for enabling this.
- **Fragility of Independent Care Home Sector** - fragility within the Care Home and domiciliary care sector means that more patients are at risk of being admitted to hospital for social care needs and are also more likely to experience a delayed discharge due to unavailability of appropriate care in the community.
- **Primary Care and Community Estate** - the aging nature of many primary care and community estates means many are no longer fit for purpose. Investment will be necessary if the Health Board is to continue to operate the numerous sites and continue to deliver care closer to patient's homes.

### **3.3 SCP 3 – Management of Major Health Conditions**

This SCP aims to deliver more systematic and proactive management of chronic disease to improve health outcomes, reduce inappropriate use of hospital services and have a significant impact on reducing health inequalities.

In the 2017/18 – 2020/21 IMTP Delivery Framework, the former SCP 5 (Chronic Conditions Management) was re-shaped and replaced with **SCP3 Management of Major Health Conditions**. It includes the following pathways, each of which has its own Welsh Government Delivery Plan and a corresponding Health Board Local Delivery Plan (LDP).

This new approach sees the strengthening of governance arrangements where existing LDP specific delivery plan groups will report to the Board through a singular Major Health Conditions Delivery Board chaired by the Director of Therapies and Health Science. The new arrangements will improve the co-ordination of our evidenced based approach to prevention across all Major Health Conditions, which is essential to achieving maximum impact on the health of our populations within available resources. Detailed progress and achievements in the management of risk and prevention of Major Health Conditions can be found in SCP1 – Improving Population Health and Well Being. It also provides enhanced opportunities to join up SCPs and pathways in key areas, such as:

- Psychology Support for Major Health Conditions – review of psychology support for people with major health conditions.
- Developing Quality Improvement skills in Primary care.
- Establishing Major Health Condition’s pages on the Health Board’s intranet and internet.

#### **3.3.1 Stroke**

Our re-designed stroke pathway was implemented in January 2016, including the establishment of a Hyper-acute Stroke Unit and Community Neuro-rehabilitation Service. Our performance against the Sentinel Stroke National Audit Programme standards and Welsh Government Quality Improvement Measures has improved significantly.

Our key focus going forward is to fully realise the stated benefits of the Stroke Services Redesign, identify further areas for improvement, and improve outcomes and patient experience based on the collection of PROMs and PREMs.

Specific areas of focus will include prevention, including appropriate treatment of Atrial Fibrillation (AF), a review of our thrombolysis protocol, increased 7 day services across the entire stroke pathway and life after stroke. The Health Board’s Stroke Local Delivery Plan is included in Appendix 4.

#### **3.3.2 Heart Disease**

Our vision for health care is for people of all ages to have as low as possible a risk of developing heart disease, and when it does occur, an excellent change of living a long and healthy life.

Our key focus over this planning cycle is to improve the pathway for detection of heart disease with consistent, timely access to cardiac diagnostic tests and treatments. This is being driven by optimisation of existing capacity, further implementation of community cardiology, and improved access to interventional cardiology with a phased increase in catheter lab sessions at a second cardiac catheter laboratory in RGH. The Health Board’s Local Delivery Plan for Heart Conditions is included in Appendix 4.

#### **3.3.3 Cancer**

For our population, we want people of all ages to have a minimum risk of developing cancer and where it does occur, an excellent chance of survival. We are actively engaged in the Transforming Cancer Services Programme and are reviewing Systemic Anti-Cancer Treatment delivered across the Health

Board as part of this work. We are interested in establishing a non-specialised radiotherapy satellite centre/local cancer centre as part of this programme.

Areas of focus for this planning cycle include unification of Breast Cancer Services in Gwent, developing and implementing a single urgent cancer pathway, consolidation of in-patient haematology services, and improve provision of soft tissue Sarcoma Service. The Health Board's Cancer Local Delivery Plan is included in Appendix 4.

### **3.3.4 Diabetes**

The Health Board has made significant progress in designing and implementing our Integrated Diabetes Service Model which has been developed on principles of co-production, delivery of surveillance, education, initiation of treatments and ongoing support as part of Care Closer to Home, protecting specialist resource for those diabetic patients with the most complex clinical needs.

During this planning cycle we will consolidate and strengthen our integrated diabetes service model. Our focus will be on reducing variations in diabetes care, establishing psychological support for children and young people with diabetes, further developing a range of educational opportunities and review of the multi-disciplinary workforce to inform diabetes service re-design. The Health Board's Diabetes Local Delivery Plan is included in Appendix 4.

### **3.3.5 Respiratory**

Our vision is for people of all ages to be encouraged to value good lung health, to be aware of the dangers of smoking and take responsibility for their lifestyle choices to reduce the risk of acquiring a respiratory condition and maximise the benefit of any treatment. When problems with lung health occur, individuals can expect early and accurate diagnosis and effective treatment so the quality of life can be optimised.

Our key focus over this planning cycle is to reduce waiting times for cancer, improve access to pulmonary rehabilitation and develop a Non-invasive Ventilation (NIV) retrieval service. In the longer term we will re-design the respiratory nursing service across primary, secondary and community services and work towards a 7 day consultant rota across RGH and NHH aligning to the Clinical Futures model. The Health Board's Respiratory Local Delivery Plan is included in Appendix 4.

### **3.3.6 Critically ill**

Patients should have timely access to, and discharge from, clinically effective critical care, where appropriate for their condition and needs and be cared for in the correct facility with highly qualified specialists. Patients and carers should be as involved in their care as they feel appropriate.

The key priority following the Health Minister's confirmation of the SCCC is to move towards a unified critical care service on one site, allied to good recognition of deteriorating and critically ill patients and safe transfer to a critical care unit which meets recognised service requirements. In addition we will seek to develop a post-anaesthetic care unit (PACU) will be developed to improve patient safety in the post-operative period, with consideration given to 7 day working.

We also aim to reduce the number of hours lost to Delayed Transfers of Care (DTOCs) by 10% every quarter until we reach a position of no more than 5% of bed occupancy lost to DTOC. The Health Board's Local Delivery Plan for the Critically Ill is included in Appendix 4.

### **3.3.7 Neurological Conditions**

Our vision is for people with a neurological condition to have access to high-quality care wherever they live in Gwent; whatever their underlying neurological condition; and devoid of any prejudice in relation to their personal situation.

We are extending the Community Neuro-rehabilitation service to patients with Acquired Brain Injury

and aiming to increase awareness of neurological conditions we will implement an awareness programme in partnership with the Welsh Neurological Alliance. We will also focus on improving sustainability of the neurophysiology service by appointing graduates into existing and new neurophysiologist posts as trainees. A second epilepsy nurse will help to reduce a backlog in follow-ups for epilepsy patients and sustain the 'See on Symptom' service.

A business case to 'right-size' our Multiple Sclerosis infusion service will be completed and roll out Patient Recorded Outcomes Measures rolled out for Parkinson's disease with the benefit of learning from a pilot project. The Health Board's Local Delivery Plan for Neurological Conditions is included in Appendix 4.

### **3.3.8 Liver Disease**

The Health Board is a national pathfinder in timely detection of liver disease. A pilot project looking at the earlier detection for advanced liver disease in people having liver blood tests in primary care and electronic alerts for abnormal liver function tests is being evaluated to determine how we can continue to build stronger links with primary care, supported by guidelines and rapid access to specialist advice ensuring high quality liver care across the whole pathway.

We are developing an Integrated Alcohol Treatment Pathway initially through the development of an Alcohol Care Team (ACT) at Royal Gwent and Nevill Hall Hospital, in line with recent multi-agency reports and NICE recommendations that strongly endorse their implementation.

Planned expansion of the workforce providing care to patients with liver disease will align with the Clinical Futures model. This is currently being hampered by recruitment difficulties; however a high-level service review will look at opportunities to expand specialist nursing roles as well as recruitment of locum posts. Work is in progress with acute medicine to implement the care bundles which aim to improve the care of the liver failure patient in the first 24 hours of admission. Alcohol liaison support will be improved with the pending appointment of 2 alcohol liaison nurses and administrator support. The Health Board's Local Delivery Plan for Liver Disease is included in Appendix 4.

### **3.3.9 End of Life Care**

For our population, we want people in Gwent to have a healthy, realistic approach to dying, planning appropriately for the event and for people dying in Gwent to have access to high quality care, wherever they live and die, whatever their underlying disease or disability and devoid of any prejudice in relation to their personal situation.

End of Life Care (EoLC) is everybody's business. We aim to improve patient-centred care for all, recognising capacity, diversity and co-existing disease, by ensuring all professionals engaged in EoLC are optimally trained to ensure they have the necessary general or specialist knowledge required. Empowering patients and their families to express their needs and preferences, and to seek the help and support they need we also aim to achieve better health for all those facing a life limiting illness, and reducing any inequality or inequity regarding access to health care.

Our focus over this planning cycle is to increase awareness and uptake of Advance Care Planning, improve bereavement support and address how the Health Board can facilitate care needs of people in response to Preferred Place of Care and Preferred Place of Death. We will also establish an appropriate clinical model for the new St David's Hospice. The Health Board's Local Delivery Plan for the End of Life Care is included in Appendix 4.

**Table 3.3.1 Summary of Key Plans and Anticipated Benefits**

Major Health Condition	Key Plans	Key Impacts
Stroke	Prevent stroke through identification and appropriate management of Individuals with Atrial Fibrillation (AF) in Primary Care	<ul style="list-style-type: none"> <li>▪ Increased numbers of patients with AF identified</li> <li>▪ Increased numbers of patients with AF on appropriate medication to prevent stroke</li> <li>▪ Reduced number of strokes due to unidentified AF</li> </ul>
Stroke	Undertake Stroke PROMs R&D Project	<ul style="list-style-type: none"> <li>▪ Validated stroke PROMs tool available for use in Wales</li> <li>▪ Improved information on patient outcomes</li> <li>▪ Improved services for stroke patients based on measurable patient outcomes</li> <li>▪ Maximise the benefits of stroke research</li> </ul>
Stroke	Review the impact of the re-designed stroke pathway	<ul style="list-style-type: none"> <li>▪ Assessment of impact on:               <ul style="list-style-type: none"> <li>▪ Performance against national standards and targets</li> <li>▪ Patient flow and LOS</li> </ul> </li> <li>▪ Identify areas for further improvement e.g. 7 day services across the pathway</li> </ul>
Heart Disease	Timely access to cardiac diagnostic treatments	<ul style="list-style-type: none"> <li>▪ Improved access to interventional cardiology diagnostics and treatment</li> <li>▪ Phased increase in catheter lab sessions facilitated through a second catheter lab at RGH</li> </ul>
Heart Disease	Roll out community cardiology clinics	<ul style="list-style-type: none"> <li>▪ Improved access to interventional cardiology diagnostics and treatment</li> <li>▪ Shorter waiting times</li> <li>▪ Increased specialist care in a general setting</li> <li>▪ Increased care closer to home</li> </ul>
Heart Disease	Progress Heart Failure ICHOM project and use PROMs to drive service improvement	<ul style="list-style-type: none"> <li>▪ Improved information on patient outcomes</li> <li>▪ Improved services for cardiac patients based on measurable patient outcomes</li> </ul>
Heart Disease	Address inequity in the provision of heart failure rehabilitation for Newport and Caerphilly through service expansion	<ul style="list-style-type: none"> <li>▪ Cardiac rehabilitation services meet national standards</li> </ul>
Cancer	Develop single urgent cancer pathway	<ul style="list-style-type: none"> <li>▪ Improved cancer pathway</li> </ul>
Cancer	Extend and develop Acute Oncology Service with dedicated Oncology support	<ul style="list-style-type: none"> <li>▪ Improved access to acute oncology support</li> </ul>
Cancer	Develop a single Haematology in-patient facility	<ul style="list-style-type: none"> <li>▪ Improved patient care and ensure compliance with Nice Guidelines.</li> </ul>
Cancer	Transforming Cancer Services Programme ( <i>in partnership with Velindre Cancer Centre</i> )	<ul style="list-style-type: none"> <li>▪ Improved access to radiotherapy and strategic anti-cancer services</li> </ul>

Major Health Condition	Key Plans	Key Impacts
Diabetes	Establish psychology support for children and young people with diabetes	<ul style="list-style-type: none"> <li>▪ Increased psychological well-being</li> <li>▪ Increased access to psychological consultation for diabetes team</li> <li>▪ Increased capacity of partner agencies e.g. education to support patients</li> </ul>
Diabetes	Reduce variations in diabetes services performance across the Health Board with quality improvement initiatives	<ul style="list-style-type: none"> <li>▪ Reduced variation in diabetes service performance</li> </ul>
Diabetes	Further development of a range of patient education opportunities	<ul style="list-style-type: none"> <li>▪ Suite of patient education tools and programmes to meet individual needs</li> </ul>
Diabetes	Review multi-disciplinary workforce across ABUHB sites	<ul style="list-style-type: none"> <li>▪ Identify gaps in workforce/opportunities for workforce redesign</li> </ul>
Respiratory	Improved access to pulmonary rehabilitation across ABUHB population	<ul style="list-style-type: none"> <li>▪ Increased access to pulmonary rehabilitation programmes</li> <li>▪ Improved quality of life</li> <li>▪ Reduced length of stay</li> </ul>
Respiratory	Development of Non-invasive Ventilation (NIV) retrieval Service	<ul style="list-style-type: none"> <li>▪ Improved NIV retrieval</li> <li>▪ Improved quality of life</li> <li>▪ Increased patient flow through resuscitation beds</li> <li>▪ Reduced bed-blocking</li> </ul>
Respiratory	Redesigned respiratory nursing service across secondary primary and community services	<ul style="list-style-type: none"> <li>▪ Improved access to respiratory nursing support</li> </ul>
Respiratory	7 day consultant rota across all sites flexible to suit needs of service	<ul style="list-style-type: none"> <li>▪ Increased flexibility to suit needs of respiratory patients</li> </ul>
Critically Ill	Further develop the PACU to improve patient safety in the post operative period.	<ul style="list-style-type: none"> <li>▪ Improved patient safety in the post-operative period</li> <li>▪ Reduced elective cancellations</li> <li>▪ Reduction in referral to treatment time for elective cases</li> </ul>
Critically Ill	Reduce delayed transfers of care (DTOC) to no more than 5% of bed occupancy lost to DTOC	<ul style="list-style-type: none"> <li>▪ Reduced DTOC (10% per quarter)</li> </ul>
Critically Ill	Meet medical staffing to patient ratios at the Royal Gwent site through consultant recruitment	<ul style="list-style-type: none"> <li>▪ Improved staff to patient ratios</li> <li>▪ More critical care follow-up clinics</li> <li>▪ Increased HDU consultant cover at weekends</li> </ul>
Critically Ill	Continue the Advanced Critical Care Practitioner (ACCP) programme. Advertise and appoint an externally trained ACCP	<ul style="list-style-type: none"> <li>▪ Improved sustainability of the critical care workforce</li> </ul>
Neurological Conditions	In partnership with Welsh Neurological Alliance (WNA) co-produce an awareness raising programme for neurological conditions	<ul style="list-style-type: none"> <li>▪ Increased awareness of neurological conditions in the general population</li> </ul>
Neurological Conditions	Complete a business case to 'right-size' the Multiple Sclerosis (MS) infusion service	<ul style="list-style-type: none"> <li>▪ Increased numbers of eligible patients are able to access treatment on a timely basis</li> <li>▪ Reduced number of patient relapses</li> <li>▪ Reduced re-admissions</li> </ul>

Major Health Condition	Key Plans	Key Impacts
Neurological Conditions	Recruit a second epilepsy nurse specialist and supporting infrastructure	<ul style="list-style-type: none"> <li>▪ Increased numbers of eligible patients are able to access treatment on a timely basis</li> <li>▪ Reduced number of patient relapses</li> <li>▪ Reduced re-admissions</li> </ul>
Neurological Conditions	Extend Community Neuro-rehabilitation Service for patients with Acquired Brain Injury (ABI)	<ul style="list-style-type: none"> <li>▪ Improved access to Community Neurorehabilitation Services for patients with ABI</li> </ul>
Neurological Conditions	Roll out PROMS (ICHOM) for Parkinson's Disease with learning from pilot phase	<ul style="list-style-type: none"> <li>▪ Improved services based on measurement of patient-recorded outcomes</li> </ul>
Neurological Conditions	Recruit a trainee neurophysiologist into existing vacancy and recruit a 2nd trainee to sustain the service	<ul style="list-style-type: none"> <li>▪ Increased sustainability of neuro-physiology service</li> </ul>
Liver Disease	Develop an Integrated Alcohol Care Pathway through the development of a secondary care based Alcohol Care Team (ACT)	<ul style="list-style-type: none"> <li>▪ Improved access to services for liver disease</li> <li>▪ Reduced admissions</li> <li>▪ Reduced Length of stay</li> </ul>
Liver Disease	Implement workforce plans following review of liver services	<ul style="list-style-type: none"> <li>▪ Improved access to services for liver disease</li> <li>▪ Improved quality of care</li> </ul>
Liver Disease	Set up a Gwent Liver Patient Panel and Support Group to facilitate the co-productive approach to healthcare service redesign	<ul style="list-style-type: none"> <li>▪ Improved co-production and support for patients with liver disease</li> </ul>
Liver Disease	Evaluate the impact of an electronic AST/ALT alert within primary care, with links to an abnormal LFT pathway, which is currently being supported by Clinical Biochemistry and the LMC	<ul style="list-style-type: none"> <li>▪ Improved links with primary care</li> <li>▪ Faster access to specialist advice</li> <li>▪ Increased quality liver care across the whole pathway</li> </ul>
End of Life Care	Implement a Public Engagement and Communications Strategy for Advance Care Planning	<ul style="list-style-type: none"> <li>▪ Increased Public Awareness of ACP</li> <li>▪ Increased understanding of the role of ACP in End of Life Care</li> <li>▪ Reduced Patient anxiety and improved patient experience</li> <li>▪ Reduced family anxiety and improved family experience</li> </ul>
End of Life Care	Develop and agree a staff education programme for Serious Illness Conversations and Advance Care Planning (ACP)	<ul style="list-style-type: none"> <li>▪ Increased Professional Awareness of ACP</li> <li>▪ Increased number of staff in all clinical departments trained in ACP</li> </ul>
End of Life Care	Develop and implement a competency based education curriculum to support end of life care, to include communication, ACP and symptom management	<ul style="list-style-type: none"> <li>▪ An agreed consistent programme to all health care professionals across Gwent.</li> <li>▪ Increased knowledge and skills of Health Professionals.</li> <li>▪ Increased confidence of Health Professionals.</li> <li>▪ Improved patient experience</li> <li>▪ Improved carer/family experience</li> </ul>

An outline plan for addressing priorities for Major Health Conditions, including timescales where available, is included at Appendix 4. The Health Board's priorities for improving the management of rare diseases are described at Appendix 4B.

### 3.4 SCP 4 - Mental Health and Learning Disabilities (MH/LD)

This SCP seeks to provide an integrated whole system model of care that improves the mental health and wellbeing of our population

Improving our MH and LD services is important because we have to ensure that the needs of our local population continue to be met as the pressure from rising demand and greater acuity of presentations for our services develops in line with demographic changes in our communities. Our services, as they are currently configured, are not sustainable in the longer term.

Last year SCP 8 set out the key priorities in our MH/LD Divisional plan. This year, those priorities are reiterated as SCP 5 which now includes Specialist Child and Adolescent Mental Health Services (S-CAMHS), adult and older adult Mental Health (MH), and Learning Disabilities (LD). More detailed plans are in place at Divisional level.

Our vision for mental health is underpinned by the national 'Together for Mental Health' Strategy and our 2012 local integrated strategies developed in partnership with Local Authorities. These aim to provide an integrated whole system service model which:

- Improves the mental health and wellbeing of the whole population.
- Better recognises and reduces the impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities and the economy more widely.
- Reduces inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness.
- Ensures individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions.
- Improves access to, and the quality of preventative measures, and early intervention and treatment services, to ensure more people recover as a result.
- Improves the values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness.

Our vision for Learning Disabilities remains aligned with our local Learning Disabilities strategy 2012-17 which seeks:

*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.*

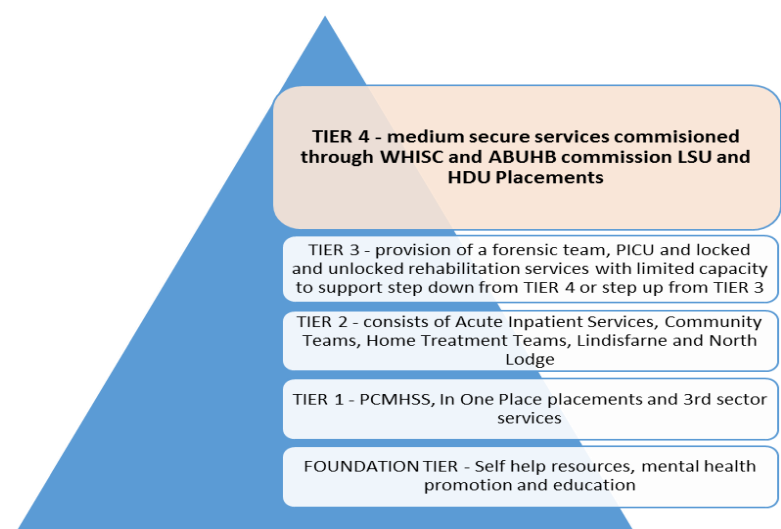
Figure 3.4.1

#### Current Challenges

Our mental health and learning disability services work in the context of an overall service model, spanning foundation level, primary, secondary and specialist tertiary services, as described in the diagram below:

Services for the target client groups are organised within a number of directorates and divisions;

- Primary Care mental health services (children, young people and adults).
- Adult mental health and specialist services (18 years to 65 years).



- Older adult mental health services (65 years and over).
- Learning disability services (18 years and over).
- S-CAMHS – (under 18 years) - Families and Therapies Division.

The majority of services are provided or commissioned at Foundation level, Tier 1 and Tier 2, with limited provision at Tier 3. Tier 4 providing low to medium secure services are commissioned from external providers.

Specialist CAMHS provide specialist assessment and treatment of serious mental health disturbances and associated risks in young people under the age of 18 years. It includes;

- crisis care and out of hours provision;
- early intervention for young people with psychoses;
- evidence based psychological therapies;
- assessment and diagnosis for Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

In addition S-CAMHS works in collaboration with the Integrated Service for Children with Additional Needs (ISCAN) to deliver integrated specialist care for children with mental health, paediatric, therapy and LD needs.

### **Demand Forecasts**

Forecasts show that demand is rising associated with an aging population and higher incidence of mental health disorders linked to social deprivation factors. Overall, data from the Welsh Health Survey (2012/13) indicates that adults in the Health Board area have generally poorer mental health and wellbeing than the rest of Wales.

Adult MH inpatient services have seen rising pressure on beds with occupancy levels above recommended Royal College of Psychiatry levels. An aging population is more likely to have at least one major chronic condition including the onset of dementia, which is predicted to rise by 39% by 2030.

CHC growth is also predicted to rise at a significant rate in adult MH over the next 3 years and will continue to be a major cost pressure for the service. This is in part due to new pathways into low secure services, including community, prison transfers and step down from medium secure units. Our scope to manage future demand in CHC is limited because we do not have a Low Secure Unit which would enable clients to be stepped up/down as appropriate and would reduce the number of externally commissioned placements.

Forecasts also indicate year on year increases in the incidence of people with learning disabilities. In Gwent 2012-20, this is expected to be around 2.3%. This is likely to impact not just on LD services and Continuing Healthcare (CHC), e.g. changing presentations and increased life expectancy, but across the whole system of health and social care. Inpatient occupancy levels on the 7-bedded Assessment and Treatment Unit are currently between 64-86%. The configuration and model for this service is being reassessed as part of the longer term review of tier 3 and tier 4 service provisions and the potential for more integrated working with MH services.

In Specialist Child and Adolescent Mental Health Services across Wales there has been a rapid, exponential increase in demand with a fourfold increase in urgent referrals. Ward admissions have also doubled. There has been an increasing demand and expectation for diagnostic services to be provided, such as Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder whilst also responding to the increase of the more urgent and complex children and young people.

### **Performance**

Informed by performance monitoring and national bench-marking, there are a number of key areas for improvement.

- Our ability to meet the Local Primary Care Mental Health Support Services (PCMHSS) measure of

80% for initial assessment within 28 days has been met for adults but has been significantly poorer for children and young people (<50%). The target for the start of intervention within 28 days for both adults and children has also proved difficult to deliver and sustain (range 44-72%). The situation is currently being managed with support from the Delivery Unit and waiting list initiatives but this is not a sustainable way forward.

- The access target for all routine and neuro-developmental patients was revised in April 2016 to 48 hours for urgent referrals, 4 weeks for a routine appointment and 26 weeks for a neuro-developmental assessment. Current performance for S-CAMHS indicates that all urgent cases are being seen within 48 hours in accordance with the revised target. Routines are at 6.7 weeks which is a significant improvement on past performance but is still not meeting the target.
- In October 2016 a new integrated service for Children with additional Needs (ISCAN) was set up in each of the children's centres across Gwent in collaboration with the heads of children's services for the local authorities. This means that all Neuro-developmental referrals are now managed through a multidisciplinary, multiagency referral meeting which will ensure the patient's pathway is as smooth as possible without the requirement to wait on individual waiting lists as was previously the case. From October 2016 all referrals are managed through the ISCAN hubs within the children's centres with a view to maintain a 26 week waiting time target in line with WG directive.
- There is however a backlog of patients within S-CAMHS awaiting assessments over 26 weeks. It is anticipated that the waiting time will be within the target by April 2017. Given that the waiting time for Neuro-developmental assessments in the summer of 2015 was over 98 weeks, this represents a significant improvement.
- The interventions implemented in 2016/17 such as development of an integrated neuro-developmental service and the extension of the emergency liaison service into weekends are considered to be important enablers for improving waiting times. These will need to be evaluated in 2017/18 to ensure the planned benefits are fully realised and performance improvements are sustained.
- MH crisis services have also been under much pressure in recent years, exacerbated by staffing shortages and service inefficiencies which result in poor patient experiences. In 2016/17 a new service model was introduced deploying local service units, new workforce rota systems and extended hours. Further developments are planned in 2017/18 including multi-agency approaches as part of the Gwent Crisis Care Concordat.
- The transfer of adult MH services back to South Powys has not concluded due to critical issues in their Readiness Assessment, e.g. having sufficient medical staff in post.

## **Workforce**

We are experiencing severe issues with recruitment especially junior and middle grade doctors and qualified MH and LD nurses. A detailed workforce plan has been developed for every Directorate. It includes a range of ongoing interventions such as a monthly recruitment wheel and student recruitment events as well as role review and redesign.

Medical staffing is a particular challenge due to the reduced allocation of junior doctors since August 2016. Staff consultation in 2016/17 on proposals for supporting the out of hours on-call rota has resulted in the Liaison and Crisis Resolution Home Treatment service being extended to midnight to provide support for junior doctors.

Nurse staffing difficulties are compounded by the preceptorship requirement for newly qualified nurses which prevents them from taking charge of shifts for the first 6 months. We also have an aging workforce which means many nurses are at or nearing retirement age. This is particularly acute in Older Adult MH inpatient services, where the shortfall in registered nurses has led to temporary ward closures since January 2016 in order to maintain safe patient care.

There are also recruitment difficulties in CAMHS, particularly for specialist roles. This is likely to be compounded by plans for further Welsh Government investment in CAMHS services across Wales which will seek recruitment of additional staff from a restricted national pool.

## **Plans for Change**

There has been really significant progress across the plan in 2016/17. Our key achievements are set out in Section 2, with further detail across the work programme in Appendix 3. Our 2017-20 work

programmes are focused on 3 priority dimensions, namely access; quality & patient safety and sustainability.

### 3.4.1 Access

Our priorities will be to reduce waiting times in key areas across all service model tiers and age category, e.g. access to assessment and intervention for Primary Care MH support services and waiting times for psychological therapies. Our key challenges are to reduce variation in service provision across different localities and ensure close working with other divisions, third sector partners and other statutory bodies such as the Police and local authorities in order to ensure services are designed around the key principles of Prudent Healthcare. To improve access to services, we will:

Table 3.4.1

	Desired Outcome/Impact	Measure	Plan	Time Frame
1	Deliver more timely assessment for Local Primary MH Support Services (LPMHSS)	80% Adults assessed by LPMHSS within 28 days.	Complete Delivery Unit recovery plan	Q1 17/18
		% service users, carers and GPs who +ve rate service.	Evaluate impact of new Third Sector contracts.	Q4 17/18
		80% children assessed by LPMHSS within 28 days.	Complete Delivery Unit recovery plan	Q1 17/18
	Deliver more timely intervention for LPMHSS	80% adults receive intervention by LPMHSS within 28 days.	Complete delivery Unit recovery plan	Q1 17/18
		80% adults receive intervention by LPMHSS within 28 days.	Complete Delivery Unit recovery plan	Q1 17/18
2	Deliver more timely access for psychological therapies	80% access LPMHSS within 28 days	Complete Delivery Unit recovery plan	Q4 16/17
3	Improve access to integrated specialist services for children with additional needs	RTT target 26 weeks.	ISCAN collaborative (part of ND Pathway prog).	Q4 16/17
4	Deliver more timely access and treatment for patients with neuro-developmental needs (e.g. ASD & ADHD).	RTT target 26 weeks.	Multi-agency neuro-developmental pathway programme. Expand Crisis Outreach Team.	Q4 16/17 Q4 17/18
5	Ensure GP access to annual health checks for people with LD	Equitable provision across Gwent.	Part of GMS contracting framework.	TBA
6	Reduce delayed transfers of care (DToC) for people with LD	DToC	Hospital based resource team for LD for discharge liaison w/s.	
7	Publish an agreed care pathway for vulnerable young people such as looked after and adopted children to ensure appropriate referrals and support services are provided between CAMHS / other specialist mental	Compliance with T4MH target.	S-CAMHS workstream	Q3 17/18

	Desired Outcome/Impact	Measure	Plan	Time Frame
	health services / local authority and youth justice system.			
8	Improve availability of behavioural support services for patients and families coping with dementia.	TBA	OAMH Behavioural support services w/s	TBA
9	Improve access to services for people with ASD and ADHD.	TBA	Implement Integrated Autism Service	

### 3.4.2 Quality and Patient Safety

We will focus on the delivery of safer care and better experiences for patients. This will include a review of opportunities to further reduce ligature risks. A number of work programmes reviewing the service models for older adults and people with learning disabilities will be carried forward from last year's plan.

The Health Board has a comprehensive Dementia Action Plan, overseen by an executive led Dementia Board, to ensure that our responses to Wales: a Dementia-Friendly Nation improve the outcomes and experiences for patients and their families living with dementia. A key element of the plan involves educating and supporting general physical health care services in the management of patients with dementia. This is covered in more detail in Section 3.8 on Older People.

To improve quality and patient safety, we will:

Table 3.4.2

Desired Outcome/Impact	Measure	Plan	Time Frame
Provide safer environments of care for patients with ligature risks.	Compliance with ligature prevention standards.	Ligature Prevention programme.	Q4 17/18
Ensure people with LD are cared for closer to home and in appropriate settings.	Number of clients repatriated to Gwent.	LD Residential services review w/s. BOLD LD community and specialist services w/s.	Q4 17/18
Ensure older adults with MH needs are cared for in the right place, at the right time, by the right people.	TBA	OAMH service redesign options consultation.	Q4 17/18
		Transfer ECT treatment from Maindiff Court to Ty Siriol at County Hospital (capital BC)	Q4 17/18
Ensure all people in crisis and in contact with the police are treated with dignity and respect.	Reduced use of section 135/136 from 2014 baseline by March 18	Crisis concordat.	Q4 17/18
Evaluate the effectiveness of MH liaison in DGHs.	Reduced number frequent attendees in EDs.	RAID Evaluation	Q4 17/18
Promote and support emotional wellbeing and resilience for patients needing specialist MH services	Compliance with Duty to Review recommendations	TBA	Q4 18/19

### 3.4.3 Sustainability

Focusing on short, medium and longer term opportunities to improve efficiencies and effectiveness, particularly in high spend areas such as CHC, the in-house management of complex patients, and staffing, in order to manage forecast rises in demand and costs through service redesign. Our work programme therefore includes service redesign and improvement at every tier of service provision. This includes a major strategic programme to review services for patients with complex needs as there

is a perceived gap in the provision of suitable environments of care for this client group, with many having to take up external placements to meet their needs.

To improve sustainability, we will:

**Table 3.4.3**

Desired Outcome/Impact	Measure	Plan	Time Frame
Provide more effective care closer to home for people with complex MH needs.	Shorter LOS Reduced costs	Interim extension of PICU.	Q1 17/18
Provide more effective and affordable care closer to home for people with complex MH needs.		Complex MH needs pathways for adult males and females. In one Place projects. (South Lodge 3 <sup>rd</sup> client transfer).	2019/20 Q1 17/18
Provide integrated and fully staffed and affordable adult low secure MH services closer to home.	Reduced LOS Reduced costs/revenue savings Workforce recruitment and retention rates	Integrated LSU, HDU, PICU Project.	2020/21
Monitor care costs more effectively.	TBA	PLIX and ICHOM w/stm	TBA

### 3.4.4 Enablers

Capital and requirements have been included in our plans and are included in Appendix 5. The highest priorities are for the reconfiguration and improvement of inpatient environments to support older adult service redesign, adult inpatient remodelling and pathways for patients with complex mental health needs.

In addition the long term sustainability of CHC provision is predicated on addressing the gap in Low Secure, High Dependency and Psychiatric Intensive Care, for which a business case for All Wales Capital of around £35m is being developed. Interim developments are proposed and being developed through the Health Board's discretionary capital funding programme. Further details, including potential internal capital funding proposals are included at Appendix 5.

### Governance and Corporate Support

The Executive Lead for this SCP is the Chief Operating Officer, supported by the Associate Director for Integration and Innovation and members of the corporate planning team. The implementation leads are identified against specific work streams and milestones from the Divisional teams. The PC, Community and MH/LD Transformation Board is the delivery board overseeing refinement of the plans, implementation and risk management. It is accountable to the Executive Team.

Additional corporate support will be provided for ongoing demand and capacity analysis and review of flow opportunities, BC development and engagement and consultation activities.

### Key Risks

A risk register and risk management plan is in place and will be a standing item on the agenda for PC/MH Board.

Key risks have been described in the context of our plans above and include:

- **Medical staffing** – if we are unable to recruit to junior and middle grade vacancies we will be unable to sustain core services. Our risk management plan is to engage the Deanery and develop a specific medical workforce strategy.
- **Nurse staffing** – if we are unable to recruit and retain sufficient nurses then there may be quality and safety implications for patient care and staff welfare. A comprehensive resource plan has been developed to improve recruitment and review and redesign workforce roles.
- **CHC Growth** – if CHC demand continues to grow at the rates predicted, then this will have a significant impact on the Health Board's financial position. A comprehensive review of the service

model and strategic investment plan is underway to ensure we continue to contain growth and provide an affordable high quality service for clients.

- **Availability of Capital funding** – if we are unable to secure the level of investment required this will severely limit plans to deliver more sustainable services in the future. A robust service model and interim infrastructure plans are in development to help mitigate this risk.

Aligning SCPs supporting a shift of services closer to home is set out at a high level in the following table.

**Table 3.4.4**

<b>Key Theme</b>	<b>Shift of Services Closer to Home</b>
Finance	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 2016/17 and these are included within the financial plan.
Workforce	Additional staff recruited to support the Primary care, Intermediate Care Fund and Mental Health schemes in 2016/17. Development of new roles, skills and multidisciplinary teams and 24 hour services during 2017/2018.
Capital	Primary Care opportunities are being pursued with Welsh government. Mental Health low secure plans also being developed during 2016/17.

## Improving Access and Flow and Reducing Waits (SCP 5 & 6)

### 3.5 SCP 5 - Urgent and Emergency Care

This SCP seeks to develop coherent, co-ordinated, high quality urgent and emergency care system that works seven days a week, and where possible 24 hours a day, in accordance with patient expectations, delivering the best clinical outcomes.

#### Introduction

There are significant pressures on the urgent and emergency care services across the Health Board that require an improved whole system approach that maximises the contribution of every service, with the aim of caring for patients in the right place, at the right time and by the right care team.

The past winter has highlighted unprecedented demand and capacity pressures on our current system resulting from a 12% increase in emergency GP referrals above the previous year, with significant increases in the acuity of the patients presenting. This has resulted in deterioration in performance of 4 hour and 12 hour targets in the Emergency Department (ED).

Delivering sustainable urgent and emergency care services remains a priority for the Health Board and our partners, we are driving change through the Urgent and Emergency Care Board which includes multi-disciplinary and partner organization representatives. The Urgent Care Board is dynamic, it agrees and sets shared clinical and management action across the care system and seeks innovative solutions that deliver:

- A preventative approach which identifies those at risk of being admitted to hospital and seeks to intervene to avoid this where appropriate.
- A proactive approach which identifies and manages those at risk of becoming delayed when in hospital.
- Effective systems and processes to identify and manage those who experience a delay in their discharge or transfer to a more appropriate setting.
- Optimises patient flow through the urgent and emergency care system

This Service Change Plan sets out the key outcomes that will be the focus of our efforts over the next three years to redesign the urgent and emergency care system to better meet the needs of the population, drive further integration across its component parts and meet national quality and access expectations.

Our ultimate aim is to deliver safe, high quality and timely services to all patients wherever they present in the system. The most immediate priority for the Health Board is to eradicate 12 hour waits in ED, ramping of patients on the back of ambulances and the use of trolleys in corridors.

