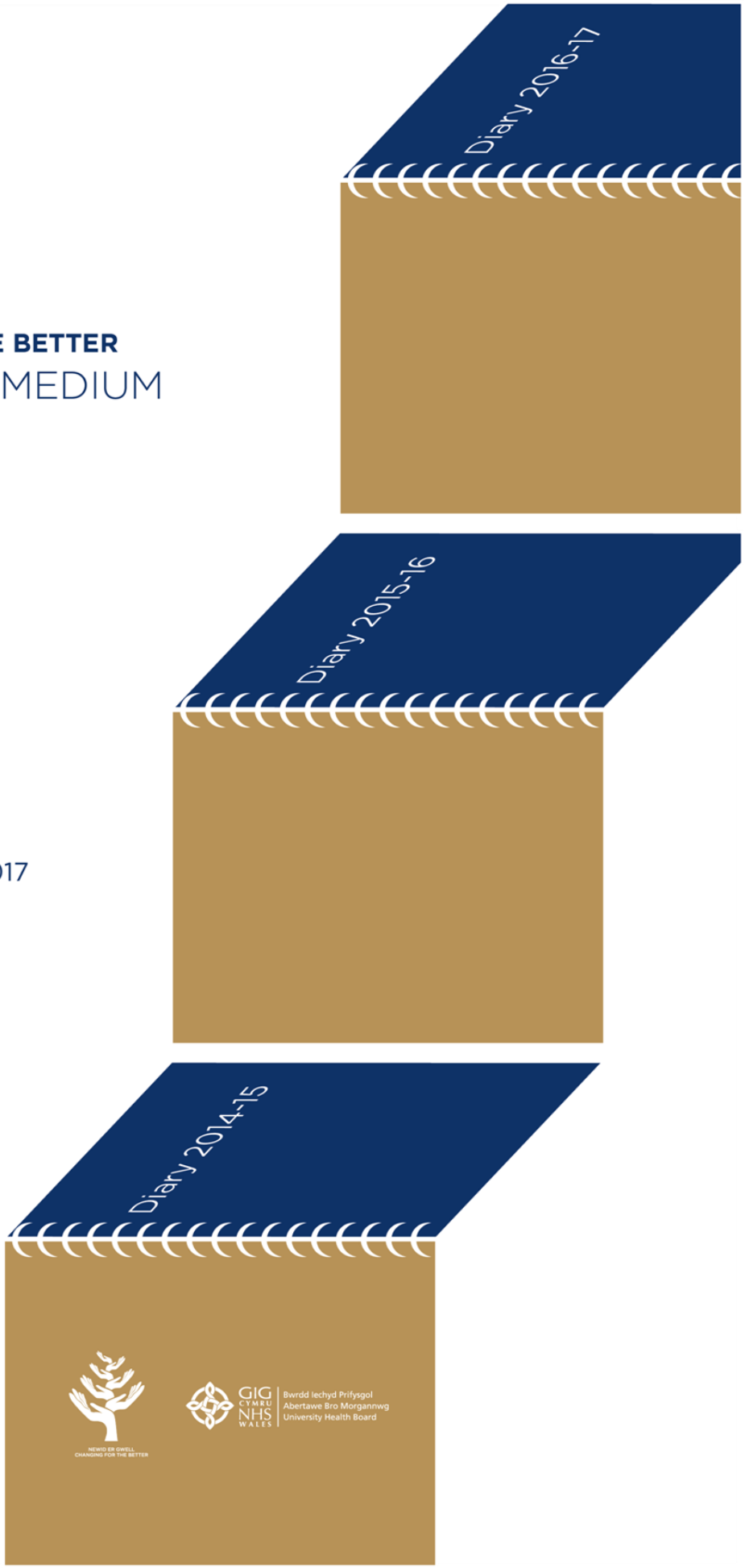
ABMU Health Board

CHANGING FOR THE BETTER
INTEGRATED MEDIUM TERM PLAN



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Foreword

The NHS in Wales is facing real challenges of rising demand, increasing expectation, recruitment difficulties and financial austerity. In ABM University Health Board we are clear that we cannot meet these challenges by doing "more of the same" nor in isolation. Working closely with our clinicians, patients, other stakeholders and organisations we have developed solutions that are ambitious, innovative, driven by standards and draw on our own successes and those of others to transform the quality and safety and delivery of care. The intent to consistently deliver high quality care in the right place at the right time by the right people is at the very heart of this plan.

This is the first time that NHS organisations in Wales have been able to plan for the medium term rather than for the year ahead. This is a very significant change that has required us to redesign our systems from bottom to top to create a plan that is ambitious in its aspiration to transform how we deliver healthcare, support and advice for the citizens that live in Swansea, Neath Port Talbot and Bridgend and indeed more widely.

Over the next three years increasingly we will deliver excellent care where people live instead of in hospital; when it is safer and better to do so. We will empower citizens to have more control of their own health so that they are less dependent on the NHS and will create responsive systems that allow people and their GPs to get prompt advice and support from specialists if they need it. We will give a greater role to groups of local primary care services in community networks, because they are best placed to understand local health needs and solutions and to help halt the widening health inequalities. This will mean increased investment to help people make healthier lifestyle choices, particularly regarding smoking and managing their weight and activity.

Not only is our plan ambitious for improvement and medium term but it is also integrated. Throughout, service intentions are matched by workforce and financial assumptions and increasingly we will work in an integrated way with local authority, third and voluntary sector partners to create joined up, more efficient and effective systems of care.

We are proud of our University status and know that through stronger alignment of healthcare, excellent education, high quality research and consistent improvement; we will deliver the best outcomes for our patients. This plan describes how we expect to do this and how, over the next three years, we will change for the better whilst using the resources available to us prudently in all that we do.

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1 Executive Summary

1.1 Introduction

Abertawe Bro Morgannwg University Health Board's Integrated Medium Term Plan (IMTP) sets out our strategy to fulfil our civic duty, both as a commissioner and provider of services, to meet local health needs. This includes our responsibilities to deliver high quality effective and efficient services and as a major employer and contributor to the local health economy.

Over the next three years we aim to improve the health of our population, the quality and safety of the services we provide, to meet Tier 1 standards and meet additional demand on the NHS through new ways of working and new models of care. We are in no doubt that we face a significant challenge to achieve this within the resources available to us.

We are determined to offer safe, excellent services to our patients and service users and to support all our communities to be healthier. We know that whilst we sometimes do this very well, there is much more that we could do. We know that by listening to our patients, we will improve the quality of care that we provide much faster. The IMTP sets out how we will change for the better over the next three years.

Our plan for the medium term must address many challenges:

- More older people, who are frail and may have complex needs; more people with chronic ill health; life style choices which result in worsening population health and widening health inequalities between our citizens.
- Difficulties in meeting the current demand for services; we are not achieving the standards for access times for primary care, unscheduled care, referral to treatment, diagnostics and cancer treatment.
- Greater demand for services in the next three years. Based on population growth projections and assuming current models of care, we estimate that by the end of 2016 there will be:
  - 3.9% more A&E attendances by people aged 85 and over i.e. 5,032 additional attendances per year (14 additional attendances per day).
  - 3.4% more day cases i.e. an additional 2,260 cases per year (6 cases per day).
  - 3.2% more inpatient admissions i.e. an extra 3,298 admissions (9 per day).
  - 102 more inpatient beds needed to meet this demand.
  - More demands on primary care and community services, as a result of an increase in the number of people who are frail and who have multiple long-term conditions.

- Inconsistent quality of care both between our services and also across the days of the week as detailed in "Trusted to Care", the Andrews Report and the Advancing Quality Alliance (AQuA) review of safety and quality report.
- The current configuration of some hospital services and the availability of trainee doctors are unsustainable and add to our staffing costs without improving the safety and quality of care.
- There are growing workforce challenges within primary care with changing workforce profile, more GPs retiring early and a shortfall in the supply of new doctors. There are other factors that could impact on the sustainability of primary care services during the next three years.
- We need to develop stronger networks of integrated community services with our partners, who also face their own challenges.
- Higher than average levels of staff sickness, which impact upon staff morale, service quality, cost and access times.
- A continued 'flat cash' financial allocation with projected rising costs in the context of an underlying deficit of £15m, will cause significant financial pressure over the term of this plan.
- Limited capital finance to invest in our estate and to support service change.

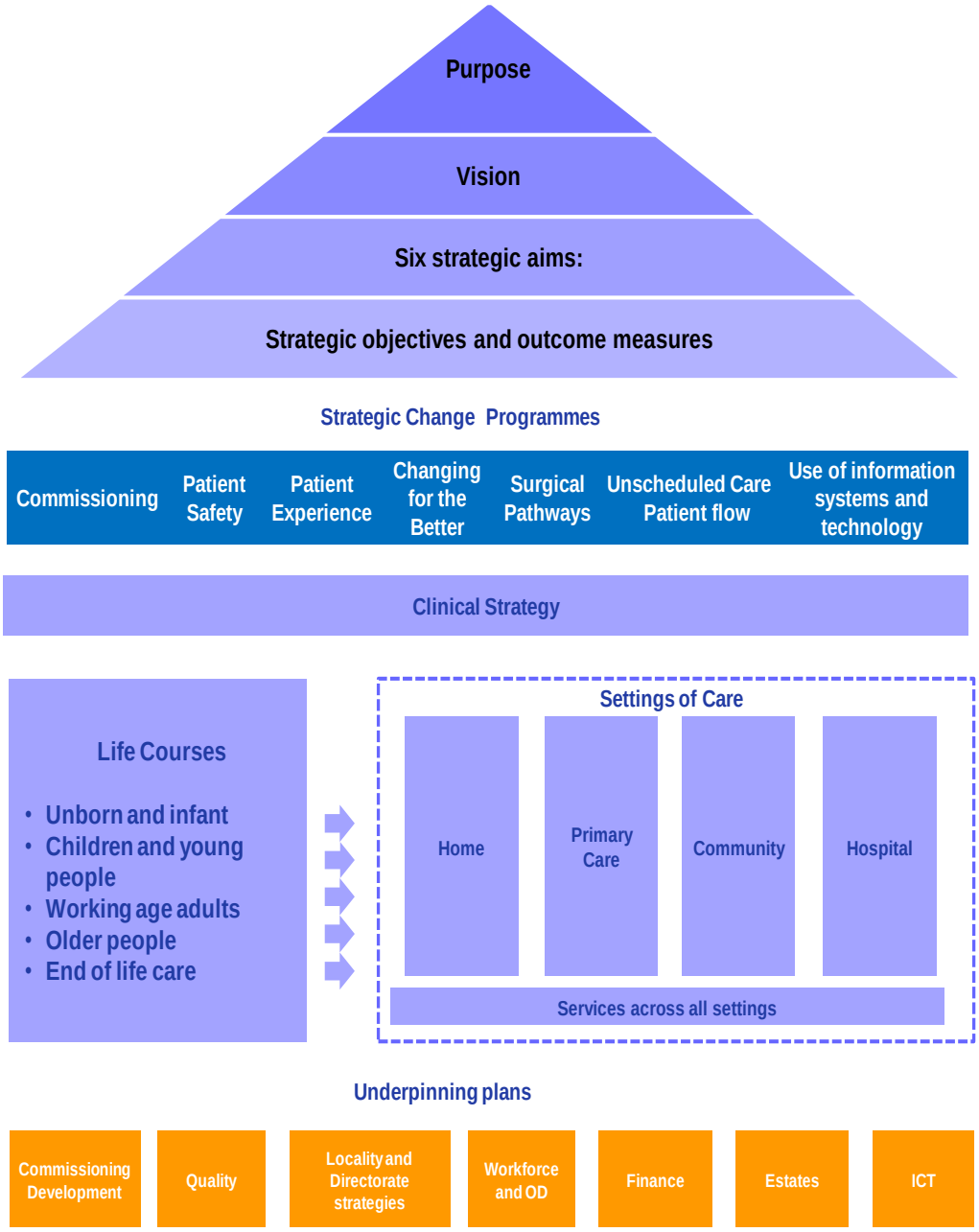
To respond to these challenges whilst improving the quality and safety of care, means that the *status quo* is not an option. We will be bold in transforming our services: providing proactive support for citizens whose health is beginning to decline, delivering an even greater proportion of care in or near where people live in integrated partnership with local authority and third sector organisations and strengthening primary care through effective networks and additional investment.

We will be prudent in how we provide care, ensuring that in future we prioritise based firmly on the needs of our citizens: agreeing with them only what is required and effective to address their needs whilst at all times minimising harm. We will measure Patients Reported Outcomes of care (PROMs) and compare those with our peers. We look forward to working with other organisations across NHS Wales in embedding these principles equitably in our approach.

1.2 Health Needs Assessment

We will be helped in this by our first Strategic Health Needs Assessment (SHNA), published in December 2013 which describes the health priorities for our local population and the evidence for shaping the key determinants of good health. We will plan our services to provide better value and greatest health gain and to halt the growth in health inequalities.

The opportunity to plan for the medium term, the focus on the health needs of our population and our University status led us in 2013 to review the purpose, vision, aims and objectives of the Health Board. We have engaged on these with our staff, partners and stakeholders to develop a shared strategic direction for our Health Board. The diagram below provides an overview of the components of our strategy.



Our purpose, visions, aims and objectives are set out below. These have been shared and engaged upon and reflect the conclusion of constructive input from a wide range of our stakeholders.

PURPOSE – WHY WE EXIST

"To fulfil our civic responsibilities by improving the health of our communities, reducing health inequalities and delivering effective and efficient healthcare in which patients and users always feel cared for, safe and confident."

VISION – WHERE WE AIM TO BE BY 2017

We wish to be an excellent healthcare, teaching and research organisation for the Abertawe Bro Morgannwg region and the wider regions that we serve. This means that:

- We will respect people's rights in all that we do and plan our services and their care with them. Wherever it is provided, care will be safe and compassionate, meeting agreed national standards, providing excellent outcomes and an experience that is as good as it could be.
- We will make it easy for everyone to get the information and advice they need to be in control of their own health and to live healthier lives.
- We will work in partnership with our communities, our staff and other agencies to meet our citizens' health and social care needs in an integrated way, usually in or near to where they live.
- We will support high-quality research, education and innovation that benefit our patients and staff and we will encourage everyone to share their care experiences with us so that we can learn how we can do even better.

AIMS

We have six strategic aims:-

- Excellent population health
- Excellent patient outcomes and experience
- Sustainable and accessible services
- Strong partnerships
- Excellent people
- Effective governance

For each strategic aim we have identified objectives, outcome measures and delivery mechanisms, which set out what we intend to do and how we will measure and deliver success. Our clinical strategy has been developed through extensive partner and stakeholder engagement over the last 18 months. In summary our clinical priorities are to: -

- Tackle the widening health inequalities and health needs across our Health Board by helping citizens to make healthier lifestyle choices and remain healthy for longer.

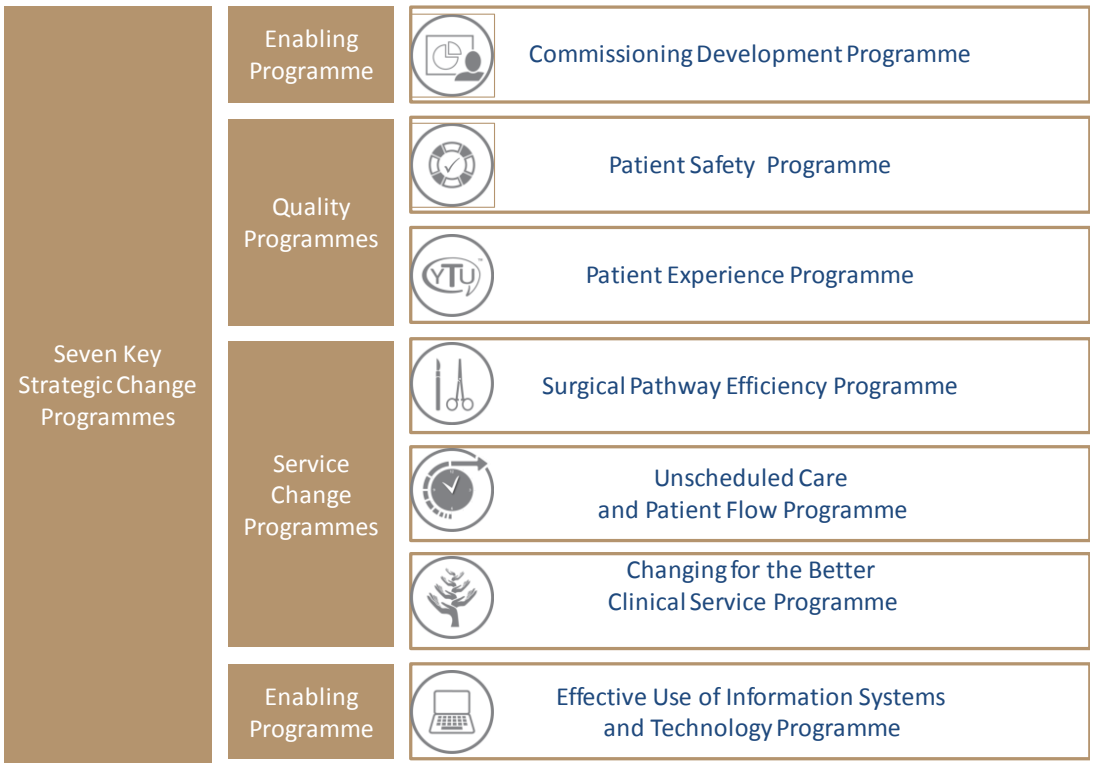
- Commit a greater proportion of our resources to delivering care outside hospitals, near or in peoples own homes.
- Strengthen our primary and community teams and integrate them with social care and the third and voluntary sectors to provide proactive, responsive services for citizens, particularly children and the elderly.
- Empower those people with long term conditions to manage their conditions better through education, information and support and to make it easier for them and their primary care teams to access expert advice and review, when required.
- Give patients the information they need; to agree with us the care we will provide and listen to and learn from their experience of that care.
- Deliver care that meets nationally agreed standards.
- Meet the best standards of care. We will transfer maternity, obstetric, neonatal and in-patient gynaecology services from Singleton Hospital to Morriston Hospital when capital funding allows. We will develop the business case for this during the period of this IMTP. We will plan with other Health Boards to place Morriston (and the University Hospital of Wales - UHW) at the centre of a network of hospitals in South Wales, caring for patients who have severe injuries ("major trauma") and to develop the business case for an enhanced pre-hospital Emergency Medical Retrieval and Transport Service (EMERTS). We are reviewing the sustainability of the current configuration of acute medical care in Swansea and Neath Port Talbot and will bring forward proposals about this early in 2014/15.
- Finalise our clinical strategy for the Princess of Wales Hospital once the outcome of the South Wales Programme and other service reviews being conducted by the South Wales Health Collaborative are published.

Based on our clinical strategy, we describe our vision for better clinical services in two ways:

- ***By life course***, setting out clearly how things will change for different groups of our citizens, patients, carers and their families by 2017.
- ***By settings of care***, describing what it will mean for our hospitals, community and primary care providers and their staff.

1.3 Our Strategic Change Programmes

We will manage our plans to achieve this future state against both national and local performance standards, using robust monitoring arrangements and effective governance systems. To support the delivery of our overall strategy we have established seven Strategic Change Programmes.



The **Commissioning Development Programme** has identified our health need and commissioning priorities and developed our smoking cessation plan. In early 2014-15 this programme will support a new planning approach for the Health Board, delivering local integrated commissioning and strategic planning of services, based on prioritised local need, evidence of best practice and value for money. Medium term planning enables us to integrate this approach from 2014-5 into a continuous and robust clinical and organisation planning cycle, informed by high quality information and analysis.

Three of our Strategic Change Programmes focus on service improvement. The **Surgical Pathways** and **Unscheduled Care/Patient Flow Programmes** will ensure that we are delivering care in the most effective and efficient manner possible. The **Changing for the Better (C4B) Clinical Service Programme** leads on delivery of our clinical strategy through transformational change.

Our **Effective Use of Information Systems and Technology Programme** is focussed initially on enabling delivery of the Strategic Programmes, allowing us to work in a more integrated manner and to use technology as close to the point of care delivery as possible, making the provision of care better and easier for clinicians and patients.

In addition to our major Strategic Change Programmes, our twelve Localities and Directorates will be delivering their local plans to respond to national priorities (including Tier I targets and national delivery plans) and

implementation of our strategic aim and objectives. Our three Localities will also be working with local partners to support the implementation of local Single Integrated Partnership Plans (SIPPs) and the development and strengthening of ten Primary Care led Locality Networks.

With our partners in the three local authority areas we have formed a Western Bay Health and Social Care Programme to focus on the integration of health and social care services in the following areas

- Learning Disabilities
- Mental Health
- Community Services - which is aligned with the Changing for the Better Programme
- Children's services and the creation of a regional adoption service

The Mental Health and Learning Disabilities directorates have service strategies of their own. ***"Changing Mental Health Services for the Better"*** is being delivered and already forms part of our clinical strategy family; **"*Forward together*"** the Learning Disabilities' Strategic Framework for Adult services, sets out collaborative partnership arrangements to develop future models of care. We will fully integrate these two important service strategies into our overall C4B clinical service strategy in 2014-15.

1.4 Quality Improvement

Our highest priority is to deliver consistently high quality care 24 hours a day, seven days a week. By this, we mean safe, excellent and compassionate care that respects people's rights and responsibilities whenever and wherever it is provided. We know that we do not yet achieve this consistently and do not always listen to what patients tell us or act on what they say. We have established two Strategic Change Programmes directed specifically at making the care we provide safer and improving the experience of that care (***Patient Experience and Patient Safety Programmes***); which will be embedded in everything we do. These will ensure that we:

- Make delivering high quality care consistently the primary consideration for all our staff
- Make it easy for everyone to tell us about their experience of care through "You Tell Us™"
- Listen to what people tell us and learn from it
- Meet the highest standards of patient safety
- Seek constantly to minimise harm
- Be open and honest in all that we do
- Learn from when things go wrong and take action to prevent it happening again

We also plan to launch a Patient Safety campaign which will coordinate widespread engagement of our staff, our patients and their families to ensure that improving quality and safety is embedded in all that we do.

We are committed to delivering an increasing proportion of care in a community, primary care or home based setting and will work with our partners to achieve this through our Strategic Change Programmes, Clinical Strategy and Western Bay Health and Social Care Programme. We also plan to explore how community networks can take on a broader range of responsibilities for planning and delivering primary and community services. We believe that networks will deliver significant benefits in coordinating care for individuals and providing comprehensive holistic care in the context of the wider family and community, particularly for older people and those with multiple long term conditions.

1.5 Finance

The financial climate in which we are operating is a challenging one. There will be no uplift in funding for inflation, future cost pressures or increasing demand. We have a £15m underlying deficit and forecast unavoidable cost pressures amounting to £80m over the next three years. This is a major challenge and at this stage, we have not yet been able to develop a plan for the next three years that meets our local health needs; provides safe and high quality services, meets national targets and yet delivers a balanced budget. We will need to undertake further work in order to do so and some of this will need to be at a national level. We cannot quantify at this stage of the contribution that a “prudent healthcare” approach will make to our IMTP.

The overall cost (including inflation and demand costs) of delivering our plan is £136m above the baseline budget. We have identified savings in the region of £101m, which leaves a financial gap of approximately £35m over the next three years. Based on our track record of delivering savings (£80m over the past three years), achieving a savings target of circa £100m is ambitious but we feel represents a fair challenge to us.

The identification of further cash releasing savings would, we believe impact on the quality and range of services we provide and more specifically, place limitations on our ability to meet national performance standards. We will therefore need to find more creative ways to do identify savings within the Health Board and across Wales. We recognise the importance of benchmarking and the delivery of service efficiency and our circa £100m savings plan uses UK national benchmarking to identify our savings opportunities. These opportunities are factored in to our financial plan.

1.6 Workforce and Organisation Development

We realise that our clinical teams do not currently have all of the skills needed to care for frail older people and that effective multidisciplinary team working is not embedded throughout the organisation.

Our workforce plan sets out a number of initiatives to ensure that our staff:

- Are appropriately trained
- Work in effective teams
- Are committed to improving the quality of care
- Are listened to.

We are committed to developing clinical leadership and working in partnership with staff in the design and running of services. We know that we must improve the engagement of our staff in the planning and the delivery of our strategy. We will do this through our Performance Appraisal Development Review (PADR) processes.

We also recognise that in delivering our plan there will be a need to invest in our workforce to give time for quality improvement activities, to develop different roles, different skill mix and different working practices; as well as additional education and training to provide excellent care for older people. Increasingly, we will recruit staff for the values they hold.

1.7 Partnerships

The Health Board has a wide range of partners and stakeholders who will be instrumental in supporting us deliver our strategy. One key NHS partner is Public Health Wales, which provides us with expert public health advice, and health protection and screening services to protect and improve the health and wellbeing of our population. Through collaboration and partnership working we will work closely with our communities, staff, local government and the third and voluntary sectors to support healthy independent living.

We plan to develop integrated health and social care services for older people who have complex needs, and have already begun this journey in areas within the Health Board. Our ambitious plans within the Western Bay Health and Social Care Programme for integrated intermediate care services is an excellent example of this and we expect to see significant investment in these services starting in 2014/15, if funding is made available through the intermediate care fund. Our vision for the delivery of integrated care is set out within our 'Statement of Intent' which has been agreed with partners within the Western Bay Health and Social care Programme.

In addition we have submitted plans for investment in enabling technologies to allow improved co-ordination of care between local authority, community, and primary and secondary care staff through the Heath Technology Fund.

Our partnership with Swansea University has been strengthened by a Memorandum of Understanding and collaboration agreement, which will deliver benefits for teaching and training excellence, recruitment opportunities and research. We wish to see much closer working with the University sector to ensure that the benefits of health-science and academic collaboration are realised for our patients and staff and also for the wider economy. There are untapped opportunities for innovation and inward investment and this could benefit the health and academic sector as well as the economic viability of local communities. Our collaborative work with other Health Boards across South Wales flourished in 2013/14 and increasingly will become more important to us in future as the outcome of the South Wales Programme is agreed and work commences to support its delivery.

1.8 Governance

In order to ensure effective governance and assurance, we will review and amend our governance arrangements. Our commitment to becoming an organisation with a strong planning and commissioning culture will be reinforced through our governance structure. The IMTP will be monitored, performance managed and reported to the Health Board in a rigorous and mature way, measuring performance against key national and local targets. The delivery of safe, high quality, sustainable services which are prudent and affordable and which meet the needs of our population are the intended products of this plan and our governance and assurance mechanisms will monitor robustly our success against this.

The development of our first three year Integrated Medium Term Plan, marks the beginning of a fundamental change in the way in which the Health Board will function. We have in place a clear clinical strategy, an emerging longer term strategy for our Health Board and plans to deliver these. In the detail which follows we describe how the IMTP has been developed, will be delivered and the outcomes we expect from it. This Plan will form the framework for ensuring that we have alignment of all our duties and responsibilities to commission, plan and deliver safe, effective, high quality, sustainable healthcare for the population we serve.

2 Health Board Profile

This section of the Integrated Medium Term Plan provides a summary picture of the Health Board's health economy, its service composition and describes the Health Board's current service and performance profile. It is important to understand this contextual snapshot as it establishes the baseline position from which the Health Board is crafting its plans for sustainability and improvement.

2.1 Introduction

Abertawe Bro Morgannwg University Health Board was formed in October 2009, as a result of a merger of the former Local Health Boards (LHBs) for Swansea, Neath Port Talbot and Bridgend and the Abertawe Bro Morgannwg University NHS Trust. Our Health Board covers a population of approximately 500,000 people and has a budget of £1.3 billion. At the end of March 2013, the Health Board employed 15,758 members of staff, 70% of whom are involved in direct patient care.

We are responsible for improving the health of our communities as well as the planning, commissioning and provision of both primary (General Practitioner, Optometry, Pharmacy and Dental services), and secondary (Hospital) care services. We are also responsible for a range of community based services delivered within patients' own homes, via community hospitals, health centres, and clinics. In addition we provide a range of tertiary services such as Burns and Plastic Surgery Services (for South Wales and the South West of England), Forensic Mental Health Services (for the whole of South Wales) and Learning Disability Services (Swansea, Cardiff and the Rhondda Cynon Taf and Merthyr Tydfil areas). Figure 1 below illustrates the geographical basis of the services provided by the Health Board.

Figure 1 : Health Board Service Provision

Whilst we provide a large range of our services for the resident population of zone 1, we also work closely in partnership with Hywel Dda Health Board to provide a number of services on a West Wales basis. Zones 1, 2 and 3 combined, represent the services we provide on a South Wales wide basis, such as Plastic Surgery. Finally the inclusion of Zone 4 represents the geographical footprint of our supra-regional Burns service for South Wales and the South West and South Central England.

2.2 Public Health Overview

We prepared a Strategic Health Needs Assessment (SHNA) in November 2013 setting out the health needs, organised by life course, for the Health Board's resident population and signposting the evidence base for tackling the problems identified. We have used this information to inform the development of the IMTP. Moving forward, we will continue to use this information to inform commissioning and the redesign of services and pathways of care to improve the population's health. The key findings from the SHNA are:

- Our local population is ageing, with the number of over 85 year olds set to more than double by 2030; presenting significant challenges for health and social care services and a need for more integrated out of hospital based approaches to care.
- Health inequalities have increased over the last ten years, with the difference in life expectancy at birth between the least and most deprived areas being 10.4 years for men, and 7.3 for women. Designing services which can engage these communities early in preventative services is fundamental to slowing the growth in the inequalities gap.
- Cancer, heart disease and respiratory disease remain the main causes of death in ABM, all of which are to a large degree preventable, particularly through reducing the prevalence of smoking and other lifestyle risk factors.

The SHNA identified many evidence-based interventions to improve and encourage healthy behaviours, through supporting individuals and also through community and environmental interventions, to improve health and decrease inequity of local populations. The required cultural change can be achieved through large scale joint action of the Health Board with our respective local authorities, Public Health Wales, Third Sector and others. Section 3 of this IMTP describes in more detail the consideration of the SHNA and our wider health service challenges.

2.3 Provider Services

2.3.1 Home based services

A range of domiciliary services, including assessment and treatment, are provided by different professionals in people's own homes, for instance: -

- **District Nursing Services** provide holistic assessment, planning and evaluation of care from engagement in the discharge planning to proactive health surveillance and health promotion for patients with long term conditions. District nurses support the management and treatment of many conditions such as diabetes, continence issues, immunisation and wound care. District Nurses also support medicines management through Nurse Prescribing and medication administration. They have a key role in End of Life Care and post bereavement support.
- **Chronic Conditions Management Nurses** are based within primary care, and support people with complex long term conditions who are at risk of episodes of frequent ill health to avoid hospital admission.

Community Resource Teams (CRTs) provide a wide range of care including rapid response, personal care, re-ablement and specialist advice and support.

Staff groups involved in the delivery of a comprehensive range of community services includes:

- Nursing
- Therapists
- Community Psychiatric Service
- Community Drug and alcohol service
- Wound care, continence, tissue viability, medicines management and specialist palliative care teams.
- Health Visitors and Flying Start Health Visitors
- Looked After Children's Health teams
- Child Disabilities Health Visiting Service
- Child Community Nursing Services
- Health Care Support Workers

2.3.2 Primary Care based services

We contract with independent practitioners to deliver primary care services, which are delivered by General Practitioners, Optometrists, Pharmacists and Dentists. The contracts are determined on a national basis. There are 77 General Practices across the Health Board. There are currently just over 300 GPs, nearly 60 Opticians, 125 Community Pharmacists and almost 300 Dentists in the area. Outside normal practice hours, the Health Board manages the provision of the GP Out-of-Hours Service. We also provide General Medical Services within Her Majesty's Prison (HMP) Swansea, and are responsible for commissioning all health care within HMP Swansea.

We directly manage two practices in the Neath Port Talbot area: in the Afan Valley and Neath town centre and one in Bridgend: Nantyffyllon. All other practices are independent. Practice list sizes vary across the area, with the lowest approximately 1,000 patients and the highest 20,000 patients.

2.3.3 Community based services

We provide community nursing, health visiting, community mental health, learning disabilities, therapy staff, as well as midwifery and school nursing services. There are a number of smaller community hospitals primary care resource centres providing important clinical services to our residents outside of the four main acute hospital settings.

2.3.4 Hospital based services

We provide hospital services from four acute hospital sites:

- Princess of Wales Hospital in Bridgend
- Neath Port Talbot Hospital in Port Talbot
- Singleton and Morriston Hospital sites which are both in Swansea.

Table 1 below describes the services provided at each of these main hospital sites. At the end of March 2013, the total number of beds in the Health Board stood at just over 2,350.

Table 1 : Health Board Acute Hospital Service Composition

		City & County of Swansea		County Borough of Bridgend	County Borough of Neath Port Talbot
		Morriston	Singleton	Princess of Wales	Neath Port Talbot
Emergency	Major Accident & Emergency Department	YES	NO	YES	NO
	Local Accident Centre/Minor Injury Unit	NO	YES	NO	YES
	GP Out of Hours Service	YES	NO	YES	YES
	Emergency Admissions for General Medicine	YES (999)	YES (GP)	YES (999 & GP)	NO (Since Sept '12)
	Emergency Admissions for Surgery	YES	NO	YES	NO
	Emergency Admissions for Orthopaedics	YES	NO	YES	NO
	Emergency Admissions for Gynaecology	NO	YES	YES	NO
	Emergency Admissions for Children	YES	NO	YES	NO
	Emergency Operating Theatres 24/7	YES	YES	YES	NO
	Acute Stroke Unit	YES	NO	YES	NO
	Critical Care (ITU)	YES	NO	YES	NO
Mother and Baby	Consultant Led Antenatal Care	NO	YES	YES	YES
	Consultant Led Births (Obstetrics)	NO	YES	YES	NO
	Midwife Led Births & Newborn Care	NO	YES	YES	YES
	Neonatal Care	NO	YES (Level III)	YES (Level II)	NO
Planned Surgery	Planned Gynaecology Operations	YES (Complex Cancer)	YES	YES	NO
	Planned Orthopaedic Operations	YES	YES	YES	YES
	Planned Operations for Children	YES	NO	YES	NO
	Planned General Surgical Operations	YES	YES	YES	YES
Other	Highly Specialised Services	YES (Full)	YES (Some) Radiotherapy and Complex Chemotherapy	YES (Some) Palliative Care beds, Rheumatology	YES (Some) IVF, Neuro-rehabilitation
	Outpatient Clinics	YES	YES	YES	YES
	Radiology (X-Ray, Scans) Blood Tests	YES	YES	YES	YES

2.3.5 Mental Health, Substance Misuse and Learning Disability Services

We provide Mental Health Services, Substance Misuse and Learning Disabilities Services. Learning Disability services are provided across three Health Boards and seven Local Authorities. Mental Health Services have changed significantly over the last 10 years or so and the Health Board now provides Mental Health services across a strong community service base complemented by modernised, fit for purpose hospital based care. We also provide Mental Health and Forensic Mental Health Services to a wider population base. Substance Misuse Services are planned and commissioned for the ABMU area by the Western Bay Substance Misuse Area Planning Board which took over responsibility for these services with the move by Welsh Government to regional commissioning from 2013-14. The Health Board has worked with partners in the 3 Local Authorities, South Wales Police, the Police & Crime Commissioners Office, Criminal Justice Agencies, and Prisons, third sector organisations, service users and carers.

The majority of Child and Adolescent Mental Health Services are provided by Cwm Taf Health Board. The planning of these services is taken forward by the ABMU Children's and Young People Mental Health Planning Group. Cwm Taf Health Board, the Local Authorities and the third sector are members of this Planning Group which has an agreed action plan to address key issues.

2.4 Commissioned and Partnership Services

Some of our residents access services from outside of the Health Board, particularly those living on the boundaries of our catchment area. Further, we do not provide every aspect of clinical care within our Health Board; as a result we commission services for our local population from other healthcare providers, principally the other Welsh Health Boards and NHS Wales Trusts. The Health Board commissions a number of secondary care organisations to provide services for our residents. Tables 2 and 3 below set out the value of the contracts we currently hold with each Health Board and Trust and also show the total quantum payable to the Welsh Health Specialised Services Committee (WHSCC) as our contribution to nationally commissioned specialist services. Our input to WHSSC is important to us as we act as commissioners within the WHSSC arrangements (spending £98m) and providing £85m of services commissioned by WHSSC.

Table 2 shows that we spend £118m on commissioning services through Long Term Agreements (LTAs) with our partner Health Boards and Trusts. We are currently working to repatriate the care of our residents from services in other Health Boards, where clinically appropriate. This will enable us to re-invest in sustainable local services.

Table 2 : Commissioner LTA Quantum Summary

Organisation	Value (£)
Aneurin Bevan Health Board	256,328
Cardiff & Vale University Health Board	7,016,702
Cwm Taf Health Board	4,466,871
Hywel Dda Health Board	4,014,937
Powys Health Board	1,179,874
Velindre NHS Trust	3,088,508
LTA Sub Total	**20,023,220**
WHSSC	98,354,172
Total	118,377,392

In section 8 of this document we demonstrate how our commissioning role within WHSSC affects our overall financial plan. We are working with WHSSC to ensure that our plans reflect a single position and the current process of sharing iterations of our plans will ensure that this remains consistent. We recognise the process that WHSSC has implemented to manage financial risks and provider pressures and we will commit fully to our partnership role within the WHSSC process.

Table 3 below provides a summary of the activity commissioned from other Health Boards.

Table 3 : Summary of LTA Commissioned Activity

Organisation	ABMU Commissioner			
	Inpatients	Day case	Outpatient	Other
Aneurin Bevan	68	74	45	-
Cardiff & Vale	1,323	880	10,983	38
Cwm Taf	634	131	859	
Hywel Dda	831	723	2,633	7,111
Powys	65	1,048	1,006	2,671
Velindre NHS Trust	236	1,963	11,135	-

We have established a joint Executive-level team with Hywel Dda to evaluate the impact on both Health Boards of service changes already under consideration within a South West Wales Acute Care Alliance.

There are already many areas where we work closely to provide care for our combined communities. In 2014/15 clinicians from our two Health Boards will

consider how to plan together better for a number of other services across the South West and West Wales region. These will include radiology, pathology, oncology, dermatology, cardiology, neonatology and neurology. The impacts on changes to these services will need to be carefully considered and the impacts on potential centralisation of more services on patients, particularly those with a disability or another equality dimension, and carers, taken into account prior to decisions being made.

Whilst we have a range of partnership arrangements for local service provision with the Health Board (which are described later in this IMTP) our wider partnership work sees us as a partner in the development and delivery of the work of the South Wales Programme (SWP) and in future with the South Wales collaborative. We (and therefore our Plan) will need to respond appropriately to the outcome of the planning work of these groups and in particular Princess of Wales Hospital which will be most affected by the final decision which emerges from the SWP.

The Welsh Ambulance Services Trust (WAST) is an important partner service provider with us. We currently have a shared initiative with WAST covering 21 individual schemes which has been developed in partnership to improve service delivery. We understand the critical nature of the interrelationships between our services and the benefits that improved service delivery will have for the patients we serve. It is our clear intention to continue to work as closely as possible with WAST colleagues to develop our shared initiatives further and to embed these service changes.

We are also currently developing plans with other Health Boards to place Morriston (and UHW) at the centre of a network of hospitals in South Wales, caring for patients who have severe injuries and to develop the business case for an enhanced pre-hospital Emergency Medical Retrieval and Transport Service (EMERTS).

2.5 Service Developments

The implementation of the Annual Plan for 2013/14 has resulted in significant service changes. These include:

- The transfer of Acute Medicine from Neath Port Talbot Hospital, and the redesign of care models allowing the Health Board to close Fairwood, Clydach War Memorial, Maesgwyn and Hill House Hospitals.
- The modernisation of Mental Health Services and the move to community based care away from institutionalised care has enabled the Health Board to close two Mental Health wards and reconfigure inpatient capacity.
- The creation of a centre of excellence for short stay and day case surgical activity in Neath Port Talbot enabling a revised service model allowing the transfer of beds from Cimla Hospital.
- The re-organisation of Vascular services across Mid and South West Wales in line with the AAA screening programme.
- Commenced provision of the South Wales IVF service in Neath Port Talbot Hospital
- The Commissioning and opening of a dental facility in Port Talbot Resource Centre allowing the centralisation of some primary and community dental services as well as reducing the demand on secondary care services.
- Commissioned Wireless Technology in Morriston Hospital and public WIFI in three of our four main hospitals.

2.6 Activity

Table 4 provides a high level summary of the activity provided by the Health Board in hospital and community settings. The list is not exhaustive but provides the context for the nature of the services that we provide and the associated volumes for each. The level of activity also carried out by independent contractors in primary care, and through other commissioned services (including those provided by the independent and third sector) is significant. It is recognised nationally that over 90% of patients' contact with the NHS takes place in primary care settings.

Table 4 : High level Activity Volumes 2012/13 Full Year

Health Board activity 2012/13	Currency	Volume
Outpatients	New	209,373
Outpatients	Follow Up	416,743
Day Cases	Procedures	66,140
Elective Inpatients	Admissions	21,703
Emergency Inpatients	Admissions	66,034
Maternity	Admissions	17,215
Births	Births	6,500
Critical Care	Bed days	25,982
A&E	Attendances	188,734
Home Based Therapy Contacts	Contacts	131,547
Community Based Therapy Contacts	Contacts	240,653
District Nursing Contacts	Contacts	390,626
Health Visiting Contacts	Contacts	220,777
Crisis Resolution & Home Treatment Assessments	Assessments	3,131
Older People Mental Health Contacts	Contacts	55,827
Primary Care Out of Hours (Apr 12- Jan 13)	Contacts	35,292

2.7 Current Status

In each of the sections which follow, tables are provided which set out our performance position against each of the National Tier 1 Standards, as at the end of November 2013 (which is the most recent data available).

The figure in the "Welsh" column provides the Welsh average performance where percentage standards are applied. In some cases where the performance measure is not percentage based, the national total number is provided which allows assessment of our Health Board's relative impact on the full national picture. Also provided for each measure is a "rank" score. This reflects where we are performing on a relative national basis; 1 being the best performer and 7 being worst.

We have provided comparative Welsh data in this section of our document as it is provided nationally and produced on a consistent footing across Wales to aid comparison. We fully recognise the richness from benchmarking and comparison on a UK wide basis and this is considered in more detail later in this document.

2.7.1 Improving Quality,

Our Annual Quality Statement (AQS) acknowledged that we have not always reliably delivered high quality care 24 hours a day, seven days a week and set out our quality and safety challenges. The AQS acknowledged that the Board had identified a number of instances of unacceptable care at the Princess of Wales Hospital and had begun a quality improvement programme. The Board asked the Advancing Quality Alliance (AQuA) to thoroughly investigate these issues. In addition, Welsh Government commissioned Professor June Andrews to review the care provided to older people at both the Princess of Wales Hospital and Neath Port Talbot Hospital. It is clear from the reviews that there have been a number of instances of completely unacceptable care and that our improvement actions require greater urgency and focus to improve systems and individual professional practice. The actions required for improvement are set out in section 5.

The AQS also referenced the reduction in Healthcare Acquired Infection that compares well with other Health Boards in Wales but demonstrates a worse position than the NHS in England. Efforts to reduce avoidable harm and mortality had a strong focus and these issues are also covered in section 6. In addition to clinical outcomes, the AQS pointed towards the need to improve communication between clinical teams, to improve communication between managers and staff and to foster a patient safety culture within the organisations, topics that are picked up in Section 7. The requirement to improve response to and learning from patient complaints, incidences of harm, claims, Ombudsman and Coroners reports was clearly stated within the AQS. Other major themes from the AQS included an analysis of our performance against Tier 1 targets and in particular the impact of poor flow in unscheduled care on quality and safety, aspects that are addressed in section 3 of this document.

Table 5 below is a summary of the current levels of performance of our key quality, safety and patient experience indicators at the end of December 2013 as set out in the Welsh Government Quality and Delivery Framework – Tier 1.

Table 6 sets out how we are performing against our 6 key Clinical Commitments which have been agreed as key complementary measures to the national Tier 1 Quality and Safety measures.

Through our monthly performance management, the Tier 1 targets and also the six key Clinical Commitments are rigorously reviewed at a directorate and locality level.

Table 5 : Jan 2014 Tier 1 performance for Quality, Safety and Patient Experience Indicators

	Standard	Measure	Target	Month 10	Welsh	Rank
Quality and safety	% of patients referred as NUSC seen with 31 days	% target	98%	97.30%	98.10%	6
	% of patients referred as USC seen with 62 days	% target	95%	86.20%	90.60%	5
	Stroke 1st hours bundle	% target	95%	80.00%	95.60%	6
	Stroke 1st Day hours bundle	% target	95%	57.60%	56.70%	4
	Stroke 1st 3 days bundle	% target	95%	91.50%	85.00%	2
	Stroke 1 7 days bundle	% target	95%	91.50%	85.00%	3
	Number of cases of C Difficile (IP 66+)	absolute	reduce	6	48	4
	Number of cases of MRSA	absolute	reduce	2	10	3
	Number of cases of MSSA	absolute	reduce	10	55	2
	Number of healthcare acquired pressure ulcers	absolute	reduce	8	171	6
	% of deaths in hospital 30 days (heart attack)	% target	reduce	5.40%	3.90%	1
	% of deaths in hospital 30 days (stroke)	% target	reduce	14.60%	15.40%	6
	% of deaths in hospital 30 days (#NOF)	% target	reduce	4.50%	5.80%	6
	% crude mortality	% target	reduce	2.20%	2.00%	2
	RAMI2012	Index	reduce	100	101	4
	% valid principal diagnostic code (3 months after episode)	% target	95%	90.60%	92.70%	6
	% valid diagnosis code 3 months after episode end (rolling 12 months)	% target	98%	97.70%	95.70%	3

Table 6 : Jan 2014 performance for Health Board six key Clinical Commitments

	Standard	Measure	Target	Month 10
6 key clinical commit ments	Hand Hygiene Audits - compliance with WHO 5 moments	% target	100%	93.50%
	% Patients with Completed NEWS Score and Appropriate Responses Actioned	% target	100%	98.50%
	% Patients where the GP has received a minimum standard discharge summary within 24hrs of Discharge	% target	100%	47.70%
	% Stage 1 mortality review forms completed	% target	100%	87.00%
	Risk assessment for Thromboprophylaxis completed on admission (National Standard)	% target	90%	80.60%
	Decision makers reviewing patients daily	% target	TBC	

2.7.2 Workforce

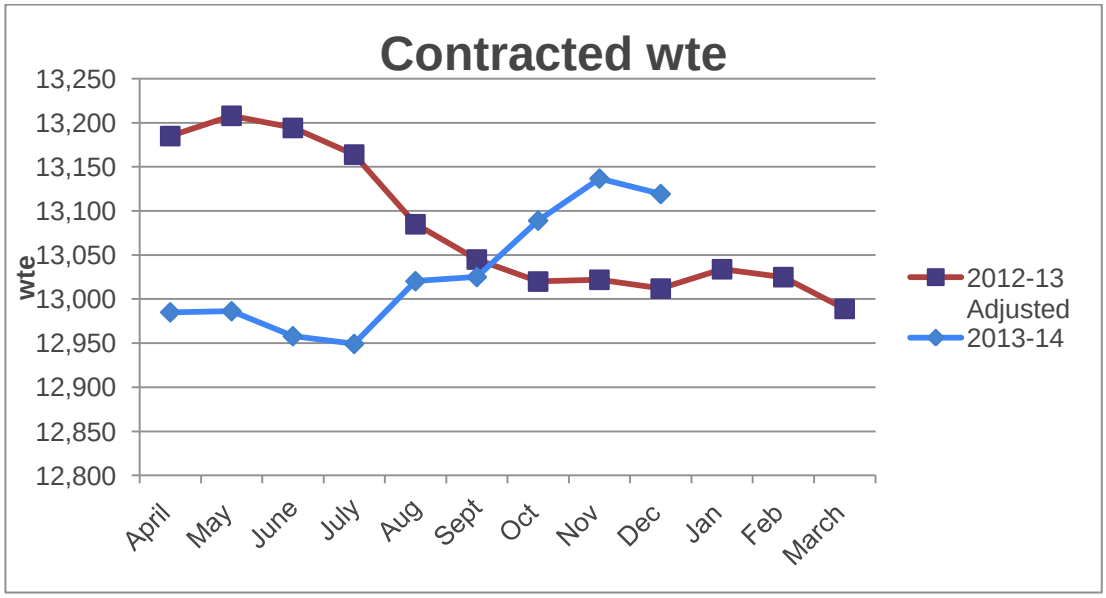
Table 7 below provides an analysis by staff group and by whole time equivalents (WTE) and number of staff in post (head count).

Table 7 : Health Board Workforce

Workforce as at December 2013	WTE	Headcount
Nursing and Midwifery Registered	4,379.41	5,149
Medical and Dental	1,297.62	1,526
Allied Health Professionals (therapists)	777.32	924
Healthcare Scientists	222.87	246
Additional Clinical Services (healthcare support workers etc)	2,453.84	3,151
Add Prof Scientific and Technical	534.15	623
Administrative and Clerical	2,125.5	2,535
Estates and Ancillary	1,297.56	1,625
Board Members	20.00	20.00
Students	11.00	12.00
Total	**13,119.27**	**15,811**

The Health Board has seen a reduction of 530 WTE since April 2012 of which 328 WTE relates to the transfer of a number of previously Hosted Services. The movement in WTE is shown in the Figure below.

Figure 2 : Health Board Workforce – Contract WTE April 2012 - December 2013



The graph shows that the contracted WTE has risen in recent months and the workforce plan shows a further increase. We estimate that we will have approximately 13,175 WTE by the end of 2013/14. This increase reflects the planned investments in nurse staffing to improve patients experience and quality of care, based on the implementation of the All Wales Staffing guiding principles for nurse staffing levels on acute wards. This in itself has caused difficulties at times recruiting nurses with the right skills.

Nationally in Wales the lack of junior doctors, due to recruitment difficulties and the impact this has on providing a safe, quality service continues to be an issue for us as with other Health Boards. We have continued to work closely with the Deanery to improve the situation and some of the solutions have been to redesign services, such as the move of acute medicine at Neath Port Talbot Hospital.

A number of recruitment difficulties at a consultant and primary care level have also been challenging, mirrored again by other Health Boards in Wales. We currently have deficits in GP workforce, General Medicine, Adult Psychiatry, Histopathology, Stroke, Ortho-geriatrics, Emergency Medicine and Radiology. At present the Health Board is involved in optimising links with Swansea University to establish clinical academic posts and short term international recruitment for medical staff, but the latter is not seen as a longer term sustainable solution.

Our Therapy Services are also experiencing difficulties in recruiting to a number of specialist posts and as a result we continue to invest in education, training and development.

In driving the transformational change required in this plan we have already made changes in the way in which we work with new roles, traditional roles being enhanced and with trials of 7 day working. This affects all staff groups and is driven by the need to meet service demand and provide safe, quality care.

2.7.2.1 Workforce Developments

Supporting and developing our workforce through the reshaping of our services remains a key priority for us in 2013/14. A strong focus has been maintained on leadership, engagement and communication and our ongoing commitment to these all feature later in this document to ensure that the Health Board has the leadership, capacity and capability to face the challenges anticipated over the next 3 years.

Listening to staff through the 2013 'Tell It How It Is' NHS staff survey has helped us focus our attention. We received a total of 3,718 responses representing a response rate of 25% (the overall response rate for NHS Wales was 27%). In summary, our staff responded saying:

Highest scoring positive statements were:	Statements producing the lowest scores were:
▲ 89% Agree that they are trusted to do their job ▲ 87% Agree they are happy to go the extra mile at work when required ▲ 82% Feel that their role makes a difference to patients/service users ▲ 80% Agree that they get support from their work colleagues ▲ 80% Agree the people they work with treat me with respect ▲ 78% Agree their employer encourages them to report errors or near misses or incident	▼ 21% Agree that senior managers will act on the results of this survey ▼ 22% Agree change is well managed ▼ 25% Agree communication between senior management and staff is effective ▼ 25% Agree senior managers here try to involve staff in important decisions ▼ 26% Agree senior managers act on staff feedback ▼ 26% Agree there are enough staff at this organisation for me to do my job properly ▼ 26% Agree they often have trouble working out whether they are doing well or poorly in their job ▼ 26% Agree that personal needs are taken into account before changes are introduced

In response, the listening has continued at an operational level where we have seen greater leadership visibility, staff focus groups organised and staff bulletins circulated, although we recognise we still have a lot to do. The improvement to nurse staffing levels mentioned earlier, also supports this agenda. Alongside this and at a Health Board level work includes:

- Delivering clinical leadership and management development programmes, including our 'Leadership Connections' programme
- Involving staff in service transformation and change through our Changing for the Better Programme
- Improving communication through our Team Briefing mechanism, the Chief Executive's blog and social networking
- Holding Health Board wide Listening to Staff events, such as the seven events we held following the publication of the Francis report attended by over 400 staff and initiatives such as Schwartz© Rounds was initiatives
- Supporting staff development through in house training programmes and our links with the Universities
- Creating a quality improvement culture through our Innovation, Support and Improvement Science (ISIS), building on the legacy of 1000 Lives and our Health Board link with the Institute for Healthcare Improvement (IHI)
- Using appraisal to engage staff in continuous quality improvement activities

- Enhancing roles, such as for our valuable HCSWs by development through our nationally recognised NVQ Level 3 Health and Social Care programme
- Promoting staff health and wellbeing through health promotion initiatives include our new Cycle to Health scheme, Wellbeing through Work, the Chairman's Challenge and Champions for Health on top of successfully achieving the Gold Corporate Health Standard in February 2013
- Celebrating best practice and achievements through national bodies, such as the annual NHS Wales Awards, prestige Professional awards and our own 'Chairman's Awards' established in October 2013

As well as great leadership and engagement, a positive and constructive relationship with Staff Side colleagues has also been maintained. Local protocols have been developed and implemented to underpin the service change agenda and support the development of a flexible and mobile workforce.

External reviews such as the AQuA and Andrews's reviews have demonstrated urgency for increased engagement with our staff, patients and citizens to learn what is important to them and together create shared values for the communities we serve.

Our agreed values will emerge through mass listening events and will clearly describe the expectations and the standards expected of us. These will become embedded into our systems of recruitment, induction, development and management of our staff.

We have appointed an experienced external team, April Strategy to support this review of our organisational values and develop a behavioural framework. From June 2014, April Strategy will help us to frame the programme and develop the leadership story with the Board. A programme of mass listening events will take place from July 2014 with priority events at Princess of Wales and Neath Port Talbot Hospitals. These will be called 'in your shoes' for citizens and patients and 'in our shoes' for staff. This information will be used from October 2014 to co create our values and the 'ABMU way'. Between November 2014 and January 2015 we will become a values-led organisation through our leadership behaviours, planning and decision making, recruitment and appraisal, measuring and improving outcomes and experience valued by patients and citizens.

Through this work we will identify clear steps to generate a culture of care built on more creative public involvement in the setting and monitoring of standards, and in the resolution of ethical issues and practical choices that arise from the need to make decisions within limited resources. This work will help ABMU to genuinely "put local citizens at the heart of everything we do",

From a performance perspective, Table 8 below sets our out our delivery on key standards as described by Welsh Government. This information has been used to inform our plans to improve performance over the next three years, which is described in Section Seven.

In addition, there will also be a strong focus on improving nursing and midwifery leadership and scrutiny of quality of care and professional standards, through the Quality and Safety Accountability Framework.

Table 8 : Jan 2014 performance – Workforce

	Standard	Measure	Target	Month 10	Welsh	Rank
Allocation and use of resources	% staff undertaking performance appraisals	% target	improve	59.0%	53.0%	4
	% of consultants undertaking performance appraisals	% target	improve	45.0%	38.0%	4
	% of SAS undertaking performance appraisals	% target	improve	32.0%	22.0%	3
	% of GPs undertaking performance appraisals	% target	improve	90.0%	88.0%	5
	% of staff completing staff survey	% target	improve	25.0%	27.0%	6
	% overall engagement index score	% target	improve	57.0%	55.0%	4
	% workforce sickness (rolling 12 months)	% target	5.1%	6.1%	5.4%	7

2.7.2.2 Performance Appraisals

The appraisal scores are marked as amber as they are based on the need to improve on previous performance. There are no targets as yet.

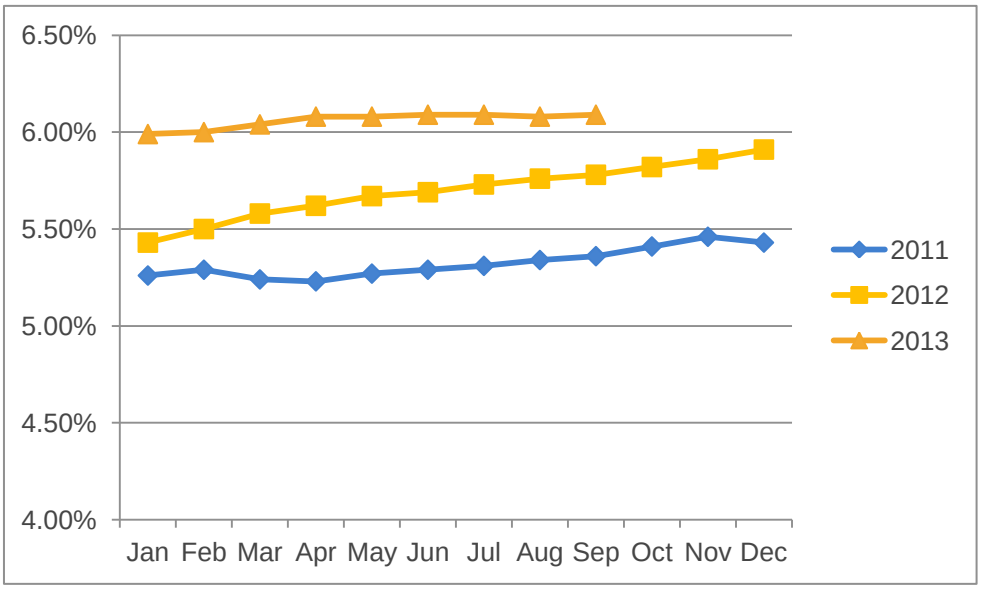
2.7.2.3 Engagement Index Score

This is related to the 2013 'Tell It How It Is' NHS staff survey and a measure to be captured in the roll out of our ABMU 'pulse' staff surveys, although our plans outlined in Section 7 will improve the current score

2.7.2.4 Workforce Sickness

We recorded over 19,000 sickness occurrences in the last 12 months, resulting in 340,000 lost days, over 900 WTE. Whilst long term sickness clearly has an impact, over 60% of sickness absence occurrences are less than 7 days. Figure 3 below shows the sickness absence performance of the Health Board on a rolling 12 month basis.

Figure 3 : Health Board Sickness absence performance – rolling 12 months



We recognise that our sickness absence performance is an outlier nationally and we are currently midway through a series of Executive led sickness absence reviews, designed to better understand and address this issue. Our work to tackle sickness levels and our financial assumptions around the impact of this work are set out in section 7.

2.7.3 Finance

The Welsh Government issued the 2013/14 Revenue Allocations in February 2012, which set out the funding for the Health Board for 2013/14.

The key elements to note within the Revenue Allocation are:-

- HCHS and prescribing allocations have a zero % uplift;
- The starting allocation for 2013/14 did not include the £10m sum provided in 2012/13;
- Funding for GMS and Dental and Community Pharmacy Contract Allocations have been issued at 2012/13 levels, whilst contract negotiations continue. Agreement on the GMS contract changes for 2014/15 has now been reached centrally although further detail of the allocation for GMS, GDS and Pharmacy Contracts is still awaited

2.7.3.1 Month 9 Position after Welsh Government Funding

The Health Board's Financial Plan identified a £32.5m financial gap in delivering a balanced financial position, prior to the commencement of the financial year. Table 9 below sets out the overall financial framework for the Health Board for 2013/14 as at month 9.

Table 9 : Health Board Financial Framework 2013/14 – Month 9 Refresh

NEW AND UNFUNDED COSTS	£m	FUNDING/SAVINGS IDENTIFIED	£m
		COST CONTAINMENT SCHEMES	(6.0)
2012/13 Service Costs		Savings Schemes 2013/14	
Previous savings shortfall	13.0	Workforce Modernisation	(8.90)
Critical Care	2.00	Medicines Management	(4.60)
Unscheduled Care	2.00	Procurement	(4.10)
Sustaining Services	3.00	CHC Measures	(2.50)
		Corporate and Energy Schemes	(1.90)
2013/14 New Costs		Additional Actions	
Pay and Non Pay Costs	17.0	Non Recurrent Variable Costs Reduction	(4.00)
CHC, NICE, WHSSC, PC Drugs	9.00	Non Recurrent Capacity Management	(2.00)
Sustaining Services/Capacity/Quality	8.50	Non Recurrent Technical/Balance Sheet Adjustments	(3.50)
Other/Contingency	2.00	Ombudsman Provision Review	(2.50)
2013/14 Additional Cost Pressures		Additional Funding 2013/14	
Prescribing NCSO	3.00	Brokerage Return	(2.30)
MMR Campaign	0.40	Francis Allocation	(1.80)
IVF Set Up Costs	0.30	Unscheduled Care Allocation	(21.8)
Lucentis Income Loss	0.30	- Immunisation Programme	(1.30)
Energy Costs	0.20	- VERS Invest to Save Funding	(0.55)
Operational Pressure	4.40		
- VERS Cost Support to I2S	0.55		
New Immunisation Programme	1.30		
WAST Support	1.30		
TOTAL	68.25	TOTAL	68.25
FORECAST YEAR END POSITION			0

In September 2013, the Health Minister released additional funding for the NHS of £150m of which we were allocated £25.45m. Some elements of the funding allocated were already committed, and were not available to reduce the forecast deficit. Some £20.5m was however uncommitted and enabled the year end forecast to be reduced to a deficit of £12m, by providing a

source of funding for the necessary investments made by the organisation in safety, capacity and unscheduled care.

In response to the identification of the £12m forecast year end shortfall, we identified further short term actions including actions in November, impacting on service delivery which when fully implemented achieve a further £6m reduction in costs and enable the forecast deficit to be reduced to £6m for 2013/14. Further measures have been identified that should enable a balanced year end out-turn to be achieved. The achievement of this position would result in ABMU Health Board having reached all of its financial targets for all of the four years of its existence. This is a credible achievement, particularly given that the last three years have effectively been a 'cash flat' funding period.

2.7.3.2 Financial Context for 2013/14

There are substantial costs from the continuous rising demand for health services in terms of patient volumes and complexity in the NHS in Wales. The key factors that drive these demand cost pressures are increasing numbers of frail elderly, lifestyle factors, new technology and new drug therapies.

The funding made available to Health Boards has been severely constrained in recent years, and the Health Board has operated in a cash flat scenario for the last three years. Table 10 below sets out the changes to the allocation received for non-specific initiatives.

Table 10 : Allocation changes 2010/11 to 2013/14

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m
2010/11 Base Allocation Uplift	5 (R)	5	5	5
2010/11 In-Year Allocation	24 (NR)	0	0	0
2011/12 Base Allocation Uplift	-	0	0	0
2011/12 In-Year Allocation	-	17(NR)	0	0
2012/13 Base Allocation Uplift	-	-	17 (R)	17
2012/13 In-Year Additional Allocation	-	-	10 (NR)	0
2013/14 Base Allocation Uplift	-	-	-	0
2013/14 In-Year Allocation	-	-	-	20
	£29m	**£22m**	**£32m**	**£42m**
Growth/Loss (to 2010/11 Base)		**-£7m**	**+£3m**	**+£13m**

It can be seen that from the 2010/11 baseline year that our Health Board has operated in a broadly cash flat scenario, despite the fact that an Annual Cost Pressure and Service Demand Pressure of around 5% per annum exists within the NHS. This has placed severe pressure on our Health Board and the service has to identify substantial cash savings of approximately £30m per annum, which is extremely challenging. Additional resources above this sum are also required to meet developments and investment needs.

The impact of pay increases and incremental progression also introduces annual cost pressures into the NHS. They along with, inflationary costs of the consumables used in the delivery of services, can add substantial new costs each year.

Whilst our Health Board has always managed to deliver a balanced position, some savings initiatives were of a non-recurring nature, which results in the Health Board carrying forward an underlying deficit from one year to another.

It should be noted that during the periods outlined above, several announcements have been made of providing additional funding to the NHS in Wales, which because of their non-recurring nature, has not materially changed the baseline funding provided since 2010/11.

It is evident that the period of 2014/15 to 2016/17 will represent a very major financial challenge, based on a zero or close to zero % allocation uplift.

2.7.4 Performance

Tables 5 and 6 above in section 2.5.1 set out our quality and safety performance for the end of November 2013 for both national and local measures. There are other key performance measures within the Welsh Government Tier 1 Framework and Table 11 and Table 12 below provide similar analysis for both the “needs and prevention” and “experience and access” domains respectively, within Tier 1.

Table 11 : Jan 2014 Needs and Prevention Performance

	Standard	Measure	Target	Month 10	Welsh	Rank
Needs and Prevention	Vaccination of all children to age 4 with all scheduled vaccines	% target	95%	86.7	87.5	5
	% uptake of 5 in 1 vaccine at age 1	% target	95%	97.70%	96.50%	2
	% uptake of MenC vaccine at age 1	% target	95%	94.40%	93.50%	2
	% uptake of MMR1 vaccine at age 2	% target	95%	96.80%	96.60%	3
	% uptake of PCV vaccine at age 2	% target	95%	96.80%	96.40%	3
	% uptake of HibMenC booster vaccine at age 2	% target	95%	96.30%	95.40%	2
	Uptake of influenza vaccination > 65	% target	75%	65.40%	67.70%	6
	Uptake of influenza vaccination > 65 for at risk groups	% target	75%	45.20%	49.70%	7
	Uptake of influenza vaccination - pregnant women	% target	75%	32.00%	43.60%	7
	Uptake of influenza vaccination - healthcare workers	% target	50%	35.90%	35.50%	4

Whilst we perform well on immunisation and vaccination targets in the first two years of life, we have further work to do to achieve higher levels of vaccination by the fourth birthday and across the 4 main influenza standards.

