Meeting Date	**29 July 2021**	**Agenda Item**	**3.2**
Report Title	**PROGRESS ON DEVELOPING THE RECOVERY AND SUSTAINABILITY PLAN**		
Report Author	Kirstie Lambert (Strategic Planning Manager) Ffion Ansari (Head of IMTP Development) Karen Stapleton, Assistant Director of Strategy		
Report Sponsor	Siân Harrop-Griffiths, Executive Director of Strategy		
Presented by	Siân Harrop-Griffiths, Executive Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	To provide an update on the development of the Health Board's Sustainability and Recovery Plan including the approach and arrangements and the timescales for production and engagement.		
Key Issues	The Health Board needs to develop a Recovery and Sustainability Plan to enable its clinical services and financial position to be sustainable in the longer term. The Plan will provide the vehicle for delivering the Clinical Services Plan, and be the basis for securing an approved IMTP for 2022/23 onwards. A Recovery and Sustainability Working Group has been established to provide assurance and oversight of the development and of the Plan and includes Independent Board members. This paper sets out the approach and arrangements for developing the Plan and presents an overview of the products required, the current status and work completed to date. A detailed timeline for developing the plan is outlined and the phasing and the requirements at stage were confirmed by the Recovery and Sustainability Working Group on 26th May 2021.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☐	☒
Recommendations	Members are asked to:			

	• **NOTE** the work completed to date to develop the Sustainability and Recovery Plan and the next steps • **AGREE** the Recovery and Sustainability Plan will be considered by the Board in December 2021

DEVELOPING THE HEALTH BOARD'S SUSTAINABILITY PLAN

1. INTRODUCTION

This report provides an update on the development of the Health Board's Recovery and Sustainability (R&S) Plan outlining for discussion and review, work completed for the period May / June 2021 and the next steps.

2. BACKGROUND

The Health Board (HB) is not a clinically or financially sustainable organisation, due to numerous factors including its clinical services model, efficiency of services and the way in which it allocates its resources. The Health Board has an Annual Plan for 2021/22 which was submitted to Welsh Government on 30th June 2021, and has a statutory duty to develop an approved Integrated Medium Term Plan (IMTP) from 2022 onwards. It will not be in a position to do this without a Sustainability and Recovery plan which covers all elements of our services and expenditure. Welsh Government have recently confirmed that they will be requiring the preparation of IMTPs for 2022/23 onwards as part of Health Board's statutory responsibilities.

A Recovery and Sustainability Working Group has been established, chaired by the Chief Executive, with Independent Member and Executive Director membership, and the scope, approach and arrangements for developing the Plan were agreed at the first meeting on 29th April 2021. Developing and implementing the Plan will require a whole system focus with clinical leadership and engagement.

The way in which the Health Board uses all of its assets, and procures all of its services, will need to support the development of the sustainability plan. The plan is necessary in order to:

- ensure service and financial sustainability for the Health Board
- provide the vehicle for implementing our Clinical Services Plan
- provide the vehicle for delivering the Clinical Services Plan, and be the basis for securing an approved IMTP for 2022/23 onwards.

In developing the plan there will need to be ongoing engagement with all our stakeholders.

3.0 DEVELOPING THE RECOVERY AND SUSTAINABILITY PLAN

3.1 Approach and governance

A Recovery and Sustainability Working Group has been established to provide assurance and oversight of the development and of the Plan. This Working Group will be supported by the IMTP Executive Steering Group IMTP (ESG) and the Integrated Planning Group (IPG) that will oversee the detailed work required to develop the R&S Plan.

The process for developing the Plan will need to be dynamic and efficient in order to effectively develop and bring together the required products. There will be multiple interdependent work streams progressing simultaneously and the timelines for developing the plan are tight when consideration is made for adequate engagement.

Developing and implementing the Plan will require a whole system focus with clinical leadership and engagement. Progress has been made on this in recent months, however, it is recognised that this is a changed way of working and support is required. The CSP principles of clinicians leading the planning of services, with the support they require alongside them is one that will mature.

There will be a clear programme approach to developing the Plan, using as far as possible, existing arrangements e.g. – Urgent and Emergency Care Board/Quality and Safety Forum etc. Each of these groups would have two roles: implementing the 2021/22 plan; and developing the service models for the R&S Plan

These will be used as Task & Finish Groups – with broader clinical engagement as required. Each will be required to provide proposals to a broader clinical group (extended Management Board) to focus on:

- What the system would look like if it was better integrated and patient centred - if time (of the patient and staff was the unit of currency we're measuring)
- Shift focus to a wellness and prevention model and reallocate resource accordingly
- The priority actions to deliver the CSP in the next 3-5 years
- The best practice we need to adopt
- The top "vital priority" to improve leadership and performance
- How we can use data to drive change

The Integrated Planning group, with membership from Strategy/Finance/Digital (BI)/Workforce/PMO/ will drive the work and develop the Plan.