During 2016/17 the Urgent and Emergency Care work programme was informed by and aligned with the 6 step framework developed by the National USC Collaborative which set out priorities for system improvement. Table 3.5.1 illustrates the framework and actions taken by the Health Board during 2016/17 to improve system performance and service sustainability.

Table 3.5.1

Step	Area	Actions 2016/17
1	Care Closer to Home (Optimising access to urgent primary and community care)	Redesign OOH (skill mix), 24/7 District Nursing, Promoting Choose Pharmacy, sustainable GP support infrastructure.
2	Agreed Pathways of Care	Stay Well Plans, Stroke Pathway, Falls Response Unit, Mental Health Pathway, Major Health Conditions Management.
3	Clinical Process Excellence	Ring fence ENP resource for Minors, test of concept ambulatory care, optimise access to senior decision maker at front door, skill mix (ANPs, ENPs, Nurse Consultants, Physiotherapist and

Step	Area	Actions 2016/17
		Occupational Therapists).
4	Hospital site management	Strengthening clinical and managerial site leadership and processes, revised escalation systems, bed capacity plan.
5	Well Managed Wards	EFU, Green2 Go, Safer bundle roll out, workforce redesign, MDTs strengthened.
6	Effective Transfers of Care	Discharge planning/EDD, DToC management, CHC management including Choice Policy implementation, community improvement plan.

### Baseline position

A high level overview of flow through the emergency system, over the 2016 calendar year, the table represents average daily activity, and sets out the range of variability in daily activity across the 12 month period, for both acute hospital sites in the following table.

Table 3.5.2

NHH	Arrival			Outcome		Admission			Discharge
	Ambulance	Walk in	Total ED	Admit	Depart	GP / Other	A&E	Total	
Mean	35	87	122	27	95	33	27	59	59
80% range ( $\pm 1.29$ sd)	27 to 43	65 to 108	98 to 146	20 to 35	73 to 116	15 to 51	20 to 34	41 to 77	33 to 86
Median	35	85	121	27	94	36	26	61	65
% split	29%	71%	100%	23%	77%	55%	45%	100%	

RGH	Arrival			Outcome		Admission			Discharge
	Ambulance	Walk in	Total ED	Admit	Depart	GP / Other	A&E	Total	
Mean	65	156	222	56	166	64	54	119	119
80% range ( $\pm 1.29$ sd)	54 to 77	129 to 183	191 to 252	45 to 67	138 to 193	29 to 100	44 to 65	85 to 153	72 to 166
Median	65	155	221	55	165	69	54	122	127
% split	30%	70%	100%	25%	75%	54%	46%	100%	

Detailed flow maps for Nevill Hall Hospital and the Royal Gwent Hospital are shown in Appendix 6. Summary of key facts are shown in the table below.

Table 3.5.3

Emergency Departments	Emergency Admissions
<ul style="list-style-type: none"> <li>▪ 30% of patients conveyed by ambulance</li> <li>▪ 70% self present</li> <li>▪ 122 average daily attendances at Nevill Hall Hospital (range 98 – 146)</li> <li>▪ 222 average daily attendances at Royal Gwent Hospital (range 191 – 252)</li> <li>▪ Large degree of variability in daily ED attendances – over 100 more people present on the busiest day compared to the least busy day</li> <li>▪ Large degree of variability in number of ambulance conveyances, <ul style="list-style-type: none"> <li>▫ average for NHH is 35, ranging from 27 to 43</li> <li>▫ average for RGH is 65, ranging from 54 - 77</li> </ul> </li> <li>▪ 11% of attendees are categorised as majors</li> <li>▪ 89% of attendees are categorised as minors</li> <li>▪ 25% patients are admitted</li> <li>▪ 75% patients are discharged from ED</li> </ul>	<ul style="list-style-type: none"> <li>▪ 55% of patients admitted are referred by their GP or another healthcare professional</li> <li>▪ 45% of patients are admitted from ED</li> <li>▪ 59 average daily admissions at Nevill Hall Hospital (range 41 – 77)</li> <li>▪ 119 average daily admissions at Royal Gwent Hospital (range 85 – 153)</li> <li>▪ Large degree of variability on daily admissions – over 112 more admissions on the busiest day compared to least busy day</li> <li>▪ 59 average daily discharges at Nevill Hall Hospital (range 33 – 86)</li> <li>▪ 119 average daily discharges at Royal Gwent Hospital (range 72 – 166)</li> <li>▪ On days when discharge process is most effective both sites experience more than a two fold increase in daily discharges achieved</li> </ul>

This shows that the number of daily discharges ultimately balances with the numbers of admissions. However, our ability to release bed resources to maximise flow through the system is made difficult because of the time that patients present to our system and variability in the volume of patients accessing services on a day to day basis. In essence the bed stock is static, patient presentations and discharges fluctuate with peaks and troughs by time of day, day of week and month of year.

**Our challenge is to ensure that the urgent and emergency care system is capable of managing “variability” in the system.**

Smoothing the variability in performance to better match capacity with the pattern of demand is the key priority for the urgent and emergency care system and essential to address the challenges the system faces in meeting Tier 1 performance targets.

### Changes in patterns of demand

The number of people presenting to emergency departments has remained relatively stable over recent years. The number of **GP referrals to our assessment units** for patients over 18 years has increased by 12% each year since 2013, resulting in 6,400 more patients entering the assessment unit in 2015/16 compared to 2013/14. This pattern has continued throughout 2016/17. Analysis of demand on assessment units across Wales suggests that our GPs refer a higher number of people for emergency assessments than their peers across Wales.

The number of “assessed out” has also increased over the same timeframe, suggesting that more patients are being referred to an assessment unit that do not need to be admitted to hospital. The introduction of Ambulatory Care Services at Nevill Hall and the Royal Gwent Hospitals has increased capacity for Acute Care Physicians (ACPs) to manage “ambulant” patients referred by their GP and following assessment and/or intervention enable the patient to return home the same day with ongoing clinical follow-up as required.

**Our challenge is to optimise the number of patients managed through “same day emergency care” or “Ambulatory Emergency Care” without the need to stay in hospital overnight.**

Understanding the nature of GP referrals and consideration of options to reduce demand on secondary care through provision of appropriate alternatives (urgent diagnostics, advice and support from specialist physicians) is a key priority for this planning cycle.

### Bed Capacity Requirements for Existing System of Care

An analysis of beds used over the past 12 months and forecast bed requirement over the next 12 months based on the assumption of 5% growth in admissions and 100% occupancy for Nevill Hall and for the Royal Gwent Hospitals are summarised below. **The forecast assumes no change in current practices.**

**Table 3.5.4**

Last 12 months actual - NHH													
Nevill Hall	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
Discharges	1,164	1,139	1,127	1,177	1,218	1,266	1,309	1,264	1,218	1,269	1,237	1,281	14,669
LOS	7.87	7.74	7.91	8.29	7.52	8.14	7.79	6.67	8.21	7.24	8.01	7.66	7.76
Occ. Beds	295	284	307	315	305	332	340	280	323	306	319	327	<b>311</b>
Next 12 months forecast - NHH													
Discharges	1209	1184	1134	1227	1269	1316	1360	1313	1266	1318	1285	1331	15213
LOS	7.91	7.77	7.94	8.33	7.55	8.17	7.83	6.90	8.25	7.28	8.05	7.70	7.80
Occ. Beds	308	297	322	330	319	347	355	292	337	320	334	342	325
Beds req	312	301	324	332	322	352	359	296	341	324	338	346	<b>329</b>
Last 12 months actual - RGH													
Royal Gwent	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Total
Discharges	2,575	2,583	2,654	2,702	2,591	2,586	2,641	2,683	2,642	2,649	2,659	2,769	31,734
LOS	6.99	6.46	6.57	6.67	6.59	6.66	6.1	6.41	6.14	6.51	6.23	6.62	6.5
Occ. Beds	581	538	601	581	569	556	537	555	523	575	535	611	<b>563</b>
Next 12 months forecast - RGH													
Discharges	2,684	2,691	2,669	2,812	2,697	2,693	2,748	2,794	2,752	2,755	2,769	2,883	32,946
LOS	7.02	6.48	6.59	6.70	6.62	6.69	6.14	6.44	6.17	6.55	6.26	6.65	6.53
Occ. Beds	608	563	629	608	595	581	562	581	548	601	559	640	589
Beds req	612	568	634	614	601	587	567	586	552	607	564	645	<b>595</b>

If we do not change our system of care the forecast illustrates that an additional 50 beds are required

across the acute hospital network to meet anticipated demand. Bed capacity requirements by specialty are shown in the following table.

Table 3.5.5

Forecast 2017/18	RGH	NHH	Total
Cardiology	35	22	57
Care of the Elderly	139	89	228
Diabetes & Endocrine	35	20	55
Gastroenterology	41	24	65
General Medicine	12	2	14
General Surgery	81	47	128
Respiratory	80	38	118
Trauma and Orthopaedics	79	70	149
Urology	12		12
Additional Beds	<b>+32</b>	<b>+18</b>	<b>+50</b>

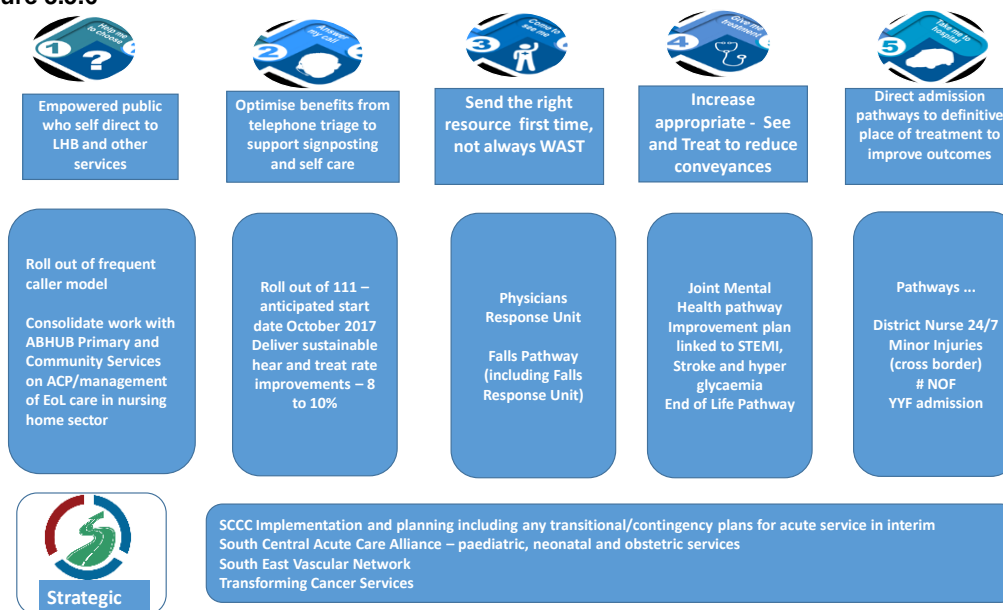
This position is unsustainable in terms of workforce and affordability; it represents a system that is over reliant on beds, where productivity, efficiency are compromised through barriers to patient flow and ultimately poor value in terms of patient experience and compromised clinical outcomes particularly for frail older people.

**Our challenge is ensure that every day a patient spends in hospital is a “green day”; enabling the system to improve patient flow, optimise bed capacity and bed availability 24/7. We also need to be able to respond flexibly, but in a planned way, to known periods of high demand.**

### Welsh Ambulance Services Trust

The Health Board and Welsh Ambulance Services Trust have established a joint forum that meets on a quarterly basis, with a view to focusing on the strategic and transformational changes that will reshape the way services are delivered locally with a view to optimising flow across the 5 steps, improve clinical outcomes, patient experience and reduce the proportion of Gwent residents conveyed to Emergency Department by ambulance. The figure below illustrates the priority actions that will be progressed during this planning cycle.

Figure 3.5.6

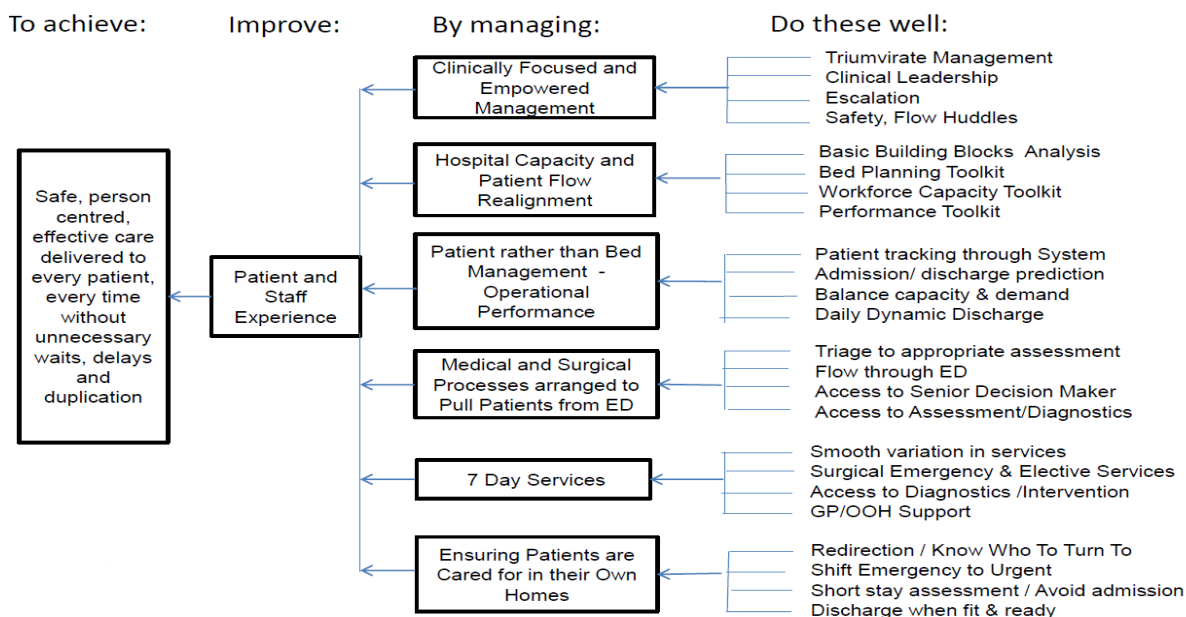


### Plans for Change

This year, the approach has been strengthened to incorporate the key components of NHS Scotland’s 6 essential actions for transforming urgent care, specifically a more focused approach to patient rather

than bed management, medical and surgical processes to pull patients from ED and strengthening hospital capacity and patient flow alignment through more robust hospital site management. This follows a recent review of our Urgent and Emergency Care System led by Professor Derek Bell<sup>6</sup>; the recommendations of the review have informed key priorities for improvement over the life of this plan.

**Figure 3.5.7**  
**6 Essential Actions to Improving Unscheduled Care Performance**



### Health Board Plans for Change

Six key work programmes, based on NHS Scotland’s 6 essential actions, are being progressed within the IMTP to transform urgent care. They are set out below:

#### 3.5.1 Clinically Focused and Empowered Management

Our Urgent and Emergency Care SCP in 2016/17 identified the following actions to ensure acute hospital site management improved:

- Clinical and site management leads within site hubs.
- Revised Escalation plan.
- Communication Processes.
- Standard Operating Procedures

As part of our strategic 2017/18 these building blocks will be developed to further improve patient and staff experience. The basis of this plan follows discussions at urgent care board and the executive flow and diagnostic visit report which the Health Board commissioned Professor Derek Bell to complete in October 2016.

The objective for the essential action this year will be as follows:

- A clear site-management process will be in place with robust communication lines across all services. Responsibility and accountability will be agreed across the system seven days a week, with an appropriate site manager to support medical and nursing leads and Divisional Managers in all services. This is crucial to ensuring central oversight of safety and flow on a day-to-day basis and supporting effective performance and management.
- Escalation plans will give managers and clinicians explicit local guidance on the sequence of priorities to be addressed during times of capacity stress. It is essential that managerial and clinical

<sup>6</sup> Professor Derek Bell, President of the Royal College of Physicians, Edinburgh and Chair in Acute Medicine, Imperial College London

teams in all services will have a full understanding of, and are in agreement with, defined site responsibilities and can demonstrate awareness of, and be accountable for, actions required for standardised processes and escalation. These will be agreed and accepted by all clinical and managerial leads, and monitoring processes will be in place to ensure they are followed as routine.

- Robust communication processes across a whole hospital site should include morning hospital-safety huddles, focusing on the day's activity and current status, and afternoon huddles, looking at prediction of capacity and demand for the next day. Such processes help inform standard operating procedures and escalation.
- Robust **Standard Operating Procedures** will be developed and implemented with inter-specialty service level agreements for time standards and practice standards, agreed across divisions and owned at all levels of the organisation.

Adoption of the 24 hour acute hospital model focuses attention on the operational management of patient flow as opposed to bed management. It provides a daily schedule for key actions that prevent ED crowding, improve ward operational processes, and encompass patient safety & flow and escalation from 8.30am to 9pm. Placing emphasis on the coordinated creation of a multi-disciplinary, patient centered discharge plan as soon as possible on presentation to the acute hospital, and then on the timely synchronized execution of the plan each day to prevent delay and ensure that patients are treated and discharged without delay.

**Table 3.5.6**

Desired Outcome/ Impact	Measure	Plan	Time Frame
Site focused operational management to support escalation and de-escalation quickly	▪ Reduction in red escalation status	▪ Appoint Operations Manager/Patient flow	Q1 17/18
	▪ Reduction in lost ambulance hours	▪ Review impacts and extend hours of operation	Q2 17/18
		▪ Review/revise escalation policies	Q3 17/18
Standard ED flow operating policy and procedures with agreed inter-specialty service level agreements for time standards and practice standards agreed across divisions and owned at all levels of the organization	<ul style="list-style-type: none"> <li>▪ Reduction in 4 and 12 hour waits in ED</li> <li>▪ Reduction in time waiting for specialty assessment in ED</li> </ul>	▪ SoPs agreed and plan developed to implement the necessary changes to deliver (e.g. job planning, diagnostic capacity)	Q2 17/18

### 3.5.2 Capacity and Patient Flow Re-Alignment

Aneurin Bevan Continuous Improvement (ABCi) directorate are supporting the delivery of a capacity and patient flow (planned and urgent/emergency) re-alignment programme. During 2016/17 this work has established a current footprint of flow into, through and out of the hospital, prospective demand for the coming 7 days are produced to enable the system to plan for anticipated demand.

Further work to be progressed in 2017/18 includes examining where solutions such as streaming and high volume specialty pathways will improve flow and the hidden consequences of altering current systems. Wider work in this area will centre on producing a combined elective and emergency capacity plan for each of the major sites, thereby providing a focus for improvement work to deliver a balanced system with optimal patient flow.

- Basic building blocks analysis (demand capacity alignment)
- Bed planning toolkit (right bed, right place)
- Workforce capacity toolkit (right staffing, right place)
- Performance toolkit (breach analysis)

The use of meaningful, robust data, to determine and ensure demand and capacity are in balance at all stages of the patient pathway. Minimising delays and ensuring patients are cared for in the right place, at the time - time is vital to the attainment of optimal patient flow.

Through ABCi, the Health Board has established the Unscheduled Care Collaborative, where teams front line staff are working on tests of change (see figure 3.5.8) and scaling up change packages that impact on:

- Shaping demand
- Creating a pull form ED model of flow
- Maximising capacity

Figure 3.5.8

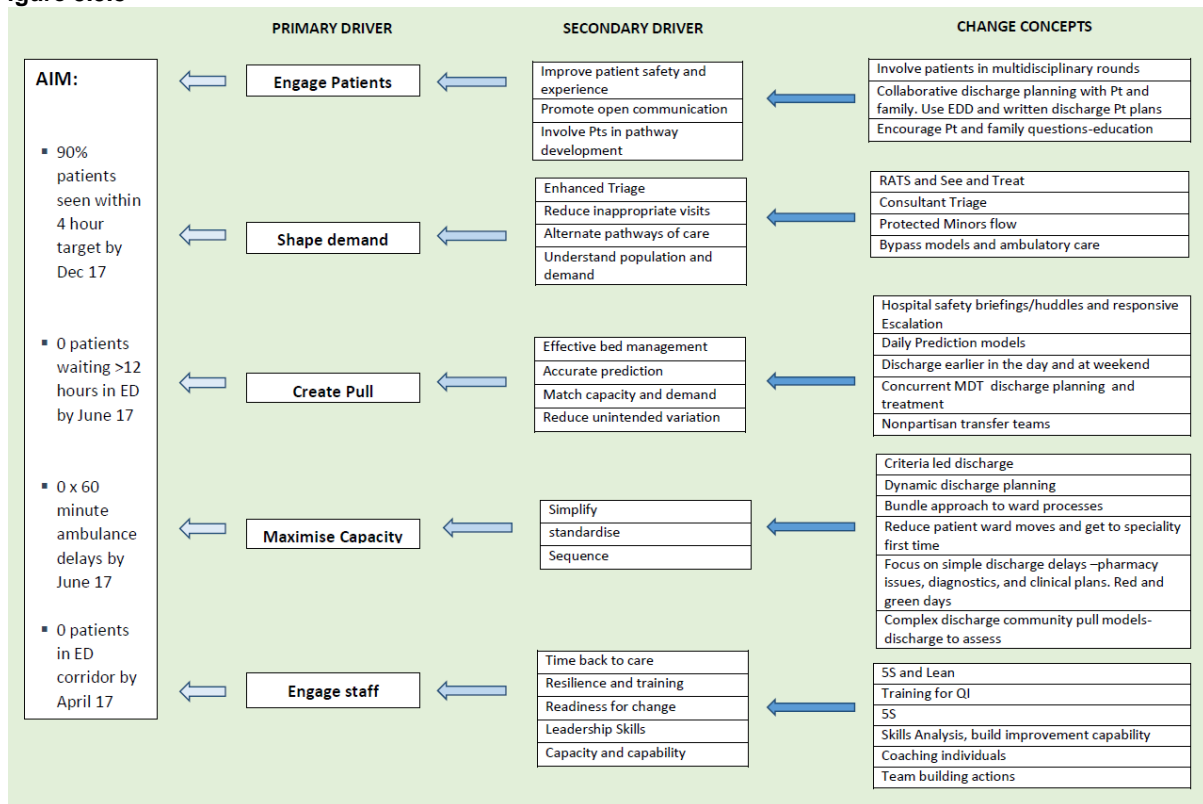


Table 3.5.7

Desired Outcome/Impact	Measure	Plan	Time Frame
Improved clinical communication, improved patient flow, concurrent discharge planning	<ul style="list-style-type: none"> <li>▪ Board rounds and huddle compliance</li> <li>▪ Increased morning discharges</li> <li>▪ Reduced length of stay</li> <li>▪ Increased rate of pull from ED</li> </ul>	<ul style="list-style-type: none"> <li>▪ ABCi collaborative plan</li> </ul>	Q1 17/18 – Q2 18/19
Bed Plan for Organization that optimizes capacity, balances scheduled and unscheduled bed capacity and is designed to meet anticipated peaks in demand.	<ul style="list-style-type: none"> <li>▪ Reduced lengths of stay by optimizing bed days to focus on value added activities</li> <li>▪ Reduction number of beds</li> <li>▪ Surge capacity plans</li> </ul>	<ul style="list-style-type: none"> <li>▪ Bed capacity plan developed</li> <li>▪ Actions/interventions to optimize bed capacity identified and plan to implement developed</li> <li>▪ Implementation plan delivered</li> </ul>	Q1 17/18 Q2/3 17/18 Q3 onwards

### 3.5.3 Patient Management

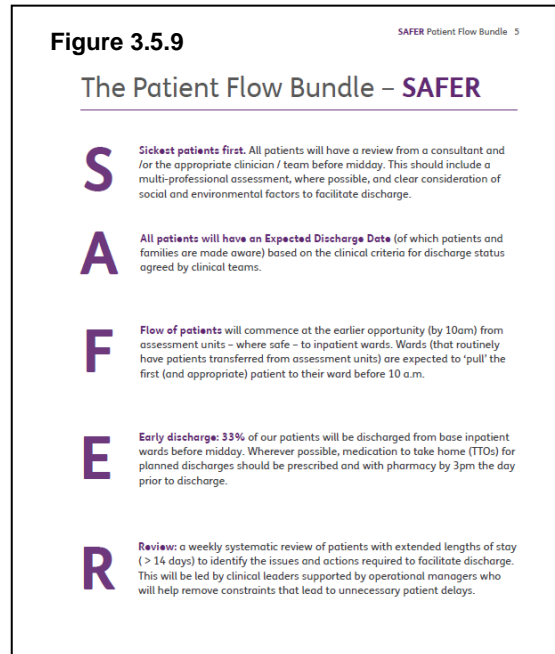
The key priority for the acute hospital component of the urgent and emergency care system is to manage how each patient flow across the system, to ensure they receive safe and effective care, every time, without unnecessary waits, delays and duplication. This involves:

- Effective patient tracking throughout the journey.
- Processes that support operational management of the treatment plan at an individual level, and – across all patients, to ensure optimum focus on discharge without delay.
- Focus on early morning and weekend discharge.
- Daily dynamic discharge.

Our focus for 2017/18 is the adoption of the “SAFER” patient flow bundle across all medical wards to embed daily dynamic discharge into our system. This builds on our experiences of piloting the SAFER bundle at both acute hospital sites over the past 12 months. Placing emphasis on the co-ordinated creation of a multi-disciplinary, patient-centred discharge plan as soon as possible after admission, and then on the timely, synchronised execution of the plan each day, prevents delay and ensures that patients are treated and discharged without delay.

Systematic implementation of the SAFER bundle will increase the numbers of discharges by site each day, increase green days (where patients receive interventions or actions that move their care forward), a decrease in red days and most significantly, improve the numbers of people that are discharged earlier in the day.

ABCi are supporting the implementation of the SAFER bundle through the Unscheduled Care Collaborative, using IHI Breakthrough Series Methodology, to ensure sustainable system level improvement for patient flow.



**Table 3.5.8**

Desired Outcome/Impact	Measure	Plan	Time Frame	
<ul style="list-style-type: none"> <li>▪ Reduction in overall LOS across all specialities progressing to best in peer group as indicated in CHKS data</li> <li>▪ Improvement in performance against emergency access target (4hrs and 12 hrs)</li> <li>▪ Improvement in ambulance handover times</li> <li>▪ Reduction in occupied bed days with improved access – emergency and elective</li> <li>▪ Better aligned flow with less ED crowding</li> <li>▪ Improved time of day transfer from ED and MAU – largest number transferred from ED and MAU between 20:00hrs and 02:00hrs</li> <li>▪ Fewer medical patients on surgical wards 'outlying'</li> </ul>	<ul style="list-style-type: none"> <li>▪ All principles of SAFER Patient Flow Bundle met consistently across all wards</li> <li>▪ Reduction in ward cumulative bed days</li> <li>▪ Daily and Weekly Discharge Targets met – Total Volume</li> <li>▪ 33% of discharges consistently occur &lt; midday</li> <li>▪ First beds available for Medical Assessment Unit by 10am (Mon – Friday)</li> <li>▪ Reduction in average ward LOS/episode by 1 day per ward (exclude stroke)</li> <li>▪ Reduction in 'medically fit days' per ward</li> <li>▪ Cardiology LOS at RGH moving to average peer review = 3 beds at RGH</li> <li>▪ Respiratory LOS at RGH moving to average peer review = 8 beds at RGH</li> <li>▪ Endocrinology LOS at</li> </ul>	Establish project management arrangements for SAFER Patient Flow Bundle with rapid role out across medicine Dec 16 – March 17	Q4 2016/17	
		Establish ABCi Collaborative membership and project plan Identify quality improvement metrics and communication strategy	Introduce the Discharge Co-ordinator(DISCO) role to the RGH site (4 temporary posts to start Jan 2017 with ICF Funding)	Q1 17/18
		Formal evaluation of project and outcomes	Formal evaluation and business case to secure funding for a total of 6 DISCO post to support ward daily discharge planning	Q2 17/18
		Agreement to support investment/funding stream – DMT		
		Appoint new permanent workforce	Q3 17/18	

Desired Outcome/Impact	Measure	Plan	Time Frame
	RG moving to average peer review = 9 beds at RGH <ul style="list-style-type: none"> <li>This provides a potential average gain of 20 beds on RGH site</li> </ul>		

### 3.5.4 Medical and Surgical Processes

Appropriate clinical pathways must be in place across internal hospital departments and specialties to give patients an optimal Unscheduled Care journey from attendance to discharge. We need to ensure that hospital departments and specialties are geared with appropriate links to pull patients from the Emergency Department in a timely manner, with appropriate workforce and job planning to ensure that this becomes a reality. This includes:

- Triage to appropriate assessment.
- Flow through ED (early decision to admit, delegated admission rights).
- Access to senior decision makers (ambulatory care, frail pathway, ENP led Minor injury services).
- Access to assessment/diagnostics (prompt access to diagnostics, specialist assessment).

The objective for the essential action this year will be as follows:

- Review, simplify and redesign of front door assessment pathway for adults and older adults to enhance access to senior decision makers, increase ambulatory care capacity and early decision to admit.
- Consolidate investment in Emergency Nurse Practitioners; delivering nurse led minor injury services that consistently deliver 95% + compliance against the 4 hour target.

These actions should ensure that there is prompt access to appropriate assessment and clinical intervention from specialists in the appropriate environment to enhance patient experience and establish care management plans promptly, minimising unnecessary waits and delays wherever possible.

Table 3.5.9

Desired Outcome/Impact	Measure	Plan	Time Frame
<b>Redesign of Emergency Front Door at NHH</b> to ensure patients are assessed in the most appropriate area for their clinical need and access the appropriate treatment as soon as possible to deliver: <ul style="list-style-type: none"> <li>▪ Effective triage and decision making at the time of presentation</li> <li>▪ Prioritisation and streamlining of patients to the most appropriate area for their need</li> <li>▪ Reduce delays in triage and assessment</li> <li>▪ Achievement of 4 hour target across all assessment areas</li> <li>▪ Rapid assessment of critically ill patients at the front door and streamlining to Resus/Majors facility</li> <li>▪ Timely senior clinical assessment to facilitate</li> </ul>	<ul style="list-style-type: none"> <li>▪ Improvement and achievement of 4 and 12 hour target across both ED and EAU</li> <li>▪ Reduced LOS</li> <li>▪ Increased assessed out rates for ED and EAU</li> </ul>	Programme Group to be established (inc managers and clinicians all Divisions, planning, QPS team and capital)	Feb 17
		Programme Group to finalise proposed "future" service model for NHH	Q1 17/18
		Proposed service model to be "tested" against corporate SCCC plan for NHH and final service model confirmed Executive Team/Board discussion and approval in principle to proposed service model	Q2 17/18
		Development of a Business Case to redesign the front door	Q3 17/18
		BC to WG for approval	Q4 17/18
			Q1 18/19

Desired Outcome/Impact	Measure	Plan	Time Frame
<p>early discharge and decision to treat or transfer onto external facility</p> <ul style="list-style-type: none"> <li>Co-located GP OOHs</li> </ul>			
<p><b>Consultant led assessment at ED/RGH</b></p> <ul style="list-style-type: none"> <li>All patients would be assessed by a Senior Decision maker at the time of arrival to ED and MAU</li> <li>Patients in ED would be streamed to a number of areas including: <ul style="list-style-type: none"> <li>✓ Redirection / Fast tracking (EGAU)</li> <li>✓ Majors</li> <li>✓ Minors</li> <li>✓ Ambulatory</li> <li>✓ D1W/MAU/SAU</li> <li>✓ Acute Care of the Elderly</li> <li>✓ SSU</li> </ul> </li> <li>ED would be less congested</li> <li>Patients would get to the right place at the right time to be seen by right clinician</li> </ul>	<ul style="list-style-type: none"> <li>Decongest ED</li> <li>Increased redirection</li> <li>Eliminate expected patients</li> <li>Reduction in corridor patients</li> <li>Reduction in patients held on ambulances outside the department</li> <li>Reduction in 12 hour waits</li> <li>Improve 4, 8 &amp; 12 hour performance</li> <li>Reduction in hospital acquired pressure ulcers</li> <li>Financial savings if Hospital Ambulance Liaison Officer not required</li> <li>Streamlining investigations (reduce costs)</li> </ul>	<p>Clinical Group to be established to lead identification of optimal service model and workforce to deliver consultant led assessment</p> <p>Agree streaming options with other directorates</p> <p>Increase streaming of ED patients to short stay</p> <p>Workforce Plan to support service model</p>	<p>Q1 17/18</p> <p>Q2 17/18</p> <p>Q3 17/18</p>
<p><b>D1W Redesign</b></p> <p>In order to promote flow, minimise length of stay it is proposed that D1W is re-designated to incorporate:</p> <ul style="list-style-type: none"> <li>Continuity of Clinical Management by ACP led Unit</li> <li>Dedicated bay for Ambulatory treatments</li> <li>Acute Medicine patients cohorted</li> <li>+/- Acute Care of the Elderly beds</li> <li>An increase in monitored spaces</li> <li>Decongestion of MAU &amp; ED seating areas</li> <li>Increased turnaround</li> <li>Improvement in the patient experience</li> <li>Ambulatory service increase to 5 days a week</li> </ul>	<ul style="list-style-type: none"> <li>An increase in discharge rate and length of stay</li> <li>Reduction in crowding</li> <li>Improvement in 4 hour transit time target</li> <li>Reduction in the number of patients over 12 hours in ED</li> <li>Reduction in ambulance delays</li> <li>Increase in early morning discharges</li> <li>Released time of Physician on call for PTWR</li> </ul>	<p>Develop SoP</p> <p>Integrate short stay capacity under ACPs</p> <p>Transfer Team established</p> <p>Establish Ambulatory Care Bay</p> <p>Increase ambulatory care from 3 to 5 day service</p> <p>Evaluate impact of service change to inform next steps</p>	<p>Q1 17/18</p> <p>Q2 17/17</p> <p>Q4 17/18</p>

### 3.5.5 7 Day Working

Our priority is to reduce variation in service and care provision across 7 days, the enhancement of 'out of hours' to improve the patient journey and prevent unnecessary waits and delays. Not every service needs to be available 24/7 but understanding the need and impact of the current provision is key to determining improvements and innovations required locally.

The focus within this planning cycle covers modernising therapy services, preparing for the introduction of 111 which is anticipated to go live within the Health Board Area by Q3 and aligning diagnostic to emergency stream.

Table 3.5.10

Desired Outcome/Impact	Measure	Plan	Time Frame
<b>Modernising Therapy Services at Front Door:</b> <ul style="list-style-type: none"> <li>▪ Establish models of service provision for appropriate services, to support transformed models of care across, e.g. 7 day Unscheduled Care</li> <li>▪ Therapy Services are integrated across acute, community and NCN models reflecting the requirements of the patient pathway</li> <li>▪ Advanced Therapy Practitioner roles, working alongside ANPs, deliver services traditionally provided by medical staff to meet service demand challenges.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Improved access and timeliness to of care</li> <li>▪ Access to Physio, &amp; OT in acute care will improve Hospital admission avoidance and Improved patient flow through Acute care</li> <li>▪ Improved access to therapy to enable earlier discharge from Green Ward and reduce LOS</li> <li>▪ Therapy performance and outcomes measured via TOMS</li> </ul>	<b>Redesign of Acute Therapy Provision:</b> Evaluate Pilot and identify resource required to support ongoing Therapy provision at the Front door (RGH and NHH) Develop inpatient therapy clusters plan to support model ward.  Evaluate Pilot of Green Ward Pilot of the impact of OT's and Physiotherapists reducing LoS and supporting complex discharge (YAB) to inform model ward development and inform future workforce plan. Continue to develop Therapy Assistant Practitioner role within inpatient therapy clusters.	Q1 17/18
		Develop business case to support ongoing Therapy provision at the Front door (RGH and NHH) And case to support ongoing Therapy provision of Green Ward of the impact of OT's and Physiotherapists reducing LoS and supporting complex discharge (YAB) to support model ward development and future workforce plan.	Q3 17/18

#### Implementing the 111 service within Gwent

The 111 service is an amalgamation of NHS Direct Wales and the GP out-of-hours service and is currently being piloted in Swansea, Neath Port Talbot and Bridgend. It is anticipated that 111 will be implemented within the UHB during 2017/18. The service will provide health information, advice and access to urgent care. Its purpose to ensure that patients are signposted to the right services and its functions, subject to evaluation of the pilots, will include:

- Identify and manage patients with complex needs by undertaking a holistic, multidisciplinary telephone assessment to determine the appropriate outcome in line with the patients' needs and wishes.
- Provide clinical support for health professionals working in the wider urgent and emergency care

system who may require advice or support in developing appropriate treatment or management plans.

- Provide clinical support to other colleagues working within the 111 service either on site or virtually by providing telephone advice to remote centres, with a potential for 3 way call management with patients.
- Support an effective interface between the 111 service and GP Out of Hours service by acting as 'flight controller' overseeing 111 call queues, assisting in routing calls to the right queue/health care professional, and making decisions as part of the wider 111 escalation process.

### Work Programme Overview

**Table 3.5.11**

1.	Confirmation of roll-out of 111 to ABUHB	Q1 2017/18
2.	Detailed plan to be submitted by Primary Care Division (end of January 2017) With implementation scheduled to commence in October 2017	

### 3.5.6 Ensuring the Patient is care for in their own home

The Health Board has developed a portfolio of services over the past few years to ensure the more patients with an unscheduled care episode can be optimally cared for, or discharged to their own home as soon as possible. These include:

- Services that enhance self-management and preventative programmes (Stay Well Plans).
- Improvements in access to enablement services for people with one or more major health conditions.
- Frailty service supporting acutely ill patients in their homes.
- End of Life pathways promoting living well and dying well at home.

