Meeting Date	**25 July 2019**	**Agenda Item**	**3.1**
Report Title	**Clinical Services Plan and IMTP 2020/21-22/23 – Progress Update**		
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Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Siân Harrop-Griffiths, Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	This paper and accompanying Appendices provide an update of the work undertaken to date in delivering the Clinical Services Plan (CSP) Programme and the aligned process for the development of the IMTP for 2020/21-22/23.		
Key Issues	The key issues addressed in this paper include: • Progress to date on the delivery of the CSP Programme • Progress to date on the development of the Integrated Medium Term Plan (IMTP) • Engagement across the IMTP and CSP development • The challenges and risks • The immediate next steps to be taken.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☐	☐
Recommendations	Members are asked to: • **NOTE** the progress made on delivering the CSP Programme and the IMTP process • **NOTE** the key risks and challenges • **SUPPORT** the next steps		

DELIVERING OUR CLINICAL SERVICES PLAN AND DEVELOPING AN INTEGRATED MEDIUM TERM PLAN (IMTP) 2020/21-23

1. INTRODUCTION

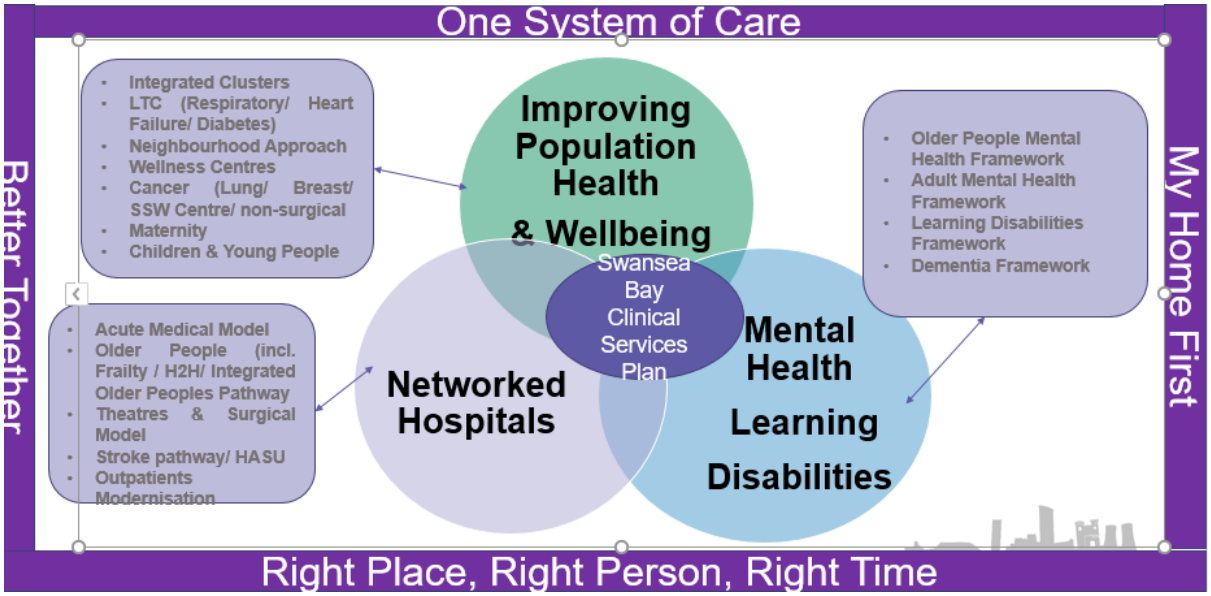
The transition from developing to delivering the Clinical Services Plan (CSP) took place in February 2019, since when there has been a focus on establishing the leadership, engagement, forums and plans required to deliver our ambitions. Governance for CSP delivery is being managed through a Clinical Services Plan Programme Board which reports to the Transformation Portfolio Board.

The Health Board also committed to seeking to develop an Integrated Medium Term Plan (IMTP) during 2019, which will include delivery of the first three years of the CSP plans.

2. BACKGROUND

2.1 CSP Programme and Timeline

The CSP was developed through a programme of clinical engagement and culminated in seven areas of ambition. These ambitions have now been aligned to form three key programmes of work; Population Health, Mental Health and Learning Disabilities and Networked Hospitals as shown in the diagram below. Whilst discrete programmes of work are in place for each programme there are interdependencies and relationships within and between the programmes to ensure that whole system/pathways approaches are implemented.



A high-level five-year CSP delivery timeline has been developed; the IMTP plans are being developed to deliver of the first three years of this. The critical path will be developed by September 2019, and a supporting capital programme will follow later in the year.

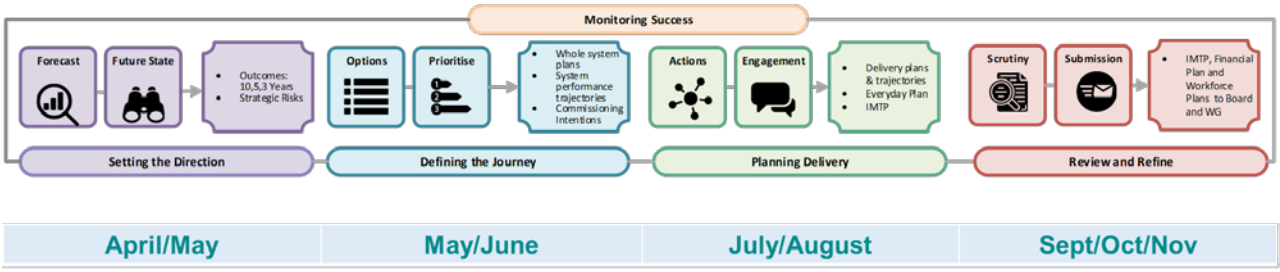
2.2 Process and Timeline for an Approvable IMTP

The national deadline for submission of IMTPs is December 2019, and developing confidence in an approvable IMTP is an enabler to support the organisation out of Targeted Intervention (TI). The Health Board had planned to share a draft IMTP for the period 2020/21-23 with the Board in September 2019 and subsequently informally to Welsh Government. This would allow ample time for discussion and engagement with Welsh Government to improve the approvability of the Plan prior to the national planning framework deadline for submission in December 2019. Recent discussions with Welsh Government, at TI and Joint Executive Team (JET) meetings, have emphasised the importance of developing and submitting an approvable IMTP at a time that is right for us, rather than to hit a deadline. However, to maintain focus and pace, we are at present continuing to drive the work to meet the national timetable. Our ambition is still to develop an approvable IMTP in 2019. If necessary, we will discuss with the Board, at an appropriate time later in the year, if this is not likely to be possible.

An Integrated Planning Framework has been developed and agreed with the Executive Board; this framework set out:

- The principles that underpin integrated planning activities in the Health Board;
- Definitions of the roles and responsibilities for integrated planning; and,
- Descriptions of the structures, mechanisms and processes that constitute the effective planning architecture of the Health Board.

The Integrated Planning Framework sets out the planning cycle:



The four key planning stages of the planning cycle achieve the following:

- **By end of April - Setting the Direction (Complete)** – the Executive Team confirmed the strategic direction for the next 3-5 years using the Enabling Objectives in our Organisational Strategy.
- **By end of June - Defining the Journey (Partially Complete) –** Development of Whole System Plans for key system areas across the Health Board in alignment with the Clinical Service Plan.
- **By end of August - Planning Delivery** – Delivery Unit and corporate teams to be supported to collaboratively develop operational and performance delivery plans to deliver the Whole System Plans and refine the plans through developing enabling plans for Workforce, Quality, Digital and Finance.

- **By end of November – Review and Refine –** Detailed review of plans and refinement of content through engagement across the Health Board and with Welsh Government colleagues in preparation for final submission.