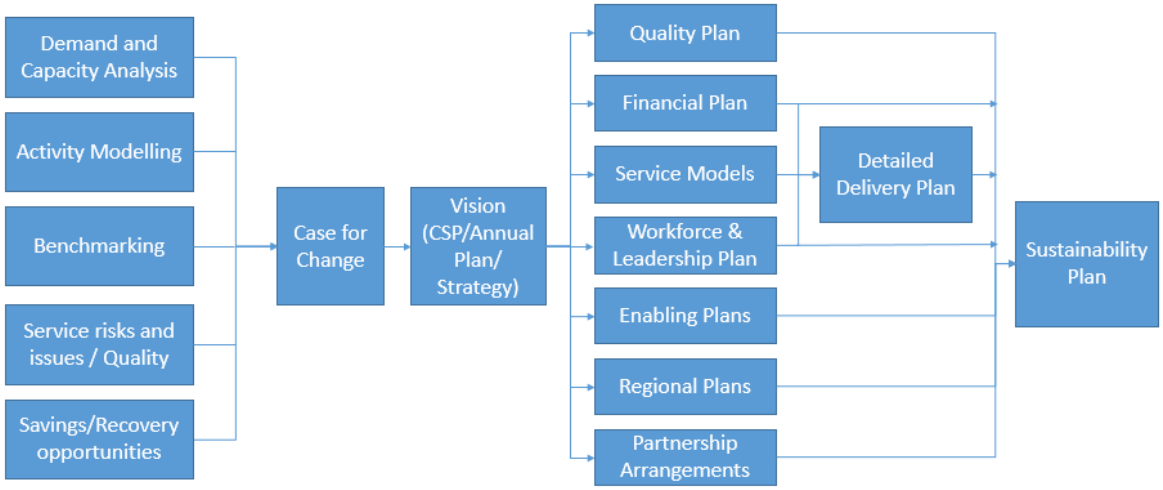
Much of the information to inform the production of the plan is already available. The key elements which require additional work are:

- Confirmation of the reasons for the underlying deficit
- Confirmation and amalgamation of the evidence to support the required changes – pulled from existing evidence available to the Health Board
- Considering the utilisation and allocation of resource and outcomes to be achieved.
- Robust demand and capacity modelling to confirm ability to deliver
- Development of the population health strategy to provide the basis upon which we can understand our ability to do more to keep our population healthy, and shift resources to early intervention, during the lifespan of the Plan.
- Further development of the clinical service models to build on the 2021/22 Annual Plan over the duration of the Plan and the impact of these on finance/workforce/capital
- Finalising the capital elements to enable production of the Strategic Portfolio Business Case

Engagement on the plan, both internally and with stakeholders, will be in line with existing mechanisms used by the Health Board. Depending on the proposals in the Plan, there may also be a requirement for public engagement/consultation on service changes. There will be ongoing engagement with the Board during the course of developing the Plan at the following touch points:

- In- committee/Board briefing session on service models – Sept 2021
- In- committee/Board briefing session to prepare Board before approval in Dec – Nov 2021
- Special Board meeting in mid-December to approve the Plan prior to submission to WG 31st Dec

An overview of the high level process for developing the plan is set out below:



3.2 Sections and Products

The plan will include the following sections:

1. Strategic Context
2. Past and Current Performance
3. Quality Plan
4. Service Development Plans
5. Financial Plan to Secure Sustainability
6. Workforce and leadership plans
7. Partnership arrangements
8. Regional plans
9. Enabling plans
10. Risk
11. Governance

To develop the above sections a number of products will be needed. Some of these are already in place and will need strengthening or refreshing others will need to be developed.

3.3 Timescales

The phasing of the plan development has been set out in four phases.

A diagram of the phasing and timings is attached in **Appendix 1**. More detailed planning will continue to be developed to set out the process and requirements for individual products.