The objective for the essential action this year will be as follows:

#### Alternatives for emergency medical assessment referrals in Primary Care

Given the large and increasing numbers of patients that are referred by their GP to acute assessment units the UHB will prioritise the development of plans for optimising access in General Practice for urgent care – e.g. same day consultation (face-to-face; telephone or home visit) with particular focus on the development of Urgent Care Hubs aligned with the Royal Gwent and Nevill Hall Hospitals Emergency Centres.

### Work Programme Overview

**Table 3.5.12**

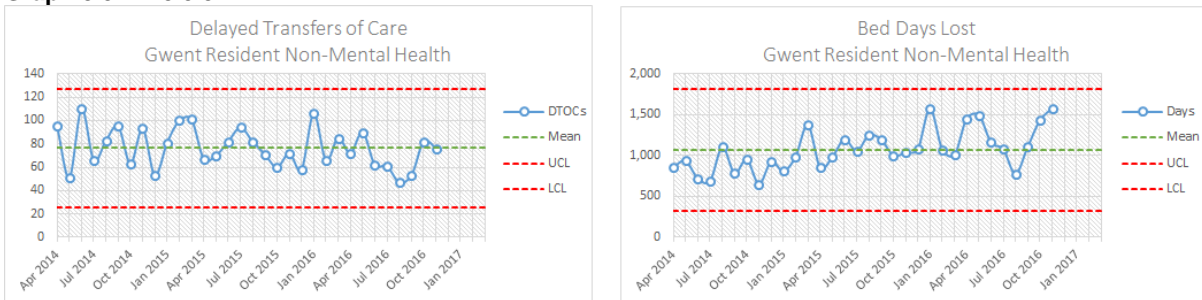
1.	Establish a multi-disciplinary group to oversee the development of plans to scope the feasibility of Community Hubs including Urgent Care Hubs	Q1 2017/18
2.	Complete a baseline assessment of the nature of GP referrals to assessment units and consider opportunities to reduce demand on secondary care services through providing alternative options in the community.	Q21 2017/18
3.	Identify options for to reduce demand on secondary care services through providing alternative options in the community, whether through workforce redesign, improved access to urgent diagnostic services, additional appointments or service reconfiguration and their feasibility.	Q2 2017/18
4.	Develop an implementation plan, including a risk assessment of deliverability	Q3 2018/19
5.	Develop contingency plans in the event of inability to achieve the alternative service options in community.	Q4 2017/18
6.	Review and monitor implementation plan	Q4 2017/18

#### Effective Transfer of Care

Early identification of patients with complex needs is well established together with robust Delayed Transfer of Care processes with partner agencies. The plan for 2017/18 further strengthens these links through reviewing the current discharge process and role responsibilities.

**Delayed Transfers of Care** there has been a general reduction in the number of Gwent residents reported as a delayed transfer of care (DTOC) for non-mental health services over the past 3 years. However, in this time there has also been an increase in the number of reported bed days lost each month. This indicates that although fewer Gwent residents are experiencing a delay in hospital, those who do experience a delay are likely to be delayed for longer than has previously been the case.

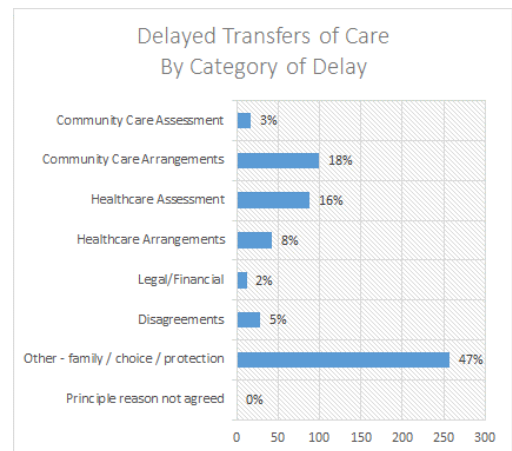
**Graph 3.5.1 – 3.5.3**



In the first eight months of 2016/17, there is a clear indication that the majority of delays affecting patient discharges from hospital related to issues involving the choice or availability of an appropriate care home placement.

This suggests that addressing the evident delays in the pathway from hospital to care home setting presents opportunities to further improve the flow of patients through the hospital system, thereby freeing up beds for those in greater need of specialist support provided in a hospital setting.

Encouragingly, DTOC performance in Gwent over the 11 month period of December 2015 to October 2016 compares well with the rest of Wales when weighted by the total population over the age of 75. However, Torfaen is an evident outlier, reporting the highest number of delays and the third highest number of bed days lost as a ratio of this population. This is consistent with the average length of stay in County Hospital which is the longest of all community hospitals in the Gwent area.



**Table 3.5.13**

		Population ≥ 75*	Accumulated DTOCs	Monthly DTOCs per 10,000 pop.			Population ≥ 75*	Accumulated bed days lost	Monthly bed days lost per 10,000 pop.
Delayed Transfers of Care (Dec15 - Oct16)	Pembrokeshire	13,540	74	5.0	Bed Days Lost (Dec15 - Oct16)	Pembrokeshire	13,540	1,126	76
	Blaenau Gwent	5,760	50	7.9		Blaenau Gwent	5,760	609	96
	Merthyr Tydfil	4,810	43	8.1		Monmouthshire	9,950	1,745	159
	Monmouthshire	9,950	103	9.4		Merthyr Tydfil	4,810	957	181
	Carmarthenshire	19,060	229	10.9		Ceredigion	7,900	1,803	207
	Ceredigion	7,900	99	11.4		Carmarthenshire	19,060	4,964	237
	Bridgend	12,360	159	11.7		Conwy	14,970	3,924	238
	Conwy	14,970	236	14.3		Newport	11,840	3,326	255
	Swansea	21,800	349	14.6		Bridgend	12,360	3,492	257
	Flintshire	13,290	231	15.8		Caerphilly	14,110	4,404	284
	Caerphilly	14,110	246	15.8		Flintshire	13,290	4,576	313
	Newport	11,840	219	16.8		Wrexham	11,350	4,164	334
	Rhondda Cynon Taf	19,230	399	18.9		Powys	15,520	5,879	344
	Neath Port Talbot	12,570	267	19.3		Rhondda Cynon Taf	19,230	7,586	359
	Gwynedd	12,610	278	20.0		Gwynedd	12,610	5,066	365
	Powys	15,520	345	20.2		Isle of Anglesey	7,820	3,337	388
Wrexham	11,350	264	21.1	Swansea	21,800	9,430	393		
Cardiff	23,640	571	22.0	Neath Port Talbot	12,570	6,438	466		
Isle of Anglesey	7,820	193	22.4	Denbighshire	9,790	5,025	467		
Denbighshire	9,790	271	25.2	Torfaen	8,170	4,851	540		
Vale of Glamorgan	11,780	334	25.8	Cardiff	23,640	14,575	560		
Torfaen	8,170	232	25.8	Vale of Glamorgan	11,780	8,685	670		

\* population based on 2015 population estimated provided by Institute of Public Care

### Medically Fit for Discharge (Green Patients) – My Care, My Home

The Health Board recognise that there are capacity and responsiveness challenges for Local Authority partners which have been heightened over the winter period. This results in patients who are medically fit for discharge staying in hospital setting longer than they require - cumulatively the impact is significant with on average three medical wards (90 beds) boarding patients who no longer need acute hospital care. The impact is magnified further when community hospitals are taken into consideration.

The focus of attending for 2017/18 is to seek new and innovative solutions that are less reliant on Local Authority Services to support the flow of medically fit patients from hospital settings in a timely manner. A pilot “My Care, My Home” is being progressed in Quarter 1, following evaluation further plans will be made to support medically fit patients returning to their preferred place of residence without avoidable delay.

Service Change Plan 2, **Care Closer to Home**, sets out plans for accessible and sustainable primary care; and integrated services for people with complex care needs – the plans have a significant impact on the urgent and emergency care system and should be read in conjunction with the priorities identified within this service change plan.

An overview of priority actions and impacts is shown below

**Table 3.5.14**

	Programme	Impact
Clinically Focused and Empowered Management	<ul style="list-style-type: none"> <li>Clinical and site management leads within site hubs.</li> <li>Revised Escalation plan</li> <li>Communication Processes.</li> <li>Bed capacity plan</li> </ul>	Smoothing the variability in performance to better match capacity with the pattern of demand. Improved compliance with Tier 1 targets for Emergency Care
Capacity and Patient Flow Re-Alignment	The use of meaningful, robust data, to determine and ensure demand and capacity are in balance at all stages of the patient pathway	Improved compliance with Tier 1 targets for Emergency Care and RTT
Patient Management	<ul style="list-style-type: none"> <li>SAFER Bundle</li> <li>USC Collaborative</li> </ul>	Increase number of daily discharges, time of day discharges. Improved productivity and efficiency (workforce, beds)
Medical and Surgical Processes	<ul style="list-style-type: none"> <li>Review, simplify and redesign of front door assessment pathway for adults and older adults</li> <li>Consolidate investment in Emergency Nurse Practitioners; delivering nurse led minor injury services that</li> </ul>	Reducing 12 hour waits Consistently deliver 95% + compliance against the 4 hour target. Reduce transit time in ED

	<b>Programme</b>	<b>Impact</b>
	<ul style="list-style-type: none"> <li>▪ Robust <b>Standard Operating</b> with inter-specialty service level agreements for time standards and practice standards, agreed across divisions and owned at all levels of the organisation.</li> </ul>	
Ensuring Patient is care for in own home	<ul style="list-style-type: none"> <li>▪ Implementing the 111 service within Gwent</li> <li>▪ Alternatives for emergency medical assessment referrals in Primary Care</li> <li>▪ Effective Transfer of Care</li> </ul>	<p>Reduction in number of patients attending ED</p> <p>Reduction in numbers of GP referrals for Emergency Medical Assessment</p> <p>Reduction in number of medically fit patients in acute hospital beds;</p> <p>reduction in bed days used for “green-2-go” cohort.</p>

### 3.6 SCP 6 - Planned Care

This SCP seeks to secure improvements in efficiency and productivity that in combination with prudent healthcare will improve access and deliver high quality, affordable and sustainable services.

The Health Board's Planned Care Board oversee the development and implementation of the transformation programme of elective and diagnostic services, including cancer services, that delivers improvements in access and is aligned with the Health Board's Clinical Futures Strategy and the National Programme for Planned Care. The aims and objectives of the Board are to lead:

- Health Board specific work-streams for:
  - Demand and Capacity;
  - Modernisation/transformation;
  - Informatics;
  - Efficiency/productivity;
  - Workforce.
- The Health Board's contribution to the current and future scope of the National Planned Care Programme:
  - ENT; Ophthalmology;
  - Urology; Trauma and Orthopaedics;
  - Outpatient transformation.
- The development of annual plans to improve elective and diagnostic access, delivering sustainable services that meet recurrent demand and aligned with the National Planned Care Programme Board.
- 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 in the table below:

**Table 3.6.1**

Planned Care Programme Board							
<b>Backlog RTT delivery</b>	<b>Outsourcing</b>	<b>Reporting and Performance Management</b>	<b>National Planned Care Programme</b>	<b>Integration</b>	<b>Cancer Delivery</b>	<b>Workforce</b>	<b>Efficiency and Productivity</b>
Profiles Activity Trackers and Plans Demand and Capacity refresh and early warning systems	Determination of need Management of contracts	Divisional - special measures Organisational - RTT assurance Compelling Score Card development via BI Escalation process and management	Implementation of existing plans Approach to develop our own plans for the service e.g. Radiology using same principles	Specific areas of work:  Optometrists Minor Oral Surgery Integrated Clinical Service Board Primary Care Diagnostic Hub Primary Care MSK Triage	Existing Structure and Approach - but governance through the Board	Recruitment  Capability  Service Improvement Focus	Delivery of Core  Comparison with peers  Benchmarking

### 3.6.1 National Planned Care Board

As part of the work of the National programme Care Board, The Health Board will be prioritising the following in 2017/18 and these will be augmented in year with the proposed extension to the scope of the Programme.

Table 3.6.2

Speciality	Health Board priorities
Orthopaedics	<ul style="list-style-type: none"> <li>▪ Msk Transformation.</li> <li>▪ Agreement on urgent category for OPD and treatments.</li> <li>▪ Expansion of knee bundle to reduce LOS for knees.</li> <li>▪ Review process and protocols for virtual fracture service within the South and extend service to North.</li> <li>▪ Continual improvement to work towards sustainable service and reduce variability.</li> <li>▪ Development of transitional plans.</li> </ul>
Ophthalmology	<ul style="list-style-type: none"> <li>▪ Expansion of ODTC- to three further sites. In addition commencement of new Glaucoma referrals to ODTC.</li> <li>▪ Utilisation of ABCi modelling tool to assist with the understanding of demand and capacity by patient condition, and potential for service redesign.</li> <li>▪ Reduction in delays of follow-up patients.</li> <li>▪ Review the HB's ability to develop clinical prioritisation to deliver service.</li> <li>▪ Development of transitional plans.</li> </ul>
ENT	<ul style="list-style-type: none"> <li>▪ OPD Transformation – service redesign (working with ABCi).</li> <li>▪ Review and agreement on urgency category.</li> <li>▪ Increase in day case rates.</li> <li>▪ Improvement in preadmission process.</li> <li>▪ Development of transitional plans.</li> </ul>
Urology	<ul style="list-style-type: none"> <li>▪ Appointment of substantive consultants to deliver sustainable service.</li> <li>▪ To develop method to track and deliver service by patient specific condition.</li> <li>▪ Urology cancers – concerns in relation to high cancer demand and high radiology input into pathway – to review pathway.</li> <li>▪ Development of transitional plans.</li> </ul>

### 3.6.2 Local initiatives

In addition to the work of the National Planned Care Board and the Health Board's efficiency and productivity work programme, the Health Board will be prioritising the following in 2017/18:

Table 3.6.3

Speciality	Initiative
Orthopaedics	<ul style="list-style-type: none"> <li>▪ Delivery of non-recurrent internal initiatives to clear backlog</li> <li>▪ Appointment of two ESPs for spines</li> <li>▪ Additional soft tissue knee post</li> <li>▪ Expansion of knee bundle to reduce LOS for knees – by a day</li> <li>▪ Reduction of LOS for THR – by a day</li> <li>▪ Development of theatre booking system to track booking (which will be rolled out to all specialities)</li> <li>▪ Spinal triage to include neck</li> </ul>
Ophthalmology	<ul style="list-style-type: none"> <li>▪ Outpatients transformation using ABCi modelling</li> <li>▪ Extension of ODTC for Glaucoma and referral of new patients</li> <li>▪ Review of utilisation for cataract lists</li> <li>▪ Increased FU Outpatient capacity</li> <li>▪ Advertisement of glaucoma posts</li> <li>▪ Managing cataract pathway</li> <li>▪ Engagement with ICHOM</li> <li>▪ Electronic DHR</li> </ul>

Speciality	Initiative
ENT	<ul style="list-style-type: none"> <li>▪ Outpatient transformation working with ABCi</li> <li>▪ Increasing day case rates</li> <li>▪ Improving and modernising preadmission process</li> <li>▪ Increase DOSA rates</li> </ul>
Urology	<ul style="list-style-type: none"> <li>▪ Mapping of service delivery by patient specific condition</li> <li>▪ Appointment of substantive consultants</li> </ul>
General surgery	<ul style="list-style-type: none"> <li>▪ Review readmission rates</li> <li>▪ Redesign of varicose vein pathway</li> <li>▪ Appointment of further two SCPs helping to modernise delivery of service</li> <li>▪ Appointment of substantive posts</li> <li>▪ Appointment of vascular advance nurse practitioner and vascular scientist</li> <li>▪ One stop vascular clinics</li> <li>▪ Virtual follow-up clinics</li> <li>▪ Introduction of nurse led claudication service</li> <li>▪ Speciality doctor undertaking independent outpatient and treatment sessions</li> <li>▪ Reduction in audit days by two per annum – therefore increase in DCC delivery</li> </ul>
Oral surgery	<ul style="list-style-type: none"> <li>▪ Complete review of delivery of service with the aim to streamline demand and capacity, review processes and service redesign</li> </ul>
Dermatology	<ul style="list-style-type: none"> <li>▪ Further expansion in Teledermatology</li> <li>▪ Review of processes and service delivery within Dermatology</li> </ul>
Gynaecology	<ul style="list-style-type: none"> <li>▪ Develop menstrual pathway.</li> <li>▪ Establish urogynaecology pathway</li> <li>▪ Improve weekend discharge rates.</li> </ul>
Radiology	<ul style="list-style-type: none"> <li>▪ Expand radiographer establishment to maximise physical infrastructure in MRI and CT</li> <li>▪ Collaborate with neighbouring Health Boards in regional response</li> </ul>
Endoscopy	<ul style="list-style-type: none"> <li>▪ Increase number of Gastro-enterologists</li> <li>▪ Increase capacity non-recurrently via Vanguard</li> <li>▪ Collaborate with neighbouring Health Boards in regional response</li> <li>▪ Development of capital case for sustainable &amp; JAG compliant endoscopy services</li> </ul>
Generic	<ul style="list-style-type: none"> <li>▪ Review of the pre-assessment pathway</li> <li>▪ Optimise theatre capacity across the Health Board, maximising the use of YYF</li> </ul>

### 3.6.3 Efficiency and productivity

Recognising the importance of improving productivity and efficiency, the Health Board will be prioritising the following in 2017/18 as part its Efficiency and Productivity work programme:

Table 3.6.4

Speciality	Initiative
Orthopaedics	Daycase rate, average LOS, excess referrals, New: FU ratio
Ophthalmology	Excess referrals
ENT	Day case rates
General surgery	ALOS, daycase rates
Urology	Excess referrals
Oral surgery	Excess referrals
Dermatology	Excess referrals
Gynaecology	Referral variation at practice level Virtual clinics to reduce FU backlogs Increase day case rates. Roll out use of myosure
Radiology	Optimise use of available infrastructure through extending working hours

Speciality	Initiative
Endoscopy	Standardise operator productivity Maximise backfilling of list
Generic	Complete roll out of Dr Dr

The above programme will support the Health Board to improve elective access and the SCP is subsequently structured as follows:

- RTT delivery including orthopaedic sustainability;
- Diagnostic waiting times;
- Cancer services;
- Outpatient transformation.

### 3.6.4 Prudent/Value Healthcare/Demand Management

In support of the Health Board's overarching prudent and value based approach to healthcare, the following will be prioritised in 2017/18:

Table 3.6.5

Speciality	Initiative
Orthopaedics	Osteoarthritis of the knee pathway Expansion of musculoskeletal pathway Spinal injection pathway Active monitoring of hip and knee patients
Ophthalmology	Glaucoma ODTC Wet AMD ODTC
ENT	Development of primary care audiology service
Oral surgery	Primary care minor oral surgery service
Dermatology	Further expansion of virtual outpatient service
Gynaecology	Labiaplasty INNU compliance. Clear referral criteria for sub-fertility
Radiology	Introduction of peripheral MRI scanning
Endoscopy	Extend roll of nurse endoscopists
Generic	Interventions not normally undertaken

The above programme will support the Health Board to improve elective access and the SCP is subsequently structured as follows:

### 3.6.5 Referral to Treatment Time

#### Baseline Position

Subject to the management of risks with a cohort of approximately 200 non-orthopaedic patients, the Health Board has plans to reduce the number of patients awaiting elective treatment to 1,200 waiting over 36 weeks at the end of March 2017, with these confined to orthopaedics. This represents a significant improvement on the outturn in 2015/16 where there were 2,682 patients waiting over 36 weeks, in a number of specialities.

#### Desired Future State

The Health Board 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.

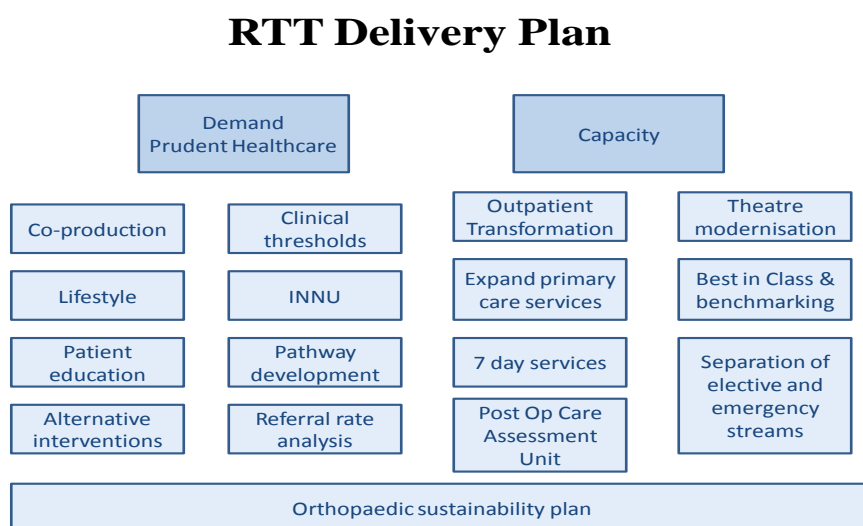
## Demand/Capacity Assessment

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 reductions to sustain the waiting list target. Whilst high level analysis has been undertaken for all specialities, more detailed subspecialty analysis has been undertaken for General Surgery and Orthopaedics.

## Plan for delivery

The Health Board's RTT delivery plan is illustrated below:

Figure 3.6.1



The Health Board 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 3.6.6

Speciality	Closing the treatment gap to achieve a maximum wait of 35 weeks	March 2018
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
Orthopaedics	Addressed through internal schemes.	500

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 is again included in 2017/18 and is fully reflected in the Health Board's Financial Plan.

## Profile for delivery

Based upon detailed plans, the Health Board's profile for improvement is included at **Annex C1**. The following table summarises the profile for improvement over the next three years.

Table 3.6.7

	March 2017	March 2018	March 2019	March 2020
26 week compliance	88%	90%	92%	95%
Breaches* of 36 weeks	1200*	500*	0	0

\*Breaches confined to orthopaedic, and subject to management of risks

### Governance Arrangements

Project Lead	Chief Operating Officer
Project Support	Divisional Managers and Assistant Directors of Performance and Planning
Project Structure	Health Board RTT Delivery Group
Reporting arrangements	Finance and Performance Committee and Planned Care Board
Plan status	Plan finalised

The Health Board has detailed profiles for improvement (Appendix C1) 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 Health Board 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 Health Board's overall workforce and financial plans and will be subject to further scrutiny.

### 3.6.6 Diagnostic Waiting Times

#### Baseline Assessment

At the start of 2016/17, the Health Board 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 endoscopy. Whilst there have been improvements in a number of modalities, there has been a deterioration in endoscopy with non-recurrent pressures in 2016/17 compounded by continued demand growth.

Table 3.6.8 – Patients waiting &gt;8 weeks

Modality	March 2016	March 2017
CT	319	0
MR	4	0
US	1437	0
Nuclear Medicine (MIBI)	5	0
Echo	206	0
Stress	36	0
Vascular US	120	0
Urodynamics	0	0
Endoscopies (all)	900	2500
<b>Total</b>	<b>3027</b>	<b>2500*</b>

\* Subject to the management of year end risk

#### Desired Future State

The Health Board seeks to deliver Best in Class diagnostic services through the following:

- Managing demand through prudent healthcare.
- Optimising capacity.
- Eliminating backlogs and providing sustainable services.

## Plan for delivery

The Health Board's Planned Care Diagnostic work programme is illustrated below for key modalities.

Table 3.6.9

Modality	D/C Gap	Solution
MRI	5,030	Commission internal capacity including peripheral MRI, together with mobile capacity.
CT	1,462	Commission internal capacity.
US	1,626	Outsource external capacity.
Endoscopy	8,085	Commission internal capacity, together with external capacity

The radiology plans prioritise the expansion of radiographer numbers to maximise the use of MR and CT infrastructure, so that all Health Board equipment operates extended days, 7 days a week. This will require the recruitment of 7.3 wte radiographers and 3.6 wte HCWS, which is a combination of converting variable pay to cover weekend lists and the expansion required to meet demand. This is considered a feasible level of recruitment and reflects the part year effect of recruitment in year. There is a residual gap for MRI which the Health Board would bridge via mobile capacity as part of the enhanced regional approach to diagnostic planning (see below). It is not anticipated that further radiographer recruitment is feasible in 2017/18 to address the ultrasound gap and as such external capacity will be again required to bridge this gap.

Through the expansion of home working, the Health Board will increase local radiologist capacity and where there are additional shortfalls will secure external reporting capacity after consideration of expansion of radiographer reporting. As described in Section 3.7.6 the Health Board is working with Cardiff & Vale and Cwm Taf Health Boards to improve Interventional Radiologist recruitment through the formalisation of an Interventional Radiology Network for South East and the provision of a 24/7 Interventional Radiology service.

For endoscopy, the Health Board's plans require the expansion of operator capacity to maximise the use of the Health Board's endoscopy infrastructure to meet recurrent demand (including high levels of backfilling and weekend lists) and the use of an external provider for additional backlog capacity. The former has identified a number of efficiency opportunities and the importance of backfilling lists to meet recurrent demand. It had been hoped to acquire a mobile suite for 12 months to enable the non-recurrent backlog to be cleared locally but this has not proven possible, and as a result it is proposed that external capacity be commissioned, and commissioning negotiations have commenced.

As part of its Gastroenterology Sustainability plan, the Health Board will be developing plans for its endoscopy services which will include a review of the current configuration of services and capital plans to meet both forecast demand and JAG accreditation.

### Regional Planning

Building on the work undertaken in support of the Diagnostic Hub at Cwm Taf UHB, the Health Board is working with Cardiff and Vale and Cwm Taf UHBs on both short term and long term plans to deliver sustainable radiology and endoscopy services in South Wales. In support of deliver in 2017/18, the UHBs will collaborate to ensure that internal capacity is maximised and that there is a collaborative approach to the closure of residuals gaps including mobile capacity. This will be augmented by the development of a strategic approach to long term sustainability across the region, informed by the work of the National Imaging Programme Board.

The Health Boards have agreed a work plan that includes:

- A review of benchmarking and efficiency across the three Health Boards with a focus on MRI and endoscopy.
- Development of a Joint Commissioning Plan for mobile MRI across Cwm Taf and Aneurin Bevan University Health Boards.
- Explore short term commissioning of external reporting within Cwm Taf University Health Board.

- Consider relative progress on demand management as a means of managing demand, including endoscopy referral criteria.
- Explore joint commissioning and external solutions (mobile and staff) for weekend working across the South East region.

### Profile for delivery

The table below summarises the profile for improvement in eight week diagnostic performance over the next three years.

Table 3.6.10

	March 2017	March 2018	March 2019	March 2020
% 8 month compliance	85%	Tbc <sup>1</sup>	100%	100%

<sup>1</sup> Endoscopy profile being confirmed with external provider

### Governance arrangements

<b>Project Lead</b>	Chief Operating Officer
<b>Project Support</b>	Divisional Managers and Assistant Directors of Performance & Planning
<b>Project Structure</b>	Health Board Access Group
<b>Reporting arrangements</b>	Finance and Performance Committee
<b>Plan status</b>	Plan drafted but not yet approved

### Workforce and Financial Impact

As demonstrated above, the Health Board 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 Health Board's overall workforce and financial plans, with the exception of the external endoscopy delivery plan, for which the Health Board recognises the need to manage the financial risks.

### 3.6.7 Cancer Services

#### Baseline Assessment

Over the last 12 months, the Health Board has shown continued commitment for cancer care. Despite a series of difficult and challenging operational pressures in delivering cancer services, there has been gradual progress and a number of improvements in the delivery and sustainability of the Health Board's Cancer Delivery Plan, as described in the Health Board's Annual Cancer Services Report ([hyperlink](#)).

#### Desired Future State

The Health Board 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 Health Board will deliver the urgent suspect cancer (USC) and non-urgent suspect cancer (Non-USC) care targets by the end of March 2017 and will subsequently sustain them.

Table 3.6.11

Parameter	2016/17	2017/18	2018/19	2019/20
Non USC	95%	98%	98%	98%
Urgent Suspect Cancer	85%	95%	95%	95%

### Demand and Capacity

There is evidence that the Health Board 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 Health Board 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 Health Board's Annual Cancer Report, can be accessed at [\(hyperlink\)](#). Through its Cancer Implementation Group, the Health Board will focus on five key priorities over the next 12 months:

- 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 Health Board. Acting on feedback and concerns raised during the peer review processes, the Health Board 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 Health Board 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 Health Board to retain its excellent reputation for cancer service delivery with our patients, Welsh Government and key stakeholders.

It is recognised that improvements in diagnostic waiting times are essential in sustaining improvements in cancer performance. The workforce plan for radiology described above is feasible, though there is a continued reliance, as with other Health Boards, on external reporting capacity.

### **Regional working to Transform Cancer Services in South East Wales**

The Health Board has played an active role in developing the Transforming Cancer Services Strategy with Velindre NHS Trust. The Health Board is supportive of both the Programme Business Case and the Outline Business Case for the development of a new Velindre Cancer Centre. This has provided the opportunity for the Health Board to review its strategy for the provision of cancer services within Gwent and in the coming year the Health Board will establish a Steering Group to oversee the development of its Cancer Services Clinical Strategy. This will necessarily be multidisciplinary and undertaken in partnership with Velindre NHS Trust. The Health Board has expressed an interest in establishing a Satellite Radiotherapy Unit at Nevill Hall Hospital as part of the Transforming Cancer Services Strategy and this will be taken forward in year, with the opportunity taken to consider how this potential development could act as a hub for cancer services in Gwent.

**Aligning our SCPs** that seek to deliver improvements in access, flow and quality of care with key enablers including finance, workforce and capital at a high level. The table below summarise the impacts that these service change plan is intended to deliver.

**Table 3.6.12**

<b>Key Theme</b>	<b>Delivering Improvements in Access, Flow and Quality of Care</b>
Finance	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.
Workforce	Additional workforce required to support Urgent & Emergency Care Plan including nurse consultants, pharmacists, ENPs/PAs/ANPs and radiographers. New workforce models are considered as part of the overall workforce plan and to support service sustainability. Better use of our resources is a key component of planned care with a focus on improving productivity.

Key Theme	Delivering Improvements in Access, Flow and Quality of Care
Capital	Capital plans include potential schemes to support A&E plans at Nevill Hall, potential improvement in breast services, and additional diagnostic equipment.
Digital Health	Extension of the Dr Dr intervention to all elective specialties, including therapies, to reduce DNAs and improve the patient booking experience.

### Outpatient transformation in the Health Board

The outpatient transformation programme has altered in scope and scale over the last 12 months. Since the previous IMTP a national Outpatient Steering group has been set up in order to support and focus attention on transforming outpatient services. One of the recognised challenges of Outpatient transformation is the overwhelming complexity of service provision. The transformation programme within Health Board, therefore, seeks to align itself to the national outpatient agenda.

The aim of the outpatient transformation programme within the Health Board is to ensure that patients receive appropriate and timely access to care, which is designed through the use of prudent healthcare principles. A three stage approach to commencing the transformation of outpatients is proposed:

#### Stage 1: Gather evidence of best practice from within the Health Board and beyond

This stage has been undertaken in line with the national outpatient agenda, seek to discover best practise within all of the Health Boards within Wales. As a consequence, a Good Practice guide is currently in development supported by all 7 Health Boards and 1000 Lives. Examples of good practice within the Health Board include:

Table 3.6.13

Stage	Example
<b>Pre – referral</b>	<ul style="list-style-type: none"> <li>▪ Community Osteoarthritis Group</li> <li>▪ Minor Oral Surgery Service</li> <li>▪ Diabetes Email Advice Line for GPs</li> <li>▪ Implementation of Primary Care Paediatric Constipation Pathway</li> </ul>
<b>Referral</b>	<ul style="list-style-type: none"> <li>▪ GP Email Advice Lines (Cardiology, Rheumatology, Urology)</li> <li>▪ High level coding of referral on receipt</li> <li>▪ Teledermatology</li> <li>▪ Advice Letters (Haematology)</li> <li>▪ Gynaecology Referral Audit</li> <li>▪ Collaborative Referral Validation; Reducing Risk in Tertiary Paediatric Cardiology Service</li> </ul>
<b>Triage</b>	<ul style="list-style-type: none"> <li>▪ Community Based Lower Back Pain Triage</li> <li>▪ Nurse Practitioners – multiple specialties</li> <li>▪ Direct listing Audiology Referrals</li> <li>▪ Direct listing hernia pathway</li> </ul>
<b>Booking</b>	<ul style="list-style-type: none"> <li>▪ Dr Dr Reminder Service</li> <li>▪ Centralised Colposcopy Booking Service</li> </ul>
<b>Utilisation</b>	<ul style="list-style-type: none"> <li>▪ Performance Management – clinic utilisation prospective and retrospective</li> <li>▪ CWS information for ad hoc analysis of clinic utilisation</li> </ul>
<b>New attendance</b>	<ul style="list-style-type: none"> <li>▪ Diagnostic coding in place e.g. Ophthalmology</li> <li>▪ Ophthalmic Diagnostic Treatment Centre for Wet AMD patients</li> <li>▪ Nurse injectors for AMD patients</li> <li>▪ One-stop Varicose Veins Service</li> <li>▪ Nurse Led Annual Review Clinic for Individuals with Serious Mental Illness</li> <li>▪ Respiratory Group Appointments for CPAP Set-up</li> </ul>
<b>Follow up attendance</b>	<ul style="list-style-type: none"> <li>▪ Virtual clinics; PSA urology, ENT, Rheumatology, Ophthalmology</li> <li>▪ Post-operative cataracts by Optometrists</li> <li>▪ Ophthalmic Diagnostic Treatment Centre for Glaucoma Patients</li> <li>▪ One stop head and neck lump clinic (Unscheduled Care)</li> <li>▪ See on Symptom Approach for MS Patients</li> <li>▪ Respiratory Drop-In Service for Patients with CPAP</li> </ul>
<b>Discharge</b>	<ul style="list-style-type: none"> <li>▪ See on Symptoms (Rheumatology)</li> </ul>

Stage	Example
	<ul style="list-style-type: none"> <li>▪ Knee Service Active Monitoring (New Project)</li> <li>▪ Electronic Discharging of Maxillofacial Patients</li> </ul>

### Stage 2: Innovation and demonstration of impact (March 2017-October 2017)

The evidence of best practice within the Health Board, and from the other Health Boards provides a great deal of scope to intervene in outpatients. The aim of stage 2 is:

- To combine the principles derived from the Best practise examples and focus those principles on one directorate in order to demonstrate impact and potential to spread and scale up.
- To develop the evidence based change package to support an improvement collaborative.
- To train frontline staff in the necessary skills to enable on-going continuous improvement within outpatient services.

ENT will be the initial focus for stage 2. The programme will be facilitated by ABCi and supported through the Planned Care Board.

### Stage 3: Outpatient Improvement Collaborative (October 2017 – April 2019)

The evidence and demonstrated impact from Stage 2 will be utilised to develop a change package to support an improvement collaborative. By utilising the IHI Breakthrough Series methodology, there is an opportunity to more effectively build capability, share learning, spread improvement, and scale up rapidly into other areas of the organisation. The intended programme, facilitated by ABCi, will take 3-5 directorates, build the necessary capability, test and implement improvements. In the following months more directorates will be brought into the Improvement collaborative, and will identified depending upon their readiness for change.

### Governance

The programme will be overseen and facilitated by ABCi. It will be governed the Health Board's Planned Care Board.

Table 3.6.14

Service	Specific Plan	Outcome
RTT	To deliver recurrent demand and further reduce elective backlogs through increasing internal capacity.	Reduce the number of 36 week breaches to 500 and to improve 26 week compliance to 90%.
Diagnostic	To deliver improvements in diagnostic waits by increasing local activity and commissioning external capacity to clear backlogs.	Eliminate >8 week waits.
Cancer	To sustain improvements in cancer performance through targeted intervention.	98% compliance achieved with non-unscheduled care target and 90% for unscheduled care.
	To develop a Strategic Cancer Plan for the Health Board.	Proposal submitted to establish a Satellite Radiotherapy Unit at Nevill Hall Hospital.

Table 3.6.15

	Mar 2017	End Q1	End Q2	End Q3	End Q4
RTT: 26 weeks %	88%	88.3%	89.5%	90%	90%
>36 weeks	1200	1,150	1,000	850	500
Diagnostic s:	2500	Tbc <sup>1</sup>	tbc <sup>1</sup>	tbc <sup>1</sup>	tbc <sup>1</sup>
Cancer: USC	85%	86.3%	87.5%	88.8%	90%
Cancer: NUSC	95%	95.8%	96.5%	97.2%	98%

<sup>1</sup> Endoscopy profile being confirmed with external provider

## Ensuring Service Sustainability

### 3.7 SCP 7 – Service Sustainability

This work programme focuses on the transition of services that are fragile and present sustainability issues over the next three years and in particular in advance of the SCCC.

#### 3.7.1 Paediatrics, Obstetrics and Neonatal Services

##### Aim

This SCP seeks to provide a transition plan for paediatric, obstetric and neonatal services within the Health Board prior to the anticipated opening of the SCCC in 2021.

