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WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Integrated Medium Term Plan 2016/17 – 2018/19

SUMMARY PLAN



INTRODUCTION

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

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

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

This report is divided into three sections:

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

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

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

This report is supported by a detailed technical document which complies with the Welsh Government planning guidance and serves as a reference document which provides greater detail and depth to the key areas covered in this overarching plan.

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.



- *Working with you for a healthier community*
- *Caring for you when you need us*
- *Aiming for excellence in all that we do*

During 2015/16, we continued to take forward our vision and our key purpose:

- Improving public health 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.
- Ensuring safety, excellence and quality in all our services at all times.
- Trusting and supporting our staff to make the right decisions for patients and to improve care.
- Effectively using resources to ensure we provide high quality, value for money patient care.



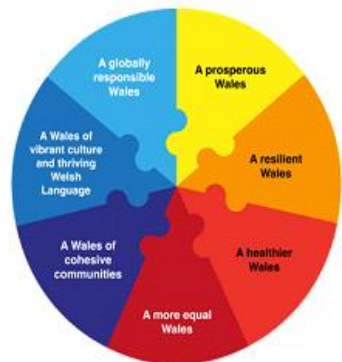
Our Values

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



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. It requires public bodies to report on such action: including, setting and publishing well-being objectives that are designed to maximise its contribution to achieving each of the 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 who need support and for transforming social services in Wales. The Act requires Local Authorities and their partners to consider the integration of care and support 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 **Welsh Government Primary Care Plan** aims to develop a more “social” model of health, which promotes physical, mental and social well being, rather than just the absence of ill health and draws in all relevant organisations, services and people to ensure the root causes of poor health are addressed. The plan seeks a health system designed around providing preventative and ongoing care to meet individual’s needs close to their homes.

These world leading pieces of legislation, and the Primary Care Plan coupled with continued focus on delivering a **Prudent Healthcare System** have shaped the Integrated Medium Term Plan 2016/17 – 18/19.



“A prudent healthcare system, in which the avoidance of harm is our watchword, in which we pitch our interventions at the minimum necessary to address the problems which patients experience, will always have primary care at its heart”.

Mark Drakeford AM, Minister for Health and Social Services (Feb 2015)

The Health Board faces the same **national challenges** that have been well rehearsed across public sector bodies; an ageing population in declining health with ever increasing complex needs; patient acuity is heightened and a disproportionate number of our adult population live with one or more chronic conditions.

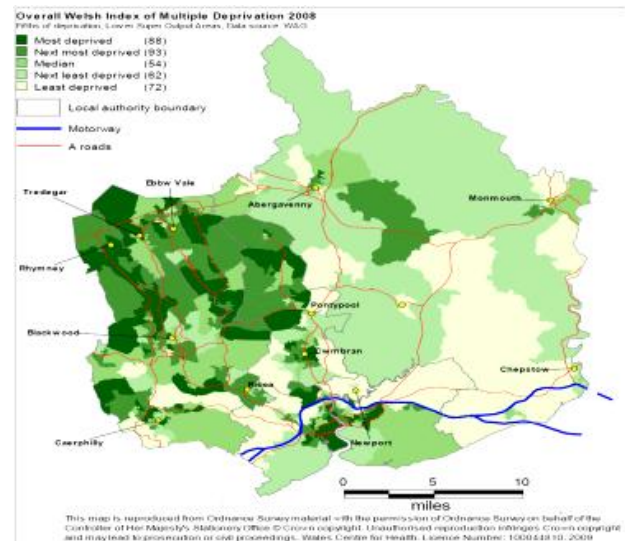
Standards of clinical care and outcomes are rightly rising, ensuring that people with more serious or life threatening needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery. Equally important is the need to harness technological advancements, providing much better and more easily accessible information and services to people to support self care, access the right care and focus delivery of the majority of care close to home.

1.3 Local context

The local population is at the heart of everything we do and covers diverse geographical areas with a mix of rural, urban and valley communities. The valley areas experience high levels of social deprivation, including low incomes, poor housing stock and high unemployment resulting in many challenges.

- 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.
- A quarter of adults are obese (BMI ≥ 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%.
- Alcohol misuse with around 41% 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 10 years lower for residents in the most deprived areas of Gwent then in the least deprived areas.
- In four of the Local Authority areas a high percentage of children are living in poverty
- 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 and is a consequence of poor health in most cases.

Our primary care and community infrastructure has developed exponentially 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 over the last 5 years at Ysbyty Aneurin Bevan and Ysbyty Ystrad Fawr, however, our hospital infrastructure is based largely on the 1960s District General Hospital model; with much of the estate no longer fit for purpose and offering poor patient environments, fragmentation and duplication of scarce clinical services across two district general hospital (DGH) sites at Nevill Hall and Royal Gwent Hospitals, with an over reliance on hospital based care.

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:

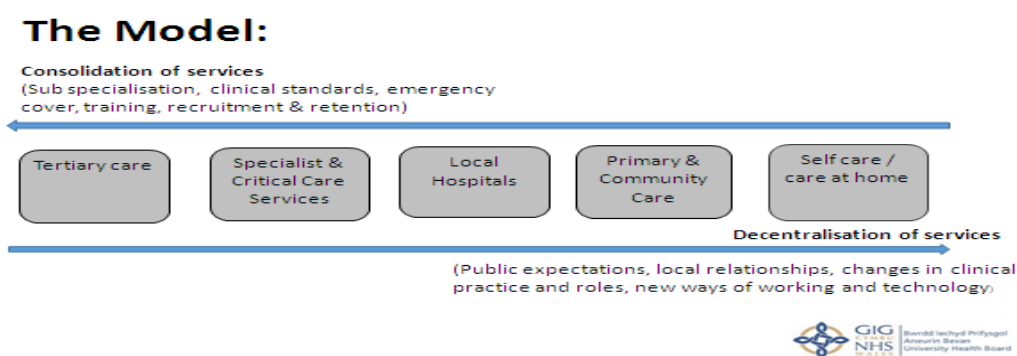
- Skills shortages, recruitment challenges.
- The ageing workforce profile.
- Deanery rota and training standards compliance.
- Provision of 7 day and extended services for a number of professional groups.
- Specialist skills spread too thinly on existing hospital site configuration.
- Increasing demand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

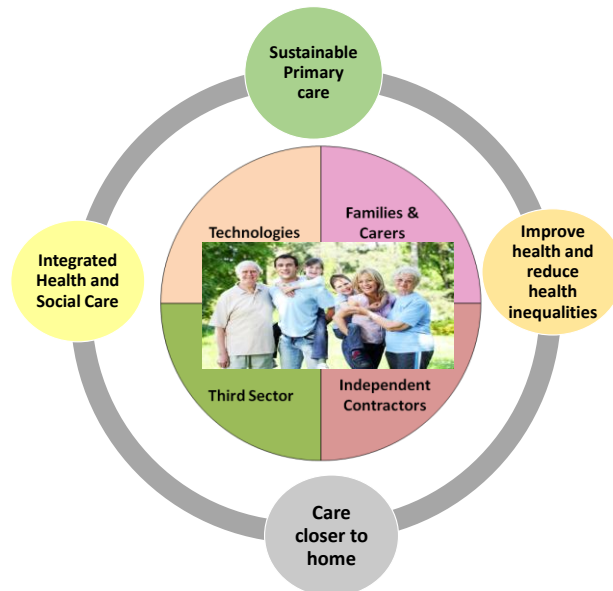
1.4 Clinical Futures Strategy

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, (using our Neighbourhood Care Networks as the foundation for this), working with partners to develop integrated teams that work at a locality level to support individuals independence and recovery, and ensuring world class hospital services for people when they need them.

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



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. Enhanced access to primary and community care services (urgent and planned) 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 Specialist and Critical Care Centre (SCCC).



SCCC – A Step Change will:

- Concentrate on sickest patients on one site
- amalgamate Emergency Department (ED) consolidating critical emergency services
- allow consistent services across 7 days
- improve access to comprehensive diagnostics across 7 days
- concentrate smaller fragile specialties
- improve patients safety – consultant led service across 7 days
- facilitate rapid turnover (<72 hours)
- separate routine/planned care from emergency care

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 and training issues and improved flow and system performance. Additionally it will improve patient experience and provide modern facilities for the delivery of care.

The Clinical Futures strategy initially developed in 2004 by the Gwent Health Community has remained both relevant and resilient for over ten years, receiving universal support across the community through extensive consultation. It responds to the local health challenges of the Gwent population and its supports a modernisation agenda that is entirely consistent with all national strategies and Royal College reports and recommendations.

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. These include:

- Being focused on our population health responsibility and commissioning role to meet population needs.
- Delivering services that are high quality and safe.
- Actively engaging patients, carers and communities and building strong partnerships to ensure services focus on need.
- Focusing prudent and value based healthcare to ensure we consistently aim to improve clinical value.
- Trusting and empower our staff.
- Driving excellence through innovation and research embedded in practice.

Quality and Patient Safety

Quality and patient safety is at the centre of our work in seeking to achieve excellence, with the patient and carers at the heart of everything we do as we strive to improve the patient’s experience and quality of service in primary care, in community services and in our hospitals.

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

Living Our Values¹



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

The 22 Health and Care Standards 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.

¹ Living our values (Figure above) requires every member of staff to consider five simple questions, which align behaviour and culture, providing an environment in which quality flourishes, with the patient at the centre and an equal partner in their healthcare.

- Compliance with fundamental aspects of Trusted to Care including dementia, nutrition, hydration, medicines and continence care.
- Aim to reduce Risk Adjusted Mortality Index (RAMI) to 90 by March 2017 and sustain this reduction to reduce/eliminate variation across our hospital sites.
- 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.
- Improving the quality improvement skills of our staff.

Population Health and Commissioning

The Health Board as a commissioning organisation is responsible for the health and well being of its population and we are developing a more structured and rigorous 'commissioning' approach to planning and delivery of services. This approach will be informed by the 'Value Based Healthcare' principles set out above to ensure the development of a commissioning system that prioritises resources to drive performance improvement in healthcare outcomes for patients and residents, within an ethical framework of decision making.

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

The Health Board will continue 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.

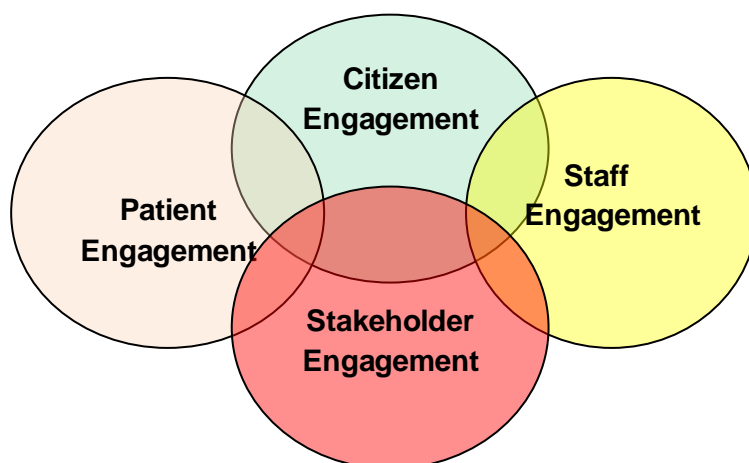
Patient Experience

Patient experience is also a key feature of this plan, ensuring the views of patients, carers and the public directly inform and impact on the way we deliver care and the development of Patient Reported Experience Measures (PREMS) to help support this work programme.

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.

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 '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. Pill Regeneration Project, Markham Winter Soup event, Communities First activities, 50+ fora.
- **People Network** - is also being established which will offer citizen views and perspectives.

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.

Prudent and Value Based Healthcare

Our Board made a commitment in 2013 to seek to make prudent healthcare an active movement for change within and outside our organisation. We see prudent healthcare as a vehicle to deliver new ways of working within a clinical value-based framework and will enable lower healthcare costs whilst also providing improved quality for patients and offering opportunities for outcomes to be collaboratively and coproduced with patients and the public. In taking forward prudent healthcare our focus is on three key areas –innovation and improvement, communication and engagement and measurement and delivery.

We seek to ensure that resources are used most effectively to deliver the highest quality of care for patients, to reduce costs, limit harm and variation in delivery and

contribute to positive outcomes for patients. This includes treatment(s) which have no, or limited evidence base and tests which may lead to over diagnosis and over treatment with the associated harms.

A number of key initiatives have progressed based around prudent principles, seeking to produce a more value based approach. There have been developments in clinical areas (including Orthopaedics, Respiratory and Dermatology services and Medicines utilisation). We have developed a relationship with the International Consortium for Health Outcomes Measurement (ICHOM). This provides an international clinically validated basis for the future measurement of outcomes – which we believe to be vital to improving the understanding of clinical value and providing services that meet the needs of our local population.