4. WORK COMPLETED TO DATE AND NEXT STEPS

Phase 0 – Establishing arrangements and Governance

- **Complete**

- The Board has been engaged on the development of the Sustainability & Recovery Plan, including a Board briefing session on July 22nd.
- The Draft Planning Principles for the Sustainability & Recovery Plan were presented to Sustainability & Recovery Working Group for consideration. The broad approach was endorsed and presented to the Board as part of the Board briefing session. Included in **Appendix 2.**
- The Draft Programme Plan and Product Log were endorsed by the Working Group.
- Welsh Government has advised that the National Planning Guidance is expected to be developed over the summer. It is anticipated that priorities will not change significantly, however in advance of receiving the guidance a piece of work analysing previous guidance, policies, programme for government and Ministerial priorities has been undertaken. This analysis will ensure that we can anticipate the new guidance with confidence and ensure that the breadth of requirements are understood.
- A communications and engagement plan has been drafted and is being reviewed and further developed. The communications plan will ensure that all necessary partners, stakeholders and interested parties are included in the development of the plan appropriately.

Next Steps

- Liaise with Leads to further develop the products and sub-products within the Programme Plan and Product Log. This will allow progress updates at a more granular level, as well as providing further opportunities to identify interdependencies **(July/August).**
- 'Touchpoints' with WG will be established across the year to ensure appropriate engagement and WG buy-in **(August).**
- The Communications and Engagement Plan will be agreed and established **(August).**

Phase 1 – Developing Cases for Change

- **May - July**

- Development of the Cases for Change was initiated in May 2021, with the Urgent and Emergency Care (UEC) and Planned Care Cases for Change drafted. Evidence of the case for change was also presented to the Board to demonstrate the approach that will be taken. Information for Planned Care will be available in mid-July which will impact on the timings for engagement and service model development.
- The cases for change have been shared with key leads to initiate discussion on the development of service models.
- Work has also commenced on developing evidence packs for Cancer services, Mental Health, and Children and Young Peoples and Maternity Services.

Next Steps

- The data transfer from Lightfoot needs to be reviewed and an understanding of the data developed so that we are confident that we are using the right data for the right service areas **(August).**
- The cases for change will be made widely available and further active engagement will be undertaken to communicate and discuss the learning and implications
- Analysis of clinical services through sustainability lens to consider services we need to invest/disinvest **(July / August).**

Phase 2a – Developing Service Models

- **July - Sept**
- Work has commenced on developing the Service Model and Detailed Delivery Plan Frameworks which will include agreed 3 year deliverables.

Next Steps

- Continued engagement with service areas via programme Boards will take place and mechanisms for developing service models and delivery plans will be established (workshops, working groups etc.) The Service Model Framework will be shared with programme areas for completion **(August/September).**
- Two workshops will take place in August and September. The first workshop with Primary Care Clusters will seek to define the future role of clusters in the context of 'hospitals only doing what only a hospital can do'. The second workshop will then outline delivery model visions and key actions required for four key areas: Mental Health, MSK, Diabetes and Frail Elderly. The choice of these four models is based on clinical areas identified by primary care as offering the greatest opportunities to 'rethink' existing system/service models. **(August/September).**

Phase 2b – Developing Enabling Plans

- **Aug - Sept**
- Leads across enabling plan areas (Digital, Capital, Workforce, Finance) have been engaged to develop processes that will support the development of enabling plans in parallel to service model development. Work is underway to develop supporting information to include the opportunities and constraints that will inform the development of service models

Next Steps

- Enabling plans will be developed in parallel to the service plans, both informing the development of service models and responding to their requirements. **(August/September).**

Phase 3 – Bringing together the Plan

- **Sept - Nov**

Next Steps

- Finalising the plan and ensuring interdependencies are addressed and producing an outline of the Final plan **(September- November).**

Phase 4 – Board Sign Off

- **Dec**

Next Steps

- While confirmation of the timelines for submission of the Integrated Medium Term Plans to Welsh Government has not yet been confirmed, it is anticipated that plans will be submitted in December 2021 or January 2022. It is therefore proposed that a Special Board meeting is convened in December to sign off the Sustainability and Recovery Plan to be submitted with associated requirements in the form of an IMTP to Welsh Government **(December).**

3.0 GOVERNANCE AND RISK ISSUES

- Risk to the development of the plan are being managed in the R&S RAID Log.
- The plan will support the Health Board to address key risks and set in place plans which respond to and mitigate those risks.
- The plan and its development will ensure the consideration of Quality and Equality impacts through employing the appropriate processes and assessments.

4.0 FINANCIAL IMPLICATIONS

There will be four phases of work to support the financial work within the Sustainability Plan

1. Validate Health Board underlying deficit
2. Develop a composite savings opportunity list and a pipeline of future opportunities using intelligence already available
3. Develop a range of opportunities through an allocation, utilisation and outcome approach
4. Understand the Investment and Disinvestment consequences of any strategic service vision which details financial sustainability, improved quality, patient experience, service excellence and better outcomes for people.