##### Baseline Position

In 2015/16, the Health Board 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 at a 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. Whilst the Health Board has successfully managed risks within year and avoided extraordinary contingency measures, significant workforce pressures persist despite a detailed action plan that sought to strengthen recruitment and retention. 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. It has therefore become apparent that the service could not be sustained in its current configuration for the five years leading to the opening of the SCCC and that a transition plan would be required.

Within year, the Health Board has reviewed the clinical model for its inpatient paediatric services and appraised the impact of potential changes on interdependent specialties. There has been an assessment of the potential impact of changes on flows by specialty (within and outside the Health Board) if inpatient paediatric and interdependent services were reconfigured. This has included the potential retention of a Children's Assessment Unit to maintain local access. An option appraisal has been undertaken which has identified a clinically preferred option which will now be subject to extensive engagement and detailed planning in partnership with Aneurin Bevan and Powys CHCs and Cwm Taf UHB and Powys THB, including the timetable for potential change.

##### Desired Future State

The objective is to develop and implement a sustainable transition plan for inpatient paediatric and interdependent services for the population of Gwent and South Powys, working closely with Cwm Taf UHB and Powys THB. Subject to the outcome of engagement, this will probably require the centralisation of inpatient paediatric and obstetrics services as a transition to the model described within the Health Board's Clinical Futures Strategy.

The detailed planning will include the further development of the clinical model, its benefits, the sustainable workforce model, enabling infrastructure changes and resultant financial impact.

##### Work Programme Overview

To support the above the following milestones have been identified:

**Table 3.7.1**

1.	Project Manager to be appointed to support the process.	Jan 2017
2.	Collaborative structure established with Cwm Taf and Powys HBs	Q4 2016/17
3.	Clinical model to be refined and workforce plans retested	Q4 2016/17
4.	Patient flows to be reassessed and subject to sensitivity analysis	Q4 2016/17
5.	Agreement of engagement approach with CHCs	Q4 2016/17
6.	Feasibility assessment of capacity and enabling actions	Q4 2016/17
7.	Engagement phase	Q1 2017/18
8.	Modification of plans in response to engagement	Q2 2017/18
9.	Development of detailed implementation plan	Q3 2017/18
10.	Potential change in service provision	TBD

**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 the inpatient paediatric clinical model is contingent upon the retention of a Neonatal Unit at the Royal Glamorgan Hospital. There will also be interdependencies with the plans of Cwm Taf and Cardiff and Vale UHBs in implementing the outcome of the South Wales programme and the completion of relevant capital developments, including potential changes in the allocation of Paediatric trainees.

**Workforce and financial issues**

The financial costs of the current service are fully reflected in the Health Board's underlying position and the workforce and financial consequences of potential changes will be established as part of detailed planning. In the light of the complexity of the potential change, it is considered unlikely that changes in the service model will be model in 2017/18.

**Risks**

The Health Board is heavily reliant upon agency and locum staff, together with consultants providing resident Tier 2 cover at nights. It has sustained services on this basis without loss of service continuity for the last year but this cannot be maintained indefinitely. Whilst potential changes in service reconfiguration are being considered, the Health Board has continued to prioritise recruitment and retention, including MTIs.

**3.7.2 Neonatal Services****Aim**

This SCP seeks to ensure that the Health Board safely sustains Level 3 neonatal services within Gwent through the development and implementation of a workforce model independent of Deanery trainees as a transition to the SCCC.

**Baseline Position**

The Health Board provides Level 3 Neonatal Intensive Care Units at the Royal Gwent Hospital, and is one of three Neonatal Units in South Wales. The strategic configuration of services was affirmed by both the South Wales Programme and more recently by Joint Committee of the Welsh Health Service Specialist Committee. In response to a Deanery requirement to both reduce the number of Tier 1 & 2 trainees and have a minimum of 4 trainees on a rota, it was determined that two of the units in South Wales would be allocated trainees, with the third sustaining services through a new workforce model.

As an interim action, from September 2016 the Health Board implemented a new workforce model for its neonatal services following the redistribution of medical trainees (with Tier 1 posts allocated to the Royal Gwent Hospital and Tier 2 posts to Singleton). This led to the Health Board implementing a Tier 2 rota without medical trainees, with Clinical fellow posts augmented by a further increase in the contribution of Neonatal consultants to providing resident night shifts. In October 2016, the Joint Committee of the Welsh Health Specialist Services Committee accepted the recommendation of an independent expert panel that Neonatal Denary trainees in South Wales would be based at Singleton and the University of Wales, with agreement that an alternative workforce model be established from

March 2017 to sustain neonatal services within the Health Board as part of the South Wales Neonatal Network.

In anticipation of difficulties in recruiting and retaining Tier 1 rota posts, the Health Board had prospectively sought to enhance recruitment to both Tier 1 and 2 rotas, though this has proven problematic due to national issues with Medical Training Initiative numbers. At the time of submission, the Health Board has plans to achieve both Tier 1 and 2 rotas, with a single gap in the Tier 1 rota.

### Desired Future State

The objective is to implement and sustain a workforce model within the Health Board that is independent of Deanery trainees as part of enhanced collaboration with Neonatal Units in South Wales as part of the Neonatal Network.

### Work Programme Overview

To support the above aim the following milestones have been identified:

**Table 3.7.2**

1.	Pro-actively enhance Tier 1 rota recruitment, in particular MTIs and ANNPs, in preparation for the loss of Tier 1 deanery trainees in March 2017.	Q4 2017/18
2.	With the WHSCC Neonatal Workforce Group, finalise the appraisal of models for enhancing collaboration of Neonatal Units in South Wales for Joint Committee consideration	Q4 2017/18
3.	Review and revise escalation arrangements as part of service continuity planning	
4.	Complete final phase of Welsh Government funded neonatal capital development at Royal Gwent Hospital	Q4 2017/18
5.	Reopen expanded and enhanced unit	April 2017
6.	Actively support recruitment and retention to support new workforce model	Throughout 2017/18

### 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.

### Workforce and financial issues

The workforce impact of the new model are described in the Health Board's workforce plans, and associated additional costs are included in the Health Board's financial plan.

### Risks

Whilst the Health Board has been successful in recruiting additional MTIs, these are a staff group with a relatively high turnover and are posts of 2 year duration. The Health Board will continue to prioritise recruitment and retention as part of enhanced regional collaboration.

### 3.7.3 Surgical Specialties

#### Aim

This SCP seeks to develop a transition plan for its surgical services.

### 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. As described in its current plan, in 2016/17 the Health Board has implemented plans to maintain the current service configuration, with acute emergency general surgery and trauma intakes at both the Nevill Hall and Royal Gwent

Hospitals. This was enabled by the appointment of additional Clinical Fellows but these have been subject to similar pressures to those described above for Paediatrics.

### Desired Future State

The Health Board will ultimately centralise emergency and high acuity elective surgery at the SCCC and the Health Board will therefore seek to initially review its workforce strategy in maintaining services on two sites and subsequently consider the extent to which progress can be made in implementing the Health Board's Clinical Futures strategy for surgical services prior to the advent of the SCCC.

### Work Programme Overview

To support the above, the following milestones have been identified:

Table 3.7.3

1.	Multidisciplinary, cross Divisional group to be established	Q4 2017/18
2.	Review and refinement of current workforce strategy, including the current distribution of Deanery trainees	Q1 2017/18
3.	Appraisal of resilience of revised workforce strategy prior to advent of the SCCC	Q1 2017/18
	Subject to outcome of the above	
4.	Mapping of interdependent services and impacts of potential changes in service configuration	Q2 2017/18
5.	Review and refinement of clinical model	Q2 2017/18
6.	Patient flows to be assessed and subject to sensitivity analysis	Q3 2017/18
7.	Feasibility assessment of capacity, enabling actions and workforce and financial impacts	Q3 2017/18

### 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 feasibility or reconfiguring of emergency general surgery services prior to the opening of the SCCC.

### Workforce and financial issues

The financial costs of the current model are fully reflected in the Health Board's financial plans underlying position and the workforce and financial consequences of potential changes will be established as part of detailed planning. In the light of the complexity of the potential change, it is considered unlikely that changes in the service model will be model in 2017/18.

### Risks

Whilst the Health Board's Clinical Futures plans enable the centralisation of emergency surgery in each specialty, it may not be possible to achieve this within the current configuration of hospital services in Gwent due to the associated interdependencies.

### 3.7.4 Medical specialities

#### Aim

This SCP seeks to develop a transition plan for its surgical services.

### 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. Whilst the Health Board has undertaken actions in 2016/17 to address the anaesthetic issue, further work is required on the Health Board's medical specialities in the context of a transition plan prior to the opening of the SCCC.

The Health Board has 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.

## Desired Future State

It is desired that the Health Board agree an Education Contract with the Deanery whilst developing a transition plan for medical specialties leading to the opening of the SCCC.

## Work Programme Overview

To support the above, the following milestones have been identified:

Table 3.7.4

1.	Establish a multi-disciplinary group to oversee the development of plans to achieve the Education Contract in medical specialties.	Q4 2016/17
2.	Complete a baseline assessment of the current medical rotas and identify 'at risk' rotas.	Q4 2016/17
3.	Identify options for bridging the gaps, whether through workforce redesign, additional appointments or service reconfiguration and their feasibility.	Q4 2016/17
4.	Develop an implementation plan, including a risk assessment of deliverability to the August 2017 deadline.	Q1 2017/18
5.	Develop contingency plans in the event of inability to achieve the deadline, including work with neighbouring Health Boards via ACA structures.	Q1 2017/18
6.	Review and monitor implementation plan	Q2 2017/18

Table 3.7.5

1.	Establish a multi-disciplinary group to develop a transition plan for medical specialties leading to the opening of the SCCC	Q2 2017/18
2.	Review the clinical model for medical specialties at each site in the Clinical Futures model and the associated medical workforce	Q2 2017/18
3.	Extend modelling to include prospective flows	Q2 2017/18
4.	Refine capacity modelling in the light of updated clinical models and flows	Q3 2017/18
5.	Determine the extent to which changes can be made prior to the advent of the SCCC	Q4 2017/18

## Interdependencies

There are a number of key interdependencies between medical 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.

## Workforce and financial issues

The workforce impact of compliance has yet to be assessed and as such is not as yet included in the Health Board's workforce and financial plans.

## Risks

Whilst the Health Board's Clinical Futures plans enable the centralisation of an undifferentiated medical take, it may not be possible to achieve this within the current configuration of hospital services in Gwent.

### 3.7.5 Breast Service Sustainability

#### Aim

This SCP seeks to deliver sustainable breast services for the Health Board in the context of regional plans for South Wales

## Baseline position

The Health Board currently provides ambulatory and inpatient breast services at both Nevill Hall and Royal Gwent Hospitals. The current configuration of services lacks critical mass and is inflexible, resulting in longer waiting times than desired and suboptimal patient experience. There is a clinical

consensus that the centralisation of services would give critical mass and improve increase flexibility, with the opportunity through improved infrastructure to revise the clinical model to improve patient experience, efficiency and productivity.

### **Desired Future State**

The objective is to provide a centre of excellence for Breast Services within Gwent that improves patient experience and access, and which is consistent with both the plans for neighbouring Health Boards and the All Wales Imaging Strategy.

### **Work Programme Overview**

The Health Board undertook an extensive engagement strategy in 2016/17 and has secured agreement of both Aneurin Bevan and Powys Community Health Councils to proceed with the development of plans to create Breast Unit at Ysbyty Ystrad Fawr. Detailed operational and capital planning has commenced which will lead to the submission of a capital case to Welsh Government in June 2017.

### **Interdependencies**

There are a number of interdependencies, which have been fully taken into consideration, with a limited number of patients with co-morbidities requiring surgery at the Royal Gwent Hospital.

### **Workforce and financial issues**

There is no change in workforce and the centralisation will result in revenue savings which will be described in the detailed capital case.

### **Risks**

The availability of capital to support the creation of a Breast Unit at Ysbyty Ystrad Fawr.

## **3.7.6 Vascular Service Sustainability**

### **Aim**

This SCP seeks to deliver sustainable vascular services for the Health Board in the context of a strengthened South East Wales Vascular Network.

### **Baseline position**

The Health Board 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 Health Board, 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 Health Boards, who have asked for further work to be undertaken in the development of an enabling implementation plan and associated financial plan.

### **Work Programme Overview**

There is an active Vascular Group, under the leadership of the Director of Finance of Cwm Taf UHB, which is seeking to finalise the associated cases and determine the potential timetable for implementation. Initial priority is being attributed to strengthening interventional radiology services in

South East Wales, which requires the recruitment to three vacant posts to establish a 24/7 service and which is infrastructure independent. The Health Board is supportive of the 2017/18 Cardiff & Vale UHB capital proposal to convert an existing radiology room to a single plane room and provide additional capacity at the University Hospital of Wales. The creation of a hybrid theatre at the University Hospital of Wales is a rate limiting step in enabling centralisation and this will be subject to a capital proposal to Welsh Government, and it is supporting by the Health Board.

### 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.

### Workforce and financial issues

The workforce and financial impacts of change are being assessed as part of the detailed work programme. In its current plan the Health Board has made provision for costs of £500k in 2017/18.

### Risks

The key risks are include the 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, the availability of capital to support the creation of a hybrid theatre at UHW and the ability to create capacity (beds and theatres) at the hub to support additional activity.

The table below sets out the links to key enablers including finance, workforce and capital at a high level.

Table 3.7.6

Key Theme	Service Sustainability
Finance	The additional costs associated with the key service sustainability issues including medical staff issues, vascular services transfer are also included within the financial plan.
Workforce	Additional medical posts required to support the service sustainability issues with new workforce models and new roles being considered and adopted. Additional workforce required to support Urgent & Emergency Care Plan including nurse consultants, pharmacists, ENPs/PAs/ANPs and radiographers. New workforce models are considered as part of the overall workforce plan and to support service sustainability. Better use of our resources is a key component of planned care with a focus on improving productivity.
Capital	A Business Justification Case will be submitted for the Breast Development in 2017/18 and the capital implications of the Inpatient Paediatric Obstetric Plan will be determined. The capital implications of vascular service changes are included within the Cardiff & Vale UHB IMTP.

The table below summarise the impacts that this service change plan is intended to deliver.

Table 3.7.7

Key Theme	Service Sustainability
Well Being of Future Generations	The sustainability plans will increasingly consider their impact on the Health Board's response to the Future Generations Act.
Quality	The work of each element of the SCP reflects current standards in developing transitional and new models of care.
Productivity, efficiency, value	In developing new models, opportunities to improve productivity, efficiency and value are fully explained.

**Table 3.7.8**

<b>Service</b>	<b>Specific Plan</b>	<b>Outcome</b>
Inpatient paediatric and obstetric services	Transition Plan developed for paediatric and obstetric services.	Following engagement, implementation plan agreed with neighbouring Health Boards.
Neonatal services	Recruitment and Retention Plan implemented to deliver new workforce model.	BAPM compliant rotas implemented to sustain neonatal services at the Royal Gwent Hospital.
Surgical specialties	Recruitment and Retention Plan for surgical specialties implemented and alternative option appraised.	Surgical services sustained in current configuration and Transition Plan to SCCC agreed.
Medical specialties	Workforce and Education Plan developed to achieve compliance.	Education contract agreed with Deanery.
	Clinical Futures medical model to be reviewed and workforce plan updated.	Transition Plan developed for medical specialties.
Vascular services	Finalisation of case to centralise arterial surgery in South East Wales, including enabling operational and feasibility plan.	24/7 interventional radiology cover provided across SE Wales following recruitment of two additional posts in the Network.  Board agreement to centralise arterial surgery with enabling operational plan.
Breast services	Development of a Breast Centre of Excellence within the Health Board.	Capital BJC approved by Welsh Government.

**3.8 Older People**

This section sets out our headline ambitions for modernising care for older people in Gwent. It sits above and supports the delivery of other strategies aimed at improving the health and wellbeing of older people including the Health Board’s Dementia Strategy; Carers Strategy; Palliative Care Strategy (End of Life Care) and recent initiatives including the Frailty Programme, Elderly Frail Assessment Units, Anticipatory Care Planning, Stay Healthy Plans and Falls Pathway. Together these build a cohesive and comprehensive approach to meeting the care and support needs of older people.

The Health Board plans to provide an overarching Older People’s Framework to ensure that service for older people across the continuum of care from Home to Home is provided in a co-ordinated and seamless fashion. The Home to Home Framework recognises the older person’s ‘natural place of home’ through the care facility, be that acute hospital care, rehabilitation or community care, back to what is the normal/natural home place for the individual at the point of discharge from Health Board care or the transfer of care from one section of the Health Board to another– this could be a family home, assisted living facility, residential home or nursing care home.

Building on current social movements such as Ffrind i Mi, the framework would have a primary focus on the wider determinants of health and well-being and will bring members of the community together to take collective action and generate solutions to common problems. The Health Board is currently exploring funding options through the Integrated Care fund to provide a senior post/role to lead on this work.

Providing high quality care and support for older people is a fundamental principle of social justice and is an important hallmark of a caring and compassionate society. Demographic changes coupled with a decade of difficult public finances means this is one of the biggest challenges facing NHS Wales.

Supporting and caring for older people is not just a health or social work responsibility – we all have a role to play; families, neighbours and communities; providers of services like housing, transport, leisure, community safety, education and arts; and also shops, banks and other commercial enterprises. It is also important to recognize that older people themselves have a critical role to play in keeping other older people out of the formal care system and living independently at home; they actually, as a whole, provide far more care than they receive.

An important concern for older people is the increasing likelihood of unplanned or emergency hospital admission. It may be the right course of action for someone who has a potentially serious or life threatening health problem that needs urgent specialist investigation or treatment in hospital. However, for many older people an admission to hospital can be followed by complications such as a serious loss of confidence and confusion that prolong their stay, compromising their independence and ability to return home quickly.

**For Older People success is:**

- Being able to stay in their own homes for as long as possible.
- Having a greater degree of personalised care, being much more involved in planning their own care and better informed about their options and choices. Anticipatory Care Plans cannot work unless older people are far more involved in decisions about their own care.
- Joined up working between health and social care in terms of service planning, service delivery and use of resources.
- Support for carers and proper funding and support for older people to create networks of community groups.
- Regular health and wellbeing checks for over 75s.
- Hospital admissions providing solutions not creating more problems – prolonged hospital stays are not a good thing for a person's general well being, especially their sense of control and independence.
- Accessible services for people with dementia.
- Appropriate housing options, currently there is little choice for people who want to plan ahead to downsize or move into more appropriately designed accommodation, capacity for sheltered and very sheltered housing is limited and family homes with granny flat annex are limited.
- Response times for adaptations to people's homes are expedient and allow people to get home from hospital.
- Information about range of common issues (for example personal care entitlements, side effects of different medications, how to navigate through health and social care systems).

**Baseline**

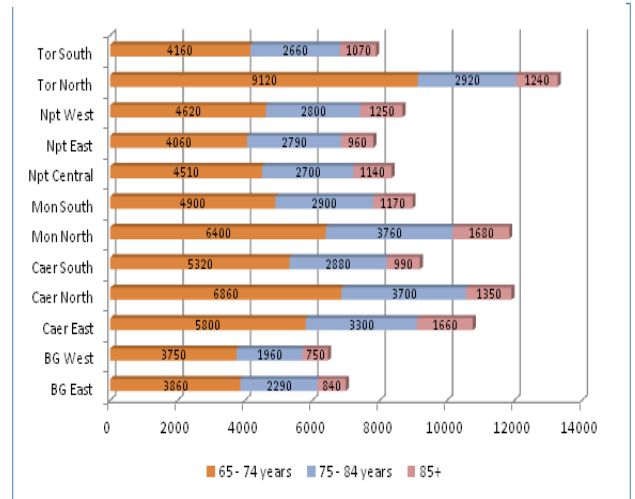
Gwent has some of the highest percentages of older people population at a Local Authority level when compared across all 22 Local Authorities in Wales:

- 1 in 5 residents are aged 65 years and older (108,500 people).
- By 2031, a quarter of our residents will be senior citizen (about 153,000 people).
- Prevalence of chronic conditions increases with age:

- At 65 – 74 years - 1 in 3 will have at least one chronic condition (21,200 people);
- At 75+ years – 3 in 4 will have at least one chronic condition (36,500 people).
- Since 1992, the number of citizens aged 85 years and older has doubled to 21,635 (2013) and is expected to be 35,440 by 2030.
- The prevalence of dementia is expected to rise from just over 7,000 (2013) to 12,000 by 2030.

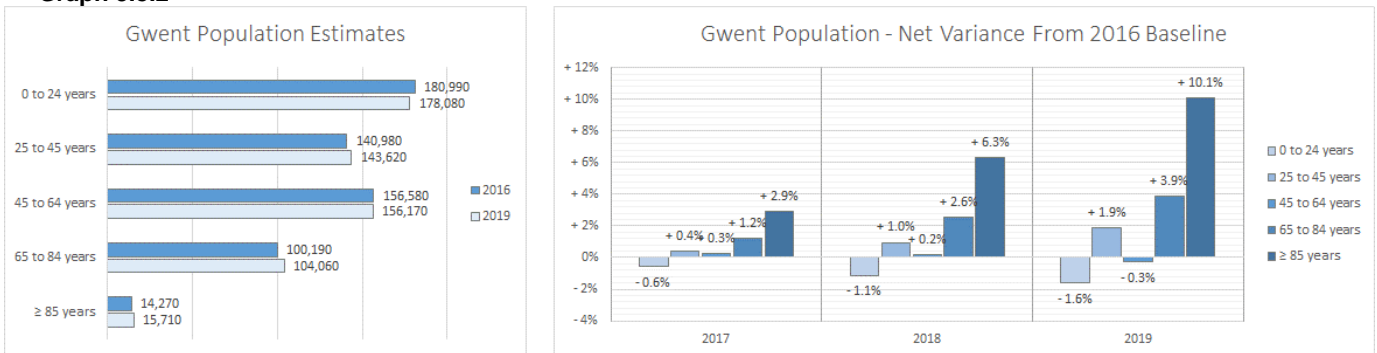
The Health Board has a higher percentage of patients with multiple morbidities, frailty, dementia and those needing help with daily living compared to other Health Boards in Wales. There are also stark differences in relation to life expectancy across Local Authority areas. Graph 3.8.1 shows the number of older people by age bands (65 – 74 years, 75-84 years, and 85+ years) by Neighbourhood Care Network.

Graph 3.8.1 - Number of older people by NCN



Over the coming 3 years it is anticipated that the total number of people aged over 65 years of age in Gwent will increase by 5% (from 114,460 to 119,770 in 2019), see the following graph.

Graph 3.8.2



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 – an illness such as diabetes, dementia or arthritis – and have more as their age increases. As the population ages it is anticipated that demand on services is likely to increase accordingly unless alternative methods of meeting older people’s needs are developed.

**Our approach to meeting the needs of older people**

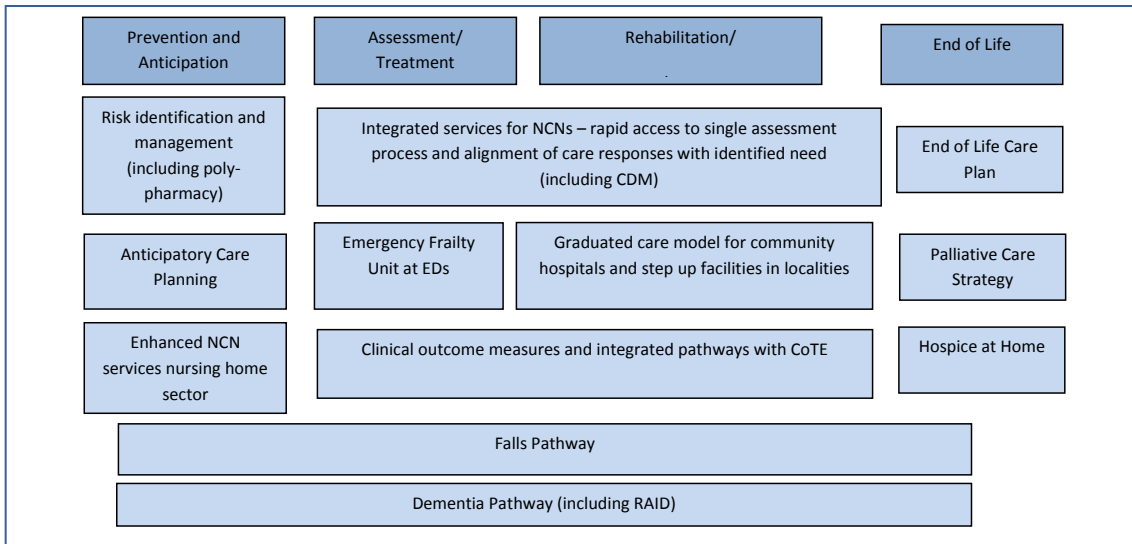
The Health Board adopts a whole system approach to the development and delivery of plans to improve services for older people. The overall scope of our Older People’s integrated pathway spans:

- Prevention and Anticipation** – health promotion, focus on healthy aging and specifically, risk stratification and anticipatory care planning of our older population with targeted intervention to minimise crises and links to the Wellbeing of Future Generations Bill in terms of preventing the preventable.
- Assessment and Treatment** – prudent healthcare principles covering person-centred non-urgent and low level supports, long term conditions maintenance, management of sub-acute and exacerbating illness within primary and community settings, urgent and acute care within hospital settings, and complex health care. The aim is to provide these services as locally and outside of hospital settings as possible, and to return patients to a state of well-being and independence as quickly as possible.
- Rehabilitation, Maintenance and Recovery**– ensuring service model integration across key areas including frailty, community and hospital based care to eliminate delays in discharging

patients home when they are medically fit and/or have reached their maximal functional ability. Supporting older people to maintain their health, well being and independence is paramount.

- **End of Life** – with an emphasis on enabling more people to die with dignity and in the place of their choice.

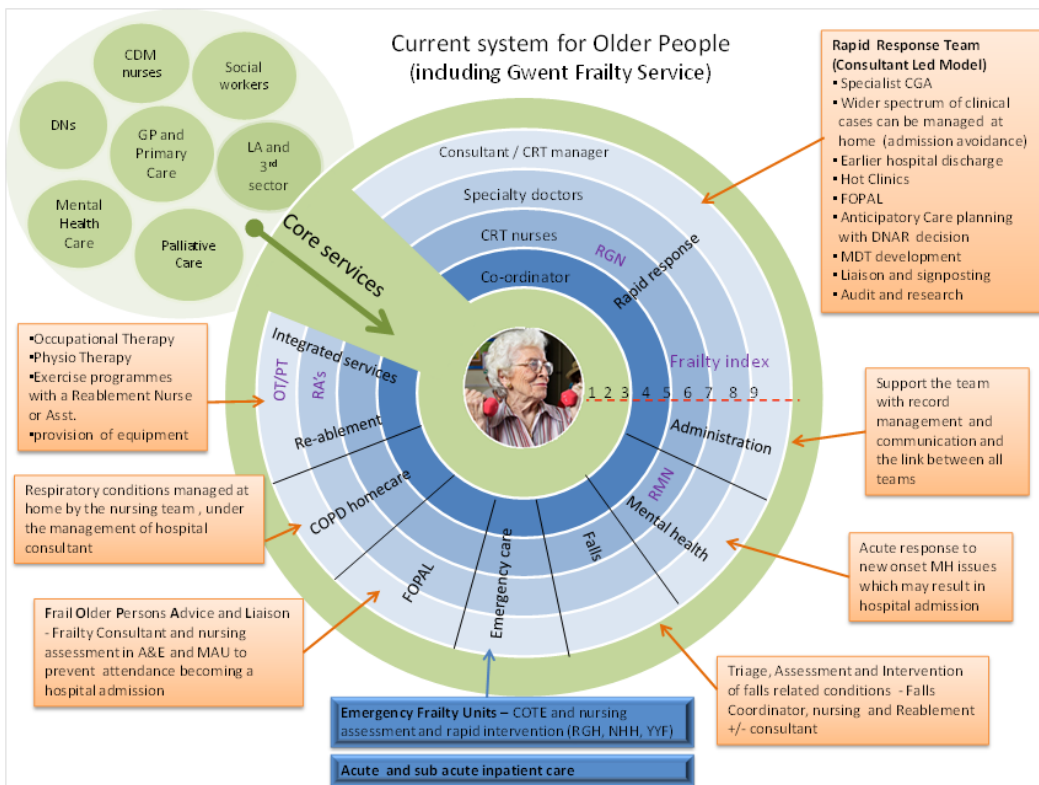
Figure 3.8.1



Elements of the overarching model have traditionally been delivered through discrete programmes, for example End of Life Delivery Plan, the Frailty Programme, or through a number of service change plans, for example, the Elderly Frail Unit within the Urgent Care Plan, or the community bed plan within the Primary and Community Divisions operational plan.

In April 2011, following the agreement of Welsh Government to invest in new services for streamlined services for vulnerable people in their own home; the Health Board launched the Gwent Frailty Service, a joint initiative between the Health Board and the five Local Authorities aimed to facilitate early discharge and provide safe alternative pathways to hospital based care for frail older people. Figure y illustrates the Gwent Frailty Model. It sets out the level of response the service provides aligned with the individual’s level of need as expressed by the Frailty Index.

Figure 3.8.2



**Dalhousie Clinical Frailty Scale:**

- 1 - Very Fit
- 2 – Well
- 3 - Managing Well
- 4 – Vulnerable
- 5 - Mildly Frail
- 6 - Moderately Frail
- 7 - Severely Frail
- 8 - Very Severely Frail
- 9 - Terminally Ill

Source: Dr J Kitson, Dr K Barnes

Through the joint development and implementation of our frailty model, local health and social care services have made progress in delivering key elements of the older persons' pathway as illustrated in the following figure.

**Figure 3.8.3**

Preventative and Anticipatory Care	Proactive Care and Support at home	Effective Care at times of transition	Hospital and Care Home(s)
<ul style="list-style-type: none"> <li>• Build social networks and opportunities for participation (social prescribing, community connectors, scripts for loneliness)</li> <li>• Early diagnosis of dementia</li> <li>• Prevention of falls and fractures</li> <li>• Information and support for self management and self directed support (living well, living longer, smoking cessation/obesity, alcohol)</li> <li>• Prediction of Risk (of recurrent admissions), stay healthy plans Newport OPP</li> <li>• Anticipatory Care Planning</li> <li>• Suitable and varied housing and housing support</li> <li>• Support for Carers</li> </ul>	<ul style="list-style-type: none"> <li>• Responsible flexible self-directed home care (respiratory and diabetes community pathways)</li> <li>• Integrated Case/care Management (CRTs)</li> <li>• 24/7 district Nursing Services</li> <li>• Carer Support</li> <li>• Rapid access to equipment</li> <li>• Timely adaptations including housing adaptations</li> <li>• Telehealthcare</li> <li>• Access to timely primary care (demand/capacity, triage, federations/mergers, skill mix)</li> </ul>	<ul style="list-style-type: none"> <li>• Reablement and rehabilitation (CRTs)</li> <li>• Specialist clinical advice for community teams (rapid access assessment teams)</li> <li>• 111, Out of hours access to Advanced Care Plans</li> <li>• Range of intermediate care alternatives to emergency admission</li> <li>• Responsive and flexible palliative care</li> <li>• Medicines management</li> <li>• Access to range of housing options</li> <li>• Support for Carers</li> </ul>	<ul style="list-style-type: none"> <li>• Urgent triage to identify frail older people (ACPs, EFU), Ambulatory Care</li> <li>• Early assessment and rehabilitation in the appropriate specialist unit</li> <li>• Prevention and treatment of delirium</li> <li>• Effective and timely discharge home or transfer to immediate care (Safer bundle in community and secondary care hospitals - LOS/DToC, in-reach teams)</li> <li>• Medicine reconciliation and review</li> <li>• Specialist clinical support for care homes</li> <li>• Carers as equal partners</li> </ul>

The Health Board continues to work in partnership with patients, carers, public sector partners and the third sector to roll out service models that work well for our communities. Our aim, over time, is to ensure consistency and equity of access for our older citizens to every component of the older person's pathway.

### **Priorities for Improvement**

#### **1. Patients with Complex Care Needs**

The Health Board continues to struggle to meet the needs of older people presenting into the acute hospital system with "complex" care needs. Essentially, this relates to people who have multiple co-morbidities and enter the system either through referrals for emergency medical assessments or as majors through our Emergency Departments. The recent review of our Emergency Care System by Professor Bell recommended a root and branch review of the whole system response to patients with "complex" care needs.

Establishing the appropriate structures, mechanisms and Executive leadership to drive and deliver this review is a key priority for 2017/18. Details to be provided in March iteration of the IMTP

#### **2. Falls Prevention**

This plan aims to reduce the number of avoidable falls in the community and hospital settings to benefit individuals in terms of their health and wellbeing

#### **Why preventing falls matters**

- Patient falls have both human and financial costs; for the individual patient the consequences range from distress and loss of confidence, to injuries that cause pain and suffering, loss of independence and, occasionally, death (Slips, Trips and Falls in Hospital, NPSA 2007).
- Falls and falls related injuries are a common and serious problem for older people. People aged 65 years and older have the highest risk of falling, with 30% of people older than 65 and 50% of

people older than 80 falling at least once a year (NICE Clinical guideline 161, 2013)

- Falls prevention is a key component of the Health and Care Standard 2.3. The standard is about minimising the risk of people falling and promotes the assessment of a range of factors which are known to increase the risk of falling, as well as the importance of developing individual care plans which aim to prevent individuals from falling in order to reduce harm and disability.
- In April 2016, the Welsh Government issued the Principles, Framework and National Indicators: Adult In-Patient Falls, WHC (2016) 022. This stated that inpatient falls are the most frequently reported adult in-patient clinical incident and are a significant patient safety challenge for the NHS in Wales. The effects of falls can range from no harm to serious injury and death. However, even those falls that do not result in serious harm can cause a great deal of distress, particularly for those who are elderly and/or frail, resulting in consequences that can threaten an individual's independence. As the average age of patients is rising the number of falls related to serious incidents is increasing, it is therefore timely to ensure the necessary safeguards are in place and being carried out to minimise the number of falls across all health boards in Wales. Serious inpatient falls will inevitably prolong the length of time a patient is required to stay in hospital and may lead to permanent disability and reduction in a patient's independence.
- In October 2016, 1000 Lives launched the National Falls Taskforce which followed on from the 'Aging Well in Wales' expert advisory group, established by the Older Peoples Commissioner. The taskforce aims to bring together partners across Wales looking to prevent falls in older people with an emphasis on sharing best practice and raising awareness - linked to this will be a National public awareness campaign; the development of home based screening programmes; data sharing; and mapping falls prevention activity across Wales. The Health Board is a member of the taskforce and is actively involved in its activities.

**How is the Health Board working to prevent falls?** The Executive Director of Therapies and Health Science is the corporate lead for falls prevention and management. Over the past two years, this heightened level of Executive oversight has seen the establishment of:

- **Falls Steering Group** - oversees the development, implementation and monitoring of a Falls Action Plan (attached) to improve the prevention and management of falls across the Health Board. The group is multidisciplinary and covers both acute and community services. The group is chaired by the Executive Director and meets bimonthly. The group involves the Community Health Council as a core member. The Group reviews and monitors falls data across the Health Board and reports progress against the Falls Action Plan to the Quality and Patient Safety Committee.
- **Preventing Community Falls** – the Health Board has well established, locality based Falls Services managed by the Community Resource Teams (CRT). Each CRT has a Falls Coordinator to oversee and coordinate the falls service. The locality based falls services receive referrals from a range of sources, including primary care, community based teams and acute hospitals. Individuals are referred to the falls service if they have previously fallen or are at risk of falling and will receive assessment and ongoing care plan from the multidisciplinary team, including medical staff. Much of the care plan is delivered in the home setting, placing an emphasis on improving and maintaining independence.
- **Preventing In-patient Falls** - the Health Board is prioritising preventing in-patient falls. There has been a real focus on this since the end of 2015, following publication of data in National Clinical Audits which shows:
  - Falls are always the highest reported type of incident on Datix, and older people account for the majority of in-patient falls.
  - The Health Board had 8.65 falls per 1,000 occupied bed days, with an audit average of 6.63 and an inter-quartile range of 5.46-7.7. (Although this data comes from incident reporting and can therefore be influenced by a positive reporting culture, the data on percentage of patients who receive the interventions to prevent falls in the NICE guidance showed that we have work to do

to ensure all patients have the appropriate interventions).

- The 2015 National Hip Fracture Database (NHFD) showed we have the highest percentage of fractured neck of femurs from inpatient falls in Wales, and the average percentage for Wales is higher than the overall audit average. The 2016 NHFD report (covering 2015 data) shows a big reduction in this percentage at RGH from 10.7% to 4.0% (but case ascertainment is 77%) and just a small reduction at NHH from 10.8% to 9.3% (case ascertainment 95%).

### **Priorities for this Planning Cycle**

The Falls Steering group has prioritised 3 areas of work to specifically reduce inpatient falls:

#### **Falls Policy**

The Falls Steering Group has overseen an update and revision of the existing Health Board Policy for the Prevention and Management of Adult In-patient Falls. The policy has been updated to:

- Reflect and incorporate NICE Clinical Guidelines 161: Falls in older people: assessing risk and prevention (2013).
- Reflect and incorporate the recent Welsh Government requirements on Health Boards set out in WHC(2016)022: Principles, Framework and National Indicators: Adult In-Patient Falls.
- Provide a new Adult In Patient Falls Risk Assessment Screening Tool and a revised Falls Multi Factorial Risk Assessment (MFA) Tool.
- Provide a revised Falls flow diagram for patients who are prescribed anticoagulants.
- Update links to other, current ABUHB policies and guidelines.