Staff Empowerment and Organisational Development

The challenges facing the University Health Board are significant, however, 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 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.
- Enhancing and protecting the well-being and health of staff.
- Building reciprocal relationships with the community we serve.

Our commitment is to equip our staff with the knowledge, skills, experience, competencies and confidence they require. 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.

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, and how our behaviours in embracing clinical research, disseminating research and innovation, embedding service evaluation and developing strong partnerships with Universities, in and outside of Wales, have changed.

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.

In summary whatever the setting, care will be provided to the highest standards of quality and safety, with the citizen at the centre of all decisions. At all times, in every part of the system, we will strive to be 'best in class', pushing the boundaries of efficiency, effectiveness and proportional interventions in accordance with Prudent Healthcare. There will be a focus on ensuring that people are supported in their home or community environment as soon as appropriate.

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

SECTION TWO – DELIVERING OUR PLAN

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 (Clinical Futures).

The Clinical Futures Strategy is an essential underpinning of the IMTP, and this IMTP seeks to provide the bridge to the proposed opening of the SCCC in early 2020. 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.

As we approach the commencement of Year 2 of our approved three year plan, it is important to reflect back on 2015/16 and capture the key achievements and lessons learnt from year 1 which has helped inform the refresh process of the IMTP.

2.1 Achievements in Year 1 of the Plan

- Living Well Living Longer project extended with over 2000 patients attended with 29% referred for further clinical assessments.
- 28% of smokers referred to Stop Smoking Wales and 38 community pharmacies now accredited for smoking cessation services, 7% with BMI>30 to Adult Weight Management Service and 25% of moderately inactive individuals referred to National Exercise Referral Scheme.
- Liver Disease Delivery Plan approved with proposals for an integrated alcohol treatment pathway.
- Establishment of the Primary Care Improvement and Support Team to support fragile practices.
- Recruitment of practice based pharmacists and having a positive impact on GP practice capacity
- Greater pace with Care Closer to Home enabled by significant investment in Primary Care Services. Over 5,000 outpatient appointments undertaken in primary care as part of the glaucoma follow up and oral surgery projects with well developed plan to implement Ophthalmic Diagnostic Treatment Centres in 2016/17 supporting further transfer of care closer to home.
- Service redesign projects implemented using the prudent principles implemented such as the development of the osteoarthritis knee pathway and teledermatology service resulting in over 1000 outpatient appointments being avoided to date.
- Significant (47%) reductions in incidence of C.difficile.

- Significant progress in mitigating forecast CHC growth delivering breakeven in year.
- Transformation of Stroke Services in the Health Board and early indications of performance improvements.
- Implementation of new clinical models in Paediatrics and Obstetrics to sustain services at NHH and for acute medicine at YYF.
- Extended Rapid Assessment Interface and Discharge (RAID) model for older adults with mental health to cover both RGH and NHH.
- Significant improvement in performance against the target for mental health assessments within 28 days
- Introduced the "Green2Go" nurse led ward
- Reduction in bed related cancellations through improved Winter Planning.
- Improvements in Category A response times.
- Reduced delayed transfers of care over time despite levels still being high
- Clinical Futures and SCCC cases submitted for funding approval.
- Strengthened engagement function with over 5,000 direct contacts with the general public.
- Delivery of improvements in elective access in the last 6 months of 2015/16
- Delivered and sustained improvements in cancer access.
- Exemplary delivery of the NMC Nurse Revalidation Pilot.
- Implementation of a Choice of Accommodation Policy to improve patient experience and transition to Nursing or Residential Homes.
- Extension of prudent healthcare programmes to encompass value based healthcare and collaboration with ICHOM.
- Collaboration with neighbouring Health Boards in the agreement of a case for capital investment in neonatal services in South East Wales.
- Updating of the Clinical Futures plan to reflect the clinical models defined by the Collaboration's Clinical Reference Groups for medical and surgical specialties.
- Increased the volume of paper records to electronic (100,000 patients records now digitised);
- Implement a text reminder service (DrDoctor) to facilitate a 30% reduction of 'Did Not Attends';
- Improved clinical communications between primary and secondary care with 8,000 discharge notifications, 10,000 referrals and 7,000 clinical letters now delivered electronically per month;
- Implemented the award winning Information Governance Stewardship programme.
- Delivery of financial balance

Whilst the Health Board delivered on a range of issues and plans in 2015/16 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 plans
- The assessment of demand growth especially around the unscheduled care service during the winter months with 20% growth above 2015.
- The workforce pressures due to the national recruitment issues and additional funding that resulted in increased posts.
- 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.

2.2 Approach to Planning in 2016/17

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



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

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

2.3 Operational Planning - Improving Operational Efficiency

ABUHB 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.

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 88 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 35,000 referrals. This will link in with the Outpatient Transformation Programme and Prudent Healthcare reviews around demand management.

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

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

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

2.4 Tactical Planning - Service Change Plans

Where there are cross-cutting workstreams, high risk issues or corporate priorities, these have been scoped and form the basis of the Service Change Plans. With a vision of integration and improvement, we are concentrating 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 aligned and organised around the 10 overarching service change plans set out in the approved IMTP and this framework has been retained. These include:

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

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



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.

2.4.1 Reducing Health Inequalities and Improving Population Health (SCP 1&2)

The aim of this programme area is to reduce health inequalities and 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 treatment of disease.

The key deliverables come under SCPs 1 and 2 which are inter-connected and include the following work streams:

- **Living Well, Living Longer** – this 3-5 year programme is about improving access and the take up of primary care in areas of deprivation and poor health in order to reduce the incidence and impact of cardiovascular disease, cancer and diabetes. Over the next 12 months, the risk assessment health checks and management plans will be rolled out to all eligible adults in the Caerphilly North and Blaenau Gwent West NCN areas and will then be extended to Newport East and West in 2017/18.
- **Reducing Inequalities in Cancer Detection and Survival** – A Health Board strategy for addressing cancer inequalities is being developed, covering five cancers of particular population health significance: lung, colorectal, head and neck, breast and liver cancers. The focus of the initial phase of the strategy being delivered through the Living Well Living Longer programme is the prevention of cancer by tackling the major modifiable lifestyle risk factors and encouraging uptake of cancer screening programmes. The next phase will focus on early diagnosis and referral of patients with cancer and will cover health seeking behaviour of patients, improving symptom awareness in both patients and professionals and further increasing uptake of screening services. It will be informed by an analysis of the results of the audit of new cases of lung and gastrointestinal cancer being undertaken by GP practices as part of the General Medical Services contract.
- **Population Health Promotion and Reducing Inequalities in Health Due to Lifestyle Factors** – includes working with NCNs and Communities First projects to map the availability of services that support lifestyle changes such as diet, smoking cessation and regular exercise. Further actions on alcohol will be implemented as part of the Health Board's Liver Disease Plan, e.g. an Alcohol Care Team is being established at RGH and NHH in the early part of 2016. Community Health Champions will be extended to other areas and there are ongoing health check and awareness campaigns to increase uptake of health screening and early detection of diseases such as cancer, diabetes and cardiovascular disease. It also aims to

address healthy living options and community support for maintaining mental well-being and the provision of foundation tier mental health support services.

- The scheme called '**Make Every Contact Count**' is about ensuring that the Health Board's service providers and its partners use the thousands of contacts they have with people, to provide information and advice about making healthy lifestyle changes.
- **Healthy Children and Young People** – The Welsh Government's 'Tackling Poverty Strategy' encompasses action to reduce inequalities in health which both increase the risk of illness and death in infancy and the risk of cardiovascular disease and diabetes in adult life. A Gwent regional action plan has been developed in a partnership between the Health Board, Public Health Wales and the Local Authority Anti-Poverty Champions. The plan focuses primarily on prevention of smoking and smoking cessation (particularly during pregnancy) and reducing teenage conceptions. A childhood obesity delivery plan for the Health Board will be implemented.
- **Reducing Inequalities for Homeless People and Vulnerable Groups** – Homeless people and other vulnerable populations experience significant ill-health, often have complex needs, and have worse health outcomes than the general population. A health needs assessment is informing the development of a University Health Board Homeless People and Vulnerable Groups' Health Action Plan, including some reorientation of dental service provision. The Living Well Living Longer programme will be extended to ensure it reaches vulnerable groups such as asylum seekers and refugees. The Health Board is also working with local authority partners on the Syrian Resettlement Programme and is represented on the Operational Delivery Board at a national level.
- **Wellbeing of Future Generations Act** – The Health Board has a leadership responsibility for improving the health of the population in conjunction with partners on Local Service Boards and other partnerships. The forthcoming legislative requirement for Wellbeing Plans will strengthen the expectation that a partnership approach is adopted to address the social determinants of health. Local Authorities have a crucial role to play in improving population health, particularly through their influence on the physical environment and local communities. The Health Board is working with all partners (the public, voluntary sector, Local Authorities, and independent sector e.g. Housing Associations) to collectively invest expertise and resources towards improving population health. This includes contributing to the development of Gwent wide Public Service Boards and the assessment process.
- **Immunisations and Vaccinations** – there are a number of programmes targeting different groups to prevent infectious diseases such as measles, mumps and influenza. These include children and young people, older people, people with chronic diseases and our staff. The Health Board will be focusing particularly on improving uptake of flu vacs by staff in order to protect vulnerable patients and reduce unnecessary spells of sickness. It will also focus on reducing the gap between the rate of those reaching the age of 2 years, who are fully up to date with scheduled childhood immunisations, across all NCN areas.

2.4.2 Supporting a further shift of services closer to home through building a NCN foundation for delivery of care (SCPs 3, 4, 5 & 8)

The overall aim of these Service Change Plans (SCP) is to strengthen primary, community and mental health care in order to establish sustainable services that support the delivery of care closer to home, with services planned by Neighbourhood Care Networks according to the needs of local populations. These will be focused on prevention, early identification of problems, early intervention to respond to needs, comprehensive management of chronic conditions, preventing avoidable admissions to hospital and facilitating timely and effective discharge.

In terms of primary and community care, 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. There are clear links, in this regard, between the work programmes cited for **SCP3** (Strengthening Primary Care and Community services), and those set out in **SCP1** (Reducing Health Inequalities), **SCP2** (Health Prevention and Promotion), **SCP4** (Bringing Care Closer to Home) and **SCP5** (Chronic Conditions Management). There are also links with **SCP 9** (Urgent and Emergency Care) relating to the provision of Primary Care Out of Hours and the interface of Community Resource Teams with Emergency Departments and Out of Hours. In addition, and in the context of strengthening the primary care element of the Clinical Futures Strategy, work is underway to develop a 'Care Closer to Home Strategy' that will articulate how a shift of focus from hospitals and illness to an integrated health and social care system will build capacity in out of hospital services and thus improve patient experience and outcomes. The Strategy will include all services delivered in primary care and will be underpinned by a five year delivery programme.

An outline of the work programmes for SCPs 3-5 is provided below:

SCP 3 – Strengthening PC and Community Services

These work programmes are designed to deliver objectives of the Primary Care Plan for Wales which include measures to strengthen leadership in General Practice and optimise the way we use our workforce to improve community support and service sustainability. Key work streams include:

- **Neighbourhood Care Network (NCN) Development** - our twelve NCNs provide the means of planning care locally with multi-disciplinary and multi-agency partners to meet local population health needs. Plans include measures to develop practice population risk stratification and care co-ordination strategies with Stay Well plans and 24/7 Community Nursing services.

- **GMS optimising access plans** – to improve access and quality of primary care ensuring patients receive equitable access to high quality services. There are a range of plans which address issues such as infrastructure and IT, reducing variation in practice, enhanced services and reviewing skills at Practice level. To date this has delivered an extended skill mix of practice based pharmacists, physiotherapists, social workers, phlebotomy services and tissue viability nurses.
- **Primary Care Out of Hours** - a revised service model has been developed with a 5 year programme to increase the numbers of advanced nurse practitioners, advanced paramedic practitioners and pharmacists to provide alternative capacity to meet demand, as the traditional GP service cannot be sustained. It is planned for nurses and paramedics, appropriately trained, to provide home visiting services and to concentrate the available GP resource for patient triage. A nurse bank is also being established to provide support for both the in hours and out of hours primary care nursing service.
- **Strong Leadership** - working in partnership with the LMC and GPC Wales, to develop and support implementation of a GMS workforce model which is clinically led by GPs but which maximises the skills and expertise of other primary care professionals.
- **Other Independent Contractor PC Services** – additional work programmes to develop dental, optometry and pharmacy services closer to home.

SCP 4 – Integration - Bringing Care Closer to Home

These work programmes are designed to deliver service transformation which results in a significant shift in the way services are provided across hospitals and the community, with some provision moving from hospitals to the community where safe and effective to do so. In rebalancing the system they will support care closer to home for our frail and older people, our patients with chronic conditions and those requiring long term care whilst allowing our hospitals to concentrate on what they do best - providing both planned and emergency care when it is needed.