3. Update on Progress

3.1 Clinical Services Plan

A Clinically-led CSP

The Director of Strategy is the lead Executive Director for implementation of the CSP and chairs the CSP Programme Board. The Health Board approved a clinically-led approach to delivering the CSP and in support of this, three clinical Executive Directors have been appointed as the executive senior responsible officers for the CSP programmes as follows:

- Improving Population Health and Wellbeing – Director of Public Health
- Mental Health and Learning Disabilities – Director of Nursing and Patient Experience
- Networked Hospitals – Medical Director.

To facilitate a system/pathway approach a number of clinical groups have been repurposed as Clinical Redesign Groups (CRG) and the membership changed to reflect primary and secondary care working together to deliver the CSP priorities in these areas. These include Older People, Outpatients, Respiratory Health, and Diabetes.

Not all of the projects will require the degree of service model change that requires a CRG and will have other formal groups in place for project delivery. Within the CSP Programmes, clinical leaders and champions have been identified to lead the design and delivery of service change. However, the identification of clinical leadership for the acute care model within the Networked Hospital programme has proven to be more complex. Recommendations on a way forward will be considered by the Transformation Programme Board in August.

The CSP Programme clinical and management leads have and will continue to meet with clinical leaders to understand and identify ways to support them in leading significant clinical change priorities for e.g. older people, frailty, respiratory health, diabetes, children and young people, heart failure, outpatients and surgery

In addition, working with the Advisory Board Group, two CSP Clinical Leadership workshops have taken place exploring what clinical leadership is needed to deliver the CSP. Specific actions were also identified to enable the clinical community to deliver changes in outpatients and acute care. A number of these ideas are currently being scoped for delivery e.g. the End of Life Care electronic record and the ‘orange phone’ for consultant advice to primary care.

Managing CSP Delivery
The Executive Board received a detailed presentation on the Clinical Services Plan in June 2019. The inaugural meeting of the CSP Programme Board has also taken place.

The discussions in both meetings informed recommendations to the Transformation Portfolio Board in July.

These included recommendations on the high-level five-year critical path, developed jointly with clinicians, the Integrated Planning Group, and the Year 1 priorities for each of the three programmes. The critical path will be continuously refined and detail added as the CSP programme progresses, and project-level planning is undertaken. The CRGs and other related CSP delivery groups e.g. Theatre Efficiency are developing detailed project delivery plans to underpin the high-level critical path. Alignment to capital plans, including the Morriston Road planning application is also being taken forward.

The Year 1 priorities are included in Appendix 1, however the pace of delivery of these are subject to programme resources being agreed. The Strategy Directorate has realigned existing planning capacity to support clinicians with the planning expertise to deliver the CSP, and corporate directorates continue to align their capacity where available to provide the enabling functions. A recently completed resource assessment has highlighted a range of capacity and capability gaps in key areas. The Transformation Portfolio Board will review an options appraisal for assessing these in the context of the pace of CSP delivery at the July meeting and will make recommendations to the Board in September.

To facilitate patient, staff and stakeholder engagement a draft CSP Communication and Engagement Plan, which builds upon the work we have done to date, including our staff 'Have Your Say' approach, will be signed off by the Transformation Portfolio Board in August.

A range of communication and engagement activities have taken place with staff to encourage engagement in delivering the CSP. This includes a new intranet CSP page which includes examples of successful clinically led projects to deliver the CSP e.g. the Respiratory CRG launch of the COPD community early supported discharge service and the Diabetes CRG roll out of insulin initiation and monitoring in primary care to reduce unnecessary hospital appointments. A Twitter account has also been repurposed to share CSP-related messages (@SBU-Strategy).

Swansea Bay and Hywel Dda University Health Board colleagues are drafting a Regional Clinical Services Plan (RCSP) and have put in place arrangements for both Health Boards to meet to review opportunities for us to collaborate, align and learn from our respective transformation programmes. The draft RCSP will be considered by the Joint Regional Planning and Delivery Committee in August.

3.1 Delivering an IMTP; Setting the Direction

Ten-year Outcomes, as well as five and three year outcome statements setting out the phased progress toward delivery of our Organisational Strategy aims and ambition were approved by the Board in May. Whole System Plans are being developed to deliver these, including our CSP ambitions.

Whole System Plans

The aim of developing Whole System Plans has been to develop overarching plans which set out Health Board's approach to the development and improvement of key

systems in line with the Health Board's strategic direction. This approach moves away from a Unit-based planning process and enables much wider engagement with clinical teams than in previous years. Historically the national NHS Wales Planning Framework has mandated that plans are in place for the main provider service areas and the advice from Welsh Government is that the Framework will not change significantly this year. The approach is in full alignment with the Welsh Government Framework in that regard.

A highly engaged process has been undertaken with Service Improvement Boards, groups and individuals to set out and describe the IMTP process and approach and the links to the Clinical Services Plan and Organisational Strategy, followed by more direct engagement on the development of plans. Engagement on the approach to the IMTP 2020/21-22/23 and the development of Whole Systems Plans has been very successful with consistent and positive feedback received. The response from key teams has been exceptional with engagement on the development of plans including significant numbers from across professions participating in the work to date.

In many cases, e.g. unscheduled and planned care, the Health Board is starting from a good foundation where maturing plans are in place, and the Whole System Plans have developed these existing plans and opportunities. In other areas, e.g. maternity and children's services, teams have been keen to develop refreshed, strengthened plans to respond to the quality and strategic challenges. The draft plans have been shared with the relevant groups for comment and further engagement and development opportunities are taking place to continue the detailed development of the plans. The Plans will be fully reviewed by the Executive Team in July and are included in draft in Appendix 2.

During August work will be undertaken to interrogate the plans from a Quality, Workforce and Financial perspective in order to draw out the impact, changes and opportunities. This work will then inform the prioritisation process in September to develop the fully integrated three-year plan.

3.2 Emerging Common Themes

There have been a number of emerging common themes from the engagement to date on the development of Whole System Plans. Some of the key themes are highlighted below:

Workforce

The desire to review workforce models and skill mix, recruit to vacant positions and ensure the stability of the workforce have been consistent and urgent themes emerging from the engagement. It is not clear if these ambitions are needs-based, affordable or achievable and this will be tested further to explore alternative staffing models, to support sustainability.

Health Promotion and Making Every Contact Count

The importance of health promotion and supporting people to live well and improve their health and wellbeing is clear. In addition, Making Every Contact Count (MECC) as a direct means of supporting this has been highlighted consistently. It is clear from the engagement that there needs to be a greater understanding of the role, purpose and deployment of MECC as well as its broader future potential.

Primary and Community Services
The role and importance of primary and community services in all plans is clear. It is partly for this reason that the Primary and Community Care Whole System Plan will be developed in response to the other plans to ensure a cross-cutting view. The Clusters are an integral part of the plans however, the role of the Clusters has not come through strongly in the plans to date. This will need to be strengthened, to meet the needs of the new Cluster IMTP Framework which has been mandated by Welsh Government.

Integration of Plans
The integrated nature of all systems across the Health Board is evident and there is clearly the will to move toward integrated plans working across operational delivery mechanisms and which recognise the interdependencies between systems. The continued development of the Whole System Plans will therefore, as a core principle, manage and draw out the interdependencies between plans at a whole Heath Board level.

4. CSP and IMTP Next Steps

We are ensuring continued alignment of the CSP and IMTP through the Integrated Planning Group and:

- July
  - Transformation Portfolio Board to agree CSP resource assessment option for discussion with Welsh Government.
- August
  - Undertake an IMTP Workshop on the Digital, Financial and Workforce impacts of the Plans and to test the feasibility and phasing of the Plans in the context of an approvable IMTP and financial plan.
  - Complete reviews of Whole System Plans (e.g. utilising Quality Impact Assessment Panel to review quality impact and implications of plans and develop the Quality, Safety and Patient Experience Plan).
  - Present the draft RCSP to the JRPDC for consideration.
- September
  - CRGs to complete development of detailed CSP project plans to underpin the high level critical path.
  - Implement prioritisation process for the IMTP plans.
  - Present draft IMTP to Board and submit on an informal basis to Welsh Government.