Table 12 : Jan 2014 Experience and Access Performance

	Standard	Measure	Target	Month 10	Welsh	Rank
Experience and Access	% patients waiting < 26 weeks for treatment	% target	95%	87.30%	86.80%	3
	Number of patients waiting over 36 weeks for treatment	absolute	Nil	2,577	16,109	3
	% patients spending no longer than 4 hours in an emergency department	% target	95%	83.90%	86.10%	6
	Number of patients waiting over 12 hours in an emergency department	absolute	Nil	294	1316	2
	Cat A responses within 8 mins	% target	65%	60.50%	57.60%	3
	LPMHSS assessments within 28 days of receipt of referral	% target	80%	35.10%	61.20%	5
	% interventions started within 56 days of LPMHSS assessment	% target	90%	89.50%	87.50%	5
	LHB residents in receipt of secondary MH services with valid CTP	% target	90%	92.00%	89.80%	5

With regard to Experience and Access it can be seen from Table 12 that our RTT position in terms of the 26 week target and the 36 week standard are not where we would wish them to be. Similarly with unscheduled care standards we have a detailed work programme and have made significant investment to develop patient flow, improve staffing levels and improve quality and safety. However, this investment is not translating into operational delivery of the standard levels and later in this plan we set out our programme to address this. The performance standards in respect of the Mental Health measure are also included here and as we develop our services to meet these challenges we anticipate improvement in performance levels.

2.7.5 Partnerships

The Health Board is committed to working with its partners to improve quality and develop joint agendas across Health and Social Care (through the Western Bay programme) and also with third sector organisations. This commitment has seen the Health Board develop a joint commitment with the three local authorities and third sector to plan and deliver improved

community services across the Abertawe Bro Morgannwg/Western Bay footprint. With our partners we have also developed a 'Statement of Intent' to set out how we intend to integrate health and social care services for older people with complex needs. This includes a commitment to aligning/pooling resources to make the delivery of person centred care easier to deliver and operating as 'one system, one budget'. We will also be developing a series of business cases focussed on frail older people and dementia to ensure the correct resources are channelled into community care and closer to people's homes and communities. These business cases are currently under development and will be further advanced in the next iteration of this plan.

2.7.6 Community Networks

We have been working with local GPs and our staff to develop ten community networks to support the strengthening of integrated primary and community services.

There are Welsh Government partnership performance metrics set primarily around working in partnership with local government colleagues to reduce delays in transfers of care between health and social care settings. We have detailed plans around intermediate care delivery, which are discussed more fully in Section 6. Table 13 below sets out these performance areas.

Table 13 : Jan 2014 Integration and Partnership Performance

	Standard	Measure	Target	Month 9	Welsh	Rank
Integration and Partnership	Number of emergency admissions for basket of 8 chronic conditions (rolling 12 months)	absolute	reduce	6,469	36,862	3
	Number of emergency readmissions for basket of 8 chronic conditions (rolling 12 months)	absolute	reduce	887	5,290	3
	Number of DTOCs non mental health (75+) (rolling 12 months)	absolute	reduce	61.9	151.5	7
	Number of DTOCs mental health (75+) (rolling 12 months)	absolute	reduce	4.4	4	3
	% GP practices offering appointments between 17:00 and 18:30 at least 2 days a week	% target	improve	86.00%	95.00%	7

2.7.7 Estates

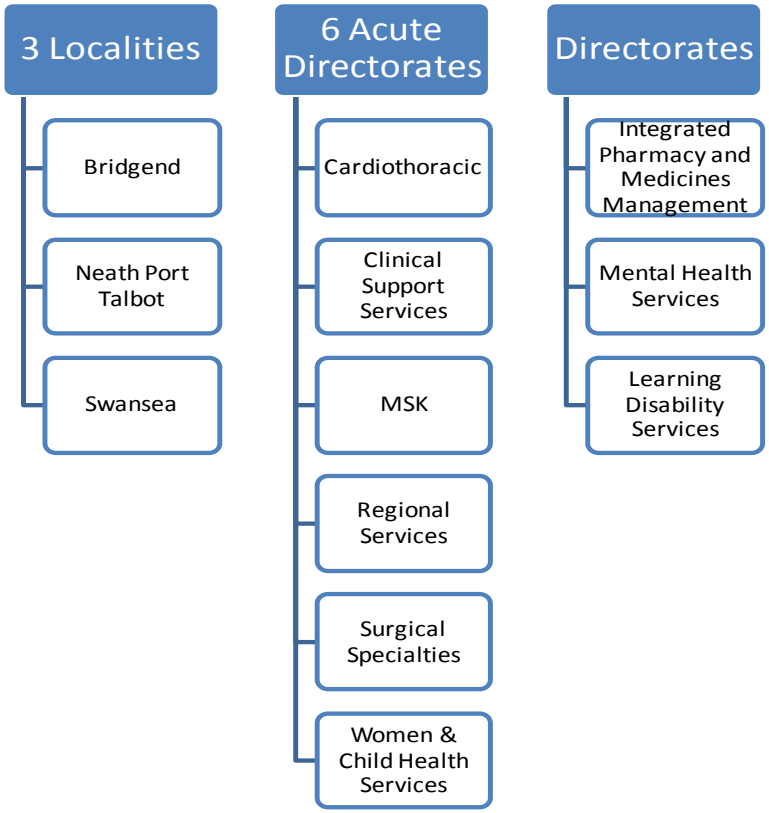
Our estate covers an area of over 152 hectares and covers a total floor area of over 330,000m^2. We have four general hospital sites, one multiservice hospital, five short-term non-acute hospitals, five long stay hospitals, six specialist hospitals and two community hospitals as well as over 50 inpatient facilities and over 35 support facilities. We have reduced the percentage of properties that were built pre-1948 from 24% to 14% and we will, in 2014/15, open Phase 1b of the significant re-development of the Morriston Hospital site. We do however have significant backlog maintenance issues that would benefit from a planned, structured investment programme.

We also have ambitious plans to reconfigure our main hospital sites which will be predicated on the availability of capital to facilitate some of these changes.

2.7.8 Management Arrangements

The Health Board operates a devolved management structure to plan and deliver its clinical services under the direction of the Chief Operating Officer. The devolved management structure is supported by a range of corporate functions, each under a Director. At present the Health Board has 12 management units focussed on service delivery, these are set out in the Organisation Chart below. .

Figure 4 : Health Board Management Arrangements - Organisation Chart



In addition to this, we have established site management arrangements on the two main acute hospital sites; Morriston and Princess of Wales hospitals, each led by and Assistant Chief Operating officer.

Each management unit has devolved financial control, clinical and management leadership and is responsible for the day to day delivery of the Health Board's clinical services.

In February it was decided to strengthen the site management arrangements at the Princess of Wales Hospital. A Director for the Princess of Wales Hospital was appointed to take responsibility for all the services on the site with support from a Chief Nurse and an Assistant Medical Director. The six acute directorates and the acute elements of the Bridgend locality have been amalgamated under his management. The Board will make further management changes over the coming months with a stronger focus on ensuring clarity of management and clinical accountability for our acute hospitals.

2.8 Teaching and Research

We are a University Health Board and have established partnerships including: -

- Swansea University Institute of Life Sciences Phases 1 & 2 (ILS)
- the ILS2 Joint Clinical Research Facility (JCRF)
- ILS2 Centre for NanoHealth
- ILS2 Imaging Centre
- ABMU's partner Clinical Trials Unit
- West Wales Organisation for Rigorous Trials in Health ('WWORTH')
- the National Institute for Social Care & Health Research (NISCHR) South West Wales Clinical Research Centre
- Wales Cancer Research Network
- Diabetes Research Network
- Wales Epilepsy Research Network
- Glamorgan University
- Cardiff University Schools of Medicine & Dentistry
- Public Health Wales.

Through these we are taking forward a number of exciting joint projects. The recent agreement of a Memorandum of Understanding with Swansea University is an important milestone in the development of our partnership. As a result of this we have secured the Wales Graduate Entry Medical degree award. In addition, the development of the Institute of Life Science (ILS) and ILS 2 at the College of Medicine at Swansea University has created a safe and effective environment for an outstanding Clinical Research Facility. We look forward to the completion of ILS 3. ILS provides rich potential for medical and health advance and also for the strong promotion of the local knowledge economy.

Further, impressive progress at the Swansea University College of Human and Health Sciences (responsible for nursing, midwifery, and allied healthcare professional education across the Region) has been made. This collaborative approach has led to the development of an ambitious programme for multi-disciplinary clinical skills teaching at the postgraduate level to support the development of new and innovative ways of working. We have other important relationships with Trinity St David's University, Cardiff University and University of South Wales for research, collaboration and education.

3 Local Health Needs and Challenges

This section provides an assessment of our Health Board's strategic and operating environment, especially local need, the demand for services, workforce pressures and opportunities. When combined with the challenges set out in section 2 above, this provides an assessment of the overall context within which we have shaped our strategy and plans to deliver it.

3.1 Strategic Health Needs Assessment

Led by our Director of Public Health, our Health Board has established a Commissioning Development Programme during 2013/14. This programme is focused on strengthening the Health Board's work in planning and delivering services to meet the needs of the Swansea, Neath Port Talbot and Bridgend populations. This will be achieved by developing our approach to improve population health through needs assessment, prioritisation of resources on the basis of health need and clinical effectiveness and measuring success for communities on the health outcomes they experience.

A key step in developing this approach is the production of a Strategic Health Needs Assessment (SHNA). This was completed in October 2013 and sets out the health priorities for the Health Board area and signposts the evidence base for tackling the key problems identified.

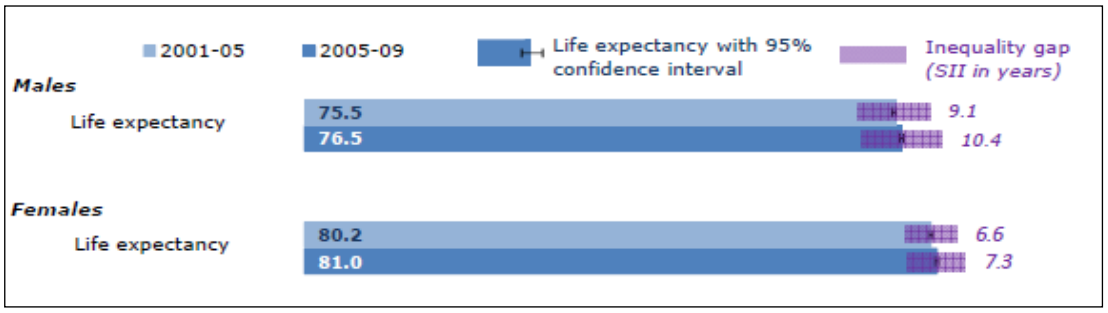
We have used the Strategic Health Needs Assessment (SHNA) to inform the development of our IMTP, specifically to: -

- Identify health needs priorities for the next three years.
- Develop a life course approach to support the future commissioning of services aligned to local health needs and priorities.
- Develop a 10 point plan to establish a future commissioning approach.

3.1.1 Reducing health inequalities

Life expectancy is increasing reflecting reductions in premature deaths, particularly from cancer and heart disease. However, inequalities have also increased over the last ten years. The difference in life expectancy at birth between the most deprived and least deprived areas in 2005-2009 was 10.4 years for men and 7.3 for women as Figure 5 below illustrates.

Figure 5 : Life-expectancy and life-expectancy gap in ABMU University Health Board



The NHS has a role in reducing health inequalities through ensuring appropriate access to services and working with local partners to tackle the wider determinants of health.

3.1.2 Cardiovascular disease, cancers, chronic obstructive pulmonary disease

Over 5,000 of our Health Board residents die each year. Heart disease, cancer and respiratory disease remain the main causes of death. All of these are to a large degree preventable, particularly by reducing tobacco use. Cancer, heart disease and respiratory disease are all associated with a poorer quality of life and consume large amounts of NHS resources.

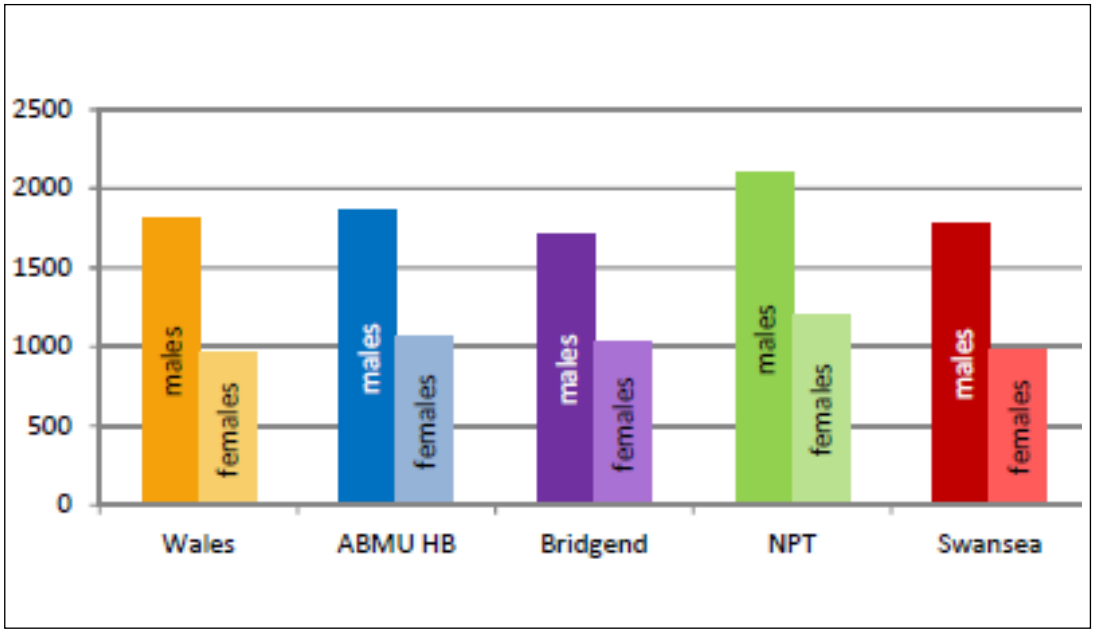
3.1.3 Smoking

Smoking is a risk factor for all three major causes of death and a major contributor to inequalities in health outcomes. Tobacco use is entirely preventable and adult smoking rates have reduced in the past but have levelled out over the last few years.

The prevalence of smoking in children and young people has reduced in Wales over the last two decades. Around 6% of boys and 7% of girls aged 11-16 years smoke in the ABMU University Health Board area.

It is estimated in 2011/12 that 23.6% of the adult population smoke in the ABMU University Health Board area. Smoking attributable hospitable admissions are above the average for Wales and there is variation across the Health Board as shown by Figure 6 below. It is well documented that reductions in smoking rates are followed by reductions in disease and mortality. A smoking cessation business case has been developed and further detail on this features later in this document.

Figure 6 : Smoking attributable hospital admissions, rates per 100,000 population aged 35+, 2008-2010



3.1.4 Obesity

This is a risk factor for all three major causes of death and a risk factor for a number of common conditions including diabetes and muscular skeletal disorders.

Levels of overweight and obese children aged 4 to 5 years are higher in ABMU University Health Board than Wales and much higher than England with 12.6% of girls and 13.8% of boys being obese. Breast feeding gives numerous health benefits to babies and is linked to positive health outcomes such as healthy weight.

Consistent with Wales and the UK adult overweight and obesity levels have continued to rise across the ABMU University Health Board area. Over 1 in 2 adults are now overweight or obese. Tackling obesity is a priority for the Health Board.

Given the prevalence of obesity and associated rise in co-morbidities, an obesity services needs assessment is being undertaken. An obesity services business case will be developed in 2014. There is a short term need to expand provision of universal and targeted interventions in order to reduce long-term need for health services to tackle the complications of child and adult obesity. The implementation of a local care pathway for weight management will be given a high priority. The care pathway will address the identification of patients who would benefit from an intervention, initial assessment and referral to specific weight management services.

As the foundation for prevention of obesity in children, the Health Board will continue to take concerted action to improve breastfeeding levels and ensure family nutrition and physical activity initiatives are integrated into current services. There is a need to increase capacity and capability by ensuring all appropriate staff are trained to systematically raise the issue of weight and offer appropriate support in line with the care pathway. Current provision of weight management services does not meet the level of need with unequal provision of level 2 community weight management services and no 'joined up' level 3 multidisciplinary team service in secondary care. The Health Board will aim to develop effective and equitable weight management services to meet the needs of children, young people and adults. Services will be targeted at patient groups such as those with chronic conditions or pregnant women where weight management will have the largest impact.

3.1.5 Alcohol

Harm is known to occur to babies born to mothers who drink excessively through pregnancy. Physical violence and domestic abuse are also known to be linked to alcohol use.

Alcohol related mortality in both males and females remains a concern for ABMU University Health Board. Excessive alcohol consumption is also a risk factor for the three biggest causes of premature death. Health issues, both physical and psychological, from excessive alcohol consumption are preventable.

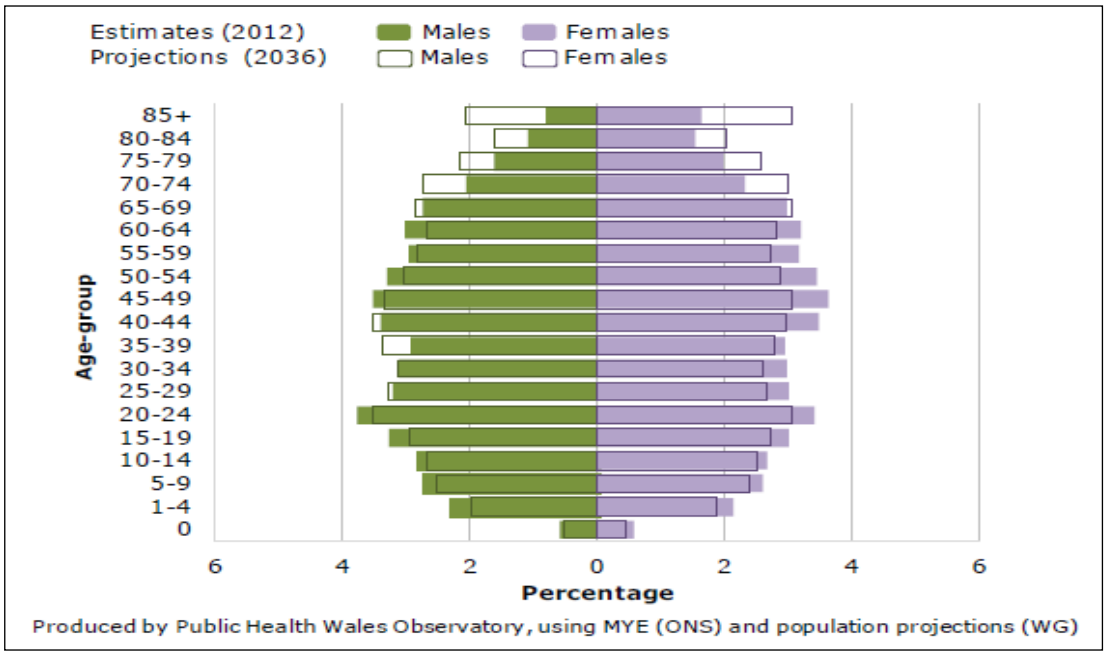
3.1.6 Mental Health

There is some evidence of higher self reported mental illness in ABMU Health Board than the Wales average. Mental ill-health is strongly linked with health inequalities and social disadvantage. The largest single area of spend for the Health Board in 2011/12 was on mental health problems and services are now being re-orientated to provide support in the community.

3.1.7 The ageing population

The resident population is ageing, with the numbers of over 85 yr olds set to more than double by 2030 as illustrated in Figure 7 below. As the number of those aged over 85 years increases, the number of frail elderly is also likely to increase.

Figure 7 : Population projections 2012 compared to 2036

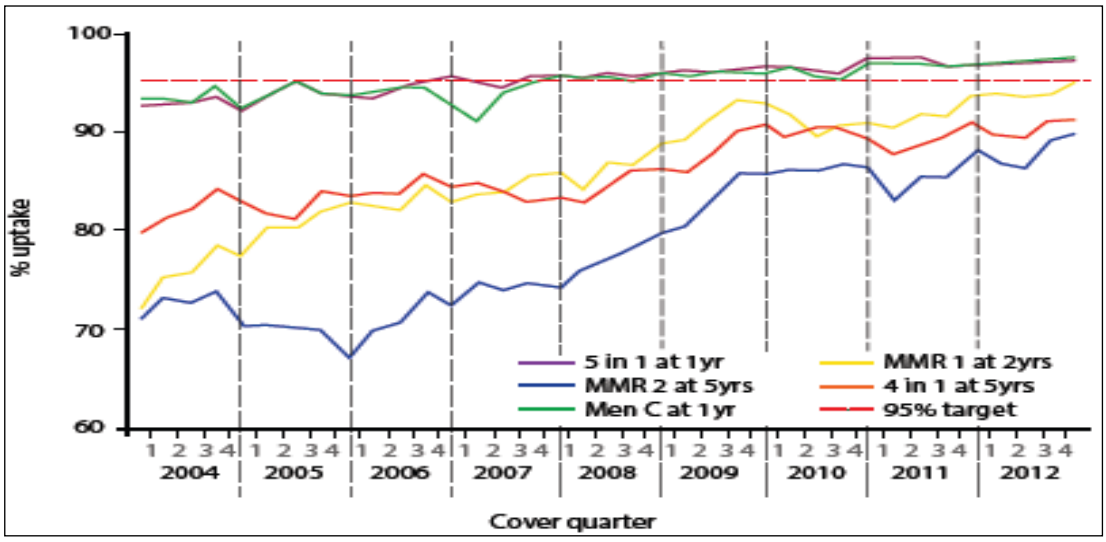


Frail elderly people are major users of NHS and social care services. Therefore the scale of support for integrated services for this group will increase, requiring close working between health and social care. The position is not straightforward and the Health Board is considering not only the population projections but also an anticipated improvement in the levels of health of older people, to try to anticipate the scale of demand over the coming decades. Later in this section we describe our approach to assessing the impact of these projected population changes on demand for services.

3.1.8 Vaccination and immunisation

Vaccination levels have risen consistently over the last five years, with measles, mumps and rubella (MMR) rates boosted by the response to the recent measles outbreak in 2013. However, for a number of vaccinations in children and adults, coverage is not at Welsh Government target levels in our Health Board. The trends for vaccination rates for children are shown in Figure 8 below.

Figure 8 : Trends for routine vaccinations in children aged 1-5 years, 2004-2012



The consequences of low levels of uptake of childhood vaccination are severe and will persist as long as children remain unvaccinated, with risks extending into adult life. Effective vaccination levels have the potential to reduce illness levels particularly in frail older people. Vaccination is also a highly effective intervention to decrease inequalities as vaccine preventable infectious diseases have a higher impact in deprived groups.

The scale of the challenge presented by the SHNA is significant and we have had to prioritise how our efforts will be concentrated for maximum benefit. Our public health priorities are listed below. -

- Smoking cessation
- Obesity
- Immunisation and vaccination
- Frailty

3.2 Commissioning Development Plan

The Commissioning Development Programme has helped us develop a commissioning plan, which aims to improve further health board planning and delivery of services on the basis of population health need, evidence of clinical effectiveness, value for money and demonstrable improvements in population health outcomes. We will need to move the culture of our Health Board to one where planning and commissioning are properly aligned, with the capability and capacity to support us and strong commissioning processes embedded in the way we work. This is a significant challenge for us and we see the development of this IMTP as the beginning of a process of organisational development to change the way we work.

3.3 Future Demand

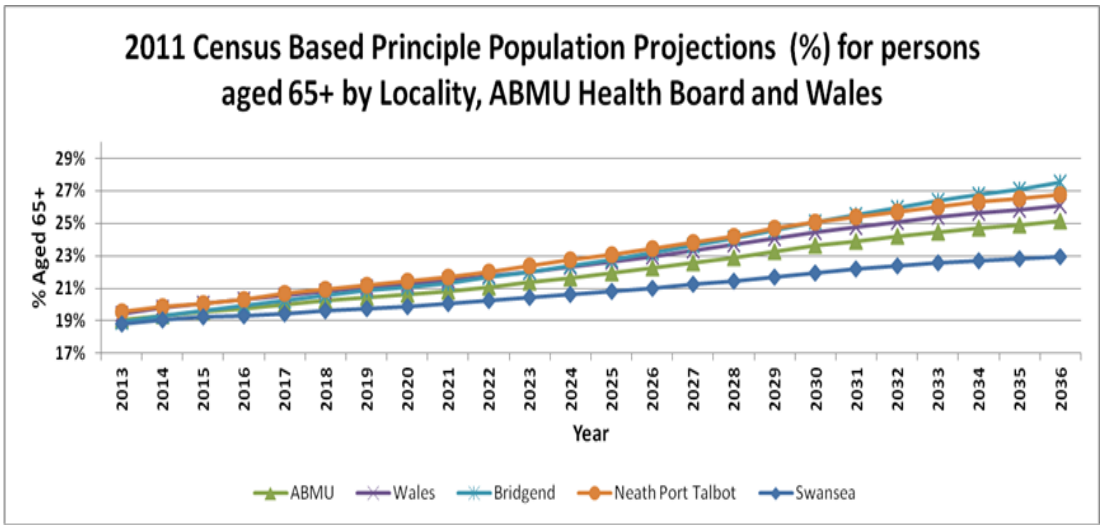
We have undertaken a capacity and demand modelling exercise to assess the impact of population changes on future demand for our services. In summary the key findings are as follows:

Based on population growth projections, we estimate that by the end of 2016 there will be:

- 3.9% more A&E attendances by people aged 85 and over *i.e.* 5,032 additional attendances per year (14 additional attendances per day).
- 3.4% more day cases *i.e.* an additional 2,260 cases per year (6 cases per day).
- 3.2% more inpatient admissions *i.e.* an extra 3,298 admissions (9 per day).
- 102 more inpatient beds needed to meet this demand.
- 4% increase in demand for district nursing and health visiting services
- 2% increase in demand for therapy services
- The changing population profile will also have an impact on the demand for core primary care services including those provided by GPs and practice teams, as well as dental, pharmacy and optometry services however this is difficult to quantify at this stage

We have based population changes on ONS 2011 census data. For illustration purposes, Figure 9 below shows how the over 65 year old population is forecast to increase for each of the Health Board's localities to 2033.

Figure 9 : Residential ABMU population growth for over 65 year olds as proportion of whole population



We have applied the above population changes against 13/14 activity baseline for the following service areas.

- A&E Attendances
- Outpatients
- Day Case Admissions
- Inpatient Admissions
- Bed days

Work is ongoing to assess the impact of demographic changes on Community Resource Teams (CRT), GP contacts, outpatients, clinical support services and Mental Health services. Our future IMTP will reflect our assessment of this demand but at present we are unable to validate our data, particularly on community and primary care impacts. We do however recognise the need to develop community and primary care services and our plans to do this are reflected in Sections 4 and 6.

The demand projections for ABMU for the next 3 years, using the most recently available census data from 2011 have been calculated using the same methodological approach as Care for older people published by the Nuffield Trust in 2012. This model projects that the over 65 year old proportion of our population will grow as follows by the end of 2016:

- 65-74 year – 9.8%,
- 75-84 – 4.4% and
- Over 85 years by 9.3%.

These growth projections have then been applied to baseline activity data in order to assess the demand impact based on the current service delivery model and current performance. This approach enables us to demonstrate that the demographic impact on demand for our current services exceeds the levels of supply and will destabilise our services

A summary of the activity growth projections are provided in the following table.

	Baseline 2012/13	2016 Increase / Decrease from Base	Average daily attendance increase / decrease
A&E attendances	180,055	-7,431	-20
Outpatients	See section 3.2.2		
Day Cases	66,467	+2,260	+9
Inpatients	104,059	+3,298	+9

3.3.1 Emergency Department Attendances

There has been a small overall reduction in the number of Emergency Department (ED) attendances over the past four years. Therefore planning an increase in the number of attendances by the increase in the population would not reflect the historic trend. However, there is growth within the age bands of ED attendances.

The % annual average movement within the age bands for periods 2009/10 to 2012/13 is shown in Table 14 below. This is based on the annual average movement within age bands for periods 2009/10 to 2012/13 multiplied by the average new attendances for the 2012/13.

Table 14 : Average Annual Movement in ED Attendance by Age band.

Age group	Annual Average Movement*
under 5 yrs	-3.6%
5 to 15 yrs	-3.8%
16 to 64 yrs	-1.6%
65 to 74 yrs	2.8%
75 to 84 yrs	1.1%
85 yrs and over	3.9%
Grand Total	**-1.2%**

Based on the attendances during 2012/13 there is a projected overall decrease of ED attendances; however there is an increase in the 65yrs and over. This equates to an increase of 11 daily attendances; of which 4 relate to the 85 years and over. The detail is provided in the following Table 15.

Table 15 : Projected growth based on a 2012/13 New ED Attendances using the annual average movement

ALL ABMU Emergency Department New Attendances	Based on 2012/13 attendances	Projected Emergency Department New attendances based on average % growth during 2009/10 - 2012/13				2016 increase from base	2016 Daily attendance Increase/ Decrease
		2013/14	2014/15	2015/16	2016/17		
under 5 yrs Based on Avg Growth	12,631	12,181	11,747	11,329	10,925	-1,706	-5
5 to 15 yrs Based on Avg Growth	21,242	20,438	19,664	18,920	18,203	-3,039	-8
16 to 64 yrs Based on Avg Growth	107,798	106,095	104,419	102,770	101,147	-6,651	-18
65 to 74 yrs Based on Avg Growth	15,095	15,524	15,965	16,419	16,886	1,791	5
75 to 84 yrs Based on Avg Growth	14,151	14,309	14,469	14,631	14,794	,643	2
85 yrs and over Based on Avg Growth	9,138	9,499	9,874	10,264	10,669	1,531	4
Grand Total Based on Avg Growth	**180,055**	**178,046**	**176,139**	**174,332**	**172,624**	**-7,431**	**-20**

3.3.2 Outpatients

The trends in outpatient attendances have fluctuated over the course of the last 4 years and are either reducing or showing little movement within all the age bands. Therefore increasing the number of attendances, to reflect population growth, would not provide an indication of increased demand for services. Further work needs to be undertaken to assess the impact of the ageing population demographic on outpatient services, which should become clearer through the Outpatient Modernisation Project, which is discussed in Section 6.

3.3.3 Day Case Admissions

The number of Day Cases has been projected using the Health Statistics Wales predicted population figures based on the Office of National Statistics (ONS) 2011 Census. Due to the number of organisational changes that have taken place it was agreed that the baseline for projecting the growth for all admitted data was the period September 2012 to October 2013.

The percentage population growth has been created by using the population base of the average 3 year population for 2011, 2012, 2013 and applying this to the number of Day Cases within the period. This equated to an increase of 3.4%, 2,260 extra day cases or an extra 9 day cases per day (based on 5 days per week) for 2016. Table 16 below sets out the detail

Table 16 : Projected Day case growth using the growth in Population (2011 census). % population increase from the population base, Average 3 yr population 2011, 2012 &2013

All ABMU Day Case	Starting Point: Oct 12 - Sept 13	Projected Change 2014		Projected Cumulative Change 2015		Projected Cumulative Change 2016		2016 Daily attendance Increase/ Decrease
		Increase (%)	Increase (n=)	Increase (%)	Increase (n=)	Increase (%)	Increase (n=)	
Under 5	646	3.6%	23	5.1%	33	6.1%	40	0
5 to 15 yrs	1,549	-1.1%	-18	-1.2%	-19	-0.7%	-12	0
16 to 64 yrs	35,682	-0.1%	-30	0.0%	-8	0.0%	17	0
65-74 yrs	15,374	6.0%	924	8.0%	1,234	9.8%	1506	6
75-84 yrs	10,541	2.5%	267	3.4%	359	4.4%	461	2
85+	2,675	3.9%	104	6.9%	184	9.3%	249	1
Total	**66,467**	**1.90%**	**1,1271**	**2.70%**	**1,783**	**3.40%**	**2,260**	**9**

3.3.4 Inpatient Admissions

The number of Inpatient Admissions has been projected using the same methodology as the Day cases.

The percentage population growth was created by using the population base of the average 3yr population for 2011, 2012, 2013 and applying this to the number of Inpatient admission for all specialty, hospitals, wards and admission methods within the period. This equated to an increase of 3.2%, 3298 extra Inpatients admissions or an extra 9 inpatient admission per day (based on 7 days per week) for 2016. This is detailed in the following Table 17.

Table 17 : Projected Inpatient Admission growth using the growth in Population (2011 census). % population increase from the population base, Average 3 yr population 2011, 2012 &2013

All ABMU Inpatient Admissions	Starting Point: Oct 12 - Sept 13	Projected Change 2014		Projected Cumulative Change 2015		Projected Cumulative Change 2016		2016 Daily attendance Increase/ Decrease
		Increase (%)	Increase (n=)	Increase (%)	Increase (n=)	Increase (%)	Increase (n=)	
Under 5	9,730	3.6%	348	5.1%	498	6.1%	596	2
5 to 15 yrs	5,101	-1.1%	-58	-1.2%	-62	-0.7%	-38	0
16 to 64 yrs	53,297	-0.1%	-45	0.0%	-12	0.0%	25	0
65-74 yrs	13,329	6.0%	801	8.0%	1,070	9.8%	1,305	4
75-84 yrs	14,073	2.5%	356	3.4%	479	4.4%	615	2
85+	8,529	3.9%	332	6.9%	585	9.3%	794	2
Total	**104,059**	**1.7%**	**1,734**	**2.5%**	**2,559**	**3.2%**	**3,298**	**9**

3.3.5 Bed Days

The number of Inpatient Bed days has been projected using the same methodology as the Day cases and Inpatient Admissions. This is detailed in Table 18 below.

The percentage population growth was created by using the population base of the average 3 year population for 2011, 2012, 2013 and applying this to the number of bed days consumed for all specialties, hospitals, wards and admission methods within the period. In addition, all zero lengths of Inpatient stays have been given the bed day weighting of 1 day. This equates to an overall bed requirement increase of 102 beds if there are no changes to the service provision.

Table 18 : Projected Bed day growth using the growth in Population (2011 census). % population increase from the population base, Average 3 yr population 2011, 2012 &2013

All ABMU Bed days	Starting Point: Oct 12 - Sept 13	Projected Change 2014				Projected Cumulative Change 2015				Projected Cumulative Change 2016			
		Increase (%)	Increase (n=)	Beds @100%	Beds @ 85%	Increase (%)	Increase (n=)	Beds @100%	Beds @ 85%	Increase (%)	Increase (n=)	Beds @100%	Beds @ 85%
Under 5	22,164	3.6%	792	2	3	5.1%	1,135	3	4	6.1%	1,359	4	4
5 to 15 yrs	7,637	-1.1%	-87	0	0	-1.2%	-92	0	0	-0.7%	-57	0	0
16 to 64 yrs	284,689	-0.1%	-239	-1	-1	0.0%	-63	0	0	0.0%	133	0	0
65-74 yrs	132,396	6.0%	7,960	22	26	8.0%	10,630	29	34	9.8%	12,965	36	42
75-84 yrs	198,122	2.5%	5,015	14	16	3.4%	6,743	18	22	4.4%	8,655	24	28
85+	154,008	3.9%	5,993	16	19	6.9%	10,567	29	34	9.3%	14,344	39	46
Total	**799,016**	**2.4%**	**19,433**	**53**	**63**	**3.6%**	**28,919**	**79**	**93**	**4.7%**	**37399**	**102**	**121**

The main contributory factors to the increase are:

- patients aged 65 years and over (+54 medical beds)
- Old Age Psychiatry (+16 beds)

A summary of the bed day changes by Specialty are detailed in table 19.

Table 19 : Projected Beds by specialty that are required in 2016 based on population growth

Specialty	Beds
Medical Specialty	54
Old Age Psychiatry	16
T&O	8
General Surgery	8
Paeds	3
Sub Total	**89**
Other Specialty Total	14
Total no. Beds	**102**

3.3.6 District Nursing, Health Visiting and Therapies

It is clear from the demand projections above, that significant additional pressure will be placed on hospital services as the proportion of our population aged over 65 and particularly over 85 years increases. This will have a significant impact in percentage activity across services delivered in our communities as follows:

- District nursing estimated 4%
- Community Resource estimated over 5%
- Therapy Services estimated 2% increase across hospital and community services
- Health Visiting 5% increase in providing support for the under 5 year olds.
- Primary Care Services

Tables 20, 21 and 22 provide the analysis of the changes demographic shifts for District Nursing, Health Visiting and Therapy Services respectively.

Table 20 : District Nursing Projected Demand 2013 to 2016

All ABMU Bed days	Starting Point: Apr 12 - Mar 13	Projected Change 2014		Projected Cumulative Change 2015		Projected Cumulative Change 2016	
		Increase (%)	Increase (n=)	Increase (%)	Increase (n=)	Increase (%)	Increase (n=)
Under 5 yrs	145	3.6%	5	5.1%	7	6.1%	8
5 to 15 yrs	75,014	-1.1%	-856	-1.2%	-906	-0.7%	-562
16 to 64 yrs	78,343	-0.1%	-65	0.0%	-17	0.0%	36
65 to 74 yrs	128,893	6.0%	7,748	8.0%	10,348	9.8%	12,621
75 to 84 yrs	108,170	2.5%	2,737	3.4%	3681	4.4%	4,725
85 yrs and over	61	3.9%	2	6.9%	4	9.3%	5
Total	**390,626**	**2.5%**	**9,572**	**3.4%**	**13,117**	**4.3%**	**16,836**

Table 21 : Health Visiting Projected Demand 2013 to 2016

All ABMU Bed days	Starting Point: Apr 12 - Mar 13	Projected Change 2014		Projected Cumulative Change 2015		Projected Cumulative Change 2016	
		Increase (%)	Increase (n=)	Increase (%)	Increase (n=)	Increase (%)	Increase (n=)
Under 5 yrs	168,597	3.6%	6,028	5.1%	8,634	6.1%	10,335
5 to 15 yrs	2,042	-1.1%	-23	-1.2%	-25	-0.7%	-15
16 to 64 yrs	50,106	-0.1%	-42	0.0%	-11	0.0%	23
65 to 74 yrs	33	6.0%	2	8.0%	3	9.8%	3
75 to 84 yrs	0	2.5%	0	3.4%	0	4.4%	0
85 yrs and over	0	3.9%	0	6.9%	0	9.3%	0
Total	**220,777**	**2.7%**	**5,965**	**3.9%**	**8,601**	**4.7%**	**10,346**

Table 22 : All Therapy services Projected Demand 2013 to 2016

All ABMU Bed days	Starting Point: Apr 12 - Mar 13	Projected Change 2014		Projected Cumulative Change 2015		Projected Cumulative Change 2016	
		Increase (%)	Increase (n=)	Increase (%)	Increase (n=)	Increase (%)	Increase (n=)
Under 5	11,587	3.6%	414	5.1%	593	6.1%	710
5 to 15 yrs	17,858	-1.1%	-204	-1.2%	-216	-0.7%	-134
16 to 64 yrs	107,868	-0.1%	-91	0.0%	-24	0.0%	50
65-74 yrs	36,242	6.0%	2,179	8.0%	2,910	9.8%	3,549
75-84 yrs	39,636	2.5%	1,003	3.4%	1,349	4.4%	1,732
85+	27,462	3.9%	1,069	6.9%	1,884	9.3%	2,558
Grand Total	**240,653**	**0.9%**	**4,370**	**1.3%**	**6,497**	**1.8%**	**8,465**

Other areas which will also see increased demand for services are care home placements, Age Concern/Red Cross activity (& other third sector services), Community transport, Community equipment and Primary care services which are likely to see unprecedented levels of demand increases across general medical services (GMS), general dental services (GDS), community pharmacy and optometry services.

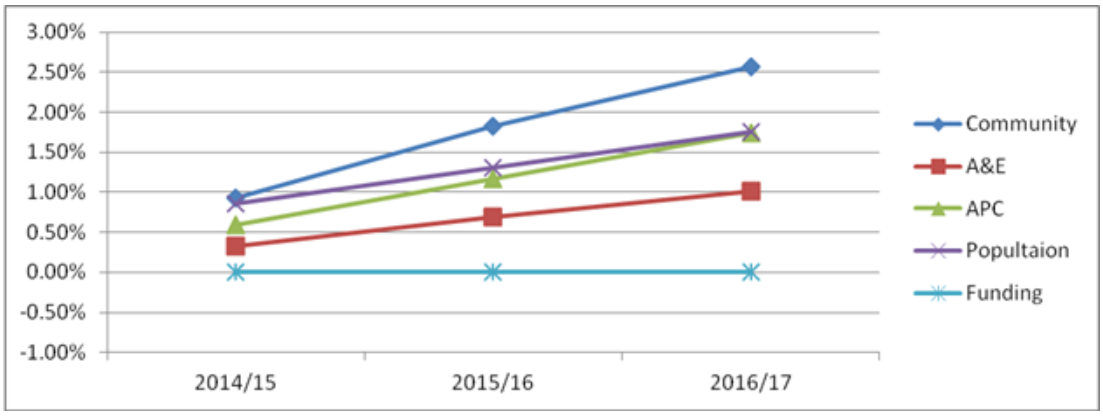
We do not yet have sufficient baseline data to make robust projections for these service areas, but we will be developing, baseline projections for core community services through the Changing for the Better Community Services Project (See Section 6). It is anticipated that a business case will be developed impacting year two of this plan and this will feature in more detail in next year's IMTP.

In summary, the changing demographic profile does have a direct correlation with increased demand. In the case of A&E attendances; whilst overall attendances are projected to decrease by 4%, the more dependent age group is increasing over 10%.

The analysis undertaken shows that response to demand growth is likely to cost around £2m (based on marginal costs) per annum for the duration of this plan which is reflected in the cost base assessment set out in Table 41, section 8.

In summary the overall impact of the demand assessments for A&E attendances, bed days, outpatient attendances, elective operating, District Nursing. Health Visiting and therapy services show demand growth. These projected changes in demand are illustrated in Figure 10 below.

Figure 10 : Showing the projected demand for services, against population growth and funding



In order to respond to this growth, provision has been made for funds to be assigned to schemes that manage demand growth within the financial plan. This assignment of funds is not dedicated to the expansion of hospital based care but to the future models of care which: -

- Tackle the widening health inequalities and health needs across our Health Board population, by helping citizens to make healthier lifestyle choices and remain healthy for longer.
- Commit a greater proportion of our resources to delivering care outside hospitals, near or in peoples own homes.
- Strengthen our primary and community teams and integrate them with social care and the third and voluntary sectors to provide proactive, responsive services for citizens, particularly children and the elderly.
- Empower those people with long term conditions to manage their conditions better through education, information and support and to make it easier for them and their primary care teams to access expert advice and review when required.

Section 8 sets out our 3 year financial framework in more detail.

3.4 Summary of key challenges

In 2013/14 the Health Board acknowledged that it did not consistently deliver high quality services 24 hours a day, seven days a week and began to take action to address this.

Through the year there has been pressure on services and at the same time, significant service change was implemented. The Board did not deliver on a number of its Tier 1 targets.

This section of our plan provides a high level summary of the immediate pressures we are facing as a Health Board; the details behind each of these are explained throughout this document.

QUALITY

- Achieving a culture which delivers high quality care, combined with high professional standards
- Listening to and taking action from patient, citizen and staff feedback
- Consistently deliver high quality care 24 hours a day, seven days a week across the Health Board
- Implement the recommendations of the Advancing Quality Alliance (AQuA) review
- Implement the recommendations of the Andrews Report "Trusted to Care".
- The impact and recommendations of external reviews
- Increased complex care requirements of our patients
- Provision of Continuing Healthcare
- The design and layout of our acute hospital estate places significant limitations on our ability to meet the needs of older people.
- A requirement to reconfigure hospital services in order to improve quality and achieve clinical and financial sustainability.

PUBLIC HEALTH

- Rising numbers of older people and increasing frailty and complexity of needs
- More people with chronic ill health
- Lifestyle choices that are worsening population health; and will increase demand on the NHS in the future
- Widening health inequalities

ACCESS

- Achieving access standards in the following areas:
  - Access to GP/Primary care
  - Mental Health Services
  - Unscheduled Care
  - Referral to Treatment access times (RTT)
  - Diagnostic access times

  - Cancer treatment access times
- Population growth, which will increase demand for services

THE CURRENT CONFIGURATION OF SERVICESWORKFORCE

- Some unacceptable behaviours, particularly towards older people
- Lack of education and training in caring for older people across the workforce
- Limitations in education and training of the workforce to provide high quality care for older people
- Higher than average levels of sickness
- Difficulties in recruiting several groups of clinical staff, particularly some types of doctors and therapy specialists
- Providing safe staffing levels across a variety of professions; linked to, effective rostering to reducing bank and agency usage; and the impact it has on safe, quality care
- Testing new ways in which we work, including further new and enhanced roles and more consistent 7 day working, particularly for unscheduled care
- Effective clinical leadership and management at all levels
- Indentifying further the right training and development needs both in teams of teams and for individuals
- Finding different ways of listening to staff as well as continuing with current initiatives,
- Effective communication
- Involving staff more in decisions and changes that affect them and the place they work,
- Managing health & wellbeing of staff in line with service demands
- Challenging behaviours that are not consist with our values
- Allow staff time to develop, reflect, plan and act on improvement
- Staff believing their ability and authority to improve the processes in which they work
- Manage poor performance through the Quality and Safety Accountability Framework

SOUTH WALES HEALTH COLLABORATIVE

- Four service areas which have clinical sustainability issues (to be addressed through the South Wales Programme). These are:
  - Neonatal Care
  - Inpatient paediatrics
  - Obstetrics and Maternity
  - Emergency Medicine (A&E)

FINANCE

- Constrained spending in the NHS in Wales with falling revenue and capital in real terms.
- Local Authority financial pressures and the impact this may have on demand for health services

3.5 Internal Operating Environment

The internal operating environment of our Health Board acts in a responsive manner to operational and strategic challenges. For instance, in response to the external review of Cardiac Services commissioned by the Health Board, we have now established a Cardiothoracic Directorate, separate from its previous host Regional Services Directorate, to focus on the specific management actions required arising from the review recommendations.

In February the Board also set up the Princess of Wales Hospital as a discrete management division of the Health Board in response to concerns about quality of care and the challenges associated with implementing the decisions from the South Wales Programme. The Board is now examining its management structure for the rest of its services and will make changes over the coming months.

During 2013/14 we have developed proposals to strengthen the role, function and responsibilities of the current Community Networks within our Health Board, and to develop them as an integral part of the organisational arrangements so that they become more autonomous and responsible for the direct management and delivery of some services. A detailed plan is being developed to achieve this by April 2015.

We believe that developing networks in this way will help us to achieve a number of objectives including:

- The commitments set out in Changing for the Better regarding the shift to deliver care closer to home
- Addressing the significant workforce challenges in primary care as a result of earlier retirement patterns, changes to the profile of the GP workforce and a shortfall in the supply of new GPs
- Developing primary care including exploring opportunities for new models of care
- Improving population health - by focussing on delivering models that will encourage people to life healthier lives and providing support to enable them to manage long term conditions.
- By encouraging and facilitating teams working together across traditional boundaries, and across health and social care, we will be able to deliver integrated, person centred care.

- Our plans to develop community networks are in line with the vision set out by Welsh Government in Delivering Local Health Care, and with the Minister's recent drive on delivering prudent health care. Change to the GMS contract which strengthen the incentives for primary care to work as part of community networks, requiring the production of network plans covering a range of specific service issues including access, integration, new ways of working and unscheduled care

It is also anticipated that the General Practitioner Committee in Wales (GPC Wales) shortly will publish a strategic paper which is expected to promote practices working together in networks.

Our proposed future role for these networks is described in Section Four, paragraph 4.7. “Delivering our Plan”.

Our Programme management arrangements (see sections 4 and 6) provide the framework to support the delivery of our Strategic Changes and we will need to refine these arrangements for the future, as we develop our Planning Cycle, to ensure that we are able to meet the challenge of achieving strong alignment between our Health Board strategy, clinical strategy, programme management, planning and commissioning.

In summary, this section describes our future pressures and challenges as determined by Strategic Needs Assessment and demographic modelling along with our future pressures in terms of service and strategic issues, such as tier 1 delivery, South Wales Programme etc. When combined with current pressures (described in Section 2), it enables us to gain an understanding of the overall context for our plan. Section 4, which follows, takes this position and sets it alongside the national and local strategic context and the current drivers for change, thereby providing us with a full picture of what we must address through our strategy and our plan.

4 Strategic Context

This section of our Integrated Medium Term Plan sets out the national strategic context and local strategic framework. Our Health Board has worked hard to engage locally with its stakeholders to develop a purpose, vision, aims and objectives which reflect our broader role in the health economy as well as that of a healthcare provider.

4.1 National Context

Welsh Government sets out the strategic context and formulates health and social care policy to be implemented by NHS Wales and its partners.

NHS Wales has produced a number of policy documents and frameworks, which describe the priorities for the future.

The Bevan Commission Report 2008-2011 ***NHS Wales – Forging a Better Future***, identified the following areas to be strengthened:

- Reduce health inequalities and inequities
- Promote a 'sea change' in public attitudes towards NHS Services, by involving the public in the complicated world of planning and prioritising services
- Drive out waste in the health system, through pursing quality in healthcare services and in integrating public services to maximise efficiencies
- Ensure effective partnerships between public health and local authorities, in health and social care and in other measures
- Create a consensus across government that will seek solutions to health problems across all policy agendas

Setting the Direction published in 2009 set out a new framework for taking forward the development of primary and community services. This policy framework set out the requirement for Health Boards, working with partners in Local Government and the third sector to establish community networks based around populations of between 30,000 to 50,000 people. The plan envisaged that networks would lead on designing and planning local health and social care services, with a particular focus on joining up care services for older people.

The specific objectives of community networks described in Setting the Direction were to: -

- Focus on preventing ill health, enabling people to keep themselves well and independent for as long as possible

- Develop the range and quality of services that are provided in the community
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated to local need
- Improve communication and information sharing between different health, social care and voluntary sector professionals
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

The ***1000 Lives Plus*** programme, in 2010, aligned the quality improvement agenda with several other national programmes in the five- year Strategic Framework for NHS Wales, making patient safety integral to all developments and plans. Eight initiatives we identified:

- Reducing healthcare associated infections
- Reducing inpatient falls
- Reducing pressure ulcers
- Reducing medication errors
- Improving use of the WHO checklist in theatres
- Improving involvement from patients and carers
- Sharing information between different clinical teams
- Improving the way "hospital at night" and critical care outreach provide seamless 24 hour ward cover.

Together for Health published in Nov 2011, sets out a five year vision for the NHS, based around community services and placing prevention, quality and transparency at the heart of healthcare, it identifies the main challenges facing the health service as:

- Rising elderly population
- Enduring inequalities in health
- Increasing numbers of patients with chronic conditions
- Rising obesity
- Expectations are continually rising
- Difficulties in recruiting specialist staff
- Challenging financial climate

Variability in quality across the service and performance that lags behind similar countries, were also identified. Despite these challenges the Minister for Health and Social Services stated that "the Welsh Model is capable of World Class Performance" and identified seven key areas for action:

- Improving health as well as treating sickness
- One system for health

- Hospitals for 21st Century as part of a well designed fully integrated network of care
- Aiming at excellence everywhere
- Absolute transparency of performance
- New partnership with the public
- Making every penny count

Working Differently – Working Together published in May 2012. This framework supports the development of the right staffing model to reflect our unique and fully integrated healthcare organisations as we continue to transform the way that we deliver healthcare in Wales. Underpinning this work are national projects exploring engagement, staff health & wellbeing, optimising the productivity of the workforce and value for money.

'***Delivering Local Health Care'*** published in 2013, reinforced this policy and Health Boards have been tasked with developing plans to strengthen the delivery of services using community networks as a key platform for delivering integrated health and social care, and also strengthening the delivery of primary care services.

The ***NHS Wales Delivery Framework 2013-14 and future plans*** published in May 2013, introduced five quality domains (needs and prevention, experience and access, quality and safety, integration and partnerships and allocation and use of staff) and identified Tier 1 targets against these domains. NHS Wales has also issued a number of Delivery Plans, which cover prevention and early intervention and focus on specific conditions and services.

Delivering Safe Care, Compassionate Care NHS Wales published in August 2013, is the Government's response to the Francis Report. The guidance focuses on creating a culture of openness, no blame and no harm by fostering:

- Engagement and the growth and development of staff;
- Staff ability and authority to improve the processes in which they work;
- Being open, honest and transparent in all that we do
- Strong & effective leadership at all levels

The ***NHS Wales Planning Framework***, published in November 2013, sets out arrangements for strengthening planning in NHS Wales and the requirement for the production of Integrated Medium Term Plans. The Framework expects the following benefits will be addressed within the plans:

- Greater assurance that high quality care will be provided, efficiently and sustainably
- Increased emphasis in improving patient and user experience and health outcomes for populations

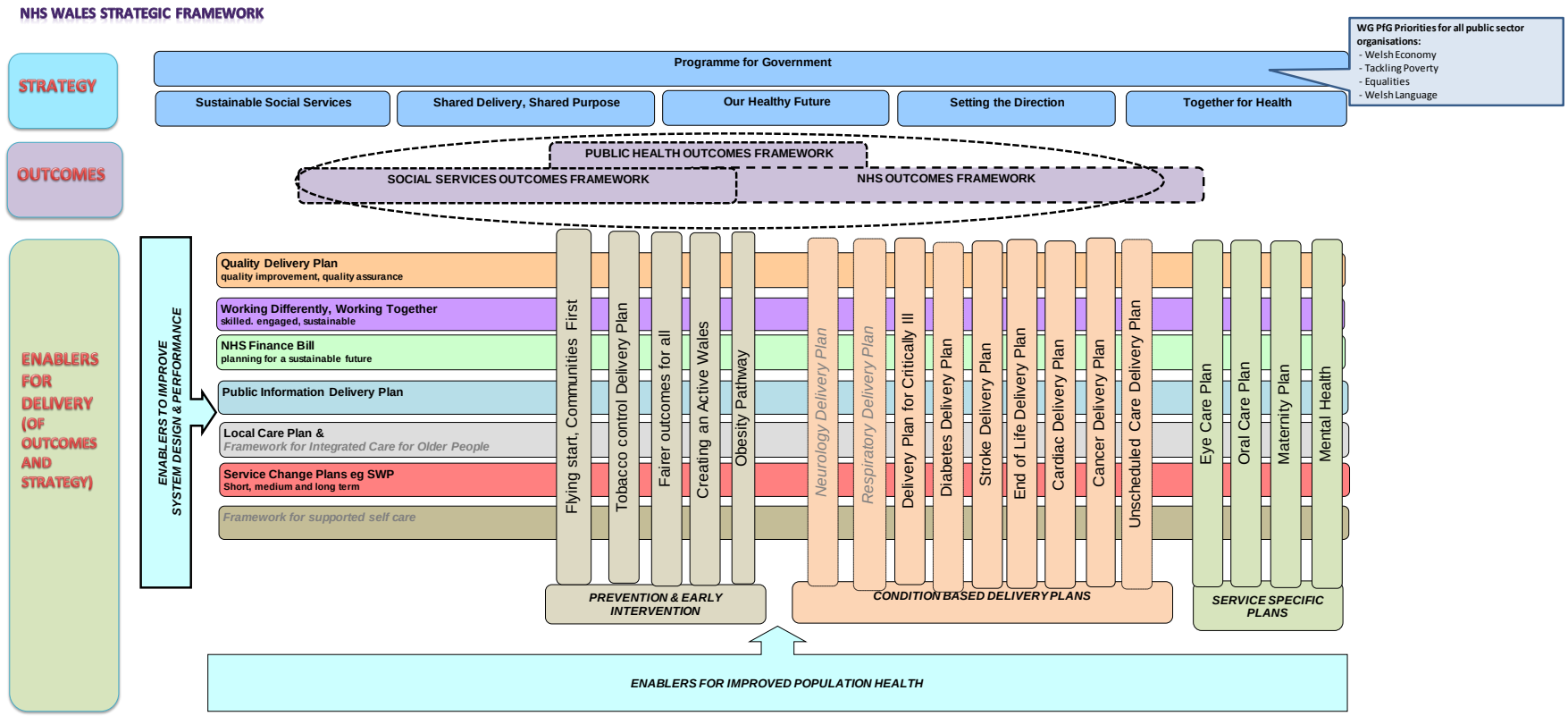
- Strengthened needs assessment and socio-economic profiling to underpin plans to reduce health inequalities and access to care
- Holistic diagnostic and consideration of all health components, including prevention, primary care, community, secondary and tertiary
- Developing and improving services with an ethos of co-production
- Modelling of activity, demand and capacity
- Accurate financial projections and risks, responding to the requirements of the NHS Finance (Wales) Bill
- Stronger organisational change programmes and supported targeted investment in infrastructure, equipment and ICT

The Williams Commission – Jan 2014

The aim of the Commission was to look hard, honestly and objectively at the way public services are governed and delivered in Wales, and how they may be improved. The full report was published on the 20 January 2014 and the recommendations have been reviewed in the context of this plan.

Figure 11 below sets out the NHS Wales Strategic Framework and serves as a powerful illustration of the complex matrix within which this IMTP is constructed.

Figure 11 : NHS Wales Strategic Framework



The Bevan Commission (BC) outlined its approach and thinking to Prudent Healthcare in its paper "***Simply Prudent Healthcare – achieving better care and value for money in Wales***". The Bevan Commission's definition of prudent healthcare (PH), principles and key objectives:-

Definition:

"Healthcare which is conceived, managed and delivered in a cautious and wise way characterised by forethought, vigilance and careful budgeting which achieves tangible benefits and quality outcomes for patients".

Principles:

1. Equity based care, treating greatest need first
2. Do no harm
3. Do the minimum appropriate to achieve the desired outcomes
4. Choose the most prudent care, openly and together with the patient
5. Consistently apply evidence-based medicine in practice
6. Co-create health with the public, patients and partners

Key objectives:

- Healthcare fits the needs and circumstances of the citizen
- Actively avoids harm and waste
- Abandons treatment or care which brings little or no benefit and
- Maximises the limited financial resources which can be drawn upon
- Adopts evidence-based medicine at scale and pace

The Minister has accepted the advice of the Bevan Commission and has asked the NHS in Wales to adopt PH as a matter of urgency as part of its response to prolonged austerity.

In taking this initiative forward the Chief Medical Officer (CMO) identified four initial areas for investigation i.e. orthopaedics, ENT, pain and prescribing. We have been asked to lead on testing how the principles of PH could be applied for Adult Hearing Services.

In consideration of the wider applications of prudent healthcare we have produced a discussion paper which, describes how ABMU will make evidence-based decisions that are consistent with the principles of prudent healthcare (PH) and in doing so, reconcile best clinical practice and optimum use of resource. This paper is attached as Appendix 1

We will work closely with Welsh Government and partners in 2014/15 to develop aspects of this approach within ABMU. The outputs from our own prudent healthcare work stream, for Adult Hearing Services and the other

three work streams in Wales, will inform this thinking once they all report in April 2014.

In addition to these key national policy documents, we have also taken into consideration the following documents, in preparing our IMTP:-

- Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (Mansell Report – Revised Edition – October 2007)
- Equality Act 2010 - Equality duty to ensure potential impacts on protected characteristics are taken into account in decisions
- Children & Families (Wales) Measure 2010
- Carers Strategies (Wales) Measure 2010
- Mental Health (Wales) Measure 2010
- Working Together for Wales: The Public Sector Workforce
- Working Together to Reduce Harm: Substance Misuse Strategy for Wales 2008/18 and locally Western Bay Substance Misuse Commissioning Strategy
- Together for Health: A Delivery Plan for Diabetes
- Together for Mental Health and locally Changing Mental Health Services for the Better
- Together against Stroke
- Together for Health: National Oral Health Plan for Wales
- Together for Health: Cardiac Delivery Plan
- Together for Health: Delivering End of Life Care
- Together for Health: Cancer Delivery Plan
- Eye Healthcare Plan for Wales
- Maternity Services Strategy for Wales
- Bridgend County Together: Single Integrated Partnership Plans SIPP
- Neath Port Talbot Working in Partnership 2012/23: SIPP
- One Swansea Plan: SIPP
- Rural Development Strategy
- South East Wales Transport Alliance (SEWTA) and South West Wales Integrated Transport Consortium (SWWITCH) and the emerging Transport Joint Working arrangements
- Child Poverty Strategy
- Social Services & Wellbeing (Wales) Bill
- Rights of Children & Young People's (Wales) Measure 2011
- Future Generations Bill

4.2 Drivers for Change

The narrative provided in sections two and three of this plan and the national strategic context above, make it clear that there is a compelling need for

transformational change. To do this our plan will need to address the following drivers for change:

- Improving population health.
- Halting the widening of, and ultimately reducing, the gap in health inequalities.
- Improving access to prevention of ill health services.
- Improving opportunities for self management and access to healthcare information.
- Consistently delivering high quality services 24 hours a day, seven days a week which demonstrate efficiency and value for money.
- Developing integrated health and social care services and out of hospital care.
- Providing care closer to people's homes.
- Reconfiguring our hospital services to improve access, quality and sustainability.
- Reviewing our estate to ensure that it meets the needs of older people
- Improving the patient experience of care.
- Maximising innovation and new technologies to deliver efficient and effective care
- Managing services within available resources.
- Improving staff engagement and the growth and development of staff
- Developing strong and effective leadership at all levels
- Creating people- centred culture, values and behaviours

4.3 Developing Our Strategy

Since the establishment of our ***Changing for the Better*** programme in 2011, we have placed effective and meaningful engagement with partner organisations, patients and carer groups, clinicians and staff plus third sector organisations at the heart of our approach to delivering strategic change. As part of this ongoing engagement process, over 350 people are directly engaged in shaping our services and discussing how services should change to deliver better outcomes for our population. In addition to this, we have in excess of 30 forums with these individuals, groups and organisations, including some specifically focused on protected characteristic groups under the Equality Act, which we regularly engage with about these issues. As part of this ongoing process, discussion on the suggested changes put forward through the Changing for the Better programme and related work, plus issues posed by the Strategic Health Needs Assessment have taken place. We have used this feedback to influence this IMTP and to develop our purpose, vision and aims and identify key objectives and measures to deliver our strategy.

Our clinical strategy and strategic programmes have been refocused to reflect health needs and stakeholder feedback. In addition we have introduced the life course concept to help us describe our clinical strategy and this has been well received.

We have considered the work of the World Health Organisation (WHO) and have decided that a life course perspective would provide a useful framework for the description of the services we provide. The WHO identifies six "life courses". Whilst these life courses would typically reflect how individuals progress through their lives, it is recognised that the life courses aren't strictly time determined, but more realistically constitute the sum total of a person's actual experience. These life courses are: -

- Unborn and Infant
- Children and Young People
- Working Age Adults
- Older People
- Frail Elderly
- End of Life Care

One of the reasons for using life courses to describe our clinical vision is to set out how we provide our services in a clear and understandable way that is meaningful for those that use them. We are also using the approach to challenge traditional thinking about services. We recognise that it will take time for some to adopt life course principles: always considering prevention and the whole pathway of care, but will work to embed it for the future.

We believe that this approach will enable us to describe more clearly to our citizens, patients, carers and staff, the future state of the services we provide.

Whilst the clinical strategy takes a life course approach, developed from public health foundations, for our staff and our partners we will also describe our future state in terms of settings of care which will portray what hospital, community, primary care and home based services will look like in 2017. These are the same services but viewed from different perspectives to allow us to describe more clearly what we plan to achieve.

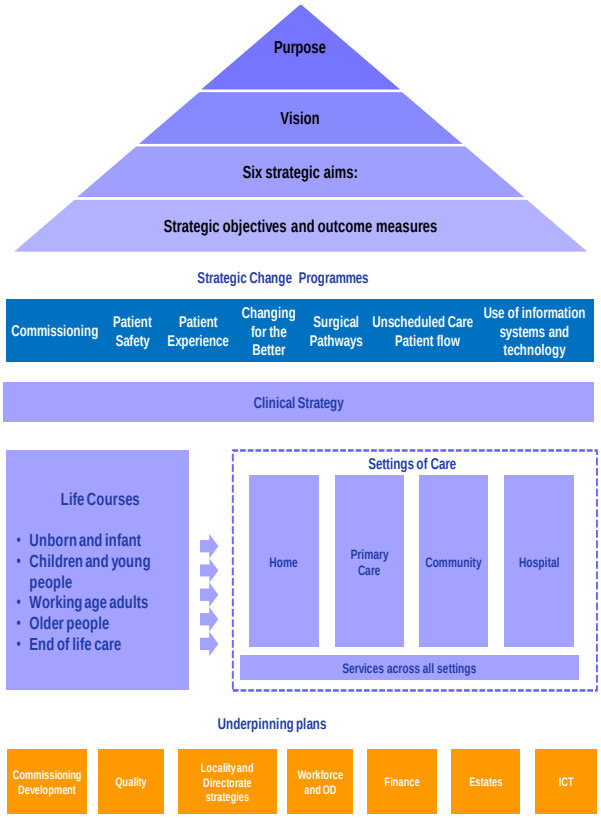
The remainder of this section of the IMTP sets out the resultant strategic framework and clinical strategy that have been developed to enable us to address the key challenges and drivers for change, described earlier in this document. For absolute clarity these are: -

- Our current pressures and service challenges (section 2)
- Our future pressures and challenges as determined by Strategic Needs Assessment and demographic modelling (section 3)
- Our future pressures in terms of service and strategic issues such as tier 1 delivery, South Wales Programme etc. (section 3)

- The national and local strategic contexts along with the key drivers for change (section 4)

Figure 12 illustrates the components of our strategic framework and shows how we will describe our clinical strategy from both a life course and settings of care perspective. It also sets out our principal delivery vehicles, our seven Strategic Change Programmes, which are further described in 4.8 below and then throughout sections 5, 6 and 9 of this document.