In addition, the Health Board is developing a ten year Care Closer to Home Strategy which will clearly articulate how out of hospital services need to transform to support the whole system change required. This Strategy will be presented to the Board in July 2016. This will be aligned to the emerging guidance for implementing the Social Services and Wellbeing (Wales) Act 2014. The Strategy will be developed with its stakeholders including Local Authorities, the third sector, professional bodies, managers, clinicians, front line staff and citizens and will be underpinned by a rolling five year delivery and outcomes framework. It will be based on the principles of prudent healthcare to ensure the whole system transformation required is as efficient as possible and represent value based care.

Key work streams include:

- Delivering more eye care closer to home, e.g. Glaucoma care in 2 PC-based centres and Wet Age-related Macular Degeneration care in one primary care based centre will see approximately 3,000 new and follow up outpatient appointments per annum transferred from hospital based glaucoma clinics and approximately 7,000-9,000 new follow up and treatment slots per annum for Wet AMD transferred from

hospital based eye clinics to the primary care based Ophthalmic Diagnosis and Treatment Centres.

- Rolling out across Newport NCNs the new referral pathway for osteo-arthritis of the knee. This is a scheme designed to enhance the management of osteoarthritis in primary care, which sets out to equip patients with the knowledge to make fully informed and appropriate decisions about their own care that relate to their personal context. This is an alternative pathway for GPs, where patients are referred to a community group managed by nurses and physiotherapists as opposed to directly to secondary care orthopaedic services. This group has the ability to refer on to alternative services
- Implementing a primary care based anticoagulation service. At present 14 GP practices within the Health Board provide a full anticoagulation service which provides a one stop shop for patients. For the remaining 71 practices patients must rely on the hospital for either laboratory analysis and/or dosing of warfarin. This scheme is in 2 phases. Phase 1 involves GP practices providing the service for their own patients currently being managed in secondary care. In Phase 2 GP practices or community service provides will provide the service for non registered patients. This is expected to transfer around 5900 patients in total on completion of the scheme. Implementation will be supported through the agreement of a National Enhanced Service for GMS.
- Continue to progress further schemes for:
 - community deep vein thrombosis service,
 - children's abdominal pain/continence,
 - community cardiology and
 - other ambulatory care sensitive conditions.

SCP 5 – Chronic Conditions Management

This work programme aims to deliver seamless, holistic and integrated care pathways for the key chronic conditions identified as national priorities, to improve prevention, clinical outcomes and living with disease. It also tackles prevention of disease through informed lifestyle choices.

Key work streams include:

- **Diabetes Pathway Transformation Plan** – Diabetes is an area where the Health Board will explore costed care pathways and consider the establishment of a 'whole system budget', whereby the entire indicative budget for diabetes care for the Health Board is delegated to NCNs. These NCNs would then work with their local Patient Reference Groups, through co-production methodology, to determine the development of patient-focused services, utilising the resources of the entire community to prevent, detect and manage diabetes. However, more work is needed to provide baseline data and agree metrics for analysis to support such a budgeting approach. This would form part of a greater programme of works to improve outcomes of chronic conditions.
- **Respiratory Delivery Plan** - priorities of the plan include; enhancing smoking cessation support, identifying variation in prescribing practice and measuring the

effectiveness of our strategies to optimise medicines. We will also explore furthering the integration of specialist care into the extended primary care team, review the Community Pulmonary Rehabilitation Service including improving the interface with Third sector to better manage pulmonary rehabilitation support; making available accessible community venues and developing a unified referral process.

- **Liver Disease Delivery Plan** - the Health Board's Local Delivery Plan responding to the *Together for Health: Liver Disease Delivery Plan for NHS Wales and its partners to 2020* was submitted to WG in August 2015. Good progress has been made on implementation. Priorities include developing an Alcohol Care Team at RGH and NHH, designing targeted community testing programmes for Hepatitis B and C and alcohol misuse prevention programmes for schools and the over 50 age group.
- **Stroke Delivery Plan** - aimed at improving and maintaining the performance in stroke services in line with the Health Board's Local Delivery Plan, Welsh Government Stroke Delivery Plan and Royal College of Physicians Stroke Standards. The priority over the coming year will be to realise the benefits of the re-designed pathway and to implement Patient Recorded Outcomes Measures (PROMs) and Patient Recorded Experiential Measures (PREMs).

Further workstreams are in place to deliver the Neurological Conditions Local Delivery Plan including development of community neurorehabilitation, refresh the Heart Disease Local Delivery Plan, deliver patient experience surveys and co-production events and targeted research.

SCP 8 – Mental Health and Learning Disabilities

The aim of **SCP 8** is to strengthen Mental Health and Learning Disabilities services as described in the 'Together for Mental Health' Strategy and 2012 local integrated strategies developed in partnership with Local Authorities.

A key objective is to ensure that the needs of local populations are met through an integrated whole system service model which means reducing variation in service provision across different localities and close working with other divisions, third sector partners and other statutory bodies such as the Police and local authorities. The service is facing pressure from rising demand and greater acuity of presentations which is not sustainable in the longer term. The 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 suitable environments of care for this client group, with many having to take up external placements to meet their needs.

The work programme consists of 13 work streams which can be described under the following overarching themes:

- **Prevention and early intervention** via the enhancement of Foundation Tier and Primary care services. These include commissioning a new service model from the

Third Sector and improving Primary Care Mental Health Support Services to consistently meet tier 1 targets.

- **Acute, crisis and inpatient services** involving reviews of adult and older adult inpatient services and Out of Hours service remodelling.
- **Improving access** to evidence based interventions such as psychological therapies, neuro-developmental pathway, older adult mental health liaison and the roll out of RAID, and reviews of community and specialist services for Learning Disabilities.
- **Accommodation and supported living** – ongoing reviews for learning disabilities residential services and a range of 'In One Place' Projects with housing for adults with mental health or learning disability needs.
- **Supporting those with complex needs** including continuing health care (CHC). Mental Health and Learning Disabilities CHC is currently seeing 30% of the overall budget for the Mental Health and Learning Disability Division spent on CHC. Demand forecasts this rising to over 50% of the budget being allocated to services outside of the NHS in the future which is not sustainable.

The Mental Health/Learning Disability CHC Plan therefore focuses on:

- Collaborative working between the Community Mental Health Teams and CHC Team.
- Reconfiguration of existing in-house assets and services to meet with change in demand.
- Defining a strategic plan which seeks to deliver more services closer to home, e.g. in a new Low secure unit, High Dependency Unit and extended Paediatric Intensive Care Unit (PICU) and via different service models for complex care.

2.4.3 Improving Access and Flow and Reducing Waits (SCP 9 &10)

To rebalance the system of care to ensure patients with urgent care needs can receive the right care in the right place, at the right time, by the right service in a coherent and coordinated system 24/7 and to improve waiting times and access to key elective services on a sustainable basis in order to ensure patients consistently receive timely, effective care.

SCP 9 - Urgent and Emergency Care

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 20% increase in admissions 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.

Delivering sustainable urgent and emergency care services remains a priority for the Health Board and clinical and management action is focused on finding 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.

We want Urgent and Emergency Care to become a coherent, co-ordinated, high quality system of care that works seven days a week, and where possible 24 hours a day, in accordance with patient expectations, delivering the best clinical outcomes and this is being driven through the Urgent and Emergency Care Board which includes multi disciplinary and partner organisation representation.

The Urgent and Emergency Care work programme is consistent with the National Unscheduled Care framework system and includes ongoing work with WAST around the 5 step model and implementing the immediate release protocol.

The key work programmes are summarised in the following table against the six National optimal outcomes.

<h2>Care Close to Home</h2>	<ul style="list-style-type: none"> • Out of Hours new model implementation • 111 project supporting primary care (2017/18 for local launch) • 24/7 community nursing and district nursing • Optimising access to GP for urgent care • Promoting Choose Pharmacy and Choose Well • 7 day rapid response and admissions avoidance in place • Sustainable GP infrastructure and support team in place
<h2>Agreed Care pathways</h2>	<ul style="list-style-type: none"> • Falls pathway and dedicated vehicle in place • Mental Health Pathway in development with dedicated vehicle • Advanced Care planning with Nursing Homes • Stay Well planning for Newport • LTC teams in place for Diabetes and COPD • Community Cardiology Project implementation • Stroke Pathway in place • Ambulatory Care Pathways identified and pilot planned
<h2>Clinical process Excellence</h2>	<ul style="list-style-type: none"> • Ring fence ENP support to minors • Development of new emergency flow model (RGH) • Development of ambulatory care facility at NHH • Improvements to ED facilities to support assessment capacity (RGH implementation; NHH - scoping phases. • Senior decision making at front door. Review of consultant capacity at NHH. • Appointment of Nurse Consultant, ANP and additional ENPs for EDs • NEWS scoring in place in ED
<h2>Hospital Site Management</h2>	<ul style="list-style-type: none"> • Clinical and managerial site leads in place • Site hubs in place to support patient flow • Revised Escalation Policy in place • Immediate Release Policy in place with areas designated • Bed Capacity Plan identified
<h2>Well Managed Wards</h2>	<ul style="list-style-type: none"> • Model ward process in place • Green2Go ward to be implemented NHH (RGH in place) • EFU in RGH • Early Morning Ward Rounds • PSAG in place on each ward • Workforce redesign to support sustainable nursing workforce • MDT arrangements to be reviewed and additional support promoted
<h2>Effective Transfer of Care</h2>	<ul style="list-style-type: none"> • Discharge Planning and EDD in place • DTOC management / Deep Dives in place • CHC timely assessment and decision making • Implementation of Choice Policy ongoing • Community Improvement Plan in place • Community Bed Plan being implemented

Further information around the programmes of work supporting the out of hospital care, front door and hospital flow is also set out below:

- **Care Close to Home** - for those people with urgent care needs this means providing a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families. Plans are interconnected with **SCP 3** and include developing a sustainable Out of Hours service model, optimising access in General Practice for urgent care – e.g. same day consultation (face-to-face; telephone or home visit) and developing a more sustainable General Practice infrastructure to support care closer to home e.g. in 2015/16 the number of practices reduced from 89 to 84, A further 4 practices will close during 2016/17. The workforce model will deliver a more skilled, supported and sustainable workforce, including pharmacists in primary care practices.
- **Agreed Care Pathways** are being consolidated and include the Newport Older Person Pathway “Stay Well Plans” and expanding the Advanced Care Planning in

Nursing Homes – recognising and managing deteriorating patients in this setting. **SCP5** illustrates the work that is being progressed to further improve chronic conditions management for diabetes and chronic obstructive airways disease focusing on minimising emergency attendances and/or admissions to hospital settings. Expanding community nursing services to 24 hour seven day services continues to increase the treatment options available to care for unwell patients in their homes.

- **Clinical Process Excellence** - for people with more serious or life threatening emergency care needs, this means ensuring they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery. Plans include measures to increase capacity for ambulatory care services minimising the need for admission and reducing delays in ED for patient with urgent and emergency medical conditions, improving compliance with waiting time targets for the minors stream by ring fencing Emergency Nurse Practitioner (ENP) capacity to meet patterns of demand for patients with minor injury or illness presenting to ED, developing an Emergency Floor model that consolidates existing emergency care and medical assessment services creating a single front door for the acutely unwell with the capacity to manage patients with a predicted short length of stay at the Front Door. At its heart the Emergency Floor Model will increase timely access to senior clinical review focusing on the ideal patient journey "**assess once, investigate once, decide once**". There will be a focus on contingency surge capacity planning following the review of winter plan for 2015/16. In addition the ongoing workforce development plans will continue delivering the nurse recruitment strategy, measures to strengthen the medical workforce and measures to maximise the contribution of the allied health professional workforce.
- **Hospital Site Management** – builds on the progress made in 2015/16 to tighten and systematise site management processes and systems. The plan aims to use information to drive decisions based on previous patterns and trends. Understanding real time data to ensure demand is understood and the divisions have clarity of the capacity required to meet demand. There are structured meetings throughout the day for site teams and there is a daily organisational conference call that brings together all acute sites, community and GP OOH to understand current position and the actions required to improve performance – this process will be consolidated and further developed throughout the life of the IMTP.
- **Well Managed Wards** – aims to ensure there is effective streaming of patients who present to acute hospitals to the most appropriate point of care, reducing the number of admissions and minimising length of stay in hospital settings. Plans include rolling out the Model Ward across all medical and surgical wards, consolidating care for medically fit patients on an Advanced Nurse Practitioner led "Green to Go" ward at NHH and further workforce redesign to develop a skilled, supported and sustainable nursing workforce.
- **Effective Transfer of Care** – aims to develop standardisation to support clinical decision making with daily board rounds, medical rounding tool including estimated date of discharge, therapy discharge plan and ceilings 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 2016/17 further strengthens these links through reviewing the current discharge process and role responsibilities. A case manager approach is being developed and a pilot progressing with Newport City Council for dedicated social work involvement to reduce system blockages which will reduce length of stay.