Engagement is ongoing on a monthly basis with Welsh Government colleagues and this now encompasses progress on the CSP and the IMTP. Following receipt of an updated list of Welsh Government policy leads, direct meetings are being arranged with the Health Board leads and Welsh Government policy leads to share and discuss the Health Board's plans and plan development to ensure proactive and thorough engagement on plans. This will be in addition to the ongoing engagement with the Welsh Government Planning Team.

4. GOVERNANCE AND RISK ISSUES

Risks that are specific to delivery of the CSP:

Clinical Leadership

- The clinical leadership approach for the new acute care model within the Networked Hospital programme has yet to be agreed. The scale of the programme of work makes a single leader approach a significant challenge. *Mitigation: options have been discussed with Executive colleagues. Conversations with key individuals are currently taking place and recommendations will be made to the Transformation Portfolio Board in August.*

Capacity and Capability

- Delivery of the CSP requires a wide range of skill sets including strategic, workforce and financial planning and programme and change management expertise. Existing resource has been aligned where possible however there remains a significant resource gap which is slowing the pace and scale of progress. *Mitigation: a resource assessment options appraisal has been developed for consideration by Transformation Portfolio Board. The preferred option will be shared with Welsh Government.*

Risks to developing an approvable IMTP include:

- **An Approved Annual Plan 2019/20** - It is important that the Health Board submits a credible Annual Plan for 2019/20, which can be endorsed by the Board and Welsh Government in order to ensure a solid foundation from which to build. *Mitigation: Discussions are continuing with Welsh Government in the context of in-year performance, the due diligence report and arbitration process. Welsh Government is commissioning external support to test the draft financial plan and to assist the Health Board in identifying opportunities to improve financial delivery, with a view to specifically identifying a pipeline of savings opportunities to incorporate into the IMTP financial plan.*

- **Delivery in 2019/20 –** Future plans are reliant on delivery in 2019/20 in particular in relation to performance and quality targets and financial savings. *Mitigation: The performance management arrangements for delivery of the Annual Plan in 2019/20, have been strengthened into a fortnightly "battle rhythm" and with enhanced reporting to Performance and Finance Committee. Additional mitigations include the development of an internal multi-disciplinary Delivery Team, which is being progressed as a priority to drive improvement. It also includes the external financial support as referenced above.*

- **Timetable –** Developing an approvable IMTP in 2019 will require significant work within a limited timescale. *Mitigation: A detailed project plan has been developed to deliver the IMTP. Every effort is being made to align processes across the Health Board, however if required specific mechanisms and activities will be arranged to ensure planning activities are undertaken in line with the September approval timescale. Welsh Government has indicated that a future TI meeting will focus on the development of the IMTP and this will provide a good opportunity to test expectations.*

- **Refining the Financial Framework –** The Health Board developed a clear methodology to support the 2019-20 Draft Plan, building on recommendations from the Financial Governance Review and WAO Structured Assessments. However, this needs further refinement, particularly on our approach to savings identification and delivery and on a financial appraisal of the Clinical Services

Plan. *Mitigation: The new Value and Efficiency Group is taking a longer term and more structured approach to identifying benchmarking and efficiency opportunities, and the emerging work programme is intended to inform the development of the IMTP financial plan. As mentioned above, the external financial support being commissioned by Welsh Government will provide targeted resources to consider a pipeline of future opportunities. The forward financial model is being developed to move beyond the traditional focus on core income and operating expenditure. This will include a more targeted approach to generating allocative value and the shifting of resources, with an initial focus on the ensuring the sustainability of proposals funded via the Transformation Fund. It will also include, a more comprehensive assessment of opportunities for income generation, as well as the affordability (and required investment) of key projects within the Clinical Services Plan.*

5. FINANCIAL IMPLICATIONS

There are no direct financial implications from this paper however the proposed IMTP approach includes an integrated financial planning process and the CSP a resource options appraisal.

6. RECOMMENDATION

Members are asked to:

- **NOTE** the progress made on delivering the CSP Programme and the IMTP process
- **NOTE** the key risks and challenges
- **SUPPORT** the next steps

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

A Quality Impact Assessment and Equality impact Assessment process will be part of the broader planning arrangements in 2019 to ensure that the IMTP is Quality and Equality impact assessed.

Financial Implications

Financial Planning will be fully integrated into the planning process for 2019, and aligned to key developments and enabling plans. The intention is to move into recurrent financial balance from the start of the IMTP, with a financially sustainable operating model.

Legal Implications (including equality and diversity assessment)

A Quality Impact Assessment and Equality impact Assessment process will be part of the broader planning arrangements in 2019 to ensure that the IMTP is Quality and Equality impact assessed. An approved medium term three year plan is a statutory duty for the Health Board.

Staffing Implications

The planning process for 2019 will include strengthened workforce planning including the involvement of the newly established Workforce and OD Forum.

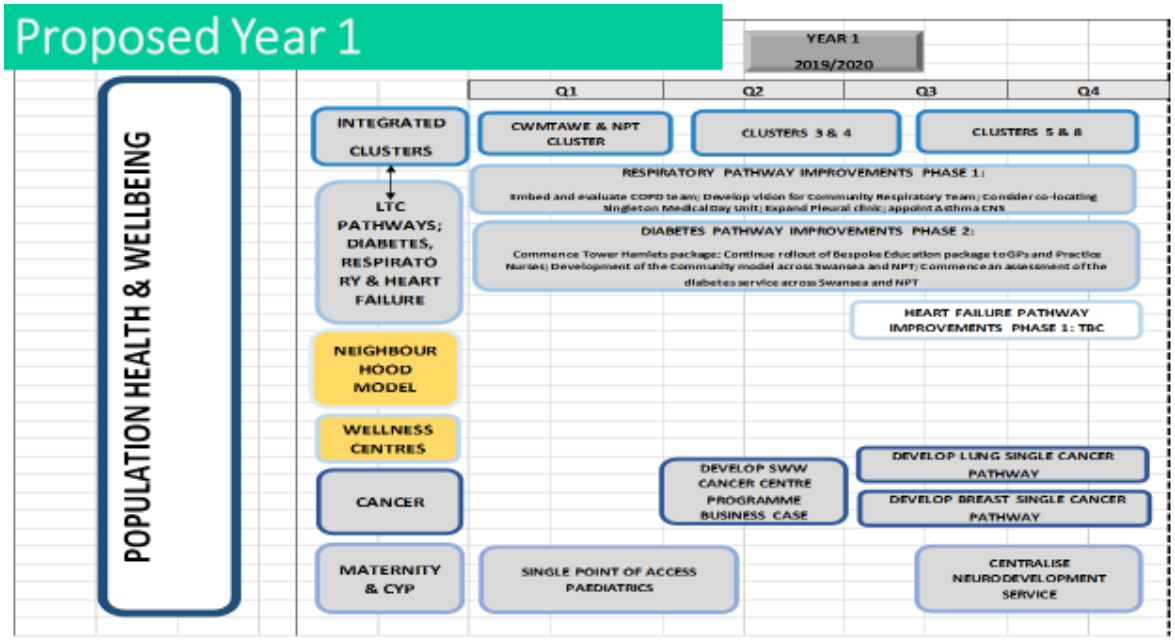
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