As part of the process of revising the Falls MFA Tool, it has been piloted on a number of inpatient wards within the Health Board to gain feedback directly from ward based staff on its ease of use and effectiveness. The policy has also been approved for publication by the Clinical Standards and Policy Group in November 2016.

#### **Falls Business Case**

The Health Board understands the importance of good compliance in adopting the revised policy, especially with regard to using the falls multi-factorial risk assessment tool when patients are first admitted to the ward; this is considered a critical step in preventing an inpatient fall. To achieve the required reduction in avoidable inpatient falls it is considered that the policy itself, with the new MFA tool and guidance will not be enough to achieve any significant difference. The Falls Steering Group has identified the need for formalised training at ward level for Nurses, Healthcare Support Workers and AHPs.

In response, the Falls Steering Group proposes an Inpatient Falls Prevention Strategy; this will include audit, training, monitoring, advice and support that covers all 103 inpatient wards (nurses, domestic and facilities), and associated clinical teams (OT, Physios and Social Workers). A falls prevention training curriculum will be developed consistent with the policy and based on best practice from existing initiatives within the UHB and across the UK.

To deliver the strategy as described, the Health Board will need to establish a new inpatient fall prevention infrastructure that will sit alongside, and complement, the existing community falls infrastructure; this will ultimately provide a single, coordinated, consistent and seamless Falls Service. A business case which seeks investment for this additional falls infrastructure is being considered.

#### **Falls Scrutiny Panel**

The Falls Scrutiny Panel was established in 2016; it reviews the investigation of all in-patient falls that result in a fracture, has 3 main aims:

- To provide an overview of in-patient falls with fractures – numbers and locations, as well as systemic issues and learning – and highlight and spread good practice.
- To review the investigation of each fall to understand whether there was a falls risks assessment and appropriate interventions were put in place to reduce the risk of falls for that individual.
- To decide whether the fall was unavoidable or potentially preventable and should be considered for referral to redress.

The Health Board's Falls Action Plan is attached in Appendix 7 and describes the full range of falls prevention activity being undertaken in both the community and acute settings (including the above inpatient falls prevention priorities) and the general direction of travel for falls prevention over the next three years of the IMTP.

Figure 3.8.4

### 3. Dementia

The regional Dementia Strategy for the Gwent area has been developed by a regional Dementia Board comprising the Aneurin Bevan University Health Board, five local authorities, third sector partners and carers, and will form the basis of our priority actions to improve the care of people with Dementia over this planning period.

We know that one in five people over the age of 85 will potentially develop dementia – on that basis currently 8,000 people in our area are living with dementia – and this impacts not only on them but their families, friends and the community in which they live.

The strategy we have developed recognises that more people are living at home with dementia than in hospitals or care homes, and our focus has been as much on raising awareness among both the general population and professionals, to make our communities more “Dementia Friendly”, whilst also improving diagnosis rates and services to support people.



### What People Living with Dementia and their Carers told us.

#### Through our engagement with people living with dementia and carers we were told

- We need to raise greater awareness of dementia in the community so everybody has an understanding of dementia and what life is like for people living with dementia
- Support when we need it

The views of people living with dementia and their carers are paramount to the plans that we make to improve services for patients and their carers. Our Dementia Board has developed strong relationships with Alzheimer's Society and in particular the local Dementia Friendly Cafes and other groups such as the Carer's Group in Pontypool. This enables us to regularly engage with people living with dementia.

We also seek to promote a fuller understanding of the carer journey, providing a platform where carers can express their views and experiences of caring for a loved one with dementia. We will link with the regional Carers Board and our high level aims are to:

- Capture the experiences of carers with a view to informing future policy and service provision
- Raises awareness of the issues around caring for someone with dementia including health and social care professionals and the wider public
- Highlight the role of carers as natural resources; carers as people with needs; carers as people with independent lives.
- Enable the Carers Strategy for Wales, Carers Measure, (2010) through the work of the Gwent Carers Board.

People living with dementia have given very clear messages about what is important for them and the quality of their life:

1. "I have personal choice and control or influence over decisions about me."
2. "I know that services are designed around me and my needs."
3. "I have support that helps me live my life."
4. "I have the knowledge and know how to get what I need."
5. "I live in an enabling and supportive environment where I feel valued and understood."

As a Dementia Board we aim to harness the partnership working in the region to meet the priorities identified by people living with dementia, their carers and the key pieces of legislation in Wales. This means identifying a framework to identify joint priorities and share responsibility and governance for actions. It is paramount that the board delivers:

1. Plans which can be achieved collectively.
2. Priorities that cannot be achieved locally and requires wider partnership involvement.
3. Priorities within each organisation that can be delivered regionally.

Our focus and priority actions are set out in the Outcome Measures Framework for Dementia shown as Appendix 8. In broad terms it will enable our health and social care community to:

- Developing Dementia Friendly Communities and creating local dementia supportive initiatives
- Delivering Dementia Friends awareness sessions and Dementia Champion training.
- By encouraging businesses and organisations to adopt dementia friendly community accreditation kite mark and logo.
- By reflecting the voice of people with dementia and the 7 priority outcomes in the work that we undertake on their behalf.
- By developing workforces which are **'Informed, Skilled and influencers'** and learning from colleagues, people with dementia, carers and best practice (see Good Work Dementia learning and development framework for Wales 2016).
- Reducing variability, duplicated effort and aligning dementia improvement activity by setting out our priority areas and desired outcomes.

### 3.9 Maternal and Child Health

#### Current Service Provision

The UHB delivers a range of maternity and children's services in both the community and acute setting. Detailed plans for maternal and child health have been developed by our Families and Therapies Division and dovetail with relevant plans and strategies in Public Health, Primary Care and Community and Mental Health and Learning Disabilities divisions as well as relevant multi-agency and multi-disciplinary partnerships and regional planning fora. They are underpinned by relevant strategies and guidance including:

- National Service Frameworks.
- Strategic vision for maternity services in Welsh strategy.
- Welsh Government screening and immunisation policy.
- Healthy Child Wales programme.
- Special educational needs guidance.

Our operational plans continue to deliver and maintain National Service Framework standards for children, young people and maternity services and important mechanisms such as complying with child safe-guarding requirements.

Breast feeding rates are monitored through our key performance indicators and reported to WG on an annual basis. All three units have baby friendly accreditation and peer support breast feeding support

has been rolled out across all sites.

Caesarian section rates are also monitored through our key performance indicators and have continued to reduce below the recommended standard of 25%. This continues to improve with the introduction of STAN fetal monitoring and additional training and education for STAN and CTG.

### Key Priorities

Our priorities are incorporated into our corporate Service Change Plans which are overseen through our executive led boards. An overview of these is encapsulated in the table below.

**Table 3.9.1**

Service Priority	Delivery Plan
Improve uptake of childhood immunisations especially disadvantaged groups.	SCP 1 - Population Immunisation and vaccination programmes
Disease prevention through population scale services to support lifestyle changes, e.g. increasing maternal smoking cessation rates, reducing childhood obesity and prevalence of Type 2 Diabetes.	SCP 1 – Implementation of a new Tier 3 weight management service for children and families. Smoking cessation action plans. Implementation of MECC within Midwifery (making every contact count).
Deliver the outcomes of the Healthy Child Wales Programme.	ABUHB HCWP Phase one implementation was commenced on 1 <sup>st</sup> October 2016.
Improve timely access to Specialist Child and Adolescent Mental Health services.	SCP 4 – Access work programme
Identify and develop the role of the lead clinician for coordinating health support for children with special educational needs.	TBA
Consolidate and evaluate the newly established multi-disciplinary service for Integrated Specialist Children with Additional Needs (ISCAN)	SCP 4- Access work programme
Provide access to appropriate health care support for victims of domestic violence, looked after children and vulnerable young people.	SCP 4 – Access work programme: integrated care pathway for vulnerable young people.
Sustainable services for inpatient paediatrics for Gwent and South Powys.	SCP 7 – Sustainability plan for paediatrics, obstetrics and neonatology
Sustainable level 3 neonatal and obstetric services within Gwent to address workforce shortages caused by the withdrawal of trainee doctors.	SCP 7 – Sustainability workforce plan for neonatology.

## Enablers

The success of developing and implementing our strategic change plans and our Clinical Future's Strategy is reliant on an effective infrastructure and enablers to underpin the delivery of safe, effective and patient centred care. Our key strategic enablers are:

- Welsh Language;
- Workforce;
- Finance;
- Estates and Facilities;
- Informatics;
- Research, Development and Innovation.

### 3.10 Welsh Language

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 of the Welsh Language (Wales) Measure 2011 which is further strengthened by the Welsh Government Follow-on Strategic Framework for Welsh Language Services in Health, Social Services and Social Care - 'More Than Just Words.....', Welsh Government's 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, and more recently feedback received from surveys undertaken at the Health Board by the Welsh Language Commissioner 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. The Executive Team have approved the recruitment of two Welsh Language Translators/Support Officers to help address this.

#### 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. We hosted the NHS Wales stand at the National Eisteddfod during the summer which has opened up new networks and opportunities for collaboration with the local community.

#### Milestones and Governance

Performance indicators will be tracked through the implementation of the Bilingual Skills Strategy, Training Plan, compliance with the proposed Welsh Language Standards, annual report to Welsh Government on the implementation of the Follow-on Strategic Framework 'More than just words..' National Outcomes Framework reporting, Primary Care Action Plan and annual report to the Welsh Language Commissioner. These are reported to Welsh Language Strategic Group which is chaired by the Director of Workforce and OD who feeds back to the Executive team and the Board.

## Benefits – Outcomes

Recruiting more Welsh speakers where possible, supporting our existing Welsh speaking staff, ensuring all staff undertake Welsh language awareness training and up skilling staff (~~in Welsh awareness and~~) who already have a certain level of 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 and will help ensure Welsh speaking patients are treated with dignity and respect. Quality and safety will be measured by patient feedback and concerns monitoring and staff training and skills will be tracked through the Electronic Staff Record.

### The principle areas for delivery in 2017 will be:

- On-going delivery of the 'Welsh Language Follow-on Strategic Framework....More than just words Action Plan/Objectives' with particular focus on the promotion and continued embedding of the 'active offer'.
- Ensure organisational readiness for the implementation of the Welsh Language Standards in 2018
- Continued collaborative working with primary care colleagues to support the implementation of the recommendations of the Welsh Language Commissioners Inquiry in to Primary Care.
- A new 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.
- Provide training for staff to ensure they have the knowledge and skills to contribute as appropriate to the delivery of the Wellbeing of Future Generations Act and Wellbeing Goal of creating a Wales of vibrant culture and thriving Welsh language.
- Ongoing participation at National Events, e.g., National Eisteddfod, Royal Welsh Show, to ensure continued engagement with our Welsh speaking public.
- On-going engagement with local schools and colleges to showcase the varying roles within the health board and to ensure students consider the health board as a future employer.

## 3.11 Workforce

At a time of national and international health workforce shortages and austerity, the pressure to control workforce costs, at the same time as deliver good quality, safe and clinically effective services, requires detailed integrated service, workforce and financial planning. This will inevitably place higher levels of expectation about extracting maximum efficiency, productivity and flexibility from existing employees. It will also rightly create a focus on leadership, management and setting the right cultural expectations on accountability and performance management.

All Health Boards face these challenges and it is critical that the Health Board develops an identity and work programme that meets these challenges and enables us to become an employer of choice. We have an ambitious programme of Divisional improvement that ensures our activities are fully aligned to the needs of the organisation both now and into the future. This will require a different way of working that embraces modern matrix structures, maximises our analysis and assessment capability, exploits intelligent technology solutions and makes our processes easier to navigate for our clients. By adopting this new approach we will rebuild our infrastructure, remove unnecessary delays, duplication and cost in order to deliver value added services and support. We have embarked on the improvement journey by developing a single data team, realignment of senior portfolios, introduced a sharper improvement focus and tools such as our integrated dashboard which allows us to triangulate data and build a set of core performance metrics. This critical review of our activities will also ensure we have the right focus and delivery mechanisms to support implementation of our Clinical Futures Strategy and in preparation for the Specialist and Critical Care Centre.

Our programme of work will be based around a number of key priorities. The priority areas are identified as follows, with a more detailed work-plan to support these activities to be found in Appendix 9.

Table 3.11.1

<b>Using Our Staff Productively And Efficiently</b> 	<b>Engaging And Developing Our Staff</b> 	<b>Sustaining Services Now And For The Future</b> 
<ul style="list-style-type: none"> <li>• Ensure all medical staff have up to date job plans</li> <li>• Reduce sickness absence to no more than 5% through effective management and targeting</li> <li>• Develop the New Ways of Working plan including defining 'the back office', end to end mapping and better use of technology and centralisation of some services</li> <li>• Implementation of Lord Carter recommendations and maximise new opportunities</li> <li>• Roll out of E- rostering and automated drop down to pay</li> <li>• Maximise the use of ESR in the management of staff and employee self-service.</li> <li>• Embed the integrated workforce and finance dashboard</li> <li>• Creation of single data team</li> <li>• Ensure that we maximise delegation and prudent workforce principles in all our service redesign</li> </ul>	<ul style="list-style-type: none"> <li>• Revise our PADR arrangements and improve our compliance to 85%</li> <li>• Development of our staff retention strategy</li> <li>• Embed our Values and Behaviours Framework</li> <li>• Create easy to navigate systems and support tools for new staff and managers</li> <li>• Develop the core skills of our managers</li> <li>• Ensure we enhance management and leadership skills</li> <li>• Listen to our staff and act on the staff survey results</li> <li>• Continue to promote employee well being and the health of our workforce</li> <li>• Implementation of the HCSW Framework</li> <li>• Implementation of our Strategic Equality Plan</li> <li>• Developing our staff with new and enhanced skills to support the implementation of Clinical Futures</li> <li>• Increase our proportion of Welsh speakers</li> <li>• Create opportunities for our staff to share/ learn from others in different sectors</li> </ul>	<ul style="list-style-type: none"> <li>• Develop innovative approaches to attracting staff</li> <li>• Development of resourcing and recruitment strategy for Nursing and Medical roles</li> <li>• Development of new roles to support service sustainability</li> <li>• Improve collaborative planning and working with other health boards and partners to share experience, expertise and opportunities</li> <li>• Development of workforce plans to support Clinical Futures Strategy and the SCCC</li> <li>• Producing the links between our Clinical Futures workforce requirements and IMTP</li> <li>• Supporting Primary Care in the creation of workforce plans to align to NCN map/priorities and develop the workforce so they are aligned to care pathways</li> <li>• Enhancing our offer of Work Experience and Apprenticeships, with a particular focus on disadvantaged groups</li> <li>• Strengthen our connection with schools</li> </ul>

**Our challenges**

There continue to be number of significant challenges in terms of increasing demand, recruitment shortages, maximising efficiency/productivity opportunities and compliance with deanery standards. 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 in nursing, therapy, estates and a number of medical specialties.
- An ageing workforce profile. For instance, 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.

- Deanery rota compliance and training standards requirements for 2016 and 2017.
- Reconfiguration of Neonatal Deanery trainees with no trainees allocated to the Health Board.
- Provision of 7 day and extended services for a number of professional groups.
- Specialist skills spread too thinly on existing site configuration.
- A competitive climate, both internally and externally, for salaries particularly in certain specialist areas and the impact this has on both recruitment and retention.
- Increasing rates of sickness.
- Reduction in the availability of locums combined with pressures to increase rates to sustain services.
- Educational commissioning numbers across Wales will not meet demand despite increases in a number of professional groups.
- An increase in educational trainees, coupled with our existing vacancies, has created difficulties in capacity to train the trainees.
- Workforce planning across care pathways which includes other parts of the health care system and realignment of workforce.
- Unlikely to recruit staff with Welsh Language skills to deliver requirements of the Welsh Language Standard.

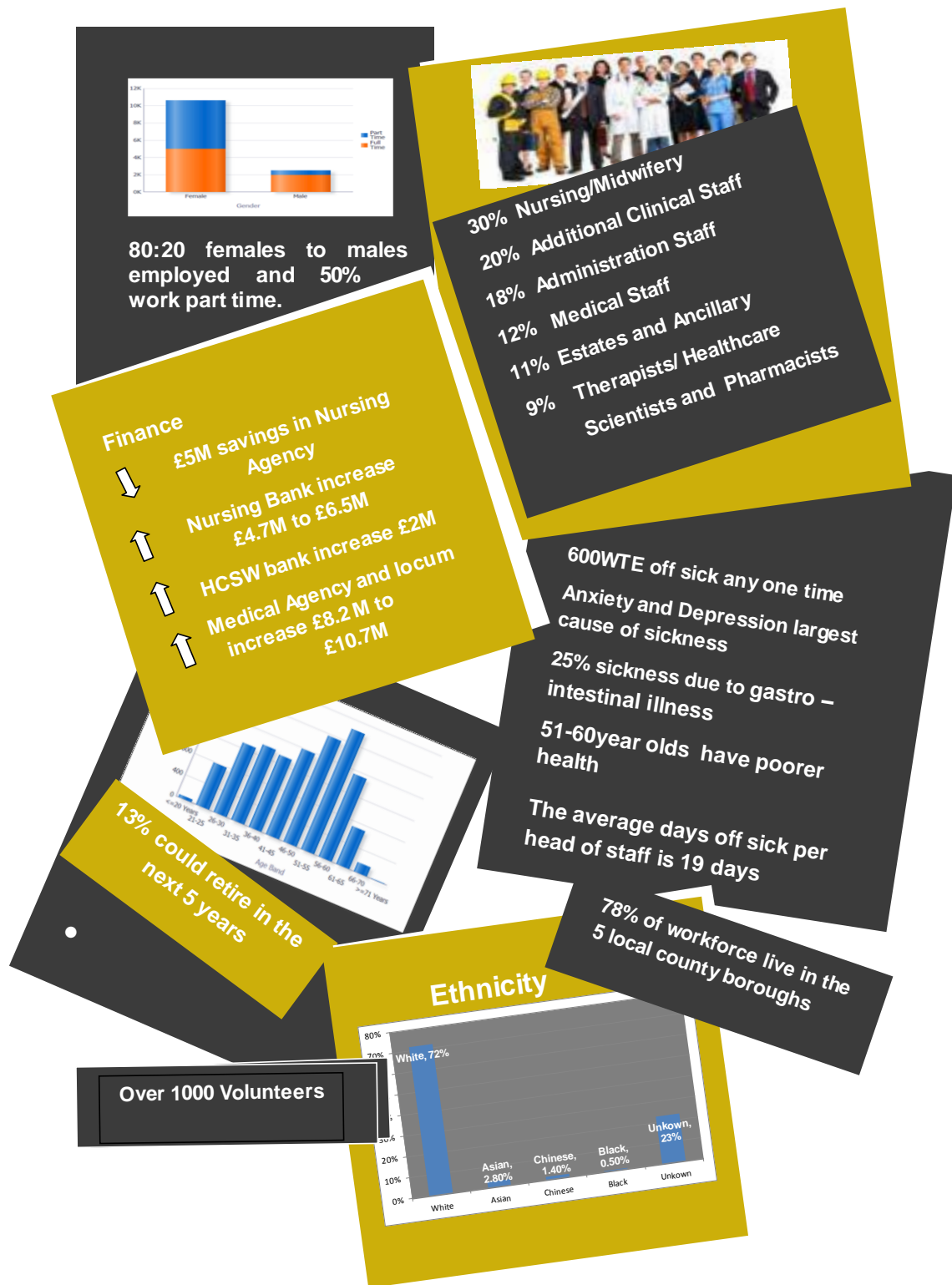


### **Shape of the current workforce**

As at October 2016 the Health Board employs 14,105 staff (11,124.97 WTE) and is the largest employer in Gwent.

Whilst the staffing group profile has not changed significantly since October 2015, the number of contracted staff in post has increased by 157 WTE staff. There have been increases in core establishments in nursing and midwifery from overseas recruitment and in Works and Estates through the recruitment of ancillary staff to reduce expenditure on variable pay. The increase in AHP's is aligned with an extended service provision to support areas such as Community Neuro Rehabilitation Service.

Figure 3.11.1



**Current profiles by professional group:**

**Nursing and Midwifery**

- The current ward vacancies across the Health Board are circa 250 WTE with particular concerns in Paediatrics, Neonates, Community Hospitals and Mental Health and general recruitment of Band 5 nurses. There are also a number of advanced practice roles both in secondary care and Primary Care which are proving difficult in terms of recruitment. Over the past year, the Nursing and Midwifery numbers have increased by 62 WTE across the spectrum of nursing profiles through overseas and local recruitment. The overseas recruitment initiatives through the HCL have resulted

in the recruitment of an additional 104 nurses over the past 18 months, but the turnover of these staff is above the average for nurses of 6.7%. The increasing demands for advanced practitioners, clinical nurse specialists and backfill for training, in addition to increasing demands for nursing to support new service change plans and primary care initiatives, has meant that the 102 additional recruits have not had the desired impact on ward nursing. An additional 77 Filipino nurses were contracted via HCL in February 2016, however due to legislative requirements and increased employment checks including English Language competency assessment, it seems unlikely that the Health Board will see these nurses commence employment. Given the situation with overseas nurses the UHB are currently developing a revised Recruitment & Retention Strategy. This will include maximising student placements and recruitment initiatives.

- In April 2016 the UHB ceased the use of off-contract agency. To date the vacancy challenge is mostly maintained using nursing variably pay through agency, bank and overtime.
- 31% of the Nursing and Midwifery workforce are 51 years and over. This has been accounted for in our workforce planning figures and additional educational commissioning numbers.

### **Medical and Consultant Dental Staff**

- In addition to the impacts of 1:11 rotas driving up junior doctor workforce demand, there are a number of specialities at immediate risk including Obstetrics, Paediatrics, Neonates and Mental Health. The long lead in time for training, the ability to release resources for training and associated backfill costs, all present further challenges.
- There are currently 26.8 WTE vacancies across the consultant workforce with specific challenges in recruiting consultant posts in histopathology and radiology, which reflects their inclusion on the National Occupational Shortage list. There are also concerns with the age profile of a number of specialities such as COTE and Anaesthetics.
- The costs of Medical Locum and agency costs have increased in areas reflecting requirements to meet 1:11, vacancies and RTT delivery.

### **Allied Health Professional**

- There have been increasing challenges in recruiting to a number of AHP professions and specialist roles. All therapy services are reporting a reduction in the number and suitability of applicants for bands 5, 6 and 7 roles.

### **HealthCare Scientists/Additional Professional Technical**

- The development of clinical pharmacist roles in GP clusters has resulted in considerable vacancies in secondary care. This will be further compounded as we continue to grow the model of Pharmacists in Primary Care.

### **Primary Care and Community workforce**

- The Primary Care General Practitioner workforce is made up of 405 GP's, 7 registrars and 94 are salaried GPs, of these 24 are directly employed by the Health Board. There is only 1 practice which is a managed directly by the Health Board.
- An additional 29 GP vacancies are covered by locum and agency.
- 29% of the 405 GP workforce is over 50 years, with the potential that 105 GP's could leave the service within the next 5 years.
- The recruitment and retention of GP's to meet demand and patient care has inherent difficulties both now and in the future. The reasons are multifaceted and include lack of doctors who wish to train as GP's due to lack of interest and financial restrictions. The nursing plan for the next 5 years forms part of the skill mix development along with Paramedic, Pharmacist, Public Health Education, Paediatric and Mental Health to support this shortfall. The plan now needs to increase its focus on developing nurses within the service to become nurse practitioners.
- Without mergers, 17 practices run by one or two GPs are unsustainable in the long term. The Blaenau Gwent area poses the biggest risk in terms of sustainability.
- There are approximately 896 WTE other staff working in Primary Care including practice nurses, pharmacists, advanced specialist nurses, healthcare support workers and administration.
- New roles are being introduced into areas such as GP OOH's including paramedics and ANP's.
- As plans develop and progress is made on the Primary Care Workforce Plan, new roles will continue to evolve including physiotherapists, audiologists, advanced practice, physicians associates, medical assistants etc which will reduce the reliance on GP's and enable a prudent

approach to workforce multidisciplinary working practices. However, this is not without its challenges and the need to wait for posts to become vacant before recruiting to these new roles.

- Since April 2016, District Nursing Services in ABUHB have commenced a monthly submission of data to the Division's Performance Team. This now allows the service to monitor performance against a set of locally agreed performance indicators and compare with peers, both locally and nationally, as part of the NHS Benchmarking Network's project for community services.
- In response to the Welsh Audit Office (WAO) review of district nursing the DN Forum has been established that oversees the work of various sub groups which are each accountable for the delivery, at pace, of a key strand of work:
  1. District Nursing Specification (Revision March 2017).
  2. Community Informatics Group:
    - a. District Nursing Scheduling Tool;
    - b. District Nursing Dashboard;
    - c. DN Mobile Informatics Working Pilot (MoWic);
    - d. Organisational Readiness WCCIS.
  3. Education and PADR performance.
  4. Patient Experience (hootvox).

The Community Informatics Group oversee the organisational readiness for the deployment of the Welsh Community Care Information System (WCCIS) which is a unique solution that will allow local authorities and health services to share care records and optimise services for citizens across Wales, delivering against the strategic requirements set out in the Integrated Health & Social Care, Social Services and Well-being (Wales) Act.

Embracing technology and accessing data/information whilst mobile (Mobile Working -MoWIC) is a prerequisite for roll out of WCCIS project within community nursing. In 2016/17 the 12 NCNs in Gwent provided funding to the Division to procure Tablets and licenses to establish and pilot the benefits of District Nurses being able to access primary care patient data in the community and to in turn write directly into primary care patient records when required appropriately. The result being that safer and timely care is provided and clinically important information is provided directly into patient's notes to reduce duplication, room for errors in third party information sharing and enhance the patients' experience.

The Project has set out the following aims for the first year, as follows:

1. Procure mobile devices to support access to the Licence and patient data.
2. Procure a Licence and test the functionality.
3. Identify and train appropriately District Nurses to use the Licence and data.
4. Evaluate the effectiveness of the Licence.

The project will be initially implemented across 2 Boroughs and will provide evidence to support associated workforce time savings through the elimination of unnecessary tasks, improve workforce productivity and flexibility. Once these savings have been assessed they will be included in future iterations of the plan.

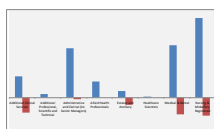
### **Nursing Homes**

A large number of nursing homes provide information on their workforce profile to inform training and educational needs and to share challenges facing their workforce. They employ more than 284 nurses, in excess of 1216 Health Care Support Workers and over 172 other staff including catering, laundry, maintenance and administration staff. Comments received from nursing homes demonstrate they are experiencing similar recruitment difficulties and becoming reliant on agency workers. The larger nursing home companies use their own bank workforce. An ageing workforce profile is also a potential problem, with on average 40 nurses expected to retire each year. These numbers will be reflected in the nurse educational commissioning figures.

Throughout 2016, 1,051 CPD/training sessions have been delivered for independent sector staff with no charge to the homes. Examples of the training provided include:

- Dementia Awareness/Dementia Friends;
- Advance Care Planning;
- Management of people with diabetes including use of pen devices;
- Management of cardio-vascular conditions;
- Deprivation of Liberty Safeguards;
- Declaration of Rights for Older People;
- Immunisation;
- Care Priorities for end of life and caring for the bereaved;
- Respiratory, Asthma, Inhalers and COPD management;
- Health promotion in a Residential Setting including infection control and nutritional needs;
- Safe administration of medication and “Just in Case” medication;
- Management of syringe drivers;
- Cancer as a long term condition;
- Verification of Expected Death.

Additionally, nursing home staff informed us that there was a need for better access to e-learning. Previously only accessible to NHS staff, nursing homes now have access to the NHS Wales learning portal where they can access on line training e.g. anaphylaxis, immunisation training etc. Further discussion is needed with the local authorities and residential homes around a specific training strategy for the unregistered workforce. From April 2017, the dedicated Professional Development team in primary care will work with the local authorities and residential homes to develop a training strategy for residential home staff. (September 2017).



**Future workforce profiles**

There is a demanding workforce change programme required for the foreseeable future. To meet the in-year challenges of minimising workforce costs, delivering the Clinical Futures Strategy and sustainable services, the Health Board will continue to ensure the existing workforce is deployed as efficiently as possible. The key Workforce development priorities for both Secondary Care and Primary Care for 2017/2018 include:

**Table 3.11.2**

Priority	Workforce Impact	Timescales
Primary Care	<ul style="list-style-type: none"> <li>▪ Development of new roles increase practiced based pharmacists, social workers, therapy staff, HCSW role as well as Advanced Nurse Practitioners, Physician Associates and the pathway to Nurse Consultants</li> <li>▪ Review of workforce models in Urgent Out of Hours Services including use of Pharmacists and Paramedic Practitioners</li> <li>▪ Development of integrated teams supporting continuing health care</li> <li>▪ Managing an aging profile and sustainability will require services that are provided by multi-disciplinary integrated teams which include medical, therapies, pharmacists, dieticians, physicians associate, Nurse Practitioners, social Workers/prescriber supporting NCN Networks.</li> <li>▪ Supporting Primary Care in the development and potential transition of workforce in practice mergers.</li> <li>▪ Alignment of Care Closer to Home Workforce plans between Secondary Care and Primary Care ensuring appropriate use of resources</li> <li>▪ Increasing the need of direct Physiotherapy services to patients across NCNs</li> <li>▪ Extend practice based social workers</li> <li>▪ Support training and education within Primary Care and Nursing</li> </ul>	2016 onwards

Priority	Workforce Impact	Timescales
	<p>homes through implementation of the Primary Care Nurse Education Strategy.</p> <ul style="list-style-type: none"> <li>Maximise the use of technology such as text reminders, telemedicine etc to release GP time to focus on the patients who need them.</li> <li>To develop a programme of Organisational Development support to enhance the delivery of the Care Closer to Home and the Social Services and Wellbeing Act. This facilitates and enables NCN's to create the environmental conditions that support the change process and to promote staff engagement, systemic cultural change and its applicability to local service delivery.</li> <li>Implement actions of the Primary Care Workforce Plan for Wales</li> </ul>	
Secondary Care	<ul style="list-style-type: none"> <li>Collaborative working with other health boards and nursing homes to sustain services</li> <li>New roles – a range of roles from all staff groups, such as PA, ANP's, HCSW and extended scope practitioners in therapies and Pharmacy to support service sustainability and Clinical Futures</li> <li>Development of band 4 in Community services</li> <li>Integrated services for mental health and Community and Primary Care</li> <li>Implementation of the Clinical HCSW Framework</li> <li>The New Ways of Working project will concentrate on defining a modern support arrangement, ensure efficient end to end processes and use of technology is maximised.</li> <li>Maximise the use of benchmarking through training and improve availability of benchmarking tools such as skill mix analyser, I view and the BI tools</li> <li>Implement recommendations from the Lord Carter report to maximise workforce productivity and efficiencies</li> <li>Maximise the use of technology such as DHR, digital dictation</li> </ul>	<p>2016 onwards</p> <p>2017 onwards</p> <p>Ongoing</p> <p>On track and ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>2017/2018</p> <p>Commenced 2017</p> <p>Ongoing</p>



## Investments and Savings

### Investments and Cost Pressures

As well as the additional resources required to ensure medical workforce sustainability, each division has also identified a range of changes to service delivery that require investment in 2017/2018 and these include:

- Meeting RTT demands requires an associated increase in core medical staffing and reduced reliance on variable pay e.g. T&O, Dermatology and Anaesthetics.
- Ongoing service changes in Mental Health including supported by ICF funding for behavioural Support and ASD
- Additional Junior Doctors and Advanced Practitioners to meet deanery 1:11 compliance in a number of surgical specialities and neonates following removal of deanery training will result in a significant number of additional junior doctors and cost pressure to the organisation.
- Resources to meet Local delivery Plans through ICF funding including respiratory, diabetes and heart failure and cancer pathway projects.
- Healthy Child Wales Programme will require additional Health Visitors
- Appointment of Health Records staff to support ongoing roll out of Digitalisation of Health Records with associated savings of 55 WTE in the next 3 years.

This has resulted in a forecasted profile for core additional staffing and associated variable pay savings in 2017/2018 as set out below:

**Table 3.11.3**

Schemes	Increases WTE	Decreases WTE	Total WTE Change
ICF related schemes	33.9		33.9
DHR appointments	19		19
Externally funded posts	5		5
1:11 junior doctor rotas	17		17
Healthy Child Wales	4		4
PICU extension	7.2	-1.5	5.7
GPOOH	3.89	-2.02	1.87
Sch Care Other	14.6	-6.9	7.7
Other investments	8.56	-4	4.56
RTT	7	-5	2
PCI Cath Lab	2.33		2.33
ED	9.47	-15.3	-5.83
Gastro/Cardiology Medical		-3.5	-3.5
Savings (workforce)		-13.7	-13.7
<b>Total</b>	<b>131.95</b>	<b>-51.92</b>	<b>80.03</b>

Whilst the Health Board will be increasing its core workforce by 131.95 WTE, there are savings which equate to 51.92 WTE through these new posts. This is being achieved through associated reductions in variable pay, agency and waiting list initiative payments.

Therefore, the overall increase in workforce which has no corresponding savings in 2017/2018 will be 80 WTE and these are associated with a number of funding streams as shown below:

**Table 3.11.4**

Description	WTE
ICF related schemes	34
DHR appointments	19
Externally funded posts	5
1:11 junior doctor rotas	17
All other investments/savings	5
<b>Total</b>	<b>80</b>

The investment in DHR will be offset in the next 3 years through the reduction of approximately 55 WTE staff. The junior doctor posts are a cost pressure to the Health Board and this was forecast in line with SCCC business case until a number of services can be centralised. The majority of posts are being funded through ICF funds and these related to projects which improve patient quality of care, some of which may have associated savings or realignment in future years.

The overall baseline for nursing may also change pending satisfactory employment checks of 15 WTE overseas nurses and the costs for these have been included within the financial plan.

The workforce WTE profile and staff group profile will change (Table 3.11.5). Additional Nurses are required to support a number of schemes including advanced practice/specialist and Local Delivery plans and CIF schemes. An increase in administration supports the ongoing roll out of DHR and Medical and dental increases are associated with meeting 1:11 rotas and RTT delivery. Additional Therapists are required to support emergency medicine, PCI expansion and heart failure and respiratory service reconfiguration. The appointment of additional nurses and clinical staff is not without risk and requires supporting strategies. These include changes in approach to recruitment and retention in addition to releasing resources through improved workforce management and service

changes

Table 3.11.5

Staff Group	Investments	Savings Variable Pay	Savings Locum/Agency
Additional Clinical Services	12.15	-8.5	
Additional Professional, Scientific and Technical	2.2	0	
Administrative and Clerical (inc Senior Managers)	28.3	-1	
Allied Health Professionals	9.2	0	
Estates and Ancillary	3.86	-4	
Healthcare Scientists	0.64	0	
Medical & Dental	30	-9.6	-12.52
Nursing & Midwifery Registered	45.6	-10.3	-6
Grand Total	131.95	-33.4	-18.52

### Savings plans

Workforce savings opportunities within the plan include:

- Workforce efficiencies through improved service efficient models including PICU and ED.
- Improved control of variable pay through the reduction in waiting list initiatives payments, some of which will be supported by increases in core staffing previously identified in investments.
- Changes in service models and skill mix in GP OOHs will reduce the need for GP locums.
- Tighter controls over vacancy scrutiny.
- An element of backfill for sickness has been included, but further opportunities are being explored to improve savings profile.
- An element of savings against specialing. There is further potential to increase savings in line with a revised escalation policy.

The Health Board has also considered the recommendations within the Lord Cater of the Coles report 2016 and a number of these already have action plans for assessing/implementation each opportunity. These include a review of administration in a number of areas; improve understanding and deployment of therapies/nursing, increasing job planning for CNS and ANP workforce and the use of acuity tools to ensure more robust alignment with care hours required. At this time we are unable to quantify the savings.

There are also opportunities to reduce workforce costs through the use of salary sacrifice schemes including purchase of annual leave, cycle to work, child care vouchers and lease cars.



### Resourcing

There have been a range of strategies produced over the last year to set out our future intentions particularly around recruitment and retention. We have initiated work to improve our branding within the recruitment market and to identify why candidates select, or not, to work for us. This will see us assessing the route of job applications and what methods work best. We are also planning to refresh our internet pages and provide a cleaner view of the Health Board, what we do, our population, values and what being an employee of Aneurin Bevan can offer to prospective candidates. These strategies have included our approach to overseas recruitment and the need to take a more blended approach to skill mixing within our clinical and medical delivery model. We continue to work in partnership with Shared Services to improve our overall recruitment performance.