This work programme continues to strengthen its clinical engagement in identifying innovative solutions to support the challenges being seen nationally. The actions identified are planned to support improved performance over the next three years in the context of increasing demand.

SCP 10 - Planned Care

This programme of work focuses on Planned Care and aims to develop and implement a transformation programme that aligns with the Health Board's Clinical Futures Strategy and the National Programme for Planned Care and delivers significant performance improvements on 2015/16 delivery targets which were not achieved in year. This requires improvements in efficiency and productivity that in combination with prudent healthcare will improve waiting times and access to key elective services on a sustainable basis in order to ensure patients consistently receive timely, effective care.

The scope of the work programme includes:

- Developing and delivering a sustainable Orthopaedic and Ophthalmology Plan that ensures treatment within 36 weeks of referral through demand management initiatives and securing the optimum capacity solutions.
- Developing a sustainable Diagnostic Service that delivers diagnostic treatment within 8 weeks of referral.
- Implementing the Cancer Services Delivery Plan that meets delivery of Welsh Government Cancer Access Target for Unsuspected Cancers of 62 Days & Non-USC of 31 Days and supports and is consistent with the regional Transforming Cancer Services agenda.
- Developing and delivering the Outpatient Transformation Programme that responds to the National Prudent Healthcare Action Plan

The Health Board's specific work-streams include the following key components:

- Demand and Capacity;
- Modernisation/transformation;
- Informatics;
- Efficiency/productivity;
- Workforce.

The Health Board's contribution to the work of the National Planned Care Programme covers ENT, Ophthalmology, Urology and Trauma and Orthopaedics.

The objectives of the work programme are to develop annual plans to improve elective access, delivering sustainable services that meet recurrent demand. This

requires a clear framework for elective demand and capacity that underpins local delivery plans, including those to eliminate backlogs.

The work programme provides a link to the Care Closer to Home Health Board work-streams, which seek to shift activity and resources from secondary to primary care where clinically and financially appropriate and a focus for the implementation of prudent healthcare initiatives in Planned Care as a means of optimising demand and delivering services.

2.4.4 Service Sustainability (SCP 6 & 7)

Ensuring services that are clinically or financially vulnerable are stabilised and maintained for our citizens, and where relevant, across South Wales

SCP 6 – Continuing Health Care (CHC)

The plans for CHC cover 3 clinical service areas within the Health Board:

- Adult Complex Health Care
- Mental Health and Learning Disabilities Complex Healthcare (see **SCP 8**)
- Children’s Continuing Care under the care of Specialist Child and Adolescent Mental Health Services (S-CAMHS), Child and Adolescent Learning Disability Services (CALDS) and the Children’s Community Nursing Service (CCNS).

In Adult Complex Health Care, changes in the management arrangements in 2015/16 has provided a specific focus on developing a sustainable service and ensuring rigorous decision making to maximise core service provision and deliver effective appropriate care for patients going forward. A new governance structure is now in place.

There was also a 12 point plan developed in year to address some of the issues facing the service. This has resulted in more timely decision-making relating to packages of care, better support and communications for staff and significant savings on high cost packages of care and agency spend. The refresh of the 3 year plan will see completion of the 12 point action plan in 2016/17 and new opportunities explored which include:

- Workforce redesign and development plan to improve recruitment and retention including dedicated management support for the Independent Review Panel process.
- Implement new model of care for high dependency patients with home ventilation - including development of a Band 4 HCSW role to care for high dependency patients such as those with stable mechanical ventilation.
- Working with five Local Authorities to review Care Home Fees and Care Home Contracts.
- Exploring opportunities of the Social Services and Wellbeing Act – e.g. Part 9 of the Act outlines a framework for the development of integrated health and social care teams providing patient care in the community. The Health Board is currently exploring delivery of two end of life care packages with two voluntary hospices.

- Improving the transition process between children and adult services.
- Consider the development of a corporate commissioning unit.

The **Community Childrens Nursing** (CCN) service is responsible for delivering a range of complex care packages within the community. The service has experienced steadily increasing demand with a major challenge around recruitment of registered nurses.

The local plan to address many of these issues include:

- Development of a strategy for alternative community based service provision for Child and Adolescent Learning Disability Services (CALDS) and CAMHS.
- Develop plan for sustainable short stay respite service for Children and Young People's Continuing Care (CYPCC). One 3 bedded respite facility in operation two weekends per month on ward 2/3 NHH. Continue to explore options for second respite facility in the South of Gwent.
- Implement and embed and evaluate effectiveness of local multi-agency transition protocol.

SCP 7 - Service Sustainability

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

▪ Acute Specialties

In the Health Board's Clinical Futures Strategy, the sustainability of a number of acute specialties will ultimately be achieved through their consolidation on to a single site, the SCCC, which is planned to open in 2020. This strategy is wholly consistent with the outcome of the South Wales Programme and the work of the South Wales Health Collaborative on the clinical models and future configuration of medical and surgical specialties.

The SCCC case describes how specialist services will be centralised as a means of providing critical mass and delivering both improved outcomes and Deanery expectations to improve medical training. It is however recognised that there will be a challenge in sustaining services prior to the advent of the SCCC and this section of our plan describes how the Health Board will address the sustainability of a number of services, with particular regard to the timetable for achieving medical educational contracts.

In the last year, the Health Board has successfully centralised gastrointestinal (GI) bleeding and its hyper acute stroke services at the Royal Gwent Hospital, delivering the plan described in its last IMTP. This is already making a difference to patient care, with improved outcomes demonstrated. This builds upon the centralised models in place for a number of specialties, including urology, ENT and maxillofacial. Due to the interdependencies of clinical services, the Health Board however lacks the physical capacity to centralise all services prior to the opening of the SCCC, compounded by the quality of the existing infrastructure of our two acute hospitals in Abergavenny and Newport.

Our plan therefore identifies how the Health Board will sustain its services prior to the planned opening of the SCCC. This encompasses both a review of the actions to sustain paediatric, obstetric and neonatal services following the implementation of a new service model to sustain services at Nevill Hall Hospital during 2015. For surgical specialties it describes how a plan will be developed to respond to the August 2016 Deanery timetable for improving training and for medical and anaesthetic specialties in August 2017.

The potential adoption of a new workforce model for neonatal services is also described, though this is complicated at the time of drafting by uncertainty regarding the identity of which of the three neonatal units in South Wales will need to adopt this new model.

▪ **South Wales Vascular Service**

Working with Cardiff and Vale and Cwm Taf University Health Boards, the plan describes how further improvements in the provision of aortic vascular services and interventional radiology will be taken forward, building on the success of the existing vascular network. This is an example of where the Health Board is working with other Health Boards on the sustainability of a number of services such as major trauma, radiology and Sexual Assault Referral Centre (SARC).

▪ **Specialist Child and Adolescent Mental Health Services (CAMHS)**

The Specialist CAMHS service has experienced rapid, exponential increase in demand and a number of recent independent reports highlighted shortcomings in the provision of services to children and adolescents across Wales. The local plan includes:

- Provision of an Enhanced Emergency Liaison Team.
- Expansion of the Eating Disorder Service.
- Reduction in waiting times.
- Enhanced child psychotherapy resources.

2.4.5 Alignment of Plans to Workforce, Finance and Capital

Each of the above Service Change Plans have been aligned to the finance, workforce and capital plans recognising there is further work ongoing to finalise priorities for investment as business cases are developed to demonstrate benefit and impact, identifying workforce solutions to support plans and the identification of further opportunities for improved efficiency and productivity. The following tables sets out the links to the finance, workforce and capital at a high level across the four themes.

Key Theme	Finance	Workforce	Capital
Reducing health Inequalities and improving population health	Funding implications have either been secured through national funding sources or included in the service investments within the financial plan. Funding for Childhood	Additional workforce to support Childhood Obesity programme have been recruited to. Ongoing development of integrated workforce for Living Well Living Longer	No capital implications

Key Theme	Finance	Workforce	Capital
	Obesity been included within the financial plan for 2016/17	Programme	
Supporting shift of care from secondary to primary through the NCN foundation for delivery of care	Financial implications of these work programmes have been secured through specific WG funding for primary care, integration and to support local delivery plans. Further local plans have been agreed for some projects in 2015 and these are included within the financial plan.	Additional staff recruited to support the Primary care, Intermediate Care Fund and Mental Health schemes in 2015/16. Development of new roles, skills and multidisciplinary teams and 24 hour services during 2016/2017	Primary Care opportunities are being pursued with Welsh government. Mental Health low secure plans also being developed during 2016/17.
Delivering Improvements in access and quality of care to patients	The indicative financial implications of the Planned Care and Urgent and Emergency Care plans are included in baseline budgets or have been identified as priority areas. These primarily relate to the solutions to deliver RTT, cancer, diagnostics, Out of Hours, the front door model and community beds and will need to be finalised in the context of the overall plan and efficiency opportunities.	Additional workforce required to support Urgent & Emergency Care Plan including 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 plans include potential schemes to support A&E plans at Nevill Hall, potential improvement in breast services, and additional diagnostic equipment.
Delivering Service Sustainability	The financial implications and opportunities relating to CHC are included within the financial plan. The additional costs associated with the key service sustainability issues including medical staff issues, vascular services transfer are also included within the financial plan.	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	Awaiting WG approval for funding of Neonatal Intensive Care Unit (NICU) scheme at RGH. Replacement equipment to sustain service been secured for Cardiology Cath Lab and potentially WG to support replacement diagnostic equipment.

Key Theme	Finance	Workforce	Capital
		resources is a key component of planned care with a focus on improving productivity.	

2.5 Strategic Work Programmes

Significant progress is being made through the Service Change Plans (SCPs) to support progress towards the delivery of the Clinical Futures Strategy and the overarching objectives of the Health Board. However, as part of the maturity stages of our planning process and as part of the refresh exercise, the Board recognises the need to strengthen the focus and pace with which the organisation achieves some of the more strategic change and system shifts required in the future, above and beyond what is being delivered through the SCPs.

Through detailed review and reflection of organisation achievements and challenges, the Board intends to develop three Strategic Work Programmes that will be developed during 2016/17 that will build on the work of the service change plans and support greater strategic change and system shifts to deliver the overarching ambitions of the Health Board. These include:



Health Inequalities - a real drive to address some of the most significant variation between our population with a specific focus on cancer



Care Closer to Home - making more significant shifts across the system through more fundamental new models of care and shifting resources to support this.



Partnership Working - strengthening existing partnerships across sectors and other organisations including collaborative regional working to support population health and the implementation of new legislative requirements

These Strategic Work Programmes will be developed and progressed through the existing structures where possible and builds on the progress already being made through the Service Change Plans and will represent an ambition and change programme that will span a longer time period but with key milestones on the journey to measure success of the programme.

Supporting our workforce and investing in organisational development and culture shift to support these programmes of work is a key enabler and requirement to delivering the system shifts and new ways of working that will need to underpin strategic change to the scale required.

This work is due to be developed during the first six months of 2016/17.

2.6 Externally Commissioned Services

Whilst the majority of the routine care to our resident population within Gwent is delivered locally (88%), we commission a broad range of services at an annual cost of approximately £190 million secured through a complex portfolio of contracts and contracting arrangements with English and Welsh Providers. Around £75m relates to hospital provided care at a secondary care level and £115m to tertiary services commissioned for our population through Welsh Health Specialised Services Committee (WHSSC). The key elements of our plans are:

- Ensuring that the Health Board receives an appropriate level of income for the services it provides to other Health Boards.
- Commissioning external capacity to support the delivery of Referral to Treatment Time (RTT) and diagnostic waiting times.
- Working with Powys Teaching Local Health Board on the future configuration of mental health services for Powys residents.
- Managing Long term Agreements with neighbouring Health Boards, including work with Acute Care Alliances on the reconfiguration of services such as Sexual Assault Referral Centre (SARC), Major Trauma and Vascular Services.
- Commissioning specialist services with Welsh Health Specialised Services Committee (WHSCC), Velindre and Welsh Ambulance Services Trust (WAST).

Additional expenditure has been included in the financial plans to reflect the commitments made or indicated for 16/17 specifically, and represents the service growth and developments primarily across cancer drugs and specialist services.

2.7 Key Enablers

The key enablers that support delivery of the change programmes are set out below covering workforce, finance, capital and informatics.

2.7.1 Workforce

Our ability to provide safe, high quality, effective, and patient centred services depends on sufficient, well motivated and appropriately skilled workforce operating within service delivery models that optimise their performance.