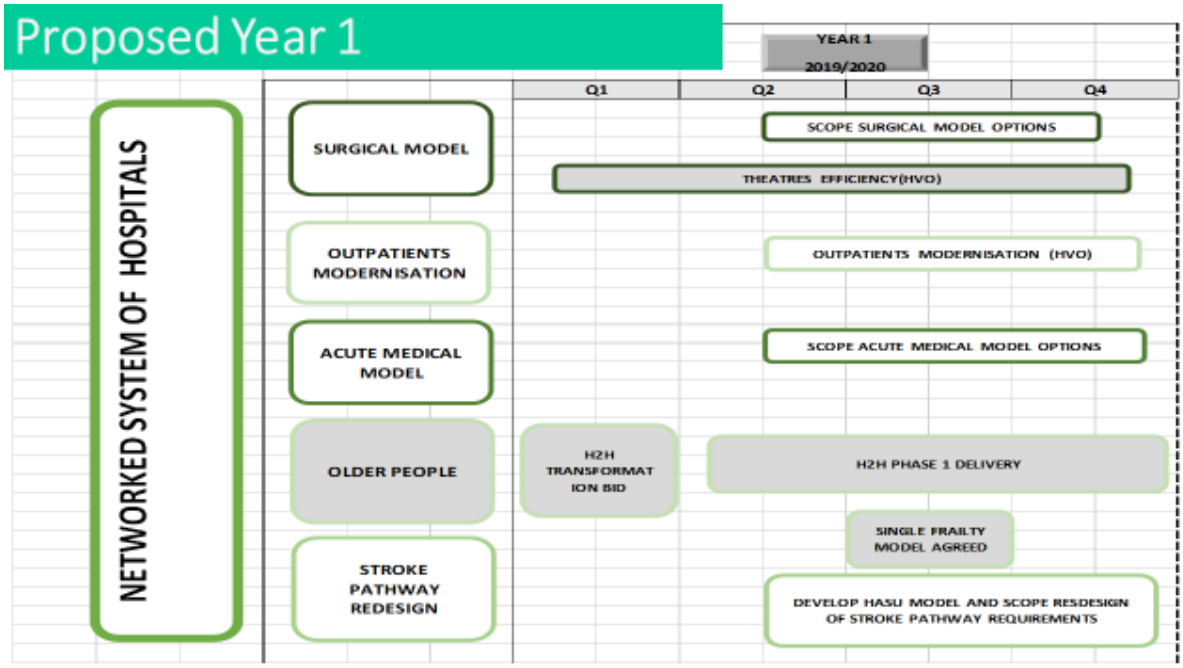
The Clinical Services Plan and Annual Plan deliver our Strategic Objectives which were aligned to our Wellbeing Objectives through the development of the Organisational Strategy.

- **Long Term** – The proposed approach to the IMTP ensures alignment with the long term vision of the Health Board as set out in the Organizational Strategy.
- **Prevention** – The development of the IMTP and the Planning Framework ensure risks and challenges and health needs (current and future) are considered enabling actions and plans to be preventative wherever possible.
- **Integration** – Key to integrated planning is the link and alignment of actions across wellbeing objectives.

o **Collaboration –** Central to the approach to developing an IMTP is the integrated approach across services, units and partner organizations. o **Involvement –** The IMTP development approach includes active involvement of partners.	
Report History	This is a regular bi-monthly report to the Board on progress
Appendices	**Appendices** Appendix 1 – CSP Year 1 Priorities Appendix 2 – IMTP Whole System Plans

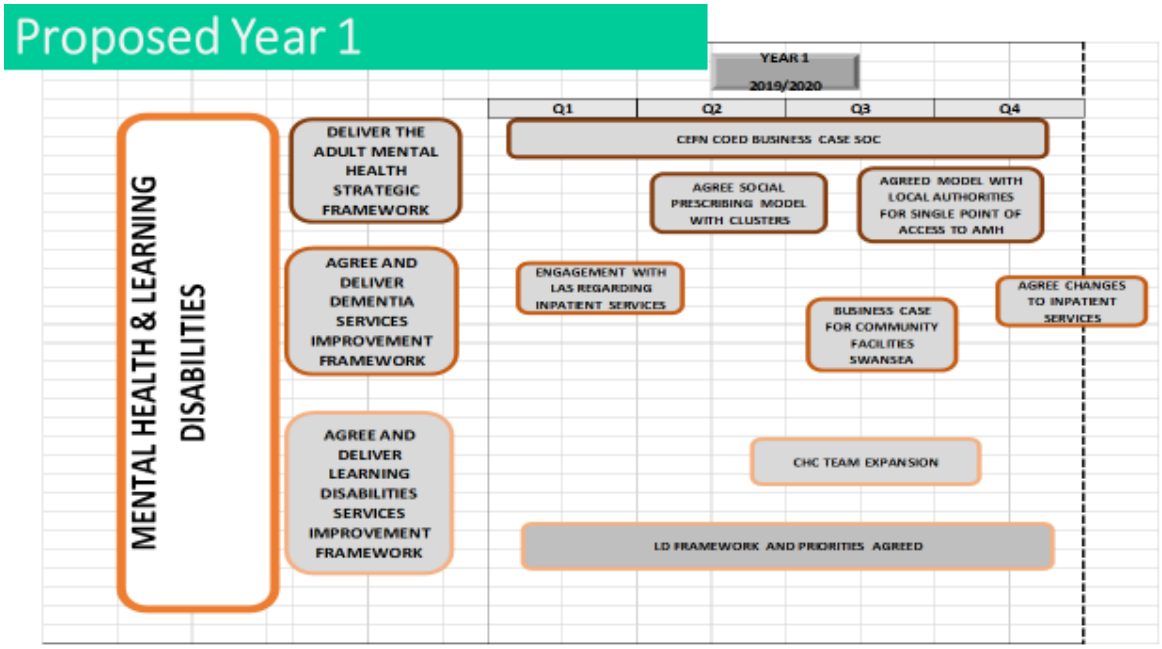
APPENDIX 1 - Clinical Services Plan – Year 1 Work Packages*





*Subject to resources being secured for programme delivery

APPENDIX 1 - Clinical Services Plan – Year 1 Work Packages*



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SYSTEM	PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	ACTION
Planned Care System	Timely access to the most appproriate clinical practitioner to manage the presenting condition	**I know where to go to discuss my condition** **I am able to see the right person quickly at a time and place that's convenient to me** **I am given the information I need to make a personal decision about my care and intentded outcome** **I am quickly referred to the most appropriate healthcare professional to address my condition** **I am kept informed about my progress on my clinical pathway**	Up to date, accessible and easily understandable signposting information Ensuring that local primary care provision is accessible (location and opening times) and provides a wide range of clinical expertise to make an initial assessment of the patient's condition Primary care practitioners are supported and empowered to work the principles of prudent healthcare E-referral route to all healthcare practitioners in a fully integrated way Clear, understandable and accessible clinical pathway information underpinned by a seamless electronic system I am kept informed about the status of my clinical referral in terms of waiting time, location, clinician Services are sustainably "right-sized" to meet the demand being placed into each clinical pathway Access to immediate specialist advice (telephone, telemed, email advice) into primary care	Implement a digital solution based on pathways of care which provides:- •information on services available •ability to book appointments •information on my position on the pathway (tracking) •who to contact for advice •who is currently responsible for my care Ensure that good quality robust information is available to understand how demand is being distributed across the planned care system Ensure that clusters provide a wide range of opening times and services across the population they serve Evidence based integrated system for supporting prudent healthcare delivery Ensure that patients with specialist requirements have access to advice outside of the digital solution Demand and capacity modelling to be undertaken across clinical pathways Explore the potential for clinical interface using digital solutions
	Timely access to modern diagnostic services	**I am informed as to why a diagnostic test is being undertaken** **I receive the diagnostic test in the most appropriate timescale for my condition** **I receive only the test required to provide my diagnosis** **I am informed quickly about the outcome of diagnostic test in a compassionate way by the right person** **I have the next stage of the pathway explained to me and I am progressed on to that next stage quickly**	Coproduction of pathway with patient Primary care practitioners are supported and empowered to work the principles of prudent healthcare Services are sustainably "right-sized" to meet the demand being placed into each clinical pathway Up to date, accessible and understandable information on my clinical care pathway	Evidence based integrated system for supporting prudent healthcare delivery Ensure that clinicians are provided with the time to deliver the right balance of face to face and non face to face communication of outcome Demand and capacity modelling to be undertaken across clinical pathways Implement a digital solution based on pathways of care which provides:- •information on services available •ability to book appointments •information on my position on the pathway (tracking) •who to contact for advice •who is currently responsible for my care
	Timely access to sustainable treatment appropriate to the presenting condition	**I understand and I am supported to prepare myself for my treatment to optimise the outcome and my recovery** **I receive my treatment in a facility appropriate to its clinical requirements** **I receive my treatment in a timely manner without cancellation or rescheduling** **I receive my treatment from the most appropriate healthcare professional** **My treatment will be evidence based, will reflect my personal choice (where possible) and will facilitate the quickest possible recovery time** **I will be discharged in a timely manner with a clear understanding of the ongoing support and treatment in place**	Prehab schemes in place Clinical Services Plan Clinical Services Plan Clinical Services Plan healthcare professionals are supported and empowered to work the principles of prudent healthcare Up to date, accessible and understandable information on my clinical care pathway	Explore and develop a range of pre-admission services to assist with optimisation of the treatment Develop and implement the surgical model Demand and capacity modelling to include bed modelling, workforce, theatre efficiency •Implement BADS 50 •Revisit principles of ERAS Implement a digital solution based on pathways of care which provides:- •information on services available •ability to book appointments •information on my position on the pathway (tracking) •who to contact for advice •who is currently responsible for my care
	Timely access to the most appropriate clinical practitioner to manage the ongoing requirements of the presenting condition	**My ongoing treatment and support is delivered by the right person quickly at a time and place (where clinically appropriate) that's convenient to me** **I am given the information I need to mange my ongoing health and wellbeing needs to maximise the clinical outcome I have previously agreed** **I have flexible access to advice when I need it in a range of outputs**	Service shifts away from traditional follow up care into other settings and via other means	Examples could include •telemed •SOS •email and phone advice •rapid access clinics