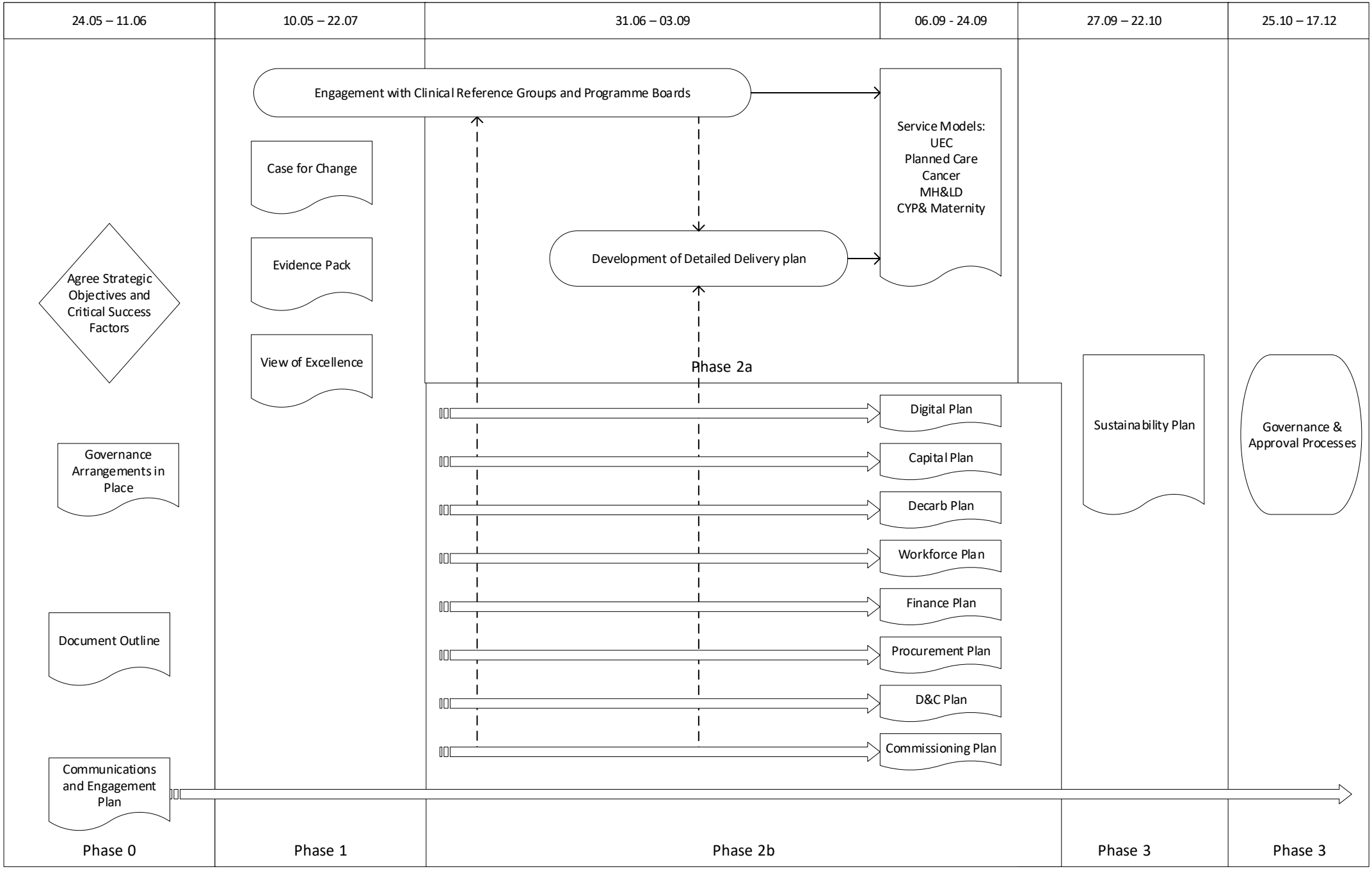
The Finance Delivery Unit are working alongside the Health Board as a critical friend, a source of constructive test and challenge on opportunities, alternative perspectives and the developmental work required on resource allocation, utilisation and outcomes.