The 13,869 health workers that we employ, together with independent contractors and the many people who volunteer to provide care to the individuals, families and communities across Gwent, are our greatest asset. Optimising how we use our workforce is a key goal for the next three years. This includes co-ordination and integration of services to provide person-centred, primary care led health care; efficient and effective use of available workforce and an expanded role for pharmacists, nurse practitioners, midwives and other practitioners. Reducing reliance on traditional medical models of care is a core component of our sustainability plans.

In a time of national and international health workforce shortages, the Health Board must build capacity to respond to the healthcare needs of our citizens by generating creative solutions to managing the supply of and demand for health workers.

Innovation in health service delivery is needed to achieve the goals of improving quality and increasing timely access to health care while making the system more effective and accountable.

The Health Board continues to face a number of **workforce challenges** including:

- Recruitment of consultant and junior medical staff in a number of specialist services e.g. medicine, mental health, radiology.
- Ageing GP workforce profile, increase in part time staff and recruitment challenges.
- Significant challenges meeting and sustaining junior doctor rota requirements impacting on service sustainability prior to the opening of the Specialist and Critical Care Centre, which is the key enabler to deliver a sustainable healthcare system in Gwent.
- Recruitment challenges in a number of non medical areas e.g. Sonographers, specialist Therapy roles, skilled craftsman
- Achieving optimum staffing levels in nursing to comply with the Nursing Principle Standards and the impending Safe Staffing bill.
- Enhancing roles within nursing and Allied Health Professionals in existing recruitment challenges.
- Sickness absence rates have improved (5.19%; 595 WTE's) with significant variation across wards and departments
- Retention of staff in fragmented unsustainable services in the outdated District General Hospitals while awaiting SCCC approval.
- Using staffing as efficiently and effectively as possible when services are under pressure and when change is required to improve services.
- Developing more sustainable non medical workforce solutions for service sustainability, Clinical Futures and for Primary Care plan in external and internal competing labour markets has left vacancies in other parts of the Health Board.

The pressure to control workforce costs, and at the same time deliver good quality, safe and clinically effective services requires detailed integrated service, workforce and financial planning. Achieving this presents a demanding workforce change programme for this year and the foreseeable future. To meet the in-year challenges of minimising workforce costs while ensuring that we retain engaged and motivated staff delivering our services, we will continue taking a planned approach to both delivering services differently and making sure we use the existing workforce as efficiently as possible using the management of change principles and framework where necessary.

These are however significant opportunities for improvement and doing things differently.

Through a process of co-production the intention to improve the Health Board's recruitment brand and strategy which would help reduce vacancies, reduce variable pay and support retention. This branding will reflect on aspirations of being an exemplar in terms of learning and development of our staff and being an outward facing employer. More innovative ways of engaging and involving our staff in identifying solutions to our challenges will be adopted. Sickness absence will be reduced by improving the people management skills of our managers and by placing the health and well being of our staff at the top of the Health Board's agenda. More

work is planned to ensure that we maximise the benefits of the unregistered workforce (Bands 2, 3 and 4) and to include the social care perspective. By developing a greater understanding of the primary care workforce we will ensure that new or amended roles are considered from a more integrated health care system perspective.

Strategic Workforce Priorities are summarised in the following table:

What	How	Why
Maximising resources	<ul style="list-style-type: none"> ▪ Implement recruitment and retention Strategy for medical, nursing and therapies and non clinical staff e.g. overseas recruitment, promotion of working within ABUHB. ▪ E-rostering and maximising benefits ▪ Job planning – 100% compliance ▪ PADR – 85% compliance ▪ Reduction in sickness by 0.5% ▪ Application of prudent workforce principles and benchmarking 	<ul style="list-style-type: none"> ▪ Reduce/eliminate vacancies (right number of staff to optimise outcomes and experience) ▪ Eliminate high cost agency spend ▪ Matching resource to patient need/acuity ▪ Optimising the contribution of medical workforce to meet service changes required. ▪ Align organisational and personal goals ▪ Sickness impacts on variable pay and creates high cost agency spend (40-50% of variable pay spend). Also affects continuity and quality of care for patient and creates pressure on workforce which impacts on motivation. ▪ To identify opportunities to do better and ensure appropriate use of resources.
Changing service models	<ul style="list-style-type: none"> ▪ 7 days services ▪ 24 hour Community Nursing ▪ Improving access to community Phlebotomy ▪ Develop a Graduated Care Model through matching patient acuity to skills. ▪ Local delivery plans e.g. stroke, liver disease – development of integrated workforce plans. ▪ Primary care workforce plan – development of primary care multidisciplinary teams, enhance skills, new roles to manage care closer to home and support the transition of care from 	<ul style="list-style-type: none"> ▪ Improve patient flow and length of stay. ▪ To meet patient needs, where possible in their homes, reduce hospital attendances and where an admission is required – minimise the length of time spent in hospital settings ▪ Realise the benefits of new ways of working on staff number and skill mix, where relevant the transfer/re-deployment of health workers across the system. ▪ A workforce that delivers the necessary standards. ▪ Skills to manage complex conditions in a community setting. Reduce demand on secondary care services. Improve medical sustainability in secondary care and primary care through team working and skill mix. Move from a medical centric decision making model to an integrated team approach to the

What	How	Why
	<p>secondary care to Primary Care through car pathway planning.</p> <ul style="list-style-type: none"> ▪ Sustainable workforce models to support RTT ▪ Technology – e health, virtual health, digitisation of Health Records 	<p>management of care</p> <ul style="list-style-type: none"> ▪ To meet targets in the most cost effective way and reduce variable pay costs ▪ Maximise the use of technology to improve ways of working and reduce workforce costs.
<p>New and Extended Roles</p>	<ul style="list-style-type: none"> ▪ Ongoing development of extended and Advanced Practitioners, Physicians Associates, practice based pharmacists, independent prescribing skills, enhanced therapy and diagnostic staff skills, Rehabilitation HCSW, Band 4 HCSW workers in community. ▪ Multi-disciplinary/multi-agency workforce planning and working in secondary care and Primary Care Local Authorities, Nursing homes, Voluntary. ▪ Development of skills Primary Care and in the community 	<ul style="list-style-type: none"> ▪ To support recruitment difficulties with primary and secondary care medical roles and improve recruitment and retention of skilled AHPs and nurses. To develop a non medical workforce sustainable solution. To deliver a prudent workforce, ensuring that health workers “do only what they can do”, in terms of skills and expertise. ▪ To create capacity to meet the healthcare needs of most citizens, in a timely fashion, close to home including <ul style="list-style-type: none"> ▫ Integration of community resources (CRTs, District Nurses, Therapies) into Network Teams focused on our 12 NCN communities ▫ Out of Hours teams ▫ RAID/LEAP – multidisciplinary team ▫ Older Persons Pathway and improved integrated working within and with organisations outside of ABUHB. ▫ Multi disciplinary teams at the front door to reduce hospital admissions and management of flow. ▪ To meet the challenges of managing complex cases and changing demographics in Primary Care and Community
<p>Organisational Development</p>	<ul style="list-style-type: none"> ▪ Implement OD strategy – leadership, staff engagement, staff retention strategies organisational values, talent management, support Primary Care, well being of staff, building reciprocal relationships. ▪ Ongoing roll out of salary sacrifice schemes. 	<ul style="list-style-type: none"> ▪ To create the capacity to become a primary care led NHS, with services predominantly delivered through NCNs, supported by a network of local hospitals and a single SCCC. To ensure ABUHB make the most of the strengths, opportunities and challenges presented. To develop a stepped change in culture and to improve services for patients and staff. ▪ Improve staff retention and reduce workforce costs

The Health Board will ensure that there is a sufficient supply of graduates and post

graduate education undertaken through the annual educational commissioning process.

There are plans for increases in mental health nursing due to the ageing workforce, independent prescribing skills, and increase in pharmacists. Supporting medical sustainability and Clinical Futures will require extended and advanced practice skills, physician associates and health care support worker development.

▪ **Workforce Impact and Outcomes**

To date a number of workforce changes and efficiencies have been identified. Some of these may increase the staff numbers but reduce cost if lower cost better value solutions are secured such as minimising the use of high cost agency staff.

The additional workforce investment schemes that have been identified as part of our three year plans, that enable the Health Board to meet performance targets and ensure sustainable services continue to be reviewed and tested as part of prioritisation and efficiency reviews to support the service, workforce availability and financial challenges. A number of consultant posts are aligned to service sustainability challenges with other (for example, orthopaedics and anaesthetics) providing recurrent capacity to meet continuing demand where previously there was overreliance on non-recurrent solutions.

The development of primary care services is ongoing and in 2015/2016 there will be the development of Primary Care Resource teams, 24 hours Community Nursing, development of phlebotomy services. There will be an increase in health visitors for further roll out Flying Start.

Our approach to reducing the variable pay bill and use of high cost agency staff include:

- Recruitment to vacancies and retention of existing staff (resilient core workforce);
- Sickness management (motivated, engaged and well workforce);
- E-rostering (optimising workforce, aligning health workers to meet patient needs);
- improved management processes and controls;
- Improvement of manager’s people management skills.
- Reduce reliance on high cost medical premium payments through improvements in core service activity
- Reducing the reliance on administration variable pay through service reconfiguration within the Referral and Booking function and ongoing roll out of Digitisation of Health Records
- Reconfiguration of beds and development of graduated ward principles.

As of January 2016 the nursing vacancy gap was 242 WTE. To meet this gap we have already recruited 96 WTE overseas nurses and a further 61 WTE overseas nurses who will start their employment in January 2017. These posts will significantly contribute to the

Scheme (savings identified)	£
Reductions in Variable Pay, reduction in high cost agency and ongoing workforce modernisation	Circa £7.8M reduction identified
Salary Sacrifice Schemes – new schemes to impact further	735K
Local Service/Workforce Plans	£2.5M

underlying workforce nursing deficit providing turnover is sustained through local recruitment and retention strategies. The nursing workforce gap will then become more sustainable which will improve staffing levels, motivation and reduce variable pay.

A summary of the main points in the workforce plan is as follows:

- Reduction in high cost agency spend as of 31st March 2016
- Developing new and extended roles to maintain service delivery adopting Prudent Workforce Principles.
- Reduction in sickness absence and delivering the outcomes for Nursing Principles through appropriate establishments and leadership.
- Developing a clinical workforce strategy that reflects anticipated future need and optimises the use of a variety of health professionals to their full scope of practice
- Implement recruitment and retention strategies for all staff groups
- Developing and implementing workforce plans for shifts in workforce from secondary to primary and community setting.
- The impacts of Local Service pressures and investments are identified
- Changes will be delivered through the Organisational Development Strategy.
- Reduction in high cost medical variable pay spend through optimising core service and recruitment where required

2.7.2 Finance

The Health Service across the UK is facing increasing demands on services within the context of wider financial austerity within the general economy. The impact of this on NHS Wales is captured and evidenced in the Nuffield Trust report of 2014 'A Decade of Austerity in Wales' which describes an increasing expectation of pressures needing to be met through a reduced real terms budget requiring savings in the region of 4% per annum.

For the Health Board, this is also within a context of historic funding allocations and consequential spend per head of population being less than the Welsh average based on both population and need.

Within this wider context, the Health Board had its three year IMTP approved in 2015/16 with an outline financial deficit of £19.7m. This position was approved on the expectation that Welsh Government would continue to support a funding settlement for the NHS in Wales in line with the Nuffield Trust assessment on a 'fair shares' basis, and the Health Board would take the necessary actions to improve the sustainability of its financial position.

During 2015/16, the Health Board has been tracking to a position which was off-plan due to:

- Workforce sustainability challenges and the use of high cost agency nursing

- Increased demand growth associated with specialised services
- Increased capacity pressure on the unscheduled care system
- Increased costs associated with planned care to support Tier 1 delivery
- Growth in CHC patients and costs

The Health Board is now forecasting a break-even position for 2015/16 due to additional non-recurrent funding from Welsh Government, and a range of non-recurrent actions. On a recurrent basis however, the Health Board has an underlying deficit which is assessed at **£26m**. This is unsustainable and the Health Board's plans need to deliver the required level of cash-releasing savings and productivity required to support a more sustainable recurrent financial position prospectively.