SYSTEM	PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	ACTION
Unscheduled Care	**1. Helping people choose and live well**	**I know how to access the right services available to me when I am unexpectedly ill** **I can access immediate advice and support easily and effectively**	Reducing unnecessary hospital attendance	Improve Flu vaccination rates for at risk groups to meet WG targets. Implement the Neighbourhood Model (Cwm Tawe). Roll-out Primary Care Cluster Model.
	2. Helping people with vulnerabilities, learning disabilities or stable long term conditions to support themselves	**I have the tools and knowledge at my disposal to help me when something unexpected happens** **I only have to tell my story once** **I am able to support myself at home and in my community** **I actively manage my conditions and am supported to do so by my health and care professionals**	Reducing unnecessary hospital attendance	Continue multi-agency approach to manage frequent attenders Evaluate and agree recommendations regarding Care and Repair Scheme
	3. Supporting people to remain as independent and well as possible when they have more complex needs	**I get the advice and support I need to live at home quickly and efficiently** **I am able to speak to/access professionals who understand my complex needs when needed** **I am supported by people who understand my needs as an older person** **I am supported effectively and given the right information as a carer of someone with complex needs**	Reducing unnecessary hospital attendance	Review of Acute Clinical Teams and opportunity for improved pathways from community and front door through Keep Me at Home Work stream of OP programme. Standardise ACT model around best practice and right size capacity for rapid response Work closely with WAST to prevent admission Improve diagnostic access within the community to prevent admission Develop a Single Point of Access Implement best practice in caring for patients with dementia across all settings Implement National Dementia Plan
	4. Providing the right type of rapid response, care support at times of crisis	**I am communicated with effectively with regards out of hours visits, ambulance response and treatments** **I can get an urgent GP appointment when needed** **I am treated and discharged quickly and efficiently when appropriate** **I am seen by and treated by the right professionals quickly in relation to my mental health needs** **I have easy access to advice and support for my mental illness or emotional distress**	Ambulance handovers Managing demand at front door	Implement fall response vehicle with WAST (funded through Annual Plan financial Plan) Reduction of longest handover waits Test feasibility of decontamination unit holding to release ambulance subject to agreement on protocols Bespoke Ambulance Liaison role to be explored Frequent Attender lead to be identified with support for benefits realisation Staffing Review – progress Kendal Block work on ED rota's Process Map ambulance handover process Participate in NCCU NEWS project with nursing homes Data availability/validation Mental Health Distress Hub/Sanctuary – new pathways from ED to be explored CAMHS – NCCU to raise CAMHs issues with national and regional on rapid access to assessment Morriston – maximise OPAS and hot clinic alternative pathways Singleton – maximise impact of iCOP investment NPT – TOCALS Strategic review of all front door schemes to test alignment, maximise benefits, make recommendations on a single model for the HB, and implement change Extension of front door models Standardise Frailty model standards of care and ways of working on all sites Comprehensive Geriatric Assessment embedded across in hospital pathways Analysis of the required capacity for Ortho geriatrics and surgical liaison to reduce length of stay.
	5. Providing the best bed based care when needed, but only for as long as it is of benefit	**I am transferred to a bed in a reasonable time following admittance** **I am treated holistically with an understanding of my complex /multiple chronic conditions** **I am discharged with the appropriate services in place so that I can live at home supported and safe** **I am treated and cared for by one team not multiple services** **I am treated in a safe and clean environment** **I am discharged home or to my place of care as soon as I am medially fit** **I receive the medicines and treatment I need for on going treatment on discharge** **I am treated with dignity and respect**	Timely Access to Emergency or Urgent Care & Rebalancing Medical Bed Capacity at Morriston Rebalancing System of Care	Morriston – AMAU, Vascular & #NOF Pathways Morriston – Hot Clinics Singleton – take forward results of bed utilisation survey NPT – moving 4 wards into 3 and changing skill mix to manage patient cohort & improve flow Gorseinon – improved flow & LOS reduction Give Me Good Hospital Care inc SAFER work programme, escalation and patient flow policies Improve Psychiatric Liaison Service to meet national standards Hospital to Home model Review community optimal model to generate efficiencies in working arrangements NPT – Early Discharge Scheme Whole System – COPD Early Discharge Scheme Development of community IV service ESD for Stroke Documentation that is transferable across all parts of the patient pathway - mobilisation in hospitals Centralise the Acute Medical Take at Morriston
	6. Helping people to recover and rehabilitate when leaving hospital after a serious illness or injury	**I am supported to get out and about and feel part of society and valued once I've recovered** **I am given and have access to the information I need on what support is available to me if changes become permanent** **I have access to the information, advice and support I need as a carer when they are discharged**		