Figure 12 : Overview of our Strategic Framework



4.3.1 Purpose – why we exist

"To fulfil our civic responsibilities by improving the health of our communities, reducing health inequalities and delivering effective and efficient healthcare in which patients and users feel cared for, safe and confident."

4.3.2 Vision – Where we aim to be

We aim to be an excellent healthcare, teaching and research organisation for ABMU and the wider region. This means that:

- We will respect people's rights in all that we do and plan our services and their care with them and their carers. Wherever it is provided, care will be delivered to a consistently high quality 24 hours a day, seven days a week. This means that it will be safe and compassionate, meeting agreed national standards, providing outcomes valued by patients and citizens and an experience that is as good as it could be.
- We will make it easy for everyone to get the information and advice they need to be in control of their own health and to live healthier lives.
- We will work in partnership with our communities, our staff and other agencies to meet our citizens' health and social care needs in an integrated way, usually in or near to where they live.
- We will support high-quality research, education and innovation that benefit our patients and staff and we will encourage everyone to share their care experiences with us so that we can learn how we can do even better.

4.3.3 Values

Our Board is currently reviewing our values statement, which will be subject to engagement with stakeholders, once agreed.

4.3.4 Strategic aims

We have six strategic aims:-

- Excellent population health
- Excellent Patient outcomes and experience
- Sustainable and accessible services
- Strong partnerships
- Excellent people
- Effective Governance

Table 23 below sets out how we will achieve our strategic aims, setting out the key strategic objectives, the outcome measures and delivery mechanisms for each.

Table 23 : Matrix of Strategic Aims, Objectives, Measures and Delivery Mechanisms

Strategic Aim: Excellent Population Health			
Objective	**Target**	**Outcome measure**	**Delivery / Strategic Change Programme**
To improve health outcomes and reduce health inequalities by tackling: • Smoking • Obesity and exercise • Vaccination & Immunisation • Alcohol and substance misuse • Poor mental health • Preventing injuries particularly in the frail elderly **Year 1 priorities:** • Smoking • Obesity • Immunisation	Tier 1	***Smoking*** Implement tobacco cessation programme to decrease smoking prevalence from 23% to 19% by 2017 and 16% by 2020. 5% of smokers make a quit attempt via smoking cessation services with a 40% validated quit rate at 4 weeks by quarter 4 2014/15.	Strategic Change Programme: Staying Healthy (including children) Smoking cessation business case Locality SIPPs
	Local	***Overweight and obesity**** Reductions every year in the levels of overweight and obesity as measured by the annual Child Measurement Programme at school entry once obesity plan in place (first full year 2015/16).	Strategic Change Programme: Staying Healthy Obesity pathway Locality SIPPs
	Tier 1	***Vaccination and Immunisation*** Achieve targets for influenza uptake in all local authority areas and for frontline staff in ABMU by end of 2014/15. 75% -Under 65 in an at risk group by quarter 4 2014/15 95% uptake of all routine immunisations by 4th birthday across all quintiles of deprivation by quarter 4 2014/15.	Strategic Change Programme: Staying Healthy Immunisation Plan Locality SIPPs

Strategic Aim: Excellent Population Health			
Objective	**Target**	**Outcome measure**	**Delivery / Strategic Change Programme**
	Local	***Alcohol and Substance Misuse*** Hospital admissions and deaths from alcohol and substance misuse reduced *	Strategic Change Programme: Staying Healthy Locality SIPPs
	Tier 1 / Local	***Mental Health*** 80% of assessments by LPMHSS undertaken within 28 days from date of referral by March 2015. 90% of therapeutic interventions started within 56 following an assessment by the LPMHSS by March 2015 90% of LHB residents (all ages) to have a valid CTP completed at the end of each month – maintain for 2014/15 100% of hospitals within each LHB to have arrangements in place to ensure that advocacy is available To reduce prescribing of antidepressants and hypnotics in primary care (average daily quantities/1000 STAR Pus)*	Changing Mental Health Services for the Better Mental Health IMTP
	Local	***Frail Elderly*** Refer to Quality and Safety section (re falls) Reduction in older people suffering hip fractures (Bridgend SIP) * Number of people diverted to community Resource	Locality and Directorate plans Locality SIPPs Strategic Change Programme - Hospital Services (Ambulatory Care

Strategic Aim: Excellent Population Health			
Objective	**Target**	**Outcome measure**	**Delivery / Strategic Change Programme**
		Teams following a fall*	project)
	Tier 1	***Quality Improvement*** Cancer mortality rate under 75 years per 100,000 Reduction in circulatory disease mortality rate under 75 years per 100,000 ***Reference Appendix B1***	Cancer Delivery Plan Cardiac Delivery Plan Locality plans
To implement our Commissioning Development Programme to use information on the needs of the local population to identify organisational commissioning priorities.	Local	Outcomes will be determined from the implementation of the 10 point commissioning development plan in section 9.3 of the plan.*	Commissioning Development Programme
To contribute to the wellbeing of our population by working with our Local Authority partners to implement our Single Integrated Partnership Plans (SIPPS)	Local	Link to smoking, obesity, immunisation, alcohol and substance misuse, poor mental health and frail elderly plus By 2020 reduce the level of burden and tooth decay at age 5 and age 12 among the most deprived quintile of the population to that recorded for the middle deprived quintile.*	Locality SIPPs

Strategic Aim: Excellent Patient Outcomes			
Objective	**Target**	**Outcome measure**	**Delivery**
Implement plans that improve performance against national and local targets (Tier 1, Quality Triggers and Quality Delivery Plans)	Tier 1 / Local	Meet Tier 1 targets annually. (***See appendix B1)*** 0 Patients waiting over 36 weeks referral to treatment by March 2015 98% of patients referred as non urgent suspected cancer seen within 31 days from April 2015 95% of patients referred as urgent suspected cancer seen within 62 days from September 2014. % procedures cancelled on more than one occasion by the hospital < 8 days. Number of FUNB appointment dates over target* Increase the percentage of GP practices offering appointments between 17:00 and 18:30 on a least two nights per week Increase the percentage of GP Practices open during daily core hours or within one hour of daily core hours Dental – % of population treated (adults and children)* GP OOH - No more than 5% of calls are abandoned Urgent calls logged and returned within 20 minutes of 90% to be reached consistently by end of April 2015 100% of transmissions by 9am with a local target of getting 70% transmissions electronically via DTS by April 2015	Locality and Directorate IMTPs Dental Strategy and Planning Group Primary Care Access Forum

Strategic Aim: Excellent Patient Outcomes			
Objective	**Target**	**Outcome measure**	**Delivery**
Develop clear and shared values and expectations, across our Health Board, and with the population we serve.		Values agreed on completion of engagement event.	Strategic Change Programme – Patient Safety
Ensure continuous improvement in patient safety creating confidence in all our services (specialist, tertiary, secondary, primary, community and commissioned) through the: Embedding of best practice and prevention methods Systematic and routine review and analysis of mortality data to identify the major causes of avoidable hospital deaths Implementation of well evidenced treatments, care bundles, pathways and approaches to achieve progressive improvements in outcomes Strengthen our infection prevention, control and decontamination processes.	Tier 1 / Local	***Quality Improvement*** 38% reduction in C. *difficile* compared to 2012/13 49% reduction in MRSA compared to 2012/13 10% reduction in MSSA compared to previous 12 months as at February 2014 Reduction in pressure ulcers by 2 per month compared to 2013/14 95% compliance with hand hygiene audits (WHO 5 moments) from April 2014 Reduction in number of falls resulting in harm by 25% year on year (no trend for 2013/14 – number vary between 118 and 322 per month) Enhanced safety of surgery – 100% compliance with WHO checklist % of GP practises who have completed CGPSAT tool kit. To reduce prescribing of antibacterial items / 1000 STAR Pus*	Strategic Change Programme – Patient Safety Progressive Improvements Project Locality and Directorate IMTPs
	Tier 1	Reduction in emergency hospital admissions for the basket of chronic conditions ***(reference Appendix B1)**** Reduction in the number of emergency hospital readmissions within a year for basket of chronic	

Strategic Aim: Excellent Patient Outcomes			
Objective	**Target**	**Outcome measure**	**Delivery**
		conditions ***(reference Appendix B1)***	
	Tier 1	Reduction to 14.7% in mortality rate for stroke 30 days post event by January 2015 (baseline 14.8%) Reduction to 4.5% in mortality rate of heart attack after 30 days post event from April 2014 Reduction to 5% in mortality rate of fractured neck of femur 30 days post event from April 2014 Reduction to % in Crude Risk adjusted scores together with mortality reviews from April 2014*	Fracture neck of femur pathway compliance – MSK IMTP End of Life Care: Strategic Change Programme – Community services , Western Bay
	Local	***Six key quality commitments*** 90% patients risk assessed for VTE in 14/15 and 95% for following years 50% compliance in daily senior review by end of March 2015 and 95% in following years (will be monitored following implementation of PIMS + at the end of 2014/15) 98% compliance for stage 1 Mortality Reviews by September 2014 70% compliance with the requirements for minimum and full discharge summaries by end of March 2015 and 95% in following years (dependent on roll out of PIMS+) 100% patients with completed NEWS score and appropriate responses actioned – (tolerance 95%)	Locality and Directorate IMTPs
	Local	Zero hospital related cross infections. Number of ‘never ‘events. – target 0	Directorate and Locality IMTPs

Strategic Aim: Excellent Patient Outcomes			
Objective	**Target**	**Outcome measure**	**Delivery**
		Number of harm incidents reported as “moderate severe” or “death”	
Address the issues of concern and standards of care highlighted at the PoW hospital	Local / Tier 1	Tier 1 targets (PoW) Ward metrics. Deliver Recommendations of AQuA report Deliver Recommendations of the Andrews Report “Trusted to Care”	PoW Steering Group
Deliver compassionate care that ensures dignity in care and care delivery.	Local	Reduction in number of complaints relating to dignity and respect compared with 2013/14 >85% compliance with standards 2 and 5 (fundamentals of care audit) >85% of patients rating their stay in hospital as ALWAYS being treated with dignity and respect. % of dementia champions which have undertaken 5 day training course* % of patients undertaking dementia assessment on admission % of butterfly scheme applied to patients opting in % of AHP and Nursing staff trained to dementia competence % of wards with staff member having postgraduate training in dementia % of patients receiving appropriate hydration % of wards assessed as appropriate environments	POINT reviews Fundamentals of care audits Multi Disciplinary Committee - Dementia Action Plan Continence Steering Group Implement of HIW recommendations on dementia.

Strategic Aim: Excellent Patient Outcomes			
Objective	**Target**	**Outcome measure**	**Delivery**
		to care for older people % of staff to receive training on dementia delirium and dying; dignity and respect* % of doctors and nurses trained to care for patients at the end of their lives Zero POVAs as a consequence of Health Board neglect or omissions of care	
Be a listening organisation, knowing how well we are doing at all times and learning from experience	Local / Tier 1	10% reduction in dissatisfaction with complaint responses in 2014/15 compared with 2013/14; a further 20% reduction in 2015/16; and a further 20% reduction 2016/17 10% reduction in formal clinical care complaints in 2014/15 compared with 2013/14; further 10% reduction in 2015/16; and a further 10% reduction 2016/17. 10% Reduction in number of investigations being undertaken by the Ombudsman during 2014/15 compared with 2013/14 10% reduction in number of investigations being undertaken by the Ombudsman in 2015/16 compared with 2014/15 10% reduction in number of investigations being undertaken by the Ombudsman in 2016/17 compared with 2015/16 By March 2015 friend and family test to be implemented across all provided services in ABMUHB.	Strategic Change Programme – Patient Experience Programme

Strategic Aim: Excellent Patient Outcomes			
Objective	**Target**	**Outcome measure**	**Delivery**
		By March 2016 95% completing friends & family test stating they would recommend the ward / department to their friends & family By March 2017 98% patients stating in Friends and Family returns that they were likely or extremely likely to recommend the ward / department By March 2015 92% of patients surveyed expressing overall satisfaction with the care provided by the Health Board; 94% satisfaction rate by march 2016; and 96% by March 2017.	

Strategic Aim: Sustainable and Accessible Services			
Objective	**Target**	**Outcome measure**	**Delivery**
Improve the safety, quality, efficiency and sustainability of our surgical pathway (See Section 6 Strategic Change Programme – Surgical Pathway)	Local / Tier 1 (RTT and cancer)	Reduced cancellations* Improved theatre utilisation, moving to 85%. Implement principles of enhanced recovery across all surgical specialities* Reduction in bed days*	Strategic Change Programme - Surgical Pathway Locality and Directorate IMTPs
Improve the safety, quality, efficiency and sustainability of our unscheduled care services (see Section 6 Strategic Change Programme – Unscheduled Care/ Patient flow for detailed description)	Tier 1	90% of new patients spend no longer than 4 hrs in an ED by September 2014 <40 patients – over 12 hr waits in emergency care facilities from January 2015 65% Cat A response times by September 2014	Strategic Change Programme - Unscheduled Care/Patient Flow Locality and Directorate IMTPs

Strategic Aim: Sustainable and Accessible Services			
Objective	**Target**	**Outcome measure**	**Delivery**
		Non mental health delayed transfers of care (DTOCs) – current performance maintained***)***	
Improve the safety, quality, efficiency and sustainability of our primary care services	Local	% GPs > 55 years (monitor) % of practice who have a closed/open list (monitor)* Vacancies within primary care* Average list size per GP *	
To transform our services through delivery of the Changing for the Better Strategic Programme i.e. **Deliver improved services for frail older people and those with dementia – strengthen community teams in each locality (See Section 6). Strategic Change Programme Community Services Project) – YEAR 1** **Redesign hospital services. (See Section6) Strategic Change Programme – Hospital Services) - YEAR 1** **Develop Rapid Access Services. (See Section 6 Strategic Change Programme – Rapid Access) - YEAR 1** Develop Pre Hospital Services. (See Section 6 Strategic Change Programme – Rapid Access) Develop Trauma Centre. (See Section 6 Strategic Change Programme – Trauma centre Development)	Local	***Community Services*** Single Point of Contact in place – increase the: % of all new contacts relating to community health and social care are directed through the single point of contact.* Reduction in bed days. (>65 years)* .	**Strategic Change Programme C4B YEAR 1:** Community Services Project Hospitals Project Rapid Access Project Western Bay Locality and Directorate IMTPs **IN DEVELOPMENT** Pre Hospital Services Project Trauma Centre Development Co-dependent Services
	Local	***Hospitals project*** Reduce WAST attendance at ED by 20% (linked to acute GP unit) Support delivery of reduced median wait in Emergency Department and Minor Injury Units from 126mins in April 2014 to 120mins in March 2015Increase in the % of patients discharged within 4hrs by 5% Increase in the % of patients discharged	

Strategic Aim: Sustainable and Accessible Services			
Objective	**Target**	**Outcome measure**	**Delivery**
Develop Women's and Children's Services. (See Section 6 Strategic Change Programme – Co-dependent Services Maternity, Newborn, Gynaecology, Neonatal and CYP) Modernise Outpatients (See Section 6 Strategic Change Programme – Outpatients Modernisation)		within 8 hrs by 5% Increase in successful WAST handovers within 15 mins by 10% Reduce admissions from 8 Ambulatory Care Sensitive Conditions (ACS) by a range of 10-20% per condition Reduction in average length of stay for adult medical admissions by one day (estimated 15,330 bed days)	Maternity, Newborn, Gynaecology, Neonatal and CYP Outpatients modernisation
	Local	***Rapid Access*** Cold site ambulatory unit in place for medical day case work and ambulatory pathways by **year 3.** Advice lines in place to minimise admissions.* Rapid access to diagnostics through e.g. extended working day for CT and US, link to 7 day working, * Reduction in bed days.*	
Implement Information Systems and Technology	Local	Achievement of key milestones identified in section 9.4. Note enabling mechanism to support the achievement of outcome measures identified in this table.	Strategic Change Programme – Effective Use of Information Systems and Technology
Implement the recommendations of the South Wales	National	Dependent on confirmation of South Wales	South Wales Programme

Strategic Aim: Sustainable and Accessible Services			
Objective	**Target**	**Outcome measure**	**Delivery**
Programme and South Wales Health Collaborative – to reconfigure clinical services across Wales.		Programme.	
To work with the Welsh Assembly Endoscopy Group to deliver the recommendations as outlined in the Ministerial letter dated February 2014		Number of patients waiting over target for endoscopy surveillance procedures * 0 patients waiting over 8 weeks for endoscopy procedures (profile to be confirmed) To implement the recommendations of the All Wales Endoscopy and Colonoscopy Task and Finish Group (Feb 2014) to include: To achieve JAG accreditation by April 2016 Barium enemas to be phased out moving to CT colonoscopy by March 2015	Endoscopy Board
Manage services within budget and identify 1.5% CIPs		CIP plans delivered	C4B Board Performance reviews. Locality and Directorate IMTPs

Strategic Aim: Strong Partnerships			
Objective	**Target**	**Outcome measure**	**Delivery**
To work in an open and transparent way in partnership with our local stakeholders to support the delivery of high quality integrated care. To work with: Our ***citizens*** to empower them and help them make healthy lifestyle choices (***linked to population health section***) ***Patients***, to learn from their experiences and to provide care in partnership with them ("co-production"). ***Local authorities, the voluntary and third sector*** to deliver integrated care and specifically implement the Western Bay Programme and seek our opportunities to work together for our patients. Ensure that the health needs of our population and prevention activities are reflected in SIPPs ***University sector*** as part of our collaborative agreement to develop plans to : Provide high quality education Built on areas of existing research strength Develop local specialist expertise Enhance recruitment Improve the clinical quality of services Identify new opportunities to across mathematics, business, and engineering for example. Encourage innovation and inward investment into our organisations and the local economy	Local	Increase in the number of patients who undertake self management support programme such as Expert Patient * Increase the number of people trained to offer structured self management programmes across primary and secondary care.* To achieve compliance with the outcome measures specified by the NISCHR AHSC monitoring framework (VO5.10.12)	Strategic Change Programme - Patient Experience Programme Locality and Directorate IMTPs South West Wales Academic Health Science Collaboration Locality SIPPs

Strategic Aim: Strong Partnerships			
Objective	**Target**	**Outcome measure**	**Delivery**
To develop a charter, setting out our commitment to respect the rights of our citizens in healthcare.	Local	Charter in place.	Patient Experience Forum
To work towards achieving UNICEF recognition and incorporation of Welsh Declaration of the Rights of Older People by 2017.	Local	UNICEF recognition achieved.	Children and Young People Strategy Group
To review our existing policies and procedures to identify opportunities to contribute to the local economy, which have a positive impact on the health of our citizens	Local	Policies and procedures identified, reviewed and agreed.	
To work to ensure that our workforce is engaged and valued.		Reference outcome measures in Excellent People.	

Strategic Aim: Excellent People

Objective	Target	Outcome measure	Delivery
Develop different roles, different skill mix, different working practices and different recruitment strategies to support the delivery of the IMTP and its change programmes.	Local	Monitor quarterly alignment with All Wales Staffing Guiding Principles on adult acute ward areas Improve half yearly on the baseline position of adult acute ward based WTE/bed matches with the all-Wales Acuity and Dependency Tool, issued April 2014 – under development Measurement of different working practices will be explored and then an outcome measure set increase in the number of junior medical staff rotas operating 1 in 11 from our March 2014 baseline.* By March 2015, number of Consultant & SAS job plans increased from our 2013/14 baseline in accordance with the Welsh average.* Changes in skill mix and banding as a result of service change evidenced using the 'Christmas Tree' tool. * Monitor vacancy rates and ensure SLA with Shared Services is delivered.* Implementation of the re-engineered consultant recruitment process during 2014/15* Number of GPs delivering more Health Board managed services * Increase in number of staff successfully	Multi-professional Education Forum Medical Workforce Board Nursing and Midwifery Forum Workforce & OD Committee Organisational Development Project C4B programme Health and Well Being programme

Strategic Aim: Excellent People

Objective	Target	Outcome measure	Delivery
		redeployed from 2013/14 baseline	ISIS
Develop a workforce model which uses benchmarking data within iView and the All Wales skill mix tool to identify opportunities that allow the workforce to adapt and respond to changing circumstances and new ways of working, including efficient rotas and working arrangements	Local	ABMU performance against key benchmarking data within iView and the All Wales skill mix too* Increase in the number of audits undertaken and improvements in rostering as a consequence of these audits.* Improve WFIS RAG rating (WOVEN) * Improve % roll out of e-rostering *	
Increase staff engagement through greater staff involvement in decision making; improved management and leadership; personal development and training; promoting a happy, healthy and safe working environment; and ensuring every contact counts Maximise team performance and productivity through effective clinical engagement and values based leadership, aligned with associated behaviours Value our staff and recognise their contribution. Assess their capability and plan future development interventions to ensure we invest in and retain talent and future leaders Implement a new approach to improvement, innovation and transformation through the ISIS (Innovation Support and Improvement Science) programme.	Tier 1	85% of staff (excluding medical) undertaking PADR with data recorded in ESR by March 2015 Improve % roll out of Employee self service, starting April 2014* Improve % of PADRs recorded in ESR as sole recording mechanism, starting April 2014* 85% of medical staff undertaking performance appraisal by March 2015 30% of staff completing the national staff survey in the organisation by March 2015 improvement in organisational climate to 59% by March 2015 Achieve 5.5% annual local sickness and absence workforce target by March 2015	

Strategic Aim: Excellent People

Objective	Target	Outcome measure	Delivery
Engage all staff in quality improvement activities and ensure they have time set aside to do this	Local	Decrease in the time spent dealing with formal Disciplinary, Grievance and Dignity at Work investigations* Increase in staff undertaking mandatory training to meet required national annual target from March 2014 baseline During 2014/15 maintain Corporate Health Standard Gold Award and scope organisational readiness for Platinum Award. During 2015/16 work towards Platinum Award. 50% of frontline staff vaccinated against flu by 2015/16	
	Local	Increase in number of staff achieving Bronze IQT from March 2014 baseline figure. Increase in number of staff qualified at a Silver IQT level from March 2014 baseline figure.	
Promote equality in the NHS both in our day to day role, when developing policy and when making decisions to improve the equality and equity of our health care services	Local	All service change proposals assessed for Equality Impact* Increase in number of staff completing 'Treating Me Fairly' equality eLearning from March 2014 baseline figure	

Strategic Aim: Effective Governance

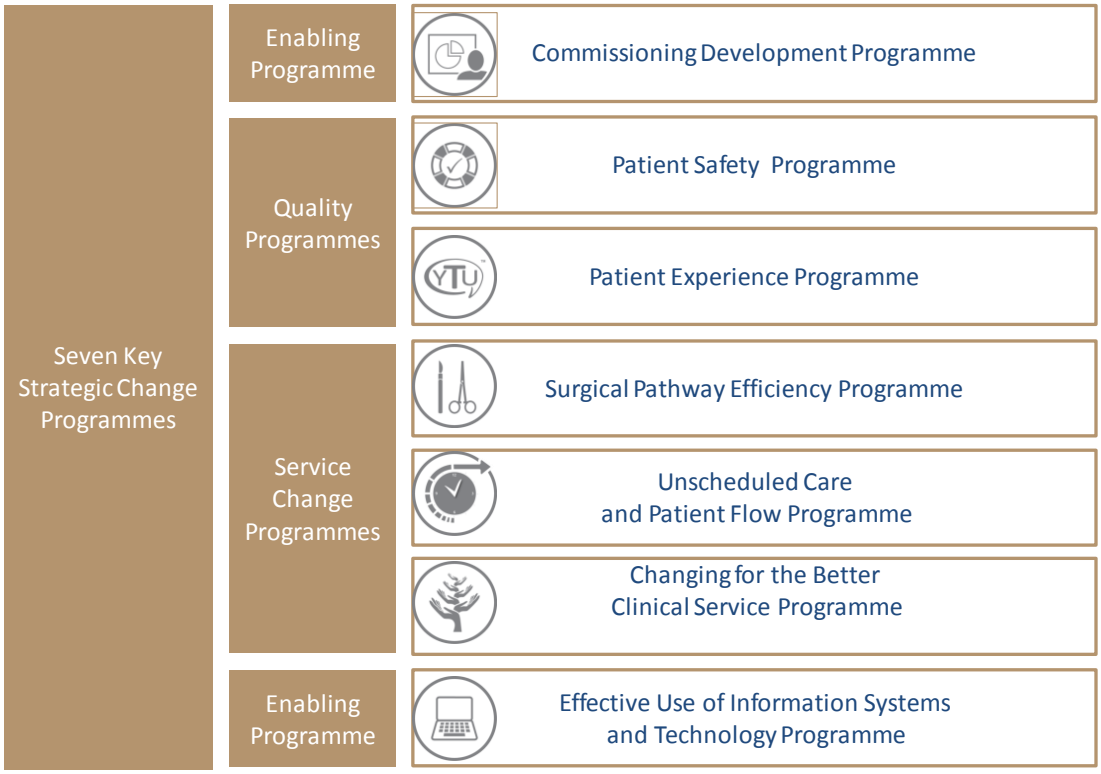
Objective	Target	Outcome measure	Delivery
Agree a clear financial resource framework within the statutory financial targets for the Health Board.	Tier 1 / Local	Board delivery against key financial targets CIP targets delivered Maintain level 3 compliance with Standards for health Services as a minimum Improved regulatory compliance ratings	Existing governance and assurance arrangements
Implement robust governance framework and performance reporting for the Board and its sub committees	Local	Performance delivered against tier 1 and local delivery targets. Improved Internal Audit assurance ratings to ensure to reasonable assurance rating in Annual Governance Statement	Existing governance and assurance arrangements
Implement recommendations from Betsi Cadwaladr/Francis reports	Local	Link to patient safety and quality.	
Improve compliance with the Standards for Healthcare in Wales.		Improved performance against Health Care standards compared to 2013/14 year on year.	
Improve data quality/analysis	Tier 1	Ensure data completeness standards are adhered to within 3 months of episodes end date	Existing Health Board performance framework.
Develop a finance regime to engage clinicians in management and decision making		In development.	

Further work to be undertaken in 2014/15 to agree baseline and targets

4.4 Strategic Change Programmes

We have established strategic change programmes to support delivery of the plan. Each programme has an Executive Sponsor, a Programme Initiation Document and trajectories for delivery. The aims of each Programme are described at the end of this section. Figure 13 sets out how these have been configured.

Figure 13 : Strategic Change Programmes



4.5 Clinical Strategy

The development of our clinical strategy has been led by one of our strategic change programmes; ***Changing for the Better – Clinical Services Programme***. We created the opportunity for over 300 stakeholders to come together to design our new clinical strategy for the Health Board. Around 50% of these stakeholders were clinicians and the other group members included representatives from: -

- Third and Voluntary sector
- Patient and Carer groups
- Local authorities
- Welsh Ambulance Services NHS Trust
- Swansea University
- ABMU Community Health Council

The programme was organised into seven work streams with groups describing what the optimum patient / carer experience would be and in this context reviewing College standards, best practice, innovative approaches within Wales, across the UK and other healthcare systems, as well as considering what we already do well and can build upon. This led to a range of proposals being put forward, which were subject to three months public and staff engagement in the winter of 2012.

The main rationale for the proposals from ***Changing for the Better*** - ***Clinical Services Programme*** is that the following will be addressed:

- We will tackle the widening health inequalities and health needs across our Health Board population by helping citizens to make wiser lifestyle decisions and to remain healthy for longer.
- We will commit a greater proportion of our resources to delivering care outside hospitals, near or in peoples own homes.
- We will strengthen our primary and community teams and integrate them with social care and the third and voluntary sectors to provide proactive, responsive services for citizens, particularly children and the elderly.
- We will empower those people with long term conditions to be able to manage their own conditions better through education, information and support and we should make it easier for them and their primary care teams to access expert advice and review when required.

In February 2013 the outcome of the engagement was discussed with the Community Health Council and a range of proposals agreed which could be implemented without further engagement or consultation. A number of issues were highlighted by the Community Health Council as needing further explanation or work in order for people to be able to have an informed view on whether they should be implemented. And finally the proposals around the South Wales Programme and changes to Neonatal, Consultant led Maternity, Inpatient Paediatric and Emergency Departments should be the subject of formal public consultation.

In the summer of 2013 we took the ideas from ***Changing for the Better – Clinical Services Programme***, which had been agreed from the engagement process and designed projects to translate these proposals into

action. (For details see C4B report 03). Using Managing Successful programmes™ methodology, we set up eight C4B projects, which have been developing implementation plans. These plans underpin this Integrated Medium Term Plan. The exception to this is our strategy for Mental Health Services. In future the development of service change plans and their implementation for Mental Health patients, their carers and their families will be incorporated within the over-arching Changing for the Better programme. A summary of the Mental Health Strategy is provided below.

4.5.1 Changing Mental Health for the better (CMH4B)

Mental Health Strategy

Changing Mental Health for the better sets out a vision for transforming the service from one based around institutional care to care delivered in communities. This strategy has been developed and agreed with local authority, third sector and criminal justice partners through the Local Partnership Board for Mental Health. It is aimed at ensuring we can deliver the best possible care in the future, taking a whole system approach that starts with health promotion and self care, and extends through to the delivery of more specialist services.

Following the lead of the National ***Mental Health and Wellbeing Strategy Together for Mental Health*** (http://www.wales.nhs.uk/sitesplus/863/opendoc/240175) the key objectives fall into four areas of work.

- ***Promoting Mental Wellbeing and helping to build resilience for all people, families and communities***
- ***Working together with people regardless of which service area in providing support and care***
- ***Improving our working together between and within organizations***
- ***Providing holistic care for the most vulnerable***

Accompanying the National Strategy is a multiagency Delivery Plan. This contains 195 separate actions prescribed by Welsh Government with the aim to deliver the outcomes expected within the Strategy over the next 5 years. Oversight for implementation of the strategy and achievement of actions in the delivery plan is not the sole responsibility of the Health Board and monitoring is undertaken by a multi agency Local Partnership Board for Mental Health.

This Local Partnership Board has identified particular areas within the strategy and delivery plan upon which to focus. These are summarised below.

Promoting Mental Wellbeing

Over time we want to:

- See less demand on mental and physical health services as people become more self sufficient and communities become more supportive.
- Develop a wellness advice and support service for individuals who may be facing difficulties

- Reduce people's experiences of mental health discrimination and stigma by improving awareness.
- Provide up to date information about available health wellbeing and social care resources.

Working together with people.

Working collaboratively with individuals in providing support and care makes the most of a person's own strengths and abilities and in doing so assists in de-stigmatising mental health and creating communities with better mental health. We want to:

- Promote positive attitudes to mental health in services and communities which will help reduce stigma and in turn contribute to people seeking help earlier and to looking after themselves better.
- Work together with carers and families so that they get appropriate information are fully involved in the care planning for the patient and are supported to continue their caring role.
- Review and strengthen mechanisms for ongoing engagement with users and carers in the design, planning and monitoring of services.
- Ensure people are engaged in the planning and delivery of their own care in line with the Mental Health (Wales) Measure 2010 as making decisions in partnership is known to improve outcomes for the individual.

Working together between organisations

As mental health difficulties can have an impact on a person's social, environmental, financial, spiritual, educational and physical needs it is important that the range of services provided by statutory and third sector in relation to all these things are aware of and cooperate with each other. We will:

- Work together to progress arrangements for integrated management for mental health services where they deliver benefits to service users.
- Develop an Integrated Service Model and Commissioning Plan for Older People with Dementia to ensure that people get support and advice for their needs early and also to ensure that there is an understanding of dementia amongst all services provided to the public.
- Work to establish a long term plan for sharing information safely and for the adoption of an electronic record system shared by health and social care.
- Work to support the development of the team around the family approach to building resilience within communities through the Integrated Family Support Service.
- Develop an approach to early intervention, using a "psychologically minded" approach to improve outcomes for those people who are experiencing psychosis for the first time.

Holistic care for the most vulnerable

Providing recovery focused support to those who develop mental health problems and mental illnesses is crucial for affecting the quality of life for these individuals and to assist them in realising their full potential.

Services and support will be delivered increasingly within community settings and as close to people's homes as possible. Where this is not possible acute inpatient care will be available with the aim of providing care for as short a time as possible in order to have the least impact

on the individual's normal pattern of life. We will:

- Increase capacity to deliver a range of Psychological Therapies across all tiers of care.
- Work together to develop a comprehensive range of accommodation with varying levels of support to provide people with options and choice.
- Work together with service users and carers to provide safe and modern hospital environments for all with mental health needs.

The action plans for delivering these Mental Health Services Strategy objectives is set out in Appendix 2.

4.5.2 Learning Disabilities Strategy

We also intend to incorporate the overall Strategic Framework for the South Wales Learning Disability Collaborative "Forward Together" within our overall Changing for the Better Programme. This strategy is summarised below. The full document is available at: http://www.wales.nhs.uk/sitesplus/863/opendoc/240446

Learning Disabilities Strategy

Introduction

As people with a learning disability are people first, our strategic aims are all encompassing, recognising that they are equal citizens of our communities. However, there are a number of areas where they require further support and development to take account of a number specific issues related to learning disabilities.

It is well documented that people with learning disabilities have poorer general health and more specific health needs than the general population. Specific patterns of health need may also arise from some of the known causes of learning disability. An example of this would be the high rate of early onset of Alzheimer's disease in individuals with Down's Syndrome.

As with the population in general people with learning disabilities are living longer, this is to be celebrated; however the consequence of this is that more will develop age related health problems.

However, the evidence from a series of reports and inquiries shows that the National Health Service is not yet commissioning or providing services in ways that adequately meet these health needs. This contributes to preventable ill-health, poorer quality of life and, at worse, premature deaths.

Strategic Aims

- Individuals with learning disabilities should have access to the same healthcare as others living in the community, with additional support to meet special health needs as required.
- People with a learning disability must have an equal right to access primary, secondary and specialist health care services and routine national health screening programmes as all other citizens.

	Objective	Commentary
General Health / Health Facilitation	• We will ensure that the right support and enabling processes are in place through further Pathway development. • We will ensure that individuals and their carers (be they paid or otherwise) have informed choices.	The Health Board's Learning Disability Service will play a key role in facilitating and supporting the change needed to address this, recognising that the responsibility for delivering these improvements rests with other parts of the healthcare system.
Complex Physical Needs	• We will determine the most appropriate response and provision to meet assessed needs. • People whose needs are more related to physical health and not their learning disability, (although this will add to the complexity of their needs), will be provided with access to appropriate services, and with their needs being met by appropriate clinicians in General Health.	It is clear that there is a growing population of children and adults with complex health needs, with the most significant factor affecting the prevalence being increased life expectancy. It is now thought that most adults with learning disabilities, who live past their third decade, are likely to survive into old age and experience the normal ageing process. Upward pressures on the incidence of learning disabilities include: • Increases in maternal age (associated with higher risk factors for some conditions associated with learning disability, such as Down's Syndrome) • Improved survival of 'at risk' infants, such as low birth weight, due to improved health care • Increases in more recently significant pre-natal threats such as HIV infection and substance abuse. • An increase in the proportion of children growing up in poverty For many their difficulties are also compounded by multisensory impairment or mental ill-health, or the requirement for invasive procedures, such as supported nutrition, assisted ventilation, and rescue medication.
Challenging Behaviour	• We will review the role and function of existing specialist residential services, with a view to developing and expanding the capacity of local	In keeping with Government policy over the last 30 years, the majority of children and adults with learning disabilities, who present with challenging behaviour, should be supported in the community. Challenging Behaviour is not a separate diagnostic entity, but describes a range of

	services for adults with learning disabilities in order to understand and respond to challenging behaviour and in so doing develop Competent Communities. • We will develop a joint strategy to increase capacity and competence in all in-house and commissioned services. In so doing reducing the use of private sector and out of area facilities and also reducing the likelihood of challenging behaviour occurring. We will move to a 7 day service ensuring a more responsive service, with less reliance on Assessment and Treatment Units. This will lead to: • The development of Closer to Home from a project, into a principle. • An improvement in the quality of life of those served and the well-being of family and formal carers supporting people who challenge.	actions by a heterogeneous group of people as a result of a range of health and social stimuli. Relatively few individuals with challenging behaviour will require healthcare provided residential services. Developing an effective strategy for this user group will therefore be dependent on agreeing a shared vision across agencies for future action. It will need to ensure that services are fully integrated with other areas of physical and mental healthcare provision, including local forensic and Criminal Justice Services. This will be built on partnership and have a whole system approach.

4.5.3 Western Bay Substance Misuse Commissioning Plan

4.5.4 Substance Misuse

Services are planned and commissioned for the ABMU area by the Western Bay Substance Misuse Area Planning Board which took over responsibility for these services with the move by Welsh Government to regional commissioning from 2013-14. The Health Board has worked with partners in the 3 Local Authorities, South Wales Police, the Police & Crime Commissioners Office, Criminal Justice Agencies, Prisons, third sector organisations, service users and carers Finally the Western Bay Substance Misuse Commissioning Plan Strategy has been developed with Local Authorities and Criminal Justice agencies in response to Working Together to Reduce Harm, the Welsh Strategy on Substance Misuse and will also need to be linked into the C4B programme.

4.5.5 Life Courses

We have adopted a “life course” approach to describing our Clinical Strategy. Not only does this approach mirror our Public Health Strategic Framework, it provides a citizen-centred viewpoint for our services and priorities. It transcends our organisational structures and promotes “whole pathway" thinking that is blind to boundaries between primary, community, secondary and tertiary care and between directorates and localities. It also encourages prioritisation of prevention of disease alongside interventions, operations and treatments for illness.

We have divided our citizens into five groups: broadly by age. The exception is the stage for those who are at the end of their lives which represents predominantly but not exclusively older people. Based on the feedback we have received from engagement we have merged the “older people” and “frail elderly” life courses into “older people” as this was felt to better represent the breadth of patient care delivered in a single categorisation, which is otherwise duplicated. We considered that these citizens required a specific focus.

- Unborn and infant
- Children and young people
- Working age adults
- Older people
- End of life care

Set out below is the detail of our Clinical Strategy. Firstly we describe the Clinical Strategy using the life course approach; this will be our primary lens for viewing the Clinical Strategy. In the section which follows we describe what delivering our Clinical Strategy life course priorities will mean for our services by care setting.

4.5.6 Life Course - What should our patients and citizens expect from ABMU in 2017?

4.5.6.1 For Unborn and infants

Safe, high quality integrated and sustainable care, delivered by a workforce that is trained to high standards for the care of women and their babies during pregnancy, childbirth and postnatal care in a clinically appropriate location, recognising their clinical acuity and personal choice, to provide the best achievable outcomes.

Babies from across ABMU and Hywel Dda requiring specialist neonatal services will be delivered where possible in a unit which can offer this care and produce results which are comparable to the very best.

	Unborn and infants
Excellent Population Health	Fewer unplanned pregnancies, particularly amongst teenagers and fewer women who smoke whilst pregnant, reducing the number of babies that are smaller than normal and more likely to require neonatal critical care and to develop chronic illness in later life. The rise in the rate of obesity in pregnant mothers, leading to complicated deliveries is halted.
Excellent Patient Outcomes	Fewer "Caesarean sections" and fewer "small for dates" babies and babies requiring critical care. The current rate of home and midwife-led delivery maintained and robust transfer protocols are in place at all times. Plans to relocate midwifery, neonatal, Obstetric and in-patient gynaecology service from Singleton to Morriston progressing well. Reduction in number of babies suffering permanent harm during birth
Excellent People	A maternity workforce that meets nationally agreed standards for numbers and skill-mix (Birth rate plus) and midwife assistants who are deployed appropriately. The number of hours that a consultant Obstetrician is available on the labour ward has increased to 24hours a day and there are advanced neonatal nurses supporting regularly the care of newborn babies.
Sustainable Services	The agreed recommendations of the South Wales programme for neonatal critical care and obstetrics have been implemented in partnership with other Health Boards and the review by South Wales Health Collaborative of gynaecology has also been implemented
Strong partnerships	The maternity liaison strategy committee has increased engagement with hard to reach communities and partner organisations. Work with partners to reduce the rate of teenage pregnancy, smoking in pregnancy and alcohol abuse in pregnancy is planned, resourced and delivering to timescale

4.5.6.2 For Children and Young People

Safe, high quality integrated, and sustainable care, delivered by a workforce who are trained to the appropriate standards for the care of children and young people, in the clinically appropriate location as close to home as possible, which delivers the best achievable outcomes. 'Right service, right place, right time and right person'. Services should be tailored to meet children and young people's needs, and they should be engaged in how these services are planned and delivered. Our next event under ***Changing***

for the Better in May 2014 will launch our phase of work looking at Children and Young People's services.

	Children and Young People
Excellent Population Health	The rate of immunisation against common diseases reaches the national and WHO target for each so that we have "community immunity" and children are no longer at risk of serious outbreaks. The rate of obesity in children starting school and teenagers has reduced. Fewer children smoke regularly and there are fewer teenage pregnancies.
Excellent Patient Outcomes	Fewer children have to be admitted to hospital to stay overnight and the numbers who develop meningitis is below the current national average. The rate of diabetes in children has stopped rising. Fewer babies in ABMU need neonatal critical care.
Excellent People	Services have been reorganised so that there are 11 paediatric doctors on the rota and every child who is admitted is seen by a consultant within 12 hours. Vacancies of paediatric doctors have fallen. There are more paediatric advanced nurse practitioners in post. The number of children presenting to our hospitals is higher than needed to provide good training in paediatrics. There is integrated working between community and hospital teams, reducing the number of children admitted and shortening the length of stay of those that are.
Sustainable Services	With partners, the recommendations of the south Wales programme about paediatrics have been implemented: recruitment and retention has improved and the GMC evaluates our training programme favourably. We have sufficient neonatal critical care capacity to manage the demand at least 95% of the time.
Strong Partnerships	Parents and children are involved actively in planning their care ("co-production") and engaged on an ongoing basis to help plan, develop and monitor service changes. Third & voluntary sector organisations and local authority partners have collaborated to form integrated community teams for children and young people across ABMU. The rights of children and young people are always valued and respected.

4.5.6.3 For Working Age Adults

Everyone has the information to make the best lifestyle decisions, to stay healthy and to plan their health for older age. There is easy access to excellent support to stop smoking, reduce drinking or to lose excess weight.

Anyone with an acute illness requiring treatment is seen in the right place, by the right person at the right time as quickly as is necessary.

Sufferers of long term conditions feel empowered and supported to care for themselves in their own communities. Care is co-ordinated well between partner agencies and based in the community. Clear access routes to specialist care are available when required, with particular provision for those who are vulnerable.

Those planning a family can find good information easily about how to make sure they are as healthy as possible before conception takes place and what to do to make sure their baby has a good start in life.

	Working Age Adults
Excellent Population Health	It is easy to find excellent advice about lifestyle choices, how to stop smoking or reduce excessive drinking and how to get help to lose weight and eat healthily. Fewer women have unplanned pregnancies and the rate of smoking during pregnancy has fallen. Smoking rates amongst adults continue to fall. Everyone who comes in contact with a health professional is offered advice to stop smoking or reduce drinking if appropriate.
Excellent Patient Outcomes	Admissions for alcohol related diseases have fallen and the number of people with type 2 diabetes has stopped going up. More patients with asthma or diabetes access a specialist nurse or clinic in their community and fewer of them end up being admitted to hospital. Complications of receiving treatment or being in hospital are much less common.
Excellent People	There are sufficient staffs in our primary and community teams to provide support outside hospitals for people who require it. Capacity in hospital services matches demand. Staffs works in well resourced community teams with colleagues from partner organisations to provide excellent timely integrated care. There are sufficient advanced nursing and AHPs' to support new and different ways of working.

	Working Age Adults
Sustainable Services	Services in primary care are organised better in community networks where there are sufficient GP's and staff to provide the services needed in that community. There are plans to make sure there are enough GPs and dentists for each community. Less than 5% of people wait longer than the target time for planned treatment (26 weeks) and waiting times in emergency departments are shorter. We only offer planned treatments or procedures where the evidence for doing so is not proven in exceptional circumstances If we have changed a service, there are enough senior doctors on duty to meet the relevant standards and to make clinical decisions about you when needed. There are fewer vacancies for doctors on our staff.
Strong Partnerships	It is easy to know where to get good advice about lifestyle and how to stop smoking, reduce drinking and to lose excess weight. Those with long term conditions manage these better themselves better, agree jointly with their clinical team how their care will be provided and know how to get help when they need it. We work collaboratively with local authority and third sector partners to provide integrated and timely health and social care where you need it.

4.5.6.4 For Older People

There is “whole system” integrated care that enables people to live healthy and independent lives, engaged in their community. Older people have choices and control over their lives and the support we give them.

We recognise that many older people are in reasonable health and not frail but that where frailty exists we ensure that care we provide treats people as individuals. Therefore, there are a range of pathways, all of which aim to promote independence, prevent avoidable crisis and inappropriate admission to hospital or long term care.

Hospitals are for those experiencing acute illness or in need of medical or other interventions that can only be provided in hospitals and not in alternative settings. We work in partnership with frail people, their families and or carers, community and primary care services, secondary care, local authority staff and services and third sector organisations.

	Older People
Excellent Population Health	Older people who are frail and those with long term conditions get the opportunities and support to take care of themselves and to be independent. There are more choices for all citizens in our communities, ensuring that no one is disadvantaged in accessing information or preventative services just because of where they live. Everyone is empowered to take ownership of their own health, supported by family, carers and their local community. Our communities have been strengthened to provide a web of support for individuals, carers and families. We always work with partners to ensure that the importance of good housing on health and well-being is promoted in all their strategies and plans All our community network publicise the range of preventative and early intervention services that they have, and these are designed in collaboration with key partners to meet local needs. Our communities have innovative improved community resilience, offering education, friendship and support through existing or new community hubs and networks with the support of the Third Sector. This may be built on initiatives such as "time-banking", befriending and social enterprise. There is good information and education provided locally supporting everyone to own and improve their personal health and wellbeing, including the self- management of long term conditions where appropriate. Older people are assessed and supported to have healthy foot care, oral health, nutrition and continence. There is a community Falls Prevention programme, ensuring that people are safer in their own homes. There are strong Expert Patient Programmes (EPP) helping people have newly diagnosed with a condition to give them the confidence to manage their own health. Every older person and their Carers receive comprehensive information on discharged from hospital so they know what to expect when they get home. Many more people have 'Flu and pneumococcal vaccination, breast and cervical screening (for women in 'at risk' groups), bowel cancer screening and regular eye and hearing tests.
Excellent Patient	We create a set of clear standards for the care of frail older people in Accident and Emergency and general medical

	Older People
Outcomes	and surgical wards We monitor global measures of wellbeing, including levels of community engagement, citizen feedback via focus groups and the amount of community education programmes being delivered We engage with local community groups to ensure information is up-to-date, relevant and easily accessible to the general population and we monitor the numbers of people being assessed, screened and vaccinated for potential illnesses Every older person who has a "low impact fracture of a bone is offered measurement of their bone fragility and appropriate treatment. People are never far away from a community venue or resource centre that can provide information and support and we have rich data and equipment available se we can monitor people who are unwell remotely and intervene when necessary.
Excellent People	All our professionals have the right skills and competencies to provide complex care in the community and are organised to be able to manage demand effectively. We train our staff alongside those from other agencies allowing the core common knowledge and skills. There are joint competency based programmes using innovative methods to embed service change principles. All of our staff have education and training to care for older people. All of our staff to have competencies in dementia, delirium and care of people at the end of their lives. All of our staff have the appropriate values and behaviours to provide high quality, compassionate care for older people. Our staff are equipped with the necessary skills and tools to be able to support people to be independent in a holistic way and signpost them to good information and advice on self care All professionals know about patient's unpaid carers and the significant contribution they will make to care, as well as the skill and competency levels in community teams and the capacity and capabilities of any third sector providers, so that they are confident to discharge people into a community web of support.
Sustainable Services	People can continue to live at home and perform daily tasks irrespective of the limitations imposed by their frailty or long term condition through better access to equipment, aids and housing

	Older People
	adaptations. There is better access to public transport alternatives so they can access the services they need. We allocate Finance and resources based on population needs and value not historical processes and criteria We use Information and technology so that we can provide effective and timely intervention by professionals, giving coordinated care, record sharing and innovative solutions for people living in the community. We also avoiding duplicating the information we ask you for or the care that we give. Our integrated community teams are co-located, maximising team-working and making best use of public sector buildings. Our community resource centres are the hub of community specialist care, for people who need the limited support to help them recover following an illness. We use Telecare and Telehealth assistive technologies more to support frail and older people to be independent in their own homes and provide additional confidence and help for carers and reduce demand on acute hospital care. We share information between sectors of care better and to combined records and assessments, so that we provide a more seamless service minimising duplication. There are effective alternative pathways for people with conditions traditionally transferred directly to hospitals for treatment so that care is administered quickly in the community in partnership with community services and Welsh Ambulance Services Trust (WAST). If you need some equipment, our community staff can provide it quickly, especially for emergency/rapid assessments. Your GP or community team can get specialist advice easily from hospital based staff without always needing to send you to the hospital Older people with mental health needs get a responsive and equitable service from Local Authority and Health Older Person's Mental Health Teams that are fully integrated. Our hospitals are appropriate environments to provide excellent care for older people.
Strong	There is a clear, common model for community services across the Western Bay partnership that recognises local variation is

	Older People
Partnerships	needed at times. The foundations of the model are built around: • Common practices and core standards of care across community teams that create a proactive rather than reactive individual care pathway away from hospitals to community • Common outcomes and performance measures, ensuring minimum quality standards that don't differ depending on where people live. • Moving from a 'push' system that is fragmented and disorganised to a 'pull' system of integrated community services: • Realignment of resource flows from secondary into community as well as realignment within the community setting • Defining need from the 'bottom up' rather than as a 'knee-jerk' reaction to pressures in the acute hospital sector; • Partnerships are developed to enhance minor housing adaptation programmes and home maintenance where levels of support are based on need, not tenure. The more specialist element of community care, largely concentrating on Community Resource Teams, is our main focus in order to address current pressures in the system. These teams will include as a minimum: • Access to community health and social care services via a single point of contact, so that people can be directed to the right service quickly including appropriate support offered by our partners in the third sector. • Urgent (health and social care) needs assessment which is holistic but proportionate and is based on full sharing of information between professionals, supported by appropriate governance arrangements • A robust medical model that supports admission avoidance and helps to keep patients within their own homes. • Tailored packages of care that respond to health and social care needs quickly but are based on individual outcomes rather than 'one size fits all' services • Rapid access to community equipment and aids, including Assistive Technology • Emergency care at home • Integrated reablement services that focus on outcomes and potential for improvement and which does not exclude people on the basis of cognitive impairment • 7 day availability, 365 days a year • Generalist as well as specialist skills within each team • Intermediate care and falls services

	Older People
	• Robust partnerships with WAST Advanced Paramedic Practitioners (APPs) • Integration with Older People's Community Mental Health Teams to access specialist intervention for those with dementia • Provision of services based on need so people with cognitive impairments are not excluded from services if they can benefit

4.5.6.5 For those at the End of Life

People have a realistic approach to dying and plan appropriately for the event. People at the end of their lives have access to high quality care whatever their underlying disease or disability. High quality end of life care is provided by ensuring that:

- End of life care needs and preferences are identified and communicated effectively, where this is wanted by patients and their families
- The care received by people approaching the end of life matches their needs and preferences.
- During the last year of life more time is spent in the preferred place of care.
- There are fewer deaths following unscheduled admission, if the person did not wish to die in hospital
- There are fewer deaths in inappropriate places such as on a trolley in hospital or in transit in an ambulance.

	End of Life
Excellent Population Health	There is greater public awareness of end of life care issues especially about children's services for end of life care and there is good planning training and implementation of advanced care directives
Excellent Patient Outcomes	There is a Single point of contact for End of Life Care for everyone that needs it. We have improved the provision of End of Life Care for people within all our Intensive Care Units through more comprehensive training For people diagnosed with Dementia, End of Life Care has

	End of Life
	improved through better protocols and training Services for people with other diagnoses that are not cancerous such as continuous obstructive pulmonary disease (COPD) and those for frail older people are available and strengthened For those dying in hospital, the AMBER care bundle is always used. If equipment is needed for end of life care at home, it is provided quickly. We have implemented fully a policy for when not to Attempt Cardio Pulmonary Resuscitation (DNACPR) More people can be supported to die within their own homes (including care homes) if that is their wish
Excellent People	All clinical staff have training in care of patients at the end of life. Appropriate staff have better training to identify those at an early stage who would benefit from End of Life Care, particularly in dementia and in children's palliative care. Our staff receive communication skills training to help discuss end of life matters with patients and their loved ones. There is more capacity for research with our University partners into end of life care
Sustainable Services	Advice and support for parents of children at the end of life is available 24/7 Services for patients dying for reasons other than cancer are improved to match those for people with cancer Our community teams have more capacity to support adults and children at the end of life and so avoid unwanted hospitalisation
Strong Partnerships	Health and Social Care at the end of life is improved and co-ordinated through 'Changing for the Better' and the Western Bay Partnership. There is improved pharmacy support for end of life care. There is better sharing of information about end of life care and better co-ordination between primary and secondary care and social care systems There are strong research collaborations in end of life care to

	End of Life
	improve how it is delivered

4.5.7 Settings of Care

Our clinical strategy will see more of the care currently provided in hospitals, delivered in different settings: usually in or near a person's home. Here we set out how our services will look in future from the perspective of the setting of care. This will help our staff and patients understand the scale of change that we envisage.

A person's home
Older people will be helped to remain in their own homes as long as possible because we will be proactive about spotting the signs of illness and frailty developing and offering help at that stage, rather than waiting until it has caused problems. This might mean giving expert advice to reduce the risk of falling at home or providing support if there are early signs of dementia for example. Sometimes we will offer technological solutions ("Tele-care") to give older people and their families' confidence to carry on living in their own home. Citizens with several long term conditions often take lots of different medicines and this can be confusing. If they are taken in the wrong way it can cause health problems. We will offer more help for people who live at home to avoid mistakes with their medicines. We know that loneliness and social isolation can also lead to physical and mental health issues and we are developing schemes with our citizens and partners to help address that. We will also work with others to make sure that everything is being done to help older people improve the warmth of their homes. For children, particularly those with long term conditions or disability, we will help them to avoid coming into hospital, again offering treatment in the home if it is safe to do so and will improve communication between hospital teams and community teams. We need to support and help patients to be independent and manage their chronic condition effectively and to extend the types of services that help people to do this such as specific rehabilitation schemes that help patients with chronic conditions such as Chronic Obstructive Pulmonary Disease, who can benefit from structured, supported exercise programmes, often run in local leisure facilities. We will continue to support the vast majority of people with Mental Health, Substance Misuse and Learning Disabilities issues to maintain their independence and live independently in their own homes by providing services within local communities. We will encourage patients to become self caring and to use their local community pharmacist as a source of advice and expertise when they have a time limited

A person's home
minor illness (such as coughs and colds).

Primary and Community care
We want people only to have to go to hospital if it is absolutely necessary: in future more care will be available in primary and community settings and there will be better sharing of information between those teams and the teams in our hospitals to help that. We will be investing in "intermediate" care services and joining up with colleagues in social care more than we do now. There will be a "core" level of service that is standard across ABMU and will have social workers and healthcare staff working in the same teams and sharing offices so that there is much less duplication and confusion. Citizens will be able to contact one number and the right person will attend to their need. When we find someone who is frail we will allocate them someone to co-ordinate their care needs and tell them who that is and how they can contact them when they need to. We will also make it much easier for everyone to get equipment they need, even if it is urgent so that they don't need to go into hospitals for the sake of something that could help them stay at home. We know that our GP's and their staff are under a lot of pressure at the moment. We are working with them and their representatives to see how we can support them to provide more care locally for patients. Our GP practices already work together in groups together with other partners in local government and the third sector: we call these community networks (CN's). These will become more important in the future and will help us to respond to the needs of local communities better. We expect that there will be ten such networks across ABMU by April 2015. Each network will care for between 30,000 to 50,000 people and will include strong links with other organisations, including third sector organisations that can complement the services provided by health and local government in a very effective way. There will be a primary care support service in place. The CN's will be aligned with community teams (including services provided by teams of district nurses, social workers health visitors and midwives) and we are planning to invest in technology to help them share information better between themselves and also with hospital staff, so that patients don't have to keep repeating information and the risk of confusing things is reduced. Our mental health community teams will be better co-ordinated with the other community teams so that care is co-ordinated better. The networks will bring a range of services together so that professionals working in communities can plan to meet the needs of their network populations, and to support and encourage new care models in community settings. We would also like to strengthen networks by devolving responsibility for some community resources to the networks so that there is greater flexibility within local teams to

Primary and Community care

innovate and develop new services

These developments will mean that General Practice will continue to be based in local communities but will increasingly operate as the "hub" of a wider system of care. One of the benefits of organising care in this way is that specialist expertise can be shared across individual practices to avoid patients having to attend hospital. It does mean however, that for some services, patients may receive some services outside of their usual General Practice but day to day care will continue to be provided locally and patients will still have a local GP practice. We will be encouraging practices to work together to meet the needs of patients within care homes – who are often frail and vulnerable, so that we provide tailored care, that is based on a care plan that anticipates patients needs. Many patients express a wish to die in their own home, rather than in a hospital setting, and we need to do more to be able to respect their wishes and support end of life care in settings other than our hospitals.

In view of the challenges for general practice recruitment and expansion we will need different workforce models in future (see section 7). There is likely to be a shortfall in the number of GPs required to meet the current and future demand as a result of the growing numbers of older people, but also the increased complexity of need in our communities. We will work with GP's to develop services specifically for those with several long term conditions.

We will also continue to invest in primary care facilities. We already have schemes underway in Mayhill, Brynhyfryd, Vale of Neath and Briton Ferry and these will be fully developed by 2017. There are other priorities within our plan to resolve issues with some of the primary care estate where there is a lack of physical space, and or problems with suitability of the accommodation.

We will explore the potential to undertake more surgical elective work in primary and community settings. This could include a range of minor surgical procedures including vasectomies. This could help to free up hospital capacity to focus on the delivery of more complex cases that can only be undertaken within a hospital setting. Further discussions on the benefits and costs of this approach will take place during 2014/15 and plans will be considered by the Changing for the Better Programme Board in due course.

We are also asking our community pharmacists how we can support people who live in residential homes better with their medication and advice and what other services they could offer for our patients. There is a need for community pharmacists and GPs to work more closely together to deliver joined up care and we will use the networks to encourage these relationships. We need to use the expertise available in community pharmacists where there is significant potential to support patient's independence and their ability to self care, and also to manage their medications with help from pharmacists. Our vision is that more patients will become 'experts' in their own condition and will know when and where to seek help from the right professional, at the right time.

We will work with our general dental practitioners to make sure that all citizens

Primary and Community care
benefit from implementation of the "Oral Health Plan" and will provide information to help people look after their own oral health better. We will use the skills of local opticians to make it easier to get eye care locally and make it quicker to see a specialist if needed. We will offer more patients the chance to have subsequent "follow up" for some eye condition by visiting their community optometrist. In support of our Learning Disability Framework we will further develop our integrated health and social care teams and our Tiered approach to Learning Disability services. We will also develop fully integrated services and formal partnerships utilising such mechanisms as section 33. Our Mental Strategy supports the delivery of services from Tier 0 to 4 on a multi-agency basis for people with mental health problems and dual diagnosis.

Our Hospitals
All Inpatient Facilities All of our inpatient wards will be reviewed to ensure that they provide appropriate environments for older people. In particular design considerations to support appropriate, continence, dementia and end of life care will be reviewed.
Morriston Hospital For some time, Morriston has been a major acute centre for South West and West Wales. However, it does not have maternity and a critical care unit for newborn babies which would normally be expected for such a centre. We will develop plans to move these from Singleton to Morriston as soon as we can. However this is unlikely to take place during the next three years because it will require building at Morriston. Morriston has the major emergency department for the area and will be an important centre for multiply-injured patients as part of a new trauma network that is now being planned for South Wales. We are developing plans to meet the highest standards for trauma care as part of this network. We want patients who come as an emergency to our hospitals to be seen by a senior doctor as soon as possible after they attend if they need to be admitted, every day of the week. We cannot do this at the moment and so we are considering how we could make Morriston the hospital where all such patients are taken from Swansea and Neath Port Talbot areas.

Neath Port Talbot Hospital

Neath Port Talbot Hospital has been through significant change in recent years. It is our newest hospital and will continue to have an important role in our network of hospitals. We will move more of our shorter stay surgery there and make best use of the excellent X-ray and diagnostic facilities, such as endoscopy. The IVF (fertility) service for South Wales is now based there and a specialist urology diagnostic centre will open shortly. The regional neuro-rehabilitation centre is well established after its move from Morriston and we will complete consultation shortly on plans to build a new acute mental health admissions and assessment unit in the grounds for the whole ABMU area, replacing the Victorian facilities at Cefn Coed hospital.

Princess of Wales Hospital

The South Wales Programme is considering the future of four of the many services in this hospital: obstetrics, neonatology, in-patient paediatrics and consultant led emergency medicine. This is expected to report shortly. It is likely that Princess of Wales and the Royal Glamorgan Hospital will work more closely together in the future to provide a full range of services and that many existing services at Princess of Wales will continue to be provided as now. Plans for the hospital will be developed further once the outcome of the South Wales Programme.

Singleton Hospital

We will transfer in-patient gynaecology, maternity and neonatal care and also the ENT ward to Morriston when we are able to do so. We expect that in the future Singleton hospital will focus increasingly on providing excellent outpatient, ambulatory / day case and diagnostic care for people who live in Swansea. There may also be a role for “step up” care for patients from the community needing a short period of hospital care.

We would like to strengthen our links with Swansea University at Singleton in the future to offer clinical education in new and innovative ways of delivering care from this site through health-science collaboration.

We are considering transferring some more of the “medical take” from Singleton to Morriston to allow us to offer seven day a week senior doctor assessment for acutely ill patients in Swansea and Neath Port Talbot. This may require the acute cancer in-patients to transfer to Morriston but we will continue to provide outpatient / ambulatory chemotherapy and radiotherapy at Singleton as well as treatment for those with minor-injuries. Short stay and day case surgery will continue.

We are celebrating the opening of the new children’s development centre at Singleton, , which will transform the experience for children with complex disability and their families: bringing together therapies and medical assessment and care from across several sites into a purpose designed centre

Cimla Hospital We are developing Cimla as a base for our Community Resource Service We do not expect there to be a GP practice on site but it will be a hub for community teams and services.
Maesteg Hospital We will develop plans to use vacant space in Maesteg to accommodate a GP surgery alongside the community teams
Gorseinon Hospital As well as community services, this hospital will continue to have some in-patient beds for rehabilitation. We are working with City and County of Swansea to develop an innovative joint management arrangement of them.
Cefn Coed We will continue to move patient care out of the older buildings at Cefn Coed hospital. The next phase of this will be the development of an acute admissions unit for the Health Board at Neath Port Talbot Hospital.
.**Glanrhyd Hospital** The plan for the clinical accommodation is well defined with the last element being the Low Secure Unit which is planned for completion in December 2014. We will review the non clinical accommodation during 2014/15 to determine what further rationalisation could take place.

4.6 Workforce

We recognise that in order to respond to key themes for delivery of the strategy we must change significantly the way in which we work. This is explained under the life course text above and in the Workforce and OD Section 7. We will need to ensure that we have the appropriate balance of skills, competency and capabilities to meet future demands, incorporating the:

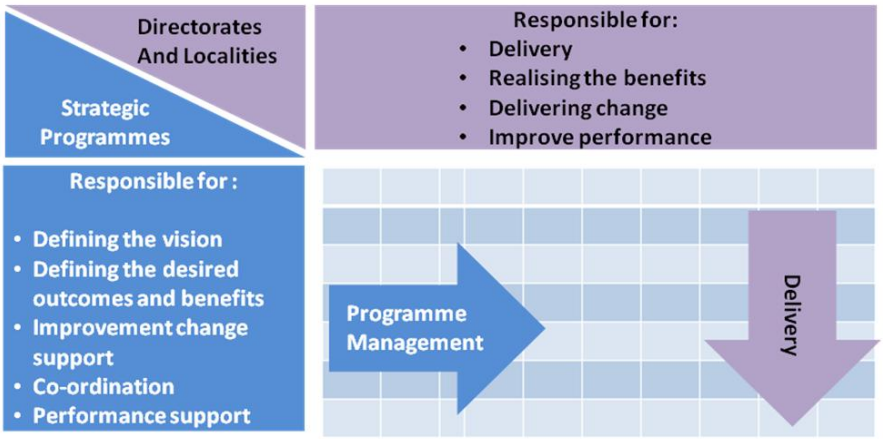
- Engagement of staff in quality improvement
- Education and training of all clinical staff caring for older people
- Commitment that a greater proportion of our staff will be involved in delivering care outside hospitals, near or in peoples own homes
- Strengthening primary and community teams and developing integrated teams with social care and the third and voluntary sectors.
- Relocation of care settings, including those services incorporated in the hospital setting

4.7 Delivering our Plan

4.7.1 Strategic Change Programmes

As mentioned earlier in this section, we have set up seven Strategic Change Programmes to support the delivery of our Plan. These Programmes are well established and are developing implementation plans, setting out the actions required to deliver the objectives of the Programmes. Once plans have been agreed, these will be assigned to the relevant Locality/ Directorate or Corporate Department for implementation. This approach is illustrated in diagram below.