For 2016/17, the Welsh Government has announced additional funding to the NHS in Wales of £260m. This is expected to be shared with Health Boards on the basis of:

- £200m general allocation to Health Boards on a fair shares basis (which for Aneurin Bevan Health Board equates to 19.3% or £38.2m) – this is to meet the ongoing impact of demand for health services as per the 2014 Nuffield Report
- £30m increase to the Intermediate Care Fund on an all-Wales basis – with the criteria for accessing this funding to be confirmed
- £30m to support the development of older people and mental health services – with the criteria for accessing this funding to be confirmed

The Health Board has undertaken a detailed assessment of anticipated funding over the three year period with the following key assumptions:

- Fair shares of £200m in 2016/17 (£38.2m) which has been confirmed.
- Fair shares of funding in line with the Nuffield Trust assessment in 2017/18 and 2018/19 of £160m and £170m respectively on an all Wales basis (and therefore £31m and £33m respectively for the Health Board). This has been indicated by Welsh Government as a fair planning assumption but yet to be confirmed.
- Funding associated with the recurrent investment in national priority services agreed in 2015/16 including primary care, Mental Health, CAMHS services, Intermediate Care Fund (ICF), and National Delivery Plans – these total £13.1m at this point but confirmation is outstanding on the allocation of recurrent national delivery plans and the recurrent use of ICF funding in 2016/17.
- Full funding of capital charges.
- Phase 3 retrospective CHC claims will be supported by AME funding until 2018/19
- Any decision to delegate centrally held funding for hospital prescriptions based in the community (WP10 (HP)) will be done on a resource neutral basis.
- The Health Board hasn't assumed the additional funding announced for ICF and Mental Health & Older People's Services. Once the use and allocation of this funding is confirmed the Health Board will assess the impact of this on its financial plan.

The first component of the Health Board's cost assessment is an increased cost of **£13.1m** relating to developments supported by specific funding allocations from Welsh Government. This materially reflect the recurrent impact of 2015/16 developments associated with Primary Care, Mental Health, and CAMHS services in particular. This excludes the recurrent impact of national delivery plans, and ICF

where the Health Board is assuming its fair shares but recurrent plans and allocations not confirmed.

The Health Board has undertaken a detailed assessment of the inflationary pressures driving an increase in the Health Board's cost base, some of which reflect national agreements and policy decisions, and others reflect local priorities and commitments.

▪ **National Agreements & Commitments**

The Health Board has assessed costs in 2016/17 of **£19m** in relation to inflationary pressures which are unavoidable and set on a national basis, which include:

- Costs of wage award and the cessation of NI rebate to employers in 2016/17
- The costs of the high cost NICE approved drugs Eculizumab, and the high cost NICE treatments for patients with Hepatitis C
- Non pay inflation
- Inflationary uplift of 1% on Long Term Agreements (LTA's) with other Welsh NHS providers who deliver care to the residents of Aneurin Bevan
- Inflationary uplift for GMS and Dental services contracts based on historic trend

It is anticipated that these pressures are the first call against the additional £38.2m made available on a fair shares basis.

▪ **Local Agreements & Commitments**

In addition to those costs which are unavoidable within a national policy context, the Health Board has prioritised a number of commitments. These total approximately **£14m** and reflect:

- Planned elective capacity to support Tier 1 delivery of RTT
- The costs of NICE approved treatments for its residents
- Increased demand and costs associated with Specialist Services
- Incremental unavoidable medical staff costs
- Increased costs in relation to demand growth and approved services being undertaken at other NHS Wales providers
- A reduction in rotational training costs from the Deanery

On the basis that both national and local commitments are realised in full this will add a further £33m to the Health Board's plan. These pressures are in principle the first commitments against the increase in funding made available to the Health Board of £38m, resulting in a residual £5m allocation to support the Health Board's underlying position and any further planned changes or pressures which are required to support service sustainability and delivery. It is essential therefore that the Health Board delivers the level of saving required to improve on its underlying financial position and support further planned changes in line with the Board's strategic objectives.

The Health Board's plan has outlined a requirement for a further **£24m** in cost pressures or additional resources to support the delivery of its plans, with key drivers to this assessment including:

- CHC growth across general CHC and more specifically Mental Health and Learning Disabilities services
- Prescribing growth
- Local sustainability challenges in particular in relation to medical staff posts
- Improving access and flow across the unscheduled care system
- Additional investment to support delivery of Tier 1 targets primarily in relation to RTT and diagnostics.

Within this financial context, every proposed investment or planned increase in use of resources will be considered in both its cost and consideration of what outcomes it will deliver and benefits it will bring to the population.

In order to achieve financial sustainability, it is essential that the Health Board delivers cash releasing savings to support this agenda, in addition to generating actions to improve its productivity and efficiency, and allow further cost control and mitigation especially in 2016/17.

Currently, planned cash-releasing savings are considered to be **2%** or **£21.5m**. Of these **£11.5m** are detailed within divisional plans, and it is assessed that further known opportunities will be delivered upon in-year to support the delivery of this level of saving. These opportunities include (but are not limited to):

- Delivering on plans to cease the use of off-contract nurse agencies from the 1st of April and fully reflecting these within divisional plans
- Increased procurement savings
- Reductions in premium payments to Medical staff
- Cost effective use of capacity
- Increased productivity and efficiency resulting in consequential cash releasing gain
- Improved workforce management including absence management, effective rostering, and improved productivity through job planning

Furthermore it is anticipated that the Health Board will have actions in place to mitigate costs to the equivalent of **£10.5m** in 2016/17, and a further £5m per annum in 2017/18 and 2018/19 through:

- Management of CHC growth through the effective deployment and system-wide capacity planning.
- Increased productivity and efficiency
- Management of Prescribing growth and effective management of medicines pathways
- Effective management of assessed cost increases in relation to non pay
- Management of any developments and commitments in relation to externally commissioned services
- Rigorous and detailed consideration of any service change and sustainability priority, with a clear view of minimising any commitment without a clear benefit in terms of outcome, health gain, value.
- Maximising the impact of 2015/16 recurrent service developments
- Maximising the impact of services implemented through additional funding allocated across Wales to support the Intermediate Care Fund and Older People Services

The combination of factors outlined above results in a projected financial deficit in 2016/17 of **£12.8m, and over the three year period of £42m.**

Further actions to reduce this deficit are dependent on further service and workforce change plans which enable the Health Board to deliver the required services within resource available, or further levels of savings and cost mitigation over and above that described within this plan. The 2016/17 assessed deficit of £12.8m is less than the year 2 assessment in the 2015/16 approved three year IMTP of £13.8m.

The plan does have an upside risk approach which improves the financial outlook. There are therefore downside risks for the Health Board to consider and manage in the delivery of this position. These include:

- Risk of delivery of planned schemes to achieve a 2% cash releasing efficiency target
- Risks to the ability to mitigate costs in line with current assumptions
- Managing demand growth and capacity to current planning assumptions
- Any increased cost requirement to support Tier 1 delivery.
- Ability to manage the scale of change required in years 2 and 3 if year 1 does not deliver service and financial balance

The assessed risk range of these issues in 2016/17 is from £0 to £22.0m, which increases in 2017/18 and 2018/19 by £30m per annum with the risk dependent on the confirmation of additional funding in line with the Nuffield Trust assessment allocated on a fair shares basis.

In summary therefore the key issues for the Health Board are as follows:

- The Health Board has an underlying deficit of £26m.
- Fair shares funding of £38.2m is being made available to support the Health Board in 2016/17, of which £33m is committed on unavoidable national commitments or unavoidable local commitments and priorities. This is in addition to £13m recurrent funding to continue the implementation of developments and plans approved in 2015/16.
- Health Board plans describe further pressures and resource requirement of £24m to address the delivery requirements of the plan.
- Planned cash releasing savings equate to 2%, with 1% currently reflected in divisional plans.
- The Health Board's plans assume cost mitigation and avoidance to the equivalent of 1% based on a number of specific high cost areas.
- The above position results in a £12.8m deficit in year 1 of the plan, with further work required to ensure that service and workforce plans are affordable and ensure that this position as a minimum is delivered and actions taken to improve.
- It is a key requirement that the Health Board continues to manage its costs in year 1 as the year 1 outturn position will have a material effect on the outlook for years 2 and 3.
- There are significant downside risks inherent within the plan that requires management as part of this process.

2.7.3 Capital & Estates

The Capital Programme not only funds estates projects but also statutory requirements, equipment and ICT replacement and developments. The capital allocation process is primarily based on a detailed risk based assessment of Divisional and Directorate priorities together with a corporate overview of investment needs resulting from individual IMTP plans, spend to save initiatives and proposals that specifically impact on efficiency, quality and performance.

The current forecast for Health Board capital funding including Welsh Government approved schemes, schemes submitted for funding and Discretionary Capital is summarised below:

	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
All Wales Capital Programme Funding					
Approved Schemes:					
RGH A&E Scheme	2,902				
Business Cases Submitted to WG for funding					
SCCC (excluding inflation, based on FBC submission)	26,686	84,892	77,930	79,939	5,394
Newport ELGH (excluding inflation, based on PBC)	100	904	2,226	2,766	3,205
NHH ELGH (excluding inflation, based on PBC)	100	527	1,090	1,557	3,763
Cardiac Cath Lab	1,774				
Neonatal Sustainability	2,016				
Total Business Cases Submitted to WG for Funding	30,676	86,323	81,246	84,262	12,362
Discretionary Capital Programme Funding					
Total Discretionary in CRL	7,209	7,209	7,209	7,209	7,209
Non Recurrent Uplift to Discretionary	3,605				
Add Forecast NBV of Disposed Properties	50	100	100	100	100
Restorative Dentistry Funding Adjustment	-61				
Total Discretionary Funding	10,803	7,309	7,309	7,309	7,309
Total Funding	44,381	93,632	88,555	91,571	19,671

As identified above a key component of the Health Board's capital plan is the Specialist and Critical Care Centre (SCCC). The Clinical Futures Programme Business Case (PBC) and the Full Business Case (FBC) for the SCCC were formally submitted to Welsh Government on 14th October 2015. The programme submitted with the FBC assumed that Welsh Government approval would be received in January 2016 to allow a start on site in May 2016, completion in May 2019 and commissioning by August 2019. This programme is now not going to be achieved as the FBC/PBC scrutiny process with Welsh Government is not yet completed.

The ongoing uncertainty regarding the SCCC is creating significant difficulties with regard to the planning of developments and estate infrastructure improvements on a number of sites, particularly Nevill Hall, Royal Gwent and St Woolos Hospitals. This is because of the significant effect that the SCCC will have on the functional content of these sites and the fact that large areas of accommodation will not be required.

The IMTP process and corresponding work to identify and address service, estate and equipment risk has identified a number of other 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 and are outlined in the Technical document, they include:

- Resolving the capacity, flow and environment in the Emergency Department at Nevill Hall hospital.
- Providing more local and cost effective mental health low secure accommodation.
- Developing plans to deal with estate infrastructure risks at Nevill Hall and Royal Gwent Hospitals and ward upgrades.
- Upgrading the Royal Gwent Pharmacy Aseptic Suite.
- Implementing the Health Board's Primary Care Estate Strategy.
- Improved car parking.
- Improving breast services.

It is also expected that the Welsh Government will be promoting several National Capital Funding Programmes in 2016/17 and possibly beyond including:

- Radiology Equipment Replacement
- Endoscopy / Decontamination
- Strategic Laundry Equipment Replacement
- IT Strategic Schemes

The Health Board's outline requirements under each programme are also noted in the Technical document.

The Discretionary Capital programme in 2016/17 will focus again on addressing the risk assessed organisational priorities and capital requirements linked to this IMTP. Funding will be allocated in early April to address:

- Environmental and functional suitability issues on a number of sites
- The upgrading and replacement of IT infrastructure and systems
- Replacement of medical equipment
- Replacement of Facilities Management equipment and infrastructure
- The upgrading of Estate infrastructure
- Clinical sustainability and delivery issues

It is estimated that the organisation's demand for capital will be circa £60m over the period 2016-2017 to 2020-2021 with Discretionary Capital funding anticipated to be only circa £40 m over the same period. It is also assumed that in most areas there will be further unforeseen capital requirements resulting in the need for a contingency to cover future requirements. This will therefore require that there is a rigorous process in place to scrutinise and prioritise demands for capital funding.

2.7.4 Digital Health and Informatics

The role of Informatics is to be a key enabler in the delivery of patient care which recognises the value and need to make information accessible and available in managing the patient journey. High quality healthcare services depend on high quality information; the right person having the right information at the right time can make the difference to the clinical outcome and experiences of a patient, service user or carer. High quality information enables healthcare professionals to make the process of care safer, more effective and efficient. As part of its role the objectives are to:

- Deliver pathway modernisation and benefits through the application of technology
- Ensure that the technology acquired and deployed both nationally and locally meets operational requirements and enables delivery of clinical requirements
- Take responsibility for clinical and business change design, implementation and benefits realisation in terms of strategic benefits delivery
- Underpin clear plans emerging from divisions and 'enable' the achievement of their objectives
- Provide the local dimensions into any national Business Case and ensure that such cases reflect local strategy and the Health Board's IMTP
- Ensure the Strategic and Operational plans for informatics are integrated fully into the Health Board's IMTP and Delivery Plans
- Inform national informatics priorities, providing clinical engagement and supporting clinical horizon scanning

In line with the previous IMTP the Informatics teams delivered significant improvements in modernising systems, digitising records, improving clinical communications between primary and secondary care and implemented the award winning Information Governance Stewardship programme.