Hospital to Home Programme
IMTP 2018/19

SYSTEM	PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	ACTION
	Prevention	**I take responsibility for my own health** **I know my current health status** **I know the risk factors for stroke, the consequences of these risks, my personal level of risk and how to minimise it** **I live a healthy lifestyle and exhibit healthy behaviours** **I can recognise if I or someone else is having a stroke and I know how to respond**	Improved health literacy Behavioural interviewing/ motivational coaching Framework for public health awareness and education Incentivise uptake of healthy behaviours Patient self-monitoring of key health indicators Regular health checks for 'at risk' cohorts from a younger age (MOT) Honest and frank conversations Making every contact count Support and advice available for people to change/improve healthy lifestyle behaviours Alternative/non-medical therapies Access to activities Access to healthy foods Public awareness campaigns tailored to the behavioural/emotional drivers , levels of health literacy and characterises of our unique local culture	Assessment of health literacy needs specific to our population Analysis of behavioural drivers for unhealthy behaviours specific to our population Explore novel ways of communicating and promoting health messages beyond traditional Public Health TV adverts and campaigns i.e. experiential learning, use of artificial intelligence, targeting emotional drivers (i.e. taking stroke survivors in to school), smart messaging on health issues and consequences integrated in to soaps and other popular TV programmes, use of social media and electronic advertising boards in public places Implement a novel and experiential programme of education and learning in school Learning from USA and others re: incentivisation of lower insurance premiums to reward those who exhibit healthy behaviours (monitored by wearable devices)- assess applicability to our NHS system. Buddy up/peer support for those who refuse support Explore benefit of wearable devices in tracking health Explore benefit of self-checks of BP, cholesterol etc. in social venues such as super markets, pubs, parks, leisure centres etc. Health checks integrated in to public places (as above) Integrate in to community venues , work places, job centres Assessment of clinical staff confidence to give frank information on risk and consequence and training if required Roll out training consistently, beyond health care professionals i.e. 'hairdresser referrals' from Canterbury model One stop shop wellness clinics Learn from countries with the lowest preventable stroke rates and highest rates of healthy behaviours Cessation services in the community and integrated in to routine appointments Increased support for drug and alcohol dependant population Explore access and provision/signposting to alternative/non-medical therapies Increase NERs referrals Social prescribing local community assets e.g. walking groups, yoga, leisure centres, park run, time in nature Healthy food only in health and public facilities (lead by example) Work with local providers in the community re: becoming more healthily/corporate and social responsibility /their contribution to health and wellbeing Cooking lessons in school and made available to parents
	Pre Hospital	**I recognise the symptoms of stroke and I know where to go and what to do I'm given the right support, and am kept informed about what's going to happen and how long it is going to take** **I have a plan in place and the support I need for my dependents** **I'm seen quickly by people with the right skills and receive the earliest possible treatment and care** **I'm taken to the right place as quickly as possible** **My destination has the right information** **My family are supported on arrival.**	Proactive and accessible information and education available and promoted Call handlers and responders give correct and consistent information when possible First contact personnel (call handlers/GP receptionists etc.) recognise and respond effectively to the symptoms of stroke At risk and vulnerable people have Urgent Community Support Plans in place Paramedics/HCP provide the right treatment and care Ambulance Capacity available to respond to strokes quickly HASU model in place in SBUHB Effective communication and transfer of information in place between WAST and ED for effective handovers Information and support is consistently made available to family/carers on arrival	Delivery of MECC in particular to those at risk of a stroke Promotional campaigns such as FAST and targeted social media campaigns Education in schools including first aid Local promotion e.g. through involvement of stroke prevention society Defined, clear and up to date pathways are in place Shared education and training on stroke pathways for Paramedics, hospital staff GPs and call handlers Staff (call handlers/GP receptionists etc.) fully trained at recognising the symptoms of a stroke Model of Urgent Community Support Plans collaboratively developed with partner organisations i.e. advance planning Dispatched staff trained and skilled in dealing with strokes Explore enhanced facilities in ambulances including links to specialist decision making Effective triage protocols and training in place Explore implementation of TWIST scheme - wake up strokes Choose well campaign Front door and handover work from USC plan HASU model developed and implemented including direct admission protocols, straight to CT pathways, ring-fenced capacity for stroke including specialist beds, Developing of nurses on Ward F to cover Ed strokes, specialist stroke nurse 24/7 HASU staff developed and teams formed in preparation Consistent and streamlined systems and processes in place in place Pre alert system from WAST/GP in place Open communication channels in place Implement live transfer of information from ambulance to HASU/ED including patient data Family liaison for stroke Stroke passport used PAS team utilised to proved information and support Stroke coordinators CNS in place with communication role at front door
			Provide information and support to individual and family throughout pathway Resources HASU as centre of excellence Skilled decision makers immediately available with capacity to deliver care and treatment	Ensure allocated Key worker roles are in place Visual map of pathways available Proactive planning for discharge and transfer Co-production conversations taking place e.g. ACP/DNACPR SLT facilitated food and drink in ED Develop and implement HASU model Investment in workforce X part of the stroke team and involved at front door Early access to diagnostics

	First 72 Hours	**I want to be kept informed and for my family /carers to receive the relevant information and be involved in any decisions** **I want any investigations I need completed within 72hours and if not someone will explain why.** **I want a confirmed diagnosis and prognosis and action plan** **I want access to the specialists I need** **I want my (and my family's) emotional needs taken care of** **I want to know what's available to me if I am well enough to go home and receive the appropriate treatment and support**		Seamless care pathways and services Ensuring appropriate staff are available an accessible for patients and family members Appropriate space available Identifying and supporting mental health issues Access to timely therapies in place Appropriate discharge process with support		Breakdown silos of care including through collaborative partnership working with Social Services Agreed minimum service specification More acute radiology off Morriston Site Pooled resources Stroke passport Digital case notes Stroke consultants available at weekend and holidays Quiet room for end of life conversations/PEG feeding available Ensure stroke ward areas fit for purpose e.g. pre-empts Investment in therapies and third sector services Rehab ethos when in hospital co-produced with patients e.g. day room Comprehensive assessments undertaken Joined acute and rehab wards for continuity of care Therapies barriers broken down I/P / OIP / Community Dedicated social workers and therapy teams for stroke across the pathway ESD Service in place Stroke specific palliative care services available Dedicated person post stroke for information and support Utilise digital technology/support groups/third sector signposting and providing appropriate support
	Rehab and Life After Stroke	**I want to go home as early as appropriate with the right support and information for both me and my family** **I want effective therapy and support to help me to achieve my agreed outcomes as close to home as possible** **I know what I can do to stop this happening again** **I want a dignified End of Life**		Co-production approach to recovery planning Access to equitable therapies and community support on Discharge Ensuring and enabling good end of life services		Use of digital technology in home or community settings e.g. virtual visits MDT in community services Key worker model Expert patient programme Specialist training across pathways and into social care Stroke specific geriatric workers that can work across teams Early goal planning Clear integrated goal planning with individuals and carers with clear clinical pathways Community stroke services - ease of access Access to specialist support Local areas coordinators / services Ensure access to equipment Access to care homes Pooling of existing teams and resources Protected therapy space/areas on wards from pre-empts and storage Access to psychology support Self management /peer support groups Discharged to assess model Advanced care planning in place Training for staff on End of Life
	TIA	**I want a diagnosis of a TIA and what it is as early as possible** **I want to be kept informed and be given the appropriate information on what happens next.** **I want to get the best treatment, support and advice on how to reduce my risks of this happening again**		Access to seven day TIA clinic/services Access to information and support and services to support health and wellbeing		Adequate staff with appropriate skills in place Ensuring timely referrals from GPs - e-referrals Updated primary care pathways enabling fast track to TIA Clinics Adequate clinics/location for services Access to radiology clinics and access to pharmacy - wrap around services GP education and Cluster TIA champions, Primary Care lead Investigation of further symptoms Capacity and demand modelling Structured review of stroke services and pool resources to one site. Benchmarking of seven day working service, acute stroke rota, nurse prescribers/consultant led TIA clinics Signposting to stroke association Links with pharmacies, ACT, GPS Access to helplines and third sector Appropriate advice and information from all services through training and clear information Life after stroke clinics on TIAs Signposting through TIA clinic on healthy lifestyles, work based health checks and in community settings Use of MECC Agreed action plans developed Use of digital technology - telemed NERS One contact point for TIA Stroke kiosks (learning from Macmillan)
		I wan the opportunity to take part in stroke research		Opportunities to join research including ambulance trails offered		All patients offered opportunities to participate at appropriate times