Set out below are a range of issues influencing our resourcing activities:

- The Health Board has the highest percentage of skill mix at Bands 1-4 compared to the average of Health Boards in Wales and it will continue to be an important focus for workforce design.
- We are in the process of recruiting MTI's or Clinical Fellows and a number of Physician Associates and Advanced Practitioners. This approach will also support junior doctor deficits in General Surgery and Anaesthetics. However as a note of caution, the reliance on Management Training Initiative (MTI) recruitment to sustain the medical model is fragile due to nationally controlled limits on the number of visa allocations. The use of hybrid consultants in neonates is also not a longer term sustainable solution.
- There are a number of solutions in place to reduce risks of medical sustainability in Obstetrics, Paediatrics, Neonates and Mental Health including the development of supporting roles including, Advanced Nurse Practitioners through internal training programmes and recruitment. To respond to the challenges of winter pressures and maintain the position of not using off contract agencies the Health Board developed a robust nursing workforce plan which included trialling incentive payments through the Resource Bank. This will be evaluated for future use.
- The Health Board launched 'Living the Code – Delivering the Care', Nursing strategy that reflects national and local imperatives and new legislative changes introduced by the Welsh Government. The Nurse Staffing (Wales) Act 2016 will underpin strategic aim 3 of the Strategy and seeks to develop a nursing and midwifery workforce, skilled, adaptable and appropriately resourced, to deliver integrated health and social care to patients and service users in all service settings across acute, community and primary care. The Health Board has commenced preparation in readiness for the Act. An implementation group has been established and work plan developed to ensure the Health Board can meet the requirements of the overarching duty 25A from April 2017 and further duties from April 2018. Key risk relates to nursing vacancies.
- Nursing workforce planning will continue to align to the Health Board's Clinical Futures Strategy and the next five years will see services being redesigned to move away from traditional models and hospital based care to a community based model. "Living the Code – Delivering the Care" embraces the concept of partnership working between statutory, voluntary and independent sector agencies and integrated health and social care will be a key objective.
- Ensuring robust preceptorship and educational development is an essential element of the workforce plan for nursing. The Health Board has a preceptorship programme in place known as the Journey of Excellence (JoE), supported by practice educators and clinical skills trainers, providing formal support and guidance to registrants. The JoE enables successful transition from student to registered nurse or midwife, supports those returning to practice, overseas staff, those new into post, or a speciality and those developing through their professional career pathway. This dedicated support provides a structured and objectively assessed pathway. This enables registrants to confidently and competently deliver safe and effective care to patients, develop professionally and build expertise working towards advanced practice. It provides a 'novice to expert' approach across areas such as clinical practice, education/training, leadership, strategic development, research and audit. The programme also aims to help with recruitment and retention for the organisation and it is supplemented by a structured approach to ongoing mandatory and professional development days for all registered nurses and midwives across the organisation.
- The organisation has developed alternative employment schemes with over 60 trainee Health Care Support Worker placements identified to support the wards. We have received funding from Welsh Government to support a number of placements.
- The Health Board has developed a number of solutions to address medical recruitment within both Primary Care and Secondary Care and these will be implemented through 2017/2018
- Meeting the Challenge: A Strategy for Therapies and Health Science 2016–21 has been developed acknowledging that Therapies and Health Science specialties are part of the solution to the major challenges facing the Health Board and NHS more generally. Examples include integrated service models, seven day services, alternative referral pathways and use of Assistant Practitioners (Band 4s).
- There will need to be an increase in trainee numbers for both pre-registration trainee pharmacists and Diploma Band 6 pharmacists. We need to review our training capacity, develop new training infrastructures and innovative training methods to meet the needs of an increased number of posts. It will also mean exploring the potential to involve community pharmacists in training plans.
- 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.

- We are also revising our retention methods to have a better understanding about why people choose to leave us and the factors that come into play when employees are considering that decision.



## **Educational Commissioning**

The future workforce requirements are supported through the annual educational commissioning process and are documented in the attached template (C18). 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. The organisation also engages with the primary care sector, nursing homes and community providers to ensure that commissioning figures meet the needs of the Health Board and the local economy.

In summary some the key drivers for education are:

### **Nursing**

- Emergency Nurse Practitioners in emergency departments providing 24/7 cover
- Advanced Nurse Practitioner roles in neonates, gynaecology and paediatrics and a number of other specialties to support medical sustainability and Clinical Futures.
- Increase in Mental Health nursing graduate numbers to meet the ageing workforce profile and service reconfiguration proposals.
- The increase in nursing educational figures reflects turnover, age and the gaps to meet the Nurse Staffing levels Act 2016.
- The increase in numbers in Paediatric nursing educational commissioning numbers reflect current analysis that since there have been no increases in paediatric graduates in the last 2 years, the vacancy gap will remain a problem in addition to increasing in staff to meet the Healthy Child Wales programme.
- An increase in higher educational certificate or equivalent to nursing numbers will continue to support sustainability of graduate nurses but also offer an extended career pathway for HCSW through grow our own. We currently have 20 band 4s on the pathway to training and we envisage these will increase.
- Independent prescribing

### **Allied Health Professionals/Healthcare Scientists/Additional Professional Technical**

- Physician associates in acute medicine and primary care
- Sustainable numbers of radiographers and those with extended scope of practice as a result of 7 day services and increases in demand for diagnostics.
- Increase in therapists to support Primary Care, 7 day services and an increase in the number of therapists with independent prescribing skills to support increased MDT working. In addition to this there will need to support to extend the scope of practice for therapists through post graduate education provision Surgical Care practitioners providing assistance with theatre medical cover and an increase in ACCP's in Anaesthetics
- Increase training numbers in Pharmacy and increase in independent prescribing skills to ensure that the service can meet the anticipated increase in workforce required for Clinical Futures including Primary Care sustainability.

### **Additional Clinical Services**

Health Care Support Worker development and programmes required to develop assistant practitioner workforce (Band 4) including areas such as Cardiology Physiology

### **Primary Care**

Through implementation of the actions within the Primary Care Workforce Plan for Wales the Health Board will continue to support Primary Care:

- A rolling programme of training is in place for independent sector nurses. Throughout 2017, a

specific focus will be paid to developing the unregistered workforce in residential homes. This will need collaboration with Local Authorities, CSSIW and providers

- The programme has been developed with Coleg Gwent as the provider and is a clinical skills diploma at level 3 based on the Credits and Qualification Framework (CQF). The importance of this bespoke programme has been identified in recognition of the need that HCSWs in general practice are educationally and clinically safe and effective. This also forms the foundation for potential further HCSW qualification for those wishing to develop as they are ideally placed to replace retiring Practice Nurses in the future.
- Discussions have taken place with the LMC regarding student nurse placements. A focus for 2017 is to develop bespoke primary care student nurse placements. This will require backfill funding to a) release practice nurses to undertake training and b) release practice nurses to have time to train students. The estimated costs are around £5,500 per student nurse placement
- There is a need to scope the current provision of Nurse Practitioners and Advanced Nurse Practitioners across the workforce in GP practice. This will be given priority for completion by June 2017. This scoping will inform a local training strategy and the support needed to skill the workforce.

There are also a number of courses that are not available within Wales which are needed to support training and education around new workforce models and ensure we continue to adopt a prudent approach to workforce development/deployment to support service demands and sustainability.

The educational graduate commissioning figures and those to support extended practice and master's level of training requirements have been reviewed by the Nurse and Therapy Directors and have been aligned to service changes predicted for the medium and longer term.



## Engagement

The views of staff and partners are critical to any organisation, and we are growing our suite of activities around engagement activities to ensure we regularly test and hear what others have to say. We have continued to use pulse surveys to get a quick view and feedback on how employees are feeling. We recently set a question from the Chief Executive about whether staff are proud to say they work for us – over 80% of staff said they were proud to work for ABUHB some or all of the time. We are also building on the success of our senior leader forum and a new 'Managers Network'. Both of these forums have a regular programme of short briefings on topical areas. These initiatives will continue to feature alongside responding to the feedback from staff surveys/medical engagement scale questionnaires, ask the Chief Executive on the intranet, back to the floor activities, together with blogs from different members of the Executive Team.

The All Wales Staff Survey has provided us with positive messages about how the organisation is developing and engaging with its staff. We are working with colleagues across the organisation to identify and prioritise actions to address areas where further improvements can be made.



## Social Sustainability

The Health Board was delighted to achieve the Platinum award, the highest level of attainment in the Corporate Health Standard. This recognises our commitment to corporate social responsibility and sustainable development.

Employment is one of the key determinants of health and wellbeing. Unemployment and poor employment practice is closely associated with ill health and a low sense of wellbeing. Employment with a responsible employer significantly improves the chances of good health, healthier behaviours and higher rates of self-reported wellbeing. As the largest employer in the local area we have continued to deliver on our responsibility to adopt and model excellent recruitment, development and employment practices. Our work with Careers Wales as Business Ambassadors, the wide range of

work experience on offer, revised Apprenticeship approach and our careers activities are all testament to this. The organisation is focusing on our Wellbeing objectives to meet the requirements of the Wellbeing of Future Generations Act. We are working closely with our Local Authority, Public and Third Sector colleagues in the Public Service Boards to ensure that the wellbeing goals prioritise the needs of our local community.

The Health Board are working with the Wales Audit Office and the Office of the Future Generations Commissioner to pilot a future focussed audit approach. This is part of a National Programme and we are the only Health Board involved in this work.



## Partnership Working

The Trade Union Partnership Forum (TUPF) and Local Negotiating Committee (LNC) provide the formal mechanism for consultation, negotiation and communication between our staff and the Health Board, embracing the Trades Union Congress principles of partnership. The TUPF has provided an excellent opportunity for managers and Trades Unions across the Health Board to meet and discuss a number of strategic issues impacting on delivery of services and workforce.

The Health Board is developing more effective and sustainable mechanisms to facilitate continual engagement of staff and widening the role of staff to strengthen links with our communities. This approach aligns to our Health Board's Engagement and Communication Strategy which ensures that engagement and communication delivers significant communication improvements for our staff, patients and wider stakeholders.

In partnership with Academi Wales and the Schumacher College, the OD team is supporting NHS Wales to increase its capacity in developing leadership approaches to manage complex social systems in a sustainable way.



## Equality and Diversity

The reduction of inequalities remains a cross cutting theme throughout the IMTP. Our revised Strategic Equality Objectives were published in March 2016. Progress was made in relation to all of the areas identified; however, recognising the long term nature of the objectives previously identified, engagement and formal consultation indicated that focus should be retained in these areas.

Particular challenges going forward, include the requirements of the new National Training Framework on Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. We are working with our public sector and third sector partners on a using a 'train the trainer' model to work collaboratively to deliver the training required. Improved scores in the Stonewall Workplace Equality Index indicate we are a more inclusive employer of staff who are lesbian, gay or bisexual. We are mindful of the national and local evidence that demonstrates the inequalities that transgender people face and will be working with NHS colleagues and National and Local third sector organisations to improve patient experience and outcomes.

We will continue with the implementation of our action plan to improve the experiences of those with sensory loss and further embed the equality impact assessment process to support the inclusive design and delivery of services. In the light of requirements of the Well Being of Future Generations Act, we are collaborating across public services to explore the options for an integrated impact assessment tool.



## Efficiency

To meet the in-year challenges of minimising workforce costs, whilst ensuring the workforce is engaged and motivated, the Health Board will continue to take a planned approach and has set out a delivery framework to achieve key workforce performance targets which can be found in Appendix 9.

Our structured work plan is clustered around the 3 themes set out earlier in this section, with a sharp focus on extracting the maximum efficiency and productivity. This work is overseen by a newly created Efficiency and Productivity Board, which combines financial, workforce, planning and procurement colleagues and ensures we are responding to the opportunities set out within national reviews such as Carter. As a Division we have contributed to the health board's self-assessment around 'enabling transformational change, staff deployment, quality and efficiency, use of digital systems etc'. This assessment allows us to benchmark our activities, understand our differences in terms of performance and cost and will be integral to our action plans to deliver the priority areas.

To illustrate the above and to underpin our work on resourcing, starting internally with medical recruitment we are mapping our processes to ensure that we have no lost or wasted time for medical staff recruitment. Together with Shared Services, we will continue to invest in our Improvement Group, which collaboratively is assessing our performance data and processes and investigating why it is taking longer for us to recruit compared to some neighbouring health boards. We aim to reduce our recruitment timelines, (which are currently 11 days above the all Wales average) by examining out vacancy scrutiny, TRAC performance, advertising, pre-employment checks, contracts and induction arrangements.

The organisation has participated in alternative employment schemes providing work experience placements for 51 individuals. These individuals have been placed in areas that are best suited to their identified needs and areas where the organisation is seeking to recruit staff

Delivery of these key workforce themes will be reported via updates against the delivery framework and to a range of boards and committees

### 3.12 Finance

#### 3.12.1 Strategic Context

The key objective of the Health 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 population's needs that are underpinned by the principles of prudent healthcare, 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.

The Health Board also has a statutory responsibility to produce and deliver a balanced integrated plan over a three year period, and achieve financial breakeven over a rolling three-year period.

Substantial service and workforce change is required over the medium term to meet these organisational objectives and priorities. This is in the context of a changing population demographic, increasing demand, and changing workforce supply which need to be managed within the resources available to the organisation. These are captured within the recent Health Foundation report "The Path to Sustainability", which outlines that these challenges drive a financial deficit over the medium term to 2031. However, these could be managed in the context of real terms funding growth of 2.2%, delivery of efficiency savings of a minimum of 1.0%, and a balanced starting position.

Within this context, the Health Boards underlying financial position in key areas has deteriorated in

2016/17 and is an underlying position which is not sustainable. Delivering financial balance in 2016/17 assumes a number of non-recurrent measures and so further significant progress is required in order to make the Health Board position sustainable going forward. Therefore in 2017/18 a Health Board priority is to address its underlying position to provide greater financial sustainability. This is a key feature of the Health Board's plan.

In order to achieve this, the Health Board need to develop solutions both in the short and medium term to:

- reduce existing costs through changing service and workforce models and delivering evidence based opportunities;
- improve efficiency and productivity;
- achieve cost containment.

The actions to achieve this are outlined in this plan and have been informed by a detailed review of the evidence base of opportunities for improvement available to the Health Board, aligned with the Value and Efficiency Framework developed nationally, which is outlined further in this section.

**In summary, the Health Board must address its underlying financial deficit and needs to make significant progress in developing its service and workforce plans within available resources. The delivery strategy to manage this agenda is multi-faceted as outlined within this chapter, with the Health Board recognising its statutory responsibility to achieve financial breakeven over a rolling three year period, and develop balanced integrated plans which achieve this requirement.**

### **Long Term 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, which include:

### **The Path to Sustainability**

This context has been well evidenced in Welsh Government commissioned reviews, originally through the Nuffield Trust report of 2014 "A Decade of Austerity" and the more recent Health Foundation report "The Path to Sustainability". The Health Foundation report describes from a balanced starting position, spending would need to rise by an average of 3.2% in real terms to meet demographic and cost pressures with a rising prevalence of chronic conditions. This can be met by a continuation of real terms funding at 2.2% per annum and efficiencies delivering at least 1% per annum. To be able to deliver within these projections, on an ongoing basis, it is vital that the Health Board achieves a balanced starting position and addresses the current underlying deficit of £22.7m.

### **SCCC/Clinical Futures**

In 2016 the Health Board has seen approval of its Full Business Case in support of the development of the SCCC as described within the Health Board's plan. From a financial perspective, delivery of the necessary service transformation is vital to ensure future financial sustainability given the development supports:

- Centralising services which allows for future years savings in particular in relation to medical staffing.
- Delivery of length of stay improvements and bed reductions to support the increased costs base of an additional site.
- Improved capability to manage future population demands, within available resources, in the context of the Health Foundation report described above.

It is also important to ensure that other aspects of the Clinical Futures Programme continue to be developed, including the development of primary and community services and maximising the efficiency of other parts of the estate - including development of business cases for the future state of Royal Gwent Hospital, and Nevill Hall Hospital.

### Brexit

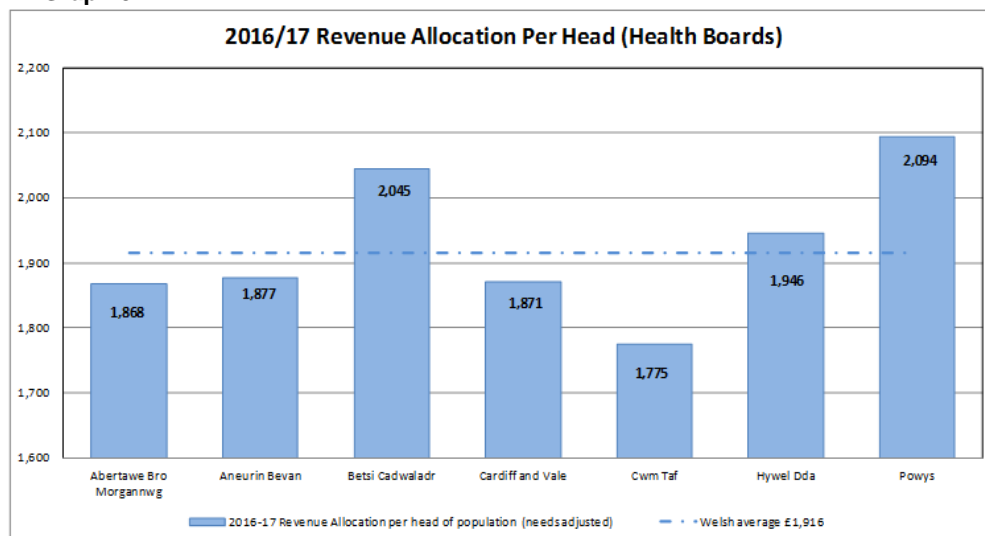
Clearly the full outcome of the UK's decision to leave the European Union is yet to be fully considered in terms of impact and this may affect the outlook for Public Sector funding in the medium to long-term. Given the lack of certainty, this plan assumes no specific impact.

### Health Board Allocation Context & Relative Position

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 co-morbidities and deprivation, high and increasing levels of chronic conditions, all consistent with the findings of the Nuffield report of 2014 "A Decade of Austerity", and the previously referenced Health Foundation report "The Path to Sustainability".

When health needs are taken into account, the Health Board receives 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, Mid and West 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 Health Board. However, more recent use of the fair shares principle has started to close the gap for the Health Board.

Graph 3.12.1



This historic position therefore provides a greater challenge to the organisation in attempting to address the needs of its population with less than its fair share of overall funding. Using the needs based formula; the Health Board would receive in the region of £23m additional funding to be in line with the average revenue allocation per head (an additional £39 per head @ 580,300 population).

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 allocation, as a minimum, will be key to ensuring that the Health Board is able to further address some of the health inequalities which exist whilst improving overall health outcomes for our population.

The Health Board acknowledges that, of the £240m funding announced in 2017/18, only £110m has been allocated to date. Given the position described above the Health Board would anticipate that the allocation of further funding in 2017/18 would acknowledge and reference the underlying Health Board allocation positions in pushing forward Welsh Government priorities. In managing the residual financial

risk identified, in 2017/18, the Health Board will discuss with Welsh Government the options that exist to ensure that its plans can be delivered within available resources.

It is also important to note that from a cost efficiency perspective, key indicators suggest that the Health Board is more efficient than both the Welsh and English average cost position, with the Health Board's efficiency challenge to achieve Upper Quartile English Reference Cost performance. This is supported by an evidence based review of available benchmarking which identifies strategic improvement themes for the Health Board which needs to be addressed. Whilst this does not change the Health Board's requirement to achieve financial sustainability and manage within available resources, it does provide an important context in terms of being clear where and how financial sustainability, linked to efficiency, effectiveness and appropriate funding can be achieved. It also places greater emphasis on delivering efficiency at even greater pace and scale.

***Given the baseline funding position for the Health Board - below need, the Welsh average and with cost efficiency better than both Welsh and English averages - the medium term approach to maximising value and use of resources, with funding allocated on a fair shares basis, is key to sustaining an integrated service and workforce plan within resources.***

### Strategy Development

In responding to the medium term outlook described above the Health Board continues to develop its Financial Strategy to respond to these challenges. This is a development programme with an aspiration to position and allow the Health Board to deliver on this challenging agenda over the longer-term, and continue its excellent delivery record of sustaining financial balance. It is anticipated that this work develops the framework which allows the development of IMTP's within the wider strategic financial setting.

The aspirations that the Health Board holds from a strategic finance perspective are to:

- Achieve 'Best in Class' with no limits to ambition.
- Create 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 through a clear business planning process.
- Ensure the resource utilisation agenda enables organisational priorities - such as improving quality - and facilitates change in line with the Health Board's strategic aims.
- Enable professional development through up-skilling the workforce and increasing capability in modern and innovative techniques.
- Meet the needs of the Health Board and Wales, being unique and bespoke to the Welsh framework and agenda.

The Strategy Development work in progress seeks to develop a comprehensive strategy for the organisation which clearly articulates and outlines:

- a) The Finance Mission Statement, Principles, & Values.
- b) The Medium-Term Financial Strategy for the Health Board.
- c) The Finance Functions OD Strategy to deliver these objectives.
- d) A comprehensive development programme for non-finance managers to deliver on the requirements of their roles within that context.
- e) A comprehensive development programme for finance staff to deliver on the requirements of their roles within that context.

As part of this development, the focus of this work will cover and deliver:

- A Health Board view of the prospective resource outlook in line with population projections making the Health Foundation and Nuffield analyses live for the Health Board.

- Developing population health based resource allocation approaches including maps of how resources are currently consumed, aligned with need, and how prospective allocations may impact on population health through tools such as STAR.
- Develop internal resource allocation frameworks which align activity, workforce, service and finance to give clear and aligned budgetary frameworks to allow delegated management within available resources.
- Develop a focus on improving efficiency and productivity to support the short-term requirements.
- Develop a comprehensive evidence base and intelligence compendium of opportunities for improvement which informs IMTP development, resource allocation, and external stakeholders on the evidence based focus of health boards plans.
- Continue to develop and maximise a Value Based Healthcare approach, building on the previously well documented approach developed within the Health Board, ensuring that this is at the forefront of the agenda locally, nationally, and internationally.

### 3.12.2 Financial Outlook 2017/18

The Health Board has undertaken an assessment of its three year financial outlook and modelled the future cost of known pressures and increases in service costs which have emerged from the planning process alongside an assessment of funding available. This includes a robust review of the Health Boards underlying position, and this section clearly outlines the Health Board's assumptions in terms of anticipated funding levels, current service plans and known or potential cost increases. These assessments are outlined as follows:

#### Underlying Deficit

In 2016/17 the Health Board had its IMTP approved with an identified £12.8m financial deficit, with approval conditional on continued progress being made in managing this plan and delivery towards a breakeven financial position. Over the course of 2016/17, the Health Board has been tracking to a position of a circa £20m deficit with the IMTP deficit of £12.8m reflecting the Health Board's best case position. In the latter months of the financial year the Health Boards financial position has significantly improved and is currently forecasting a break-even position for 2016/17. However this position is supported by additional funding received from Welsh Government to support Winter performance (£9.97m) which is non-recurrent in nature, and some material items which are non-recurrent in nature such as GMS rates rebates, which don't support an improvement in the Health Board's underlying financial position. Therefore, the Health Board continues to have an underlying position that it needs to take action to address.

In developing its 2016/17 IMTP the Health Board outlined a planned savings level of 2% of turnover (£21.5m) and 1% cost mitigating actions (£10.5m). To date within 2016/17 projected savings delivery is approaching 2% at £18m, and a number of cost mitigating actions have been implemented to deliver on this position. Of note within this financial year, the Health Board has successfully implemented the cessation of the use of high-cost premium off-contract agency nursing (e.g. Thornbury) since 1st April 2016, and seen a significant turnaround in its Adult CHC growth position where the Health Board was previously an outlier. However, there have been further unplanned cost pressures in-year off-set by non-recurrent financial benefits.

The assessment of the Health Board's underlying position for 2017/18 as modelled as part of this planning process is a deficit of **£22.7m**. This represents an increase of **£10m** above the outlined 2016/17 IMTP deficit position of **£12.8m**. Key issues within 2016/17 which affect the Health Boards deteriorated underlying position are:

- Significant workforce pressures in relation to medical staffing in supporting delivery of activity and performance requirements, and sustaining medical rotas on multiple sites in particular at junior doctor level.
- Challenges within Mental Health services in relation to operational nursing and CHC growth.
- Commitment of resources to deliver key performance targets in relation to the 8 week diagnostic position and 36 week RTT position in order to deliver an improved 36 week breach position from 2,648 at 31st March 2016 to 1,200 at 31st March 2017.
- Increased medicines expenditure in relation to primary care prescribing, WP10 expenditure following delegation of this item to Health Board budgets, and pressures within secondary care in

relation to Hep C, MS drugs, and Clinical Haematology.

- Increased expenditure in relation to specialised services in relation to the Health Board's services commissioned through WHSSC and EASC, and
- These pressures have been off-set by significant improvement and cost mitigation in the Adult CHC position, and also through material non-recurrent benefits in relation to GMS rates rebates, and reduced Welsh Risk Pool premium payment.

***In summary, the Health Board has seen a deterioration in its recurrent underlying position in 2016/17 with this position being assessed at £22.7m at the outset of 2017/18. This is materially off-plan against the underlying position outlined at year 2 in the Health Board's 2016/17 three year IMTP (of £12.8m). A key component of the Health Board's required improvement prospectively is significantly reducing this underlying position through delivering improved efficiency, and maximising the value of investment made in 2016/17. A more sustainable underlying financial position has to be achieved on a recurrent basis.***

## **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 Health Board has based its starting assumption from the Allocation Letter for the recurrent baseline of 2017/18 and developed a set of planning assumptions for further funding increases across the additional two year period.

In the 2016/17, Welsh Government presented a one-year budget which included additional funding of £240m for NHS Wales in 2017-18. In the allocation letter received from Welsh Government £110m has been confirmed as allocations to Health Boards, with £90m to be allocated to support inflationary pressures including provision for pay awards for NHS employees, the cost of the UK Government's Apprenticeship Levy and other inflationary pressures. A further £20m Mental Health ring-fenced funding is also confirmed in its allocation to Health Boards. From a Health Board perspective this equates to £17.2m and £3.8m (totalling £21m) for Aneurin Bevan respectively.

Welsh Government has further confirmed that funding for certain specific issues will be held centrally until the amounts required for 2017/18 are confirmed. Materially this includes any increase to the GMS and GDS contractor allocations to support any agreed inflationary uplifts. Therefore, the Health Board has excluded any allocation assumption and the costs of any contract uplift agreed through national negotiations due to the assumption that it will be funded.

The Health Board has assumed that it will receive £3.1m as its fair share of the Treatment Fund announced by Welsh Government in December 2016 which equates to £16m for Wales on a recurrent basis. Within its cost assessment the Health Board has included its assessment of the financial impact of new Technology Appraisal guidance and the impact of NICE which it considers the Treatment Fund will support, both from a Health Board provider perspective and assessments provided for the impact of the treatment of Aneurin Bevan residents at Velindre NHS Trust.

The Health Board's plans include an ambition to push forward in a number of service areas, which reflect both national and local priorities. Although this is not an exhaustive list, the following represent a number of key areas which the Health Board would want to progress:

- The development and delivery of sustainable service and workforce models that ensure optimum performance delivery on a recurrent basis. This includes:
  - Improving RTT performance in both 26 week compliance and a reduction in the patient cohort waiting greater than 36 weeks for treatment from 1200 at 31st March 2017 to 500 at 31st March 2018. This will include a plan that delivers elective services for orthopaedics through in-house sustainable solutions and removal of the reliance on external outsourcing for this specialty in 2017/18 and beyond, based on current demand levels.
  - Delivering sustainable improvement in access to elective care for all other specialties with only a small volume of outsourcing capacity being required for Ophthalmology in 2017/18.
  - A focus on sustainable improvement methodologies in the unscheduled care system which will

improve and sustain performance during our transition process in advance of the SCCC. The recently established Urgent Care Collaborative from within the Health Board is a key enabler supporting this work programme which is now accelerating at a greater pace.

- Enabling sustainable improvements in the delivery of 8 week diagnostic waits over the course of 2017/18, with further clarification required for the solutions identified for Endoscopy in the context of significant increases in demand.
- Improving health outcomes for the Health Board's population in the context of:
  - Continuing to ensure funding allocations are distributed on an increasing fair shares basis recognising inequity within the Health Board area and addressing funding settlements relative to other parts of Wales,
  - The Health Board having a growing and ageing population which is accessing health care services, and an increasing proportion of the population being over 65 years of age
  - Supporting the Health Foundation assessment 'The Path to Sustainability' which indicated that Health Boards should be able to achieve sustainability on the provision of 2.2% real terms growth and 1% efficiency. The allocation of resources proposed within our Plan would reflect an allocation approaching a 2% real terms increase in line with this assessment.
  - Increased medicines costs specifically in relation to NICE approved treatments and demand for existing treatments, outside the scope of new technological appraisals which it is assumed will be supported by the Treatment Fund.
  - Increased specialised services demand, with particular challenges in relation to Thoracic and Neuro services. This would enable the Health Board to continue its investment in some of these areas whilst the benefit of the revised risk sharing arrangements are gradually realised.
- Supporting the transitional elements of the Health Boards plans in developing future sustainable services, specifically this includes:
  - Developing a comprehensive Value & Efficiency approach. This includes continuing to implement and embed the Health Board's Value Based Care programme and approach to outcomes capture, and also delivering on its opportunities and efficiency programme on key strategic themes such as a prudent approach to managing demand, and improvements in length of stay. These programmes will deliver future sustainable improvements for the Health Board,
  - Supporting the Health Board's transition to the full implementation of its Clinical Futures programme through supporting changes to primary care models and the care closer to home agenda,
  - Developing sustainable service solutions through a collaborative approach with other partners across both the Health Board area and regional footprint,
  - Supporting the Health Board's transition to the service model and standards outlined in the SCCC full business case through implementing enhanced medical models and achieving 1:11 rota compliance in key surgical specialties

In order to bring forward some of these plans, this presents a residual financial risk of £15m, in 2017/18, which the Health Board will need to discuss with Welsh Government in terms of ensuring that service and workforce plans, which meet agreed national priorities, can be delivered within available resources.

For clarity therefore, the Health Board is making the following key assumptions in relation to funding:

- The Health Board will receive £21.05m for Discretionary and Mental Health services in line with the WG allocation letter
- The Health Board will receive a further allocation of £3.1m in relation to its fair share of Treatment Fund funding as described above
- The Health Board will discuss with Welsh Government the actions required to manage the residual financial risk of £15m regarding further cash releasing savings, cost avoidance and/or additional funding allocations,
- The Health Board is assuming fair shares of funding of £170m in 2018/19 and £170m in 2019/20 (years 2 and 3) respectively. This represents an allocation to the Health Board of approximately

£33m, which on the assumption inflationary growth remains at circa 1% per annum would support the Health Board with an allocation to meet 1% inflationary pressures and 2% real terms funding growth

- Funding assumed excludes prospective allocations to support inflationary costs associated with GMS and GDS contractor costs therefore the funding and costs of any contract negotiations are excluded, and
- As per principles outlined in the allocation letter, the Health Board is assuming that the following pressures are funded from its fair shares made available in 2017/18 (and on a recurrent basis):
  - National pay pressures:
    - 1% for A4C and medical & Dental Staff;
    - The impact of living wage moving to £8.45 per hour;
    - The cost of Consultant & SAS Doctor and Commitment Awards;
    - Auto enrolment.
  - Government level decisions:
    - Apprenticeship Levy;
    - Pensions Administration Charges.
  - Non Pay Inflation.
  - 2% uplift to LTA's and SLA's.

The assessed value of these inflationary pressures are broadly in line with the £17m inflationary funding received to date:

- The Health Board is assuming additional allocations in line with Capital plans and full funding of capital charges. This includes any additional depreciation and impairment costs in 2017/18 in addition to any impact of the revaluation exercise being undertaken from April 2017.
- It is assumed that there is no payback liability or impact of any under-spend associated with National Delivery Plans, Primary Care or Mental Health funding in 2017/18.
- Welsh Government will continue to hold the budget for the difference between the cost of prescribing and the cost of dispensing and any risk associated with this will be borne centrally.
- The Health Board is assuming that should any Phase 3 retrospective CHC provision be required in 2017/18 that this will be matched by AME funding, and that this will be reflected when this position is confirmed in line with Welsh Government's Resource Planning Assumptions.
- It is assumed any increased inflationary costs for GMS and GDS will be funded centrally as outlined above.
- The Health Board is assuming the continuation of specific funding streams which are historically treated as in-year allocations as listed within the anticipated allocations schedule.
- The Health Board is assuming that ICF funding for Tranche 1 and 2 including WCCIS and Autism are recurrent as per the WG allocation letter, and that funding for Tranche 3 will be recurrent in line with the Health Board's assumed commitments on these schemes, pending confirmation of the future allocation the Health Board will receive. The Health Board's assumed allocation within this plan for Tranche 3 is £2.5m.
- It is assumed that any impact to financial flows as a result of changes to the Cross Border Protocol will be resource neutral to the Health Board.

On this basis the anticipated allocation over the next three years therefore is as follows:

**Table 3.12.1**

<b>Allocation Assumptions</b>	<b>2017/18 £m</b>	<b>2018/19 £m</b>	<b>2019/20 £m</b>
Health Board Allocations	1,133.53	1,140.72	1,173.83
16/17 Anticipated Health Board Allocations ®	7.18	-	-
(NEW) Additional WG Funding	-	33.11	33.11
<b>Sub- Total Allocation Increase</b>	<b>1,140.72</b>	<b>1,173.83</b>	<b>1,206.93</b>
<i>Additional Anticipated In Year Funding</i>			
Revenue	5.49	6.49	6.49
<b>Sub-Total</b>	<b>5.49</b>	<b>6.49</b>	<b>6.49</b>
<b>TOTAL WG Allocation</b>	<b>1,146.21</b>	<b>1,180.31</b>	<b>1,213.42</b>

The Health Board also receives an additional £96m (based on 16/17 levels) income though a range of other sources, primarily from other Health Boards for patients flows, education and training and Local Authorities, which supports the Health Board's total funding envelope as follows:

**Table 3.12.2**

<b>Total Income</b>	<b>2017/18 £m</b>	<b>2018/19 £m</b>	<b>2019/20 £m</b>
Income (equals 16/17 m10 estimate)	95.5	95.5	95.5
WG Allocation	1,146.2	1,180.3	1,213.4
<b>Total Funding</b>	<b>1,241.7</b>	<b>1,275.8</b>	<b>1,308.9</b>

While no assumptions are made at this stage of the plan on any material changes to these income levels, the Health Board 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 will be considered as such for years 2 and 3 in particular.

It is worth noting that the Health Board is also undertaking a full review of its Resource Allocation Framework to align delegated budgets to known and identified areas of financial opportunity and improvement to support the development of a more sustainable financial position as described above.

Furthermore, this plan identifies a number of areas which the Health Board wishes to progress, in line with national policy and its local strategies and the resourcing required to support its delivery. Should there be an opportunity to resource further changes, during the period of the IMTP, the Health Board would welcome having further discussions with Welsh Government.

***In summary, the Health Board has assumed funding in line with the outline allocation letter received from Welsh Government, and the supplementary Resource Planning Assumptions provided, and made a series of assumptions in line with that position. It is anticipated that further funding will become available on future confirmation of issues such as GMS/GDS contractor inflation.***

### **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 Health Board 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, medical advancements and Government decisions.

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% in year one followed by 3.5% in subsequent years. The following table summarises the total cost growth for the three year period:

**Table 3.12.3**

<b>Increased Demand and Inflation Costs</b>	<b>2017/18 £m</b>	<b>2018/19 £m</b>	<b>2019/20 £m</b>
Pay (Inc Pension / apprenticeship levy..)	17.13	15.35	14.89
Non-Pay	3.24	6.03	7.95
Prescribing	3.51	3.24	2.23
Primary Care (Contracts & Other)	1.54	0.99	0.57
NICE	9.30	6.40	6.27
CHC	3.40	3.40	3.47
WHSSC	3.53	2.36	2.40
Externally Commissioned Services	3.35	2.85	2.82
<b>Total Net Costs</b>	<b>45.01</b>	<b>40.62</b>	<b>40.59</b>
	3.9%	3.4%	3.3%

The key assumptions supporting each of these assessments is outlined as follows, and are reflective of Welsh Government's Resource Planning Assumptions document:

### **National Pay Increases**

Pay represents a significant element of the Health Board's budget and is a key driver of cost in both current and future years. The Health Board 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 £8.45 per hour. As outlined above this is assumed to be funded from the Health Board's allocation for 2017/18 and future years.

Other pay costs modelled as part of this plan assessment include:

- Medical Staff costs associated with Consultant and 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 is 0.5% of the organisation pay-bill (less any benefits in kind payments) starting in April 2017 at an estimated cost of £2m per annum.

### **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:

- Auto enrolment of staff on to the Pension scheme whereby any members of staff not enrolled in the NHS pension scheme will be auto-enrolled into the scheme, staff have to actively opt-out rather than opt in. This is commencing from October 2017 and will cost approximately £5.7m per annum on a recurrent basis, and assessed as £2.9m on a part year basis in 2017/18.
- NHS pension scheme administration charge of approximately £0.267m per annum commencing from 1st April 2017.
- Indications that there will be a change to the discount rate used in the calculations of employers contribution leading to an increase in costs of almost £4.8m from 2019/20.

In line with national pay pressures it is assumed that the impact of these changes is supported by the additional revenue for inflationary pressures made available across NHS Wales.

### **Non-Pay**

An assessment has been made to establish the potential impact on local non-pay costs for inflationary pressures across the three years. This assessment has been undertaken working in conjunction with the national modelling group using HSCI and procurement advice in parallel with local issues at

Divisional level and the Health Board's established Procurement Review Group. Inflationary cost increases are anticipated in particular in relation to medical and surgical purchases.

In addition to non-pay inflation, the Health Board is anticipating non-pay pressures in key areas, in particular in relation to All Wales Rates VOA (Valuation Office Agency) changes to 90 day stay rules and revaluation, at a value of approximately £0.8m.

### Primary Care

Primary Care prescribing has been estimated utilising the most recently available PAR data alongside an estimate of item growth.