Figure 14 : Relationship between Strategic Programmes and Directorates and Localities



Detailed descriptions of each of these Programmes is provided in the sections of the document outlined in the table below.

Table 24 : Document structure and referencing of programmes

	Strategic Programme	Detailed Description
	Commissioning Development Programme	Section 9 Building Capacity and Delivery
	Patient Safety Programme	Section 5 Quality Improvement
	Patient Experience	Section 5 Quality Improvement
	Surgical Pathway Efficiency	Section 6 Service Change Plans
	Patient Flow / Unscheduled Care	Section 6 Service Change Plans

	Changing for the Better (C4B) Programme	Section 5 Quality Improvement Section 6 Service Change Plans
	Effective Use of Information Systems and Technology	Section 9 Building Capacity and Delivery

These change programmes have been prioritised by the Health Board Executive Team as key to the delivery of our strategic agenda.

4.7.2 Community Networks

Our community networks will be an important vehicle for delivering the clinical strategy of the organisation. We plan to develop these networks to fulfil the following key functions:

- **Improving population health and tackling health inequalities**

  The Community Networks will become key vehicle for developing and assessing information about local health needs as a key component of community network plans and informing more effective resource management. They are ideally placed to support improvements in population health and progress health promotion initiatives such as targeting obesity, smoking, alcohol and teenage pregnancy, working closely with the third sector to maximise community resilience.

- **Developing and expanding primary care services**

  The Community Networks will be responsible for the development of primary care services within the network, recognising the ongoing importance of the contractual relationship with individual practices, but encouraging practices to work together more effectively and share skills and expertise. The development of a clear capacity and workforce plan for primary care as part of the overall network plan will be essential and this will provide an opportunity to consider new ways of working in relation to priority areas such as access and frail older people. The networks will have authority to utilise enhanced services budgets in more innovative ways, oversee prescribing budgets and to employ and manage staff to support primary care. The networks will have a clear focus on the quality of care delivered within a network using data to drive a focus on quality and service improvement [e.g. through tools such as SAIL).

- **Managing community health services**

  The Community Networks will have direct management responsibility and accountability for delivering improved community health services for the network population (with the exception of specialist community services which cannot be divided into community networks). This will include budgets and direct management of staff. The networks will have a key role in developing pathways for long term conditions, end of life care and frail older people.

- **Shaping service integration with social care**

  The Community Networks provide a vehicle for shaping the development of integrated care in conjunction with Local Authorities. This could include the delivery of the social care services provided /commissioned for the network population such as social work services, occupational therapy, and home care. To start with the networks will focus specifically on the needs of particular groups such as older people with complex conditions, using risk stratification tools to identify and share information on vulnerable patients, agreeing how services will be reshaped to meet need, inputting to the development of commissioning plans for social care.

- **Developing pathways between primary and secondary care.**

  The Community Networks will have a different relationship with relevant secondary care services, incorporating the direct management of some staff and resources traditionally located in secondary care - for example, in relation to care of the elderly – and redesigning pathways and service models in these areas. For other secondary care services – for example, in relation to chronic conditions, end of life care – the Community Networks will have a more defined relationship with secondary care through specific service level agreements setting out the input needed for their population to maintain them out of hospital as far as possible. The service level agreement (SLA) may include access to Consultant advice, support from specialist nurses, outreach clinics, discharge information etc.

The Community Networks could also be a vehicle for delivery of other relevant services delivered in the community such as mental health – particularly in terms of the local primary care support service and dementia services. The third sector will have a significant contribution to make to this approach. By having a local ownership and control, the networks will be able to work with third sector organisations, maximising the potential contribution of not for profit and voluntary sector services within an area.

Further work will be needed to achieve the new vision of community networks. Over the next few months we will be working with our communities to design the governance and organisational arrangements that need to support the networks. In particular we will need to identify the financial mechanisms to enable networks to be appropriately resourced.

The new GMS contract changes from April will encourage practices to work together within network areas and will incentivise practices to develop pathways that support frailty, end of life care and the early detection of cancer, as well as promoting good access to primary care services. The contract changes also remove some of the treadmill of bureaucracy and allow GPs to spend more time with their most vulnerable patients, particularly frail older people.

4.7.3 Welsh Government Local Delivery Plans

The table below provides a summary of our progress in developing the Welsh Government Service Delivery Plans. These plans will support the delivery of both national priorities and our local objectives.

Delivery Plan	Commentary
• Stroke • End of Life • Cardiac • Cancer • Unscheduled Care • Maternity • Oral Care • Critically Ill • Diabetes • Respiratory	Delivery plans have been developed. Where relevant, actions are also incorporated into Locality and Directorate IMTPs Final draft of respiratory plan received in April 2014. Health Board plan is to be developed.
Mental Health (Together for Mental Health)	Local Annual Report submitted to the Local Partnership Board
• Neurology • Eye care	Plans are in the process of being developed, which will include action plans and identify lead responsibility for delivery.
• Local Health Care	See 4.7.2 in process of engaging with local stakeholders, which will lead to the development of a Community Network Plan

4.7.4 Tier One and Local Performance Targets

We have worked with clinicians and managers to develop trajectories for each of the Tier One targets, as well as a range of local performance targets e.g. endoscopy. We have identified the actions required to deliver these targets and lead responsibility. This information is set out in Appendix B1

Performance against trajectories and agreed actions will be reviewed via the existing monthly performance review mechanism with Directorates and Localities.

Areas where we will be providing particular focus are the delivery of actions that will be taken to deliver the required targets under all stroke bundles, RTT, cancer and unscheduled care. As the IMTP is implemented and the benefits from other Strategic Change Programmes are realised we will review the scheduled care assumptions for RTT, cancer, diagnostics and follow ups not booked (FUNB), to ensure that we are making the most efficient and effective use of all of our resources to deliver the required capacity to meet these targets.

4.7.4.1 Stroke Bundles

We have developed plans detailing actions that will be taken forward to deliver the required targets which include:

- Centralisation of the admission of stroke patients in Swansea to a dedicated stroke unit based on Ward F in Morriston (this service is currently provided across Singleton and Morriston).
- Recruitment of an Early Supported Discharge Team to support stroke patients in the community.

The above actions will ensure there is always a stroke bed available and there will be no wait for stroke patients to be admitted. Access to a dedicated bed is currently an issue.

Plans are being developed in 2014/15 to replicate this model in Princess of Wales Hospital by creating a dedicated stroke unit. Work is underway to develop plans to ring fence 2 beds to minimise delays in admission.

4.7.4.2 RTT/Endoscopy

Detailed delivery plans have been completed for all specialties with a backlog of patients waiting over 36 weeks for treatment as at February 2014. These include:

- Gastroenterology (all related to Endoscopy waiting times)
- Plastic Surgery
- Cardiac Surgery
- Orthopaedics
- Spinal
- General Surgery (30% related to Endoscopy waiting times)
- ENT
- Urology
- OMFS

- Gynaecology

The funding to support the backlog is included in the finance section of this plan. Monthly trajectories have been produced for each of the above specialties in line with the following actions:

- Build on the robustness of our existing capacity plans and operational processes;
- Inclusion of the impact of the efficiency gains linked to the Health Board's strategic change programmes.
- Implementation of the recommendations of the Endoscopy and Colonoscopy Task and Finish Group via the Endoscopy Board

These trajectories will be monitored weekly to ensure any deviations against profile are managed with early intervention.

4.7.4.3 Cancer

A robust Executive lead approach has been put in place for the management of the 31 and 62 day access performance since the second quarter of 2013/14.

Significant progress has been made in the last 9 months relating to the process management of patients on these pathways which has resulted in improved performance. However, performance in Urology has not improved as anticipated. Therefore the main focus for the Health Board in first quarter of 2014/15 is ensuring that all actions included in the Urology cancer delivery plan are completed.

We will continue to manage the performance weekly as well as manage the interface with our tertiary providers. We will also receive a weekly report on progress with any patients on the tertiary element of the pathway and ensure prompt escalation of issues via the agreed arrangements with other Health Boards.

4.7.4.4 Diagnostics and follow ups not booked

We are in the process of finalising profiles for diagnostic waits and delayed follow up numbers, which will show a reduction during year one and beyond. These profiles are supported. Actions for delivery of these profiles is set out in Directorate and Locality IMTPs.

4.7.4.5 Unscheduled Care

Over the last 12 months we have experienced high levels of emergency pressure which has severely affected our ability to carry out elective activity

and the number of cases cancelled due to lack of available beds continues to impact significantly on the core capacity delivered.

Delivering sustainable unscheduled care services remains a top priority and key challenge for the Health Board. Our current projections aim to achieve 95% by year end against the 4 hour target of 95%. Our approach to the delivery of this important target is through the Strategic Change Programme - Patient Flow/Unscheduled Care.

The programme commenced in 2013/14 was and is underpinned by the implementation of:

- A dedicated team focusing on patient flow and delays for patients staying over 15 days
- Consultancy support and intervention from Finnamore into the Emergency Departments
- Investment in a range of capacity and staffing initiatives including increased senior decision making and introduction of 7 day working in a number of areas.

At Morriston hospital a number of the initiatives supported to improve patient flow and performance did not take effect until Quarter 4, following which there is evidence of incremental and sustainable improvement in performance against the Tier 1 targets. This improvement has continued into the first quarter of 2014/15.

At the Princess of Wales Hospital a number of initiatives supported in 2013/14 are only beginning to come to fruition in Quarter 1, largely as a result of lead in times to recruit additional staff in hospital and community services, alongside the implementation of new models of care as outlined below.

- establishment of the AMU(22/4/14) – initial evaluation is positive but there are flow issues from the unit to the hospital, which are being addressed
- consider the establishment of a Surgical Assessment Unit – Quarter 2 2014/15
- commencement of 4 Advanced Nurse Practitioners(6/5/14) who should have an immediate impact on reducing and ultimately eradicating any delays in minors(completing their induction this week)
- Increased clinical engagement and action to address the breach reasons including delays in initial assessments, specialty reviews and management of the service out of hours. The latter is linked to work to improve 'Hospital at night' services
- the appointment of a new Community Geriatrician who commenced on 22nd April 2014 and will take the lead in developing frail elderly services and alternative pathways to prevent admission.
- 2 new Consultants in ED taking up post until Sept 2014.
- Appointed an ACP (15/5) and a further post to be advertised.

- 2 replacement Cardiologists - interviews early July
- 2/3 CoTE posts– adverts 2/3 weeks
- Chief Nurse reviewing staffing levels in ED/AMU

The early part of 2014/15 will focus on consolidating the initiatives commenced at the end of 2013/14, and then realising further sustainable improvement through

- the full implementation of the Finnamore recommendations to improve the 'front door' of our hospitals,
- implementation of additional prioritised investment to deliver increased hospital and community capacity,
- the spread and mainstreaming of the patient flow programme, in association with the 1000 lives improvement and National collaborative.

Building on these plans and investment in services in 2013/14, we are moving toward a sustainable improved delivery of the unscheduled care targets. There is however a range of factors that will affect the sustainable delivery of the unscheduled care target and whilst plans are in place to mitigate these risks, more sustained manifestation of the risk, or risks impacting in combination will affect performance. The key risks are set out below: -

- Fragility in medical staff in the Emergency Departments and Acute Medicine at both Morriston and Princess of Wales Hospitals.
- Timescales to embed the roll out of sustainable service improvement via the Patient Flow Programme.
- Impact of infection issues arising from limited cubicle facilities
- Impact of factors such as 'flu and cold weather.
- Limitation of current service configuration e.g. medicine model for Swansea and capital availability to address this.
- New pressures emerging at Morriston Hospital as a result of specialist service provision e.g. vascular services and major cancer work.
- Impact of capacity pressures in GP out of hours (GPOOH) and increasing difficulties in filling shifts.
- Impact of capacity pressures in independent sector, particularly in Bridgend.
- Lead in time for Community Resource Team (CRT) expansion which is designed to improve patient flow.
- Change in Deprivation of Liberty Safeguards which may lead to additional congestion in hospital beds.

4.7.5 Underpinning plans

There are a number of underpinning plans, which also support the delivery of the IMTP. Whilst Strategic Change programmes are our driver programmes, these will not be delivered without support across a number of disciplines. Listed below are the underpinning plans that support delivery of the overall plan. The content of these plans is described in sections 6-10.

- Quality
- Workforce and OD
- Finance
- ICT
- Estates
- Planning & Commissioning

4.7.5.1 Locality and Directorate Integrated Medium Term Plans (IMTPs)

In addition to these, each Locality and Directorate has developed their own local IMTP. These local plans have been generated as part of our strategic planning process and have informed the development of our IMTP. The plans describe how each Locality and Directorate will support us in delivering our three year plan.

4.7.5.2 Prioritising local initiatives

In order to increase workforce engagement in the planning process and to promote openness and transparency in decision making, we have also used the planning process to prioritise proposed service initiatives. This process has been led by the Department of Public Health and has involved senior clinicians and managers ranking initiatives against a list of agreed weighted criteria. The process has concluded and the outputs will be used to inform Executive Group decision making on investment in local initiatives.

At this stage this ranking has been limited to consideration of local initiatives only. It is planned to extend this process to include all initiatives in the following years. These local initiatives are described in the local IMTPs. The detail of these initiatives is not included in this Integrated Medium Term Plan, as they are many in number and at a micro level of detail. However they are factored into the overall financial plan for the Health Board and their alignment to our strategy and clinical strategy have been tested and agreed.

4.7.5.3 Single Integrated Partnership Plans

Our three Localities will also be working with local partners to support the implementation of local Single Integrated Partnership Plans (SIPPs) and the development and strengthening of our emerging plans to develop Primary Care led Locality Networks.

5 Quality Improvement

Ensuring that we consistently deliver high quality care 24 hours a day, seven days a week is our absolute priority. Changing for the Better will become our Programme for quality and service Improvement and will incorporate two existing strategic change programmes: "Patient Safety" and "Patient Experience". This section describes how we will achieve this aim

5.1 Our ambition

The main objective of our Quality Improvement programme is consistently to deliver high quality care 24 hours a day, seven days a week, and to demonstrate continuous improvement in outcomes that are valued by citizens and patients. This recognises that they are equal partners with us and that we need to 'walk in their shoes'. We will do this by engaging with our staff, listening to our patients, being open and honest and acting on what we hear.

We will ensure our staff have time to engage in quality improvement; do their job to a high professional standard and at the same time, improve their job. We will ensure that they are clear about:

- the aim of the improvement they want to make;
- the measures they will use and;
- changes that will make an improvement.

Our intention is that quality will be a golden thread running through the delivery of all our services in primary, secondary and community care, and in our commissioning of services. Partnership working with Local Authorities and the Third Sector will be pivotal in shifting the balance of care provision to community settings, reducing reliance on secondary care whilst delivering high quality secondary care services.

During 2014-5 the Medical Director and Director of Nursing and Patient Experience will bring together existing quality, safety and experience initiatives into Changing for the Better, creating: a single quality and service improvement programme that will address both national and local quality and challenges.

We will redesign our systems to implement agreed best practice standards of care for all our patients, and routinely use "care bundles" to deliver high quality, reliable, consistent care. We will have a zero tolerance for poor care, "never" events and avoidable harm, and we will measure ourselves against the best and not just the average. We want to ensure that poor care or poor

patient experiences are never tolerated and that we have the confidence of our citizens, our patients and their families in the care we provide.

We will be open and transparent, reporting how well we are doing at each Public Board Meeting and every year in our public quality statement and will review our priorities annually to focus on where we need to improve further. We will also capture validated measures of outcomes valued by patients in patient reported outcome (PROMs) in all major service areas by March 2017. We will also ensure that all staff receive quality improvement training (IQT).

Our quality improvement work will be informed by information and feedback from patients and carers. Specific initiatives to increase the scale of this feedback are being implemented through a patient experience programme. We know that our systems for collecting information about safety and quality need to be improved and we will do this during the duration of this plan. In particular we will implement processes to capture at scale the experience of our patients and will work with our University partners to combine these with other sources of information (e.g. complaint, incidents and praise) to create an "experience dashboard" for the Board. To scrutinise our performance and to demonstrate our commitment to safe and excellent care the Board will set aside 25% of the time in its meetings to discuss these items.

Finally, through appreciative enquiry we will learn from our considerable success in preventing hospital acquired pressure ulcers, improving stroke care and implementing Enhanced Recovery after Surgery (ERAS) to spread knowledge of system redesign and delivering consistently high quality in all services throughout the Health Board.

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5.2 National Context

Tragic failings such as those reported in February 2013 by the ***Robert Francis Report*** into Mid-Staffordshire NHS Foundation Trust have confirmed the importance for the Board of robust and effective processes and systems for assuring the safety and quality of our services.

The ***Berwick Report (2013)*** outlined the importance of all health organisations, whether they provide or commission health related services, placing the quality of patient care, especially patient safety, above all other aims by:

- Engaging, empowering and hearing patients throughout the entire system at all times.
- Fostering the growth and development of all staff including their ability and support to improve the processes in which they work.

- Embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

These are important principles which have been echoed in ***Delivering Safe Care, Compassionate Care',*** the Welsh Government and NHS Wales's response to the ***Robert Francis Report***.

Delivering Safe Care, Compassionate Care describes the outcomes that we want to achieve and which will contribute to:

- Achieving shared values and expectations
- Doing the right things well
- Being a listening organisation – knowing how well we are doing
- Being open, honest and transparent in all that we do
- Ensuring strong & effective leadership at all levels

A review of published research has highlighted that typically across developed economies, 5 -10% of in-patients experience avoidable harm during a stay in hospital and that hospitals may have about 40 preventable deaths per year. The most common categories of avoidable harm include:

- Healthcare associated infections
- Medication errors
- Delays in diagnosis and treatment
- Venous thrombo-embolism
- Falls in hospital

There is significant opportunity to reduce avoidable harm to patients; although our patient safety performance compares well with other Health Boards in Wales, we acknowledge that we can do even better, particularly in respect of Healthcare Associated Infections.

National and international evidence confirms that many of the common causes of avoidable harm can be reduced to very low levels or in some cases eradicated by mandating proven practice and care bundles.

The ***1000Lives Improvement programme*** continues to support learning and to spread best practice across NHS organisations and provides an important focus for Quality Improvement methodology. We work closely with the programme and in collaboration with other Health Boards to implement evidence-based change that results in quality improvement.

5.3 Local context

During 2013-4 we reviewed the quality of our services against expected standards. We identified particular concerns about the care of older people

at the Princess of Wales Hospital and immediately began a programme of quality improvement. As part of this programme we invited external scrutiny and also supported reviews commissioned by Welsh Government and inspection bodies. We have been open and transparent about the findings of these reviews and about the actions that we have put in place to remedy the failings.

One of our actions in 2013 was to commission the Advancing Quality Alliance (AQuA) to undertake a wide-ranging, independent quality and safety review of the care provided at Princess of Wales hospital. Their final report was received in May 2014. The report set out 51 recommendations to address concerns related to:

- The use of mortality data
- Clinical care
- Reliable care systems
- Leadership
- Roles and responsibilities
- Documentation and informatics
- End of life care

The Board recognises that the findings of the AQuA report are equally applicable to all of the ABMU hospitals with learning that has relevance across the whole Health Board. In 2014-5 we will act upon all 51 recommendations by redesigning our systems to ensure consistent delivery of high quality care 24 hours a day 7 days a week. We will commission AQuA to review each of our other acute hospitals so that we can be assured that the quality of care is consistent across all of our hospitals.

Actions are detailed in Appendix 3 and are summarised as follows:

- Review levels of medical and nursing staff and cover including optimising medical rotas to ensure appropriate and best access to senior medical opinion
- Ensure wide engagement of all staff across the Health Board in patient safety improvement work
- Improve the quality and timeliness of discharge summaries
- Ensure a more consistent delivery of evidence-based clinical care, in particular through the more effective use of Care Bundles
- Tackle a number of significant system issues which are impeding the reliable delivery of patient care, in particular by improving patient flow for emergency admissions
- Strengthen leadership and governance at all levels in order to:
  - develop and implement a robust Quality & Safety Strategy
  - improve clinical engagement in quality improvement activity
  - make demonstrable improvements in the handling of safety incidents, complaints and patient experience data

  - ensure safe staffing levels and improve staff motivation and morale
- Further improve documentation and coding to ensure that improvement efforts are based on robust intelligence
- Work with partners to further improve end of life care for patients and their families

The 'Trusted to Care' Report commissioned by Welsh Government from Professor June Andrews concluded that there had been some unacceptable care provided to older people at the Princess of Wales and Neath Port Talbot hospitals relating to:

- Variable or poor professional behaviour and practice in the care of frail older people
- Deficiencies in elements of a culture of care based on proper respect and involvement of patients and relatives
- Unacceptable limitations in essential 24/7 services leading to unnecessary delay to treatment and care
- Lack of suitably qualified, educated and motivated staff particularly at night
- Adversarial and slow complaints management
- Disconnection between front-line staff and managers and confusion over leadership responsibilities and accountabilities
- Problems with organisational strategies on quality and patient safety, capacity development and workforce planning.

The recommendations are summarised below:

- Create a set of clear standards for the care of frail older people in Accident and Emergency and general medical and surgical wards within the two hospitals, within three months of publication of this Report, and audit them quarterly thereafter
- Develop a quality and patient safety strategy which focuses on the realities of care, connects the Board to the experience of patients, monitors standards in practice and shapes Board decisions accordingly
- Identify clear steps to generate a culture of care built on more creative public involvement in the setting and monitoring of standards, and in the resolution of ethical issues and practical choices that arise from the need to make decisions within limited resources
- Implement a skills and knowledge programme to ensure all staff working in its hospitals understand and are equipped to meet their obligations to frail older people
- Run an intensive education programme on delirium, dementia and dying in hospital
- Develop more cohesive multi-disciplinary team practice in the medical wards at the two hospitals, built around shared responsibility and accountability for patient care and standards of professional behaviour

- Introduce a coaching scheme for front-line clinical leaders provided by senior people from outside the two hospitals
- Adopt a "zero tolerance" approach to the improper administration of medicines for all clinical staff, drawing a clear line in the sand within three months of the publication of this Report
- Address hydration, mobility and feeding practice for all older patients and publish audited results on a quarterly basis
- Review how well ward accommodation supports care for those with dementia, delirium, cognitive impairment or dying at both hospitals, covering physical design of the clinical spaces and equipment available
- Simplify and strengthen management and clinical accountabilities and review ward staffing procedures to guarantee the right clinical and support staff are in the right place to meet the needs of older people at that time
- Overhaul local procedures on adverse incidents and complaints to build greater staff and public trust and confidence in their effectiveness
- Introduce a fully operational 24/7 approach to services including diagnostic services, pharmacy, therapies and social work
- Decide what has to be done for ABMU genuinely to "put local citizens at the heart of everything we do", using external creative expertise.

The Board accepted all the findings and recommendations and concluded that although the Andrews Report is centred on practices at the Princess of Wales and Neath Port Talbot hospitals it has implications and actions for everyone across the Health Board. We have apologised unreservedly to patients, & their families or carers who have been let down by the poor care described in the Andrews Report. The Board believes that most of our care is of a high standard, but some care has been very poor. We are determined to put things right and we will work urgently to replace any remaining pockets of poor care with consistently excellent care.

The immediate steps taken by the Board were to:

- **Hold face to face briefings to** ensure **everybody** is clear about the high standards of care we must provide for our frail older patients
- Define **never events** and brief staff on these
- Establish **strengthened inspections & monitoring** by senior clinical staff & directors
- Secure **external clinical expertise** from a nationally recognised expert on the care of frail older people to start working on defining clear standards of care, supported by the Royal College of Nursing (RCN)
- Confirm the contract to work with **external experts on establishing Values** to underpin everything we do & confirmed associated timetable for the next 6 months
- Establish a **multidisciplinary Taskforce** of experienced staff to **accelerate improvements**

The Board is determined that we will put things right and provide consistent, excellent care in the future. Further action is being taken on the issues raised particularly in relation to:

- Medication
- Hydration
- Night-time Sedation
- Continence care

The Report specifically required the Board to develop clear standards for the care of frail older people to address some poor practice that it highlighted in the report. We will do this as a matter of urgency over the coming weeks in partnership with staff and with further support from external experts, patients, carers and relatives.

The Board has given an explicit instruction that there are some issues in the report which are completely unacceptable and should never happen in any of our hospitals:

- Patients being given prescribed medication but then not being observed taking it;
- Staff signing the medicines chart to say that a patient has taken medication when they have not seen this;
- Inappropriate use of sedation for “aggression”;
- Patients being told to go to the toilet in bed;
- In addition we must ensure that patients are appropriately hydrated

In order to ensure these things do not happen we are taking immediate further action, including:

- Additional staff training guided by external experts will be provided.
- An urgent review will be undertaken into the use of sedation
- A checklist will be specifically developed to check medication, continence and hydration, with both regular and unannounced spot-check inspections carried out by senior personnel and Board members
- A review will begin of the environment of wards for dementia care

In addition, the Board has already:

- Established a standardised evaluation tool for ward / department based unannounced visits, used by all
- Implemented an unannounced visit programme across the organisation using the standardised evaluation tool to identify issues
- Established a central record of issues raised through visits & follow up of required actions implemented on all including feedback to Board
- Introduced a communications campaign to challenge behaviours and highlight poor care

- Reviewed the self medication policy to ensure this can be simplified for implementation as a positive option for patients across the Health Board
- Established a process to report any bed moves between 8pm & 8am as adverse incidents to the Board
- Identified & removed "extra" beds within ward layouts & established a process to report any variance as adverse incidents to the Board
- Developed & made widely available clear guidelines for staff on what to do when a patient without capacity refuses medication
- Audited ward rounds and identified concerns about their timing & frequency & developed an action plan to make these
- Established a clear process for recording issues raised through Concerns Clinics, following these up & giving feedback to those involved
- Made a commitment that every Board meeting has a presentation from a relative or patient who is frail and elderly and has experience of current services

A detailed action plan setting out the Board's actions over the next 12 months has been developed and discussed with the Board. This will be made available on a dedicated web page once approved by the Board. The Board are clear that:

- All staff share the responsibility for the safety of our patients and to provide dignity and compassionate care – nurses, doctors, pharmacists, managers, support staff and others
- We must all take action to ensure that poor or unacceptable practice is eradicated
- We are determined to emerge as a Health Board where all our hospitals provide excellent, patient centred care
- We must drive forward improvements which are already underway at an even quicker pace

5.4 How are we doing now? Quality and safety challenges

Although much of the care that we provide is of good quality, we have identified six main safety and quality challenges:

Outcomes for patients: We need to improve systems for recognising and treating patients who are deteriorating. We also need to reduce Healthcare Acquired Infections that are higher than they could be when compared with comparable NHS Trusts in England. There are also inconsistencies in using interventions that are proven to have the highest impact in terms of good outcomes such as deep vein thrombosis (VTE) assessment and appropriate prophylaxis and other care bundles against other causes of avoidable harm.

We must consistently measure and act on measurement of quality, clinical outcomes and survival outcomes to provide assurance about the quality of care. Functional outcomes and patient experience must be routinely recorded and acted on. We know that although there has been a consistent reduction in the numbers of patients dying in our hospitals our risk-adjusted mortality rates in hospital (RAMI) do not compare well with the best in the UK.

Culture and Communication: Surveys show that engagement by some senior clinicians with management colleagues is poor and that junior members of staff are not well integrated into efforts to deliver high quality and prevent harm. The values of the organisation are not always demonstrated, shared or understood by our staff. We are sometimes defensive rather than open and transparent when things go wrong. We have commissioned a major public and staff listening exercise to determine and embed the shared values and expected behaviours across the Health Board.

Our response to concerns or complaints is slow, bureaucratic and adversarial. We do not have good systems in place to learn from and share the lessons that could prevent repetition. We are not always clear where accountability for systems design, service delivery or the quality of care is held throughout the organisation.

Guidelines and Pathways: While some departments have developed systems to implement best practice guidelines and care, others are less well developed and some departments do not measure processes and outcomes systematically or benchmark internationally. In particular, the system for routine reviews of in-patient deaths is not working consistently in some areas and the opportunity to reduce avoidable harm is being lost.

Feedback from Patients, Citizens and Staff: Systems to ensure the virtuous cycle of learning from incident reporting, complaints management, timely and effective investigation, feedback and action are not in place Responses are often slow, bureaucratic and do not address the issues. We will act to ensure that this feedback is seen as 'golden'. We will ensure that our systems for closing the loop on action are robust and the assurance and accountability arrangements clear.

Clinical Information and analysis: The link between clinical audit activity and clinical risk is not always clear, and too often our information and technology systems do not support the collection of clinical data easily. Further, patients and carers are often not as involved as they should be in audits of care.

5.5 What are we going to do? Quality Improvement Priorities

During the period of this plan we will focus on:

- Understanding and Developing shared values and expectations with our staff, patients and citizens
- Implementing systems that deliver consistently high quality care 24 hours a day, seven days a week
- Improving the care of frail older people
- Improving the quality of primary care services
- Being a listening organisation knowing how well we are doing
- Being open and transparent in all that we do
- Developing strong leadership at all levels
- Ensuring dignity and compassion in care

5.5.1 Shared Values and Expectations

- We have commissioned April Strategy to work with us to understand the values and expectations of our staff, citizens and patients.
- We will communicate to staff, patients and citizens our shared values and expectations for improving quality throughout 2014-15.
- We will develop an accountability framework, which ensures that responsibilities for delivering consistent high quality care, 24 hours a day, seven days a week are clearly and simply stated. [2014-15]
- We will set out and communicate the services we provide, pathways of care and the standards of service that we will consistently deliver for our patients. [2014-17]

5.5.2 Implementing systems that deliver consistently high quality care 24 hours a day seven days a week

- We will develop a positive culture of quality improvement through openness, no blame and zero tolerance to poor care and avoidable patient harm, by reliable delivery of best practice standards.
- We will ensure good hydration, mobility and feeding practice for all older patients and publish audited results on a quarterly basis
- We will ensure that all relevant patient safety alerts are implemented. [2014-17]
- We will ensure that evidenced treatments, care bundles, care pathways and approaches are embedded reliably in practice, across all our services. [2014-17]
- We will ensure that all clinical and managerial staff are provided with learning from sentinel events such as incidents, complaints, claims, never events, ombudsman and coroner reports and mortality reviews so that they can use this information to improve the care that is provided. [2014-15]
- We will significantly and continuously reduce the incidence of all healthcare associated infections in hospital and community settings to a level comparable with ‘best in class’. [2014-17]

- We will ensure that the learning from the Andrews and AQuA reports is used to improve services across all our hospitals. [2014-15]
- We will ensure that our services are designed around the outcomes and experience valued by patients and citizens ensuring dignity, respect and compassionate care for all. [2014-17]
- We will improve communication and collaboration between secondary and primary care, and the third sector. [2014-17]
- We will ensure that there is safe, effective and timely information sharing across health & social care. [2015-17]
- We will take forward actions to improve the quality of primary care services. 2024-17]

5.5.3 Improving the care of frail older people

These are set out in our response to 'Trust to Care" detailed in section 5.4.

5.5.4 Improving the Quality of Primary Care Services

The Kings Fund identified a number of ways in which practices can create an environment that supports quality improvement. The Health Board will work in partnership with practices to develop:

- A culture that supports systems thinking, encourages peer review, is open about performance and variability, and that balances challenge against support
- The transparent sharing of data on performance at a local level with patients, citizens and with professional peers
- Strong professional leadership and a team ethos that puts the quality of care first and recognises the need to continually strive to improve
- Team-based approaches that engage all staff in measuring, understanding and improving quality
- Use of data and information tools, such as decision aids and best-practice guidelines that can prompt general practice professionals in clinical real time, data-analysis tools that allow benchmarking of performance between practices or predict the risk of admissions, statistical techniques that help triangulate performance data and monitor trends over time
- Training and support for the acquisition of improvement skills
- Support structures that promote the regular sharing of ideas and experience between practices
- Protected time and incentives for individuals and the team to think, train and undertake quality improvement
- For the minority of practices that perform poorly, governance arrangements to enable effective and timely remedial action.

There are five key actions which will support Primary Care in quality improvement: We will:

- Support Primary Care to improve service quality, including access to those services;
- Support Primary Care to improve its ability to attract and retain GP's.
- Increase the involvement of Primary Care in the commissioning of services
- Maximise the extent to which patient's care is delivered in primary care;
- Increase the extent to which primary care staff work together in networks, providing opportunities that make networking attractive.

In 2014-15 we will start with initiatives relevant to falls, medicines management, infection control, mortality reviews and the reduction of medication errors because these cut across secondary and primary care. We will also improve discharge planning and deliver against actions relevant to the 'Robbie Powell' case.

Further work to improve quality in primary care will be taken forward in years 2015-17 including:

- Use of the primary care clinical governance toolkit
- Examination of variation in prescribing, referral and admission rates.
- Discussion with primary care of QOF achievement and variation in terms of QOF achievement, including exclusion rates
- Examination of prescribing data, particularly the achievement against AWMSG quality targets
- Discussion of complaints, including feedback from CHC, and patient satisfaction scores including information from appraisals
- Promoting audit activity
- Engagement with primary care in pathway development.
- Taking action to ensure appropriate staffing levels and transferring work from GPs to other clinical and non-clinical staff
- Working with Primary Care to reduce reliance on locum staff
- Using peer cluster analysis to share primary care quality indicators with GPs.

5.5.5 Being a listening organisation – knowing how well we are doing

- We will develop systems for collecting and acting on feedback from patients, citizens and staff that value this as a golden opportunity for quality improvement. We will ensure that listening to patients is seen as part of the 'day job' is valued and embedded across all areas and that we 'nip issues in the bud'. [Year 2014-17]

- We will ensure timely, open and respectful response to complaints and that our system is designed to learn from complaints and protection of vulnerable adult incidents. [2014-15]
- We will ensure that investigations of complaints and incidents happen quickly, are thorough and the outcomes reported to the Board, with a detailed monthly 'ward to board' analysis of all themes arising from complaints, patient experience, incidents and claims. [2014-15]

5.5.6 Being open and transparent in all that we do

- We will develop systems to collect and analyse information and make this available to clinicians, managers, the Board and the public to support decision making, improve quality and hold individuals and services to account. [Year 2014-16]
- We will establish clear accountability arrangements, quality assurance and reporting mechanisms; that enable assurance to be gained from ward to board. [Year 2014-16]
- We will develop strong leadership at all levels
- We will improve partnership working with clinical teams to support quality improvement. [Year 2014-17]

5.5.7 Ensuring dignity and compassion in care

- We will ensure that every patient feels safe and cared for and that our staff behave with the utmost care, compassion, dignity and respect at all times and in all situations [2014-7]

5.6 How are we going to do it?

Our Strategic Programmes and specific projects for dignified and compassionate care

Our Quality Improvement programme incorporates two linked themes:

- Improving Patient Safety and;
- Improving Patient Experience

With these two programmes as a starting point we will develop a quality and patient safety strategy which focuses on the realities of care, connects the Board to the experience of patients, monitors standards in practice and shapes Board decisions accordingly

5.6.1 Patient Safety Programme

Our patient safety programme is one of our seven Strategic Change Programmes and forms part of our Quality

Improvement Programme. It is led by the Medical Director. It is focussed on reducing avoidable harm and developing a positive safety culture. The overarching vision set for the programme is to ensure:

Continuous improvement in patient safety, creating confidence in our services

The Patient Safety Programme will:

IMPLEMENT WELL EVIDENCED TREATMENTS, CARE BUNDLES, PATHWAYS AND APPROACHES TO ACHIEVE PROGRESSIVE IMPROVEMENTS IN OUTCOMES

Over the course of 2014-17 we will implement a programme to ensure that all clinical teams are delivering care and treatments consistent with best practice standards and NICE guidance.

In the first year, we will support and encourage clinical teams to improve awareness of and implement all forms of quality standards using the NICE 'into practice' guidance. We will also ensure within the first year that no treatments on the NICE 'do not do' list are delivered within ABMU Support to individuals on delivering best practice will include discussion in appraisal and revalidation interviews.

In successive years, reliable delivery of high quality care will increasingly be monitored through examination of variation in clinical outcomes and through root cause analysis from mortality and harm reviews, incident reporting and complaints investigation. Thematic analysis of repeated incidences will be fed back to clinical teams through an integrated Datix system. Where possible we will commission independent external support to inform our mortality reviews and to provide reports on our serious incidents.

Our clinical audit programme will be designed to ensure that appropriate actions are taken and that there is continuous improvement in harm reduction. Quality improvement will be embedded where necessary within our performance management framework to ensure that key quality indicators receive appropriate robust scrutiny.

Our 'Progressive Improvements' work has eight objectives for 2014-15: -

- Reducing healthcare associated infections
- Reducing inpatient falls
- Further reducing pressure ulcers
- Reducing medication errors
- Improving use of the World Health Organisation (WHO) checklist in theatres
- Improving involvement from patients and carers
- Sharing information between different clinical teams

- Improving the way "hospital at night" and critical care outreach provide seamless 24 hour ward cover.

In subsequent years we will introduce further initiatives that have been proven to improve patient safety and reduce harm, including reducing avoidable acute kidney injury, providing appropriate intravenous fluid therapy and reducing surgical site infections.

STRENGTHEN OUR INFECTION PREVENTION, CONTROL AND DECONTAMINATION PROCEDURES

To reduce harm to patients and to have infection rates that are amongst the best in the UK we will complete the final stages of implementation of all elements of Welsh Governments 'Commitment to Purpose' Strategy (2011) through a whole scale change project across both primary and secondary care. We will aim for a:

- 50% reduction in MRSA Bacteraemia from our baseline position in November 2013, equating to 13 fewer cases by March 2015 (an average reduction each month from 2 to 1.2).
- 50% reduction in C. *difficile* infections from our baseline position in November 2013, which equates to 91 fewer cases by March 2015 (an average reduction each month from 19 to 14 cases).

While we have seen a reduction in healthcare transmitted C. *difficile* infections, we have identified a prevalence of C. *difficile* infection in our communities. Therefore during 2014-15 we will be focusing on reducing the susceptibility of our population to C. *difficile*. As a first step we will utilise the Berkshire whole scale change model and a dedicated team (project manager, antimicrobial pharmacist and infection control nurse) to undertake data focussed reviews of antimicrobial and proton pump inhibitors prescribing practice at individual GP/consultant level. We will work closely with Public Health Wales Laboratories utilising information that they hold in relation to GP testing and surveillance.

We will also progress the cultural changes that have resulted from the infection prevention Board over the last two years.

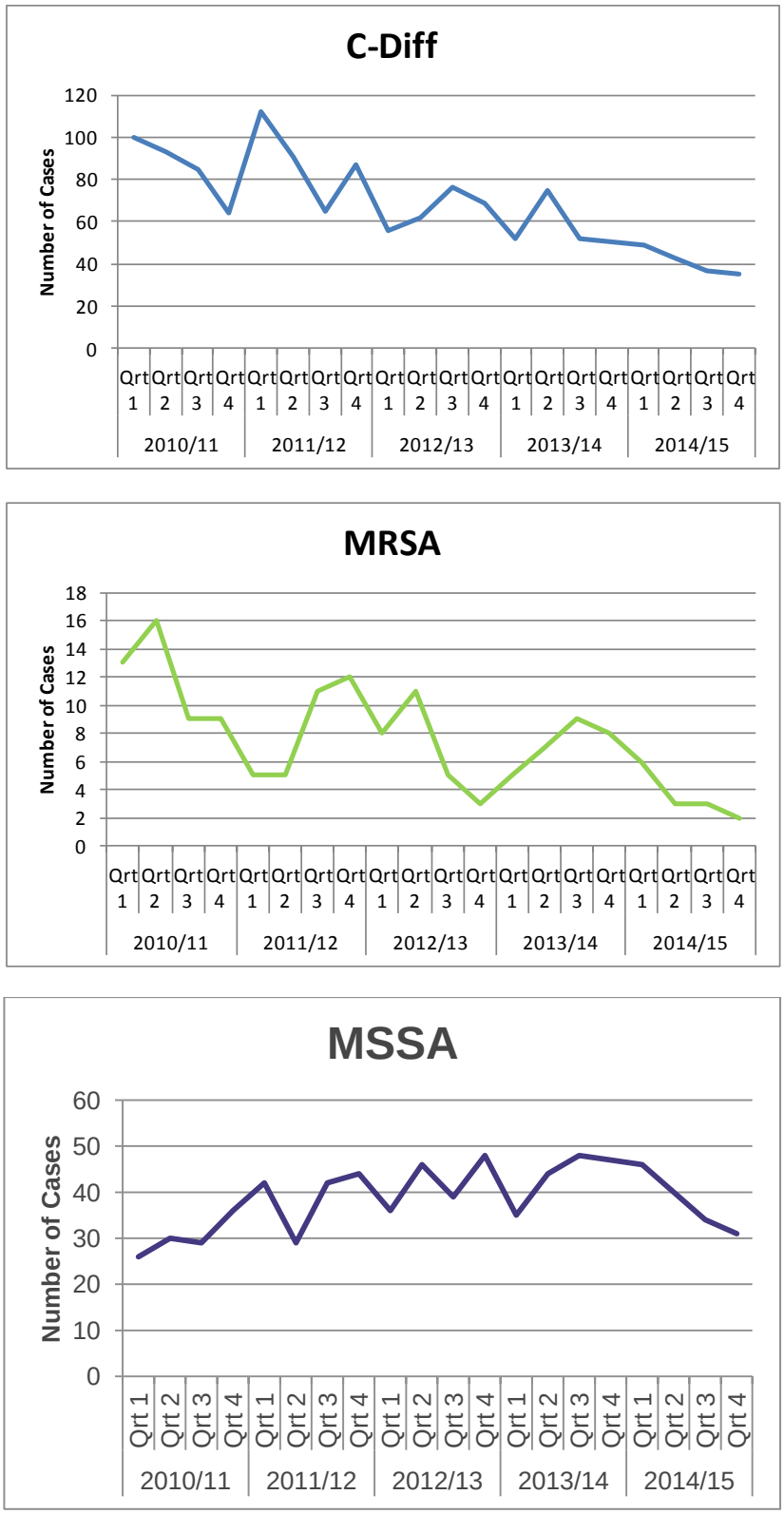
However, we have identified that these changes alone are not enough if we are to achieve 'whole service' change and meet mandatory targets.

Therefore, over the next 12-months more robust ward to board reporting of all healthcare acquired infections, the root causes and contributory factors will be introduced. We will ensure more of our clinical managers are trained in root cause analysis to increase understanding of how healthcare acquired infections occur. We will also focus on:

- Implementing chloraprep® (2% chlorahexidine) skin preparation for all peripheral and central cannulas inserted, renal temporary lines and blood cultures across all secondary care services.
- Ensuring full compliance across all clinical areas with the peripheral cannula, central line and urinary catheter insertion and maintenance care bundles.
- Ensuring full compliance with the STOP campaign.
- Ensuring that all antimicrobial prescribing protocols are congruent with national guidelines for all conditions.
- Ensuring 100% compliance with standard precaution and hand hygiene training.
- Meeting fully the minimal cleaning frequencies as outlined in the National Standards of Cleanliness (NSOC) in all acute hospital sites and ensure separate hostess arrangements.
- Using hydrogen peroxide proactively as part of routine cleaning regimes.
- Ensuring implementation of a fully planned theatre cleaning prevention programme.
- Ensure good theatre discipline in relation to IPC transmission prevention
- Creating negative pressure isolation rooms in the Emergency Department and on respiratory wards at the Princess of Wales and Morriston Hospitals and starting to increase systematically single en-suite room provision so we reach a minimal of 25% capacity in all clinical areas. The timescales for this will be determined by the availability capital and the need to balance operational pressures as our transformation change benefits are realised.
- Develop a Health Board wide central decontamination suite for the decontamination of all invasive devices and equipment.

The figures below show our historical performance and trajectories for the period 2014/15 for C. *difficile*, MRSA and MSSA

Figure 15 : Showing historical performance and trajectories for 2014/15 for C.*difficile*, MRSA and MSSA



IMPROVE DIABETES MANAGEMENT

We have started to increase the knowledge and skills for all ward staff on Diabetes and to implement monthly monitoring of compliance with standards of diabetic care. In 2014-15 we will enhance this knowledge to increase competence of our nursing staff in managing patients with Diabetes. We will improve the management of less complex patients on the wards with appropriate and timely referral to the diabetic specialist nursing team.

The Health Board will implement an upgraded blood glucose monitoring point of care system to prevent the system 'work around' we have identified, and we will continue to conduct regular system, documentation and practice audits.

Diabetes management will be continue to be monitored closely throughout 2014/2015 to test and ensure that practice is safe and effective across all services, and that all staff have the necessary skills and knowledge to safely care for the diabetic patient. This will be monitored through:

- Ongoing monthly spot check audits by Lead Nurses throughout 2014/15.
- The monitoring of complaints and incidents via the DATIX system
- The standardisation of documentation relating to diabetes.

Table 25 below provides a summary of the investment, savings and benefits to be delivered by this project.

Table 25 : Patient Safety Programme Summary

	2014/15	2015/16	2016/17
Investment £	228,437	164,390	246,249
Savings £	-314,150	-471,225	-471,225
Benefits	• A reduction in unnecessary deaths and harm; • a reduction in healthcare acquired infections; • Improved patient experience through safer and seamless care; • More efficient and effective care; • Reduced medication costs; • Reduced bed-days; • Reduced length of stay; • A reduction in re-admissions; • Less complaints; • Less litigation; and • Improved organisational reputation.		
Workforce	No impact on workforce figures		
Risks	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

5.6.2 Patient Experience Programme

We know that our culture has not always valued patient experience or acted on this to improve services. Our response to concerns and complaints has been slow, adversarial and bureaucratic. In 2014-15 we will make this quicker, more effective and with robust governance to deliver the recommendations of ***"Designing Good Together: transforming hospital complaints handling"*** and of Professor June Andrews. We will also ensure that we integrate our learning from all aspects of patient experience: feedback, complaint, praise, litigation, incidents and external reports into a common "dashboard".

A full review of how the Health Board responds to concerns and implements the Putting Things Right Legislation has been undertaken. The main issues for the Health Board to meet its requirements in relation to Putting Things Right are:

- Review our procedures on adverse incidents and complaints to build greater staff and public trust and confidence in their effectiveness
- Ensure contact with complainants on receipt to agree what needs investigation, the form that should take and timescale for completion.
- Ensure that an investigation is rapidly undertaken for serious concerns.
- Identify evidence of actions taken and concluded to ensure lessons have been learnt
- Improve objectivity in consideration of redress by this being undertaken by clinicians not involved in the care
- Ensure that responses are not defensive, written using jargon, in plain English covering a chronology of events and address the complaint i.e. what went wrong, why it went wrong, and what action has / will be undertaken to prevent that occurring in future
- Meet legislative timescales
- Reduce formal correspondence by prioritising face to face or verbal contact with patients or complainants
- End the practice of complainants being instructed to put concerns in writing rather than staff documenting the complaint, providing the complainant with a copy of that and resolving the issues
- Provide central clinical oversight of complaints processes and responses
- Centre concerns are management around the needs of patients or complainants
- Undertake themed analysis by clinical area to give assurance that themes are not being repeated within the same clinical area or across services.
- Ensure that patients and relatives are aware of how they can raise concerns when they arise within our clinical services
- Proactively manage e-mail concerns and take opportunities to nip issues in the bud and for them to be immediately addressed
- Ensure Senior staff resolve the most complex issues
- Improve sign off procedures in relation to complaint responses

***Immediate Further Actions*:**

- Training of governance teams in improved concerns handling
- Implement Concerns Clinics across the Health Board including Primary & Community Care Services
- Erect posters in each clinical area advising patients or relatives with relevant contact details should they wish to discuss any aspects of care.
- SNAP 11 will be rolled out from May 2014 to facilitate emailed concerns with linked feedback mechanisms to be available for patients so that issues can be nipped in the bud
- A notes viewing area on each site to expedite access to Health Records.
- Totally revised complaints process to be developed and implemented focussed on the clinical care / treatment related complaints, verbal and face to face contact and engaging with patient / complainant in how a complaint is investigated
- Redress panel to be developed to consider possible allegations of harm, complaints to determine if there was breach of duty of care and causation
- Post formal complaint management satisfaction surveys to be commenced
- Dedicated medical sessions within patient feedback team to support the function
- Concerns / customer care training to be provided to lead nurses/ governance teams
- Ward by ward training in customer care and concerns handling to commence May 2014
- Accountability & responsibility of complaints to be reaffirmed

The Patient Experience Programme is one of our seven Strategic Change Programmes and forms part of our Programme for Quality Improvement. It is led by the Director of Nursing and focuses on creating a culture that puts patients, service users and carers and their experiences, at the heart of everything that we do. The programme will deliver the infrastructure and mechanisms that will enable the organisation (at all levels) to listen and immediately act upon what our patients, service users and carers are saying, so that we systematically learn from their experience. The Programme's overarching vision is one of:

Being a listening organisation – knowing how well we are doing – Learning from Experience

We consider this area to be of such significance and importance that the Patient Experience Programme's whole focus is on making us not just 'a listening organisation' but an organisations that 'actively listens, hears and acts'.

We are extremely fortunate to be assisted in this by 650 enthusiastic volunteers who help us by talking with patients, service users and carers to obtain their views on our services and to assist us in dealing with any issues of concerns at the earliest opportunity. We estimate that they provide a total of 117,000 volunteering hours per annum. 'Volunteering England' has estimated that this is equivalent to a contribution of £1.625m per annum.

However, we are not utilising our volunteers as well as we could. During 2014-5 we will provide them with a single Governance Framework and offer volunteering and patient support options that are consistent across the Health Board.

The delivery of good healthcare is not about 'doing to' but about 'doing with and for'. We are committed to driving cultural change for co-production so that all staff see patients, service users and carers as 'individuals with individual needs' and see clinical teams working directly with patients and carers to solve issues and problems at the earliest opportunity and before they escalate.

We want to ensure that our staff, clinicians and managers listen to what patients (under their care and accessing their services) have to say, and that the Board has a whole system picture, in order to gain assurance that departments and services are working together to provide one, fluid, excellent patient experience.

To achieve this, we will:

- **Introduce a Health Board wide patient experience barometer utilising the 'Friends and Family Test'** to provide a real time indication of the quality of care being delivered in all hospital services [2014-15] and primary care services. [2015-16]
- **Establish a clinically led combined Patient Experience Improvement Team (PEIT)** that ensures that the Health Board values patient experience and effectively and efficiently receives and responds to all patient experience feedback [2014-15]
- **Develop a Patient Advisory Liaison Service (PALs)** to provide patient focussed advice and support seven days a week that will be implemented across all acute hospital sites. (2015-16)
- **Develop a better equipped and resourced Patient Feedback Team** that will ensure that we learn from experience and improve quality.
- **Develop an integrated web based reporting system for POVA, complaints, claims, and incidents that is integrated with Myrddin – "**DATIX web" and works across all healthcare settings to facilitate more efficient and effective reporting, and better analysis of information down to patient, ward, GP practice, clinical levels. [2014-15].

- **Roll out SNAP v 11 – a web-based patient experience system** to routinely capture patient experience and patient outcome data that will be used to improve quality of care and services. [2014-15]
- **Implement a single patient experience electronic platform** that facilitates effective triangulation and analysis of all patient experience and outcome data received from all provided and commissioned services. This will ensure that all such data is themed, triangulated, aggregated and fed back at a service delivery, specialty, Directorate / Locality, Health Board level to form part of the relevant quality dashboards. This work will be undertaken in conjunction with the University Swansea so that opportunities for links to SAIL can be maximised. [2015-6]
- **Adopt You Tell Us™ as the ABMU Patient Experience 'Brand'** that is promoted widely [2014-15]
- **Develop and implement an effective mechanism for the Health Board to capture patient reported validated health gain and outcomes (PROMs)** [2015-17]
- **Provide opportunities for patients, service users and carers to give immediate / point of care electronic experience feedback.** [2014-15]
- **Develop patient experience and outcome measures**, [2014-17]
- **Create a comprehensive and effective Patient Experience Feedback Section on the home page of the Health Boards intranet site.** [2014-15]
- **Develop a Health Board wide equivalent of the 'patient charter' that sets out clearly what patients can expect when they access our inpatient and out of hospital services.** [2014-15]
- **Create tools for clinical and management teams to collate meaningful patient experience feedback** (e.g. patient stories, specific surveys). [2014-15]
- **Develop a Health Board wide volunteer service.** [2014-15]
- **Enable 'real-time' public reporting of outcomes and actions** to support systematic learning from experience. [2014-7].
- **Respond to the findings of the Evans review.**

5.6.2.1 Co-creating Health

We recognise that in the past, our services have not always been designed around the outcomes and experience valued by patients and citizens. There is growing evidence that more than a third of patients would not choose some treatments such as elective operations if they were fully informed about their options including risks and benefits.

We intend to increasingly apply the principles of co-production in commissioning and delivery to use the potential and resilience within individuals, families and communities to:

- Improve their services, their health, their environment and their life circumstances
- Work in partnership with patients and citizens to design and deliver health services together
- Support people who use our services to contribute to the production of these services
- Encourage service users to consider themselves as equal partners in design and delivery

Our services will have compassion at its heart with dignity and respect as core values. They will support people with the tools, confidence, competence and self-efficacy to make decisions and to manage their own health and well being. Our services will provide people with treatment and care when it is needed and meet psychological and emotional health and welfare of individuals as well as physical.

Our services will empower individuals with complex and long term conditions with the skills to better look after themselves with greater focus on customer care, valuing people and treating them with dignity and respect. We will embed shared-decision making to create a more equal partnership between patients, citizens and our staff.

Working in co-production our staff will bring technical knowledge, strong values and commitment to excellence with our service users bringing their knowledge about themselves and together they will devise and agree the goals and actions to be taken, such as an activity plan, taking medication or having an operation. Co-production has the potential to transform the nature of the relationship people have with their services by getting more involved in their own health and wellbeing and in return being given more influence over setting service priorities and managing their own care.

We have already trained over 400 staff in co-creating health and will develop an e-learning module to enhance our training programme. A co-creating health framework will increasingly be used to support clinicians in their interactions with patients, moving away from the traditional ‘consultation’ model.

5.6.2.2 Arts in Health

We are committed to the use of art to improve our environment and the overall patient experience. In support of this commitment we have established Arts in Health Group; This Group has developed a strategy, which has been endorsed by the Board.

Environment improvement: To ensure that all ABMU buildings are pleasant and interesting places to be in

- Adopt the allocation of "1% for art" in capital projects
- Increase the involvement of patients in the development of capital projects

Experience and engagement: To contribute to people's sense of wellbeing through facilitating their participation in the Arts

- Develop a programme of projects in a range of art forms that contribute to wellbeing
- Train staff and volunteers to be involved in the delivery of arts projects
- Build a database of patients stories to gain feedback on the impact of art on patient experience

Evidence based practice: To continually research; involving artists to help us think creatively

- To have at least one project which asks research questions and informs practice
- Contribute to the development of a Welsh Arts in Health organisation and build links with Arts in Health organisations internationally
- Run a series of symposiums and events leading up to an international conference in 2017

Sustainability: To create an Arts programme, which has reliable resourcing

- Continue to fund the Arts Co-ordinator post through Charitable Funds
- Establish partnership projects with all three local authorities
- Build the relationship with Arts Council Wales (ACW) so that they consistently fund a programme of art projects

Table 26 below provides a summary of the investment, savings and benefits to be delivered by the patient experience programme.

Table 26 : Patient Experience Programme Summary

	2014/15	2015/16	2016/17
Investment £	454,038	636,499	883,504
Savings £	-	-	-
Benefits	• A reduction in unnecessary deaths and harm; • A reduction in healthcare acquired infections; • Improved patient experience through safer and seamless care; • More efficient and effective care; • Reduced medication costs; • Reduced bed-days; • Reduced length of stay; • A reduction in re-admissions; • Less complaints; • Less litigation; and • Improved organisational reputation.		
Workforce	1 x band 8a, I x band7, 1 x band 6 and 1 x band 5		
Risk	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

5.7 Compassionate and Dignified Care: specific actions

We will thoroughly review and update our action plans for improving the quality of continence care, care of people with dementia, care of people at the end of their lives and the Older Peoples Commissioner action plan in line with recommendations by Professor Andrews' review.

We will continue to improve dignity in care and care delivery throughout the next three years through action taken from nursing assurance processes; the POINT review mechanism and annual Fundamentals of care Audits. We will expect all staff to provide dignified care at all times, and we will monitor this on an ongoing basis through the care indicators that we have set.

We have set a number of specific priority areas for improvement in delivering compassionate and dignified care.

5.7.1 Improving Quality of Care for People with Dementia

We have invested heavily in providing world class specialist mental health facilities for people with Dementia. In addition, the Western Bay partnership has a programme of improvement of care for people with dementia in their own homes and in residential care. The overwhelming proportion of patients

in our hospitals are over 80 years and more than half of these will have some degree of dementia. This requires that all our staff are skilled in caring for people with cognitive impairment. We will accelerate improvements in the care of people with dementia on general medical wards:

- We will review our services against the NICE guidance on caring for people with dementia
- Each of our acute hospitals will participate in the National Audit of Dementia.
- The Multi-Disciplinary Steering Committee will increase the pace of implementation of the Health Board's Dementia Action Plan.
- People with dementia, their carers, families and voluntary groups will be involved more in designing services and providing feedback on their delivery.
- The dementia care pathway will help us understand how many patients with Dementia are admitted to our hospitals. This will be piloted, evaluated and rolled out across the Health Board. The business case for quality approach will be used to make an investment bid for additional liaison psychiatry resource for Swansea and Neath Port Talbot Localities.
- The butterfly scheme has been rolled out across acute hospital wards, but has variable implementation and we will ensure it is used routinely.
- Booklets such as the Alzheimer Society 'This is me'", Reach out to me" will increasingly be used to provide Healthcare staff with information about the lives, personality, families, likes and dislikes.
- We will improve the care of patients with dementia at the end of their lives.
- Dementia champions have been identified for all ward areas and will all have completed a five day training program by the end of 2014.
- The Wales Dementia Care Training Initiative that has provided a 'train the trainer' programme will be rolled out across the Health Board.
- The e-learning module developed within the Health Board will be used to provide all Health Board staff with basic understanding of caring for people with Dementia.
- Further training will be provided to all Nursing and AHP staff to ensure they have competency in caring for patients with Dementia
- Each ward will have a nurse with postgraduate training in caring for people with dementia
- We will review our estate to ensure that every ward where older people are cared for is appropriate to meet their needs.
- The Board will work in partnership to support the 'Dementia Friendly Communities' work.
- An intranet site has been set up which identifies the ward champions and support available within the Health Board to support dementia care. Work will continue over the next 12 months to build on this work and to make this information publicly available on out internet site.

- Regular reports will be provided to the Board on progress in improving care of people with Dementia.

A priority area that has been identified for further development is improved training for those delivering care to people with dementia and as a consequence a training needs analysis has been undertaken and further training is planned for 2014.

Future work will include: -

- Introduction of a training program for all health care support workers to include time spent within a mental health care setting.
- Development of multiagency and integrated approaches to dementia care.
- Further training to support the embedding of dignified care within all Health Board ward settings. An evaluation of the Butterfly Scheme, from a patient and carer experience will be undertaken on collaboration with Swansea University.
- Development of our environments of care so that they are dementia friendly; ensuring full implementation of nationally recognised environmental standards for dementia patients in acute clinical areas.
- Ensuring that we are fully meeting all nutrition, fluid and medication needs of all our dementia patients.
- More education and support to educate staff about the need to express concerns about the care of older vulnerable patients

5.7.2 Improving Quality of Continence Care

The Andrews report identified that “patients had been instructed to urinate or defecate in a pad”. We will ensure that patients’ continence needs are clearly assessed and met. A Continence Framework is in place and covers both primary and secondary care settings. This framework clearly outlines the expected patient care, and includes a standardised referral process.

.During 2014 we will ensure:

- All relevant staff are fully aware of the framework
- Regular auditing of the delivery of good continence care is in place which includes spot checks, and patient feedback
- Robust agreed collaborative care plans are in place for all patients
- Continence training is provided for all front line health care staff.
- The use of inappropriate continence products is minimised.
- That further development of systems and processes is progressed to support continence management within the community and secondary care settings.
- The integration of the All Wales continence bundle within the nursing assessment documentation process.

- Continence (Champions) are in place in all ward areas.
- Awareness is raised in relation to the continence intranet site

5.8 Using Information Technology to support Quality Improvement

Currently the lack of electronic ways of working and joined up information results in clinical staff often collecting data for the purposes of measurement rather than data being collected as part of the clinical process. The Quality Improvement Programme will be underpinned by effective, accessible and intuitive information systems which support the clinical process.

The move from paper to electronic records will significantly reduce clinical risk by providing instant access to complete and up-to-date information. In addition, the live view of patients described above, will enable the recording of clinical information such as electronic requesting and reporting of diagnostic tests, patient observations and clinical alerts, electronic prescribing and pathway delays.

The table below summarises the Informatics requirements across the Health Board. Most requirements are relevant across a number of the Programmes - as detailed within the table.

Strategic Change Programme	Informatics Service Requirements
Patient Safety Programme	• Digitise Health Records • Invest in electronic prescribing systems • Implement Clinical Portal to provide patient flow management, single view of patient records and enable electronic ways of working such as ePrescribing, test requesting and electronic observations • Implement a single electronic solution for recording and sending transfer of care / discharge summaries documents • Provide the GP Summary Record across emergency care settings • Implement the National ED System - paperless working in the emergency departments • Implement the National PACS system to provide a single view of radiology images • Implement a single Theatre System across the Health Board • Implement electronic workflow and data capture for pre-assessment • Implement Outpatient self-registration, patient flow and “paperlite” working • Modernise Outpatient Scheduling through the use of technology

Strategic Change Programme	Informatics Service Requirements
	• Implement digital dictation • Implement solutions to capture and utilise electronic records in the community (including the National Community Care Information Solution) • Rollout MS Sharepoint to enhance workflow and document management across the organisation • Ensure ICT equipment is robust and reliable • Invest in technology to support Bring Your Own Device (BYOD) • Implement a Patient and staff Feedback System • Provide better information through the use of digital dashboards • Implement National SCI Diabetes System • Implement National Laboratory Management System (LIMS) • Implementation of a single Endoscopy system for ABMU • Implement the National OpenEyes Ophthalmology patient record system • Implement a sexual health system • Consolidate Audiology into a single system
Patient Experience Programme	• Implement Outpatient self registration, patient flow and "paperlite" working • Modernise Outpatient Scheduling through the use of technology • Implement the National ED System - paperless working in the emergency departments • Implement a single electronic solution for recording and sending transfer of care / discharge summaries documents • Implement a Patient/Staff Feedback System • Implement solutions to capture and utilise electronic records in the community • Implement improved patient entertainment solution at NPT • Implement solutions to capture and utilise electronic records in the community (including the National Community Care Information Solution) • Digitise Health Records • Modernise Outpatient Scheduling through the use of technology • Implement National SCI Diabetes System • Provide the GP Summary Record across emergency care settings
Surgical Pathway	• Digitise Health Records

Strategic Change Programme	Informatics Service Requirements
Efficiency Programme	• Implement Clinical Portal to provide patient flow management, single view of patient records and enable electronic ways of working such as ePrescribing, test requesting and electronic observations • Implement a single electronic solution for recording and sending transfer of care / discharge summaries documents • Provide the GP Summary Record across emergency care settings • Implement the National PACS system to provide a single view of radiology images • Implement a single Theatre System across the Health Board • Implement electronic workflow and data capture for pre-assessment • Implement digital dictation • Ensure ICT equipment is robust and reliable • Invest in technology to support Bring Your Own Device (BYOD) • Implementation of a single Endoscopy system for ABM • Modernise Outpatient Scheduling through the use of technology
Patient Flow / unscheduled Care Programme	• Digitise Health Records • Implement Clinical Portal to provide patient flow management, single view of patient records and enable electronic ways of working such as ePrescribing, test requesting and electronic observations • Implement a single electronic solution for recording and sending transfer of care / discharge summaries documents • Provide the GP Summary Record across emergency care settings • Implement the National ED System - paperless working in the emergency departments • Rollout MS Sharepoint to enhance workflow and document management across the organisation • Implement the National PACS system to provide a single view of radiology images • Implement a single Theatre System across the Health Board • Implement electronic workflow and data capture for pre-assessment • Implement solutions to capture and utilise electronic records in the community (including the National Community Care Information Solution)

Strategic Change Programme	Informatics Service Requirements
	• Ensure ICT equipment is robust and reliable • Invest in technology to support Bring Your Own Device (BYOD) • Implementation of a single Endoscopy system for ABMU
Changing for the Better Programme: **Community Services** **Hospital Services** **Rapid Access** **Pre hospital services** **Trauma Centre Development** **Staying Healthy** **Outpatient Modernisation** **Maternity, Newborn, Gynaecology, Neonatal, Children and Young People**	• Digitise Health Records • Implement Clinical Portal to provide patient flow management, single view of patient records and enable electronic ways of working such as ePrescribing, test requesting and electronic observations • Implement a single electronic solution for recording and sending transfer of care / discharge summaries documents • Provide the GP Summary Record across emergency care settings • Implement the National ED System - paperless working in the emergency departments • Implement the National PACS system to provide a single view of radiology images • Implement Outpatient self-registration, patient flow and "paperlite" working • Modernise Outpatient Scheduling through the use of technology • Implement digital dictation • Implement solutions to capture and utilise electronic records in the community (including the National Community Care Information Solution) • Ensure ICT equipment is robust and reliable • Invest in technology to support Bring Your Own Device (BYOD) • Implement National SCI Diabetes System
Commissioning Development Programme	• Digitise Health Records • Rollout MS Sharepoint to enhance workflow and document management across the organisation • Ensure ICT equipment is robust and reliable • Implement a Patient Feedback System • Provide better information through the use of digital dashboards • Improve Clinical Coding timeliness

6 Service Change Plans and Initiatives

This is a critical section in our Integrated Medium Term Plan. This section describes the key change/transformational programmes that have emerged as priorities based on our diagnostic of national strategic context, local strategic context and challenges, statutory duties and local ambition. For our three main change programmes this section sets out how these will deliver our objectives and drive out the expected benefits.