Current Programme

The Health Board has a 3 year IM&T plan in place, which sets out the programme of work to support the implementation of its Clinical Futures strategy and to enable service improvement. As part of the Health Board's full IMPT, the Informatics IMTP takes in account the various national and local strategies and standards including the "Informed Health and Care – A Digital Health and Social Care Strategy for Wales", the Clinical Futures Strategy and the Strategic Outline Plan. The Informatics programme of work reflects its role as a key enabler within this strategy and plans to deliver the technology to further support clinical futures (including telehealth) and the specialist clinical care centre. Specific projects to support service change at a Divisional and Directorate level are included in the Health Board's IMTP and within the Informatics programme. The overarching priorities for 2016/17 are centred on the themes of:

- ***Core Capacity, Capability and Sustainability: ensuring that the Health Board can continue to work***

To ensure that the current the ICT technical infrastructure remains "healthy" and fit for purpose the Informatics IMTP seeks to consolidate and manage the software and hardware, identify demand led requirements from agreed local priorities and ensure

that the security arrangements are maintained to the high standard expected. "Cybersecurity" is an increasing threat and will remain high on the Informatics and ABUHB's risk registers.

▪ **Digital health and integrating systems: supporting the 'Once for Wales' national programme**

Clinical Portals are at the centre of care delivery and one of the key aims for both national and local informatics services is to underpin clinical care with a digitised patient record, ensuring that clinicians and others can view and update that holistic record from a portal wherever the patient presents and so support safe care and improved decision making. The Health Minister requires all Health Boards to fully utilise the Welsh Convergence Plan (WCP) and ABUHB is committed to a plan, in which the functionality of Clinical Work Station (CWS) and WCP converges to a point that enables the use of WCP in place of CWS.

▪ **e: Clinical Records Development & Implementation: supporting the Service Change Plans**

Digitising the Health Record has resulted in over 25% of the 400,000 acute patient records held by the Health Board are now digitised with every new acute patient record digitally created. This ensures that clinicians are able to instantly view the record wherever the patient presents at acute services and supports improved decision making and once the initial investment is repaid, deliver savings estimated at £1M per annum. Each division has unique but also overlapping priorities for Informatics support and we continue our plans to implement National systems to gain efficiencies and effectiveness as follows:

Division	Priorities			
Scheduled Care	Point of Care Testing	Outpatient transformation via telehealth	Text reminders to reduce DNA rates	Theatre System replacement and PROMS/Clinical Outcomes
Unscheduled Care	Emergency department system replacement	Electronic Patient Flow Management to reduce LOS and DTOC's	PREMS	Point of Care Testing
Family and Therapies	Modernise the telecoms and PC infra-structure in community sites	Improved Business Intelligence systems	Community Care System implementation	Virtual Flow to support step up and step down processes
Mental Health & LD	Replace current information system with Community Care system	Further implementation of CCIS to support multi agency working	Modernise the telecoms and PC infra-structure in community sites	
Primary Care	Support electronic transfer of information between	Introduce Electronic Test Requesting into practices	Provide a system to support primary care triage of referrals	

Division	Priorities			
	Secondary and Primary Care			
Corporate	Technology to support deskless staff	My Health On line	Greater emphasis on mobile technology – support CF strategy	

This programme of work is flexible to allow for the changing circumstances throughout its lifespan depending on the availability of national and local resources, including capital and revenue funding as well as reflecting the priorities for the Health Board.

- **Information: promoting and supporting service improvement**

Over the next 2 to 3 years, the development of the Health Board’s Information Service and the provision of information to clinicians and managers will utilise a Business Intelligence approach. Proposed areas of development include:

- A focus on patient pathways, enabling the analysis of activity and events in more meaningful ways
- Achieving comprehensive access to primary care data, a crucial component in understanding and promoting the shift in focus from acute to primary and community care services that is at the heart of Clinical Futures.
- An increased concentration on patient experiences and outcomes

A Business Intelligence approach will also be taken in the provision of information to the people who use or are interested in the services we provide. They will be provided with access to comprehensive and detailed information about our services that is understandable and useful. A crucial component of much of the information we produce and use is the accurate and timely classification or coding of the problem, diagnosis and treatment of each individual patient.

- **Information Governance**

Information Governance is one of the essential regulatory components that facilitate the effective and efficient delivery of services. Good Information Governance provides patients, families, partners, service users and staff with the confidence that the Health Board is creating, collecting, storing and using information correctly and within the law. Over the next few years there will be increasing scrutiny around the public sector compliance with IG standards and legislation and the IG Team will ensure that the Health Board remains fully compliant.

- **Resources**

Informatics does not have a permanent ring fenced allocation of capital funds each year, however, the capital investment from local discretionary funding for ICT over the last six years has ranged between £1m - £3m per annum. Investment must to continue in these areas to support business continuity and defend against cyber-

attacks.

It is recognised that the current funding level is sufficient to manage the current state but any future developments will require additional resource as noted in the detailed Informatics IMTP. The total level of ABUHB spend on Informatics is lower than the recommended 2% of total revenue expenditure at 0.73% and lower than the all-Wales average of 0.83% [WAO Diagnostic Review of Capacity and Resources – November 2015]. With several significant further changes e.g. the new SCCC, adoption of WCCIS and Welsh Clinical Portal convergence, investment is paramount to ensure successful implementation and realisation of the benefits.

The Health Board will ensure that it continues to take advantage of systems and processes that puts patients at the centre of care following them through all phases of their care at hospital, in primary and community care settings and with care partners with seamless transfers of care (clinical flow).

SECTION THREE – 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.

3.1 Delivery Approach

Our approach will be based on effective delivery and assurance principles by promoting effective leadership, positive culture, mutual support, strong governance and accountability and robust performance management. This will be achieved by:

- Empowering leaders to deliver change at all levels within the Health Board.
- Providing support to enable leaders to understand, model and address complex, systemic challenges to delivery of our objectives.
- Being explicit about how staff are expected to contribute to change from their role in optimising their department's performance to wider organisational challenges.
- Having meaningful (not multiple) matrices that allow progress to be measured.
- Ensuring that there are clear structures and accountabilities for deliver change and integrated structures to monitor their delivery.

The Governance and Assurance Framework for the organisation is attached as Appendix 1 and is the structure that will be used to support the delivery framework.

This framework will assist in the monitoring of progress against achievement of key priorities and ascertaining they are having the appropriate impact and outcomes. This monitoring will measure progress of key deliverables both in terms of actions and against agreed profiles. There will be reporting arrangements to ensure escalation where appropriate and support to effect remedial actions. This approach will be underpinned by having strong focus on the delivery of Service Change Plans which will have clarity on delivery arrangements including:

- Clinical and managerial leads.
- Status of detailed plans.
- Key milestones and timescales.
- Integrated outputs (quality, operational, efficiency, workforce and finance), that form the basis of tracking of plan delivery.
- Risks and mitigation plans.

To ensure that the Health Board's strategic priorities are being delivered an integrated planning tracker will be developed for each Service Change Plan and incorporated into the performance management framework, providing the means by which progress would be measured quarterly and includes the following:

- Progress against key project milestones within the quarter.
- Delivery against performance milestones.
- Delivery of planned workforce changes.
- Delivery of financial benefits.
- Realisation of quality, patient experience and performance outcomes.
- Key risks and mitigating actions.

- Enabling support required.

There is clarity on priorities, action and key deliverables for 2016/17 but less granularity for 2017/18 and 2018/19. The delivery framework and governance structure will continue to be reviewed and will be strengthened as required as we progress through the planning and delivery process.

3.2 Outcomes & Performance Framework

The refreshed plan will have a greater focus on outcomes and performance with a new performance management framework being developed for the organisation during 2016/17. This will be developed around the NHS Outcomes and Delivery Framework introduced by Welsh Government in 2015/16 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.



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 table below sets out the key metrics that are included as part of the National Outcomes & Delivery Framework and the planned performance over the next three years.

TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Monthly	% of patients waiting less than 26 weeks for treatment – all specialties	95%	91.5%	88.4%	88.5%	90.0%	92.0%	95.0%
	Number of 36 week breaches – all specialties	0	891	2,329	2,550	1,200	500	0
	% of patients waiting less than 8 weeks for diagnostics	100.0%	59.5%	85.4%	77.0%	85.0%	92.0%	100.0%
	% of new patients spend no longer than 4 hours in A&E	95%	92.1%	91.8%	80.0%	92%	93.50%	95%
	Number of patients spending 12 hours or more in A&E	0	154	230	600	200	100	0
	% of Cat A Ambulance responses within 8 minutes	65.0%	49.9%	50.6%	62.0%	65.0%	67.5%	70.0%
	Number of over 1 hour handovers	0	1	1	458	100	50	0
	% of patients referred as non-urgent suspected cancer seen within 31 days	98.0%	98.3%	99.4%	98.0%	98.0%	98.0%	98.0%
	% of patients referred as urgent suspected cancer seen within 62 days	95.0%	96.2%	95.1%	92.2%	95.0%	95.0%	95.0%
	% compliance with acute stroke QIMs:	stroke care 4 hours rgh compliance	95%		11.4%	59.2%	95.0%	95.0%
stroke care 12 hours rgh compliance		95%		65.5%	97.4%	95.0%	95.0%	95.0%
stroke care 24 hours rgh compliance		95%		44.2%	80.3%	95.0%	95.0%	95.0%
stroke care 72 hours rgh compliance		95%		77.0%	94.7%	95.0%	95.0%	95.0%
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Monthly	% of assessments by the LPMHSS undertaken within 28 days from the date of referral	80%	41.3%	23.4%	80.0%	90.0%	90.0%	90.0%
	% of therapeutic interventions started within 28 days following assessment by LPMHSS	80%	73.3%	78.2%	60.0%	80.0%	80.0%	80.0%
	% of LHB residents (all ages) to have a valid CTP completed at the end of each month	90%	88.5%	92.2%	90.0%	90.0%	90.0%	90.0%
	% LHB residents sent their outcome assessment report 10 working days after assess	100%			TBC	100.0%	100.0%	100.0%
6 monthly assessment	% of hospitals with arrangements to ensure advocacy available to qualifying patients	100%			100.0%	100.0%	100.0%	100.0%
SAFE CARE - I am protected from harm & protect myself from known harm								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Monthly	DToC delivery per 10,000 LHB population - mental health	Reduction (rolling 12 months)	3.3	2.9	2.04	1.6	1.5	1.4
	DToC delivery per 10,000 LHB population - non mental health		21.7	20.3	16.7	13.0	12	11
	Number of cases of C Difficile per 100,000 of the population	28 per 100,000			33.5	28.0	28.0	28.0
	Number of cases of MRSA per 100,000 of the population	1.5 per 100,000			2.1	1.5	1.5	1.5

STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Quarterly assessment	% estimated LHB smoking population treated by NHS smoking cessation services	5% (end of fin year)	1.1%	1.3%	2.0%	3.3% (1.9% AB) (1.4% SSW)	4% (1.9% AB) (2.1% SSW)	5% (2.2% AB) (2.8% SSW)
	% smokers treated by NHS smoking cessation services who are CO- validated as successful	40% (end of fin year)		38.3%	40.0%	40.0%	40.0%	40.0%
Monthly	Number of emergency admissions for basket of 8 chronic conditions per 100,000 of population	Reduction (12 months trend)	1284	1286	1287	1200	1140	1083
	Number of emergency readmissions for basket of 8 chronic conditions per 100,000 of population		260	277	252	240	228	217
Annual assessment	% uptake of the influenza vaccine in the following groups:	Over 65's	70%	70%	67.0%	67.0%	70%	70%
		Under 65's in at risk groups	55%	53%	48.0%	48.0%	50%	55%
		Pregnant women	47%	45%	75.0%	75.0%	75%	75%
		Healthcare workers	50%	39%	40%	41.0%	50.0%	50%
Quarterly assessment	% uptake of childhood scheduled vaccines up to the age of 4:	5 in1 age 1	97%	98%	95.0%	95.0%	95%	95%
		MenC age 1	97.50%	98.50%	95.0%	95.0%	95%	95%
		MMR1 age 2	97.10%	96.50%	95.0%	95.0%	95%	95%
		PCV age 2	96.70%	96.60%	95.0%	95.0%	95%	95%
		HibMenC Booster age 2	95.90%	95.70%	95.0%	95.0%	95%	95%
Annual assessment	% of reception class children (aged 4/5) classified as overweight or obese	Annual reduction			25.1%	24.6%	24.6%	24.0%
Quarterly assessment	Number of contacts to the mental health C.A.L.L.	Quarterly improvement			3714	3,890	4,085	4,289
	Number of contacts to the Wales Dementia helpline				76	84	92	102
	Number of contacts to the DAN 24/7 helpline				868	911	957	1004
Monthly	Of those practices set up to use MHOL, % who are offering appointment bookings	Improvement (12 month trend)			71.8%	80%	85%	90%
	Of those practices set up to use MHOL, % who are offering repeat prescriptions				63.5%	75%	80%	85%
EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Monthly	% Crude Mortality	Reduction (12 month trend)	1.86%	1.75%	1.71%	1.60%	1.55%	1.50%
	RAMI 2015		115	113	109	100	98	96
	% valid principle diagnosis code 3 months after	95%	93%	99%	95.0%	95.0%	95%	95%
	% valid principle diagnosis code 3 months after	98%	98%	98%	98.0%	98.0%	98%	98%
Annual assessment	Number of Health & Care Research Wales Clinical Research Portfolio Studies and Commercially	Annual improvement			75	82	90	99
	Number of patients recruited into Health & Care Research Wales Clinical Research Portfolio Studies				4,462	4,908	5,153	5,411
Annual assessment	Number of Audits the organisation is participating in against the national clinical Audit Programme	Annual improvement			36	36	37	38
Annual assessment	% people aged 50+ who have a GP record of blood pressure measurement in the last 5 yrs.	Annual improvement			92.9%	94.0%	95%	96%
TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Annual assessment	% GP practices offering appointments between 17:00 and 18:30 at least 2 days a week	Annual improvement	99%	100%	99.0%	99.0%	99%	99%
	% of GP practices open during daily core hours or within 1 hour of the daily care hours		75%	92%	96.0%	97.0%	98%	99%
Quarterly assessment	Patients treated by an NHS dentist in the last 24 months as % of population	Improvement (12 month trend)	56.4%	56.5%	57.0%	59.0%	61%	63%
Monthly	Number of follow-up appointments delayed past their target date (booked & not booked)	Reduction (12 month trend)	80,969	33,977	24,000	18,000	12,000	6,000
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Annual assessment	% of over 65 registered as having dementia with their GP practice	Annual improvement			3.2%	3.4%	3.60%	3.80%
DIGNIFIED CARE - I am treated with dignity & respect & treat others the same								
Measure	Target	Profile						
		Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19	
Monthly	% procedures postponed on >1 occasion, had procedure <=14 days/earliest convenience	Improvement (12 month trend)	50.0%	38.2%	36.5%	50%	55%	60%

SAFE CARE - I am protected from harm & protect myself from known harm								
Measure		Target	Profile					
			Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Monthly	Number of healthcare acquired pressure sores in a hospital setting	Reduction (12 month trend)	44	12	29	22	20	18
Quarterly assessment	% compliance with National Patient Safety Agency Alerts issued prior to Apr-14	100%	100%	100%	100%	100.0%	100%	100%
	% compliance with National Patient Safety Agency Rapid Response Reports issued prior to Apr-14		100%	100%	100.0%	100.0%	100%	100%
	% compliance with Patient Safety Solutions Wales Alerts issued after Apr-14				100.0%	100.0%	100%	100%
	% compliance with Patient Safety Solutions Wales Notices issued after Apr-14				87.5%	100.0%	100%	100%
Monthly	Of the Serious Incidents due for assurance within the month, % which assured in agreed timescale	90%			80.0%	90.0%	90%	90%
	Number of new Never Events	0			3	2	1	0
OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful use of them								
Measure		Target	Profile					
			Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	Mar-19
Monthly	% staff absence due to sickness	Reduction (12 month trend)	5.5%	5.4%	5.5%	5.0%	4.90%	4.80%
	New OP DNA rates for selected specialties (E&P)	Reduction (12 months trend)	9.6%	8.0%	7.3%	7.0%	6.80%	6.50%
	Follow up OP DNA rates for selected specialties		9.9%	9.2%	8.5%	8.2%	8.00%	7.50%
Annual assessment	% of total medical staff undertaking performance	Annual improvement		80.0%	88.0%	90.0%	92%	94%
	% of total non medical staff undertaking		60.6%	61.0%	74.4%	85.0%	87%	89%

In addition to the above at a high level the following tables set out what the organisation is 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%.
- Improved uptake of smoking cessation to 3.3% population.
- Improved uptake of flu vacs by staff to 50%.
- Completed roll out of Living Well, Living Longer to North Caerphilly and Blaenau Gwent West.
- Introduced 24/7 community nursing services.
- Introduced community phlebotomy services.
- Transferred more specialist hospital services to primary care settings to bring care closer to home.
- Refreshed chronic condition delivery plans such as Cardiology and introduced community cardiology service.
- Produced strategic outline case for Mental Health and Learning Disabilities complex care services and business cases for interim HDU and extended PICU.
- Sustained clinical services under pressure from medical staff shortages e.g. in paediatric and neonatal services.
- Achieved financial balance.
- Reduced emerging admissions to acute hospitals by approximately 7%.
- Reduced delayed transfers of care by 20%.
- Improved operational efficiency and effectiveness.
- More care provided by integrated teams.
- More care planned and delivered around NCN communities.
- Started building the SCCC.
- Reduce the number of patients waiting more than 36 week for treatment by 50% to

1,200.

- Further reduce the incidence of C.difficile and Staph aureus infection to deliver population denominated targets (equivalent of 20%).
- Agreement of an implementation plan for the further centralisation of vascular services in South East Wales.
- With neighbouring Health Boards, commenced phased introduction of the Imaging Academy for Wales.
- Established a new service model for Sexual Assault Referral Services in South Wales.
- Redeveloped the Neonatal Unit at the Royal Gwent Hospital to address infection control risks and increase network resilience.
- Reduced sickness absence by 5%.
- Eliminated >8 week waits for diagnostic tests.
- Improved the RAMI (2015) performance from 109 to 100.
- Improved 4 hour performance to deliver 92% compliance, with parallel improvements in 12 hour and WAST performance.
- Developed and implemented a new performance management framework
- Defined the work programme and delivery structure to support the new strategic programmes.
- Removed the use of off-contract agency

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.
- Health inequalities in our most deprived communities will be reduced, and there will be fewer premature deaths due to conditions such as cancers, heart attacks and stroke.
- Services will be delivered in an integrated health and social care system built around our 12 Neighbourhood Care Networks.
- Services will be more focused on prevention, anticipation and supported self management.
- In partnership with Local Authorities and the third sector, cohesive services for children, older and vulnerable people will be available to all. We will have in place an up-to-date, agreed suite of care pathways that assist both healthcare staff and patients understand and achieve the best approaches for care which are safe, citizen centred, clinically and cost effective.
- We will have sustainable 24/7 primary care services to ensure that urgent and planned primary care is locally accessible.
- We will have established a more equal relationship between patients and professionals, based on openness and sharing information.
- We will shift the balance of our services by increasing the number of specialist services, currently provided in our hospitals, being delivered in a primary care setting with collaboration between practitioners across the whole system.
- Technological opportunities will be maximised, to enable clinicians and social care practitioners to share information about patients, and which will also enable patients and carers to access appropriate, timely and relevant information.
- When hospital treatment is required, and cannot be provided in a community setting, day case and ambulatory care treatment will be the norm.
- There will be 24/7 access to consultant led hyper-acute and specialist care,

facilitated by consolidating these service in the newly opened Specialist and Critical Care Centre at Llanfrechfa Grange in 2019.

- Whatever the setting, care will be provided to the highest standards of quality and safety, with the citizen at the centre of all decisions. At all times, in every part of the system, we will strive to be “best in class”, pushing the boundaries of efficiency, effectiveness and proportional interventions in accordance with prudent healthcare.
- The health service in ABUHB will be regarded as a caring and improving health system built on a model where integration, partnership working, prudence and public participation are all paramount.
- Eliminated 36 week breaches and delivered 95% 26 week compliance.
- Achieved 95% 4 hour compliance in the Emergency Department, eliminating 12 hour trolley waits.

SUMMARY

In summary, the Aneurin Bevan University Health Board's IMTP for 2016/17-2018/19 starts with year two of the approved plan and has been refreshed based on the reflections of year one and a look ahead for a further year into 2018/19 and is consistent with the Welsh Government process to maintain approval status.

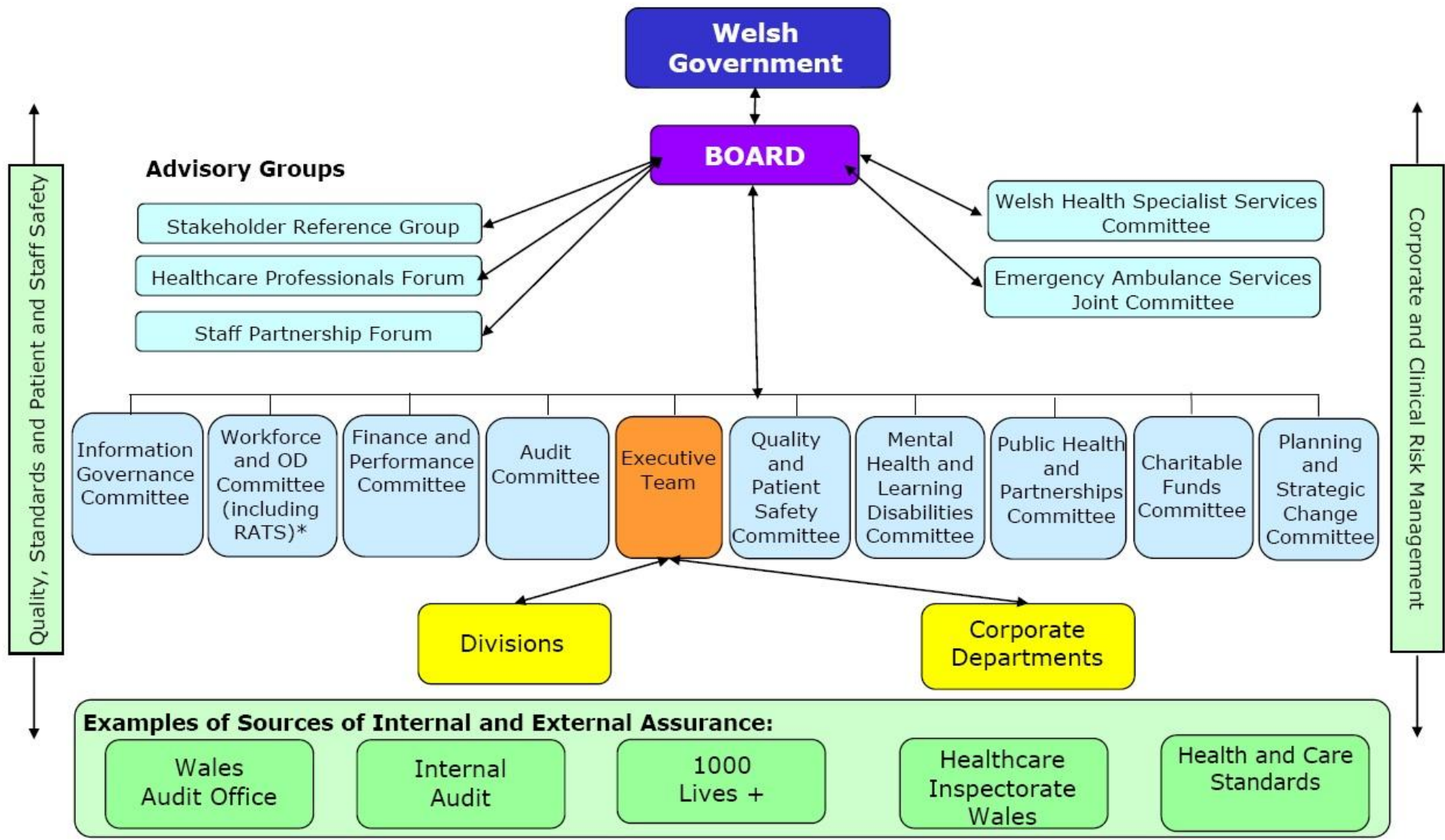
The Health Board has a strong overarching strategy in Clinical Futures which is consistent with the national strategies and legislation and responds to the significant challenges facing the health system at both a national and local level.

The patient and citizen is at the heart of our plan and quality and patient safety remains at the centre of our work with a greater focus on patient experience and engagement with co-production and the prudent agenda driving the ambition for value based care.

The approach to planning is being developed to differentiate between the programmes of work that support improving operational efficiency, service change and improvement and wider system change. A comprehensive work programme is established and being continually developed to ensure delivery of the strategy and supports the strengthening of the 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 2016/16. The outcomes and delivery framework is also a fundamental component of ensuring delivery of the plans. The key outcomes of the service plans and performance against national targets are set out with a greater focus on quarterly reporting as we commence 2016/17.

Further detailed information on all components of this plan can be found in the supporting [Technical Document](#).



* RATS - Remuneration and Terms of Service Committee