The rate of prescription items dispensed in the community in Aneurin Bevan has risen by an average of 2.02% over the last 5 years. The prescribing growth forecast in the IMTP takes account of this growth and is assessed at £3.5m net of cost avoidance actions being put in place.

It is intended through the continued delegation of prescribing budgets to Neighbourhood Care Networks (NCNs), the review of the use of incentive schemes and ongoing support of the medicines management team that any additional in-year cost growth is managed through off-setting savings. Further review over and above existing savings assumptions for loss of exclusivity items is taking place, at this stage much of these savings identified are off-setting the cost growth indicated.

In addition, the Health Board's plans assume that additional funding will be made available to cover the GMS and GDS contract uplifts, and at this stage with any potential inflationary increase unknown both the potential cost and funding is excluded from this plan.

### NICE

The Health Board 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 which continues to be a cost pressure across the three years.

This assessment is based on growth in demand of existing treatments, growth in new treatments, and growth in new NICE Technological Appraisal (TA) guidance issued in 2017/18 both internal to the Health Board and externally via WHSSC and Velindre NHS Trust. A robust review of all new appraisals, horizon scanning and loss of exclusivity has been undertaken to inform this view. This assessment currently reflects a cost growth of £9.3m over 2016/17 levels as follows:

Table 3.12.4

NICE-HCD	£m
Increased Demand on Existing Treatments - Internal	3.4
Increased Demand on Existing Treatments & New TAG - Velindre	3.6
Growth on new treatments & New TAG - Internal	2.4
<b>Total</b>	<b>9.3</b>

A significant element of this relates to the assessed impact of new NICE TA guidance both internal to the Health Board as a provider and through Health Board contracts with WHSSC and Velindre. As a result the Health Board has assumed its fair share of Treatment Fund funding recognising that this will support new TA developments.

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 available resources via the Health Board's Medicine Management Board.

### Continuing Healthcare (CHC)/Funded Nursing Care (FNC)

The effective management of complex care needs remains a key partnership challenge for both the NHS and local government. At the outset of 2016/17, Community CHC was expected to continue to grow in line with previous year's trends, however, the Health Board has managed to reduce this growth very successfully in this area over the course of this financial year and this position is being sustained on a recurrent basis.

Projected CHC/FNC growth from a community adult perspective within the IMTP relates to two distinct issues:

- CHC Demographic Growth and FNC growth & conversions;
- Anticipated Care Homes Fees increases.

The demographic growth assessment is based on a robust assessment of forecast trends having considered the significant change in patient cohort in 2016/17, and anticipated care homes fees increases are reflective of the likely fee structure required to support care home sustainability within the Health Board area in 2017/18. A comprehensive review of the Health Boards fees structure is being undertaken to support this assessment.

There is no provision for Phase 3 IRP on the assumption in line with Welsh Government guidance that any provision required in 2017/18 will be supported by AME funding. It is acknowledged that should any settlements occur within 2017/18 that this will be at the Health Board's financial risk.

There are significant potential risks which are not yet considered in this plan in relation to the potential re-alignment of Funded Nursing Care rates to England and the impact this may have on CHC rates.

Mental Health CHC pressures have continued to grow but at a reduced rate compared to previous years, with specific issues in high cost patients and low secure placements. The Health Board's current plan indicates an increase in the growth assessment of Mental Health and LD CHC in the forthcoming years. The CHC/FNC cost growth of £3.4m includes assumptions on cost avoidance actions to mitigate and manage projected cost growth.

It is essential that the Health Board continues to focus on delivering the necessary change in service models that will address this underlying and growth position. Failure to change the current pattern of service delivery will be a material financial risk to the three year plan.

### **Externally Commissioned Services**

The Health Board commissions and provides a broad range of services at an annual net cost of approximately £183m secured through a complex portfolio of contracts and contracting arrangements with English and Welsh Providers. Around £62m relates to hospital provided care at a secondary care level and £121m to tertiary services commissioned through Welsh Health Specialised Services Committee (WHSSC). Key anticipated pressures in relation to externally commissioned services equate to £3.4m, and relate to:

- English growth – with the latest assessments indicating a demographic growth trend with English providers and risks associated with HRG version 4+ implementation.
- Cwm Taf growth – In 2016/17 there is an increasing flow of Aneurin Bevan residents to Cwm Taf services which is currently assumed to be a recurrent growth issue.
- Powys repatriation – The plan reflects potential proposed repatriations of Powys residents to local services and the consequential income pressure to the Health Board's financial position.
- A 2% inflationary uplift to providers, and a reciprocal uplift to the Health Board's provider contracts, in line with Welsh Government's Resource Planning Assumptions

The Health Board's plan assumes any impact of the Cross Border Protocol is resource neutral.

In addition as a key commissioning intention for 2017/18 included in the plan, the Health Board has given notice to Cardiff & Vale Health Board that it is intending to adjust planned levels of activity relating to ABUHB patients, to a level that is reflective of expected demand. In line with the agreed Collaborative Board processes, this reduction in commissioned service will be negotiated with Cardiff

& Vale Health Board to develop a contract with revised activity volumes. This will be prospectively over a 3 year timeframe, aligning changes to service provision required for Aneurin Bevan residents and ensuring improved value is delivered for ABUHB patients utilising ABUHB commissioning resources.

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.

### **Specialised Services**

The Health Board's assumptions in relation to the overall WHSSC plan reflect the plan which is being developed for agreement by Joint Committee. In totality the Health Board has a provision of a circa £5m gross investment in relation to WHSSC and EASC plan which reflects the rollover position, the full year effect of 2016-17 investments and agreed 2017-18 investments made within 2016/17. In addition a 2% inflationary uplift has been reflected in line with Welsh Government Resource Planning Assumptions. Subsequently in accordance with the Joint Committee decision the Health Board has also recognised 1/3<sup>rd</sup> of the Risk Share Pooling Adjustment in 2017/18 equating to a reduction in contribution of £1.496m reflecting the Health Board's lower utilisation against its funding contribution and receiving the Year 1 benefit of this re-alignment.

In relation to EASC the Health Board is making available its share of the £135.6m EASC allocation with a 2% inflationary uplift for 2017/18. It has been agreed that this commissioning allocation will be used to agree the WAST IMTP and any other Health Board related schemes are in line with EASC commissioning intentions and assumptions.

It is anticipated that as part of the planning process WHSSC, with support from Health Boards, will develop a programme of savings & efficiency plans, ultimately to allow a final plan to be approved by Joint Committee which will consider affordability and outline choices to manage specialist services within a resource envelope reflecting the growth assumptions made within the Health Boards plan as outlined above.

### **Other Key Assumptions**

Other key expenditure assumptions relevant for consideration as part of the Health Boards plan, and consistent with Welsh Government's Resource Planning Assumptions are as follows:

- This plan assumes that given recent trends in the All Wales Risk Pool position that the Health Board's provision for potential claims over and above the £75m funding available on an all-Wales basis will not be required on a recurrent basis. The Health Board acknowledges that any provision required above this level would be the Health Board's risk to manage on an in-year basis.
- The Health Board is assuming that there are no changes to the personal injury discount rate (Ogden rate) which have an impact to this plan.
- This plan assumes that in line with Welsh Government Resource Planning Assumptions there is no benefit to the Health Boards plan of any recurrent impact of rates rebates pending further dialogue with Welsh Government on its intended application in 2017/18.
- The Health Board's plan is materially aligned with the plan assumptions of Velindre NHS Trust however given the significant financial challenge this presents to the Health Board there is an expectation cost pressures are managed and mitigated where possible in contribution to the Health Board's cost avoidance requirement.
- This plan excludes the cost of addressing the Health Board's endoscopy 8wk wait backlog, but recognises that any plan put in place to address this in 2017/18 is likely to be at the Health Board's financial risk.
- This plan excludes any potential cost associated with the development and impact of the Imaging Academy.
- This plan assumes that the rollout of the 111 service will be separately resourced.
- This plan assumes that provisions made for key inflationary pressures such as wage award and the living wage are sufficient to support the outcome of these commitments made and negotiated by Welsh Government.

## Resourcing Delivery

Given population needs and 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, local cost pressures and investment choices are reflected within this plan to support and enable delivery. Specifically these include:

- Resource requirements to support delivery of activity to support achievement of a 36wk RTT position of no more than 500 breaches as at 31st March 2018
- Resources to support sustaining zero x 8 week diagnostic breaches for all modalities other than Endoscopy
- Resources to support medical rota sustainability and 1:11 in key surgical specialties in line with the Health Board's transition to SCCC
- Resources to support primary care infrastructure and care closer to home in support of the Health Board's transition plan to maximise its Clinical Futures strategy

Further investments and developments are minimal within the plan which presents a risk, with potential investments of circa £8m not featuring within this plan. The Health Boards plans therefore focus on ensuring that any new development is self-financing through demonstrating sufficient savings or benefits to support the investment, or secure a funding source such as the Intermediate Care, Efficiency through Technology, Innovate to Save, and Invest to Save Funds. To support this, an enhanced Business Case Appraisal process is being implemented within the Health Board as part of the IMTP process from 1<sup>st</sup> April 2017.

***The Health Board's plan reflects a detailed cost assessment of inflationary pressures and demand growth in line with the assumptions detailed in the section above. Assumptions are consistent with the Resource Planning Assumptions guidance issued by Welsh Government and are anticipated therefore would be supported by WG. In addition, this plan assumes that investment is minimised within the resource available, but is essential in certain priority areas to support Tier 1 performance delivery and the Health Board's transition plans to the SCCC and Clinical Futures programmes.***

### 3.12.3 Response to the Financial Challenge

#### Savings Plans Progress

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 both the short and medium term from within the assumed resources available from Welsh Government. Financial sustainability will only be achieved through a combination of delivering cash releasing savings through improved operational efficiency and productivity, increasing the value based approach to use of resources, 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.

Plans to date have identified opportunities to the value of **£11.2m** which are summarised as follows:

**Table 3.12.5**

<b>Savings Identified to date</b>	<b>2017/18 £m</b>	<b>2018/19 £m</b>	<b>2019/20 £m</b>
CHC Savings	0.68	0.06	-
Commissioned Services	1.05	0.50	-
Medicines Management	2.80	1.86	0.63
Workforce Savings	3.37	0.39	0.29
Non-Pay	2.53	0.19	-
Accountancy Gain	0.75	0.50	0.25
<b>Identified Savings</b>	<b>11.18</b>	<b>3.49</b>	<b>1.17</b>

Planned savings in place include:

- Savings associated with Medicines management relating to loss of exclusivity across a number of specialities.
- Accountancy gains are included to the value of £0.8m for Adult CHC in particular.
- Savings relating to commissioning opportunities are also included and relate to other Welsh Health Boards these are being progressed with relevant organisations and primarily relate to Cardiff & Vale Health Board as outlined above.
- Workforce savings primarily relating to reductions in medical pay as a result of investments in technology, new roles and substantive posts to mitigate variable pay costs along with further reductions in variable pay for nursing staff. Workforce savings are low currently in the context of the Health Boards change requirement and further improvement is required.
- Non-pay savings relate to procurement opportunities in core clinical services and the clinical waste contract.

The expectation within the Health Board as part of its planning process is a minimum 3% cash releasing saving from both delegated and corporate budgets, and further progress is required and anticipated in this area informed by evidence based benchmarking and opportunity work which the Health Board is progressing at pace. In lieu of the processes the Health Board has in place and evidenced opportunities available, this plan assumes a further **£9m** savings will be delivered in order to deliver a balanced integrated plan. Processes are being established to translate assumed further savings into deliverable plans with immediate effect.

***Planned savings outlined above - both planned and further assumed savings - represent approximately 2.0% of the Health Board's expenditure base, 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 delivery plans to ensure that the required level of saving materialises in line with the requirement outlined in this plan.***

### **Efficiency & Productivity**

In developing and supporting delivery of this agenda the Health Board has focussed on four key areas of work:

Establishing a local **Efficiency & Productivity Board** – a monthly Board which reports to Executive Team and Finance & Performance Committee has been established to develop and over-see the Health Board's programme, with core membership across the Health Boards leadership team. This development will support both local requirements and what emerges from the National agenda. In addition, the Board will seek assurance and support progress with key organisational themes, such as Procurement, through over-seeing the established Procurement Review Group.

Developing an **Opportunities & Benchmark Evidence Base** – a significant exercise has been completed which consolidates all benchmark information available to the Health Board and triangulates to key themes the Health Board needs to progress and opportunities which need to translate to delivery plans in support of this position. This information includes:

- A detailed analysis of Welsh Government indicators.

- A detailed analysis of CHKS productivity and efficiency indicators including direct comparison to appropriate peer groups, and the 5 'outstanding' rated English Foundation Trusts.
- A review of available benchmark information such as costing information, Albatross, NHS Benchmarking Network, IView (workforce), and internal information such as Theatres throughput and performance.
- Consolidating all known Health Board opportunities for improvement and further opportunities for technical efficiency such as avoiding premium payments.

The evidence base has been developed and shared widely within the organisation to inform the development of Health Board plans. As part of its Delivery Framework, the organisation has developed programmes of work around key cross cutting themes with Executive Leadership and management support provided to each theme to support the translation of the evidence base for opportunities for improvement into tangible delivery plans which support delivery of the Health Boards plan.

**Value & Efficiency Framework** – building on the development of the opportunities and benchmark evidence base described above, the Health Board and its finance leads are actively supporting the Value & Efficiency framework work being led by Directors of Finance to maximise peer learning to inform development of savings plans. In addition, the Health Board is also extending its wider learning to other specific NHS organisations outside of Wales to consider what learning can be taken from a wider evidence base of savings delivery plans.

**Carter Review Self-Assessment** – The Health Board has undertaken a review of the Carter report and undertaken a self-assessment of the Health Boards plans and progress against the themes of the Carter review. Progressing areas which are relevant for the Health Board will feature as part of the ongoing work of the Efficiency & Productivity Board described above.

#### **Resource Allocation Framework**

The Health Board is also progressing its internal resource allocation framework to the same timeframe as its IMTP, in order to ensure that its budgetary framework supports the delivery of the objectives outlined in this plan. Specifically this includes:

- Ensuring a simultaneous budgetary and IMTP focus on delivery of a balanced position in line with the statutory and governance arrangements of the Health Board.
- Reviewing all delegated budgets funding baselines and underlying positions against the evidence base of opportunities to focus the required actions for financial improvement on the established evidence base.

#### **Cost Containment Strategies**

In addition to delivering an increased level of savings described above, the Health Board has a level of cost increase due to inflationary pressures and service or demand growth which isn't affordable and needs to be managed and contained. Therefore part of the Health Board's actions to progress an improvement in financial sustainability relates to managing and containing cost growth to a value of a further **£6m**, above what is included within this plan. Development of these actions will include a focus on:

- Workforce productivity to off-set workforce pay pressures.
- Cost avoidance associated with pay inflation such as pension auto-enrolment where the current assumption is that all staff auto-enrol and remain on the pension scheme
- Maximising return on unavoidable costs where these are minimised e.g. the apprenticeship levy.
- Managing and reducing non-pay inflation and develop other non-pay savings to off-set any price increases.
- Developing actions to mitigate and manage high cost NICE growth.
- Continuing to off-set prescribing growth through the development of medicines management actions and working with Pharmacy professionals to maximise opportunities to manage growth.
- Further progress with mitigating and managing CHC cost growth

#### **3.12.4 Risks & Assumptions**

The assessment provided in this plan is based on the best information available at this stage and has a number of key risks and assumptions, the most material of which are:

- Management of the residual financial risk of £15m in 2017/18 and agreement with Welsh Government on the actions required to deliver the integrated service and workforce plans within available resources,
- Funding is assumed of £21m for inflationary pressures and mental health ring-fence for 2017/18 in line with the allocation letter issued by Welsh Government, and a further £3m in relation to the Treatment Fund. Failure to secure this level of funding would present a risk to the delivery of this plan.
- Future years funding is based on fair shares of projected funding in line with previous IMTP assumptions, and broadly equates to a sufficient allocation to support 1% inflationary growth and 2.2% real terms growth in line with the Health Foundation's "Path to Sustainability" report.
- The Health Board acknowledges that any settlements in relation to Phase 3 IRP which occur in 2017/18 will be a financial risk for the Health Board to manage on an in-year basis which represents a further financial risk.
- ICF expenditure and funding are assumed to be aligned with no favourable or adverse impact to this financial position.
- The all-Wales Risk Pool is assumed will be managed within the £75m funding available on an all Wales basis and no further provision will be required.
- Key assumptions on inflationary pressures are noted, however potential GMS/GDS contractor inflationary costs are not included in line with Welsh Government guidance and are assumed to be supported by future funding should a net inflationary cost be agreed.
- Full funding of capital charges is assumed.
- 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.
- This plan assumes no adverse impact of any financial risks and challenges which present as a result of the financial settlements of partner and stakeholder organisations.
- 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 assumptions outlined in this chapter. It should be recognised that in line with Joint Committee decision the Health Board is assuming its Year 1 benefit of the Risk Share Utilisation and should this not be delivered this would present a risk to the delivery of this plan.
- This plan excludes approximately £8m of potential investments having prioritised resources required to support tier 1 delivery and transitioning to SCCC and Clinical Futures in line with those plans. Any further investment without a clear funding source would present additional risk to this plan.
- Any cost associated with plans to support an improvement in the organisations backlog associated with 8wk diagnostic waits for Endoscopy are not included in this plan. The Health Board acknowledges that any such solution would probably be its financial risk to manage and would be additional to the £15m financial risk identified.

In developing this plan, the Health Board is describing a likely and best case position of financial break-even based on the assumptions outlined within this section. However, this plan as described, provides a positive assessment of risk and reflects the Health Board's ability to deliver a balanced integrated plan in line with the principles outlined above. Should downside risks materialise in the context of these assumptions, the worst case position associated with those risks are outlined below and equate to **£33.8m**:

**Table 3.12.6**

Description of Risk	£m
Not achieving required savings / Cost avoidance	4.5
Implementing Developments	4.3
External Risks	3.9
Phase 3 IRP settlements	1.6
Welsh Risk Pool	1.5
Risk Share Utilisation (WHSSC)	1.5
Residual Risk to be managed	15.0
Endoscopy	1.5
<b>Total Risk Range</b>	<b>33.8</b>

### 3.12.5 Years 2 & 3 (2018/19 – 2019/20)

In developing its 3 year plan the Health Board has made a number of assumptions in relation to years 2 and 3 as follows:

- Funding is assumed to be approximately £33m per annum in line with previous IMTP assumptions, and reflects a requirement for 1% inflationary funding and 2% funding growth in real terms as outlined by the Health Foundation report “The Path to Sustainability”.
- The Health Board’s underlying deficit is reduced to approximately £6m due to the carry forward effect of delivering further savings and cost avoidance on a recurrent basis which makes the recurrent position more sustainable than in 2017/18.
- Inflationary and demand growth are reflected based on the best known information at this point in time. This requires re-assessment on an ongoing basis as the Health Board continues to develop its transition plan to the SCCC and a resourcing strategy which underpins primary and community care capacity is in place to enable that transformation to happen.
- Savings are assumed to be in the region of 1% in line with existing evidence bases, of which approximately 30% and 10% have plans in place currently to deliver in years 2 and 3 respectively. Further savings will be developed over the next 12 months as the Health Board’s delivery of its Value & Efficiency framework starts to embed into organisational ways of working.

On the basis of the assumptions outlined above the Health Board is projecting a balanced IMTP over a 3-year period, on the basis that actions will be agreed between the Health Board and Welsh Government to manage the residual financial risk of £15m in 2017/18 and recurrently in Years 2 and 3 of the IMTP.

### 3.12.6 Summary

This chapter outlines the Health Board’s revenue financial plan for 2017/18, the three year period from 2017/18 – 2019/20, and the financial outlook on a wider long-term basis, based on the financial modelling of the existing service and workforce assumptions. The outline position is set out in the following table:

**Table 3.12.7**

	2017/18 £m	2018/19 £m	2019/20 £m
WG Allocation - Inflation	17.22	33.11	33.11
WG Allocation - Ringfence MH	3.83	-	-
WG Allocation - Treatment Fund	3.06	-	-
Anticipated Allocation Adjustments	2.43	1.48	1.48
<b>Incremental additional Funding Expected</b>	<b>26.53</b>	<b>34.58</b>	<b>34.58</b>
Underlying Deficit	22.75	20.07	5.90
Service Demand and Inflation	38.00	29.93	29.99
Local Pressures	7.00	10.69	10.60
Required Savings & Accountancy Gains	- 26.23	- 26.11	- 11.91
<b>Total Net Costs</b>	<b>41.53</b>	<b>34.58</b>	<b>34.58</b>
<b>Divisions (Surplus) / Deficit</b>	<b>15.00</b>	<b>- 0.00</b>	<b>- 0.00</b>

**This assessment identifies that based on the assumptions outlined within this plan that the Health Board has a £15m residual financial risk in 2017/18 which it needs to manage through agreed actions with Welsh Government. On the basis that these actions are identified and successfully implemented, the Health Board can deliver a financially balanced plan for the 3-year IMTP period of 2017/18 – 2019/20. This chapter outlines a number of delivery actions which are required to ensure that this plan delivers within the assumptions and parameters described, and the Health Board’s delivery framework is now critical to ensuring this is achieved. Early discussion and agreement with Welsh Government will be key in the effective delivery of the plan.**

### 3.13 Capital & Estate

This section summarises the Health Board 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, spend to save investments 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.

In strategic capital planning terms the next year is seen very much as a period of transition for the Health Board. The very recent approval of the Specialist Critical Care Centre at Llanfrechfa Grange provides welcome certainty but a number of other issues will become clearer during 2017-2018.

- The formal response by Welsh Government to the Clinical Futures Programme Business Case (PBC), any resulting revisions to the PBC and the resulting development of plans for the future of the RGH and NHH post-SCCC.
- The outcome of the 6-Facet survey of our estate and implications for our developing Estate Strategy.

This will mean that by 2018-2019 the Health Board will have in place a co-ordinated Estate Strategy and a prioritised Capital programme reflecting our Clinical Futures clinical strategy and service planning and our plans to redevelop our asset base accordingly.

#### The Estate

The Health Board currently has an estates portfolio of 71 properties, some of which are over 100 years old and struggle to sustain modern services. 46% of the estate is over 40 years old.

From the 6 facet survey to be completed in late 2016-17 a strategic plan will be prepared for medium and long term investment and rationalisation that will deliver a network of facilities that enable the effective, safe provision of healthcare in premises that are:

- well utilised;
- cost effective;
- accessible;
- fit for purpose;
- aligned to the Clinical Futures strategy.

The resulting Estate Strategy will also be closely aligned to the ongoing work to develop Primary Care facilities to support the Care Closer to Home initiatives.

The following section and table set out the currently forecast Health Board 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. Detail about current and potential AWCP-funded projects is given in Appendix 5.

### **All Wales Capital Programme**

In addition to approved All-Wales Capital Projects – particularly the Specialist Critical Care Centre - 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 Health Board'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 following table:

Table 3.13.1

	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000
<b>All Wales Capital Programme Funding</b>					
<b>Approved Schemes:</b>					
SCCC (excluding inflation, based on FBC submission)	38,782	115,835	83,247	62,107	35
<b>Business Cases Submitted to WG for funding</b>					
Clinical Futures Programme					
Newport ELGH (excluding inflation)	75	150	904	2,226	2,766
NHH ELGH (excluding inflation)	75	150	527	1,090	1,557
Sub Total Clinical Futures	150	300	1,431	3,316	4,323
<b>Total Business Cases Submitted to WG for Funding</b>	<b>38,932</b>	<b>116,135</b>	<b>84,678</b>	<b>65,423</b>	<b>4,359</b>
Funding Submissions to National Programmes					
Radiology Equipment Replacement	6,531	5,444	3,100	4,449	2,246
RGH Endoscopy Decontamination (JAG Compliance)	500	2,000			
IT -Strategic Schemes including WCIS	11,000	11,000	11,000	11,000	11,000
Sub Total National Programmes	18,031	18,444	14,100	15,449	13,246
Projects Post Scoping Meetings					
Upgrade RGH Pharmacy Aseptic Suite	3,500	100			
Centralisation of Breast Service	1,000	3,500			
Mental Health Strategy	800	2,000	17,000	14,000	1,200
Sub Total Projects	5,300	5,600	17,000	14,000	1,200
Strategic Projects & Investments					
Provision for RGH Car parking	500	1,500	500		
Estate Infrastructure Risk	500	1,000	1,000	1,000	1,000
ABUHB Ward Upgrade Programme	500	2,000	2,000	2,000	2,000
Strategic Laundry Equipment Replacement Programme	480	500	500	350	350
Interim Measures to support paed's sustainability	1,000	250			
Investment in 4th MRI		1,600			
Investment in Omnicell - Revenue releasing	2,520				
Refurbishment of NHH A&E	250	2,000	2,000		
Sub Total Priority Developments	5,750	8,850	6,000	3,350	3,350
Primary Care Investment					
Enabler for Tredegar Resource Centre	750				
Tredegar Resource Centre		250	1,250	2,500	1,000
East Newport Resource Centre		250	1,250	2,500	1,000
Urgent Care Hub for Newport		50	150	3,500	2,500
Sub Total Primary Care Investment	750	550	2,650	8,500	4,500
<b>Sub Total AWCP Unfunded Requirements</b>	<b>29,831</b>	<b>33,444</b>	<b>39,750</b>	<b>41,299</b>	<b>22,296</b>
<b>Total AWCP Requirements</b>	<b>68,764</b>	<b>149,580</b>	<b>124,428</b>	<b>106,722</b>	<b>26,655</b>

## Primary Care

The capital investment priorities are driven by the "Care Closer to Home" strategy which provides the strategic direction that all future borough and NCN plans. Current schemes are set out in Appendix 5A.

## Developing the Discretionary Capital Programme

As there is a consistent shortfall between the capital funding available and the demand for capital the Health Board 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 Health Board 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 £64m over the period 2017-2018 to 2021-2022 with Discretionary Capital funding anticipated to be normally circa £10.8m 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 3.13.2**

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
<b>Funding</b>					
Total Discretionary in CRL	7,209	7,209	7,209	7,209	7,209
Recurrent Uplift to Discretionary	3,605	3,605	3,605	3,605	3,605
Add Forecast NBV of Disposed Properties	20	30	50	50	50
<b>Total Discretionary Funding</b>	<b>10,834</b>	<b>10,844</b>	<b>10,864</b>	<b>10,864</b>	<b>10,864</b>
<b>Applications:</b>					
<b>Direct Service Allocations:</b>					
Statutory Maintenance	500	500	500	500	500
H&S Fire Safety allocation	75	75	75	75	75
Imaging - X Ray Tube Replacement	50	50	50	50	50
<b>Total Direct Service Allocations</b>	<b>625</b>	<b>625</b>	<b>625</b>	<b>625</b>	<b>625</b>
<b>Balance of Available Funding</b>	<b>10,209</b>	<b>10,219</b>	<b>10,239</b>	<b>10,239</b>	<b>10,239</b>
<b>Unfunded Demand Against Available Capital</b>					
<b>Divisional Capital Requirements</b>					
Risk Scored 20-25	7,520	4,672	2,789	1,673	1,646
<b>Balance of Available Funding</b>	<b>2,689</b>	<b>5,547</b>	<b>7,450</b>	<b>8,566</b>	<b>8,593</b>
Risk Scored 15-19	5,825	8,451	12,003	18,226	24,221
<b>Balance of Available Funding</b>	<b>-3,137</b>	<b>-2,904</b>	<b>-4,554</b>	<b>-9,660</b>	<b>-15,629</b>
Risk Scored 10-14	3,750	4,214	9,739	15,152	18,116
<b>Balance of Available Funding</b>	<b>-6,887</b>	<b>-7,118</b>	<b>-14,293</b>	<b>-24,812</b>	<b>-33,745</b>
Risk Scored <10	2,573	2,573	6,898	9,336	12,685
<b>Balance of Available Funding</b>	<b>-9,460</b>	<b>-9,691</b>	<b>-21,191</b>	<b>-34,148</b>	<b>-46,430</b>

In summary it is estimated that the organisation's demand for Capital is estimated to be in excess of £64m over the period 2017-2018 to 2021-2022 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.

### 3.14 Innovation, Development and Research

#### Innovation

The Aneurin Bevan Continuous Improvement (ABCi) team is a corporate division that focuses its efforts on supporting the Quality Improvement agenda within the Health Board. Its aim is to foster a culture of improvement and innovation within the organisation. The team has four key objectives:

- To building the necessary capability for improvement within the Health Board.
- To creating conditions that supports innovative thinking and system design.
- To supporting the delivery of strategic objectives through collaborative methodologies.
- To building networks both within, and outside of the Health Board.

These objectives are seen by the team to be mutually self-reinforcing, encouraging the engagement of frontline staff to see improvement as a key component of their daily work.

### **3.14.1 Building Capability for Improvement and Innovation**

Achieving improvements in the patient experience, outcome and financial efficiency requires rigorous methodology that is rooted in the Science of Improvement. By embedding this methodology at the frontline the capability to test, measure, implement and sustain improvement increases drastically. Further, it reinforces a culture of innovative thinking. To date, training members of the Health Board in improvement techniques has been the mainstay of ABCi's work. Its training programmes, which are aligned to the national Improving Quality Together strategy, have attempted to build such skillsets at all levels of the organisation.

Having trained over 4000 members of the workforce ABCi has begun to realign its strategy, now focusing on building a cadre of technical experts within the Health Board. To achieve this it:

- Has evolved the Improving Quality Together (IQT) programme to align more closely to the needs of the Health Board. It has continued to develop its IQT Gold network, which remains the only such Improvement network in Wales.
- In 2017/18 it will further develop the IQT programme through partnering with BMJ Quality to support individual improvement programmes and encouraging publication of work delivered and develop IQT Gold modules in more advanced improvement techniques such as Statistical process control, Lean, and Human factors.
- Has launched its Mathematical Modelling course, with a second cohort is planned to start June/ July 2017.
- Continued to develop its Enhanced Leadership and Management Programme focused on building skills in improvement and leadership amongst senior members of the Health Board.

### **3.14.2 Creating the Conditions for Innovative Thinking**

ABCi is very well placed to support and develop innovations within the organisation. Whilst much of this innovation takes place as individuals and teams take part in training programmes and improvement collaboratives, the team has also developed a 90-day innovation cycle to build rigor and pace to projects. Whilst the underlying methodology is still evolving the innovation cycles are beginning to demonstrate impact within the organisation. Examples include:

- An Ophthalmology simulation model that more effectively enables the team to understand demand/ capacity issues, enabling them to make better planning decisions. Similar models are in development for other divisions and directorates.
- A system dynamics model of unscheduled care, providing a deeper understanding of the impact of management decisions across Gwent.
- Innovation in reducing falls risk on wards.

A number of these projects will be spread to other areas, in addition to being incorporated within larger improvement projects such as the Unscheduled Care Collaborative. Increasingly, ABCi is looking to apply to funding bodies to support innovation in practise. Within the next 12 months it intends to apply for a number of grants that enables it to scale up some of its innovation work, and support innovation within the organisation.

### **3.14.3 Supporting the Delivery of Strategic Objectives through Collaborative Methodologies**

ABCi has supported many projects in the last several years. Many of these have been through training programmes, such as IQT Silver. This cohort provides a considerable resource to support some of the larger strategic objectives within the IMTP such as SCP 5 – Urgent and Emergency Care, and SCP 6 – Planned Care.

ABCi is now using the IHI Breakthrough Series methodology to build, support and deliver on large scale improvement programmes. This methodology is used globally, and has delivered improvements across many complex healthcare issues within primary and secondary, improving safety and operational efficiency. The improvement collaborative methodology has a number of intended impacts for the Health Board:

- To support the transformation agenda within the IMTP and beyond.
- To continue to develop a network of improvement experts within the Health Board.
- To foster a culture of innovation and improvement.
- Extend the scope of the Unscheduled Care Collaborative.
- This has initially focused at the Royal Gwent, and will spread to Neville Hall Hospital and beyond in the coming months.

#### **3.14.4 Building Networks Inside and Outside of the Health Board**

A key aspect of innovation and improvement is in harvesting learning, evidence of best practice and developments in technology. Achieving this requires us as a Health Board to build internal networks, and look beyond our organisation and learn from others. ABCi is key to supporting this, and it actively seeks to develop learning networks and partnerships with other organisations within Wales and beyond.

- ABCi works closely with the R&D department in order to ensure that generation of new evidence is translated into practice.
- ABCi and the Value Based Healthcare Team are beginning to develop aligned thinking as to how the Health Board designs effectively for value.
- At the present time ABCi has active external relationships with:
  - Cardiff University School of Mathematics, supporting the mathematical modellers within the ABCi team.
- The Bevan Commission, supporting:
  - The Bevan advocate scheme;
  - The Bevan innovators scheme;
  - ABCi is currently one of the Bevan Innovation Hubs for Wales.
- 1000 Lives, supporting the development of the Quality Improvement agenda within Wales.
- Improvement teams within other Health Boards.
- BMJ Quality, supporting the reporting of projects and encouraging publication of improvement work to BMJ Quality Improvement Reports.
- Institute for Healthcare Improvement, one member of the team is active faculty for IHI.
- Essentia Trading Limited, providing training in Flow in Healthcare.
- A learning network with Welsh Water.

**Indicators of success** the ABCi team is committed to rigorously measuring its impact in supporting improvement and innovation within the Health Board. Whilst not exhaustive, a number of measures are outlined below:

- Number of staff trained.
- Number of improvement projects completed.
- Number of publications/ presentations at conferences.
- Kirkpatrick evaluation of training programmes, evaluating experience, learning, behaviour change and outcome.
- Collaborative specific measures.

#### **Key objectives for 2017/18**

- Build capability:
  - To continue to enhance IQT Silver.
  - To develop IQT Gold modules, beginning to build higher levels of improvement expertise.
  - To continue the development of the Enhanced Leadership and Management Programme.
  - To further develop and deliver further cohorts within the mathematical modelling course.
  - To develop a safety course.
- Support innovation:
  - To continue to evolve the 90-day innovation cycles within the Health Board.
  - To continue to foster links with WG, other NHS providers, third sector providers and industry.
  - To enhance the partnership with Cardiff University and other academic institutions.

- To apply for external funding to support innovation within the Health Board.
- To support strategic transformation objectives:
  - To embed the Unscheduled Care Collaborative, and spread to other hospitals within the Health Board.
  - To develop an Outpatient improvement collaborative.
  - To develop similar methodologies to support the safety agenda, e.g., pressure ulcers.

### 3.14.5 Research and Development

#### Current position and key objectives

Establishing R&D as a core activity across clinical and non-clinical practice is a key objective for the Health Board. The fostering of a strong culture of Research that feeds into practice is being realised, where the quantity and quality of research and innovation is increasing. The robust R&D strategy underpins and is the basis for this and the Health Board's R&D strategy will be refreshed and developed further by June 2017.

The Research & Development Division Welsh Government (R&D Division WG) is the national body that provides funding for some research through NHS funding allocations, Activity Based Funding (ABF). The amount received by the Health Board is circa £800k out of a total budget of £13.45m. Welsh Government 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, the R&D Division 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, the Health Board hosted studies requiring sample sizes of between 10-50, however these are now reduced to 2-3 patients.

The R&D Office has a workforce comprising non-clinical and clinical staff, each of whom has a clear role, demonstrating their contribution towards meeting the WG KIs. This includes leadership and management, trials organisation, research governance and the delivery of research. Each team member understands their roles, responsibilities and accountability.

To date our research focus has resulted in increasing research in specific topic areas, some new, whilst bringing new CIs into the Health Board. It enabled new PIs to become active, as well as increasing capacity and capability. This is shown in Appendix 10.

#### Benefits and Outcomes

As a University Health Board, 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 Health Board. On the other hand, the HEIs have benefitted from even closer partnership working through increased grant income, new joint grant applications, increased access to Health Board patients, staff and premises, rapid processing of permissions and increased research student placements.

The R&D Department has increased the number of academics and HEI departments that it partners with, bringing in more high quality research into the Health Board. 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 Health Board. 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.

A summary of progress in 2016/17 and plans for 2017/18 are included at Appendix 10.

### 3.15 Digital Health

In 2016/17 the Health Board drafted a 5 year Informatics Strategic Outline Plan (SOP) which sets out how it aims to facilitate the provision of high quality health improvement and health and social care across through supporting and enabling the strategic developments in analytics, information management and communication technologies. At the heart of the plan are the principles from the “Informed Health and Care: A Digital Health and Social Care Strategy for Wales” (2015).

The SOP details the technical infrastructure and information required to deliver and enable the Health Board’s strategy, the annual delivery plan for 2017/18 and future Integrated Medium Term Plans (IMTP). The programme identifies that the resource needed to deliver the NHS Wales’ and Health Boards strategic objectives, to mitigate risk and sustain its infrastructure, systems and services is insufficient. The cost is inevitably challenging and the SOP identifies an additional revenue investment of £7m per year and additional capital investment of £11m per year if the Health Board were to deliver against all the objectives within the strategy and SOP over the next three years.