6.1 Introduction

Clinical service change will be delivered by three of our seven Strategic Change Programmes, i.e.

- Surgical Pathway Efficiency

- Patient Flow/Unscheduled Care

- Changing for the Better – Clinical Strategy Programme

Both the Surgical Pathway and Patient Flow/Unscheduled Care Programmes will deliver immediate operational changes, centred on improving patient safety, efficiency and productivity, quality and value. The Changing for the Better Programme will focus on delivering transformational service change. Both the patient experience and patient safety programme will be crucial in supporting improved patient safety throughout our three main change programmes.

6.2 Benchmarking and Continuous Service Improvement

Working alongside these three Strategic Change Programmes, we are developing our organisational capacity and capability to benchmark performance and support continuous service improvement.

To date the Department's of Informatics and Finance have worked together to make available a range of benchmarking materials and tools. Appendix 4 provides a summary of the benchmarking materials used to date. Most recently our Board has signed up to the Albatross Patient Cost

Benchmarking project which enables users to benchmark performance against 59 English Trusts through a dashboard.

Performance can be compared based on Cost, Length of Stay and Theatre Time and analysis undertaken at HRG, Procedure and Diagnosis level.

A specialty specific performance index was developed reflecting average cost, LOS and Theatre time at an HRG level. Peer groups for each specialty were identified as follows:

- Where we were performing above the average (where possible) the ten organisations whose position in the index was immediately above ABMUs
- Where we were performing below average, the ten organisations immediately above the average.

The Albatross benchmarking tool was used to assess the impact of aligning our performance with the average of the peer group identified in each specialty.

This exercise has identified a potential direct cost saving of approximately £15m, which is made up of a mixture of semi - fixed and variable costs, which we would hope to release.

Further work is being carried out to develop this benchmarking information, to ensure that we are comparing ourselves with similar organisations. We are working closely with clinicians and managers in each of our service areas to:

- Develop the dashboard to compare performance across numerous dimensions with either a specific comparator Trust or an appropriate peer group.
- Enable users to drill down into data to identify factors potentially influencing variation such as a patient's age, residence, consultant or clinical classification.
- Plot performance on a quarterly basis to assess trends and the impact of service changes.
- Support local teams in developing skills in using the dashboard to support continuous service improvement.

This work has been piloted with a number of clinical teams e.g. cardiothoracic services. Once, completed the learning will be rolled out to other service areas.

The Strategic Programmes have also used the Albatross benchmarking tool to test service improvement assumptions.

The table below provides a summary of the planned service improvements to be delivered by each of the three Strategic Change Programmes:

Strategic Change Programme	Proposed Improvements
Surgical Pathway Efficiency	• Reducing length of stay • Maintain short stay surgery targets and target improvement in a small number of specialties • Maintain operations on day of admission rates with targeted work in ophthalmology and, oral maxillo-facial surgery, to improve performance • Maintain day case activity rates, with targeted improvement in a small number of areas • improving start and finish theatre times • Reducing cancellations on the day of surgery • Extending operating hours, to achieve 85% utilisation. • Creating capacity to improve performance against RTT targets
Patient Flow / Unscheduled Care	• Reducing bed days used by patients for emergency medical admissions • Reducing LOS for patients who are medically fit for discharge • Delivery of 90% performance against 4 hr wait target • Improve Category A response times •
Changing for the Better – Clinical Strategy	• Reducing emergency department attendances by 20% • Reducing admissions from eight Ambulatory Care Sensitive (ACS) conditions by a range of 10 – 20%. • Reducing the average length of stay for adult medical admissions by one day. – Single Point of Contact: Increase the number of all new contacts relating to community health and social care are directed through a single point of access within each locality area. – Rapid Response: 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response – Intake: 100% of all potential new homecare clients receive intake intermediate care...(Note: Partnership Deliverable) – Review: 100% of homecare clients for whom a potential significant change is identified receive review intermediate care. .(Note: Partnership Deliverable)

The remainder of this section describes the scope and content of each of the three Strategic Change Programmes. There are many interdependencies between the programmes but in order to help with the translation of our plan into the overall financial framework, individual financial and benefits summaries of each the programmes is provided.

6.3 Surgical Pathway Efficiency Programme

In December 2012 our Health Board instigated a Surgical Pathway Efficiency Programme, in recognition of the opportunities that

existed to improve patient experience and maximise the utilisation of theatres across the Health Board. The latter was based on an external consultancy review by CAPITA in 2012.

The projected benefits of the Programme are potentially wide ranging and include:

- Routine delivery of best practice by embedding the principles of Enhanced Recovery After Surgery
- Improved patient experience and reduced cancellations (linked to patient experience programme)
- Enhanced safety of surgery (linked to patient safety programme)
- Supporting delivery of RTT and cancer targets

Earlier in this document we recognised that we are not yet achieving performance levels that we aspire to and in particular RTT and cancer access are areas where we need to do better. Our planned care improvements will be driven through this Surgical Pathway Efficiency Programme.

The CAPITA report identified the following potential opportunities:

Opportunities to realise financial benefits:

- Reduced bed numbers through:
- Length of Stay reductions
- Lower pre-operative bed use (increase admission on day)
- Increase in day case rates
- Reduction in number of operating theatres (as yet not defined): -
- Predominantly through us using what we plan to use e.g. start and finish times, cancellations on the day of surgery
- Increased use of physical space e.g. over and above 2 session days and/or 7 days a week for elective rather than 5
- Reduction in premium rate payments e.g. Waiting List Initiatives
- Removal of variable pay e.g. staffing levels, short term sickness

Opportunities to improve the utilisation of the resources:

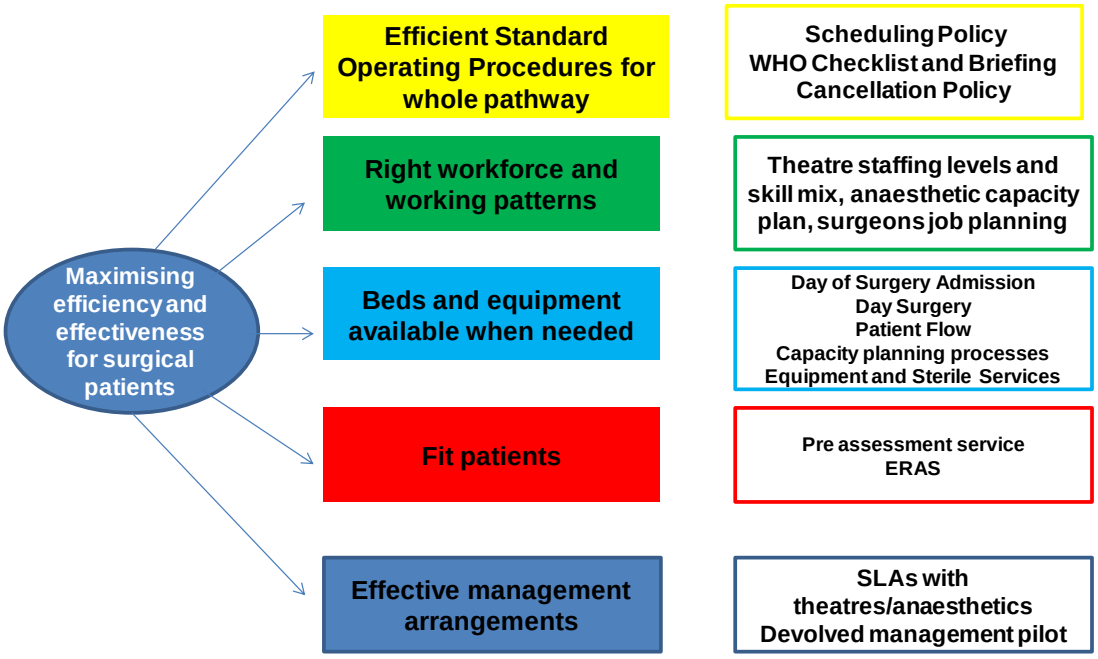
(It should be noted that this list includes areas where efficient practice was already evident).

- Use of theatres e.g. cases per list/available time is high
- Use of planned capacity is running at 60-70% therefore there is significant potential gain in the system in terms of numbers of theatres required.
- Most short term cancellation is for bed availability (LoS and patient flow) and patient not fit or not requiring operation (Pre-assessment

Through the MSK and Surgery Directorates there has been a reduction in 25 beds in Neath Port Talbot hospital during 2012/13 as a result of implementing some of CAPITA recommendations

We have refreshed the structure of the Programme to build upon the findings from CAPITA and to reflect the current performance position of the Health Board. Figure 16 below illustrates via a driver diagram how the aim to improve bed and theatre utilisation translates in to drivers and interventions. The interventions in particular demonstrate that this programme is taking a whole system approach to surgical pathways and that successful delivery of this programme will ultimately ensure that we use our capacity as efficiently and effectively as possible to meet our demands for surgery (which will underpin our delivery of RTT and cancer targets). This will also allow us to release some financial benefits either in terms of reduced premium rate costs or the release of stepped costs around bed and theatre numbers.

Figure 16 : Surgical Pathway Efficiency Programme Driver Diagram



The Programme is well developed and key milestones for the programme are agreed and profiled. The majority of the milestones are to be achieved in 2014/15, which will enable benefits realisation to begin in 2014/15 but to really gain traction in 2015/16 and beyond.

In 2015/16 the Programme will assess the impact of the changes made and will develop plans for theatre rationalisation. This assessment will include reviewing the impact of both this Programme and the ***Changing for the Better – hospital services project***.

Sections 2 and 3 above highlight the pressures that the Health Board is currently experiencing in respect of access times for both cancer patients and urgent and routine elective patients. It is our plan that by delivering the benefits from both the Surgical Pathway Programme and the Patient Flow/Unscheduled Care programme that our elective capacity and demand for both cancer and non cancer care will be in balance. Detailed models at Directorate and Locality level have been worked up to support this planning assumption. This will not address the estimated backlog of RTT patients that will be waiting in excess of 36 weeks at the end of March 2014, but specific resource has been identified outside of these programmes to enable this backlog to be removed over the course of 2014/15. Our aspiration is to deliver the Tier 1 access targets by the end of 2014/15.

Table 27 below sets out the financial arrangements for this Programme and the benefits realisation planned from its delivery.

Table 27 : Surgical Pathway Programme Summary

	2014/15	2015/16	2016/17
Benefits	• Delivery of Tier 1 cancer and non cancer access targets • Improved use of resources:- • Increase day of surgery admission rates • Increase theatre utilisation to 85% (inc improving start and finish times) • Increase day surgery • Reduced cancellations on day of surgery • Potential rationalisation of surgical bed capacity and theatres		
Investment £	204,081	484,661	1,241,000
Savings £	-504,000	-3,708,000	-5,502,000
Workforce	In 14/15 we anticipate savings will be achieved through a reduction in premium costs. We are currently working through the detail of the workforce implications in years 2 and 3.		
Risk	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.4 Patient Flow/Unscheduled Care Programme

Unscheduled care performance has continued to be an ongoing challenge for us during 2013/14 and has been a major priority in terms of investment and programme support.

There is an increasing focus on mortality associated with unscheduled care and the need to capture a wider range of clinical and quality indicators to help monitor progress.

Improvement programmes for Unscheduled Care have been in existence for a number of years and in 2013/14 we established an Unscheduled Care and Patient Flow Programme Board with a comprehensive action plan across 5 main areas:

- Pre hospital pathway
- "Front door" service models
- Patient flow
- Effective operational management
- Capacity

For 2014/15 the focus will be on two key components. First, implementing the recommendations from the Finnamore Report produced in December 2013, in relation to 'Front door' emergency developments at both the Princess of Wales and Morriston. Second, rolling out the Patient Flow Programme to ensure that capacity is effectively managed through efficient operational processes, 7 day working and appropriate staffing. This will improve performance against the following Tier 1 targets:

- 4 hour performance
- 12 hour performance
- Ambulance handover performance
- Excessive ambulance handover performance
- WAST response times
- Non mental health Delayed Transfers of Care
- Primary care access.

.There are close links between this Programme and the ***C4B Clinical Strategy Programme as well as both Patient Safety and Patient Experience programmes***. In 2014/15 the ***Patient Flow/Unscheduled Care Programme*** will focus on the 4 main components set out in Figure 17 below.

Figure 17 : Unscheduled Care Programme Illustration

FRONT DOOR (Based on Finnamore Recommendations)	FLOW (Based on work associated with the national collaborative)
• Maximise use of alternatives to ED attendance – primary care access, care home support, WAST interface, GP admissions units • Deliver improvement in ambulance handover and response times, with a particular focus on long waits • Optimise use of IM&T current and future • Establish clear lead clinical and operational roles for managing ED flow to support delivery of 4 hour wait standard • Increase triage capacity in EDs to remove bottlenecks and prioritise effectively • Stream majors, minors and resus effectively supported by appropriate resources • Improve specialty interface with clear protocols for daily input from medicine, surgery, MSK in particular • Continue to implement ED medical and nursing workforce plans to provide safe decision making 24/7	• Roll out of Flow Programme using FISH training and expertise to identify, measure and resolve bottlenecks and constraints in patient flow, with a particular focus on care of the elderly • Agreed emergency assessment models in place for all unscheduled care specialties, supported by access to diagnostics and ambulatory care pathways • Ward bundles and Board Rounds implemented to agreed criteria on all wards • Progress towards 7 day working in terms of: • Senior medical decision makers • Diagnostics • Therapies • Community health and social care services • Specifically target reductions in delays and waste for patients staying over 15 days, with a particular focus on care of the elderly

• Deliver improvement in 95% 4 hour target • Significant reduction in 12 hour breaches • Zero 1 hour ambulances delays	• Deliver improvements in 90% ambulance handover in 15 mins • Contribute to 60% ambulance response times

The main focus of this programme is on process and quality improvement. It is not setting out to reconfigure services and settings, but is aiming to improve the system within which the service is delivered. There will be a shift in 2014/15 to an improvement science approach rather than a programme management approach. The development of Innovation, Support and

Improvement Science Project (ISIS) as a resource and support for the programme will be critical (ISIS is described in more detail in Section 7).

Any substantial service changes associated with unscheduled care will be included in ***Changing for the Better Programme***, with some dependent on the outcome from the South Wales Programme. This cross referencing work has been carried out to ensure that there is alignment between this important programme and the ***Changing for the Better programme***.

The milestones for the Programme therefore need to be reviewed on an annual basis to ensure they reflect progress that has been made.

2014/15	• Continued implementation of WAST pathway initiatives • Continued improvement in primary care access • Full implementation of recommendations from Finnamore's review about Emergency Departments at Morriston and POWH • Redesigned assessment services at Morriston and POWH for acute and frail elderly patients • Full implementation of Patient Flow Programme at Morriston and Princess of Wales Hospital sites in conjunction with national programme: - – Ward bundles and board rounds – 7 day working – Service Level Agreements (SLAs) with in patient support services • Implementation of comprehensive SOPs for whole hospital working at each hospital site. • Implementation of site focused management
2015/16	• Full implementation of Patient Flow Programme at NPT and Singleton Hospital sites • Achievement of best practice bed days used across medicine. • Roll out of Patient Flow programme to other specialties
2016/17	• Ongoing focus on performance improvement and delivery of best practice

Significant resource has been earmarked in our financial plan to support unscheduled care development, which demonstrates our ongoing commitment to improvement across this Programme. Table 28 below sets out the financial arrangements for the Programme, building on the £4.5m invested in 2013/14.

Table 28 : Unscheduled Care/Patient Flow Programme Summary

	2014/15	2015/16	2016/17
Investment £	328,000	384,000	384,000
Savings £	-	-	-
Benefits	• 4 hour performance • 12 hour performance • Ambulance handover times • WAST response times		
Workforce Profile	Band 8C 1.00 WTE, Band 7 1.00 WTE, Band 6 1.00 WTE, Band 3 1.00 WTE		
Risk Profile	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.4.1 Seven Day Working

We recognise the importance of providing consistently high quality care 24 hours a day, 7 days a week, particularly in unscheduled care where there is clear evidence that this can affect morbidity and mortality. As part of the ***Unscheduled Care and Patient Flow Programme*** the Health Board has been introducing a number of improvements to 7 day and extended day working including:

- Enhanced cover from Emergency Department Consultants, and this will be further extended as recruitment progresses
- Increased availability of senior decision makers in acute medicine on weekends, at Consultant and/or Registrar level
- Continuity of cover over weekend from nurses targeting “outlying” patients to ensure that they receive appropriate care
- Dedicated Radiology CT lists on weekends to ensure ongoing support and availability of diagnostic tests
- Increased levels of phlebotomy to ensure rapid access to test results
- Increased access to therapy in key areas during weekends and bank holidays to ensure ongoing multidisciplinary care of patients
- Flexing CEPOD capacity to minimise delays for patients over weekends

The Health Board is committed to building on these schemes over the next year to ensure that 7 day working is a core feature of our service delivery. Additional priorities will include:

- 7 day access to endoscopy, key diagnostics, therapies and pharmacy services

- Extended day cover by senior nurses
- Extended cover by the Acute GP Unit
- Extended 7 day capacity in community teams

However, not all of these initiatives will be feasible on all sites, both in terms of staffing constraints and cos. Decisions will need to be made about where to concentrate 7 day working efforts, to ensure that they deliver maximum benefits and that are in line with the Health Board's strategic direction.

6.5 Changing for the Better (C4B) – Clinical Strategy Programme

This Strategic Change Programme is made up of eight projects: -

- **Community services**
- **Hospital services**
- **Rapid access**
- Pre hospital services
- Trauma centre development
- **Staying healthy**
- Outpatient modernisation
- Women, Children and Families

We have prioritised the projects within ***C4B – Clinical Strategy Programme*** to ensure that the correct focus is give to the projects which best fit our chosen strategic direction (those marked in bold print above). Our aspirations are to: -

- Provide care closer to patients in their own homes
- To avoid the need (wherever possible) for hospital based care
- To provide sustainable fit for purpose services

These aspirations have led us to primarily focus on Staying Healthy, the Community Services, Hospital Services and Rapid Access projects first. The other projects are progressing and will contribute change within the 3 years of our plan.

Quality Improvement is embedded within all of the above strategic change programmes.

The remainder of this section sets out the scope of the four prioritised **C4B *Projects*** and sets out the detail of the changes planned.

6.5.1 Staying Healthy

The ***Staying Healthy Project*** has adopted a life course approach and aims to reduce health inequalities observed in our most vulnerable and disadvantaged communities. The scope of the Staying Healthy project will be to implement health improvement initiatives on each of the National priorities throughout its course. (As outlined below):

- Reduce health inequalities
- Reduce Smoking
- Increase participation rates in physical activity
- Reduce unhealthy eating (we are developing a broader business case for the management of obesity)

- Increase vaccination and immunisation rates to target levels
- Stop the growth in harm from alcohol and drugs
- Reduce teenage pregnancy rates
- Reduce accident and injury rates
- Improve mental wellbeing
- Improve health at work

In our Strategic Aim for Excellent Population Health we stated that we will prioritise smoking, obesity & vaccination & immunisation and that staying healthy is the key programme for delivering this. We will use the ABMU Public Health Strategic Framework and Public Health Wales IMTP to help guide our actions on these prioritised areas over the three years.

A business case to increase our smoking cessation capacity has been developed for 2014/15 and we will finalise a business case for tackling obesity, including increasing physical activity, as early in 2014/15 as possible. The ABMU Strategic Immunisation Group will review the lessons learnt within ABMU and across Wales from this year's influenza campaign and make recommendations for running the 2014/15 campaign. We have already made changes to the way the childhood immunisation programme is run, with Health Visitors targeting children who are late completing their preschool immunisations. We will continue to develop the programme, guided by our progress moving towards the Tier 1 target.

The project will also include improvement initiatives targeting vulnerable groups and people with long term conditions as these were identified by other work streams within Changing for the Better as a priority actions.

Table 29 below summaries the overall impact of the programme.

Table 29 : Staying Healthy Project Summary

	2014/15	2015/16	2016/17
Investment £	268,887	322,508	483,102
Savings £	- 9,716	-179,148	-179,148
Benefits	• Improvement in our communities' Public Health by: – Concentrating on key components of the Public Health Strategic Framework and targeting prioritised areas to reduce e.g. Teenage pregnancies. • Increased staff knowledge and skills in relation to communicating and promoting health improvement & psychological wellbeing. • Increased integrated working across the range of organisations and third sector partners. • Embedding public health objectives in directorate, locality and wider partnership plans and ensuring that Staying Healthy is a very high priority for everyone. • Raising the profile of public health and ABMU Health Board's Public Health Strategic Framework 2013/2014 and communicating this out effectively. • Reducing inequalities and inequities in service provision across the ABMU Health Board area. • Contributing to the outcomes of the ABMU Health Board's Public Health Strategic Framework 2013/2014 and beyond. • Longer term savings in Health resources such as reduced bed stays for surgery if smoking cessation is implemented, reduced terminations of pregnancy, mental health needs being addressed, reduced number of unnecessary admissions for poorly controlled Long Term conditions.		
Workforce	Band 5 Smoking Cessation Officer 2.00 WTE. Band 3 A&C 1.00 WTE		
Risk	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.5.2 Community Services

The Community Services Project is centred on delivering improved services for Frail Older People and those with Dementia. This is a joint project between Western Bay and Changing for the Better.

In September 2013, the Health Board and Local Authorities in our Health Board area signed up to a joint commitment (Delivering Improved Community Services) to plan and deliver integrated community based services for their local population.

The three key themes within **Delivering Improved Community Services** are:

- Keeping older people well and healthy in their own communities
- Strengthening community teams in each locality, e.g. Community Resource Teams (CRTs) , community networks/core services etc
- Ensuring community services are sustainable, including workforce, estates, technology and finance

In the summer of 2013 an outline business case (case for change) was developed, which described concerns regarding the future of community services, given the potential demand from older people in future (including population growth). The 'Do Nothing' option or status quo was quite clearly not an option both from a quality of care perspective and because of the potential costs to the health and social care system.

The priority focus initially for the project is strengthening community teams and in particular the Intermediate Care Tier/CRTs, given recommendations in the above case for change and the potential benefits this gives with regards the unscheduled care and Local Authority long term care pressures. This was also as a result of the baseline analysis of the current 3 CRTs showing inconsistent models across the ABMU area. The project is focused on standardising community service provision across the area, but with local flexibility where appropriate and ensuring a scaling up to the optimum level of service delivery.

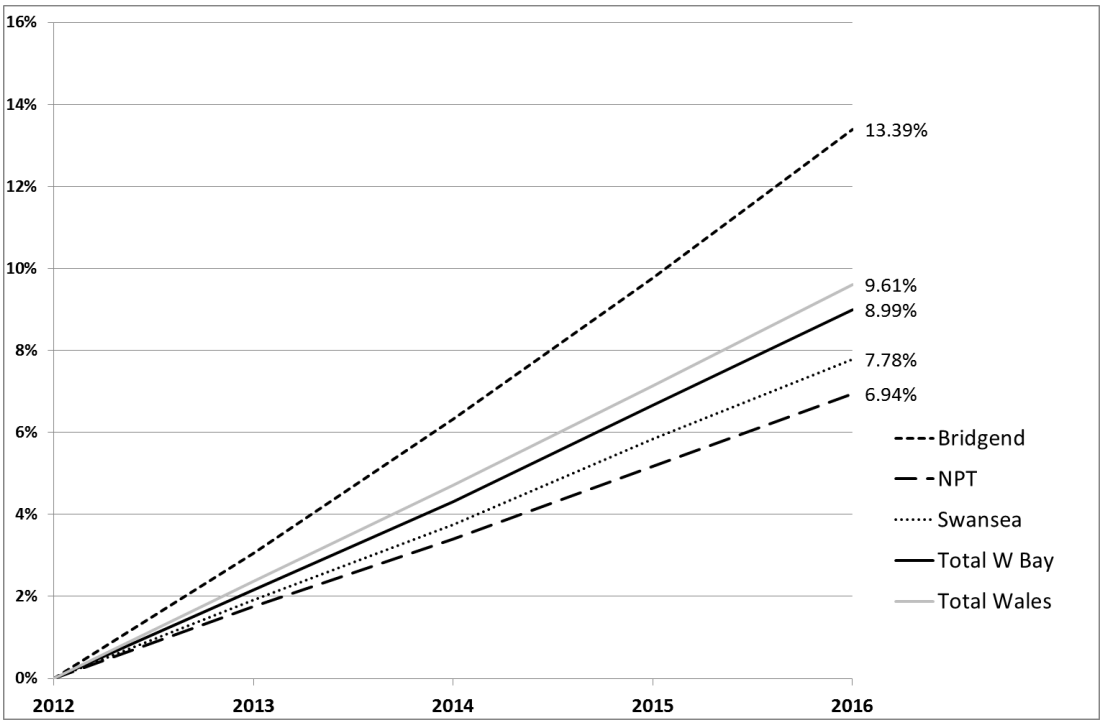
Since the Boards and Cabinets signed off the joint commitment document in September 2013, work has been focused on developing a more detailed business case for the above Intermediate Tier. This has included detailed modelling of data, working with service teams to develop a service model that can be standardised across the three localities and analysing financial impact.

It is also important to point out that work to address the other two key themes is also underway but at a slower pace. Links to the Staying Healthy Project and Public Health Wales teams are established with regards community

wellbeing development. As part of ensuring that services are sustainable, a £2.6m proposal has been submitted to Welsh Government's Health Technology Fund in order to provide the capital costs for improved technology and equipment for community teams. The revenue implications of this proposal are planned to being picked up as part of the Western Bay collaborative fund.

The Community Service Project has built on the population Strategic Health Needs Assessment approach and has considered how demand would impact on health and social care services if no change were introduced. Figure 18 below illustrates the rate of projected change in the numbers of frail people in each of the Western bay localities over 5 years, compared to each other and to Wales as a whole.

Figure 18 : Western Bay Estimated Frail Elderly Population Growth Rate



Our demographic analysis work has determined that should we adopt a "do nothing" approach, the annual additional cost of 'doing nothing' rises from £1.53 million in 2013/14 to £5.92 million in 2016/17.

Delivering Improved Community Services sets out a number of high level aims which the project wants to achieve, as follows:

- Support for people to remain independent and keep well
- More people cared for at home, with shorter stays in hospital if they are unwell
- A change in the pathway away from institutional care to community care

- Less people being asked to consider long term residential or nursing home care, particularly in a crisis
- More people living with the support of technology and appropriate support services
- Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies
- More treatment being provided at home, as an alternative to hospital admission
- Services available on a 7 day basis
- Earlier diagnosis of dementia and quicker access to specialist support for those who need it

The priorities to be taken forward over the next three years are set out below by year of impact.

Year	Community Services Project - Priorities
2014/15	• Implementation of the intermediate care model and investment plan. Detailed implementation plans for Intermediate Tier to be agreed with Localities and Local Authorities for integrating into implementation to commence April 2014 • Develop core community services across the ABMU area, e.g. chronic conditions management, district nursing, care home commissioning, social care etc, in line with intermediate care implementation. • Further integration of community services will take place including further work to build Older People's Community Mental Health into core community and intermediate care models, with a clear plan for dementia. • Detailed work around the integration agenda will be carried out with a clear governance structure – building and developing the option appraisal on extent of integration with Local Authorities and Third Sector • A detailed Frailty Model for local health economy will be developed as a result of both national and local pressures with a detailed implementation plan prepared by March 2015. A Frailty Think Tank/Symposium will be established in ABMU/Western Bay to design this system of care.
2015-16	• Implementation of Intermediate tier continues, evaluation and benefits realisation reviewed • Implementation of Core community services, Older People's Community Mental Health model and community networks structure begins based on business cases and implementation planning agreed in 14/15 • Detailed service models and business cases designed and agreed based on planning work carried out in 14-15 • Implementation of the Frailty Model during 15/16 in line with WG timescales, where services for Frail Older people will be developed as a whole system of care. • Further strengthening the opportunities through remodelling hospital and specialist services to shift resources into the community

2016-17	• Implementation of Intermediate tier continues, evaluation and benefits realisation reviewed • Implementation of core services and networks continues, evaluation and befits realisation reviewed • Implementation of the Frailty Model and those linked service development planned in 15/16, e.g. hospital interfaces, specialist mental health interface, etc • Detailed service models and business cases designed and agreed in 15/16 drive the implementation in 16/17 • Further implementation of innovative community service initiatives ensuring care truly defaults to a community setting.

This intermediate tier service redesign begins to address, on a partnership basis, the impacts of the demographic pressures on our hospitals supporting patients in their community setting. The Business Case for this development contains detailed modelling of impacts and benefits by Locality, which demonstrates that there is a direct fit with our strategy for our hospital services. Our assumption is that this business case will only be implemented upon successful attraction of funding from the Intermediate Care Fund.

In addition to our work on developing intermediate care with our partners, we have now commenced work on developing, in a structured way, baseline projections for core community services. This will be the next phase of work within the ***C4B Community Services Project***. It is anticipated that a business case will be developed impacting year two of this plan and this will feature in more detail in next year's IMTP.

Table 30 below provides a summary of the investment, savings and benefits to be delivered by this project.

Table 30 : Community Service Project Summary

	2014/15	2015/16	2016/17
Investment £		3,334,000 2,861,000	3,854,000
Savings £	-1,419,000*	-3,334,000	-3,854,000
Benefits	• Single Point of Access: These are established in each locality and increasingly all new contacts for community health and social care are directed through this route • Rapid Response: 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response. • Intake: 100% of all potential new homecare clients receive intake intermediate care. • Review: 100% of homecare clients for whom a potential significant change is identified receive review intermediate care. • Step down care: 100% of post-acute care that is suitable for domiciliary intermediate care is delivered at home rather than in a hospital bed. • Step up care: Step up care provision is expanded proportional to future change in the frail older population. • Residential intermediate care: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments. • Addresses current and potential future capacity issues for community services. • Minimises the use of long term care home placements.		
Workforce	45 additional members of staff (detail included in the Western Bay Business Case)		
Risks	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

*

Community services requires the reinvestment of its savings into community services as part of the funding arrangements for the Western Bay Health and Social Care Programme. The Health Board recognises the potential requirement for bridging funding in 2015/16 and 2016/17 and is committed to its contribution to this.

6.5.3 Hospital Services

The purpose of this project is to establish and improve the coordination of services within hospitals (serving our Health Board Area) into a 'network' of hospitals serving the health care needs of the population of Swansea, Neath Port Talbot and Bridgend and wider region. This will help to provide improved quality, safety and sustainable services and a workforce mode, delivering clinical care on a 7 day a week basis.

We recognise that improving the quality of scheduled and unscheduled medicine is a high priority, and how medical services are organised will have a significant impact on a range of complementary disciplines and services. The Royal College of Physicians set out recommendations to provide patients with safe, high quality healthcare, following the review conducted by Sir Michael Rawlins, through the Future Hospital Commission. We have reflected the findings of this work in our own local models of care and our ***C4B Hospital Services Project*** focuses on providing a sustainable medical model for the population we serve.

Establishing a sustainable model for medicine is crucial pillar in the clinical strategy of the Health Board. Our work on this project has led us to consider the long term models for our acute hospitals. The proposals in this plan begin to address our immediate service pressures, but these must also fit with the longer term strategic view for our hospitals. At a recent Changing for the Better event we began to extend the engagement and discussion about the future role of our hospitals beyond a three year planning horizon and we will continue to do this over coming months. We wish to be as transparent as possible with our stakeholders about the pressures we are facing and the impact his could have on a longer term basis on our acute sites. Our capital programme (set out in section 8) begins to move our hospitals to address immediate pressures, but this does not prejudice our current discussions about the longer term acute hospital models of service delivery.

Within the three year time frame for this plan we have an agreed service model that we are working towards. Some of this plan will be predicated on the availability of All Wales capital funding, and we are realistic that we may need to revise this plan once we have a clear understanding of this constraint. Set out below are the main elements of our proposed model.

6.5.3.1 Acute Hub for Swansea & Neath Port Talbot

- The Acute Care Hub will be based at Morriston and will bring together the clinical areas, which focus on the initial assessment and stabilisation of acutely ill medical patients. These include:
- The Clinical Decision Unit (acute medical unit)
- The ambulatory care provision
- Short-stay beds

- The Acute General Practice Unit (AGPU)
- The Out of Hours (OOH) General Practice service. The Emergency Department and close collaboration with the Welsh Ambulance Service.

The Acute Care Hub will focus on patients for the first 48 hours of their care.

6.5.3.2 Consolidation of Acute Services on the Morriston Hospital Site

To achieve a significant number of the quality improvements, identified by clinicians, it is essential to consolidate the care of acute patients onto one site for the population of Swansea and Neath Port Talbot.

6.5.3.3 Morriston Hospital

Major Acute Hospital, serving ABMU Region and providing specialist services to South West Wales.

- Complex unscheduled medicine,
- Related outpatient services
- Full 24/7 Emergency department, with Level 3 critical care and anaesthetics
- Acute Hub incorporating Acute GP unit, ED, Clinical Decision Unit, GP OOH,
- Specialist diagnostics
- Full range of general acute services

6.5.3.4 Singleton Hospital

Local Hospital serving the population of Swansea and providing a Cancer Centre for South West Wales and some non acute specialist services for Swansea and Neath Port Talbot.

- Minor Injuries Unit
- Non complex Ambulatory Medicine
- Outpatient services
- Direct Access Diagnostics
- Rehabilitation & Community Services Base / Hub
- Direct access to specialist and major acute services available at Morriston Hospital
- (Appropriate services to support South West Wales Cancer Centre)

6.5.3.5 Neath Port Talbot Hospital

Local Hospital serving the population of Neath and Port Talbot while providing some non complex services for the whole ABMU region.

- 24 /7 Nurse Led Minor Injuries Unit

- Outpatient services
- Direct access Diagnostics
- Rehabilitation & Community Services Base / Hub
- Non Complex Ambulatory Medicine
- Direct access to specialist and major acute services available at Morriston Hospital;

6.5.3.6 Princess of Wales Hospital

It should be noted that the scope of the ***Changing for the Better Hospital Services Project*** does not include any changes to services at the Princess of Wales Hospital at the current time. The outcome of the South Wales Programme is agreed, implementation of these changes will be led by the management team in the Princess of Wales Hospital working with colleagues in neighbouring Health Boards.

6.5.3.7 Ambulatory care

The provision of Ambulatory Care pathways will be a core component of the future model of medicine and will be crucial link for the Acute Hub. Ambulatory care pathways will include both diagnostic advice (led by acute physicians) and specialty 'hot clinics' available at least 5 days a week, on referral from the acute hub.

Eight high volume Ambulatory Care Sensitive conditions have been identified, where it is clear (from examination of bench marking information) that there is potential to make significant improvements, they are:

- Heart Failure
- COPD
- Pneumonia
- Urinary Tract Infection (UTI)
- Diarrhoea and Vomiting (D&V)
- Cellulitis
- Falls
- Atrial Fibrillation

Each condition will require different service changes to increase the number of patients who are seen on an ambulatory pathway. The detailed changes have been identified and the settings in which these service changes can be delivered have been considered. Further detail on the specific changes is available.

This is a complex series of services moves and changes. Set out below are the key milestones for the first three years of the project.

2014/15	• Establish Ambulatory Care as the default approach / setting for managing medical patients • Identify space for the development of the Acute Hub (specifically the relocation of the Acute GP Unit) on the Morriston Site • Establish sustainable Frail Elderly Assessment Unit Model • Scope the Implementation of the Singleton Minor Injuries Unit (a consistent model with NPT hospital) • Develop two new medical wards on the Morriston Site to provide additional acute medical bed capacity
2015/16	• Establish a acute hub for medicine for Swansea & Neath Port Talbot (Increase the capacity of the Morriston Acute Medical Unit (Clinical Decision Unit) to enable an increase in acute referrals on the Morriston Site • Reverse the roles of Ward R & Ward C following a renewal of the Wards • Initially admit Cardiology, Respiratory and Gastroenterology patients to Morriston only • Consolidate the consultant teams for those specialities
2016/17	• As a second stage admit all acute admissions to a single acute site • In Morriston Hospital establish one 7 day general medical on call service with appropriate capacity • Collocate Acute GP Unit into the Acute Hub with appropriate services • Further extend Ambulatory and Community Services capacity • IT Infrastructure

The table below provides a summary of the overall impact of the project.

Table 31 : Hospital Services Project Programme Summary

	2014/15	2015/16	2016/17
Investment	883,773	3,609,102	5,406,268
Savings	-508,000	-1,524,240	-2,540,400
Benefits	We anticipate the implementation of these moves delivering a wide range of benefits in terms of demand management, access, quality, safety and finance. For 2014/15 we plan to: - • Reduce WAST attendance at ED by 20% • Support delivery of reduced median wait in Emergency Department and Minor Injury Units from 126mins in April 2014 to 120mins in March 2015 • Increase successful WAST handover completion rate by 15mins by10% • Reduce admissions from 8 Ambulatory Care Sensitive conditions – reduction of admissions by a range of 10% -20% per condition • Reducing the average length of stay for adult medical admissions by one day. The benefits of Ambulatory Care Pathways have been well documented they include: • Patients avoid unnecessary hospital admissions; • patient experience is improved by reducing admission and therefore the risk of hospital-acquired infections; • Supports GPs / Primary care to manage patients safely at home once a definite diagnosis has been made (or excluded), and consequent advice on management is given; • Enhances cost-efficiency by improving the use of resources		
Workforce	7 Medical Consultants 7 Middle Grade Medical Doctors 3.5 Medical Secretaries Increase in Acute General Practice Staff by 29% to develop 7 day working 5 Nurses support Acute Hub	4 Medical Consultants 5 Middle Grade Medical Doctors 2.5 Medical Secretaries 2.35 Clinical Fellows	2 Medical Consultants 2 Middle Grade Medical Doctors 1 Medical Secretary 2.65 Medical Fellows
Risks	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.5.4 Rapid Access

The overall objective is to provide a model for rapid access services in each of the localities in ABMU that are specialty specific and proactively provide a range of rapid interventions. These will include specialist advice, rapid assessment, diagnosis and treatment for those patients at risk otherwise of requiring emergency admission to A&E.

In order to achieve this overall aim, the project will establish a one-stop assessment and diagnostics model that:

- Improves access
- Avoids inappropriate admission to secondary care
- Integrates primary, community and secondary care services.

There is comprehensive evidence, both locally and nationally, of the benefits of developing services that allow primary and community care professionals to access treatment, diagnostics and advice in order to avoid emergency department admissions for non-urgent conditions/episodes.

In October 2013, a clinical timeout was held bringing together a range of clinicians to present and debate models of best practice within Rapid Access across the specialties within the ABMU area. The timeout resulted in the development of a set of principles:-

- Rapid Access is seen as an organisational ethos within ABMU, so that:
  - patients are cared for by the right people, in the appropriate clinical setting, with the level of urgency proportionate to their needs
  - professionals have the right tools, systems and job plans to enable them to respond effectively and efficiently to patient needs.
- Technology is designed to support rapid access to advice, assessment and treatment, ensuring the patient record is updated in real time.
- The technology is supported by clear, well communicated processes and guidance.
- There are clear points of contact for professionals and the public, with referral routes defined and well communicated.
- Rapid Access is owned by everyone involved and there is professional buy-in at every level of the organisation, with a commitment from all to support its effective use when patients and professionals need it – so that Rapid Access becomes ‘part of the day job’.
- Patient need must be the priority, so that if a patient requires rapid access to a particular service they should be referred, assessed, treated and discharged with no unnecessary delay and through the best pathway for them. This will often avoid attendance at the Emergency Department or a hospital admission.
- There is recognition from all professionals that Rapid Access will require a change in the way we work.

- RAPID actually means rapid!

The scope of the Project includes the development of the following components of rapid access:

Rapid assessment and treatment	• Ward based assessment – direct access for primary care - specialty specific • Day Unit / Cold site Ambulatory Centre • Hot clinics – specialty specific • All with multi-disciplinary Team (MDT) approach
Specialist advice lines	• Consultant to GP / Specialist Nurse to GP, etc • 24 hour Email service (generic advice) • Immediate phone advice service (Real time advice) • E-referral response route (specific advice)
Urgent Diagnostics	• Point of care testing • Available within primary care practice, e.g. Electro-cardiogram (ECG) • Available in community hospital / resource centre, e.g. ultrasound, echo, X-ray • Available in acute hospital, e.g. MRI, CT

In light of the three focus areas for Rapid Access above (assessment, specialist advice and diagnostics) and linked to the work being taken forward on the High Impact Conditions (eight ambulatory care conditions) and the acute care reconfiguration in Swansea and NPT, a number of priorities will be taken forward within the project over the next three years. These are set out below by year of impact.

2014/15	**Rapid access to assessment/ward (Cold Site Ambulatory Unit)** • The aim is to establish a safe, efficient and well supported model for a Cold Site Ambulatory Unit to undertake medical day case work as well as ambulatory pathways that have the maximum effect on emergency admissions. • A pilot project has been established which builds on the current initiative being carried out on Ward 10 Singleton. The aim is to strengthen the unit in the short term to further test its effect on the system. Whilst this is taking place, development of a model for the ambulatory unit will commence focusing on key pathways. **Rapid Access to Specialist Advice** • This element of the project will focus on the development of advice lines (phone/email) for the following specialities in 14/15: – Cardiology – Respiratory – Gastroenterology This is to support the acute re-configuration in Swansea and NPT.

	Rapid Access to Diagnostics It is recognised that without development of diagnostic services, the rapid access agenda cannot be developed within current capacity levels. As a result, the following developments will be phased over a three year period in order to support the rapid access initiatives: - • Hot reporting/A&E reporting to develop a 'hot reporting' rota to support the unscheduled care pressures • Extended working day (CT and US) to 1) increase capacity and 2) give patients more choice. This increase in capacity would be to accommodate rapid scan requests from GPs, with current services at capacity • Weekend working to be rolled out where appropriate (assessing impact of current pilot initiatives). This could give routine Outpatient slots for increased patient choice in future. • Point of contact radiologist 'duty' on hospital sites to cover all GP requests for advice, rapid special diagnostic test booking, warm/hot reporting and plain films
2015/16	• Evaluation of Ward 10 pilot and identify activity that can be moved from Morriston Renal Day Unit • Specific model developed in line with community services virtual ward initiative, e.g. use of singleton as the diagnostic centre for patients needing urgent testing in order to return home for their ongoing care. • Finalise model for Cold Site Ambulatory Unit and analyse preferred location, co-location and test the model, e.g. to locate within the Acute GP Unit (AGPU), Surgical Assessment Unit (SAU) space at Singleton once clinical moves have started? Identify other locations in ABMU where the model can be implemented in line with the Rapid Access principles of development. • Evaluate advice lines and plan further roll-out to other specialities, e.g. Cancer, Osteoporosis, etc. • Diagnostic provision further expanded to cater for community services, e.g. virtual ward models
2016/17	• In line with acute clinical reconfiguration in Swansea and Neath Port Talbot (movement of Acute Hub/AGPU) implement the Cold Site Ambulatory Unit at Singleton in partnership with Swansea University, providing a state of the art facility that has excellent training and teaching programmes but also treats the clinical conditions not needing to be admitted to an acute hospital site. • Acute Ambulatory Unit model implemented in other general hospitals within ABMU as part of the network approach to hospital provision, • Roll out of advice lines to remaining specialities where appropriate • Further refinement of diagnostic models and capacity plans

Table 32 below summaries the overall impact of the project.

Table 32 : Rapid Access Project Summary

	2014/15	2015/16	2016/17
Investment £	607,844	1,060,912	1,589,197
Savings £	-240,000	-710,000	-1,180,000
Benefits	• An ambulatory unit in each hospital, supporting admission avoidance. • Facilitate a change in culture with regards clinical practice and patient management based on the principles of Rapid Access • Specialist assessment of patients within 4, 12, 24, 48 and 72 hours (depending on complexity and urgency of patient condition) of a possible deterioration of a medical problem, to prevent admission into acute hospital. • Prevent/reduce multiple visits to hospital by providing a one stop medical, diagnostic workup and multidisciplinary assessment. • Improve patient satisfaction by keeping services local. • Enable older people and those with LTC to maximise their independence and prevent premature entry into long-term care • GPs and community staff will have additional routes to access to specialist advice from Consultants and Specialist Nurses e.g. over the phone, email, Skype, etc. • People will be able to access ward-based assessment where staff know them and are familiar with their condition and medical history		
Workforce	**Rapid Access to Assessment / Ward** Pilot on Ward 10 introduced Dec 13 to Mar 14 – Band 5 Nurse 2.00 WTE. Band 2 Support 2.00 WTE Ward Based Assessment (Medical) – Consultant 1.00 WTE. Junior Doctor 2.00 WTE **Access to Diagnostics** Hot Reporting/A&E Reporting – Consultant 2.40 WTE. Band 7 Radiographer 1.00 WTE. Band 6 Radiographer 1.00 WTE Extended Working Day (CT and US) – Consultant 2.70 WTE. Band 6 Radiographer 4.60 WTE. Band 4 A&C 1.40 WTE. Band 2 Porter 3.20 WTE Point of contact Radiologist - Consultant 4.00 WTE, Band 4 A&C 2.00 WTE		
Risks	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.5.5 Overall impact of the Patient Flow/Unscheduled Care and C4B Clinical Strategy Programme on future medical bed numbers

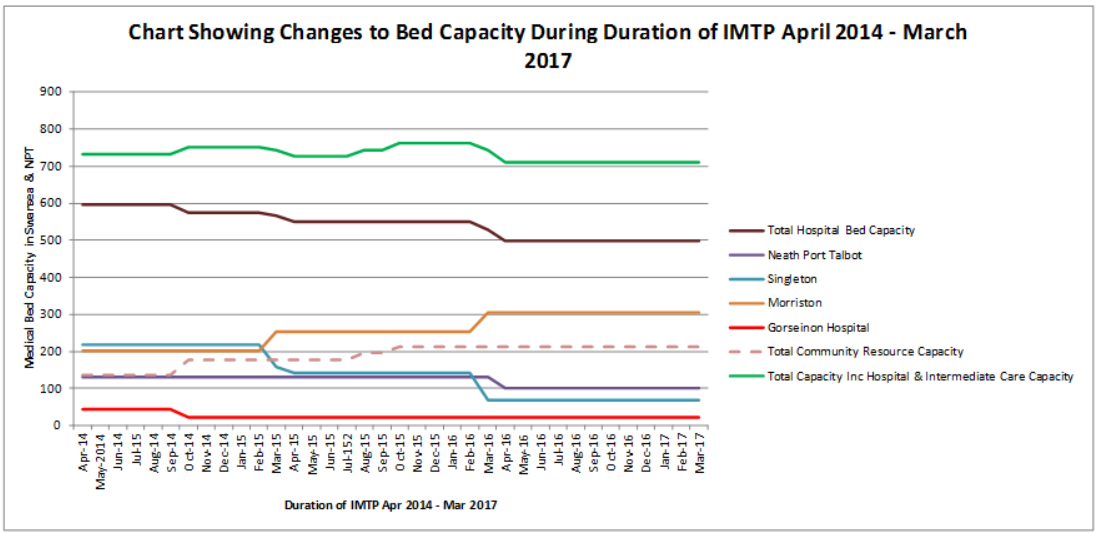
An expected benefit of three of the ***C4B Projects*** (i.e. Community Services, Hospital Services and Rapid Access) is a reduction in the number of hospital medical beds. These bed reductions are summarised in the table below.

Table 33 : Showing projected changes in medical beds

	Pre – Acute	Acute	Post Acute
Beds saved by March 2017	36	49	93
	• Establishing 9 High Impact Condition Pathways **Hospital Services** • Establishing (Hot Site)Acute Hub located on Morriston Site **Rapid Access** • Establishing Cold Site Ambulatory Care Unit (co-located on Singleton site) • Establishing Specialist Advice lines • Establishing appropriate 7 day diagnostics • Pre-hospital Services • WAST Pathways	**Hospital Services Project** • Medical Workforce • Nursing Workforce • Establishing an effective Discharge Lounge • Establishing appropriate 7 day diagnostics	**Hospital Services Project** • Medical Workforce • Nursing Workforce • Establishing an effective Discharge Lounge • Establishing appropriate 7 day diagnostics **Community Services Project** • Establishing an effective Intermediate Tier of Care

Figure 19 below provides an overview of the projected changes in beds and community resources over the next three years. This shows that the total number of hospital beds will fall over the next three years, but that this will be balanced with an increase in community resource capacity. The graph shows that total capacity (which includes a combination of hospital beds and intermediate care capacity) fluctuates over the first two years, but levels out in year three. These fluctuations reflect the implementation of the various project initiatives.

Figure 19 : Showing changes in bed capacity



This diagram is provided for illustrative purposes. The precise timing of the step and step down own bed capacity on the different sites will be guided by the availability of capital funding to create sufficient capacity at Morriston Hospital to accommodate the clinical model. The capital requirements are set out in the finance section (Section 8) below and we are working with Welsh Government at present to agree the overall capital programme to support the IMTP.

6.5.6 Changing for the Better – Other Projects

C4B Clinical Strategy Programme comprises 8 projects. The three projects described above are the main priority projects within the overall programme i.e. the projects which address the most urgent demands for us as a Health Board. They complement the ***Unscheduled Care / Patient Flow Programme*** in particular and given our need to meet the challenges faced by our unscheduled care services, the synergy across these initiatives is critical to addressing immediate pressures and future sustainability.

The remainder of this section briefly describes the other 5 projects within the ***C4B Clinical Strategy Programme***. Each has a summary table using the same format as above to illustrate the commitments and benefits of each. The 4 projects are:

- Pre hospital services
- Trauma centre development
- Outpatient modernisation
- Co dependent maternity, Newborn, Gynaecology, Neonatal and Children and Young People's services

6.5.6.1 Pre hospital services

The aim of this project is to develop and strengthen services, with the Welsh Ambulance Service and other partners, to provide alternatives to the public / patients arriving unnecessarily at the Emergency Department and within Primary Care. The project has focused on developing new Pre hospital Pathways with WAST including**: -**

- Alcohol
- End of Life
- Care home conveyance
- Stroke
- Fracture Neck of Femur (#NOF)
- ATMIST – system for patient early alert, pre-alert and handover

FREQUENT ATTENDERS

The Project is piloting work that identifies a numbers of frequent attendees at the Emergency department. Once identified they are contacted by the third sector (Red Cross) who work with them closely for a 12 week period on a behaviour change programme.

PUBLIC EDUCATION

The project is focused on continuing to inform the public of what unscheduled care services are available and when they should be appropriately accessed. This is being progressed through the “Choose Well Campaign” a priority of this Campaign is to communicate and engage with ABMU staff on the Key messages.

DIRECT ACCESS

This project will be working with Specialities to develop Direct Access Pathways for Patients from the Community and Patients who WAST are conveying. This work is closely linked to the developments of an acute hub. Table 34 below summaries the overall impact of the project.

Table 34 : Pre hospital services Project Summary

	2014/15	2015/16	2016/17
Investment £	125,468	86,785	130,000
Savings £	-155,520	-155,520	-155,520
Benefits	To reduce the numbers of unnecessary A&E attendances		
Workforce	The project is working closely with Welsh Ambulance Service in order to increase the competencies of Paramedics in order to enable them to be able to resolve more patient conditions at home without conveying them to Hospital.		
Risks	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.5.6.2 Trauma Centre Development

This project will support the development of ideas and a service specification as part of the South Wales Trauma Network Collaborative. Specifically, this project has been established to ensure that all actions required to enable Morriston Hospital to play a key role, along with the University Hospital of Wales Cardiff, in the provision of Trauma Centre services for South Wales. The progress of this project is as follows: -

- A gap analysis of appropriate services, against the national standards for Major Trauma, has been completed. The gap analysis identified a number of areas that will require development including:
  - Major Trauma Rehabilitation – ability to meet the requirement for a rehab prescription within 72hrs and the additional rehab that is required.
  - The requirement to establish a system / service for the coordination of care for patients with complex major trauma, once the patient leaves intensive therapy unit (ITU).
  - Ability to provide 24/7 major trauma lead.
- A business case is being prepared for the establishment of the South Wales Trauma Network.
- Our Health Board is in the process of advertising for a Clinical Lead for Major Trauma

Table 35 below summaries the overall impact of the programme.

Table 35 : Trauma Centre Development Project Summary

	2014/15	2015/16	2016/17
Investment £	17,644	30,041	45,000
Additional Income £	-		
Benefits	To be developed as part of the process of producing a business case.		
Workforce	Detail to be developed as part of the process of producing the business case.		
Risks	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.5.6.3 Outpatient Modernisation

We recognise that in the majority of cases we still operate a very traditional model of outpatient delivery. There are many benefits to be gained from modernising the way outpatients care is provided, particularly for clinical services which manage patients with chronic conditions and where patient numbers requiring care are projected to rise. The current scope of this project is set out below: -

- National Benchmarking (look at other areas that may have had successes and failures in increasing collaboration and reducing demand on traditional outpatients and learn from these.)
- Look at innovative ways to provide the core benefits of an outpatient attendance in the patient's home.
- Intelligence on medical training requirements (i.e. does this negatively affect the way we plan to undertake outpatients in the future in terms of learning opportunities)
- Effectiveness of booking systems and alternatives approaches used elsewhere
- Effectiveness of our communication back to referrer or GP via electronic transmission. Could we discharge more and offer "See on Symptom" access? Can we improve communication in terms of e-advice?
- Why do we bring so many patients to a hospital clinic and what are the alternatives that have been proven effective in other areas / countries.
- What is the quality of information sharing both referral in and appointment summary etc? Are we sending the patient appropriate accurate information? What IT/hardware is available to help with this?

- Are we getting the best use out of our consultant time (sessional use, and could we consider virtual clinics or rapid access email advice for GPs etc)?
- Patient pathways and how do these need to change to modernize our service?

Table 36 below summaries the overall impact of the programme.

Table 36 : Outpatient Modernisation Project Summary

	2014/15	2015/16	2016/17
Investment £	7,842	-	-
Savings £	-292,421	-1,462,106	-2,924,212
Benefits	• A preventative model that reduces demand on the service. Reduce number of referrals by 5% in year 2 and 10% in year 3. • Patients only attend if really necessary. • More rapid access to diagnostics and better co-ordination of test results • Alternatives to traditional consultant outpatient appointment provided • Capacity created to support delivery of national outpatient targets i.e. – RTT waiting times – 31 and 62 days cancer targets – New to follow up ratios – Percentage of DNA (Did not attend). – No of FUNB (follow up not Booked Patients) • A single information system to link services. • Patient focussed system to allow co-ordination of appointments. • Standardisation of patient information across the Health Board. • Electronic referrals from primary to secondary care (100 % compliance) • Electronic discharge letters from secondary to primary care that is accepted by GPs. (100% compliance) • Patients should come away from their appointment with relevant information. • A Direct access model for the patient. • More One stop shop clinics. • Early senior review with a clear treatment plan. • Better follow up management (reduce the numbers). • Rapid access or hot clinics as needed. • Junior Doctor supervision. • Rapid specialty advice in more specialties. • Community based clinics/ Network. • More use of telemedicine / email advice. • Greater flexibility of timings of clinics		

Workforce	Modelling to take place on clinic numbers and level of support in each staff group.	Future modelling to consider workforce in relation to fewer clinics being held in hospital and more advice / care being given in the community.	Consultant job planning discussions where appropriate. Post change evaluation of workforce and further modelling.
Risk Profile	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.5.6.4 Women, Children and Families

To meet the best standards of care, we plan to transfer maternity, obstetric, neonatal and in-patient gynaecology services from Singleton Hospital to Morriston Hospital, when capital funding allows. The capital requirement is key to the implementation of this project and given the likely scale of the investment needed, the actual delivery of this will be outside of the 3 years covered by this document. Given the scale of the planned change we feel that it is prudent to begin preparations now to enable us to construct the necessary business cases to support the move. The current work programme includes:

- Developing a vision statement for a fully integrated service model.
- Integration of services involving community the multi-disciplinary team (Community Paediatricians, Therapies, child and adolescent mental health services (CAMHS), integrated sexual health, drugs & alcohol services, Community Paediatric Nursing, third sector services, safeguarding etc) into a community setting (either new build, adapted or use of community buildings/GP premises)
- Baseline data Collection of epidemiological and relevant demographic data to provide a profile of ABMU Health Boards population likely to be affected by alteration of current service model.
- Undertake comprehensive bed modelling by speciality.
- A profile of current inpatient services by speciality.
- Workforce Modelling Maternity and Newborn, Neonatology, Gynaecology, Inpatients Paediatrics including risks and financial pressures.
- Cost analysis of capital funding required to implement an integrated service model for all inpatient paediatric, neonatal, obstetric and gynaecological services located on the Morriston site. Engage with Welsh Government on capital allocations.
- Following the completion of the South Wales Programme, implement with other Health Boards the required changes to establish Princess of Wales Hospital as a regional centre with regard to inpatient paediatric, neonatal, obstetric and gynaecological services.

- Formulate robust Long Term Agreement, which accurately reflect the cost of services provided as a specialist or tertiary centre.
- Pathway approach to plans within each speciality, i.e. Children, Young People and Families – Pathway/Protocol for :
  - Well child
  - Acutely unwell child
  - Complex needs child CHC
  - Looked after children
- Implementation of Paediatric Community Resource Team/Outreach Team
- Implement a single point of access

Table 37 below summaries the overall impact of the programme.

Table 37 : Co dependent maternity, Newborn, Gynaecology, Neonatal and Children and Young People's Project Summary

	2014/15	2015/16	2016/17
Investment £	18,036	324,935	845,737
Savings £	-	24,857	298,310
Benefits	A healthier population • Increased vaccination rates • Reduction in smoking in pregnancy • Increase in self-management • Improvement in morbidity Better quality services– • Compliance of multi-disciplinary standards/adherence to professional standards. • Percentage of patients satisfied with their care • Compliance with waiting time targets • Achievement of local benchmark targets • Improvement in RAMI, • Reduced mortality rates below the national average • Achievement of the National neonatal audit project measures Better patient experience – positive feedback from patient surveys Motivated and sustainable workforce • Medical workforce rota compliance • Positive feedback from staff surveys • Reduced sickness and absence levels.		
Workforce Profile	Community Paediatric School Nurses – 1.5xBand5	Community Paediatric Nurse Band 6 and Band 7,	Community Paediatric Nurse Band 6 and Band 7, Community Neonatal Nurse - 3xBand7,

		Community Paediatric School Nurses – 1.5xBand5, Midwife Lead Public Health – Band 7	Community Paediatric School Nurses – 1.5xBand5, Gynaecology/Midwifery Nurse Practitioner – 4xBand7, Midwife Lead Public Health – Band 7, Paediatric (Neonatal) Nurses – 11.5xBand5
Risks	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

6.5.6.5 Summary

The three Strategic Change Programmes within this section will underpin our service change and service transformation agenda. They are clearly aligned with our Strategy. Resources have been assigned to enable these to be progressed (subject to All Wales capital in the case of the hospital services project)..

7 Workforce and Organisation Development

This section of our Plan focuses on key Workforce and Organisational Development priorities including engagement, leadership, workforce planning, training and partnership.

7.1 Introduction

In developing a workforce plan to support the delivery of our strategy, we recognise that our staff are our biggest asset and they all have a vital role in creating safe and effective care for the people of ABMU; and in shaping the future of our services. We recognise that our current workforce does not universally have the education and training to care for frail older people. Our senior clinical leaders have not felt empowered to lead change. We also realise that our staff are often working in individual professional communities of practice rather than effective multi-disciplinary teams. We will provide training in care of people with dementia, continence care and care for people at the end of their lives across the workforce. We will implement a skills and knowledge programme that ensures all staff working in our hospitals understand and are equipped to meet their obligations to frail older people. In particular, we will run an intensive education programme on delirium, dementia and dying in hospital. We will develop more cohesive multi-disciplinary team practice across the Health Board built around shared responsibility and accountability for patient care and standards of professional behaviour. We will introduce a coaching scheme for front-line clinical leaders to ensure we build upon their leadership abilities and management skills to redesign our systems with continuous improvement built in. We will simplify and strengthen management and clinical accountabilities and review ward staffing procedures to guarantee the right clinical and support staff are in the right place to meet the needs of patients at that time. We also recognise that our future workforce will require different roles; different skill mix and different working practices and that we will need to work collaboratively with our partners and stakeholders to support the development of integrated services.

Effective workforce planning is more than getting the numbers of staff right. It is about getting the staff with the right skills to meet our future demands, performing with the right values and behaviours. Our Workforce Plan supports the development of the right culture, built with the right staffing model, with the right skills, supported by effective management and clinical leadership that will successfully transform the way we provide care and services to the patients and carers, citizens and the communities we serve – our ‘Excellent People’.

Earlier sections identified the work on understanding and embedding values to meet the challenges facing our organisation and provide drivers for change.

7.2 Workforce Picture 3 Years Ahead

The impact of implementing our 3 year Plan on the profile of Whole Time Equivalent (WTE) shows the overall workforce numbers are not expected to change significantly, but we are improving the cost effectiveness of our workforce. Over this period of time, workforce numbers will move from 13,175 to 13,419. Appendices B11 - 15 sets out in more detail how the workforce change is distributed between staff groups, in terms of WTE and cost and also set out the recruitment challenges, workforce changes and education requirements arising from the full range of changes planned to date.

Within this plan, we have identified a wide range of integrated service, workforce and financial initiatives. The impact upon the workforce can be broadly categorised by requiring: -

- Significant role redesign with new roles and joint roles between health and social care, as a result of service changes and the need for more care delivered closer to patients' homes, illustrated by our ***C4B – Clinical Strategy Programme***.
- Relocation of staff and the times we work, related to proposed changes to care settings, which are aimed at improving and accelerating access to and quality of care. These changes are reflected in our **Surgical Efficiency Pathway, Patient Flow/Unscheduled Care and C4B Clinical Strategy Programmes.**
- Reduction in posts and headcount related to the introduction of new technology; management and administrative restructurings; investment and reconfiguration of the workforce to meet nationally agreed standards for numbers, skill mix and different ways of working.
- Focus on training and development so that staff are equipped with the right skills and competencies to deliver safe, quality care.
- Concentrate on reducing variable pay through better ways of working and reducing sickness absences as outlined in Section 8, Finance

7.2.1 Workforce in General

It is vital that we use the talent and experience of our workforce to provide services that improve health and improve care together, while creating future workforce sustainability. Achieving this balance needs a different mix of skills, competency and capabilities to the current ones. We will continue to work in partnership with the Universities and other education providers to deliver

learning opportunities, alternative ways of accessing education and accessing new funding streams.

In addition to raising the profile as a University Health Board, the ABMU Multi-Professional Education Forum provides a mechanism for discussing the education priorities arising from the ABMU Clinical Strategy to ensure that the education requirements of the future workforce are met, in line with policy and strategy. For 2014/15 the priorities are:

- Development of Advanced Practitioner roles in line with service re-design, including the development of an Institute of Advanced Practice Strategic plans for addressing public health education and awareness raising – 'Making Every Contact Count'.
- Primary care and development of Community Networks, through the creation of an educational programme for Primary Care Practice Managers.

We are also piloting a number of small initiatives that begin to provide services for unscheduled care, in particular on a 7 days a week basis. These are described in section 6 within our ***Unscheduled Care/patient Flow Programme*** and our plan is to evaluate these pilots robustly before committing to the final model of 7 day working.

7.2.2 Nursing Workforce

The majority of our workforce and consequently the majority of care is provided by our nursing staff. Our workforce plan illustrates the:

- Effective utilisation of the total nurse staffing resources, whilst ensuring that nursing standards are maintained and high quality care delivered.
- Role changes, skills, training and development we need to deliver our Strategic Change Programmes and our Life Course outlined under Strategic Context

The key workforce actions for 2014 -2017 are:

- Systematic review of our nursing workforce numbers in acute ward areas against the All Wales Staffing Principles. (We have already targeted quality investments to improve nurse staffing levels on our medical and surgical wards).
- Implementation of an all-Wales Acuity and Dependency Tool for all adult acute ward areas from 1st April 2014 (this will replace the All Wales Staffing Principles).
- Manage performance through the Quality and Safety Accountability Framework.

- Build further the capacity and skills of staff to deliver safe, quality care and invest in new skills and redesigned roles for primary care and community settings.
- Provide strong nursing leadership at all levels
- Continue to promote the embedding of research and innovation into the roles of staff and teams through our collaborative approach with the Swansea University College of Human and Health Sciences
- Implements national training and education initiatives that ensure future sustainability for Wales.
- Further development of the Healthcare Support Worker (HCSW), utilising the All Wales Code of Conduct, and Delegation Guidelines, Guidelines of Delegation to ensure HCSW roles are utilised to full potential and support skill mix in clinical areas.
- Stopping the use of high cost nursing agencies through effective recruitment to vacancies and 'growing' and ongoing recruitment to the Nurse Bank.
- Develop further training for those delivering care to people with dementia and at induction, as a consequence of the training needs analysis
- Drive the effective utilisation of e-rostering functionality in nursing areas to deliver maximum benefits realisation and ensure better use of staffing at nights and at weekends.
- Invest in the development of aspiring ward managers through good succession planning, nurturing talent, and supportive management frameworks.
- Fully embed the Advanced Practice Framework (NLIAH 2010) ensuring good governance exists for all nurses working at this advanced level of practice
- Ensure robust preceptor ship arrangements are in place to support and develop new registrants, thus enhancing recruitment and retention

Although recruitment to general nursing posts is buoyant, the Health Board continues to experience difficulty recruiting at times nurses with the right skills to take forward service change. The 3 year plan will introduce different ways to attract applicants, through succession planning, staff rotational programmes, providing access to improved career pathways and by providing rewarding careers for staff.