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CANCER SERVICES	Preventing Cancer	**I don't smoke** **I understand so I make good decisions (Support me - digital)** **I'm given every opportunity to eat well** **I'm given every opportunity to exercise regularly** **I have access to support and advice and information** **I consume alcohol responsibly**	Smoking Cessation Services and advice, information are easily accessible Every contact with the health service is an opportunity to reinforce healthy lifestyle behaviours Vaccinations Information and advice made available digitally self care - medicines management Target health inequalities	Help me quit campaign Smoking cessation services No smoking culture on sites MECC is embedded Brief intervention Vaccination programme HPV PKB - Directed information and support Digital Forums /groups/support/Coaching Needs assessments and targeted intervention Early years healthy behaviours
	Detecting Cancer Early	**I know what to look for and self check** **I have access to screening and attend my screening appointments** **I present early to health services as soon as I have concerns** **I want my health care provider to respond quickly and refer me appropriately** **I know what to expect and feel supported** **I am tested quickly when appropriate** **I was diagnosed early**	Access to Information on how/why Promote and target screening (process for ensuring screening - need to understand HB role?) link to MECC? Early years? GP /Optician access /hours Virtual presentation? Information and support available Rapid Diagnosis(tic) Centre Straight to test FIT Testing MDT & Outpatient Appointments	Awareness Campaigns - National Understand screening processes/management Consider role within MECC Gap training Implement Primary Care Quality toolkit Explore opportunities for Virtual self presentation Primary Care Key Worker?? Information and expectation of pathway Expansion of RDC service (5d/wk.??) One stop shop diagnosis processes for tumour sites - optimal pathways Demand and capacity modelling Improved communication between Primary & Secondary Care Implement FIT Testing Implement optimal pathways Developing & implementing consistent and efficient HB protocols
	Delivering Fast Effective Treatment and Care	**I get the treatment and care which are best for my cancer, and my life (most effective treatment)** **I received treatment quickly and safely** **I receive treatment in the most appropriate setting, close to home as clinically safe and appropriate** **I am supported and have the information I need and I am aware of and am doing the things I need to do to support myself through treatment** **I am treated with dignity and respect** **I know what I can do to help myself and who else can help me**	Precision medicine and modern technology Surgical model Prehabilitation Peer review Optimal pathway No Surgical Cancer Centre Strategy - (Arch) Chemo /haematology at home/outreach/alternative settings Bone marrow transplant Nutrition Access to information, support and advice	NICE guidelines Access to Clinical trials Cancer centre - up to date equipment Demand and Capacity modelling for treatment Gynae oncology model Regional opportunities Service resilience (workforce) Develop and implement model for prehabilitation JC Accreditations Participate in Peer reviews Implement action plans Implement optimal pathways CT Sim PET Scan LINACS Morriston location Ambulatory chemo Surgical re-design Acute oncology services - MSCC pathway Demand and Capacity modelling for treatment Unit expansion Improve nutritional screening within MDTs and earlier in the pathway Pump primed posts for H & N services. Access to video-fluoroscopy Rehabilitation Macmillan cancer service and support service pods Access to services e.g. dieticians Remote monitoring/PKB Expansion of key worker model Access to Clinical Nurse Specialist
	Meeting People's Needs	**My concerns are identified and addressed** **Those around me are well supported** **I can enjoy life** **I feel part of a community and I'm inspired to give something back** **I'm treated as an individual**	Access to information and support Mental health and wellbeing Rehabilitation Concerns and Complaints PROMs Treatment Summaries PREMS	Cancer Alliance (Third Sector) Key worker Offer of HNA Education patient programme Cymru Hope CISS Maggies Tenovus Complimentary therapies TYA (teenager and young g adults with cancer) Tumour site specific AHPs Non Tumour site specific team Capacity and Demand Process for addressing concerns and implementing actions Implement PROMS GP Cancer Care review Interface and communication between secondary and primary care Implement PREMS

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Maternity System	Gynaecology	**I am treated with dignity and respect** **Seen by the most appropriate person with the right skills and understanding** **I am seen in a timely manner at a convenient time and place (Appointments not cancelled)** **I know who to contact** **I have prompt/direct access** **Not in ANC/seen in appropriate, sensitive setting** **Seen in a timely manner** **I have a responsible professional/named nurse/consultant** **I have a named midwife as early as possible** **For other gynae emergencies I have access to a clinician** **I have early access, early contact** **Seen promptly by someone who can help me and give me options to have my problem solved**	Inpatient care HDU/ITU/Different hospital Early pregnancy emergency USS Bloods HcG Vaginal examinations Nurse sonography Other gynae emergencies e.g. DUB clinks available / one stop clinics Prevention of admissions Triage PKB	Px seen by nurse post op/HESW not student A&E HCG on all suspect ectopics Neath/Singleton Abuse of service - route early USS dating of pregnancy Weekend - 7 day service Gynae not on site of A&E New gynae clinic in Morriston 5 days 7 day 9-5 adjacent is ?? Gynae Chronic pain pathways - acute flare-ups Rapid genuine ref to gopd/existing team Resole access to GOPD FUN B Telephone triage for cold gynae refs Virtual clinic -- cons/specialist nurse Stop all W/L New FY rations (depends on clear management plan and adequate time for 1st appt
	Antenatal	**I understand who the professional responsible for my care is** **I have a supportive and informed discussion about my birth options** **I have been informed about and have access to NHS antenatal classes** **The information I receive at NHS antenatal classes is sufficient and helpful** **My antenatal clinic appointments are supportive, and not rushed** **I have the unbiased information I need about birth choices** **I receive and am directed to useful information about my pregnancy** **My partner (or chosen person of support) is involved in discussions and decisions** **I have a named midwife whom I see for all or most of my appointments who is compassionate and supportive.**	Staffing Suitable educator Environment Information availability Process	Recruitment/retention Community midwife to remain in community Skill mix Drs Key personnel/outside agency? Managing expectation of women Privacy Structure of area App/website Appointments to time
	Intrapartum	**I have been supported in my birth place choice** **I have choice about where to birth and am well informed on these choices** **I know where I am going to give birth** **I understand and am reassured about what would happen if an emergency situation occurred in an MLU** **My birth environment is supportive and positive** **If I am transferred to an OLU it is for clinical reasons rather than staffing or internal systems** **I am listened to and only have to tell my story once** **I am given information which is clear and consistent and easy to understand** **I receive timely care** **I receive care in a safe environment**	Sufficient workforce in place Quality environment Effective processes in place	Separation of elective lists in main theatre Increased staffing - midwives/obs/anaes staff to cover EL work Medical staffing to look at separation of gynae/obs cover Move to Morriston Site ITU on site 3rd theatre/review back up theatre Review management of cases to improve flows PN flows NNU influences /Review processes Clear medical decision making plans Review of IOL protocols Staff training/ ?? Central monitoring Champions in CTG - lead
	Postnatal	**I would like a midwife who has the time and energy to give me supportive/compassionate care** **I would like to work in a job where I feel valued and I give good care** **I would like management to listen to concerns**		Breastfeeding - appropriate knowledgeable support Analgesia Wound care single rooms Discharge lounge Day rooms for meals Contraceptive services Next pregnancy information Community on calls for community Hospital not reliant on community Enhanced role for HCSWs Midwives to attend nurse prescribing course Ttos signed on CDC before being transferred to postnatal ward Reassessment of VTE score Postnatally on CDs