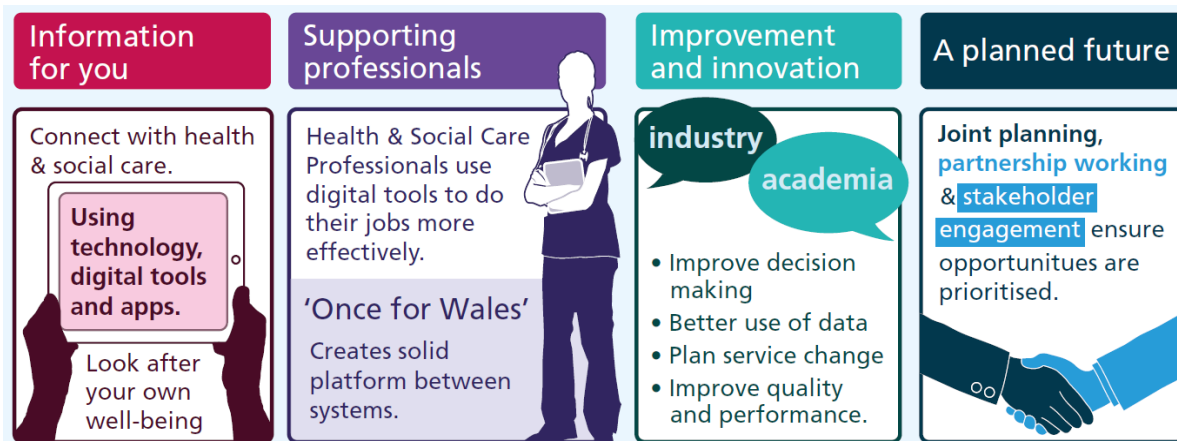
Transforming our services to a digitally enabled one and in doing so, ensuring that our services are fit for purpose and can cope with new and different expectations from our citizens, professionals and institutions, is complex and is continuous. We have considered the significant opportunities of achieving a shift to a primary care led NHS, reducing demand on hospital services and providing efficient, sustainable services. We have set out how we will realise the opportunities which arise from the accelerating pace of change in digital technology and the increasing power of social innovation, however, its success is in part dependent on wider policy, economic, social, technological and potentially legislative enablers.

However, we are clear that we must achieve qualitative and quantifiable gains across all strategic objectives, in addition to improving health outcomes; changing the culture of the organisation and improving our population’s experience and satisfaction with our care and services. These are essential to ensure sustainable services, which are able to keep pace with the needs of a rapidly increasing, progressively ageing and more clinically complex diverse population.

At the heart of our plans for this year and the next 5 years are the principles from the “Informed Health and Care: A Digital Health and Social Care Strategy for Wales” (2015). The vision is centred on the delivery of key strategic enablers which are also the focus for the Strategic Outline Plan (SOP):

- **Information for you:** Empowering people to look after their own well-being and connect with health and social care more efficiently and effectively, with online access to information and their own records; undertaking a variety of health transactions directly, using technology, and using digital tools and apps to support self-care, health monitoring and maintain independent living.
- **Supporting professionals:** Enabling health and social care professionals to do their jobs more effectively with improvements in quality, safety and efficiency by the provision of improved access to digital tools and information. These will be based on common standards and interoperability between systems, providing access to structured, electronic records in all care settings to join up and co-ordinate care for service users, patients and carers.

Figure 3.15.1



- **Improvement and innovation:** Ensuring the health and social care system in Wales makes best use of data and information to improve decision making, plan service change and drive improvement in quality and performance. This will be delivered through collaboration across the whole system, and with partners in industry and academia, ensuring digital advances and innovation are harnessed and greater flexibility and agility in the development of new services and applications is facilitated.
- **Planned future:** Delivery of transformed health and social care services, through: Joint planning, partnership working and stakeholder engagement at local, regional and national level, and ensuring that the infrastructure, resources, competencies and connectivity is in place to grasp opportunities as they present.

The approval of the Specialist Critical Care Centre (SCCC); a fundamental keystone to the Health Board’s Clinical Futures Strategy, provides a focus and a step-change in the way we deliver services and the way in which the services are supported by technology and information systems.

### Plans for 2017/18

Our programme for the next few years will be focussed on the delivery of the key strategic enablers of:

- Information for you;
- Supporting professionals;
- Improvement and innovation;
- Planned future.

The programme for the year (and subsequent years) is dependent upon national and local definitions and requirements and therefore, we will remain flexible in our delivery schedules and resources. We will continue to work closely with NWIS and our partners to deliver solutions and improvements and to ensure appropriate sharing of information across organisational boundaries.

The Health Board will continue to take advantage of systems and processes that places patients at the centre of care following them through all phases of their pathway at hospital, in primary and community care settings and with care partners with seamless transfers of care (clinical flow). Our significant investment priorities for the 2017/18 are:

#### 1. Patient Empowerment

We will be moving to a position where we can offer staff and patient’s access to systems and resources outside of the Health Board environs in order to provide clinical and support services. We will move forward in developing a mechanism by which patients can access their record over the internet – allowing them to monitor their own care and to ensure that their details are accurate.

We will further develop enabling services which allows 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).

We recognise the importance of new ways of working linked to the Well Being of Future Generations requirements and our Clinical Futures strategy that promotes and enables better co-ordinated care through a targeted and pro-active approach through improved service provision using telehealth/telecare technology such as, bedside health transaction and using video (Skype) consultations at the patient's home and in the community.

The Health Board is developing a full clinical and business strategy sitting under Clinical Futures called "Care closer to Home". The strategy is going through internal consultation and is driven by senior clinicians. Informatics requirements will be met initially through investment in a 3rd party platform which is in final procurement and business case stage which will provide capability large scale for telehealth through the national Skype infrastructure. The Health Board developed bids against this to the efficiency through technology process and whilst feedback was positive the bids were not successful (Information for People and Tele health) in this year's round, although the panel did recommend some funding for next financial year.

## **2. Value Programme**

The Health Board's Value programme is leading in terms of financial and clinical appraisal of effectiveness being driven from patient outcomes and experience. We will continue to invest in this critical area and share best practice with colleagues in Wales and beyond. Informatics is critical in delivering this agenda from how the information is collected from the patient through to how the information is presented to help make better decisions with the patient and commission services that add the most value.

Building the capability to capture integrated data sets for both clinical conditions and patient populations is a prerequisite to radical redesign of the way healthcare is delivered to meeting changing patient needs. The Health Board has secured a partnership with a third party to adopt AGILE approaches to develop new models of capture and how the data can be presented, analysed and used at all system levels is essential to success. The Health Board will seek to test this in coming months and commit to feeding back the learning through the Clinical and Informatics Networks and at Welsh Government.

## **3. Business Intelligence**

We recognise that it is information that enables continuous improvement and empowers better decisions about well-being, health and care to be taken. The Health Board aims to be leading in providing access interpretation and presentation of care data into meaningful and useful intelligence whilst improving information quality and data standards and ensuring the right quality information is provided, using clear governance and standards in data and data collections. We will ensure fair and equal access to information to providers, regulators, commissioners and the people of ABHB.

The Health Board has a variety of databases, systems and processes that creates a complex network of data sources from which Information Services create meaningful sets of information to support and inform the care of the individual and the performance of the organisation. Providing information based on individual patient level will enable policy makers, executives, managers, clinicians, care providers and the public to make decisions about care based on the same underlying data. This year we will deliver an Information Strategy that will enable:

- A structured retrospective measures of outcomes and processes: How did we do?
- A real time clinical and management tools: How are we doing?
- A prediction and modelling services: How will we do tomorrow?

## **4. Electronic Patient Flow**

The Electronic Patient Flow Management (EPfM) programme is a national programme being led by the Health Board on behalf of NHS Wales. The Health Board is key in managing the risk in investment and taking the benefits led approach engaging with operational and clinical teams, national organisations and commercial partners. This year the Health Board will undertake project work to understand implementation and benefits realisation ahead of the Full Business Case and procurement. This project will integrate the National Emergency Department and PAS systems to provide patient flow management thus improving the intra-hospital flow leading to reductions in length

of stay and delays in discharge so increasing the capacity with the same resource.

#### **5. Welsh Emergency Department system (WEDS)**

During 2016/17 the transition from a local system to a national system was completed. Throughout 2017/18 we will continue to monitor its use and determine future requirements, including, developments integrating the system to provide an electronic patient flow management system.

#### **6. Convergence with National Programme**

The Health Board remains committed to the convergence of the Health Boards clinical portal (Clinical Workstation – CWS) and the national NHS Wales Clinical Portal (WCP). This will provide access to the Primary Care Record and other vital information stored about our patients in other health organisations. The CWS functionality documentation has been completed detailing the functionality and benefits. The Convergence programme will seek to reconcile shortfalls in the national applications so that care is not unduly affected and other Health Boards benefit from the national improvements. Concordat has been agreed and a detailed delivery plan completed. It is understood that this is not simply a technical implementation but a complex cultural and change management project.

#### **7. Welsh Community Care Information System (WCCIS)**

The delivery of the Health Boards Clinical Futures strategy is inextricably linked to the delivery of WCCIS with a profound effect upon the delivery of a number of services across health and social care. Delivering the system aims to provide an integrated health and social care record enabling information about an individual to be available to practitioners from the NHS and Social Services.

This is a large project with implementation over several years. This year will focus on preparing the Health Board for its implementation. A programme is being developed with Local Authority colleagues to enable the Health Board to decide its investment strategy; understanding the technical requirements, preparing staff, reviewing processes and procedures and developing the relevant business cases. This will have impact upon many service areas with their current paper or electronic mechanisms replaced by WCCIS. All service will be included in any preparation work.

Aneurin Bevan UHB has established a programme for the implementation of WCCIS which is well represented by all recipient professions including District nurses. Using the Benefits Model from NHS Wales Informatics service, the national benefits include efficiency are currently being expanded upon and localised to the Health Board with baselines being reviewed. The programme however is complex and depends not only on one system but its integration with other systems as part of the contract which on a local and national basis is being progressed.

#### **8. Clinical Correspondence**

Aneurin Bevan University Health Board is an NHS Wales exemplar in the field of digital communications between secondary care and primary care. This year we have improved this process further through the ability for a clinician to dictate a document such as, a result report, which is captured electronically. This electronic voice file is transcribed by administration staff, electronically authorised and digitally sent to GP's including any attachments required such as shared care protocols. Each digital file is associated with the relevant patient electronic health record. Currently over 130,000 digital clinical communications documents, in addition to e-Discharge notifications, have now been sent to GP's where they are imported into the GP electronic health record. There are currently over 30% of GP practices (within the Health Board geographical area) live with this functionality, including both EMIS and INPS practice sites. We will continue to roll out this functionality throughout 2017/18. There will be further opportunities for expansion of all current elements of digital communications to and from secondary care with the implementation of the Welsh Community Care Information system which will encompass Mental Health & Learning Disabilities, Community and Therapy Services.

#### **9. Digitisation of the current paper Health Record**

The digitisation of the current paper record will continue with further progress of the Health Boards Digitisation of Health Records (DHR) project into eForm creation and use.

The Health Board has over 25% of its 400,000 acute patient records digitised with all 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.

This year is the first of a three year focus where we believe that digitisation will reach the point whereby majority of our acute patient records are digitised. The importance of this project cannot be underestimated in terms of improving patient safety, service efficiency and clinical efficacy. We recognise the pressure placed on our Health Records services to maintain both the paper record libraries and the DHR programme, and the impact on the workforce of the increased expectation that more and more records should be digitised.

## **10. Enterprise Content Management**

Enterprise Content Management will form the basis of collecting clinical and administrative data in a structured format enabled by rapid forms development with workflow for assigning tasks or sign off. A dedicated infrastructure will provide a platform for access to and input of information on mobile devices and fits in with the Health Board's strategy on staff mobility and agile working which will bring huge change to the way we deliver healthcare services. This will also provide collaborative opportunities by using knowledge gathered through experience and shared through the social platforms in order to improve decision making and reducing chances of committing errors. This year will see significant developments in the planning and preparation for change which affect the way in which we do our business including potential changes to our portals, eForms, workflow, document management and our intranet and internet management.

## **11. Technical services, devices and cyber-security**

There are significant investments to be made in our technical infrastructure in order to ensure that we have the capacity and technical capability, not only, to improve the delivery of our services but also to sustain the current requirements. Therefore, we will continue to upgrade and replace devices. This will include mobile devices that support all of our staff (medical, clinical, administrative and others) support the new ways of working requirements and also server and network devices that ensure the information remains available and secure.

We will make significant integration improvements to our Wi-Fi network enabling staff patients and visitors to access both free and secured Wi-Fi connectivity throughout Secondary, Community and Primary care settings.

Network access controls will continue to be enhanced to improve security to reduce the threat and restrict any impact of "cyber-attacks". We will need to invest in our security arrangements to keep pace with the continually evolving technological threats.

We will move to a different model of licence agreements with our application providers, where a revenue based solution will ensure latest product availability. This is a significant change to previous capital based models and will require year on year investment of approximately £1million for Microsoft products alone.

## **12. Innovation**

Partnerships are already established with Research and Development. The Health Board is represented on the Board of the new Technology Adoption Hub, hosted by Velindre NHS Trust to bring an evidence base discipline to new technology.

The Health Board is also working with the Alacrity Foundation on collaborative projects including the co-production of an Autism app for young people. The Health Board is also engaged on the European Innovation stage with membership of the ECH Alliance (a pan European innovation eco system) and will be supporting WG colleagues in establishing a pan Wales eco system. We are recognised as being attractive research, and product development partners for commercial enterprises directly and positively impacting upon patient care. The Health Board will work with organisations and commercial corporations who are keen to work with us. Currently national agreements are being discussed with the Health Board well positioned when agreements are in place.

### **13. Governance & Assurance**

We recognise that the governance of information and the systems providing and using information is one of the essential components that facilitate the effective and efficient delivery of services. Good governance provides patients, families, partners, service users and staff with the confidence that the Health Board is creating, collecting, storing and using information correctly and within the law.

Our Assurance Framework will recognise the other vital facets in delivering benefits through informatics, Safety, Security and Benefits.

This year we will be reviewing our approach to evaluate the success of new technologies and implementation will be based on a benefits-led approach and we develop a benefits realisation programme to provide an evidence based mechanism to assist with future projects and sustain these over the life of the service.

To continue and improve confidence in the way we work we will review our performance and assurance framework to ensure continued confidence in the way we work. The existing mechanism is perhaps unsuited to the current climate and we will endeavour to provide a structure that enables clear oversight and ownership of delivering the digital health strategy, which enables robust and transparent assurance of the way in which this is managed. Using our new governance structures we will be able to prioritise on value proposition affordability and achievability.

Our approach is one of individual and collective responsibility, where the governance of information is integral in the day-to-day working practices. The success of the IG Stewards programme shows the positive impact of this approach and therefore, we will continue to develop the IG Steward concept across the organisation. In tandem we will review our delivery and monitoring programmes for policy and training, using improved computerised systems.

The next few years will see an increased scrutiny around the way in which we collaborate and integrate with our service partners as well as with IG standards and changes in legislation. We will review our compliance monitoring mechanism and evaluate a change from the current Caldicott Principles in Practice (C-PiP) to the NHS England or Wales equivalent IG –Toolkit. We will continue to work closely with other organisations to use the Wales Accord on Sharing Personal Information framework to introduce and assure that information is shared appropriately between agencies.

The next year will see a major change in the confidentiality and privacy laws with a new European Union General Data Protection Regulation (GDPR), followed with changes to UK law. We will put processes in place enabling the Health Board to respond quickly and positively to any new requirements.

Working once for Wales will ensure pragmatic policies, procedures and guidance and we will continue to work with our partners to produce policies that are consistent across NHS Wales.

In line with these policies we will undertake regular check and reviews of staff use of Health Board information systems and develop further our programmes to test, check and audit the quality and integrity of the information recorded and stored on the various media with the Health Board. The new National Integrated Intelligent Auditing Solution (NIAS) allows us to monitor access to information but it is recognised that this is resource intensive.

#### **Financial Investment**

Given the scale of ambition and opportunities presented through technology, additional investment in the informatics agenda will be required to deliver the priority programmes over the next three years. Whilst the financial outlook for NHS Wales and the Health Board is challenging, the potential benefits to be delivered through technology development is potentially significant. The Wales Audit Office Report (Diagnostic Review of ICT Capacity & Resources) demonstrated that the Health Board past investment of 0.73% of budget has not met the recommended 2% level and that we are lower levels of investment across Wales despite high levels of clinical engagement and satisfaction with systems.

The draft strategic outline plans across Wales identify significant levels of investment required to

deliver the ambitions set out in the National Digital Health Strategy The priority work programme for the next three years will be dependent on revenue and capital investment availability through both the National and local (Aneurin Bevan University Health Board) infrastructure, capacity and capability, as many of the solutions are interdependent and considered to be more clinically and cost effective if approached on a “Once for Wales” basis.

Welsh Government has made some provision for capital and revenue for informatics development. Nevertheless local governance structures and processes will be used to prioritise based on value proposition and affordability whilst exploring all other avenues to realise funding opportunities.

The programme has the potential to offer significant service and financial benefits, if an equal and disciplined focus of achieving our strategic objectives is maintained. The programme has been considered so as to facilitate the improvement and addressing the drivers of increasing healthcare costs: demands on care, expensive but sophisticated treatments and management of long-term conditions.

### **Conclusion**

The plan provides a stable foundation by which the Health Board can move forward and build on the previous work by continuing to provide a robust delivery and management framework. It ensures that staff and partners are included in decision making and delivery processes and are responsible for the information they hold, record and use and ensure that the risk to service users care is minimised. At the heart of all of this is the care provided to the patient and the delivery of this year’ plans for Digital Health services and mechanisms allow our longer term strategic plans to be fulfilled.

### **3.16 Governance**

The Health Board has 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 to ensure that the health services we provide and commission and the health of the population we serve can be optimised. The Health Board also needs to ensure it maximises the opportunities provided to work in new and innovative ways through partnership approaches offered by the Social Services and Well Being Act and the Well Being of Future Generations Act to foster the integration of health, social and community based services and ensure that these are appropriate now and sustainable for future generations.

The Health Board is focused on ensuring that our organisation is structured, has decision making arrangements and assurance processes that ensure that all that we do is aligned to citizen and patient centred goals and objectives. This enables the organisation to deliver services of the highest standard and quality and seeks to ensure that the Health Board responds promptly to any circumstances where our services do not meet our expected standards. This requires the organisation to have at its centre the needs and interests our patients and the public and requires the Health Board to ensure that the public interest is at the centre of all that we do.

These values and approaches have been borne out in our own and independent assessments over recent years. However, the Health Board as an organisation is not complacent and is aware that there is continuing work that has to be undertaken to further develop, especially to continue to realise the opportunities and requirements of our status as a University Health Board.

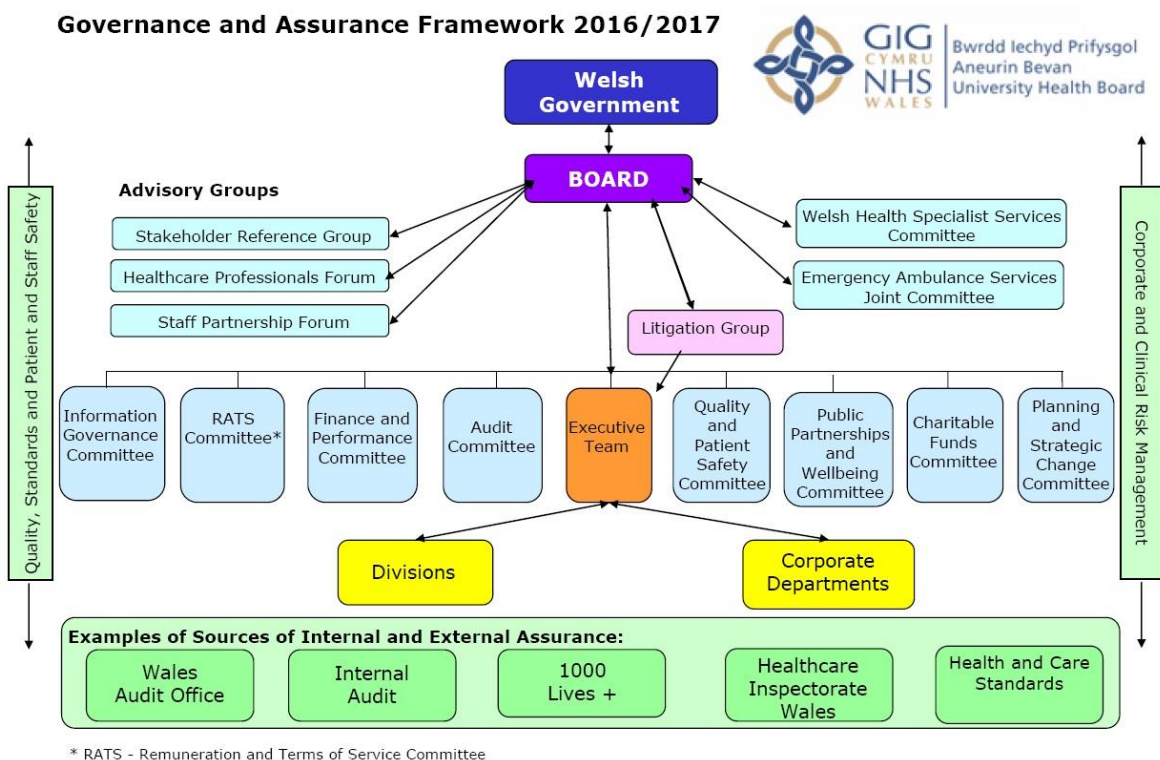
We also have to ensure our governance and assurance arrangements are clear and our Board Assurance Framework clearly maps our required sources of assurance. Also that we are clear about the threats to the delivery of our stated objectives as outlined in the IMTP and that we have mechanisms to assess and track risks to the achievement of those objectives and assurance that these are being managed in accordance with our legal and other requirements. We also have to know whether we are on track to achieve our objectives and if not we need to have early warning systems to ensure that remedial action can be taken.

Our Board is clear that it is accountable for these governance requirements and internal control within the organisation, with the Chief Executive (as Accountable Officer) responsible for maintaining appropriate governance structures and procedures and assurance arrangements. 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 Health Board 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 via the IMTP, 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 Health Board 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 Health Board's governance and assurance arrangements have been established in accordance with our Standing Orders and Standing Financial Instructions. The Health Board'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 Health Board and its Committees. Further information on Governance framework and arrangements is included in the Health Board's Annual Accountability and Governance Report, Annual Report and the Annual Quality Statement, which are available via the Health Board's web pages. The Health Board's governance and assurance arrangements are outlined in the following diagram.

Figure 3.16.1



\* RATS - Remuneration and Terms of Service Committee

The Health Board 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 Health Board is achieving its objectives and meeting our responsibilities. The extent to which Health Board 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 2016 highlighted that the organisation's governance arrangements have continued to progress to meet our stated goals. Through this external assessment of the Health Board 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 Health Board has committed to a range of actions in response to the Structured Assessment to be delivered during 2017/2018 and these include: (This section will need to be updated and clarified following agreement of the Structured Assessment):

- Introduce a Programme Management Office to ensure that there is sufficient capacity and infrastructure to facilitate the delivery of the IMTP, service plans and the delivery of the SCCC.
- Build upon our work on assurance mapping and the further development our assurance framework to ensure that the Health Board clearly articulates its corporate objectives and maps required assurances, identifies threats and risks to the successful achievement of those objectives. This will include the introduction of new arrangements for risk management and the reporting and tracking of risks against corporate objectives and the identification of what additional assurance that might be required. New style risk and performance dashboards will be used at the Board and its Committees.

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.

The Health Board will also be going through a period of significant change over the coming year with a new Chair and Independent Members as the current post holders reach the end of their tenures in post. Therefore, the Health Board will need to actively plan for this and develop a programme to support the new Board members and ensure that the governance and assurance arrangements of the Board are not jeopardised, undermined or weakened during this period and that the Health Board's positive reputation for good governance is maintained.

## SECTION FOUR – OUTCOMES & DELIVERY FRAMEWORK

This section focuses on the outcomes and delivery framework for 2016/17 and beyond to ensure the service plans deliver the desired outcomes and benefits to the patients and populations of Gwent and South Powys.

### 4.1 Delivery Approach

Our approach is based on effective delivery and assurance principles by promoting effective leadership, positive culture, mutual support, strong governance and accountability and robust performance management. This is 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.

This framework enables the monitoring of progress against achievement of key priorities and ascertaining they are having the appropriate impact and outcomes. This monitoring measures progress of key deliverables both in terms of actions and against agreed profiles. There are reporting arrangements to ensure escalation where appropriate and support to effect remedial actions. This approach is underpinned by having strong focus on the delivery of Service Change Plans which gives clarity on delivery arrangements including:

- Executive leadership
- 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 is used for each Service Change Plan and incorporated into the performance management framework, providing the means by which progress is 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 2017/18 but less granularity for the subsequent two years. The delivery framework and governance structure continues to be reviewed and will be strengthened as required as we progress through the planning and delivery process.

### Cross Cutting Opportunities

In support of both improving operational performance and delivering the Health Board's Financial Plan, a cross cutting work programme is being taken forward under the leadership of specific Executives.

**Table 4.1**

<b>Key Area</b>	<b>Executive Lead &amp; Support</b>
Organisational Bed Capacity & LOS	Chief Operating Officer/ Director of ABCi
Urgent Care Collaborative	Director of ABCi/Chief Operating Officer
RTT and Diagnostic Sustainability / Regional Plans	Chief Operating Officer/ Director of Planning & Performance
Demand Management	Chief Operating Officer/ Director of Public Health
Outpatient Transformation	Director of ABCi/Director of Planning & Performance
Improving Quality, Value & Variation	Medical Director / Nurse Director/ Executive Director of Therapies & Sciences
Therapies Review	Executive Director of Therapies & Sciences/ Director of Workforce & OD
Medical Workforce: Rates of Pay / Rotas / Job Planning	Medical Director/ Director of Workforce & OD
Nursing Workforce	Nurse Director / Director of Workforce & OD
Workforce efficiencies – sickness / e-rostering	Director of Workforce & OD
Theatres	Director of Finance/Chief Operating Officer
Accommodation Review	Director of Workforce & OD/Chief Operating Officer
Specific Projects (Llanwenath / Omnicell / Dr Dr)	Director of Planning & Performance /Interim Director of Finance

This will align opportunities identified through benchmarking to a prioritised service of interventions, with a clearly defined work programme enabled by corporate support (Planning, Workforce and Finance) and with defined outcome measures (financial and non-financial). This will be delivered through a programme management approach.

#### **4.2 Outcomes & Performance Framework**

The refreshed plan has a greater focus on outcomes and performance with a new performance management framework that were implemented across the organisation during 2016/17. This has been aligned with the NHS Outcomes and Delivery Framework as part of a new approach to performance management which has a greater focus on the improvement of population outcomes rather than just simply process.

Figure 4.1



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 e.g., PROMS, PREMS, ICHOM.

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 following table 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, with their alignment to the Health Board's Service Change Plans.

Table 4.2 - Health Board Profile for Improvement in 2017/18 and SCP alignment

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care								
Measure	Target	Profile					Related SCP	
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20		
Monthly	% of patients waiting less than 26 weeks for treatment – all specialties	95%	88.20%	88.0%	90.0%	95.0%	95.0%	SCP 6
	Number of 36 week breaches – all specialties	0	2682	1200	500	0	0	SCP 6
	number of patients waiting less than 8 weeks for diagnostics	Improvement	3484	2500	tbc	0	0	SCP 6
	% of new patients spending no longer than 4 hours in A&E	95%	76.8%	85.0%	90.0%	92.5%	95.0%	SCP 5
	Number of patients spending 12 hours or more in A&E	0	743	400	300	100	0	SCP 5
	% of Cat A Ambulance responses within 8 minutes	65%	62.60%	75.0%	75.0%	75.0%	75.0%	SCP 5
	Number of over 1 hour handovers	0	483	150	100	50	0	SCP 5
	% of patients referred as not suspected cancer treated within 31 days following diagnosis of cancer	98%	97.6%	95.0%	98.0%	98.0%	98.0%	SCP 6
	% of patients referred as urgent suspected cancer seen within 62 days	95%	90.5%	85.0%	90.0%	95.0%	95.0%	SCP 6
	% compliance with acute stroke QIMs	<4 hours = direct admission to Acute Stroke ward	95%	56.3%	70.0%	90.0%	95.0%	95.0%
<12hrs = CT scan		90.1%		98.0%	98.0%	98.0%	98.0%	SCP 3
<24hrs = assessed by a Stroke Nurse		94.4%		98.0%	98.0%	98.0%	98.0%	SCP 3
<72hrs = formal swallow assessment		85.2%		98.0%	98.0%	98.0%	98.0%	SCP 3

INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities									
Measure	Target	Profile							
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20			
Monthly	% of assessments by the LPMHSS undertaken within 28 days from the date of referral	80%	73%	80%	90%	90%	90%	SCP 4	
	% of therapeutic interventions started within 28 days following assessment by LPMHSS	80%	58%	80%	80%	80%	80%	SCP 4	
	% of LHB residents (all ages) to have a valid CTP completed at the end of each month	90%	92%	90%	92%	92%	92%	SCP 4	
	% LHB residents sent their outcome assessment report within 10 days of assessment	100%	100%	100%	100%	100%	100%	SCP 4	
6 monthly assessment	% of hospitals with arrangements to ensure advocacy available to qualifying patients	100%	100%	100%	100%	100%	100%	SCP 4	
SAFE CARE - I am protected from harm & protect myself from known harm									
Measure	Target	Profile							
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20			
Monthly	DToC delivery per 10,000 LHB population - mental health	Reduction rolling 12 months	0.8	1.8	1.5	1.4	1.3	SCP 4	
	DToC delivery per 10,000 LHB population - non mental health		17.4	16.0	14.0	12.0	11.0	SCP 5	
	Number of cases of C Difficile per 100,000 of the population	20 per 100,000	44	28	25	22	20	Q&S	
	Number of cases of MSSA and MRSA per 100,000 of the population	28 per 100,000	16	20	17	16	15	Q&S	
STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health									
Measure	Target	Profile							
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20			
Quarterly assessment	% estimated LHB smoking population treated by NHS smoking cessation services	5% (end of fin year)	2.1%	2.8%	3.5%	4.0%	5.0%	SCP 1	
	% smokers treated by NHS smoking cessation services who are CO- validated as successful	40% (end of fin year)	39%	47%	48%	55.0%	60.0%	SCP 1	
Monthly	Number of emergency admissions for basket of 8 chronic conditions	Reduction (rolling 12 months)	1289	1300	1250	1100	1083	SCP 3	
	Number of emergency readmissions for basket of 8 chronic conditions		264	260	230	225	217	SCP 3	
Annual assessment	% uptake of the influenza vaccine in the following groups:	Over 65's	75%	67.7%	68.0%	70.0%	70.0%	70.0%	SCP 1
		Under 65's in at risk groups	49.4%	50.0%	55.0%	55.0%	55.0%	SCP 1	
		Pregnant women	43.7%	50.0%	55.0%	60.0%	70.0%	SCP 1	
	Healthcare workers	50%	40.8%	42.0%	45.0%	50.0%	50.0%	SCP 1	
Quarterly assessment	% uptake of childhood scheduled vaccines up to the age of 4:	4 in 1 pre school booster	95%	84.7%	85.0%	95.0%	95.0%	95.0%	SCP 1
		HibMenC Booster	94.7%	95.0%	95.0%	95.0%	95.0%	SCP 1	
		Second MMR dose	83.7%	85.0%	95.0%	95.0%	95.0%	SCP 1	
	Rate of calls to the mental health line CALL	Quarterly improvement	227.30	192.84	192.84	192.84	192.84	SCP 1	
	Rate of calls to the Welsh dementia helpline		1.20	3.18	3.18	3.18	3.18	SCP 1	
	Rate of calls to the DAN 24/7 helpline		53.60	41.50	41.50	41.50	41.50	SCP 2	
Monthly	Of the practices capable of offering My Health on Line, the percentage who are offering appointment bookings	Improvement (12 month trend)	77.4%	83.0%	88.0%	88.0%	90.0%	SCP 2	
	Of the practices capable of offering My Health on Line, the percentage who are offering repeat prescriptions		89.3%	98.0%	99.0%	99.0%	99.0%	SCP 2	

EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful								
Measure	Target	Profile						
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20		
Monthly	Crude Mortality for patients under 75 years of age	Reduction	0.60%	0.62%	0.60%	0.59%	0.58%	Q&S
	% of episodes clinically coded within one month post episode end date	95%	75.1%	85.0%	90.0%	91.0%	92.0%	Q&S
TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care								
Measure	Target	Profile						
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20		
Annual assessment	% GP practices offering appointments between 17:00 and 18:30 at least 2 days a week	Annual Improvement	93%	95%	97%	98%	99%	SCP 2
Annual assessment	% of GP practices open during daily core hours or within 1 hour of the daily care hours	Improvement	100%	100%	100%	100%	100%	SCP 2
Quarterly assessment	Patients treated by an NHS dentist in the last 24 months as % of population	Annual Improvement	57.0%	57.0%	58.0%	60.0%	SCP 2	SCP 2
Monthly	The number of patients waiting for an outpatient follow-up who are delayed past their agreed target date (booked & not-booked)	Annual Improvement	24938	25000	15000	10000	6000	SCP 6
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities								
Measure	Target	Profile						
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20		
Annual assessment	Percentage of people with dementia in Wales aged 65 years or over who are diagnosed (registered on a GP QOF register)	Improvement	53.9%	55.0%	60.0%	62.5%	65.0%	SCP 2/4
DIGNIFIED CARE - I am treated with dignity & respect & treat others the same								
Measure	Target	Profile						
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20		
Monthly	% procedures postponed on >1 occasion, had procedure <=14 days/earliest convenience	Improvement	26.8%	35.0%	40.0%	50.0%	60.0%	SCP 6
SAFE CARE - I am protected from harm & protect myself from known harm								
Measure	Target	Profile						
		Mar-16	Projected March-17	Mar-18	Mar-19	Mar-20		
Quarterly assessment	Number of Patient Safety Solutions Wales Alerts that were not issued within the agreed timescales	Improvement	0	0	0	0	0	Q&S
	Number of Patient Safety Solutions Notices that were not assured within the agreed timescales		0	0	0	0	0	Q&S
Monthly	Number of new Never Events	0	0	0	0	0	0	Q&S
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-16	Projected March-17	Mar-18	Mar-19	Mar-20		
Monthly	% staff absence due to sickness	Reduction	5.3%	5.3%	5.0%	4.9%	4.8%	Workforce
	Patients who dna - new opa - specific specialties	Reduction	6.4%	6.9%	6.5%	6.4%	6.3%	SCP 6
	Patients who dna - follow-up opa - specific specialties		7.3%	7.4%	7.0%	6.9%	6.8%	SCP 6
Annual assessment	Percentage of staff undertaking performance appraisal	Improvement	69.7%	68.0%	72.0%	75.0%	80.0%	Workforce

In addition to the above, at a high level, the following tables set out what the organisation is planning 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% for Hib/Men C boost.
- Improved uptake of smoking cessation to 3.5% population, with 40% validated as successful in quitting.
- Improved uptake of flu vacs by staff to 45%.

- Extend roll out of Living Well, Living Longer.
- Transferred more specialist hospital services to primary care settings to bring care closer to home.
- Refreshed chronic condition delivery plans such as end of life and respiratory services.
- Commenced redesign of older adult mental health services following consultation.
- Developed a transition plan for paediatric and obstetric services following engagement and in partnership with Cwm Taf and Powys Health Boards.
- Implemented and sustained a new workforce model for neonatal services which is independent of Deanery training.
- Provided more effective care, close to home for patients with complex mental health needs.

Improved operational efficiency and effectiveness:

- More care provided by integrated teams.
- More care planned and delivered around NCN communities.
- Started building the SCCC, with transition plans developed to manage the period to opening.
- Eliminate >8 week diagnostic waits, in particular to improve access for cancer treatment.
- Further reduce the incidence of *C.difficile* and *S.aureus* infection to deliver population denominated targets, building on previous successes.
- Reduce the number of patients waiting over 36 weeks to 500, with 90% compliance at 26 weeks.
- Agreement of an implementation plan for the further centralisation of vascular services in South East Wales, with 24/7 interventional radiology provided across the South East region.
- 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.
- Reduced sickness absence to < 5%.
- Reduced crude mortality in >75 year olds to 0.6%.
- Improved 4 hour performance to deliver 90% compliance, with parallel improvements in 12 hour and WAST performance.
- Defined the work programme and delivery structure to support the new strategic programmes.
- Sustained the position where off-contract agency has been excluded from usage.

By the end of Year 3 we hope to achieve or have made significant progress towards:

- Everyone able to live longer healthier lives at home, or in a homely setting. The Well Being of Future Generations will underpin the core business of the Health Board.
- 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 2021.

- The services provided by the Health Board will be planned on a regional basis.
- 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 the Health Board 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.

## APPENDICES

	<b>Descriptor</b>	<b>Format</b>
1	Plans for Quality Improvement - 2017-20	Word doc
2	Scope of the Health Board’s Value Based Healthcare programme: Assessing the Value and Measuring What Matters	Adobe
3	Integrated Performance Report	Word doc
4	Local Delivery Plans	Word doc
4A	Health Board’s priorities for improving the management of rare diseases	Word doc
5	Detailed Information on All-Wales Capital Projects	Word doc
5A	Current Schemes – Care Closer to Home, Primary Care Projects	Word doc
6	Emergency Department patient flows (by acute hospital site)	PowerPoint
7	ABUHB Action Plan in response to Principles, Framework and National Indicators: Adult In-Patient Falls, WHC(2016)022	Word doc
8	Dementia Board Outcome Measures Framework 2016/2017	Word doc
9	Compendium of New Roles and Workforce and OD Work Plan	Word doc
10	Research and Development – current position, objectives, priorities and programme for 2017/18	Word doc

## TEMPLATES

Comprehensive set of updated mandatory templates are attached