7.2.3 Consultant and Junior Doctor Workforce

In Section 2 we referred to the significant workforce challenges for this Health Board from 2014 onwards, caused by the current deficit in consultant and junior doctor numbers. Other factors, including pension and tax changes which are beyond the control of NHS Wales, are also likely to impact on the demand/supply of the future consultant workforce.

Our service and then workforce plan includes redesigning roles to help support the consultant and junior doctor supply gap. In addition, we continue

to Work closely with the Wales Deanery where the key actions for 2014-2017 are:

- Pursue overseas Medical Training Initiatives (MTIs) in a number of specialities, with the support of the respective Royal College and the Deanery. These doctors can only work for the NHS for a maximum period of 2 years and there can be a long lead in time to secure these doctors in post. However, once established MTIs can provide a useful supply of junior doctors.
- Adopt different ways of promoting training in Wales which will radically change the way training is configured. The Health Board is currently working with the Service Reconfiguration Leads appointed by the Deanery in relation to Anaesthetics, Paediatrics, Neonatology, Obstetrics and Gynaecology, Core Medicine and Core Surgery.
- Ensure that our young doctors have the knowledge and skills to support the delivery of excellent care, especially for the frail elderly
- Optimise links with Swansea University to establish Clinical Academic posts at consultant and junior doctor level.
- Continue to engage fully with junior doctors to listen to their feedback and work together to deliver improvements in working practices and experience. This should help improve feedback to the GMC to ensure positive messages flow from their experience of working in ABMU which will in turn help attract further young doctors to work in Wales and this Health Board.

In addition, short term international recruitment of medical staff will need to continue, but this is not seen as a longer term sustainable solution.

Undoubtedly, our work with the Wales Deanery provides us with a number of specialty challenges, specifically where the number of training grade doctors are being reduced and also the number of doctors required on a rota is being broadened from a 1:8 to a 1:11. This will concentrate the training grade doctors on fewer sites and raises concerns for the sustainability of existing clinical services. As a consequence our IMTP has identified an expansion of Advanced Practitioners to mitigate some of these risks to service sustainability.

The Health Board has been reengineering its Consultant recruitment process, which will be implemented in 2014/15. This aims to attract high quality candidates and the revised process will allow the Health Board to ensure we are selecting candidates with the most appropriate qualities and We are also working to ensure the effective utilisation of our current medical staffing resource. There are important national initiatives underway which may help the Board including maximising the outputs from the current amended Consultant Contract in Wales. A new Junior Doctor Contract is also being negotiated on a UK basis which will simplify the contract and link pay to competence. Locally we will continued to focus on improvements to the

Consultant job planning with plans to encourage more team job planning to allow greater flexibility, increased capacity and the development of service sensitive outcomes.

Finally, on the horizon is the reshaping of junior doctor training as laid out in the Greenaway Review. This will produce a medical workforce to meet the changing needs of the population. Timescales are not yet known but some of these changes may begin to impact during the life of this 3 year plan.

7.2.4 Primary Care Medical Workforce

A joint report produced by the Wales Deanery and the National Leadership and Innovation Agency for Healthcare (NLIAH) in July 2012 summarised work undertaken to model the anticipated future supply of new GPs in Wales and to compare it against the most likely levels of future demand. The conclusion of the review indicated that there is likely to be a shortfall in the supply of GPs in the near future, mirrored in ABMU and referred to in Section 2.

The forecasting work took account of the current supply and also a range of 'demand' factors that are likely to impact on the overall number of GPs. The paper noted that the future demand/supply of doctors is influenced by many different factors which can change over time and that forecasting exact requirements is not a scientific process. As a result of the national review, ABMU undertook its own analysis of the workforce position and our initial assessment has highlighted:

- A potential shortfall in the number of GPs given predicted retirement patterns and on the basis of the 'known' shortfall in the number of GPs being trained
- Earlier retirement patterns could result in a markedly worse situation
- At the same time, demand for a strong and robust workforce within primary care is needed to address some of the demand factors including the impact of an ageing population, an increase in the number of people who have complex medical conditions, as well the transfer of services from secondary to primary care.

Since the Deanery report was published, the factors described under consultants around pension and tax changes that are beyond the control of NHS Wales are also likely to impact on the supply of GPs. Other factors that are relevant include:

- An increasing proportion of the workforce who wish to work part time
- Changing models that mean that there are a different range of options from the traditional, equity sharing partnership model, including salaried doctors, doctors working on a session basis in a variety of settings, as well as salaried (non profit sharing) partnerships.

A number of scenarios using different retirement profiles have been developed to help to assess where shortfalls are likely to occur. Localities will continue to risk assess their areas and consider other factors that may impact on the sustainability of general medical services (for example, factors such as the condition/suitability of premises). The impact of a shortage of GPs could have a number of different impacts:

- Growing list sizes – Our current ratio of GPs per head of population is consistent with the national average. However this masks variation across the 11 Community Network areas and a reduction in the number of GPs will worsen the overall ratio. Growth in the number of older people, and an increase in patients who have multiple chronic conditions will place additional demands on primary care.
- Pressure on access – growing list sizes will inevitably result in pressures around access arrangements with a potential for the improvements in access were secured post 2004 being eroded.
- Closed Lists – with pressures on both list sizes and access arrangements, there is potential for practices to feel that the only way of managing demand is to consider 'closing lists'.
- Quality – sustained workload and service pressures could impact negatively on the quality of service provision and standards of care, which in turn, could impact on other parts of the healthcare system, and also restrain the wider objective of population health improvement
- Sustainability – in some cases, factors may combine to make independent general practice unsustainable in some parts – particularly if there are poorer premises. Unforeseen issues (for example, ill health) may force premature retirement leading to an increase in the number of practices that the Health Board will have to step in and manage which would expose the Health Board to increasing clinical and financial risk.

In 2015/16, the Health Board will be considering a range of options to tackle the issues as in reality, no single approach is likely to produce benefits. The following is an initial set of options that will be worked up over the coming months and appraised in terms of feasibility and costs/benefits. The options span short, medium and long term actions:

Short- medium term

- Initiatives to encourage and support doctors to work in ABMU including more proactive recruitment/retention plans, flexible working opportunities and exploring ways of securing added value through our University Health Board status
- Supporting practices to work together more effectively – using existing network structures to consider other models including federated working
- Employing GPs in supernumerary roles
- Developing our own 'managed' GP provision, building on the OOH/AGPU services to help address particular workforce challenges

- Maximising skills across the wider primary care team including practice nurses, specialist nursing roles, pharmacists to help address some of the workload. Using GPs more effectively to manage complex conditions by freeing up their time

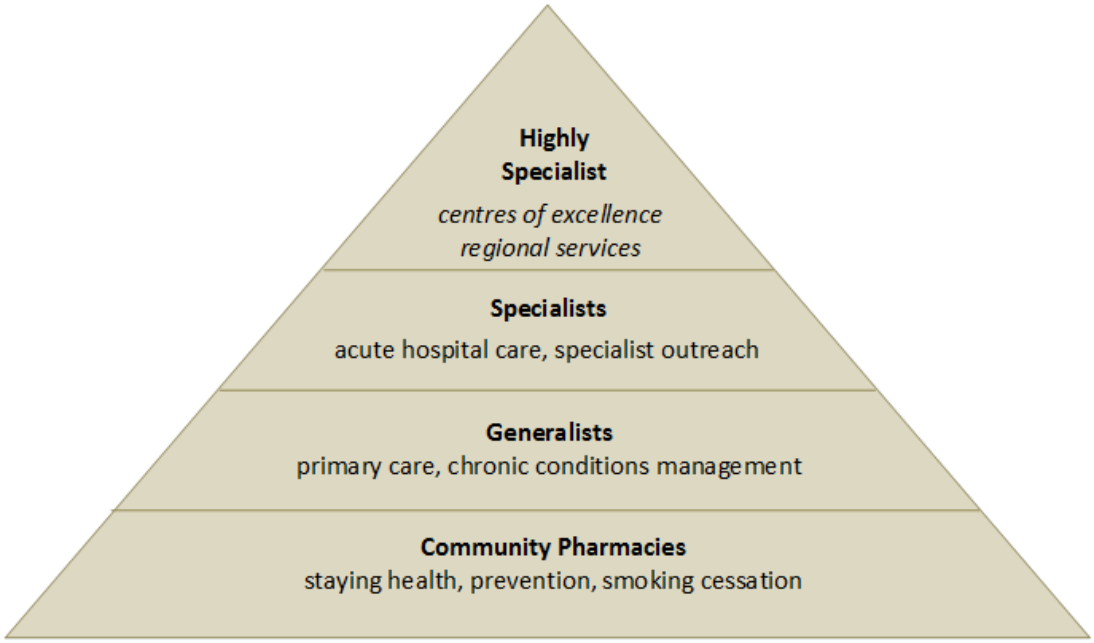
Longer term

- Considering new radical models of care that move away from traditional professional based models to more locally defined and driven solutions, learning from the experience from elsewhere e.g., NUKA model in Alaska which has a strong foundation of being 'customer owned' and driven
- Creating new roles that enable us to vertically integrate primary/secondary care provision , working alongside the Deanery
- Addressing other factors that impact on recruitment, including premises, estates issues and addressing issues that impact on GP workload that are within Health Board control

7.2.5 Integrated Pharmacy & Medicines Management Workforce

We are pleased to say that for this staff group recruitment is buoyant across the Health Board to address the service changes in this 3 year plan. The majority of the service change initiatives will require recruitment to more junior posts to backfill those already in specialist roles to take on additional tasks. We, therefore, recognise ongoing succession planning will be necessary for many specialist posts

The increase in pharmacist graduates has allowed the Health Board to appoint to junior pharmacist posts at lower bands compared to five years ago. The strategy of the "pyramid" career structure as detailed below provides a strong foundation on which to build the extended roles of pharmacists including speciality and advanced practitioners supported by junior colleagues, technicians and others.



Nevertheless, the reconfiguration of services in this plan will impact on both the undergraduate and postgraduate training structures, not only within our Health Board but across Wales. In collaboration with the Modernising Pharmacy Careers (MPC) Wales the Health Board will continue to ensure the development of the pharmacy profession to influence and develop the future delivery of pre and post registration education and training. Consideration will be given to rotational training posts, based on future configuration, to ensure robust and comprehensive training. Changes in the delivery of training will provide greater opportunity for further development of roles and allow for further integration of the pharmacy workforce within services.

In December 2013 Health Minister Mark Drakeford approved plans to introduce the role of Consultant Pharmacist to the NHS in Wales. Consultant Pharmacists will have advanced roles in patient care, leading edge practitioners, be research active and contribute to teaching and learning in their designated area of expertise. They will be required to provide leadership within the profession and ensure the highest level of pharmaceutical expertise is available to patients. The Health Board will be looking for opportunities, in many cases linked to the service change initiatives to develop Consultant Pharmacists posts to take the workforce forward and to enhance and advance patient care.

In addition, pharmacy staff will continue to take on new roles such as prescribing, previously completed by clinicians. This will require an increase in overall headcount but is cost effective in terms of the clinician duties they are replacing and providing a holistic view on all elements of medicines management in patients. A number of the service change initiatives require non-medical prescriber pharmacists; a significant number of our workforce

already hold this qualification but ongoing consideration will need to be given with regard to additional staff undertaking the course.

7.2.6 Therapies, Healthcare Science and Psychology Workforce

Therapists play a key role in providing a wide range of community, outpatient and inpatient services. They are autonomous practitioners who take clinical responsibility for patient care, increasingly in roles previously performed by medical staff. All of our therapy services remain under pressure across all life courses. The growing therapies waiting lists are reported at the highest level of risk on our ABMU risk register caused by:

- Increase in patient activity as described in Section 2, together with the need to provide intensive therapy to reduce stay in hospital while at the same time providing quality, safe care
- The need to support new ways of working to meet services needs and the move towards providing services closer to people's homes, creating pressures in therapies input to core services
- Difficulties to recruit into a number of specialist posts, particularly in dietetics, paediatric, occupational therapy and speech and language therapy.
- The development and expansion of patient self-referral
- Alongside the service changes planned in the IMTP the key workforce actions for 2014 -2017 to address the above pressures will be to:
- Invest more in therapies as part of the Intermediate Care Services with our Western Bay partners, recognising the requirement to treat people closer to home
- Develop an Early Supported Discharge team for stroke, which will be a key element of our ability to deliver our Tier 1 responsibilities
- Invest in inpatient therapies as part of the delivery of the IMTP
- Launch a recruitment strategy to ensure core therapies resource is appropriate and flexible, directed at our Health Board priorities

In addition, we will continue to invest in education, training and development of advanced practice and consultant therapists to deliver clinical expertise and leadership, including supplementary prescribing across appropriate therapy professions as part of the development of advanced practice. Our planned developments of advanced practice include:

- Speech and Language Therapy to deliver services for patients with swallowing disorder, head and neck cancer and autistic spectrum disorder to release medical staff capacity in ENT and Community Paediatricians
- Physiotherapists and Podiatrists will increasingly take on expert practice in musculo-skeletal disorders, releasing orthopaedic surgeons time
- Orthoptists will increasingly manage patients with glaucoma and other eye conditions, releasing time of ophthalmic surgeons

- Imaging services where a number of initiatives will be taken forward to increase capacity, support sonographer services and release time for radiologists

Healthcare Scientists play a key role in diagnosis and increasingly in managing patients as autonomous practitioners. Research and development skills underpin their training. Similar to the picture described for Therapies, Scientific Services are under pressure due to the increase in patient activity as described in Section 2. In addition, there are:

- Pressures on our diagnostic and imaging services with the increase in demand for scientific support (such as MRI scanning)
- Specific capacity constraints in radiotherapy treatment to be addressed within the IMTP
- Increased requirements to deliver evidence base practice through research and development
- Needs to support new ways of working to meet services needs, such as Audiology and Cardiac Physiology

Modernisation of the scientific workforce will, therefore, continue with new training arrangements for assistants, practitioners, scientists and consultant scientists. Development of the latter is in partnership with the Royal Colleges.

Consistent with the principles of Prudent Healthcare, the transfer of patients with hearing loss balance disorder and tinnitus from ENT surgeon clinics will require significant increase in Audiology capacity, in particular the growth of the assistant practitioner workforce, supported by the development of an educational programme at Swansea University.

Practitioner Psychologists are employed in a wide variety of autonomous practice roles throughout the Health Board, with a Doctoral level of basic training. They make particular contributions in helping people understand their mental health issues and in behavioural change. There are pressures across the Health Board, but these are particularly acute in Neuropsychology and in Psychological Therapy for common mental health disorders. It is intended to increase Neuropsychology provision in stroke and to invest in Psychological Therapy to reduce costs of prescription medication.

7.2.7 Workforce Flexibility

We continue to operate a redeployment policy as part of our workforce sustainability approach, designed to maximise the opportunities for staff who are displaced following service change. It provides a framework in which suitable alternative employment will be sought for staff in such situations, balancing the availability of such alternatives against an individual's circumstances.

We will also continue to make good use of a wide range of flexible employment practices to support our staff and any requirement they have in terms of work/life balance, including Voluntary Early Release (VER) Scheme and Voluntary Reduced hour's contracts.

We are committed to managing changes in service through the All-Wales Organisational Change Policy, where those changes impact on our staff. The sensitive management of staff surpluses is a core component of our commitment to staff, captured in the ABMU Joint Statement signed by the Chief Executive and Staff side in 2012. In that statement it was made clear that the protection of employment was an important guiding principle in how we meet the financial challenges we are facing.

We have agreed that redundancy would only be considered after all other options had been exhausted. We have also developed in partnership a VER Exchange scheme, which would provide for a broader opportunity for staff to make use of VER where there were known surpluses within the Health Board. This will be a key pre-redundancy measure put in place to avoid wherever possible the need to enter discussions on voluntary or compulsory redundancy.

7.2.8 Workforce Modernisation

Redesigning our workforce is a core component of our integrated workforce planning cycle. We will provide Localities/Directorates with: -

- Benchmarking intelligence covering skill mix / grade mix across all staff groups at all levels to help inform our ongoing approach to workforce planning
- Support to redesign the workforce, identify good practice sites and research innovative workforce models
- Support in using benchmarking data within iView and the All Wales skill mix tool to analyse the Health Boards skill/grade mix by staff group, occupational code and specialty.

Advice, analysis and support to facilitate a review of all variable elements of the pay bill in order to deliver a 20% reduction as set out in Section 8 of the Plan. Constructive dialogue will then take place with Directorates/Localities based on any potential opportunities identified as a result of the analysis to help inform workforce plans and the performance framework. This dialogue could be supported with further research and organised visits to good practice sites.

7.2.9 Partnership working

We highly value our strong relations with Trade Unions and Professional Organisations. The Health Board includes a Non Officer Member

representing Staff Organisations to maintain openness and involvement at the most senior level of the organisation, and to provide assurance to the Board on matters relating to the effectiveness of partnership working arrangements and staff involvement.

The Partnership Forum is the formal mechanism for consultation, negotiation and communication with accredited and recognised Staff Organisations. A Health Board Partnership Agreement has been developed which sets out a framework for managing the relationship in accordance with Agenda for Change Principles of Best Practice, the TUC Principles of Partnership Working and the Welsh Government Partnership Advisory Forum and Operating Arrangements.

In addition, we meet separately with Local Medical Committee (LMC) where strategic medical issues are discussed. The LMC operates within secondary and primary care and deals with matters relating to terms and conditions and medical and dental employment issues.

We will continue to work closely with its Local Authority and third sector partners in Bridgend, Neath Port Talbot and Swansea, as well as together under the Western Bay Programme. As part of this over-arching work-stream a workforce development sub group of the Western Bay Programme has been formed to enable a more cohesive approach to developing workforce plans across health and social care, with particular emphasis on the development of Community Services.

7.3 Driving our Organisational Development and Culture

Our Organisational Development plan over the next 3 years will focus on achieving our aim “Excellent People” by developing a citizen-centred organisational culture which maximises team, individual and organisational potential through valuing and engaging our staff and excellent leadership. In doing so, we will enable our 7 strategic change programmes including our patient experience and patient safety programmes. Over the next 3 years we will focus on:

- Shared values and associated behaviours
- Prioritising, creating and delivering sustainable staff engagement
- Individual staff training and development
- Service and process improvement

7.3.1 Shared Values and Behaviours

Our starting point is having a set of clear, concise, local and shared values that everyone understands. We need to ensure our values, aims and

priorities thread through all that we do and behave, reflecting the "ABMU Way"

In the first year of the plan we will embark on re-establishing our values by listening to staff, patients and our citizens through large scale engagement events. We will then use the new set of values to build an aligned behavioural framework that is measurable during the appraisal process and fits with the requirements of our Health Board.

As well as establishing a values communication and publicity campaign we will hold large scale staff awareness 'big conversation' events on our new 'ABMU Way' and to capture ideas and feedback from staff on what needs to be done, which will inform the plan.

Following this and over the next two years we will reproduce the plan and also embark on a programme of embedding our values and behaviours into everything we do, including recruitment and induction, training and development programmes, policies, publicity material and incorporating into the annual PADR process.

7.3.2 Prioritising, Creating and Delivering Sustainable Staff Engagement

Staff engagement describes what happens when people think and act in a positive way about the work they do, the people they work with and the organisation that they work in. Better staff engagement means better patient outcome and when we talk about staff we are including all staff groups, all volunteers along with those on a secondment or training placement.

Using feedback from the NHS Staff Survey 2013 as our baseline measure, we will be:

Ensuring every role counts - a crucial factor in aligning staff engagement with the vision, values and aims and priorities of the organisation itself.

We will continue to introduce 'listening to improve' concepts, using ideas from staff as a result of our values programme. This will include a staff ideas 'Lets Just do it' programme, linked to the spread of Improving Quality Together training to all staff. We will continue to work in partnership with Trade Unions and professional groups and involve and listen to our Junior Doctors more in service change. We will also:

- continue to have an open approach to two way communication with a focus on listening, using a range of methods, such as 'big conversation' style events, smaller staff focus group events, using social media, Team Briefing and other conversation concepts such as Link Listeners;
- promote the improvement changes under the Innovation, Support and Improvement Science (ISIS) project and 'Let's Just Do it';
- be proactive as a result of listening to staff 'pulse' surveys, and;
- embed team based working.

On the 11th November 2013, the first Chairman's Awards Ceremony was held as a new organisation wide celebration event for staff. Feedback has been extremely positive and reaffirms the value in investing time to recognise staff achievement and raising the profile and morale of individuals and teams. We will continue to run the Chairman's Awards each year. The Chairman's' Awards have also sparked local events at departmental level to recognise and acknowledge staff contribution

Strong clinical leadership and management - , building a clear sense of purpose and contribution, able to motivate teams and individuals and with a focus on improving performance. We will continue to provide a bespoke Clinical Directors leadership programme and learning sets based on the new NHS Leadership Model, in partnership with Swansea University Medical School. In 2014/15, we will review the programme and undertake a benefits realisation exercise before embarking on our next priority areas, which is supporting clinical leads within our Strategic Change Programmes. The Consultant Development Programme will also continue to be delivered to support newly appointed consultants to develop their leadership and management skills.

We will continue to develop the skills of managers to enable them to lead teams effectively, based on organisational objectives and values, starting with the Chief Operating Officer's Senior Management team. Again the programme is structured using the new NHS Leadership Model and will be reviewed in 2014/15 to inform new and existing management and leadership development programmes, such as our *Managing to Deliver Programme* for First Line Managers and the Middle Managers Programme, *Leading to Deliver.*

A Leadership Connections Master Class Programme, launched in October 2013, will continue as a mechanism for providing leadership development and networking opportunities for clinical leaders and general managers at all levels in the organisation.

Focus on staff health and well being - promoting a happy, healthy and safe working environment. ABMU has placed a significant focus on staff health and well-being based on the 'Health Work and Well-being Action Plan for Wales'. The specific objective is to enhance the lives of the workforce through the provision of preventative, health improvement information and advice; providing support for those who may go off work due to sickness, long term illness, stress or other reasons, as well as support for those required to cover for absentees. A programme of work has already begun to improve information, advice and access to provision by gaining a better understanding of workforce needs and proactive management of workforce issues.

To support the increased focus on staff health and wellbeing the development of an Integrated Staff Health and Well-being Service will be established during 2014/15. Service developments and improvements have already been achieved within occupational health, staff counselling, psychology and muscle and joint services. Invest to save type ventures will be considered to pilot new approaches in 2014 and beyond with the aim of reducing sickness absence, producing efficiency and cash releasing savings, such as the provision of health and well-being support from day one of absence to individuals that work within areas with high sickness levels.

We achieved the Corporate Health Standard Silver Award in October 2012 and Gold in February 2013. During the 2014/15 year a plan will be developed to assess our organisational readiness for the Platinum Award and we will work towards this during 2015/16.

A 'Lighten Up' Programme will be rolled out in 2014/15 with the aim of equipping the workforce to better deal with work/life stressors. This programme will be incorporated into our Clinical Leadership and Management Development programmes, to help build the resilience needed for the organisational pressures and changes referred to in the 3 year plan.

To monitor our progress with staff engagement we will be rolling out 'pulse surveys' linked to our patient experience survey, conducted regularly to measure staff satisfaction and feelings at various times throughout the year. This is further explained in Section 7.5.

7.3.3 Personal Development and Training

Our objective is to match the needs of the Health Board and the individual to deliver safe, quality care that matches the needs of our citizens. It can increase effectiveness, provide opportunities for individuals to progress and can help staff to feel valued by the organisation.

We will identify and provide development and training to suit the needs of individual staff based on our ABMU priorities. This will be generated in part by the

Performance Appraisal Development Review (PADR) and medical appraisal process and delivered with support from our Medical, Nursing and Therapies Corporate Directorates, such as:

- Intensive training for those delivering care to people with dementia and dementia 'awareness' training at induction
- Continence care training, and;
- End of Life Care

In addition, Statutory and Mandatory Training is fundamental to the delivery of high quality patient care and to the overall success of ABMU. Our plan is explained in Section 7.5.

Linking the learning outcome of Improving Quality Together (IQT) training and the need to undertake continuous service improvement as a core knowledge and skills component of the role (explained under ISIS below) will allow staff time to and help believe their ability and responsibility to improve the system in which they work. Also in the process, there will be explicit questions within the documentation to promote discussion around the values and behaviours are being enacted.

We will also improve the engagement of our staff on our organisational objectives and citizen - centred culture, values and behaviours through our PADR processes. In doing so we will be adopting in 2014/15 the national guidance 'Supporting Citizen - Centred Development Reviews in NHS Wales – a Simplified KSF' and its accompanying documentation, to ensure consistency, further simplification and reinvigoration of the PADR process

The monitoring of staff having an annual appraisal or performance appraisal development review (PADR) is outlined in Section 7.5

Talent Management and Succession Planning - Enhanced Clinical Leadership will play a pivotal role in transforming our services and practice to deliver the clinical strategy as set out in 'Changing for the Better'. Clinicians will lead the process of change and therefore the engagement, leadership skills and behaviours of our clinical leaders are critical. In 2014/15 we will develop a framework and test tools to select individuals to participate in a Development Centre to further identify their leadership development needs. By 2015, our Talent Management Framework will be in place across the organisation helping us to identify our future leaders, assess the ability and capability of our staff and help us plan for future development interventions to ensure that we invest and retain our talent for the future.

In addition, and in partnership with Swansea University and Academi Wales, we will develop together, a suite of development opportunities to support our current and future clinical leaders and managers by maximising all our resources. This includes opportunities such as attending Academi Wales Summer School, their Medical Leadership and Senior Leadership Development Programmes as well as such programmes that focus on developing women aspiring to leadership roles. In addition we will tap into external development routes, such as the army's Exercise Medical Stretch events and training events with the Territorial Army to develop staff leadership skills and team building.

Finally we will be developing our Coaching Framework in 2014 to develop and sustain a coaching culture where staff are constructively challenged and developed by line managers.

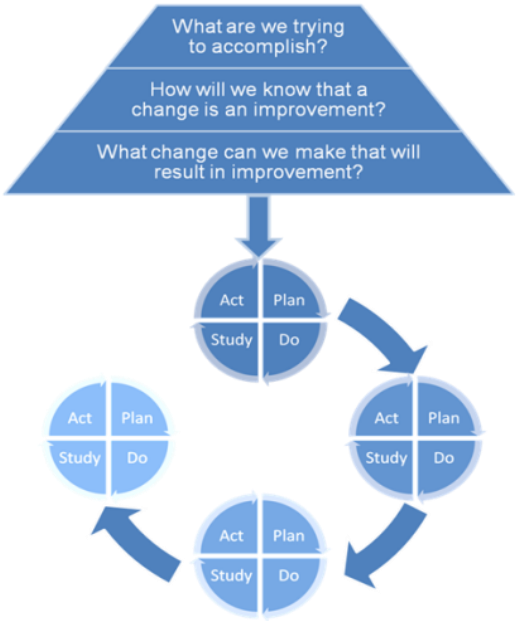
7.3.4 Service & Process Improvements

Our ISIS (Innovation, Support and Improvement Science) Project is a planned and systematic quality improvement programme following an evidence based approach to embedding sustained organisational performance. At its heart is the belief that frontline staff understand their own work best and what needs to be done to improve it. ISIS purpose is to develop mass engagement of frontline staff, to develop their skills and support them in their endeavours to drive continuous service and process improvement.

Focussing on 'excellent people' the Health Board's organisational development agenda will be joined with ISIS under one banner to improve patient outcomes and the patient experience. ISIS will: -

- Create an improvement culture inspired and energised by a leadership that is united by one purpose - a future in which everyone has the best care and health possible
- Support clinical teams to create new and innovative ways of doing things united in delivering our purpose
- Build the capability within the workforce to constantly adapt and improve

From 2014/15 and onwards, ISIS will:-



- Use Improving Quality Together (IQT) and its Model for Improvement as the bed rock for developing our quality improvement skills and continue to build on the number of staff trained at an IQT Bronze and Silver level, applying their knowledge to delivering improvements in line with our strategic objectives.
- We will continue to support team and leadership development to improve capability, productivity and performance
- Drive the use of measured outcomes and processes across ABMU using run charts, variance and root cause analysis as standard improvement tools.
- Generate an improvement culture using our own 'ABMU Change Day' and appraisals to generate small change improvements.
- Drive the Model for Improvement as out standard improvement tool, ensuring we start with identifying the real issues using improvement methods.
- Create an improvement environment using Health Board space and technology to showcase, recognise/register and celebrate improvement work, feeding into the Chairman's Awards, NHS Awards and others
- Value frontline staff contribution by offering their support to other teams and to our strategic programmes, recognising their input and creating an ISIS movement
- Organise ISIS learning events, including hearing from our Institute of Healthcare Improvement (IHI) Clinical Fellow, then support applying the learning across the board
- Sign up and work with Swansea University on improvement science to bring challenge, research and test different improvement approaches, creating additional resource, innovative practice, academic papers, articles and award submissions at the same time

ISIS will drive the improvement culture (the ABMU way of working), develop the clinical leaders, and provide support to teams in a learning environment where sustainable improvements will arise from the frontline staff. In doing so ISIS will have a small team made up of a clinical lead, improvement facilitators with data analysts input joining other frontline staff who are making improvements to patient outcomes and the patient experience.

7.4 Equality

Our Strategic Equality Plan 2012-2016 set out our corporate vision and commitment to delivering equality and human rights. Our three Equality Outcomes are: -

- Better Health Outcomes
- ABMU to be a First Choice Employer
- Improved Patient Access and Experience

Our approach for 2014 onwards will be to build on work already started and rollout the 'Treat Me Fairly' eLearning resource for all staff as part of their statutory and mandatory duty. This learning will help staff think about their day-to-day role and what they can do to promote equality in the NHS.

The Equality Act 2010 requires us (as a public body), to undertake Assessments of Impact on existing and proposed 'business activities' (i.e. policies, practices, procedures and service improvements/developments). We will continue to use our Assessment of Impact Toolkit to help us make fair financial decisions and to improve the equality and equity of our health care services. We will achieve this by ensuring that we think carefully about the potential impact of our work on different communities, groups, staff and service users.

7.4.1 Welsh Language

We will support the delivery of the Welsh Government's Welsh Language Framework 'More Than Just Words' by raise awareness amongst line managers of the 'Active Offer' principle as part of performance appraisal development reviews (PADRs); ensuring staff surveys are also available in Welsh, and promote the Welsh Language Strategic Framework in development programmes, which fosters a supportive ethos which empowers patients to speak to staff in their own language.

7.5 NHS Wales Delivery Framework

The Framework tells us about the NHS Wales priorities and the expected performance targets year on year to drive up standards and outcomes in Wales. This section describes where we are and where we want to be in relation to engagement and managing our workforce as part of the Framework.

7.5.1 All staff to have an annual appraisal or performance appraisal development review (PADR)

Performance appraisal is an opportunity for individual employees and line managers, to engage in a dialogue about their performance and development, as well as the support required from the manager. To be successful they should also be used as a basis for making staff development and improvement plans.

Recognising that the Health Board is currently reporting high level compliance with staff having had an annual PADR, we need to be confident that the process is a dialogue between staff and their line manager that reflects on past performance and reaches an agreement about what should be done in the future. The plan for 2014/15 is to understand the quality of the PADR process. This will then determine subsequent plans as a result.

The introduction of Employee Self Service within the Electronic Staff Record (ESR) system in 2014/15 and its roll out over the next 2 years will improve the recording, monitoring and measurement of PADR activity across the Health Board. From April 2014, recording of PADRs in ESR will be the only data source recognised by the Welsh Government for this Tier 1 target and therefore requires a change in how data is currently captured at Directorate and Locality levels. There are risks with performance reporting in the rollout phase and these include:

- For 2014/15, the reported % PADR compliance for ABMU using ESR will significantly reduce until nominated managers have retrospectively enter all PADR activity undertaken in the last 12 months. Overall compliance may also reduce due to the quality of the information available within the system compared to the current manual data collection process

The Health Board is on course with medical appraisal arrangements and revalidation in primary and secondary care. Work is also continuing both nationally and locally to reach agreement on appropriate medical appraisal arrangements for clinical academic colleagues and how this information can best be presented for revalidation recommendations. An initial assessment of the Health Board's performance against the draft Appraisal Quality Management Framework standards will be undertaken both to test the suitability and practicality of the standards themselves and to assess further work needed within the Health Board in 2014/15.

7.5.2 Statutory and Mandatory Training

The training and development of staff is fundamental to the delivery of high quality patient care and to the overall success of ABMU. Driving this is the Health Board mandatory training framework based on the UK Core Skills Training Framework. The first priority of the plan is to ensure that staff is competent to do their job, identified in the PADR and corresponding

development plan. This will include adequate provision for the training requirements identified to meet statutory and mandatory responsibilities in health and safety and risk management.

Supporting the delivery will be the UK Core Skills Training Framework to standardise the key statutory and mandatory requirements, to deliver level one compliance indicators for all staff, adopted by NHS Wales in April 2014.

In January 2014 all staff will have access to e-learning mandatory training material via Learning@NHSWales. For us, staff will be able to undertake level one mandatory training electronically. The advantage being that release from the workplace will be reduces which should help with compliance.

In addition the plan to move towards Employee Self Service for all staff within Electronic Staff Record (ESR) system over the next three years will mean that the staff record will be updates as soon as the e-leaning module has been completed. This will give managers real time access to mandatory training compliance for their area.

7.5.3 Staff Surveys

In response to the results of the NHS Staff survey, the Partnership Forum and our Health Board have agreed a way forward, including establishing a Staff Survey Steering Group as the mechanism for providing corporate direction and leadership. The mantra for this group is a commitment to listen and act and is jointly chaired by the Director of Workforce & OD and Staff Side Chair.

Its purpose is to oversee the delivery of Directorate and Locality Staff Survey Improvement Plans and acts as a vehicle for sharing best practice locally and nationally. In 2014/15, the Steering Group will become the centre point for coordination, sharing, and understanding all staff survey to support its purpose of direction and leadership. This includes the:

- Forthcoming Medical Engagement Scale to assess medical engagement in management and leadership
- Annual Fundamentals of Care Nursing Staff Survey
- National Training Survey GMC

Another significant staff engagement measure planned for 2014/15 on a rolling programme will be the rollout of 'pulse surveys' linked to our patient experience survey, conducted regularly to measure staff satisfaction and feelings at various times throughout the year. Completion rates will improve year on year with staff responses collected electronic, available across the Health Board following the project rollout and driven locally. The information will helping our Directorates and Localities to focus on specific actions and/or particular topic areas, feedback to staff on the actions taken and reported upwards to the Staff Survey Steering Group.

The 'pulse' survey questions will be based on specific measurement of engagement levels covering Involvement, Advocacy and Motivation, monitored nationally as the 'Overall measure for organisational climate' Tier 1 Target with an improvement in % rate based on the current climate and as a result of the applying the Organisational Development and Service Improvement section of this plan . Pulse surveys will also be used to identify short term evaluation criteria to assess the success of staff engagement strategy on a specific service change.

7.5.4 Achieve annual local Sickness and Absence workforce targets

The Health Board recognises it has the highest sickness absence level of all Health Boards in Wales. Sickness levels have risen steadily during the past 15 months. As a result, we have developed a Sickness Absence Improvement Plan that:

- Supports sickness absence management through clear and consistent reporting and visibility of sickness absence trigger points and trends.
- Provides intensive support to hotspot areas, linking sickness absence to other key clinical, quality and financial indicators.
- Provides a clear governance and performance management framework to help deliver and sustain improvements.
- Up-skills managers to ensure they have the necessary competencies to manage sickness absence with compassion to improve overall people management skills to support the **Excellent People**.
- Contributes towards the achievement of a 20% reduction in total variable pay as identified in Section 8 of the Plan.

Our aim is to reduce sickness absence levels to the 5.08% target in two years and aims to reduce to 4.5% in 2016/17.

7.5.5 Staff Flu Vaccination

We are committed to ensuring that as many staff as possible receive the flu vaccine, with a particular focus on those with direct patient contact. Staff campaign communications are focussed on the protection of patients, colleagues, ourselves and the wider community. The Director of Workforce and Organisational Development is Chair of a sub group of the Influenza Steering Group. Since 2011, numbers of staff receiving the vaccine in the workplace have increased each year. This trend has continued with the aim of 50% of the frontline workforce being covered. In the following two years we would expect an incremental increase to continue, so that the 50% measure is exceeded.

8 Finance

This section of our Integrated Medium Term Plan sets out, in detail, the financial structure of the Plan. Building on the projected position for 2013/14 set out in section 2, consideration is made of the financial outlook for the three year period of the plan and the opportunities which exist to contribute savings and efficiency gains to the plan. Our plans around capital expenditure are referenced here although they are introduced in section 5 above and workforce considerations are also factored in. Finally a Financial Risk profile is provided.

8.1 Current Revenue Position and Financial Context

This is described in detail in section 2.5.3 above.

8.2 Income, Cost and Investment Assumptions (Appendices C3, B4, B5 and B6)

8.2.1 Income Assumptions

Our Revenue Allocations from Welsh Government for 2014/15 were issued on 31st December 2013. These confirmed a further year of zero % inflationary uplift across Health Board allocations. The revenue allocations also confirmed the recurrent distribution of the £150m additional funding announced by the Health Minister in October 2013.

The Health Board income assumptions for 2014/15 to 2016/17 are set out in Table 38 and show the zero % inflationary impact over the next 3 years.

Table 38 : Summary Income Assumptions

ABMU – Summary Income Assumptions	2014/15 £m	2015/16 £m	2016/17 £m
Revenue Resource Limit	937	937	937
Other Income	241	241	241
Total Income	**1,178**	**1,178**	**1,178**

8.2.2 Cost Assumptions

The continuous rising demand for health services in terms of demographic changes, volume and complexity increases the cost pressures upon the NHS in Wales. The key factors that drive these demand cost pressures are increasing numbers of frail elderly, lifestyle factors, new technology and new drug therapies. This is described in more detail above in section 3 of this IMTP.

The impact of pay increases in terms of wage awards and incremental progression along salary scales also introduces annual cost pressures into the NHS. They, along with inflationary costs of the consumables used in delivery services, can add a substantial new cost each year. The following tables are based on estimates and do not reflect the actual Pay Awards that are yet to be agreed.

Along with other Health Boards in Wales we also have substantial cost pressures arising from the demand for fee increases for patients cared for in Care homes. Given the scale of the costs supported by Health Boards, any stepped increase in fees generates a substantial additional cost pressure to our overall bottom line expenditure plans.

The NHS Wales cost pressures experienced in previous years and envisaged for the 2013/14 period can be utilised to produce a local potential cost pressure assessment for a further 3-year period. It is considered that elements of this could be avoided by management effort to contain cost increases to a lower level. The resulting reduced forecast cost pressure analysis is outlined in Table 39:-

Table 39 : Potential Cost Pressure Assessment 2014/15 – 2016/17

	Actual	Actual	Forecast		
	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
Pay	7.0	12.0	10.0	9.0	8.0
Non Pay	3.0	3.0	4.0	4.0	4.0
ChC	2.0	2.0	4.0	4.0	4.0
NICE	3.0	2.0	2.5	2.5	2.5
WHSSC	2.5	0.5	2.0	2.0	2.0
Primary Care Drugs	4.0	3.5	3.0	3.0	3.0
Demand & Growth	-	-	2.0	2.0	2.0
Inflationary/Growth Pressures	21.5	23.0	27.5	26.5	25.5
Unscheduled Care	2.0	4.5	4.0	0	0
Sustaining Services/SWP	2.0	1.0	-	3.0	3.0
Service, W'force & Safety	-	1.0	-	2.0	2.0
Contingency	2.0	1.0	2.5	2.5	2.5
Tier 1 Targets – R.T.T.	-	-	6.5	(2.5)	(2.5)
Underlying Deficit	-	-	15.0	-	-
Strategic Change Fund			4.0	7.0	6.0
TOTAL	**27.5**	**30.5**	**59.5**	**36.5**	**35.5**

Table 9 in section 2.5.3 explains that for 2013/14 the Health Board is forecasting a balanced position, which remains a challenge for the Heath Board to achieve.

The inflationary and growth cost pressure assumptions for the Health Board have been validated against the outcome of the National Cost Assessment undertaken for NHS Wales. It should be highlighted that our plan has excluded the financial effect of the Pension and national insurance Changes anticipated in 2015/16 and 2016/17 as advised by Welsh Government. If these costs need to be addressed through existing resources, these would have a significant financial impact, estimated as £15m in 2015/16 and a further £11m in 2016/17.

There were cost pressure risks arising from services commissioned through WHSSC arrangements in both 2012/13 and 2013/14 years. Our financial plan provides for reasonable cost increases over the 3-year planning period that reflects our anticipated commitment within the Commissioning Plan of the WHSSC Commissioning Board. Work is ongoing through the WHSSC

Management and Joint Committees to mitigate the financial consequences in future years through strengthening the Clinical Prioritisation processes.

It can be seen that, even with only a reasonable expectation of annual cost pressures and key investment increases during the 3-year period, the total cost impact continues to require a substantial savings requirement.

Table 40 below sets out a potential range of how the costs may vary over the short to medium term.

Table 40 : Potential Range for Costs 2013/14 to 2016/17

	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
Optimistic	27.0	53.5	32.0	31.0
Calculated range	32.0	59.5	36.5	35.5
High End	39.0	69.5	43.0	42.0

There is a significant range of costs that could emerge in the forecast period under consideration. There is, however, a 'floor' below which it is difficult to envisage costs falling below and this floor is materially above what can reasonably be managed through savings, whilst delivering the service aspirations of the NHS in Wales.

8.2.3 Investment Assumptions

In addition to the inflationary and growth pressures the Health Board has identified additional cost requirements to support the operational delivery of services. Section 5 of our IMTP sets out the investments required to deliver our strategic change programmes. In addition section 6 sets out the requirement to invest in our patient quality programmes and section 9 sets out the investment requirements of our commissioning programme and our ICT programme.

In addition to this we have identified specific investment areas in recognition of the existing pressures, future pressures and strategic context set out in sections 2, 3 and 4 respectively. In summary these are: -

a. The Unscheduled Care Investment reflects the full year impact of the schemes implemented in 2013/14 to increase unscheduled care capacity across secondary, primary and community care sectors.
b. The Sustaining Services/South Wales Programme investment is enabling the Health Board to sustain clinical service models whilst South Wales Programmes outcomes are decided and enacted and to support costs of new service models. It currently reflects the impact of sustaining services in areas such as Emergency Medicine and

Paediatrics where significant recruitment difficulties are being experienced and also supporting the significant service impact of the withdrawal of Deanery training status.

c. The Health Board has assessed the costs of delivery of Tier 1 36 week Referral to Treatment target based on the current projected year end position at the end of 2013/14. It has been estimated that to recover this position by the end of 2014/15 will require an investment of £6.5m although this is currently under review.
d. The Quality Investments are supporting ongoing improvements to nurse staffing levels, and other quality initiatives.
e. The Strategic Change Fund provides targeted investment to enable the Health Board's seven Strategic Change Programmes.
f. The cost assumption also includes the underlying deficit carried forward into 2014/15, which is valued at some £15m. It is essential that this is addressed within the plan.

The reference letters a) to f) in the text above are relevant to letter references in Table 41 below.

8.2.4 Cost Base for 2014/15 to 2016/17

Both ourselves and the whole of NHS Wales undoubtedly face a challenging financial outlook over the medium term; responding to the cost-pressures arising from increasing demand, inflation, strategic requirements and local pressures. Effective management of our forecast financial outlook will require a comprehensive funding strategy that will need to encompass efforts at Welsh Government, National, Health Board and service level.

Table 41 sets out our estimated cost base for the 3 year period covered by this IMTP.

Table 41 : 3 Year Financial Plan (Costs)

Costs	2014/15 £m	2015/16 £m	2016/17 £m
Pay	10.0	9.0	8.0
Non Pay	4.0	4.0	4.0
ChC	4.0	4.0	4.0
NICE	2.5	2.5	2.5
WHSSC	2.0	2.0	2.0
Primary Care Drugs	3.0	3.0	3.0
Demand Growth	2.0	2.0	2.0
SUB TOTAL UNAVOIDABLE COST PRESSURES	27.5	26.5	25.5
a. Unscheduled Care Investment	4.0	0.0	0.0
b. Sustaining Services Investment / SWP	0.0	3.0	3.0
c. Tier 1 targets (incl. RTT)	6.5	(2.5)	(2.5)
d. Workforce Investment	0.0	2.0	2.0
SUB TOTAL DISCRETIONARY INVESTMENT	10.5	2.5	2.5
Contingency	2.5	2.5	2.5
e. Strategic Change Fund	4.0	7.0	6.0
f. Underlying Recurrent Deficit	15.0	0.0	0.0
Total Projected Cost Base	**59.5**	**39.5**	**37.5**

8.3 Achieving the Savings Required (Appendices B7 and B8)

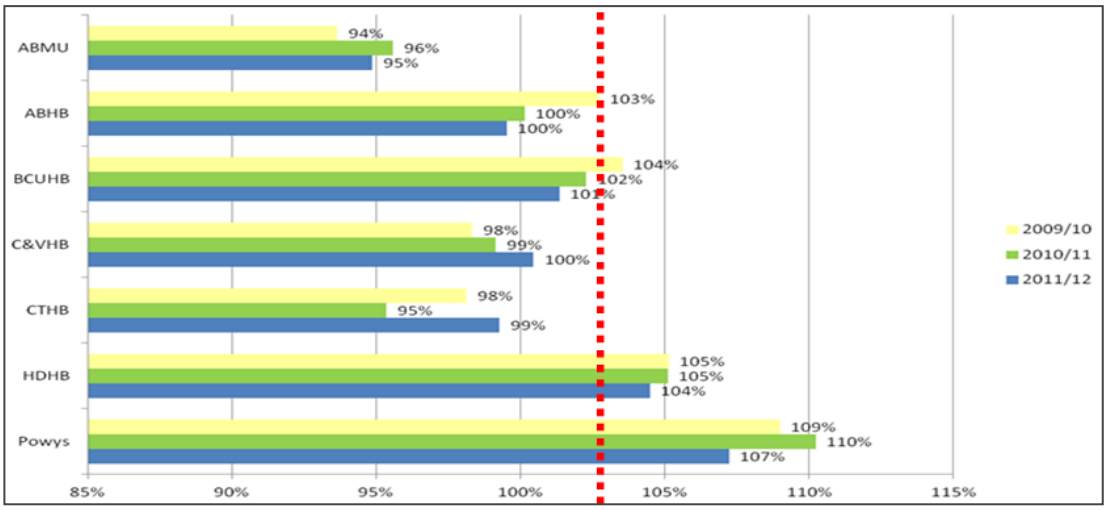
Given the scale of the challenge, our Directorates/Localities are working to produce Integrated Service, Finance and Workforce plans that bring together service plans, access delivery plans, workforce plans and finance and savings plans into one coherent Integrated Plan. These plans will identify the measurable targets on a month by month basis to allow clear comparison with delivery. Much of this work is complete at the end of January 2014, but we continue to refine these plans to ensure that they are aligned to our strategies; our programmes and that they represent value for money.

8.3.1 Performance Benchmarking - All Wales Cost Index

In setting the context of the financial overview it is important to note that the cost efficiency of the services provided by the ABMU Health Board compares favourably with the cost of services provided by other Health Boards in Wales. The latest Welsh Assembly Government produced analysis on the 2009/10 and 2010/11 cost statements shows the ABMU Health Board with a cost index that is significantly below the All Wales average service cost of a 100. This cost index ranks first in Wales, and represents a service cost

performance that has consistently been ahead of other Health Boards. Figure 20 below shows the relative position of the Health Board in the All Wales Cost Index

Figure 20 : All Wales Cost Index



Figures presented on a like for like basis excluding Primary Care

It should however be borne in mind that, whilst the Health Board compares favourably with regard to its cost efficiency, opportunities still exist to improve service productivity and efficiency.

In addition, the Health Board has benchmarked services with English Providers through a range of mechanisms described in Appendix 4. These exercises have evidenced the cost effectiveness of the Health Boards services against the average whilst also identifying opportunity for improvement and savings against higher performers. This benchmarked performance gain has been included within our savings plans with the IMTP.

8.3.2 Financial Framework 2014/15 to 2016/17

Table 41 above sets out both the forecast Investment and Costs and the proposed means of funding. It is proposed that the means of funding is achieved over 4 levels:-

- **Level 1** - Welsh Government
- **Level 2** - National/ Health Board Collective Effort
- **Level 3** – Health Board wide
- **Level 4** - Directorates/Localities

8.3.2.1 Level 1 - Welsh Government

As stated earlier in this section, at present, we have been directed to assume that there will be no Welsh Government funding is assumed from general allocation uplift to Health Boards over the period 2014/15 to 2016/17. There may, however, be further opportunities to consider policy changes whereby income can be received. This may not result in allocation uplifts, but in income/cost reductions in Health Boards.

8.3.2.2 Level 2 - National/Health Board Collective Effort

There is considerable scope for Health Boards to work collectively to agree action that would produce savings or income to the benefit of individual Health Boards. The collective effort would encompass:-

- Pay and Terms and Conditions negotiations
- Savings in Non Pay through Better Procurement
- Savings in ChC costs through national strategy
- Self funding decisions through WHSSC Prioritisation Strategy
- Savings in Primary Care drugs costs through national Strategy

These savings will be progressed through a range of national groups or sub groups of the standing national committees.

8.3.2.3 Level 3 - Health Board Wide

An exercise promoted by the Welsh Government some three years ago identified 14 High Value opportunities across Wales. Our potential share of these opportunities (estimated at our allocation share of 17%) is shown in Table 42 below:-

Table 42 : ABMU Potential Share of All Wales Opportunities

	All Wales Opportunities	ABMU Health Board Potential	ABMU Savings in last 3 years	ABMU Savings Planned for next 3-years
Capture the Opportunities of Integrated Care				
	£m	£m	£m	£m
Care Pathways and Settings	100-170	17-29	4.4	3.5
ChC	40-50	7-9	11.1	6.0
Unscheduled Care	50-100	9-17	3	0
I.T.	20	3	0	0
Improve Quality and Financial Stability by reducing harm, waste and variation				
Wasteful Interventions	100-200	17-34	0	3.5
Acute Performance	150-250	26-43	12.5	10.5
Non Acute Performance	65-100	11-17	1.5	4.0
Mental Health	30-50	5-9	5.7	4.0
Medicines Management	70-100	12-17	19.8	13.0
Procurement	100-170	17-29	12.8	15.0
Prevention	NYQ*	NYQ	0	0
Empower the Front Line				
Streamline the Centre	NYQ	NYQ	2	2.30
Streamline Management	NYQ	NYQ	2.7	3.5
Workforce	NYQ	NYQ	3.4	32.0
TOTAL		**124 - 207**	**78.9**	**96.30**

*Note this excludes the contribution from other income.

Whilst we will strive to make progress over time against the required efficiency and productivity targets in the areas identified in the table above, it is likely that we will not be able to achieve the target levels in all areas. However, it is evident that whilst good progress has been achieved in some notable areas, more needs to be achieved in others. It should also be borne in mind that our services have already been demonstrated to be some 6%

more efficient than the Welsh average, and that would equate to a savings achievement of some £40m.

It is also important to note that the efficiency gains shown in Table 42 may not be cash releasing, but capacity releasing. Throughout this 3 year planning process, efficiency is being pursued as core business for the Health Board, and the means have been identified to ensure that cash savings or cost avoidance opportunities are maximised through productivity and performance improvements. Specifically we anticipate that the Unscheduled Care, Surgical Pathway and Changing for the Better Programmes will be demonstrating significant efficiency gain as part of their overall benefits realisation.

As described throughout this document, we are implementing major service change through a range of Programmes and Projects that are already underway. The 7 Programmes and allied Projects report to our Changing for the Better Delivery Board. They are managed through the use of Managing Successful Programmes approach and each one is led by a designated Executive Lead. The Programmes and Projects have been evaluated for their savings contributions in the 3 Year period ahead and these are shown in Table 43 below. Section 5 above described the financial and benefits assumptions for the Unscheduled Care/Patient Flow, Surgical Pathway and Changing for the Better Programmes. Within Section 6 the financial arrangements for Patient Experience and Patient Safety Programmes are set out and in Section 9 which follows this is set out for Commissioning an Effective use of ICT.

Table 43 : Potential Savings Contributions

	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000
Programmes				
Unscheduled Care/Patient Flow		} 4.0	} 7.0	} 6.0
Surgical Pathway				
Changing for the Better 'Collection of Projects'				
Patient Experience				
Patient Safety and Outcomes				
Commissioning				
Effective Use of ICT				
Projects				
Workforce Modernisation		0.2	0.3	0.3
Variable Pay		2.3	1.5	0.4
National Pay		5.0	5.0	5.0
Sickness		2.0	1.5	1.0
Procurement		1.0	1.0	1.0
INNU		0.2	0.2	0.2
Energy		0.25	0.25	0.0
Corporate & FBC Management Costs		2.2	0.25	0.75
Devolved Management Costs		0.75	0.25	0.0

Our overall assessment is that our seven Strategic Change Programmes will deliver sufficient savings to cover the investment required to fund them , apart from the first year when the Health Board will 'pump prime' £2m of investment. . This investment amounts to £4m in the first year and then £ 7.0m in Year 2 and £6.0m in Year 3 with a cumulative recurrent impact in 2016/17 of £17.0m of investment delivering £17.0m worth of savings and significant other benefits in term of benefits realisation for demand management, Quality improvement and reconfiguration of services in line with our strategy. Update above table and insert a SCP table showing investment and savings by SCP

There is much detail behind the financial assumptions for the Projects referenced in Table 43 above and this is covered later in Section 8.4.

8.3.2.4 Level 4 - Directorates/Localities

Having identified the savings contributions to be made by plans at Welsh Government, National and ABMU Health Board level, it will be important to ensure that savings targets established to be delivered by Directorates/Localities do not 'double count' the savings that are planned to be achieved.

The following savings categories will need to feature in all Directorate and Locality plans:-

- Service Location/Facility Rationalisation – realignment of services to enhance service quality and improve efficiency of service delivery. It is recognised that the Health Board will progress some of the large scale schemes, which will require consultation and will form part of our longer term plan. However, there are many smaller issues which may be able to be actioned by Directorates and Localities more quickly.
- Service Performance – the Health Board is not performing optimally and there are many areas where improvements can be made in patient pathways to improve efficiency.
- Service Reduction – given the current economic climate, all services must be reviewed for clinical effectiveness and robustness of service model. This must be clearly linked to LTA requirements to fully understand the impacts of any service changes or reduction.
- Housekeeping schemes – identifying areas for further cost efficiencies.
- Medicines Management – review of all drug/prescribing opportunities. This will be supported by the Medicines Management Team, and could be in addition to the Integrated Medicines Management Savings Strategy being pursued at Health Board level.
- Workforce Redesign – it is imperative that opportunities are fashioned that allows the workforce to adapt and respond to changing circumstances and new ways of working. Some schemes will be progressed through the Workforce Modernisation Plan at Health Board level, but there would also be opportunities that arise for Directorates/Localities to take action in changing the skill mix and roles of their staff.

8.3.3 Savings Plans for 2014/15 to 2016/17

Table 41 above set out the forecast cost base for us for the 3 year plan. The overall impact of the four levels is that cost containment and savings will deliver £33.4m in year 1, £36.25m in year 2 and £31.65m in year 3. Table 44 below sets out our anticipated aggregate position when pulling together all of the four levels of funding and savings described above. Appendix B2 refers.

Table 44 : 3 Year Financial Plan (Savings and Net Position)

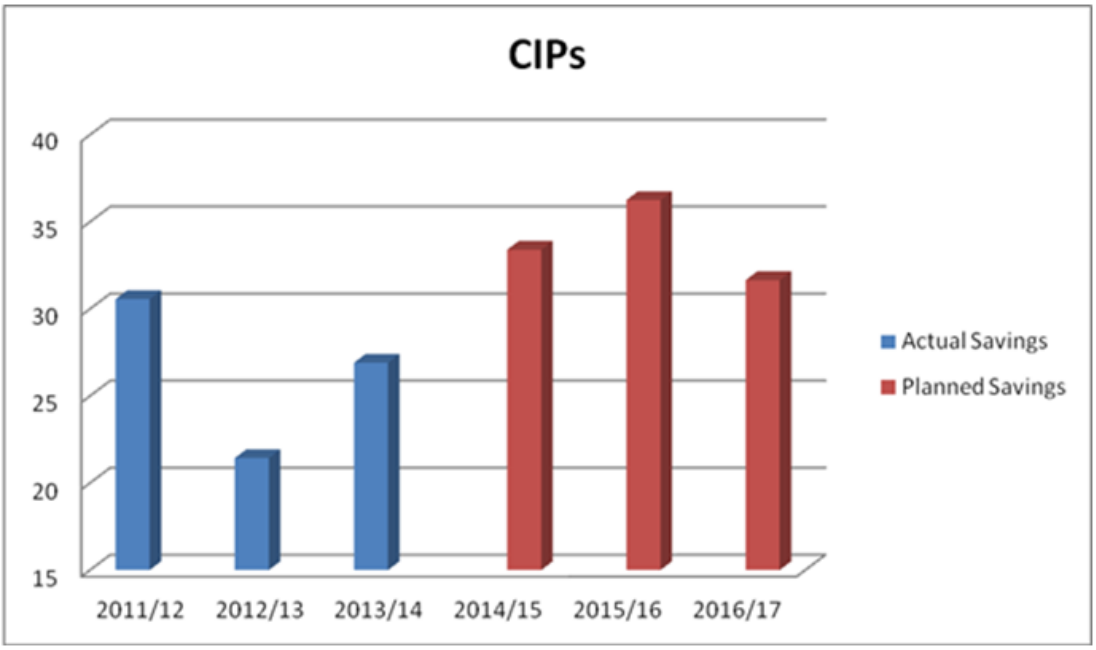
Total Projected Cost Base (as per Table 41)	**59.5**	**39.5**	**37.5**
Funding	**2014/15**	**2015/16**	**2016/17**
1.Additional WG Allocation	TBC	TBC	TBC
2.National/ HB Collective Effort			
Pay Restraint	5	5	5
Non Pay/Procurement	3	3	3
ChC/FNC	0.5	0	0
Primary Care Drugs	1.5	1.5	1.5
3. ABMU Health Board			
7 Programmes	2	9	6
ChC	1	1	1
Primary Care Drugs	1.5	1.5	1.5
Projects			
• Workforce Modernisation	0.2	0.3	0.3
• Variable Pay	2.3	1.5	0.4
• Sickness	2	1.5	1
• INNU	0.2	0.2	0.2
• Corporate Management Costs	2.2	0	0
• FBC Clinical Administration (Morriston)	0	0.25	0.75
• Devolved Management Costs	0.75	0.25	0
• Energy Strategy	0.25	0.25	0
• Procurement	1	1	1
4. Directorate/Locality (1.5%)	10	10	10
Total	**33.4**	**36.25**	**31.65**
Repayment of 2013/14 Overspend	**0**	**0**	**0**
SHORTFALL	**26.1**	**3.25**	**5.85**

The Health Board has also considered its financial position after the receipt of potential allocation growth, on a fair shares basis, as indicated by the Welsh Government. The net position of the Health Board is shown in the table below.

Table 45 : Health Board Net Position

	2014/15 £m	2015/16 £m	2016/17 £m
Planned Surplus/Deficit	26.1	3.25	5.85
Potential Allocation Growth	(5)	(10)	(10)
Net Position	21.1	(6.75)	(4.15)

The graph below identifies the scale of the challenge set down by this Plan in terms of savings delivery. It can be seen that the total planned savings for each of the three years of this Plan are significantly in excess of those achieved in the current year and past two years.



When we combine our cost and funding bases we produce a final assessment of our financial outlook for the next 3 years. The last row of Table 44 shows this shortfall as being £26.1m in year 1, £3.25m in year 2 and a deficit of £5.85m in year 3. The total recurrent deficit for the duration of the plan, at present, is £35.2m. With potential allocation growth over the three years, this total recurrent deficit would be £10.2m.

The Board considers that within a zero % uplift over the three year period it will not be possible to deliver a balanced plan and deliver the service targets set down by the Welsh Government. A process of prioritisation is required to identify a realistic and deliverable Plan and this process has been prepared to a stage where we are now discussing our implementation plan to carry out the work.

8.3.4 Summary of Financial Projections for 2014/15 to 2016/17

Given the scale of the challenge, Directorates and Localities are working to produce Integrated Service, Finance and Workforce Plans for 2014/15 the 3-year period 2014/15 to 2016/17 that bring together service plans, access delivery plans, workforce plans and financial and savings plans into one coherent plan. These plans must identify the measureable targets on a month by month basis to allow clear comparison with delivery.

Funding the anticipated costs for the period 2014/15 to 2016/17 will require an approach that includes Welsh Government, National Strategies and collaborative working by all Health Boards, ABMU Health Board wide saving strategies and savings programs developed at the Directorate/Locality level.

It is clear that given the financial challenge, significant savings will need to be made through reductions in workforce costs. Based on the current pay/non pay expenditure ratio, it would not be unreasonable to anticipate over half of savings being delivered through workforce efficiencies and changes to Pay Costs.

At this stage, the integrated planning process has not identified a balanced plan and therefore the financial schemes that are available do not meet the full savings targets established. The Board considers that it will not be possible to deliver a balanced Plan and deliver the service targets set down by the Welsh Government. A process of prioritisation is required to identify a realistic and deliverable Plan.

It is clear that the Health Board has a shortfall on its cost improvement programme (CIP) plans for 2013/14 and that this will translate into a material underlying recurring shortfall carried forward to the commencement of 2014/15. Efforts are continuing to:-

- Review schemes currently identified
- Identify additional schemes to meet CIP target
- Seek additional savings to address any carry forward deficit.

The starting budgets have been established as a result of working through the methodology and assumptions outlined earlier in this report.

8.4 Executive Led Savings Projects

Table 43 above sets out a number of Executive led Projects for which savings are assigned to Directorate and Locality financial plans for delivery. Described below is the detail of the work undertaken to identify the savings figures profiled in our Plan.

8.4.1 Workforce Modernisation

We are actively engaging in benchmarking activity to identify opportunities to maximise the skill mix and efficiency of the workforce, using All Wales Skill mix Analyser and iView data. Current benchmarking data identifies the average cost per WTE at ABMU to be around £130 per WTE above the welsh average.

We are also exploring the opportunities to reshape the workforce, supporting efficiency and productivity improvements through 7-day working, with a number of pilot schemes about to commence. The results of these pilots will be used to further refine and understand the impact on service models.

The Medical and Dental Workforce is a fundamental part of the workforce modernisation project, with greater emphasis on job planning and outcome measures and use of alternative workforce roles to support reductions in available medical staff.

8.4.2 Variable Pay

We spend around £26m per annum on variable pay costs. Elements of this variable pay are not paid at premium rates, as it relates to bank. Similarly the full £26m could not be identified as a saving as the costs are incurred covering vacant posts, the ‘premium’ element could however be reduced significantly. Table 46 below sets out the potential deliverable savings through this approach.

Table 46 : Variable Pay Potential Cost Release

Opportunity	Premium Cost £000	2014/15	2015/16	2016/17
• Bank use for absences that should be rostered i.e. annual leave, study leave	200	100	100	0
• Replacement of bank usage where it is deemed more expensive than overtime	150	150	0	0
• Replacement of overtime where it is more expensive than bank	650	325	325	0
• Cessation of Contract agency removal of premium	300	90	90	120
• Cessation of Non- contract agency removal of premium	850	425	255	170
• Cessation of overtime-removal of premium (non-nursing)	750	375	375	0
• Replace WLI with alternatives regular additional sessions	600	300	300	0
• Reduction in Medical Agency (10% reduction)	300	300	0	0
• Reduction in irregular Additional Duty. Hours/sessions	400	200	100	100
Total	**4,200**	**2,265**	**1,545**	**390**

The delivery over 3 years reflects 20% reduction in total variable pay which is considered to be achievable.

8.4.3 Sickness Absence

We recognise that we have the highest sickness absence level of all Health Boards in Wales. Sickness levels have risen steadily during the past 15 months and the Health Board's relative position when compared to other Health Boards in Wales is poor. Table 46 below is also referenced at the end of our workforce section (section 7 – Table 26). Our aim is to reduce sickness absence levels to the 5.08% target in two years and aims to reduce to 4.5% in 2016/17. Table 47 below identifies the potential cost benefit available through reduction in sickness absence rates.

Table 47 : Projected Sickness levels to 16/17

	2014/15	2015/16	2016/17
	%	%	%
Sickness Rate	5.50	5.08	4.50
	£m	£m	£m
Estimated Saving	2.0	1.5	1.0

8.4.4 Interventions Not Normally Undertaken (INNU)

The NHS has historically identified marginally effective and ineffective interventions (procedures and medicines) that are deemed to have no or limited clinical value. These are routinely considered to be low priority and will not normally be provided by the NHS.

We have inherited established policies on Interventions not Normally Funded (INNF) from our three predecessor LHBs. The three policies were reviewed in 2010 by the previous Director of Public Health and a revised list of Interventions Not Normally Undertaken (INNU) for consistent application across the Health Board was developed. The list was adopted by the Executive Team but was not formally implemented throughout the Health Board or routinely monitored.

An extensive review was undertaken by the Health Board in conjunction with Public Health Wales to compare the new list which is based on Cardiff & Vale's list, and old LHB policies as well as ensuring that it reflects the most recent evidence based guidance.