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Children's System	Early Years	**My parents are healthy and make positive healthy behavioural choices** **My mother makes healthy choices during pregnancy** **My family is supported and given the right information after birth to make good choices for my health**	Encouraging/ empowering families to be more aware of Public Health issues. Reduce low weight birth through Incl and Reduce complications within pregnancy and ante/postnatal for the mother due to health promotion messages in relation to cessation of smoking, not drinking alcohol, keeping to a healthy weight and having the recommended vaccinations. Babies are born healthy and childbirth is a safe and positive experience for women in the SBUHB Reduction of under 18 conception rates. Increased uptake in the percentage of babies' breastfed at birth and six weeks.	Public Health campaigns MECC (School nurses, Health visitors, Midwives) MECC Alcohol substance misuse services Smoking cessation services Healthy eating/Physical activity (NERS) Vaccination programme Robust Maternity Services Public Health messages (School nursing) Robust Sexual Health services School health nursing promoting Breast feeding Breastfeeding Coordinators delivering direct support Midwives delivering training and support through antenatal classes
	Early Intervention and Prevention	**My mother and I receive fast, effective and safe neonatal care if need** **My family get the information and support they need to provide me with a healthy and happy start to life** **I have opportunities to reach my full potential** **My family and I have access to support and opportunities for fun , play and development** **I have a start to life free of adverse childhood experiences**	Implanting the transitional care unit Ensuring appropriate capacity of critical care across the region Ensuring appropriate skilled workforce requirements to deliver critical care Centralise high risk obstetric and neonatal care co-located with appropriate support services. Engage with local education authorities and public health on all health promotion and prevention campaigns Breast feeding Empowering parents/carers to maximize their skills as we aim to give their children the best start. This will include working in partnership with local authority to support families with employment and housing issues. In collaboration with partners in the Local Authority working to support the achievement of improved readiness for school, increased educational attainment reducing inequalities and improved employment opportunities Every child (0-7 years) and family within SBUHB will receive the Healthy Child Wales Programme, along with a range of assessments Work in collaboration with local authority to reduce the number of children in need of protection.	Complete build Increase the uptake of scheduled vaccination of children up to the age of 4yrs. Reduce the percentage of young people who smoke and drink alcohol by participating in the HBSC survey. School health nursing promoting Breast feeding Breastfeeding Coordinators delivering direct support Midwives delivering training and support through antenatal classes Identifying and addressing needs at an early stage can help to prevent the difficulties that they can experience from arising. Promotion of healthy eating and increasing physical activity for children and young people to encourage a healthy weight and reduce obesity. Early identification of speech, language & communication development and any other developmental delays access to services at a universal and targeted level Family Resilience Assessment Tool, Perinatal Mental Health Assessment Domestic Abuse Inquiry monitoring of child's growth and development. Promotion of Joint working / commissioning with local authority to assist in addressing risk factors early. Increase in the uptake of joint training opportunities Early identification of any additional needs / disabilities to ensure that children and young people reach their full potential and contributing to the additional learning needs process (Additional Learning Needs Bill 2016). Early identification of children where there are safeguarding concerns and referrals to appropriate services to work collaboratively with services to ensure that their wellbeing needs are holistically met (Social Services Wellbeing Act 2016).
	Safety, Wellbeing and the Health of school aged children and Young People		To work in partnership with the LEA and schools to support learners with additional learning needs from 0-25 years Offer opportunities for engagement and support recognize the needs of the individual and support them to achieve and Ensuring the framework for School Nursing and the Healthy Child Wales Programme is equitable Build multidisciplinary and multi-agency networks among professionals to support the best outcomes for children and young people Support healthy behaviours and choices.	implement the Additional Learning Needs and Education Tribunal (Wales) Bill. Establish the role of Designated Educational Clinical Lead Officer (DECLO) as required by the ALN Bill. Facilitate School Health Nursing Service staff to work in partnership with multi-disciplinary and multi-agency colleagues to ensure the best possible outcomes for children and young people in whatever setting they receive their education including EOTAS pupils and pupils who are electively home educated. Act as advocates in line with the NMC Code, the School Health Nursing Service will support the lobby to make registration of all electively home educated children and young people compulsory and inspection of the education content provided. Implement the Healthy Child Wales programme Analysis of data to ensure that support can be provided early Raise awareness of services available by helping to join them up and drive improvements for children and young people. Facilitate these networks to ensure all professionals feel supported Work with Western Bay Youth Offending Services to develop access for children and young people to assessment and intervention from speech and language therapy services as appropriate. Behaviour training on a multi professional basis. This would include agencies such as police and youth offending teams Vaccination programmes Implement Healthy Child Wales Programme Engagement with the Prevent programme to raise awareness of the risk of radicalisation School nursing programmes working with LEA to ensure healthy choices encouraged in the schooled
	Keeping Children and Young People Safe	**I have the right to be kept safe from abuse, neglect and other forms of harm** **If I ever need, I know where to go to get help if I am exposed to any form of abuse or harm** **I'm made safe and taken to a place of safety if required.**	We will work in partnership with other agencies to safeguard children and young people Ensuring safe and competent workforce to regsonise and deal with children exposed to any form of abuse Support and implement the SARC regional Plan We will ensure that arrangements are in place for the prevention, protection and support of children and families experiencing any form of gender based violence, domestic abuse and sexual violence. This will include Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), Honour Based Violence (HBV), Human Trafficking and Female Genital Mutilation (FGM). We will provide a safe environment for children and young people and consider the Rights of the Child in line with the UNCRC in the provision of all our services.	We will ensure that arrangements are in place to consider the impact on children and young people living in an environment where they are exposed to mental illness We will ensure that arrangements are in place to consider the impact on children and young people living in an environment where they are exposed to substance misuse. We are committed to learning lessons from reviews and following any concern raised We will have clear governance arrangements in place for safeguarding children and young people. Ensure advocacy service available and actively offered for children Community Paeds vacancies filled Appropriate training Appropriate nursing resource in place Identify and develop appropriate site for SARC service Develop and implement new model for SARC services We will provide safe clinical care to children and young people. We will ensure that arrangements are in place to meet the statutory requirements for Looked After Children (LAC). Ensure Implement risk assessments for young people admitted to adult services
	Children and Young People with Complex Conditions	**Early identification and assessment** **Receive the right, timely care in the most appropriate setting** **Effective and safe transition of care to adult services** **Appropriate end of life care as appropriate**	MDT approach in place to identify complex needs Ensure safe timely and effective care is in place	Implementation of revised care pathways which reduce mortality and morbidity and promote self-management for common long term conditions. Children with a long term condition participate in the development of, and have an up to date copy of their care pathway which will be shared with all care providers (including schools) and delivered in a coordinated way. Pain and symptom management to ensure that severe pain and other adverse symptoms are kept under control e.g. spasticity management Access to timely therapy assessment and intervention as appropriate. Timely access to specialist equipment e.g. seating, sleep systems and communication aids. Skilled in-reach and outreach workforce to avoid admission and facilitate early discharge Development of specialized nursing and therapy posts. Registered and unregistered workforce.

		Appropriate end of life care as appropriate **My family is supported and given the information and opportunities for respite they need.**		End of life care and support is in place		All healthcare staff dealing with children and young people with long term conditions in any care setting, to be encouraged to have a working knowledge of the latest information and communicate appropriately with children and their families. Advance care planning to ensure that families receive the support and care they need in a timely manner. This will include fast track continuing care packages. Psychological and counselling support for both the child and the family. Continue to develop jointly funded posts with partner agencies and ensure appropriate evaluation. Develop appropriate transition model at speciality level for community care End of life care including provisions for the child to die in their own home, if this is their choice access to support from Ty Hafan. Bereavement support for the family during and following the child's death.
Emotional Health and Wellbeing		**I will have access to appropriate skilled professional to support my health and wellbeing**		Ensure effective local service for children and young people with Neurodevelopmental conditions Ensure effective local primary CAMHS services in place Ensure Crisis support is in place Effective transition to adult services CAMHS		Appropriately resource the NDC service Implement the all wales referral pathway Work with children and families to provide appropriate post diagnostic support Joint working with Local authority and CAMHS to support the above, including the development of training packages. Development of joint working with local authority Development of training packages. Review management structure for Crisis Intervention Teams Western Bay Plan
Timely care and treatment for children and young people who are acutely unwell		**My family/carer has the information and advice necessary to care or me when I'm ill and if necessary am taken to the right place in a timely manner** **I'm seen by the right person on arrival** **If necessary I'm admitted to the right inpatient facility where I receive safe and effective care** **My family is supported throughout my admission and able to stay with me where appropriate** **I'm discharged with the right support and advice to the right place in a timely manner**		Work with primary and community health services partners to promote care at home, with adequate support and advice, for common less serious childhood illnesses and injuries. WAST service trained and skilled to manage paediatric emergencies Development and implementation of the Single Point of Access for Paeds Ensure medium term sustainability of acute paed services		Choose well campaigns / 11 GPs given appropriate advice and support including email advice line GPs included in development of acute [paediatric care WAST included in development of acute paediatric model Agree scope of model Develop detailed model including workforce and design Maintain out of hours rotas Improve ED environment (medium term solution) Develop specialist nurse input/workforce to improve support to families and CYP