Following this review, a draft version was circulated to all secondary care Clinical Directors and Clinical Leads for comments. The final version of the list, which reflects all of the comments received, was approved by the Effective Practice Approval Committee (EPAC) on 17th May 2013.

Our INNU project is focussing on the launch of the INNU list and subsequent implementation of a full INNU policy through monitoring activity and reviewing compliance with clinical criteria set in the policy. It is essential that the policy is embedded into the Organisation and so the Project will focus on engaging with the Directorates/ Localities to ensure that they take ownership and accountability for implementing the policy, reviewing compliance and addressing non compliance. There will also be a focus on ensuring Primary Care are following the policy and making referrals in line with the clinical criteria.

The effect of compliance with the INNU policy across ABMU should be to reduce the number of referrals which proceed to surgery which are of low priority. The financial benefit of this work has been identified by the Project over 3 years and is presented within the overall financial plan.

8.4.5 Corporate Management Costs

We are committed to ensuring that we have the appropriate level of management costs to reflect our delivery agenda but which are ultimately as low as possible within this. We have undertaken, and are continuing to undertake, a number of management and administrative service reviews in order to reduce cost and improve performance. Corporate Management and administrative costs have been subject to a full review in 2012/13 that resulted in a 3-year programme to reduce corporate management costs by 20%. The financial plan contains the savings from this programme in 2014/15.

We have also initiated a review of Directorate and Locality Management and administrative costs with a view to identifying a 3-year programme to reduce costs to be implemented from 2014/15 through to 2016/17. This review will consider the management cost savings arising from a restructuring of management capacity and also the cost savings arising from a review of the potential to modernise administrative working practices.

The Health Vision Swansea (HVS) Programme at Morriston Hospital and also the Effective Information Systems and Use of technology programme are enabling programmes for this modernisation and cost reduction. This modernisation of administrative working practices will also encompass the working of medical secretaries and their associated support. The Morriston element of savings from this work has been identified within the HVS Clinical Accommodation and Diabetic Centre Outline Business Case submitted to the Welsh Government in December 2013. A recurrent savings of £1m from 2016/17 is included within the Plan.

8.4.6 Devolved Management Costs

The Health Board is currently reviewing its management arrangements for service delivery. Discussions are ongoing with key stakeholders to determine revised arrangements for implementation in 2014/15. The revised arrangements will enhance the delivery capability of the Health Board and its ability to deliver its strategic vision. In addition, the revised arrangements shall be targeted with generating £1m recurrent savings over a 2-year period.

8.4.7 Energy Strategy

The Health Board has targeted further improvements in Energy efficiency across its estate and this is aligned with spend to save investment in the Capital Plan.

8.4.8 Procurement

As well as supporting the collective work across Health Boards and Procurement savings and Cost avoidance, the Health Board recognised that

there are local opportunities to improve the cost effectiveness of our service inputs. Directorates and Localities are working up plans supported by the Procurement Services Division of Shared Services

8.5 Capital (Appendices B13, B14 and B15)

In light of the opportunity presented by a three year planning framework we have taken the time to consider the objectives of our Service Change Programmes and to reflect this in our capital planning assumptions. We have therefore developed the Capital Programme to support service modernisation and dovetails with the service sustainability agenda within the physical estate.

It should be recognised at this early stage that the capital programme needs to support the delivery of the Health Board's statutory requirements in terms of the estate performance and maintenance and capital requirements within this 3 Year Plan. It also needs to support the significant clinical equipment and clinical technology replacement programme to ensure the safety and efficiency of service delivery.

Our capital plan supports the rationalisation of the Health Board estate at a time where alterative clinical models are being implemented, particularly within our Localities to provide care closer to patients in their homes in a community setting. This programme of work enables the focussing of more specialist services onto the main acute hospital sites as community based models reduce the requirement for services to be provided in traditional models in community hospitals.

Our overall plan is made up of two elements.

- Discretionary Capital Allocation
- Capital funding from the All Wales Capital Programme for specific schemes.

Along with other Health Boards, we have a considerable and growing problem with the amount of capital required to eradicate our backlog maintenance problem, replace and maintain our medical and IMT equipment to the recommended replacement standards. It is estimated that the replacement cost for just these three elements is considerably in excess of £100 million.

8.5.1 Discretionary Capital Programme 2014/15 – 2016/17

Our discretionary Capital Allocation is £7.673 million. A number of factors may improve the position through the year such as additional capital in the form of the Health Technology Fund and other Welsh Government initiatives.

We know that we will face significant demand for Discretionary Capital from 2014/15 onwards, with particular emphasis on the expected requirements for major clinical equipment replacement (including imaging), ICT, and statutory/fire safety expenditure.

It would be unrealistic to assume that the Discretionary Allocation can contribute in any significant way to facilitate major service redesign or reconfiguration as it is insufficient to discharge maintenance and replacement obligations. In light of the comments made above, we have decided that priority will be given to the following categories of capital: -

- To review how well ward accommodation supports care for those with dementia, delirium, cognitive impairment or dying covering physical design of the clinical spaces and equipment available
- To maintain service continuity – particularly replacement equipment including evidence of risk assessment
- Statutory requirements
- Spend to save investments.

Our work to rationalise our estate means that the investment is required to focus on the three acute hospitals accepting that Neath Port Talbot Hospital has a different funding regime as it has a PFI contract. Without the investment identified the risk of a systems failure which would compromise patient care increases and also the considerable rise in backlog maintenance costs.

It should be noted that there are also plans for the rationalisation of the Health Board estate leading to capital receipts from property sales and these are outlined in Table 48 later.

Maintenance of existing technology and refresh of aging ICT devices and components is a key component of the Health Board's capital priority to maintain service continuity. The clinical risks associated with failure of this vital infrastructure are recognised in the Health Board's assessment of risks. It should also be noted that we are unlikely to make any additional capital investment for additional ICT to support development and modernisation based on our discretionary allocation.

8.5.2 All Wales Capital Programme

The main elements for the All Wales Capital Programme relate to the approved plan for the Redevelopment of Morriston Hospital and the Modernisation of Mental Health Services across ABMU. Strategic programmes for ongoing maintenance of Morriston Hospital, Princess of Wales Hospital and Singleton Hospital have been submitted to Welsh Government. An ambitious strategic programme for Information Technology, both within and outside the hospital environment and a programme for the

replacement of existing medical equipment is also nearing completion and the description of this work is set out in section 9 which follows.

Table 48 below sets out the current indicative 5 Year All Wales Capital Programme for 2013/14 to 2017/18 and the range of facilities that the indicative programme affects.

Table 48 also sets out the range of capital requirements to fulfil all of the ambition of the Health Board. It is understood that capital resource is scarce and we accept that once preliminary discussion are held regarding capital, prioritisation will need to be undertaken to allocate scarce resource to the projects and programmes which deliver the critical path of this 3 year plan.

In terms of priorities the capital programme must strike a balance between maintaining the fabric of the existing estate (hence the infrastructure projects) and supporting the strategic development of our services to improve the quality of care we provide. This must be seen in the context of our main hospitals, but also in the context of Mental Health facilities and our primary care estate. The schemes identified in the current All Wales capital programme need to be progressed and the improvement of the Cardiac Intensive Care Unit is a key quality and safety issue for the Health Board and is a high priority.

A small number of schemes remain to be confirmed and quantified and these will be discussed and developed with Welsh Government over the first half of 2014/15 as further clarity becomes available on the national picture for capital availability.

Table 48 : Indicative All Wales Capital Programme Requirements – ABMU

	Scheme	2014/15 £m	2015/16 £m	2016 /17 £m	2017/18 £m	2018/19 £m
	Discretionary Allocation	7.673	7.673	7.673	7.673	7.673
Capital Programme	Morriston Hospital Phase 1B	23,119				
	Morriston Hospital Clinical Accommodation	10.195	7.959			
	Morriston Hospital – Demolition Work		2.200			
	Acute Mental Health Unit	6.400	10.000	3.000		
	OPMH Assessment Unit	1.000	12.400	2.800		
	Mental Health – Day facilities	2.653				
	New Low Secure Unit	9.429				
	Singleton Hospital Aseptic Suite	4.960				
Capital Requirements to Support IMTP	Increasing CITU capacity and Cardiac Centre	3.000	4.000	30.000	30.000	
	Unscheduled Care Capacity	3.000	TBC	TBC	TBC	
	IMT Strategic Change Programme	6.500	5.600	6.400	2.000	2.000
	Centralisation of Maternity Services	2.000	4.000	20.000	30.000	14.000
	Implications of the SWP	TBC	TBC	TBC	TBC	TBC
	Ward reconfiguration – Morriston	TBC	TBC	TBC	TBC	TBC
	Morriston Hospital Critical Care capacity	TBC	TBC	TBC		
	Replacement of Catheter Laboratories	2.000	2.000	2.000		
	Provision of Integrated Theatre	1.000	2.000			
	Surgical Robot	3.000				
	Renal Morriston	2.000	2.000			
Infrastructure Requirements	Medical Equipment Replacement	2.000	2.000	2.000	2.000	2.000
	PoWH Infrastructure	2.000	2.000	2.000	2.000	2.000
	Morriston Hospital Infrastructure	2.000	2.000	2.000	2.000	2.000
	Singleton Hospital Infrastructure	2.000	2.000	2.000	2.000	2.000
	Morriston Hospital reconfiguration			15.191		
	Morriston Hospital demolition phase	1.000	1.000	1.913		
	Replacement of Linear Accelerators	2.000	3.000	3.000	3.000	
	Primary Care Development Schemes	1.000	2.000	2.000	2.000	2.000
	EMRTS	0.111	TBC	TBC		
	TOTAL	99,965	73.877	102.007	82.673	33.673

In January 2013, Chief Executive Colleague's considered a proposal to develop an integrated Emergency Medical Retrieval and Transfer Service (EMRTS) for Wales. With strong clinical evidence behind the proposal it has been agreed to develop a business case for the EMRTS model.

In ABMU we have agreed to support the development of the business case and identify the revenue and capital requirements for a sustainable resilient service. The EMRTS Project Board has been established to oversee the development of the business case and any capital requirements will feature in future ABMU capital plans once these have been robustly quantified. This business case will be developed by the end of June 2014.

Some of the key issues affecting the Estate are as follows: -

8.5.3 Morriston Hospital

The current redevelopment of Morriston Hospital must be seen in the context of resolving the inadequacies that have been present for a number of decades. This must be regarded as the start of the remodelling of the hospital and not the end.

It is becoming increasingly clear that Morriston Hospital will need to be continued to be developed in order to enable it to deliver the services of the major acute hospital. In future, it will be the only hospital within Swansea with a medical intake and it is ideally situated to support services in Neath Port Talbot and West Wales and the changes that are required are as follows: -

- The need for wholesale demolition of the redundant estate.
- Upgrading and essential engineering work for the remaining part of the hospital built in 1985 and 1997.
- Capacity to support the accommodation requirements of the Hospital Services Project under Changing for the Better
- Increased accommodation for Unscheduled Care.
- Improved and increase physical accommodation for the interim solution for the Cardiac Centre.
- Additional Critical Care facilities.
- Transfer of the Maternity, Neonatal and Gynaecology service from Singleton Hospital.
- Upgrading of Renal facilities.

The Strategic Change programmes set out in section 5 above relate principally to developing increased accommodation for unscheduled care on the Morriston Hospital site. Our priority within the Hospital Services project under Changing for the Better is to commence with this development first as it marks a sequence of events within the Hospital services plan to reconfigure services.

8.5.4 Singleton Hospital

Over the next 5 years there will be changes in the range of services that will be provided by Singleton Hospital. There will need to be significant investment to remodel the physical accommodation and also investment into the physical and engineering infrastructure of the hospital.

Additionally a robust and realistic replacement programme for the Linear Accelerators needs to be agreed with Welsh Government. See Table 47 above.

8.5.5 Princess of Wales Hospital

The outcome of the South Wales Programme was agreed in March 2014. The Princess of Wales Hospital will become a Regional Centre when it is anticipated that significant capital works will be required. This capital requirement cannot be assessed as yet but as the service models emerge more precise assessments can be made...

Irrespective of the outcome of the South Wales Programme it will be necessary for investment into the physical and engineering infrastructure within the hospital.

8.5.6 Mental Health Services

Both Cefn Coed Hospital and Glanrhyd Hospital have undergone considerable transformation over the last 5 years. With the approval of the Full Business Case for the Low Secure Unit only the following elements are outstanding.

- Adult Acute Assessment facilities for the Health Board;
- Older People's Assessment Beds for Swansea;
- Day Care facilities for the West of Swansea;

Plans for the rationalisation of the Cefn Coed Hospital and Glanrhyd Hospital sites will now be progressed. The disposal of the remainder of the old part of the Cefn Coed site can only proceed with the reinvestment of the sale proceeds, which would allow the site to be vacated.

8.5.7 Primary Care facilities

Development of the Primary Care Estate has presented its own challenges. Approval has now been received to develop Primary Care Centres at Briton Ferry, Vale of Neath and Brynhyfryd. It is anticipated that these facilities will open towards the end of 2014.

A Primary Care scheme for Mayhill is presently being progressed in partnership with the City & County of Swansea.

A baseline mapping of primary care estates issues is underway. An initial assessment, which has not yet been completed, has highlighted a number of issues that will need to be considered in the context of the three year plan. There has also been a recent change in process for determining priorities and considering how estates developments will be funded by Welsh Government – the impact of which is still being assessed.

Across ABMU, the following priorities have been identified for year 1 of the IMTP:

- Undertaking a comprehensive review of the Health Board and GP owned estate in terms of its functional suitability and service utilisation to inform a potential investment programme for improvement grants
- Considering strategic options for the location of administrative bases for community based staff, including options for co-locating staff with other areas such as social care, as part of the development of integrated care services
- Establishing a clear review and inspection programme for the primary care estate that reviews the functional suitability and compliance with statutory legislation (within the contract requirements)
- Identifying options for rationalising the estate including the use of branch surgeries, poorly utilised community clinics and minimising the use of clinical space for administrative duties as part of the use of technological solutions for community service staff (Health Technologies Programme)
- Aligning estates plans with the wider development of community networks
- In light of devolution of responsibilities for managing primary care estate, establish clear processes for decision making and providing assurance to the Board on the quality and delivery of the primary care estate.

Specific developments to be progressed up to 2016/17:

8.5.8 Bridgend

- Development of Maesteg Community Hospital as a primary care resource base with a consequent relocation of BronyGarn and Nantyfyllon Surgeries
- Porthcawl – development of a new surgery to incorporate Portway and Victoria Road surgeries
- Aberkenfig – redevelopment of existing surgery

8.5.9 Neath Port Talbot

- Cimla Hospital – redevelopment into a base for primary and community services
- Dyfed Road – strategic solution to accommodate population growth and service pressures in Neath Town Centre
- Cwmavon /Afan Valley– dealing with the poor fabric of the estate

- Upper Swansea Valleys – addressing the security of tenure issues and ensuring a sustainable service solution
- Coed Darcy – meeting the demand for access to primary care as a result of new housing developments

8.5.10 Swansea

- Identifying a solution to the constraints within Dyfatty/High Street area
- Finalising proposals for Gorseinon Hospital.

8.5.11 Information Technology

The modernisation of services and clinical practice will require a sustained and focused investment in Information and Communications Technology. The provision of high quality information and pervasive access to this information via technology remains at the heart of the Health Board's improvement programmes. Significant progress has been made in implementing the building blocks for the delivery of information and systems to support clinical staff in delivering care; most notable a single view of patient events is now available following the roll-out of the Myrddin PAS system across the whole of the Health Board. Work is planned and systems in place to deliver live information in an in-patient setting and help to manage the flow of patients in hospital. Much work remains to provide the joined-up information and technology that is the enabler of the strategic change programmes and projects. Moving this agenda forward with pace remains a significant challenge and will require capital and revenue investment in informatics in order to grow capacity and change the focus to the future rather than the current challenge, which is maintenance of the present infrastructure and systems.

Clinical improvement, pathway redesign and information are inter-related to the extent that they cannot be seen as separate elements. The Transformation Programme within the Health Board cannot achieve the service improvements planned without the corresponding investment in enabling technologies.

In addition to the significant requirement for technology refresh, the key clinical developments the Health Board plan requiring capital resources for ICT over the next three years include:

- Procurement, implementation of the national emergency department system to support patient flow.
- Development and integration of a single theatre management system together with the infrastructure to enable the move from paper-based to full electronic working.

- Development of electronic recording and sharing of information between health and social care. This will be subject to a separate bid to the Health Technology Fund.
- Implementation of paper-light working as part of the new Morriston outpatient facilities.
- Digitising health records to provide electronic records available as required across 4 hospital sites. This will significantly improve the availability of clinical information to inform care decisions.
- Implementation of an integrated facility for maintaining live in-patient information and managing flow within secondary care.
- Providing a wireless infrastructure in Singleton to support access to clinical information and the point of care and free Wi-Fi for patients, which is also available on our other main hospital sites.

8.5.12 Land and Property

As a consequence of our extensive service modernisation programme, there has already been a considerable rationalisation of our Estate. The future disposals set out in Table 49 below have been approved by the Health Board.

Table 49 : Health Board approved disposals

Site	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Fairwood Lodge	0.175				
Cefn Coed Hospital	2.700	8.125	10.200		
Briton Ferry Health Centre	0.100				
Resolven Health Centre	0.050				
Glynneath Health Centre	0.040				
Pontycymmer Clinic	0.015				
Caerau Clinic	0.075				
Ogmore Vale	0.100				

8.5.13 Delivering Successful Capital Programmes

The Health Board has a successful track record in delivering capital programmes to time and cost, and also utilising the investment to lever service improvement. The Capital Monitoring and Management functions are overseen by the Capital Investment subcommittee of the Board.

Well established and effective Capital and Finance team working is key to this level of performance and both teams share information on Projects in real time on a single information Portal. The quality of the working with

agents and service partners is also an important factor in the quality of capital governance.

We welcome the useful guidance recently issued by the Welsh Government and believe these further changes will enhance further the quality of capital governance within NHS Wales.

8.6 Cash Flow Forecast (Appendix B10)

The forecast cash deficit for 2013/14 is as per that submitted with the month 11 monitoring returns.

The cash receipts included for each year for revenue are the totals as per the RRL in the SCNE reduced for the depreciation amount as this is non cash

The cash payments are based on the expenditure in the SCNE less depreciation which is non cash with an additional £2.3m of cash payments each year included each year to reflect the forecast deterioration in working balances due to cash payments for provisions.

The overall worsening deficit is directly linked to the forecast I & E Deficit each year. In addition, it should be noted that 2014/15 assumes that capital creditors for major schemes will be fully discharged to eh approximate value of £4m. At this point, no cash inflow from Welsh Government has been assumed to cover these payments.

The "Other (incl Non Cash Limited)" line includes anticipated disposal receipts up to £0.5m which is the current limit for Health Boards to retain.

The overall scale of cash deficits each year are significant and are broadly equal to one month's salary payments, totalling £28m, rising to the equivalent of three months by year 2016/17 at £102m.

Table 50 : Cash Flows Forecast

Cash flows 2013/14 to 2016/17				
	2013/14	**2014/15**	**2015/16**	**2016/17**
	£'000	**£'000**	**£'000**	**£'000**
Receipts:				
WG Revenue Funding	916,091	913,505	913,505	913,505

Cash flows 2013/14 to 2016/17				
WG Capital Funding	40,365	38,021	7,673	7,673
Other (incl Non Cash limited)	277,344	241,553	240,998	240,998
Total Receipts	**1,233,800**	**1,193,079**	**1,162,176**	**1,162,176**
Payments:				
Revenue	1,192,652	1,183,458	1,187,153	1,192,003
Capital	43,383	42,270	7,673	7,673
Other	0	0	0	0
Total Payments	**1,236,035**	**1,225,728**	**1,194,826**	**1,199,676**
Bank & Cash B/F	**2818**	**583**	**(32,066)**	**(64,716)**
Bank & Cash C/F	**583**	**(32,066)**	**(64,716)**	**(102,216)**

NOTE: Requirement to submit Monthly Profile will be met as part of Monitoring Returns Submissions

8.7 Risks and Sensitivity (Appendix B9)

It is important to emphasise that the assessment of our financial challenge for 2014/15 as described above is based on the latest information available. It is inevitable that even marginal changes on budgets of more than £1billion can have a major impact on our ability to achieve financial targets.

In setting out the financial challenge facing us for the period 2014/15 to 2016/17 the key assumptions and risks built into the financial projections are: -

- Zero % income growth for 2014/15 to 2016/17. This represents a significant challenge to ABMU to deliver services whilst facing increased inflationary cost pressure.
- The projected annual run rate for CIP savings in each of the following 3 years exceeds the Health Board's historic delivery pattern.
- The savings target established for the three years amounts to over £136m which equates to a CIP target of 12%. This would be a considerable achievement, particularly given the fact that there has already been substantial savings achieved over the recent past for the new ABMU configuration of services.

- Our cost performance is significantly better than the average for Wales and is some 9% better than that of Betsi Cadwaladr University Health Board and Aneurin Bevan Health Board services. This means that it is more difficult for ABMU Health Board to meet all the service and financial targets than other Health Boards in Wales.
- Given the service and financial pressures that are currently present, the ABMU Health Board carried forward an underlying deficit of some £15m into 2014/15. This will have to be addressed in addition to the savings requirements in the period 2014/15 to 2016/17 in a £136m savings requirement.
- Addressing the backlog required to meet access standards will put a considerable strain on financial control and will require a stepped improvement in operational performance. £6.5m is identified in the financial plan to meet RTT standards.
- The scale of the challenge over the next three years will require a review of clinical services provided to identify their relative effectiveness and priority. It is not envisaged that improved performance alone can deliver the financial savings required.
- The scale of the plans required to be delivered for the period 2014/15 to 2016/17 will inevitably run the risk of slippage in actual delivery, resulting in a risk of an in year overspend.

The Health Board has undertaken a Strategic Risk Assessment of its financial plans to identify 'downside' risk and 'upside' opportunity. This strategic risk assessment is presented in Table 51 below.

Table 51 : Financial Scenarios

'Downside' Risk	14/15 £m	15/16 £m	16/17 £m	'Upside' Opportunity	14/15 £m	15/16 £m	16/17 £m
1. Demand in excess of Plan	1	1	1	Demand Unlikely to be less than Plan	0	0	0
2. National Pay Negotiations	5	5	5	Full mitigation of Pay Cost	(5)	(4)	(3)
3. Programme Savings Slippage	2	2	2	Rationalisation of Investments with low financial return	(5)	(5)	(5)
4. Directorate/Locality CIP Slippage	2	2	2	Other Income	(1)	(1)	(1)
5. Other LHBs Retraction of Services	2	0	0	Growth in service provision to other LHBs	0	(1)	(1)
6. Increased Expenditure to meet Tier 1 targets	0	2	2	Cost mitigation WHSSC Commissioned Services	(1)	(1)	(1)
7. Additional ChC volume and price growth	1	1	1	HB share of WG Growth funding	(5)	(10)	(10)
8. Social Services Effect on flow	tbc	tbc	tbc	Other Partnership Service Models	(1)	0	0
	13	**13**	**13**		**(18)**	**(22)**	**(21)**
Baseline Plan	26	4	5		26	4	5
	39	**17**	**18**		**8**	**(18)**	**(16)**

It can be seen that the Baseline Plan has significant 'downside' risk as well as 'upside' opportunity. Sound financial planning indicates that a Baseline Plan presents a reasonable financial assessment of the position of the Health Board, given these risks and opportunities. The Health Board's Financial Plan presents such a position.

It is clear that decisions will be required on service priorities, national pay cost management and Health Board investment funding in order to enable the Baseline Plan to be realistically revised towards a balanced position.

8.8 Financial Management, Development and Governance

8.8.1 Evolving our Finance Future

The evolution of the Finance Function, and the financial management and governance of the whole Health Board, has been the subject of significant work over the last 12 months. The issue by the Welsh Government of the "Financial Regime" guidance has informed this work, alongside evidence of best practice across service sectors.

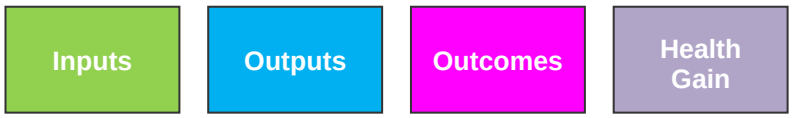
A Finance Future Development Board was established consisting of Senior Finance Officers, Clinical and Service leaders and external representation. The external input of Public Health, Swansea University, the Welsh Government and the Wales Audit Office has enhanced the quality of our work. The Board is planning to finalise and endorse a medium term development strategy, entitled "Finance Future", in the new year. This work builds on the existing Finance Function Management and Development Framework, "Compass".

At the heart of "Finance Future" is the role of Finance as a service partner enabling the alignment of Finance, Patient Experience and Clinical Outcomes throughout the management and accountability structures to enhance value. The organisational, technical and personal development dimensions of this role are explored and a framework for action set down.

'Finance Future' sets the future finance role to support the delivery of the Prudent Healthcare agenda. More detail is provided in Appendix 5 later.

'Finance Future' has been developed to ensure our Finance Function facilitates the ambition of the Health Board to deliver excellent patient outcomes, experience of service and value, supporting the Integrated Medium Term Plan. We have developed Finance Future in conjunction with Finance people and stakeholders. Finance Future describes how Finance will change its focus from being predominantly inputs based to consider value from a patient perspective.

To inform choices and to provide insight into services and opportunities, we need to alter the scope of our financial activities. We need to develop new financial perspectives on our health services. We have developed a Financial Model for change that assists us in shifting our focus to activities that offer much more value. In this way we can support clinical and service decision making from 4 perspectives.



High performing NHS organisations are able to demonstrate Clinical and Finance teams are working together. There is an understanding that cost reduction without maintaining or improving outcomes may lead to a 'false saving and have a detrimental impact on the delivery of care'. Department of Health: Effective Clinical and Financial Engagement Nov 2013.

Finance Future needs to fit alongside the complimentary work of other clinical and professional groups within the Health Board, and a part of Finance Future is ensuring these relationships grow and strengthen.

Our Finance Future should enable the Health Boards Clinical Strategy to be realised. It should also do so in a way that promotes the values of the Health Board and the positive behaviours demonstrated by those values, engaging the workforce in the use of resources to deliver healthcare of quality and value.

9 Building Capacity and Delivery

This section captures more detail on the underpinning strategies for the delivery of the IMTP. In particular this section picks up the detail of two of our seven Strategic Change Programmes, Commissioning and Effective use of ICT.

9.1 Organisational Development and Culture

See section 7 Workforce and Organisation Development

9.2 Service & Process Improvements

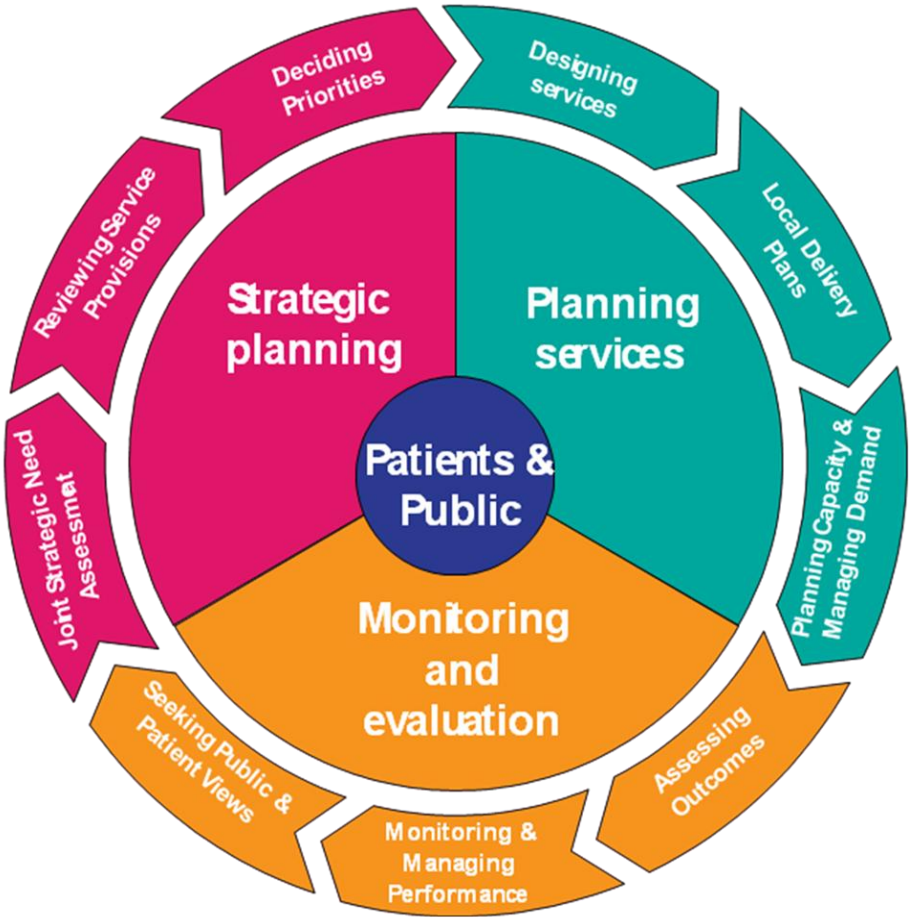
Our ISIS (Innovation, Support and Improvement Science) programme will support the Health Board's Organisational Development agenda. One element is 'People/Staff development' in improvement and systems methodology, enabling the workforce to lead improvement in their daily working processes and increasing understanding that our staff have two jobs; to do their job and continuously improve what they do. ISIS will implement a programme of service improvement and best practice, using tried and tested methodology which is understood by all.

9.3 Commissioning and Planning

The Commissioning Development Programme has a specific commissioning development project within it which aims to further improve health board planning and delivery of services on the basis of population health need, evidence of clinical effectiveness, value for money and demonstrable improvements in population health outcomes.

The focus during 2013/14 has been to better understand current Health Board capabilities in relation to the commissioning cycle (see Figure 20 below) to inform future capability planning. The cycle in Figure 20 has been modified to align with Welsh Government planning guidance and will now form the basis of our development work during the period between January 2014 and March 2014. The cycle also draws on research which considered best practice in England in terms of commissioning models and organisations which plan services effectively.

Figure 21 : Proposed Health Board Planning Cycle



Our Strategic Needs Assessment now provides us with the information we need to begin to develop plans which shape the future configuration of our services and the alignment of our priorities in terms of delivery of care. In order to analyse, prioritise and design the plans to respond to the Strategic Needs Assessment we know that we must fundamentally change the way in which we plan our services through an integrated commissioning and planning cycle. We have therefore undertaken a process of engagement to develop a 10 point plan for further improving health board commissioning capability during 2014-17

The engagement process culminated in the development of a 10 Point Commissioning Capability Development Plan for 2014-17. The actions have been informed by three engagement events held with the Health Board Chief Executive, Executive Directors, Non officer members, managers and clinicians, as well as some local authority and third sector colleagues. The plan builds upon progress already made within the Health Board to further improve the planning and delivery of Health Board services on the basis of population health need and demonstrable improvements in population health outcomes.

The plan is divided into two sections planning and delivery, both contain actions which aim to develop and/or enhance the Health Board's delivery of the commissioning cycle.

The 10 Point Commissioning Development Plan is set out in Table 52 below

Table 52 : 10 Point Commissioning Development Plan

Ref	Action	Benefit
1	Raise the level of understanding of commissioning cycle through a designated programme of sessions	Improved staff understanding of Health Board and individual role in commissioning and the planning of services on the basis of population health need and outcomes
2	Consult with and agree an enhanced clinical leadership role in commissioning	Improve communication between clinical sectors to support service change Clinical objectivity in Health Board decision making Clinical engagement in need assessment Clinical leadership for pathways Engage GPs leads within community networks at strategic HB level
3	Host an 'austerity conversation' with the public as part of public engagement in decision making	Transparency Public awareness & ownership Opportunities for innovation in service improvement
4	Develop a Joint Strategic Health & Social Care Need Assessment (JSNA) to inform planning and prioritisation of health and social care services.	Improve understanding of forecast population need & service impact. Improve prioritisation process Improve understanding of & ability to develop integrated H&SC priorities Support Health Board role as local health economy leader Target resource on population need
5	Write a commissioning framework aligned to planning cycle to embed commissioning approaches in business planning	Improve understanding, governance and implementation of commissioning Support strategic prioritisation processes Align planning and commissioning functions & processes
6	Undertaken commissioning cycle quality review and 'coaching' approach with service improvement managers delivering significant change projects	Understand potential 'blocks' to delivering service improvement Improve commissioning quality of service improvement projects Enable staff to learn and develop through their work

Ref	Action	Benefit
		Informs development of commissioning framework proposed at Ref 3.
7	Test pathway improvement project(s) with primary & secondary care engagement and an agreed financial envelop to explore new ways of working	Allow a new way of working and financial model to be tested Encourages clinicians to work together and with partners to innovate Will be needs, evidence and outcome focused Support National Delivery Plan implementation.
8	Develop a defined service improvement function/team with a dedicated business support team/function to plan and drive planning for and delivery of service improvement	Co-ordinated prioritised approach to service improvement Skills sharing Underpinning business requirements for service improvement supported by Objective clinical leadership Target resource for 'big ticket' change
9	Design service specification & schedule documentation for use on all service Commissioning/improvement projects	Clear service delivery requirements Agreed quality and outcome schedules Focussed monitoring data
10	Prioritise the IM&T programme to aid commissioning information capability development, in particular actively support the SAIL database development project	Ability to underpin board decisions with robust intelligence Better informed service improvement Improved performance management Access to linked health and social care data to inform needs assessment ref 4.

The first 5 elements of the plan are already agreed and being developed. The final 5 elements are draft only are currently being discussed within the Health Board. It is anticipated that by the final draft of this document the agreed position will be in place and in the process of implementation.

The Health Board will ensure that the Commissioning Development Programme remains a strategic enabling programme for the Health Board and that the actions above are embedded into organisational processes as they are agreed.

Alongside this work we a project within the Commissioning Development Programme which is considering the application of Interventions Not Normally Undertaken Policy (INNU) and another project which is looking at our Individual Patient Funding Request process (IPFR) and how this relates to our future commissioning intentions. The IPFR process is currently under

review nationally and our work here is currently awaiting guidance from the national review before progressing further.

Table 52 below provides a summary of the investment, savings and benefits to be delivered by this project.

Table 53 : Commissioning Programme Summary

	2014/15	2015/16	2016/17
Investment £	211,728	180,246	270,000
Savings £	-	-	-
Benefits	See table 52		
Workforce Profile	3 x Band 6 (2x data analysis and 1 x Clickview Dashboard Data Copier) plus support for clinical engagement, learning and development and information support.		
Risk	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.		

9.4 ICT strategy

9.4.1 Future state

In order to start to address these issues we have established Effective Information Systems and Use of Technology (EIST) as one of seven priority programmes, which are managed as part of the MSP programme management arrangements and is integrated with the service improvement agenda as a key enabler for change and modernisation. Details of how each of the projects within the EIST Programme enable and support the individual service improvement projects are available together with a breakdown of costs with sources of funding.

The aim of the informatics strategy is to provide clinical staff with an electronic, patient-centred view of information in order to support high quality care. Clearly, this information needs to be up-to-date, accurate, and available wherever care is being delivered. Making this a practical reality for our clinicians is a significant challenge in light of the continued reliance on the paper health record, the number and variation in IT systems in use across the organisation, and the level of investment in technology required to enable and sustain change and modernisation.

We continue to support the development and delivery of national IT products and services working in partnership with NWIS. In the short to medium term, the approach will be to identify opportunities that maximise the benefits of investment in existing information and technology in order to provide more

joined-up clinical information. This approach will support prioritised service improvements and ensure the workforce become familiar with more electronic ways of working in order to fully exploit the benefits from national products when these become available.

In addition to a focus on more integrated information, easy access to information will need to be addressed. We have continued to invest significantly in ICT infrastructure. With greater reliance on electronic information, levels of investment will need to increase significantly, not only to maintain a robust and resilient infrastructure that is highly available, but also to provide access for increasing numbers of clinicians as we move away from the paper records.

In order to prosecute this plan we are working with Welsh Government colleagues in order to develop a Strategic Outline Programme for submission to the Welsh Government funding. Approval of the programme will allow business cases to be submitted for individual projects over the next three to five years and ensure that there is a sustained long term period of Informatics investment which will support the Health Board's service improvement strategy.

In addition, a bid will be submitted to the Health Technology Fund in order to make information available electronically across health and social care and improve services that maintain independence and reduce unscheduled admissions into hospitals. This bid is being made in partnership with the Western Bay Programme which is providing the ongoing revenue support for this exciting development.

In the meantime, if the enabling programme attracts sufficient capital funding to proceed, the Informatics Directorate will require additional resources in both Clinical Coding and Health Records in order to improve existing performance associated with maintaining the current paper-based processes. Details are included in the financial spreadsheet.

9.4.2 Service Change

Over the next 3 years, the successful implementation of the technology solutions listed below will support significant service modernisation and efficiencies across primary, secondary and community care. All are based on the fundamental principle that high quality care in the 21st century cannot be delivered with paper based information recording and delivery.

- Develop a business case to seek resources to develop and implement a Clinical Electronic Records Management System, moving from a manual paper health records system to an electronic scanning viewing and creating of records system. The solution will manage the legacy of paper records and remove the dependency on paper in the future.

- Implement the ABMU clinical portal in Swansea, to provide a single live ward management solution across the organisation, with access to standardised discharge summaries, referrals, results and images etc.
- Implementation of a document management system to allow improved access to existing and newly created electronic patient documents.
- Procure and implement a single ED system across the organisation (ABMU are leading the development of a national framework contract for an ED system for NHS Wales).
- Implement the National Laboratory Information Management System (LIMS) to support the workflow of the pathology departments within the national model, and provide the platform to allow the introduction of electronic test requesting in both primary and secondary care.
- Implement the National RADIS (Radiology Information System) and PACS solutions across ABMU, allowing clinicians to work with images and reports across the organisation, and share with the rest of Wales.
- Provision for the electronic sharing of information between primary and secondary care: referrals, discharge summaries, clinic letters, GP Summary record (IHR) etc
- Implement a single Theatre Management System, TOMS, across ABMU.
- Integration and seamless ways of working between these systems to support patient flow.
- Implement a patient flow system at the new Morriston Outpatient building, which will allow patients to self register upon arrival and help coordinate their journey through the department.
- Implement electronic clinical data capture forms to reduce the volume of paper creation and facilitate process efficiencies that benefit patients and staff.
- Implement a “patient experience” electronic feedback system
- Support and promote mobile working in hospital and community care through the development of simple/intuitive health “apps” on mobile devices.
- Implement Qlikview Dashboards to provide dynamic and interactive access to Health Board information.
- Implement wireless infrastructure at Singleton Hospital.
- Increase the number of devices available to improve access to information at the point of care for clinical staff.
- Reduce paper-based working by introducing electronic test requesting and prescribing.
- Improve availability and timeliness of Clinical Information to support service improvement and operational management
- Improve the provision of Health Records and Outpatient Administration service

Set out below are the key milestones for this programme.

2014/15	• Tech refresh to maintain services and enable innovation • Clinical Portal utilised across ABMU • Live Admissions, Discharges and Transfers (ADTS) on all wards • Provision of the IHR in assessment units • Introduction of standardised Electronic Discharge Summaries across the HB. • Provision of discharge summaries and clinic letters to GPs electronically • Theatres system implemented across HB. • Emergency Department system implemented across HB. • LIMS implemented across ABMU. • Implementation of an outpatient flow system across Morriston Outpatients • Implementation of a Document Management System within the Clinical Portal. • Introducing electronic working and sharing information in the community with mobile technology solutions. • Implementation of further Qlikview Dashboards. • Electronic support for pre-assessment redesign in Swansea. • Implementation of a “patient experience” feedback system. • Development of scanning business case for a Clinical Electronic Records management System • Improved provision of Health Records and Outpatient Administration service
2015/16	• Tech refresh to maintain services and enable innovation • Integration of the Clinical Portal with the Welsh Clinical Portal • Implementation of the WCP IHR across all emergency care settings • Implementation of Electronic Test Requesting for Primary and Secondary Care • Implementation of a single PACS system across ABMU • Implementation of the RADIS (Radiology management) system in Swansea • Migration to the New National Integration Engine (to replace JCAPS) • Implementation of electronic referral workflow • Further development and innovation to support patient flow, clinical work flow and clinical data capture/audit • Further development and innovation of mobile applications to further enable service efficiencies • Implementation of Clinical Electronic Records management System
2016/17	• Tech refresh to maintain services and enable innovation • Implementation of the National Community Care Information Solution (CCIS) • Implementation of the Welsh Care Record Service (WCRS) • Further development and innovation to support patient flow, clinical work flow and clinical data capture/audit • Further development and innovation of mobile applications to further enable • Service efficiencies Wireless infrastructure at Singleton Hospital

Table 54 below provides a summary of the investment, savings and benefits to be delivered by this project.

Table 54 : ICT Programme Summary

	2014/15	2015/16	2016/17
Investment Profile £	294,016	623,081	875,285
Savings Profile £	-11,000	-22,290	-144,290
Benefits Profile	• Staff able to access one device for both work and personal information/systems, enabling smarter ways of working - measured via structured staff feedback Enhanced patient experience during hospital stays/visits through the provision of free public wifi access - measured via patient feedback mechanisms • Improved patient experience in the out patients setting through the implementation of electronic patient flow - measured via data analysis (reduction in waiting times etc) and also as part of patient feedback mechanisms. • Increased availability and timeliness of clinical information through the implementation of a paperlite document management system. Measured via structured clinician feedback and data analysis e.g. electronic record usage statistics, reduction in paper case note requests, reduction in waiting times etc • Efficiency improvements in the management of patient pathways through the implementation of a single PAS - measured via data analysis (reduced waiting times, increased % of case note availability etc) and reduction in complaints relating to appointments/administration. • Better management and control of patient flow across all wards in ABMU, through the implementation of live ward management (PIMS+ portal). Measured via data analysis – reduction in lengths of stay; hospital cancellations; outliers; DTOCS etc. and reduction in complaints relating to hospital stay. • Improved timeliness and quality of discharge summaries, through the further development and implementation of a single Discharge Summary system (PIMS+ portal - eTOC). Measured via data analysis – compliance with minimum standard, Clinician/GP structured feedback. • Better management and control of patients throughout the emergency departments, through the procurement and implementation of a new ED system. Measured via data analysis – reduced turnaround times, breach rates, improved levels of structured data to inform service modernisation etc. • Increased efficiencies in the utilisation of theatres and associated resources, through the successful implementation of a single theatre system. Measured via data analysis – theatre efficiency measures, reduced cancellation rates, improved levels of structured data to inform service		

	modernisation etc. • Improved performance information though the use of digital dashboards, supporting robust service improvement decision making. Measured via data analysis – usage statistics; structured staff feedback
Workforce Profile	TBC – includes additional workforce to undertake coding, development, project management and support to the growing infrastructure
Risk Profile	Initially risks and mitigations are identified in the Programme/Project initiation Document (PID). All Programmes /projects are required to review their risks regularly and report any change in their monthly highlight report to the C4B Service Delivery Board.

9.5 Intrastate – Capital and Estate

We continue to measure our estate against the six national performance indicators as set out in the bullet point below: -

- Physical Condition
- Statutory and safety Compliance
- Fire Safety Compliance (new measure)
- Functional Suitability
- Space Utilisation
- Energy Performance

Table 54 which follows, sets out our recent levels of performance and our planned trajectory for 2017/18. This table is also referenced in Appendix B13 which follows

Table 55 : National performance Indicators – Estates

	2011/12	2012/13	2017/18
Physical Condition	81%	86%	90%
Statutory and Safety Compliance	73%	92%	92%
Fire Safety Compliance	100%	100%	100%
Functional Suitability	93%	93%	95%
Space Utilisation	98%	98%	98%
Energy Performance		70%	100%

With the ongoing agreed capital investment, plus the approval of the infrastructure Business Justification Cases we anticipate the improvement in performance as set out in table 54 above. Should this funding not flow over the next 5 years we will have to revisit our assumptions around 2017/18 performance.

9.6 Research and Development

We are committed to further developing and maintaining a culture which recognises research as integral to the delivery of high quality and effective health care services and places research at the heart of clinical delivery.

As a University Health Board, we are committed to leading and delivering world class research, recognising the essential regional health and economic benefits to be gained from a health service which is research focussed.

Our Research Strategy & Policy will align with clinical services across the Health Board to actively engender a culture of clinical and academic excellence, facilitating improved patient outcomes and financial benefits.

This will be achieved by building on existing networks with our University partners, neighbouring Health Boards and national R&D infrastructure networks. We will lead the South West Wales Regional hub of the Academic Health Science Collaboration (AHSC).

We will harness the expertise offered by existing regional research networks to enable our clinical teams to deliver high quality research programmes across all clinical specialities.

Moreover, through strategic investment of the research and development budget, we will support new areas of research and further enhance our existing areas of clinical research excellence in Burns, Cardiology, Cancer, Diabetes, Haemostasis and Renal.

Engagement with Industry is a key national aim for UK Health Research. We are nationally recognised as a NHS Organisation which fully engages with Industry Sponsored research. Our vision is to further enhance our reputation for positive engagement with local, national and international Industrial partners (technical & pharmaceutical). Such engagement will ensure full access to novel treatments for our patients and also deliver regional economic benefits through the development of research programmes to support the pipeline developments arising from local Small and Medium Enterprises (SMEs) and healthcare spin-out companies.

Our Research Strategy & Policy will recognise the importance of translational research, innovation and effective Intellectual Property management as defined outputs of a vibrant research culture. There will be a focus to ensure, wherever possible, we will glean optimum reward from our engagement with Industrial partners.

Our Aims and Objectives are to: -

Establish ABMU as a leading NHS Organisation for Research

We will achieve this by:

- Focussing on increasing primary care involvement in research
- Achieving Centre of Excellence status with Pharmaceutical companies and maintaining preferred site status.
- Ensuring rapid start up times and completion on target for research programmes.
- Delivering on target for 1st patient recruitment within 30 days and the Annual Operating Framework target to double number of patients entered into clinical trials within 5 years (from baseline year 2011).
- Delivering on NISCHR Key Indicators.
- Increasing the number ABMU staff awarded protected time for research via the AHSC clinical research programme.
- Build on the status of the Health Board as a Biomedical Research Unit to achieve recognition as a Biomedical Research Centre.
- Increase the number of ABMU Chief/Principal Investigators and attraction of research grants across both clinical and non-clinical research programmes.

Maintain and enhance joint governance and collaboration with Swansea University

We will achieve this by: -

- Ensuring operational success of the Joint Clinical Research Facility (JCRF). The JCRF is a joint clinical research initiative between the Health Board and Swansea University, housed within the ILS2 and Morriston Hospital and will offer new opportunities to engage in early stage clinical trials, in partnership with SIMBEC, a Phase 1 specialist clinical research company.
- Enabling increased capacity for research programmes requiring imaging via the dedicated imaging suite within ILS2, thereby easing the pressure of clinical trial radiology requirements within the clinical service.
- Maintaining robust collaborative sponsorship and governance arrangements with Swansea University via the continued use and development of Joint Standard Operating Procedures and delivery of a consistent approach to research governance management issues.
- Maintaining and enhancing R&D Quality Assurance processes to monitor and govern cross-Organisational R&D activity.
- Develop a Joint R&D Communications Strategy & Commercialisation Strategy.

Actively support innovation within ABMU and develop effective exploitation of associated Intellectual Property Rights (IPR).

We will achieve this by:-

- Increasing the Intellectual Property (IP) portfolio of the Health Board, for example, through successful application to national innovation schemes such as the NISCHR INVENT scheme and building on existing collaborations with academic partners.
- Developing shared IP management processes with Swansea University to facilitate greater benefits from IPR exploitation.
- Actively advertising ABMU Health Board as a NHS Organisation keen to engage with the business community on collaborative research programmes and commercial collaborative investigator led studies.
- Actively engaging with academic partners to explore and develop collaborative research programmes involving novel technology.

Maintain current clinical areas of research excellence and identify and support areas of growth for news areas of R&D activity

We will achieve this by: –

- Strategically allocating the R&D budget to allow clinicians access to necessary resource to develop areas of research interest, aligned to NISCHR priorities.
- Supporting research ideas via the provision of a research design service through collaboration with our Partner Clinical Trials Unit 'WWORTH' and the AHSC funded methodology specialist posts.
- Delivering an effective research governance sponsorship service for in-house research.
- Maintaining a robust scientific peer review process for in-house research, as delivered by the Joint Scientific Review Committee, a joint Committee with Swansea University.
- Providing specialist training opportunities to ABMU staff on research methodologies and good clinical practice.
- Supporting researchers' with external grants through effective use of networking and membership within various national groups such as MediWales.

Develop a culture which actively embraces research as an alternative treatment pathway for the benefit of patient care, recruitment and retention & attraction of high quality individuals to work within the region.

We will achieve this by: -

- Enabling service capacity via successful bidding to Academic Health Science (AHSC) investment schemes and performance management of posts funded via AHSC.
- Protecting AHSC posts via the R&D budget and through the strategic investment of R&D funds according to set research priority areas.
- Supporting & training new Investigators to engage in research activity, in particular, by attracting commercially sponsored research to the Health Board, thereby offering opportunities for new Investigators to gain exposure to research and enhance their skills within a structured programme of activity.
- Enabling recognition on the budget lines for the income generated and cost savings from commercial research activity and actively encouraging directorates to utilise this benefit to engage in further research programmes.
- Ensuring all Consultant job plans has the potential for R&D activity and active University involvement via both University and R&D funding streams.

9.7 Innovation and Technology

We agree with the findings of the NHS Social Care and Business work stream of the Health & Wellbeing Best Practice & innovation Board and recognise that there are many untapped opportunities for us to be innovative in how we deliver care ourselves and in partnership with others. As a University Health Board we have both opportunities and responsibilities to maximise our collaboration with academic partners to benefit our patients, our staff, the academic sector, the local economy and Wales more widely.

We have set out our intentions to innovate through our memorandum of understanding and collaboration agreement with Swansea University and will seek similar agreements with Trinity St. David's, Cardiff and South Wales Universities. These relationships will be not just with direct health related partners but also engineering, mathematics, business, enterprise and entrepreneurship. We will give due consideration to Intellectual Property (IP) protection at the early stages of innovation to ensure that financial benefits flow appropriately to the NHS.

In future we will encourage our clinicians always to consider opportunities for innovations in how clinical care is delivered and to develop technologies and devices in partnership with others which could bring inward investment into Wales and technology transfer out of it, whilst benefitting our patients.

We wish to build on our collaboration with the Medical Research Council (MRC) Farr Centre for Health Informatics Research in the Institute of Life Sciences for innovative analysis of the wider impacts and determinants of health for citizens and to understand better the effect of changes of how care

is delivered across all sectors of healthcare. We are partners in the Welsh Wound Innovation Centre both at Board level and also through the Welsh Centre for Burns and Plastic Surgery. The Health Board also collaborates with Swansea University College of Medicine to create an important academic, research, education and innovative clinical focus on the treatment and complications of traumatic injury.

Our recent joint award of £800,000 from SBRI to increase the utility of the SAIL database will bring significant benefit for NHS Wales and makes best use of the integrated approach to health and social care in Wales. We are submitting bids to the Health technologies Fund to introduce innovation in our "out of hospital" settings.

We will also seek innovative solutions to the financial challenges facing us. We will develop different ways of working with others across sectors in Wales to maximise the opportunities for capital investment, external funding grants and loans for the mutual benefit of our patients and citizens.

9.7.1 Technological Opportunities

Considerable technological advances have been made in the diagnosis and treatment of illness and disease. This has in some cases led to changes in how and where these services are provided e.g. microsurgery, telemedicine, point of care testing. There have also been advances, which support patients in self managing their conditions. These technologies provide us with the opportunity to transform the way we have traditionally provided our services.

9.8 Collaborations and Partnership Working

For us to deliver on our priorities and make a real difference to the health and wellbeing of its population, co-production and partnership working are critical principles which need to underpin everything we do. In particular making sure that all our partners and stakeholders work with us to identify what services need to change and what our priorities should be, and then work with us to design these changes, implement them and evaluate them in order to deliver the best possible outcomes for the public, patients and their Carers.

9.8.1 Engagement with the Public, Patient and Carer Groups

In line with the Principles for Public Engagement (signed up to by the Board and based on the NHS Wales Guidance for Engagement and Consultation on Changes to Health Services) we have a well established and comprehensive approach to continuous engagement with stakeholders, as well as formal public consultation when required. This is targeted at particular client groups by disease group and age group – for example

Children & Young People's Forums, Older Peoples Networks. In conjunction with the Abertawe Bro Morgannwg Community Health Council, our Health Board works with all its partners and stakeholders on an ongoing basis to involve them in our work and the changes we plan. We use a variety of mechanisms, some regular, some *ad hoc*; to make sure we involve people appropriately in our work, and in a way which supports their ongoing engagement. . Increasingly we are establishing co-production in how we develop plans for changing our services. This enables us to listen to our patients, carers, support groups and the third sector and develop plans taking their views into account on an ongoing basis.

The Health Board particularly needs to ensure that the requirements of the Carers Measure (Wales) are implemented so that:

- Carers have the information they need, when they need it, to carry out their caring role
- Carers are involved in all aspects of the planning of the care for the person they are caring for, including agreeing discharge plans before arrangements are put in place.

9.8.2 Statutory Partners we need to work with

Increasingly to deliver on its priorities, our Health Board needs to work with a range of other statutory organisations and sectors. These critically include the Local Authorities within the ABMU area, and those bordering the area. We and the three Local Authorities within the ABMU area have formed the Western Bay Collaborative, a formalised arrangement for taking the integration of key services forward on a regional basis, particularly focusing on Children's, Mental Health, Learning Disability and Community Services in the first instance. With the emerging picture of regionalisation arising from the Williams Commission, we will work with partner Local Authorities according to the changing organisational structures to ensure that this work continues to progress at pace.

In addition to Local Authorities we work with a range of other statutory Authorities such as the Police, Probation, Prisons, Fire and Natural Resources Wales on particular areas of common interest.

9.8.3 Other Health Organisations we need to work with

We also work with other Health Boards across South Wales and across all Wales plus organisations beyond Welsh borders to deliver a full range of services for our population. In some instances other Health Boards provide services for our population and often we provide services for other Health Board's populations. Through the Welsh Health Specialised Services Committee within Wales we all work together to plan and commission very

specialist health services. These arrangements are linked with our partners in England where appropriate.

We also work with a wide range of primary care organisations that we contract with to provide services for our population. Included in this are GP Practices, Community Pharmacies, Optometrists and Dental Practices. Increasingly groups of GP Practices and other primary care providers are working in partnership with us and other sectors to form Community Networks to plan and develop services for small populations within the ABMU area.

We also have a key relationship and common work programme with the Welsh Ambulance Services Trust both in relation to their emergency ambulance service and the transition from national to more local non-emergency ambulance services. As the Health Board plans service changes over the three year period, transport and patient accessibility will be key considerations. The Health Board will work with partners in local authorities, third sector and other health boards and trusts to ensure that improved options for transport to our services are is available for patients, carers and service users where possible. This will include consideration of innovative ways of developing transportation services to better meet patients and carers needs

Fundamental to achieving a wide range of our priorities is the key alignment of work programmes of Public Health Wales and our Health Board, particularly in relation to the wider determinants of health and reducing health inequalities in our area.

9.8.4 Sectors we need to work with

We have a well-established relationship with the third sector both on a local and national level, with a strong commitment to joint working, partnerships and co-production. These relationships operate at both a strategic level through the Councils of Voluntary Services and Third Sector Forums across the area, and also operationally as services support the clinical services and other interventions we provide or commission. We will continue to strengthen these relationships by focusing on joint work around cross cutting strategic agendas such as Child Poverty and Domestic Abuse.

Housing Associations, private and not for profit residential, nursing and domiciliary care providers are also key sectors who we increasingly work with on mutual agendas.

Over the past few years issues of transport, particularly public transport to and from our hospitals and other sites where we provide services has been a constant theme and increasingly one we need to strategically lead with our partners in Local Authorities and Public Transport and community transport providers. We already have established mechanisms for discussing common

issues, but this has in the past tended to be reactive once changes occur and our intention as a Health Board is to move towards more strategic planning for transport services, including building capacity in the system to improve access to our services. This will include trialling some innovative approaches to transport alternatives in partnership with Local Authorities, transport providers and the University.

9.8.5 Working with Education Establishments

As a Health Board we work with Primary, Secondary schools and Colleges on some issues of mutual interest, but increasingly we recognise the important role these institutions can play in taking some of our priorities forward. We have learnt a lot from the engagement mechanisms we had to establish during the Measles outbreak in particular, and are committed to developing these links in a more ongoing way in future.

We have a formal collaborative arrangement in place for the Universities in our area, including importantly (but not exclusively) the Schools of Medicine, Schools of Nursing and Health Sciences, as well as well developed links for Research and Development and partnership working in relation to the Institute of Life Sciences in Swansea.

9.8.6 Working with Equality Groups:

We continue to strengthen the ways in which we can engage with people who have protected characteristics under the Equality Act. In particular making links with Churches / faith groups, Black and Minority Ethnic groups, older people, disability groups, pregnant women, Lesbian, Gay, Bisexual and Transsexual communities, the homeless, women's groups and developing a range of ways in which we can engage these groups on consideration of our plans, priorities and development is critical to ensuring that we understand any differential impacts of these on these protected groups.

10 Stewardship and Delivery

This section of the Integrated Medium Term Plan sets out the planning, delivery and assurance model for the Health Board. Throughout this document reference has been made to the fact that the adoption of a 3 Year Planning Cycle has been the catalyst to work differently and create a culture shift in the Health Board. Set out below are descriptions of the systems we will have in place to ensure that the planning culture is embedded. This should be read in the cognisance that we have committed one of our 6 strategic aims to the delivery of Effective Governance.

This section builds on the detail of Section 9, which has described how we will work in the future.

10.1 Operating Model – planning model and cycle

We are finalising a new planning and commissioning model, which will build on the guidance in 'NHS Wales Planning Framework'. We will be engaging with local stakeholders to support us in the development of this model and to ensure that we learn from our collective experience of developing the current IMTP

The implementation of this model will form part of an overall organisation development programme, to support our staff in adopting new ways of working.

10.2 Delivery/management arrangements

The current management arrangements are based on a Directorate/Locality structure (as previously described in Section 2).

As mentioned earlier, we plan to develop and strengthen our Community Networks. This development will support us in delivering the Clinical Strategy, specifically in providing integrated care and care closer to home. It will also support us in addressing significant workforce challenges in primary care, due to changes in training numbers, the early retirement programme and changes to the GP training programme. The recent changes in the General Medical Contract will also provide greater flexibilities. Our next step is to construct a detailed plan for the development of community networks during 2014/15 for implementation from 2015/16.

This development, together with the implementation of the South Wales Programme, will have implications for our overall management

arrangements. In February 2014 a Board Director was assigned management responsibility of the Princess of Wales Hospital. We plan to review the remaining arrangements in early 2014 with a view to any planned changes being implemented by 1st April 2015.

We have now appointed a substantive Medical Director and a substantive Director of Nursing and Patient Experience, both of whom will take up post in early 2014/15, We will also recruit a Director of Strategic Planning in early 2014/15 to further strengthen the Executive Team. Section 7 above describes the wide range of initiatives that the Health Board has underway to develop capability at directorate and locality level.

10.3 Strategic Change Programmes - Governance and Assurance

Each Strategic Change Programme has a nominated Executive Lead, who is the accountable officer. Monthly performance reports are produced by each Programme and their related projects. Progress and performance is reported to and reviewed by the Changing for the Better Delivery Board on a monthly basis.

In addition the wide-ranging ***C4B Clinical Strategy Programme*** has established a Programme Assurance Group to provide assurance to the Programme Lead via the Changing for the Better Programme Board,

The terms of reference for the Programme Assurance Group is to ensure that all C4B Projects are run well, deliver change effectively and produce the desired outcomes. This Group meets bi-monthly and its key objectives are to:

- Assess project adherence to the vision and objectives, reflecting best practice and emerging innovation.
- Identify any gaps and areas of overlap across the Programme, which run the risk of inefficiencies, duplication or failure to progress. This remit is to be extended to include consideration of gaps and overlaps with Locality and Directorate IMTPs and 'other projects' across ABMU.
- Ensure the appropriate collation of data to support:
  - Baseline measurement
  - Evaluation and audit of agreed outcomes
  - Continual review of alignment with the Programme and Project aims
  - The identification of projects that are not progressing or not delivering the required outcomes, so that decisions can be made on their continuation or change of approach
  - Evidence of benefits for patients and the ABMU population from the C4B programme, so that improved standards of care and value for money can be demonstrated.

Each Project is required to:

- Complete and maintain an information matrix (which has been developed by Internal Audit). This matrix provides a record of project activity and is used by the group to scrutinise the work of each project.
- Include patient reported outcomes, patient reported experience and measures of transfers of care / communication between teams within the outcome measures for each Project.
- Maintain and regularly update the Project Risk Register

10.4 Corporate Governance

10.4.1 The Board

Our Health Board is made up of a Non Officer Chairman and Vice Chairman, with a Chief Executive, Executive Directors and Non Officer Member (NOM) / Independent Members (IM) and Associate members. Our Board is responsible for:

- Setting the strategic direction of the organisation within overall policies and priorities of the Welsh Government and the NHS
- Establishing and maintaining high standards of corporate governance
- Ensuring delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility
- Ensuring effective financial stewardship by effective administration and economic use of resources
- Ensuring effective communication between the organisation and the community including stakeholders regarding planning and performance and that these arrangements are responsive to the locality's health needs
- Appointing, appraising and remunerating executives

Our Board functions as a corporate decision making body and its principal role is to exercise effective leadership, direction and control. Executive Directors and NOMs are full and equal members sharing corporate responsibility for all the decisions of the Board.

Our Board meets every other month in public, details of meetings are posted on the Boards internet site. The Board also holds bi monthly development sessions to consider its development needs and discusses future development proposals.

10.4.2 Board and Committee Membership

Our Board is supported in its role by a number of committees, each chaired by a NOM to reflect independence and objectivity, which provide scrutiny on the delivery of key areas of work. The committees review matters set out in an Annual Work Programme and meet regularly during the year.

A brief summary of the role and remit of each committee is set out below.

- **Audit Committee**

  The Audit Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance;

- **Quality & Safety Committee**

  The Committee plays a pivotal role in providing assurance that patient safety is being managed and receives national and local reports associated with quality & safety issues. Our current Quality Assurance Framework is attached as Appendix 6

- **Workforce & Organisational Development (OD) Committee**

  Established in February 2013, the Committee provides assurance to the Board in relation to the discharge of responsibilities around workforce issues;

- **Remuneration and Terms of Service Committee**

  The Committee provides assurance to the Health Board's regarding arrangements for remuneration and terms of service, including matters of contract, in accordance with the requirements and standards determined for the NHS in Wales;

- **Charitable Funds Committee**

  The Committee's role is to monitor arrangements for the control and management of the Health Board's Charitable Funds;

- **Mental Health Act Monitoring Committee for Mental Health (MH) & Learning Disabilities**

  The Committee receives national and local reports on issues that impact upon the provision of services, oversee compliance with the MH Act 1983 and associated Codes of Practice and ensures that effective arrangements are in place regarding Associate MH Managers;

- **Hospital Managers Power of Discharge Committee**

  This Committee ensures that the role of Hospital Managers when exercising their powers of discharge under the MH Act 1983 are conducted in a fair, reasonable and lawful manner;

- Pharmaceutical Applications Committee (PAC)

  The Committee reviews applications from pharmacies for new contracts or applications in regard to proposed changes to premises as part of the NHS (Pharmaceutical Services) Regulations;

- **Welsh Health Specialist Services Joint Committee**

  This Committee is attended by each of the Health Boards in Wales and enables the planning and commissioning of specialist and tertiary health services. The Chief Executive is ABMU's representative.

  The Health Board also has three Advisory Groups, these being:

- **Stakeholder Reference Group (SRG)**

  The SRG provides a forum to facilitate full engagement and active debate. Its membership includes elected representatives for protected characteristic groups under the Equalities Act. Members also include statutory bodies such as Local Authorities, Police, Fire and Rescue, Environment Agency, etc. The Group has the remit to examine any aspect of the Health Board's work in relation to how it affects stakeholders. **Health Professionals Forum (HPF)**

  The HPF's role is to provide a balanced, multidisciplinary professional advice to the Board on local strategy and delivery. The Forum has responsibility for facilitating engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity;

- **Local Partnership Forum (LPF)**

  The Forum provides a formal mechanism whereby the Health Board, as the employer, and trade unions/professional bodies representing the Health Board employees' work together to improve health services for the citizens of the ABMU area.

10.5 Governance Arrangements

For the NHS in Wales, governance is defined as: "a system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to

achieve their objectives." In simple terms this sets out the way in which NHS bodies ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector.

The Welsh Government's Citizen Centred Governance principles embody what the Welsh Government wants public services to be focused on the needs of citizens, with citizens who are engaged and involved in the development of services and who receive services which are efficient, effective and innovative in their design and implementation. The principles are:

- **Putting the citizen first** – Putting the citizen at the heart of everything and focusing on their needs and experiences; making the organisation's purpose the delivery of a high quality service
- **Knowing who does what and why** – making sure that everyone involved in the delivery chain understands each other's roles and responsibilities and how together they can deliver the best possible outcomes
- **Engaging with others** – working in constructive partnerships to deliver the best outcome for the citizen
- **Living public sector values** – being a value-driven organisation, rooted in Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership
- **Fostering innovative delivery** – being creative and innovative in the delivery of public services – working from evidence, and taking managed risks to achieve better outcomes
- **Being a learning organisation** – always learning and always improving service delivery
- **Achieving value for money** – looking after taxpayers' resources properly, and using them carefully to deliver high quality, efficient services.

These principles are reflected in our values, purpose and strategic objective which are set out in the IMTP in Section Four.

10.6 Assurance

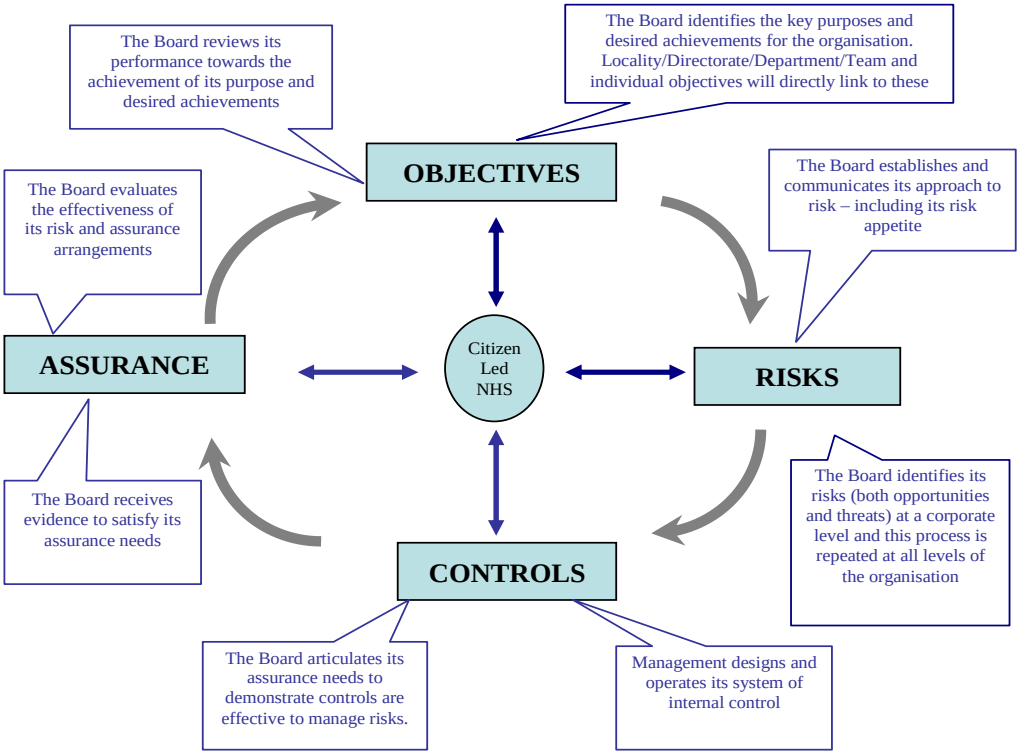
It is critical that we are able to demonstrate assurance to our Board that we are discharging our duties appropriately. We have assessed that assurance in respect of our Health Board should be defined as follows:

"**Assurance** provides Board members with the evidence that the Health Board is operating effectively, achieving desired outcomes, delivering on its strategic vision, meeting its strategic objectives through effective risk

management, in a manner which upholds the Citizen Centred Principles and is in accordance with all statutory requirements."

Further, Welsh Government has issued guidance for Boards on Risk /Assurance, this is summarised in the diagram below:

Figure 22 : Welsh Government Assurance Framework



We have committed to work within this framework and we have designed our governance arrangements accordingly.

As a Health Board we recognised that any assurance, whatever its source, will not be a guarantee that offers absolute certainty. As such our Board must look to gain 'reasonable' assurance that the organisation's ways of working enable our Board to perform effectively across the full range of activities (the "breadth" of assurance) in order to deliver our strategic vision. Defining what is considered 'reasonable' provides our Board with the opportunity to discuss and debate the importance of assurance in a meaningful way, taking into account the nature of our Health Board's activities and core values, as well as the views of our citizens, community partners and other stakeholders on what 'reasonable' might mean to them. The result of these deliberations will determine the level of assurance that it our Board requires (the "depth" of assurance) in relation to particular

activities. Specifying both the breadth and depth of assurance required is sometimes described as 'risk appetite'.

We have summarised below a number of the tasks that are carried out to provide Board Assurance.

Organisational Objectives

The first stage in developing a system of assurance involves setting out the principal aims and objectives against which our Board requires assurance. These are now clearly set out in the Integrated Medium Term Plan. These are set out in Section 4.

Obtaining Assurance

One of the tasks of our Board is to provide assurance to the public, Welsh Government and other bodies that we are operating effectively and providing safe and effective services. Our Board Members, both Executive and Non Officer Members seek and gain assurance from a variety of sources. These include receipt of reports, informal walk rounds and asking critical questions. This section sets out the formal arrangements in place to support our Board to provide assurance. These are:

Personal Objectives

Once organisational objectives have been approved by our Board they are used as the basis of the objectives for our Chairman and Chief Executive. Our Chairman will then use these as the basis for NOM objectives and our Chief Executive will do the same for the Executive Team. These will then be cascaded through the organisation using the PDR/job planning process so everyone sees how their role helps meet the objectives of the organisation.

Annual Governance Statement (AGS)

This is the overarching vehicle used to provide assurance and is included in the Annual Accounts each year. The draft Statement is prepared by our Board Secretary and shared with our Chairman of the Audit Committee, Internal Audit and the Wales Audit Office. The final draft is considered by our Audit Committee and Board as part of the approval of the Annual Accounts each year.

The AGS is based on 'Doing Well, Doing Better Standards for Health Services in Wales'. The self assessment against these Standards for Health Services are a critical element of our governance and risk management arrangements and help underpin the AGS.

The Governance and Accountability module, which in itself is the subject of an annual self assessment by the Board, is a key and over arching element supplementary to the Standards for Health Services. In 2012/13 our Board's self assessment score was recorded as level 3 – developing. This is set out in the AGS.

At the same time the annual Structured Assessment undertaken by the Wales Audit Office provides levels of assurance regarding governance arrangements and the action plan following the Structured Assessment is integrated into the Governance and Accountability module, which forms part of the overall Health Care Standards improvement plan. Our Board regularly reviews progress against this action plan, to ensure that gaps in assurance have been addressed.

Our Director of Nursing is the Executive lead for the Standards and reports to the Quality and Safety Committee and Board on the self assessment process and resultant action plan to improve compliance against the Standards

Annual Assurance Statements

The AGS is also underpinned by a requirement for our Directorates and Localities to produce annual assurance statements, setting out the management arrangements in place in Localities/ Directorates to ensure effective organisational arrangements. These include a response to the following as a minimum:

- Locality/Directorate objectives which are linked by clear thread to the Health Board's objectives. In future these will also reflect our life course approach.
- Localities/Directorate structure and how main key meetings are structured e.g. Locality/Directorate Board, Risk Management Group, Health & Safety Group, Clinical Risk Group etc., and whether there are terms of reference and appropriate minutes/action planning.
- How performance is managed and monitored and where performance is reported.
- The Risk Management arrangements, including the management of the Locality/Directorate risk register, and capacity to manage risk and effective engagement of risks with stakeholders
- What serious incidents have occurred and how these have been managed and addressed.
- Mechanisms for monitoring compliance with the Standards for Healthcare Services in Wales and performance during the year. Also, for those Standards that are judged below the development level (3) confirmation that action plans are in place and being progressed.
- Performance against PDRs and confirmation that roles and responsibilities are clearly defined.

- Confirmation that a scheme of delegation is in place, including for financial matters as required by Oracle.

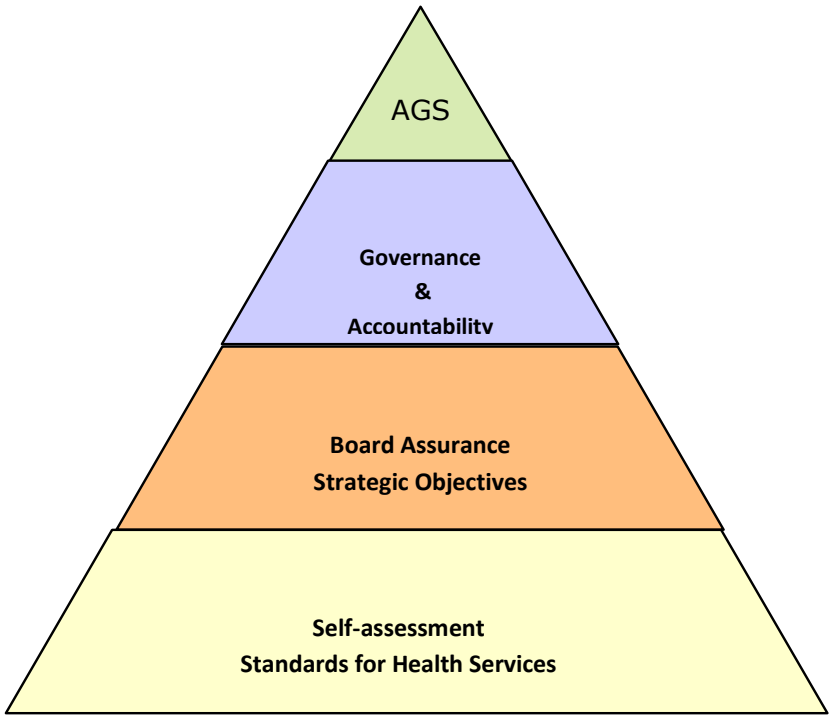
These responses are underpinned by Directorate/Localities self assessments against Standard 1: Governance & Accountability as well as their overall performance against the 26 Standards for Health Services in Wales.

Governance in Year Reviews

Each year Internal Audit undertake an in year review of governance to assess progress and report key findings to the Audit Committee, together with an agreed action plan.

The overall approach is set out in the diagram below.

Figure 23 : Annual Governance Statement Structure



This hierarchical approach provides an integrated assurance framework that supports an assessment of assurance at the different levels of detail.

Annual Quality Statement

The Board produces an Annual Quality Statement. The Statement provides assurance on the quality of services provided by the Health Board. The draft Statement is considered by the Quality and Safety Committee and Audit Committee prior to being submitted to the Board.

ANNUAL ACCOUNTS

The Annual Accounts process is well established and provides assurance to the Board each year on financial governance

ANNUAL REPORT

Each September the Board receives the Annual Report that sets out the main achievements within the Health Board for the previous financial year

BOARD BUSINESS CYCLE

The Board considers reports throughout the year as part of the business cycle and many of these reports will provide the Board with assurance.

10.6.1 Assurance – Performance Management and Reporting Framework

The objectives and KPIs in the Integrated Medium Term Plan will form the basis of our performance management and reporting arrangements, which will include a regular review of risks and any actions required to mitigate these. For example:

- Monthly Directorate/Locality Performance reviews chaired by the Chief Operating Officer, supported by key executive colleagues.
- Each Strategic Change Programme being overseen by the Changing for the Better Delivery Board, which meets monthly
- Regular reporting to the Board and Board Committees.

This will provide assurance that the implementation of the Integrated Medium Term Plan will have rigorous governance arrangements.

PERFORMANCE MANAGEMENT FRAMEWORK

A Delivery and Accountability Framework for our Directorates and Localities is in place. This is based on monthly performance review meetings, which feed into our Board Integrated Performance reports. These reports set out current performance against agreed indicators in the IMTP and are cross referenced to the risk register.

10.7 Risk Management

Effective risk management is integral in enabling our Health Board to achieve our objectives, both strategic and operational in delivering safe, high quality services and patient care. We manage risk within a framework that devolves responsibility and accountability throughout the organisation. The

Framework sets out the levels at which staff groups are responsible and can take action and when they have to escalate risks above their agreed tolerance level. All risks identified, once qualified, which have a risk rating of 16 or more are required to be discussed at the Risk Management Review Group as this has been set for the tolerance limit of high risks when decisions need to be considered as part of a specialist group within the organisation.

We run a Management Training Programme providing training at two levels:

- Level 1 is available to all grades of staff and is part of mandatory/statutory training. The training provides an overview of risk management as well as how to complete a risk assessment and highlights the importance of identifying mitigating actions to reduce and manage those risks.
- Level 2 training is provided to managers of band 6 and above. The training is practical and informative and enables managers to indentify and take mitigating action to reduce risks if they cannot be eliminated. The role of Risk Registers is also included within the training.

In February 2013 a revised Risk Management Training Programme for 2013/14 was launched which incorporates local data and analysis of incidents, complaints and claims to enable our staff to prioritise risk assessments and management in their work area.

Performance against risk management training is reported to and monitored by the Risk Management Review Group on a bi monthly basis.

10.7.1 Risks

We have ten high risks on our Corporate Risk Register. These risks have been summarised and grouped under the organisation strategic aims:

Table 56 : High risks on the Corporate Risk Register

Strategic Aim	Risk	Mitigating Actions
Excellent Patient Outcomes	**Quality & Safety** Service changes not effectively managed leading to potential disruption to delivery of quality and safety	• Maintain performance management arrangements. • Align Executive Directors to critical projects to support delivery through the change process. • Agree zero tolerance performance measures which cannot be relaxed during period of change.
	Healthcare Acquired Infections This risk was scored as 12 for the 2nd quarter of 2013/14 although increased to 16 in the 3rd quarter of the year as a result of the increase in outbreaks/ infections. This risk is linked to one of the 6 key safety indicators: WHO 5 moments of hand hygiene. A target of 95% compliance has been set and in October 2013 performance was recorded as 92.8%.	• Continue with current management arrangements. • Consider implications of zero tolerance approach. • Focus backlog maintenance efforts in high risk areas. • Ensure full compliance with Hand Hygiene requirements. Monitored through Infection Prevention Board. Reviewed monthly through the performance meetings on the quality section of the performance scorecard.
	Patient Experience Failure of the Health Board to meet the public and patient experience and dignity of care expectations of local people and national requirements e.g. Ombudsman and Healthcare Inspectorate Wales.	• Develop mechanisms to capture patient experience • Meet requirements of Older persons Commissioner
Sustainable and Accessible Services	**Unscheduled Care** Difficult to achieve waiting times in A&E and handovers which may lead to delays in assessing and treating patients and a risk of the right care not being given at the right time. Pressures on the service from a number of factors which include changing profile of patient, increased demand, major service change in unscheduled care services, reduced opportunities for surge capacity due to refurbishment programme and service change, medical staffing pressures, Norovirus.	• Plan for flexible use of beds (including critical care) during known periods of high demand. • Accelerate community schemes to assist with admission avoidance. – Focus on rehabilitation services reducing length of stay for unscheduled care patients. – 5 key elements of plan focussed on Pre Hospital initiatives – Effective ED's

Strategic Aim	Risk	Mitigating Actions
		– Patient Flow – Efficient operational processes – Improved capacity (acute & community)
	Focus on improving Dignity in Care and the needs of older people Increasing challenge of providing healthcare models for aging population. Over next 20 years care resident population will see a 24% increase in people of a pensionable age and 15% increase in people of non working age. Providing services to enable citizens to live independently at home is a major challenge.	• Action Plan to implement 12 key recommendations within the Older People Strategy. • Number of Programmes to support delivery of this priority: C4B, South Wales Programme, Delivering Capacity, Workforce and financial plans, Leadership development, Developing infrastructure, Strengthening Partnerships, Public Health Strategy.
	Access for scheduled care Insufficient bed capacity to meet demand at peak times can have a major impact on service delivery around access particularly	• Comprehensive pre-hospital alternatives programme incorporated into the USC and patient flow programme, building on previous work with partner agencies, to reduce avoidable hospital attendance. • Capacity plans will increase acute and community capacity by 286 beds/ bed equivalents) by March 2014 to deliver 85% medical bed occupancy. • Capacity plan in place for critical care. • Surgical Pathway efficiency programme will deliver improvements in emergency surgical capacity.
	Follow ups not booked Length of follow up OPD lists. Patients are waiting over their target dates in numerous specialties. There is potential for patient harm.	• Working with Directorates to review clinic capacity, clinic templates/ follow up policy/ virtual clinics/ SOS follow up/validation of lists etc in order to reduce FUNB problem.
	The Health Board fails to secure appropriate levels of medical staffing and risks the inability to safely and consistently maintain rotas	• Development of service contingency plans • Recruitment campaigns • Ongoing discussions with Deanery

Strategic Aim	Risk	Mitigating Actions
	External Factors The outcome of the consultation on the South Wales Programme and the intentions and actions of other Health Boards may have an impact on ABMU services which could destabilise local plans.	• Full engagement in the South Wales Planning process. • Early engagement with partner Health Boards to discuss commissioning intentions and their service redesign plans. • Design robust LTA arrangements which accurately reflect the cost of services provided as a specialist and tertiary centre.
	Public and Stakeholder Engagement Failure of the Health Board to fully engage with key stakeholders and partners in timely ways on strategic and service plans	• Ongoing open and transparent engagement with Community Health Council partners. • Continued involvement of all Health Board partners in the Changing for the Better programme. • Clear, clinically led justification for proposed changes whilst ensuring a balance between local accessible services and central specialised services which benefit from economies of scale.
Sustainable and Good Governance	**Availability of Capital** Failure of the Health Board's current estate to be fit for purpose to deliver planned service provision and high quality patient care	• Development of estate strategy • Ensure that plans clearly justify the need for capital expenditure and rigorously test these plans. • Engage with Welsh Government on capital allocations for 2013/14 and beyond.
Excellent People	**Workforce sustainability** Aim is to deliver services effectively through trained competent staff and develop new roles as services change over time. Ensuring workforce planning and compliance with Mandatory and statutory training. There are a number of staff shortages in medical, nursing and therapy services across the Health Board which need to be considered in conjunction with the Changing for the Better and South Wales Plans.	• Continuous development and training to be provided for all staff affect by service changes. • Promote greater flexibility and mobility of staff. • Engage staff in service change design. • Medical workforce issues are seen as a lever for service planning and factored into C4B and South Wales service plans. • Ongoing discussions and communication with Deanery about recruitment position. • Recruitment campaigns for additional non training posts to fill gaps.

Strategic Aim	Risk	Mitigating Actions
		• Specific Medical Workforce Group for Integrated Medicine and Paediatrics to develop short term workforce plans. • Medical Workforce Board to consider current and future shape of the medical workforce. • Review of primary care in terms of recruitment and retention underway. • Number of workforce risks have been identified by NPT Locality relating to staffing issues of therapy staff. Action plans being worked through to ensure appropriate controls are in place.
Good Governance	**Achieving financial balance for 2013/14 is a statutory requirement.** Number of factors mean that this risk is high and include: • Ability to deliver CIPs and cost containment measures • ITU activity levels above funded levels as a result of increased demand • Ability to recruit to medical staff • Investment required in Unscheduled care Capacity and Nurse Staffing levels • Capital Resource limit • Capacity and Demand Issues for Unscheduled Care and cost of Delivery of RTT targets.	• Continually seek additional savings schemes as part of core business. • Reinforce mitigating actions set out under “Pace” above.
	Records management The inability to access records stored off site or held in community based settings, particularly out of hours, can present a risk to patient care. GPOOH access to Hospital records – links to the Robbie Powell Recommendations issued by Welsh Government.	• Development of business case for an offsite storage solution.

Strategic Aim	Risk	Mitigating Actions
	Delay in electronic discharge summaries and ensuring minimum data set completed Lack of timely discharge information provided to General Practitioners may lead to patient harm - minimum standard of information - specific follow up instructions, medication and diagnosis	• Single PAS project & rollout of PIMS+ portal to Swansea I by March 2014 will provide single solution for creating discharge summaries as part of Admission process.
	Failure to ensure lessons are learned and triangulated with patient experience Increased volume of work entering the department - 50% increase in complaints over past 3 years / continual increases in volumes of incidents reported / increasing Serious incidents and Never Events / increasing litigation / increasing numbers of cases progressing to Ombudsman / NHS Redress requiring far greater input to achieve compliance / changes to HM Coroners requirements demanding greater co-ordination. Decrease in staff. This is linked to the Patient14 Experience Programme and actions set out to mitigate the risk.	• Progress restructuring and redesign of corporate functions provided by the existing department to ensure ownership is appropriately allocated to increase awareness and likelihood of improvement actions being realised and more effective in reducing recurrence.

10.7.2 Sensitivity Analysis

The upside and downside risks associated with our plan have been explored and quantified in Section 8, para.8.7.

10.7.3 Risk Management Strategy

The key elements of the Risk Management Strategy include:

- Risk Management roles and responsibilities;
- Strategy Objectives;
- Significant Risks for the organisation;
- Risk Management Reporting Structure;
- Risk Management process;
- Risk Registers;
- Risk Management Training;
- Standards for Health Services in Wales.

Each of our Executive Directors are responsible for managing risks within their area of responsibility and ensure that:

- There are clear responsibilities for clinical, corporate and operational governance and risk management
- Our staff are appropriately trained in risk assessment and manage
- There are mechanisms in place for identifying, managing and alerting the Board to significant risks within their areas of responsibility through regular, timely and accurate reports to the Executive Board, relevant Board Committees and the Board.
- There are mechanisms in place to learn lessons from any incidents or untoward occurrences and that corrective action is taken where required.
- Details of the key risks within their area of responsibility are reported to the Board.
- Compliance with Health Board policies, legislation and regulations and professional standards for their functions.

Our Executive Directors are supported in these duties by Assistant Directors, Clinical Directors and Locality Directors. Together they ensure that robust systems are in place for risk management. In addition our Director of Nursing has specific responsibility for progressing compliance with 'Doing Well, Doing Better Standards for Health Services in Wales' within the Health Board, as well as specific strategic responsibility for key areas of patient safety. Our Director of Finance also has specific responsibility for financial risk management and for providing regular, timely and accurate financial reporting to the Board in line with requirements and professional standards.

10.7.4 Operational Risk Management Arrangements

Our clinical/Locality Directors are responsible for the management of risk within their Directorate/ Locality. They ensure that they have effective arrangements in place to identify and manage risk. When risks are identified outside their control, our Directors are required to communicate this effectively through to the Chief Operating Officer.

Each Directorate/Locality has a clearly defined structure to ensure the appropriate management of risk which has been confirmed within their annual return of their Annual Governance Statements for their specific areas of responsibility. This includes Directorates/Localities maintaining up to date Risk Registers and maintain a log of risks they have mitigated to a risk tolerated level and risks that have been terminated.

10.8 Financial Controls, reporting and audit arrangements

As set down in Section 2, the financial reporting system of the Health Board has been developed significantly in 2013/14. Every budget holder has bespoke variance, trend and drilldown analyses available to them “online” by way of a business intelligence dashboard. This is given full insight into their functional expenditure against allocated budget.

The financial management of Health Board outputs has been developed by the implementation of the commissioning analysis tool and the patient cost benchmarking dashboard. Both of these business intelligence tools enable managers to compare the expenditure on their service areas against other service providers. These benchmarking tools will continue to be rolled out and integrated into the financial management of the Health Board.

We have also developed, in conjunction with HFMA, a bespoke budget holder e-learning resource that has been rolled out across our delegated accountability structure. This e-learning resource sets down the responsibilities of budget holders and the techniques available to them in discharging those responsibilities. This e-learning training is reinforced by face to face training and education by the Devolved Finance Function.

We are planning on implementing Service Line reporting for a number of regional services from 1st April 2014. This will be accompanied by reshaping of the WHSSC LTA in order to clearly attribute income for work completed to each service. There are cultural as well as technical challenges with the successful implementation of these pilots.

ABMU Finance has engaged with Internal and external stakeholders to produce a financial strategy to underpin the Medium Term Plan entitled “Finance Future”. This strategy (discussed in more detail in Section 5) sets down the direction of travel for financial management and reporting within the Health Board.

10.8.1 Internal Audit

NWSSP Audit & Assurance Services provide internal audit, specialist audit and consultancy services to ABMU Health Board. Audit & Assurance is responsible for providing an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, internal control and governance arrangements support the achievement of the organisation's agreed objectives.

NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in Wales, and the Strategy has been approved by ABMU Health Board. The Strategic Audit Plan is largely based on the system of assurance operating within ABMU together with the organisation-wide risk assessment.

An Annual Operational Plan is prepared each year drawn from the Strategic Audit Plan outlining the scope and timing of audit assignments to be completed in the year ahead. Both Strategic and Annual Plans are developed in discussion with Executive Management and approved by the Audit Committee on behalf of the Board.

The risk based plan identifies auditable areas within eight assurance domains that include:

- Corporate governance, risk and regulatory compliance
- Strategic planning, performance management and reporting
- Financial governance and management
- Clinical governance quality and safety
- Information governance and security
- Operational service and functional management
- Workforce management
- Capital and estates management

The Strategic Planning, performance management and reporting assurance domain will include provision for internal audit review of the Integrated Medium Term Plan (IMTP), and it is intended as part of this review to look at the processes established for the management of implementation and execution of the IMTP.

10.9 Stakeholder engagement and support

We have a proven track record of effective engagement and consultation and implementing significant service change, not only with the public, patients, Carers and our staff, but also a wide range of partners as well as groups with protected characteristics under the Equality Act. We are committed to, and ensure that we continually engage with these groups on the issues facing the

Health Board. In line with this we are planning to engage on the proposals within these plans in a two phase approach.

PHASE 1 – FEBRUARY 2014

We will produce a Phase 1 summary engagement document in a range of accessible formats which will outline the service changes proposed in the IMTP according to 3 groupings:

- Those proposals already engaged upon / consulted upon which have therefore been included in the Plan for implementation.
- Those proposals which have been engaged upon / consulted upon where further work was required before they could be agreed. The engagement document will highlight the further work undertaken and the proposed way forward being proposed.
- Proposals which are new and have not been engaged upon. The engagement document will highlight these and the reasons for their inclusion and the implications of these changes.

After Phase 1 of the engagement it is intended that the Health Board review feedback with the Community Health Council to gauge their views on those proposals which have caused concern and which need further work or possibly public consultation.

However it is also recognised that the IMTP as it currently stands is not financially balanced and that therefore there are a further range of proposals which will need to be developed as part of the iterative development process with Welsh Government and partners prior to the agreement of the final IMTP. Therefore Phase 2 of the engagement will enable us to engage on these further proposals.

PHASE 2 - MARCH – APRIL 2014

We will produce a Phase 2 summary engagement document in a range of accessible formats which will outline the additional service changes proposed in order to deliver a balanced IMTP. A discussion on the outcomes of this engagement will be held with the Community Health Council in line with Welsh Government guidance on Consultation and Engagement to agree any further requirements for engagement or consultation arising from the engagement feedback.

10.10 Developing Governance arrangements

Our Board is taking a number of actions to strengthen governance arrangements. These include.

- A review of governance arrangements, led by the Chairman. This includes a review of Board Committee structures and performance reporting arrangements
- A review of executive portfolios led by the Chief Executive to further clarify accountabilities
- An action plan developed in response to the Francis Report and the report into Betsi Cadwaladr University Health Board
- Strengthening clinical governance arrangements, using the methodologies being piloted at the Princess of Wales Hospital
- Working with Academi Wales to define the Board Development programme.

Appendix 1 Prudent Health Care

Improving Resource Usage through Prudent Healthcare, Maximising Clinical Value, Clinical Effectiveness and Evidence based Practice

Paper sponsored by: Eifion Williams, Director of Finance and Hamish Laing, Director of Clinical Strategy

Introduction

There is a need to agree how ABMU will make evidence-based decisions that are consistent with the principles of prudent healthcare (PH) and in doing so, reconcile best clinical practice and optimum use of resource. We will need to be mindful of the plethora of guidelines and opinions that exist in clinical practice.

Whilst a great deal of expenditure across NHS Wales is linked to clinical decisions which aim to improve care and outcomes, the effectiveness of interventions varies (sometimes even within particular client groups). There is also variation in both approach and practice to patients with similar characteristics within and between specialist clinicians and clinical teams for reasons which sometimes are unclear.

This paper considers opportunities that exist to make better use of the clinical and financial resources that are available, through identifying areas of practice that should be changed. The outputs from our own prudent healthcare work stream for ENT (see appendix 1) and the other three work streams in Wales (orthopaedics, ENT, pain and prescribing) will inform this thinking once they all report in April 2014.

Prudent Healthcare (PH)

The Bevan Commission (BC) has outlined its approach and thinking to Prudent Healthcare (known in US/Canada as Parsimonious Healthcare) in its paper “Simply Prudent Healthcare – achieving better care and value for money in Wales”. It is defined as:

“healthcare which is conceived managed and delivered in a cautious and wise way characterised by forethought, vigilance and careful budgeting, which achieves tangible benefits and quality outcomes for patients”.

The BC proposes that the objectives for Prudent Healthcare in Wales must ensure that:

- Healthcare fits the needs and circumstances of the citizen
- Actively avoids harm and waste
- Abandons treatment or care which brings little or no benefit and
- Maximises the limited financial resources which can be drawn upon
- Adopts evidence-based medicine at scale and pace

PH is underpinned by six principles:

- Equity based care, treating greatest need first
- Do no harm
- Do the minimum appropriate to achieve the desired outcomes
- Choose the most prudent care, openly and together with the patient
- Consistently apply evidence-based medicine in practice
- Co-create health with the public, patients and partners

The Minister has accepted the advice of the Bevan Commission and has asked the NHS in Wales to adopt PH as a matter of urgency as part of its response to prolonged austerity. Below we propose a range of actions that we should take that are consistent with PH. Others, particularly those relating to co-production and co-design will need to be added once the PH work streams report. A cost- benefit evaluation will also be required to assess the potential impact of these actions for ABMU.

1. **Compliance with the existing INNU framework**

Interventions Not Normally Undertaken (INNU) represent interventions where the evidence suggests very little, if any, effective health gain from intervention and in many cases possible harm. There is already an extensive list of INNUs developed at an all-Wales level through Public Health Wales endorsed by the Health Board (Appendix 2 - INNU policy).

https://howis.wales.nhs.uk/sitesplus/888/page/48736

Whilst there is likely to have been a reduction in procedures undertaken against this list over recent years there is still the potential to reduce further. There is the need to undertake action to ensure compliance and also to test that exceptions have been appropriate and comply with existing clinical exceptionality pathways.

2. **Compliance with NICE “Do not do” list**

NICE have produced guideline “Do Not Do” lists and there is a need to ensure that these practices are now no longer taking place. NICE also provides

Evidence-based advice on areas of clinical practice that are not deemed cost- or clinically-effective.

- 867 Clinical Guideline Do Not Do's
- 52 Technology Appraisal Do Not Do's
- 7 Interventional Guidance Do Not Do's

3. **Requests for diagnostic investigations in Radiology and Pathology**

Timely and appropriate access to diagnostics in a clinical pathway may save duplication and inappropriate intervention or avoid out-patient utilisation. Inappropriate requests and access has been acknowledged for many years to be a problem. This has led to two key papers: Making the Best use of Clinical Radiology (RCR 2007) and the Criteria for Appropriate Radiology (ACR 2009) the former being agreed by NICE as conforming to highest standards of accreditation of evidence.

Evidence suggests that despite this authoritative clinical guidance that there is still growing demand for investigations and tests driven by population needs and that adherence to these standards is poor. Clinical decisions and a growing evidence base (e.g. NICE) for correct assessments to be completed as part of clinical pathways of care. These extend across the whole health economy and relate also to reduction in waits in primary care for appropriate diagnostics.

There is a need to review local practice to ensure that requests for these tests are not routine but rather justified on an individual clinical and evidence based basis from both primary and secondary.

There are options to seek to mitigate and challenge some of the underlying demand growth without compromising care and access for patients. There is the need to consider:

To what extent are junior doctors/clinical teams making requests on a routine basis, rather than as a reflection of what the individual patient requires and there is a rationale for tests rather than it being a routine approach?

To what extent are tests driven by known co-morbidities of patients, and hence demand increasing with an increasing older population?

Is there a dialogue between requesting clinician and radiologist with a focus on the patient's best interests as well as ensuring optimum resource utilisation?

4. **Pre-operative Smoking Cessation**

There is strong evidence that people who smoke are more likely to have lung, heart and infectious complications; have reduced bone fusion after fracture and impaired wound healing; be admitted to an intensive care unit; have an increased risk of in-hospital mortality; and remain in hospital longer.

Patients can reduce their risk of a wide range of complications if they stop smoking eight weeks before elective surgery, with improved recovery and outcomes, including reduced wound related, lung and heart complications; decreased wound healing time; reduced bone fusion time after fracture repair; reduced length of hospital stay; in the long term reduced risk of heart disease, cancer and premature death.

This smoking cessation pre-operative intervention should be seen as a basic component of evidence based commissioning for elective surgery.

http://www.cardiffandvaleuhb.wales.nhs.uk/optimisingoutcomes

5. **Pre-operative Weight Management**

Obesity is a recognised risk factor for a wide variety of peri-operative complications. Research highlights that obese patients are likely to experience:

- A nearly 12-fold increased risk of a post-operative complication after elective breast procedures
- A 5-fold increased risk of surgical site infection (SSI)
- An increased risk of SSI as much as sixty percent (60%) when undergoing major abdominal surgery
- A higher incidence of SSI (up to 45%) when undergoing elective colon and rectal surgery
- An increased risk of bleeding and infections after abdominal hysterectomy
- A higher incidence of peri-operative deep venous thrombosis and pulmonary embolism
- Increased risk of complication after elective lumbar spine surgery
- An increased risk of restrictive pulmonary syndrome, including decreased functional residual capacity (for morbidly obese patients).

Additionally, it is understood that around 50 percent of patients who are obese have a poor outcome following joint replacement surgery compared to less than ten percent of patients with a healthy Body Mass Index (BMI).

Reasons for this include:

- A significantly higher risk of a range of short-term complications
- A less likely outcome of surgery improving symptoms

- A higher risk of the implant failing, requiring further surgery
- A higher incidence of weight gain following joint replacement surgery.

This weight management pre-operative intervention should be seen as a basic component of evidence based commissioning for elective surgery.

http://www.cardiffandvaleuhb.wales.nhs.uk/optimisingoutcomes

6. **Effective Medicines management**

There is currently a strong medicines management approach in place in the NHS in Wales to ensure high quality, cost effective prescribing. Over the years substitution policies have been a cornerstone of prescribing advice work. While they will remain key, volatile pricing structures and fewer opportunities for uncomplicated drug switches, mean different approaches must be explored.

These need to focus on the patient by maximising outcomes from medicines while reducing harm which can lead to unscheduled care and admissions. Therefore, in addition to current work programmes, areas being further explored include:

a) Polypharmacy: Recent interest in tackling polypharmacy has been further re- enforced by The Kings' Fund's "Polypharmacy and Medicines Optimisation (2013) publication. Polypharmacy can be subdivided into 'appropriate' and 'problematic' the latter can be defined as the prescribing of multiple medications inappropriately, or where the intended benefit of the medication is not realised. For example treatments not evidenced based, risk of harm outweighs benefits, drug interactions, unacceptable 'pill burden', demands make it difficult to achieve clinically useful medicines adherence, prescribing medicines to treat side effects of other medicines. Measures need to be implemented to aid in systematic polypharmacy review to enable these clinical situations to be identified and improvements made.

b) Maximising effective outcomes: The evidence for and impact of prescribed medicines requires regular review to maximise outcomes for patients. This may involve compliance issues, dose titrations, polypharmacy reviews, chronic condition management, working in partnership with health and social care teams to improve medicines management in community settings etc. Innovative models such as network based clinics and use of Non Medical Prescribers etc. may aid in this.

c) Improving practice against key national prescribing indicators: In addition to the annually updated Welsh national prescribing indicators, Health Boards will also need to take into account any additional target areas highlighted in other advisory documents such as NICE's :Key therapeutic topics – Medicines management options for local implementation."

d) Use of formularies/managed entry/prescribing support software: Prescribers need to be informed and supported in their prescribing choices. Effective formularies, managed entry processes and supporting software such as Scriptswitch and acute based systems can all aid in this and should be further developed to ensure processes and implementation are robust.

e) Welsh Audit Office (WAO) Report on Primary Care Prescribing (2013): Each Health Board should consider and implement the range of recommendations from WAO audits undertaken in 2013 after a local assessment of the potential gains available.

f) Systems re-design: Opportunities to redesign prescribing systems to improve quality whilst maximising the use of resources should be explored and implemented where appropriate e.g. prescribing of dressings, continence and stoma products etc.

g) Greater role for Pharmacists in medicines management: Explore options to maximise the accessibility and skills of pharmacists across all sectors to improve medicines adherence and thereby improve health outcomes and reduce waste associated with non-adherence to medicines

h) Adherence to NICE/AWMSG advice: Robust mechanisms improve adherence to NICE/AWMSG guidance should be explores and implemented. Further work needs to take place to ensure that the 14 NICE “Key therapeutic topics” are recognised and that local practice are adherent to the principles they contain.

i) Repeat Prescribing: Good practice in managing repeat prescribing should be developed and implemented across NHS Wales to ensure that repeat prescribing processes do not inadvertently contribute to medicines waste or adversely affect patient care

j) Develop and mandate a national essential medicines list: agree a list of essential medicines that patients would receive free of charge. Access to other medication not on this essential list would result in a fee to patients wishing to receive them

k) Develop a prudent approach to antibiotics prescribing:

The Public Health Wales report “Antimicrobial resistance and usage in Wales (2005–2011)” presents the different prescribing and antimicrobial resistance (AMR) patterns across Wales. The report shows that AMR in Wales has increased over the seven years reported for some of the major pathogens. In some cases there is considerable variability in resistance rates between different hospitals and health boards in Wales, suggesting an opportunity to reduce antibiotic use in some areas. The UK Five Year Antimicrobial Resistance Strategy was published in September 2013. This has been developed collaboratively with the UK devolved administrations

and will provide surveillance and a coordinated plan of action needed to address this issue. The overarching goal of the strategy is to slow the development and spread of AMR. It focuses activities around three strategic aims:

- Improve the knowledge and understanding of AMR,
- Conserve and steward the effectiveness of existing treatments,
- Stimulate the development of new antibiotics, diagnostics and novel therapies.

The Health Protection Agency (HPA) states "Prescribers are advised to use simple generic antibiotics where possible and to avoid broad-spectrum antibiotics (e.g. co- amoxiclav, quinolones and cephalosporins) where narrow antibiotics remain effective" as they increase the risk of methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile and resistant urinary tract infections. Broad-spectrum antibiotics need to be reserved to treat resistant disease, and should generally be used only when narrow-spectrum and less expensive antibiotics are ineffective. The guidance advises when it may be appropriate to consider a broad-spectrum antibiotic

7. **Targeting clinical variation**

There is a need for a robust programme to target waste, harm and variation which leads to changes in clinical practice. It requires a focus that can help develop habitual behaviour that strives for excellence across all clinical teams.

Some variation reveals the detailed individual decision making that is occurring in systems is taking place that indicates both resilience and the achievement of excellence. Other variance (usually wider variance) however reveals unacceptable differences in practice. Smoothing this variance will lead to better resource use and better value.

There are a number of specific interventions that must be challenged and should be subject to standardised approaches.

8. **Prioritisation processes to inform Board and clinical decision-making processes**

Given the resource constraints within the NHS in Wales there is an increasing need to ensure that processes for the allocation of resources by local health boards are prudent, transparent and evidence based.

Local health boards have responsibility for planning as well as delivering health care to meet the needs of their populations. Whilst it is possible, as can be seen above to identify efficiencies in delivering health care which lead to better resource utilisation it is becoming increasingly necessary to make difficult decisions about prioritising resource allocation. Inevitable this

will lead to discussions about where funding should be invested or potentially disinvested. These discussions will need a robust framework to take place within.

The NHS Wales Planning Framework requires health boards to implement the commissioning cycle. This cycle provides the framework for NHS planning and includes the prioritisation of services within available resources. Currently the All Wales Prioritisation Framework (currently under review) has in a limited way supported some decision making when comparing clinical interventions. It adopts an agreed set of criteria including health gain delivered, affordability and clinical effectiveness.

The challenge we now face is how to develop such approaches for use by health boards in a way that appropriately engages the public, clinicians and stakeholders in understanding and contributing to difficult decisions about where we spend public resource. Health Boards will need to develop governance arrangements which support prioritisation processes, including decision making and engagement approaches.

It will be essential to develop capability and capacity in understanding health need, evidence of effectiveness, health outcomes and health benefits, calculating cost effectiveness and affordability, collating benchmark and programme budget data to assess quality for spend to inform our development of business cases. In turn we will need to agree criteria & process by which to prioritise those business cases for future resource allocation.

Additionally these ways of working will need to support decision making with regard to disinvestment of resources where it is evident that alternative approaches offer greater value for money i.e. better outcomes, quality & efficiency.

To deliver the above it will be essential to further develop capability and capacity across Wales to implement the commissioning cycle as the framework to support prioritisation taking place effectively; the newly emerging All Wales Commissioning Network is sign of the willingness amongst health boards for this.

Developing an effective Commissioning capability and capacity within each Health Board will provide the means for evidence based approach to decision making and support for priority setting. This in turn should facilitate the re- design of clinical pathways. This will require clear policies to be developed including a transparent and inclusive decision making framework, a clear set of criteria for determining priorities and robust monitoring, governance and information systems. Decision making will need local intelligence to support cases for investment and/or disinvestment and service change will need to include patient views.

Summary

This paper outlines a number of opportunities representing a programme to improve value across the NHS in Wales and introduce the principles of prudent healthcare.

This requires the right culture and processes of clinical challenge to be established and an expectation that the “correct clinical conversations” are taking place. There is also the need to ensure that there is the appropriate infrastructure in place to support and monitor progress in delivery.

Good clinical engagement is essential in delivering the potential outlined in this paper. They also require the concerted support of all clinical leaders with a preparedness to challenge those clinicians and groups that present barriers to this approach.

Eifion Williams and Hamish Laing – 26th February 2014

This paper is based on work for NHS Wales and has had very significant contributions from:-

- Dr Paul Buss and Andrew Goodall (ABUHB) Judith Vincent (ABMUHB)
- Kerry Broadhead (ABMUHB) Alun Lloyd (WG)
- Bevan Commission

Appendix 2 Mental Health Strategy – Action Plan

Changing Mental Health for the Better (CMH4B) - Action Plan

The following tables summarise the actions being progressed over the next 3 years. Detailed information on progress to date and actions moving forward are included in the Local Partnership Board Annual report which is available via the following link.

http://www.wales.nhs.uk/sitesplus/863/opendoc/228546

Promoting Mental Health

Action	Aimed to deliver on Tier 1 target?	Action in WG delivery plan?	Year
Local Primary Mental Health Support Service With only 12 months experience of operating the Local Primary Mental Health Support Services under Part 1 of the Mental Health (Wales) Measure 2010 across the 3 local authority areas we feel it is appropriate to maintain a focus upon development and improvements in delivery of this area of service.	✓		1
Developing the range of Tier 0 'Emotional Wellbeing Services' available in partnership with the third sector We will develop a wellness advice and support services for individuals who may be facing difficulties		✓	2

Working together with people.

Action	Aimed to deliver on Tier 1 target	Action in WG delivery plan	Year
Improving Service User experience We will undertake a regular cycle of service user satisfaction surveys, questionnaires and feedback sessions making it as easy as possible for people to let us know what they think and will publish the results.		✓	1

Action	Aimed to deliver on Tier 1 target	Action in WG delivery plan	Year
We will ensure people are engaged in the planning and delivery of their own care in line with the Mental Health (Wales) Measure 2010 as making decisions in partnership is known to improve outcomes for the individual.	✓	✓	1
We will review and strengthen mechanisms for engaging with users and carers in the design, planning and monitoring of services.		✓	1
Carers In line with "Valuing Carers" - our Carers Information and Consultation Strategy and the requirements of the Mental Health (Wales) Measure 2010, we will aim to work together with carers, including young carers, and families so that they get appropriate information and advice and are supported to continue their caring role. This will include ensuring that they are involved in the care planning of the person they care for, with appropriate guidance in place on sharing information with carers.		✓	1

Working together between organisations

Action	Aimed to deliver on Tier 1 target?	Action in WG delivery plan	Year
Development of Psychiatric liaison Link workers within Community Resource teams to improve dementia care As part of locality development workers are to be embedded into local Community Resource Teams to provide links to the Older People's CMHTs together with the provision of advice, support and education. The development of these roles within each locality recognises the specialist role and function of Older People's CMHTs linked to an integrated mental health service. The link workers will help Community Resource Teams address issues of cognitive impairment for those patients receiving treatment for physical illness. They will also facilitate clear referral pathways between the CRT and the specialist CMHTs.		✓	1
Perinatal Services We will implement in collaboration with Women and child		✓	2

Action	Aimed to deliver on Tier 1 target?	Action in WG delivery plan	Year
health a Perinatal mental health service model across all 3 localities.			
Integrated Working Development of Integrated Older Peoples Community Mental Health Teams with links to the Community Networks		✓	2
Dual Diagnosis In partnership with the Area Planning Board the Directorate will develop an integrated care pathway for people who present with dual diagnosis across the adult age span including older people, training needs analysis will be undertaken and a training plan will be developed, link worker roles will be developed in all secondary care teams. A small team of specialists will work initially in the Neath Port Talbot area to provide supervision, advice and consultation for the link workers and some specialist assessments and evidence based interventions for those individuals that require additional input. This will be evaluated by the dual diagnosis sub group of the Area Planning Board which will recommend the future service direction.		✓	2
General Hospital Liaison Development of Old Age Liaison Psychiatry link to the Frail Elderly Assessment Service in Morriston Hospital.		✓	2
Delivering on procurement Having agreed a joint procurement and contract monitoring process for high cost placements we aim to implement the process in order to deliver efficiencies.		✓	1
Further Improvements to range of accommodation Through improvements in needs mapping in each local authority area we plan to develop services that further increase our range of accommodation options and access to meaningful vocational occupation.		✓	2
Mental Health services for children and Young People **Our priorities will be to address the following in partnership:-**			
• Review and agree the service specifications for CAMHS including the development of benchmarking and performance management measures.		✓	1
• Develop and agree a service specification for Youth Offending Service.		✓	1

Action	Aimed to deliver on Tier 1 target?	Action in WG delivery plan	Year
• Further work required to review pathways and transition between services in light of the introduction of the Mental Health (Wales) Measure 2010, capacity within Local Primary Mental Health Support Services and definitions of secondary mental health services that are congruent with adult mental health services.	✓	✓	1
• Ensure clear pathways are put in place for children with mental health problems in crisis to reduce admissions to adult inpatient facilities with further work needed to revisit existing plans to meet crisis needs of young people who are 16-18 years of age.		✓	1
• Develop clarity in respect of the needs of Looked After Children, Care leavers and services for Children, Young People and Families with Neurodevelopment disorders			1

Holistic care for the most vulnerable

Action	Aimed to deliver on Tier 1 target?	Action in WG delivery plan?	Year
Recovery into practice To build on the work commenced at the "Recovery into Practice: a whole life – whole systems approach" conference there will be a thematic learning programme around "Recovery into Practice for mental health workers" and "Recovery into Practice for family members and people with lived experience".		✓	1
Care and Treatment Plans under Part 2 of the Mental Health (Wales) Measure 2010 Audit processes will focus on improvements in the co production of care and treatment plans, improvements in the quality of plans, the development of service user focused goals and service user satisfaction with the Care and Treatment planning processes in light of service user feedback and the findings of audits.	✓	✓	1
Pilot the development of First Episode Psychosis service We will develop a hub and spoke model for specialist		✓	1

Action	Aimed to deliver on Tier 1 target?	Action in WG delivery plan?	Year
intervention with people who are experiencing psychosis for the first time, with practitioners from a range of service settings, including LPMHSS, CRHT, inpatient services, CAMHS and CMHT, acting as link workers within a community network.			
Capital Programme We aim to continue to make progress in the implementation of the capital programme for the modernisation of mental health services, particularly in relation mental health acute assessment facilities as we are committed to improving our collective responses to people who require urgent care. This includes:-			
• Modernisation of Inpatient Services for People with Challenging Behaviour by the centralisation of PICU services in the POWH		✓	1
• Consultation on Centralisation of Acute Assessment Admission beds on the Neath Port Talbot Hospital Site.		✓	1
• Re-provision of the Swansea Older Peoples Inpatient Acute Assessment Services currently located at Cefn Coed Hospital		✓	3
• Development of 28 bed Low Secure Unit at Glanrhyd Hospital Site.		✓	1
Physical health of people with mental health problems The physical health monitoring of people prescribed neuroleptic medication can be improved by the introduction of specific physical health monitoring clinics. This service improvement is currently being piloted in 2 Community Mental Health Teams in Swansea. The aim is to provide these clinics in every Community Mental Health Team across the Health Board area.		✓	1
Access to Psychological Therapies During the year we will be exploring service developments to improve access to psychological interventions across all service areas.		✓	1

Action	Aimed to deliver on Tier 1 target?	Action in WG delivery plan?	Year
Medicines management As part of our approach to focus on improving services provided for people with dementia we aim to take forward work on medicines management in relation to antipsychotic prescribing.		✓	3

Appendix 3 Improving Quality, Safety and Standards of Care at the Princess of Wales Hospital

Initiative	Aim	Outcome Expected
6 Key Clinical Commitments		
VTE prophylaxis	i. Every patient admitted or pre-assessed for admission to hospital to have a documented risk assessment to identify those at increased risk of Hospital Acquired Thrombosis including pregnant women. ii. Every patient identified at risk, to have a documented risk assessment of the complications of thromboprophylaxis. iii. Every in-patient to have a documented reassessment for the above every 48 hours or if their condition changes e.g. post operatively. iii. Patients who are unable to receive pharmacological interventions to have one of the following mechanical methods: • Graduated compression stockings (surgical patients only)* • Foot impulse device • Intermittent pneumatic compression device iv. Unless contraindicated pharmacological prophylaxis to be given to all 'at risk' patients. v. Patients encouraged to mobilise as soon as safely possible after their surgery or their acute illness vi. Patients educated in the various methods of prophylactic treatments to ensure compliance	A reduction in hospital deaths where pulmonary embolism and deep vein thrombosis (VTE) are either the cause or a contributing factor.
Care of the deteriorating patient	i. All doctors and nurses trained in the use of the 'NEWS' early warning system. Ii.All Nurses screen patients for sepsis when NEWs score indicates Iii.100% compliance with sepsis 6 bundle within 1 hour for all patients screened as being	Reduction in deaths and long term harm from life threatening conditions like sepsis.

Initiative	Aim	Outcome Expected
6 Key Clinical Commitments		
	septic Iv.Trial of electronic NEWs scoring linked to automated response v.Patients regularly assessed using the NEWS system -deteriorating patients, meaning life-threatening conditions like sepsis are spotted earlier and stopped more quickly.	
Daily senior review	i. Every patient is assessed at least once a day by a senior clinician	Reduction in deaths and long term harm from life threatening illness and conditions due to their early identification. Reduction in the length of stay for some patients. Greater efficiency in the use of medicines.
Mortality reviews	i. A review of every hospital death is undertaken to identify shortcomings in care. ii. Early feedback and learning from hospital reviews to clinicians to ensure improvement in practice.	A reduction in hospital deaths due to sub-optimal practice.
Hospital discharge summaries	i. A discharge summary is issued to the patients GP within 24 hours of discharge. ii. Detailed discharge summaries are issued within 48 hours of discharge	Improved and safer care pathway for patients. A reduction in re-admissions

Initiative	Aim	Outcome Expected
6 Key Clinical Commitments		
Hand washing	All staff, who come into contact with patients, follow the World Health Organisation (WHO) '5 moments for hand hygiene' guide as the basis for effective hand hygiene: • Before patient contact. • Before clean/aseptic procedure. • Before aseptic technique. • After body fluid exposure. • After patient contact. • After contact with patient surroundings.	Reduction in deaths or harm from hospital acquired infections. Reduced lengths of stay.

Appendix 4 Benchmarking tools

The benchmarking tools in use within our organisation are:

- **NHS Benchmarking:** ABMU is a member of the NHS Benchmarking Network. The NHS Benchmarking Network works with its members to understand the wide variation in demand, capacity and outcomes evident within the NHS and define what good looks like. This supports providers in delivering optimal services within resource constraints, whilst also allowing commissioners to achieve the best balance from available commissioning resources. The Benchmarking Network newsletter is available on Portal and there are more than 40 individuals set up to access a wealth of benchmarking information via the website.
- **CHKS:** In order to quantify the potential for further efficiency savings as a service provider, the Health Board commissioned CHKS to benchmark service level costs with efficiency and outcome measures, comparing the Health Board with high performing providers in England. The aim of the exercise was to identify outlying services; provide insight into the drivers of variance and to produce an action plan where there look to be opportunities to generate savings without sacrificing quality of care.
- **CHKS Signpost:** Signpost is used at different levels across the Health Board, providing easy access to user-specific information for consultants, clinicians, managers and information analysts. Signpost is a user-friendly 'dash-board' which enables access by all designated users.
- **National Clinical Audits:** ABMU has participated in a number of clinical audits in 2012/13. Details of these audits and links to the published reports are embedded in the attached document.
- **Reference Costs:** Welsh health Boards are required to submit reference costs to WG on an annual basis. These are incorporated into a specialty cost statement (WCR1) breaking down fully absorbed costs and activity by specialty and point of delivery and generating average unit costs and an HRG cost statement (WCR2) breaking down the costs and activity for admitted patient care by Healthcare Resource Group (HRG)
- And cost driver. Welsh Government incorporates this into an All Wales average. For each Board, activity is costed at HRG level (for APC) or specialty (for non APC) using the All Wales average costs. The resultant derived cost is compared to the cost reported by the Board to generate a cost Index. The cost index for ABMU was 95.69 demonstrating the relative cost efficiency of ours services within Wales. Detailed working papers are made available to drill down into this variance to specialty, POD and HRG level.

- **Commissioner Reference Group:** The Health Board is a member of the Commissioner Reference Group within the NHS Benchmarking Network. The Group is in the process of creating a programme of work for 2014/15, including a proposed enhancement of the Total System Benchmarker toolkit. This toolkit presently contains activity, financial, quality, mortality and disease prevalence data for a large of number of English Healthcare bodies and provides a modelling functionality. The opportunity is for inclusion of the Health Boards of Wales, whilst expanding on the outcome measures, though a collaborative work programme. Additional work programmes include Acute Reconfiguration, Pathways (proposed Diabetes), Children's Services and Medicines Management.

In addition, Finance and Informatics colleagues have been working to acquire, implement and rollout two new benchmarking dashboards that can assist the Health Board in their Service Improvement and performance work.

These are Albatross and Comparative Health Knowledge System (CHKS) Insight:

- **Albatross:** A Patient Cost Benchmarking Tool that will enable ABMU to compare costs for admitted Patient Care treatments with other similar Health Service providers, enable drilling down into the component parts of HRG costs, enable sharing / accessing of variance reports and ensure easy extraction of data from existing costing systems. In December we provided information to Directorates on where there are opportunities for them to improve performance.

  Each Directorate/Locality/Programme have addressed action/ savings/ benefits from the information in their plans. We will open up access to Albatross to a wider audience in the New Year with appropriate support and training.

- **CHKS Insight:** A healthcare intelligence programme that combines expert analysis and benchmarking advice with an online monitoring and reporting system. We plan to tailor the Insight programme to match our specific priorities and objectives and use the variety of presentation formats and bespoke reports to engage all stakeholder groups in more informed decision making. CHKS Insight will allow us to focus on the indicators that are most important to our organisation, to directorates and to specialties.

Recent work by Public Health has developed an NHS Expenditure and Health Tool (SPOT in England). This should be useful to us from a Commissioning perspective going forward.

PATIENT COST BENCHMARKING WITH ENGLISH PROVIDERS

Albatross (Patient Cost Benchmarking) collects patient level clinical, demographic and cost information and enables access to this information through a business intelligence dashboard. The dashboard facilitates the presentation of comparative analysis of data in a flexible and effective manner.

In order to undertake the comparative analysis, we have identified specialty "improving performance" Peer Groups against which to benchmark Cost, Length of Stay and Operating Theatre Time.

Using the dashboard to compare performance with these Peer Groups, it has been possible to scope the potential for performance improvement with resultant productivity improvement and cash releasing saving.

Access to the Albatross Dashboard has been arranged for all Directorates and Localities, and Programmes and Project leads, and a series of meetings have been arranged to provide familiarisation and to explore the potential opportunities.

Specialty specific performance Indices and Impact Statements have been developed and utilised to underpin the IMTP.

Appendix 5 Progressive Financial Management

Alongside the development of "Finance Future", the Finance Function has developed and implemented a number of financial and service analysis tools to enhance insight into the financial and service performance of the Health Board. These tools enable clinical and service leaders to access, at any time, a wide range of information on their services. The information is capable of being presented in graphical and/or tabular forms and its structure allows drill down and trending at the click of a button.

A significant education and training programme has been developed and delivered to support the transition to this way of working.

We have implemented three core products under this Finance Informatics initiative, namely:-

- Financial Reporting and Budgetary Dashboard (450 users)
- Service Benchmarking and Cost Analysis Dashboard - Albatross (140 users)
- Commissioning Activity Dashboard (125 users).

The Financial Reporting and Budgetary Dashboard is an interactive system, analysing and presenting budget and expenditure at the click of a button. Information is presented as charts, trends and in tabular form as required and users can also drilldown to transaction detail. The Dashboard enables service users to gain greater insight into the utilisation of resources and opportunities for improvement. ABMU Finance has provided comprehensive training to 450 budget holders across the Health Board. The Budget Holder Dashboard has transformed our ability to understand and manage our resources.

Albatross is a financial benchmarking tool that enables us to benchmark acute admitted patient care performance against the other Welsh Health Boards and 60 English Trusts. We have fast tracked the implementation of this Albatross System within our Health Board to support the Health Board's IMTP process. Albatross collects patient level clinical, demographic and cost information and enables access to this information through a business intelligence dashboard. The dashboard facilitates the presentation of comparative analysis of data in a flexible and effective manner. In order to undertake a comparative analysis, we have identified specialty "improving performance" Peer Groups against which to benchmark Cost, Length of Stay and Operating Theatre Time. Using the dashboard we have compared performance with these Peer Groups to scope the potential for performance improvement with resultant productivity improvement and cash releasing saving.

The Commissioning Activity Dashboard is a bespoke product developed by ABMU Finance, in partnership with Public Health, Service leaders and

G.P.'s, to enable resource consumption and activity to be viewed from the perspective of Commissioners at a range of levels from Health Board, Localities, Community Networks, and G.P. Practices. It presents the full cost of Health Board Services across four elements, namely, Acute Services, Mental Health & Learning Disabilities, Community Services and Primary Care. The objective of the Dashboard is to enable resource consumption across the patient pathway to be identified to facilitate service redesign and modernisation.

In 2014/15, our Health Board plans to implement Service Line Reporting (SLR) for certain Regional Services commissioned by WHSSC. The intention is to align income and defined activity in a transparent manner. The process will also facilitate the benchmarking of performance within the identified services.

As well as delivering the technical input to develop the required financial information systems for SLR, we are working with Service Leaders to understand the opportunities that this way of operating offers their teams and how to improve delivery.

In Finance we are also working with the Commissioning Development Programme to establish a Prioritisation Framework and associated financial mechanisms to enable decision making at Health Board level. This work includes the developing roles for Community Networks in the operational delivery and planning of Health Board services.

INTEGRATING FINANCE

As well as setting the foundations for "Finance Future" through technology and informatics developments, the Finance Function has also been working to enhance the Health Board's capability in integrating financial, patient experience and clinical outcomes. Finance has established strong links with the Patient Experience Programme and Patient Safety Programme.

Finance is managing the technical set up of the Health Board wide Patient Experience Capture System, SNAP2, in order to ensure alignment with Financial Accountability structures and to maximise the reporting capability of the product. The delivery of the outputs from the Patient Experience System will be integrated into the Management Reporting Portal in a seamless fashion.

Our Devolved Finance Managers will align Patient Experience results alongside the financial performance of Resource Managers and budget holders. This will enhance our understanding, and delivery, of value.

Our Devolved Finance Managers are also co-leading, along with our Informatics partners, the rollout of the new Performance Dashboard across

the Health Board. Again, this will further integrate financial and service performance to improve decision making.

We have secured funding from the Western Bay Programme to integrate with our three Local Authority Partners their costs for Social Care into our Commissioning Analysis Dashboard. This enables the integration agenda and enhances pathway redesign and resource shifting between service sectors.

In addition, ABMU Finance hosts and leads the programme Management Office for the Health Board's Strategic Change Programmes. Through this role, Finance works to ensure alignment of Finance, Quality, Workforce, Facilities and Performance within the planning structure. For 2014, the Locality, Directorates and Strategic programmes, and allied projects, are fully integrated into a database that allows plans to be viewed from operational and strategic perspective. This integration enables the Health Board to manage its matrix accountability structure in a clear and focused manner.

Each of our Health Board Strategic Programmes and aligned Projects has a lead Financial Manager integrated into the Programme Project Team.

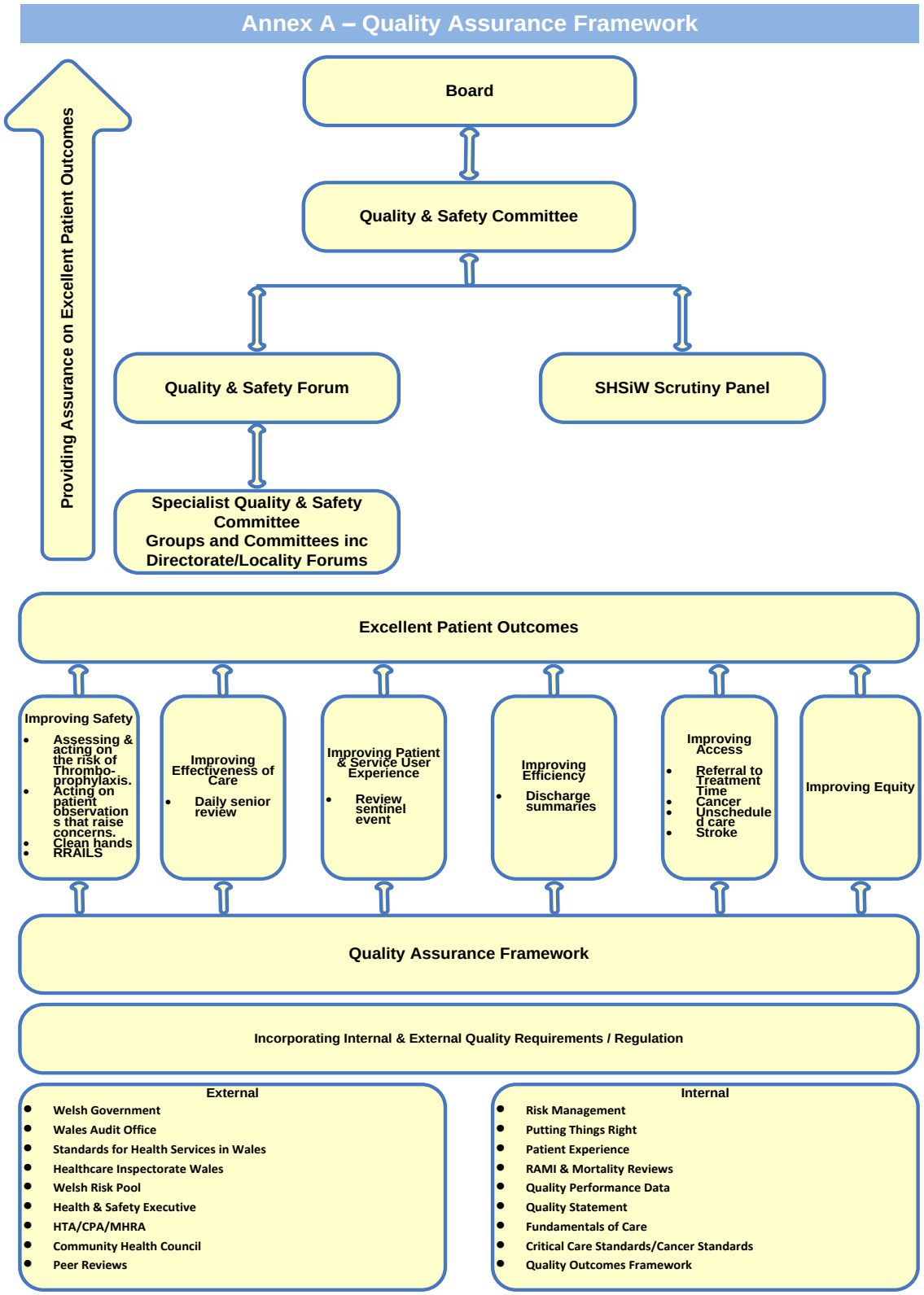
QUALITY AND EXCELLENCE

ABMU Finance first achieved International Organisation for Standardisation (ISO) certification in 1997 and has maintained this certification for sixteen years. This certification demonstrates our commitment to quality, training and improvement, indicates our clear policies and defined objectives and evidences our effective systems which are made clear to all of our people.

Since 2007, ABMU Finance has participated in the Wales Quality Improvement movement and has been very successful in this process. ABMU Finance achieved the prize for "The Most Improved Organisation" in 2008, "The Public Sector Prize" in 2009, and the Chairman's Award for "Financial Excellence" in 2011. In 2012, ABMU Finance opted to undertake the site visit approach. ABMU Finance was visited by an experienced team of Assessors who have a wide knowledge and understanding of the EFQM Excellence Model. This is a bespoke approach whereby the team spend a number of days within ABMU Finance to understand how ABMU Finance manage and operate and how using our management approach; we deliver our objectives and key targets. In 2012, ABMU Finance achieved the Gold Award and the "Strategy" prize.

In 2014, the Finance Function will commission a review from the British Quality Foundation and invite a dedicated team of committed and focused assessors to spend time within our Function and compile a comprehensive

feedback report which will inform our strategic planning and the future direction of our function.

Every member of the ABMU Finance Team has completed the bronze level Improving Quality Together national learning programme.

Appendix 6 Current Quality Assurance Framework