5.0 RECOMMENDATION

Members are asked to:

- **NOTE** the work completed to date
- **AGREE** the Recovery and Sustainability Plan will be considered by the Board in December 2021

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		
No direct implications of this report, however the Sustainability Plan is predicated on improving quality, safety and patient experience.		
Financial Implications		
No direct financial implications of this report, see financial implication section for detail on developing financial Sustainability Plan		
Legal Implications (including equality and diversity assessment)		
A Quality Impact Assessment and Equality Impact Assessment process will be part of the broader planning arrangements to ensure that service models detailed in the Sustainability Plan are quality and equality/ diversity impact assessed.		
Staffing Implications		
No direct impact outlined in this report however there will be significant staffing implications as a result of new service models outlined in the Sustainability Plan – risks and implications to workforce form an integral part to planning arrangements.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
As outlined in the report, development of the Sustainability Plan will involve a refresh of our Strategic Objectives which will be aligned to the WBFGA and five ways of working.		
Report History		
Appendices	Appendix 1: Programme phasing and timings Appendix 2: DRAFT Planning Principles for the Sustainability & Recovery Plan	


24.05 – 11.06
10.05 – 22.07
31.06 – 03.09
06.09 - 24.09
27.09 – 22.10
25.10 – 17.12
Engagement with Clinical Reference Groups and Programme Boards
Service Models:
UEC
Planned Care
Cancer
MH&LD
CYP& Maternity
Case for Change
Evidence Pack
View of Excellence
Development of Detailed Delivery plan
Agree Strategic Objectives and Critical Success Factors
Governance Arrangements in Place
Document Outline
Communications and Engagement Plan
Phase 2a
Digital Plan
Capital Plan
Decarb Plan
Workforce Plan
Finance Plan
Procurement Plan
D&C Plan
Commissioning Plan
Sustainability Plan
Governance & Approval Processes
Phase 0
Phase 1
Phase 2b
Phase 3
Phase 3

Goal	Work package	Action	Action	Status	Week 14-Jun (1)	21-Jun (2)	28-Jun (3)	05-Jul (4)	12-Jul (5)	19-Jul (6)	26-Jul (7)	02-Aug (9)	09-Aug (10)	16-Aug (11)	23-Aug (12)	30-Aug (13)	06-Sep (14)	13-Sep (15)	20-Sep (16)	27-Sep (17)	04-Oct (18)	11-Oct (20)	18-Oct (21)	25-Oct (22)	01-Nov (23)	08-Nov (24)	15-Nov (25)	22-Nov (26)	29-Nov (27)	06-Dec (28)	13-Dec (29)	20-Dec (31)	27-Dec (32)
Establish the governance and project management arrangements nececsary to ensure effective and efficient development of the plan	Strategic Direction	0.1	Agree Strategic Objecitves	Ongoing																													
		0.2	Agree Critical Success Factors	Ongoing							28-Jul																						
		0.3	3 Year Deliverables	Ongoing							28-Jul																						
	Project Arrangements	0.4	Project Plan agreed	Ongoing		21-Jun					28-Jul																						
		0.5	Product Log agreed	Ongoing		21-Jun					28-Jul																						
		0.6	Approval Timline agreed	Ongoing					14-Jul																								
		0.7	Establish Working Group Arrangements	Ongoing		21-Jun																											
	Document	0.8	Examples and guidance researched	Ongoing																													
		0.9	Service Model Framework Developed	Ongoing							28-Jul																						
		0.1	Detailed Delivery Plan Template Developed	Ongoing																													
		0.11	Document outline developed	Ongoing																													
	Communications & Engagement	0.12	Stakeholder Analysis	Ongoing		21-Jun																											
		0.13	Communications Timeline agreed	Ongoing							28-Jul																						
Developing the Case for Change and the evidence to support the development of the service models	UEC Case for Change	1.1	Collate available information on UEC system and service for Case for Change	Ongoing																													
		1.2	Case for change shared with Managemetn Board	Ongoing						21-Jul																							
		1.3	Case for change endorsed by SWG								28-Jul																						
		1.4	Board Briefing on Case for Change	Ongoing						22-Jul																							
		1.5	Case for change engagement UEC Board	TBC																													
	Planned Case Case for Change	1.4	Collate available information on Planned care system and service for Case for Change	Ongoing																													
		1.5	Case for change shared with Management Board							21-Jul																							
		1.6	Case for change endorsed by SWG								28-Jul																						
		1.7	Board Briefing on Case for Change							22-Jul																							
		1.8	Case for change engagement PL C Board	TCB																													
Phase 2a - Developing the Service Models																																	
Development of the service models through engagement with programme Boards and Clinical Reference Groups	Whole System	2a.1	Workshop: Role of Integrated Clusters	Not Commenced									11-Aug																				
		2a.2	Workshop: Developing a Sustainable System	Not Commenced									12-Aug																				
	UEC Service Model & Delivery plan	2a.3	Developing ServiceModel	Not Commenced																													
		2a.4	Developing Detailed Delivery Plan																														
		2a.5	Sign Off Service Model and Plan																														
	Planned Care Service Model & Delivery plan	2a.6	Developing ServiceModel	Not Commenced																													
		2a.7	Developing Detailed Delivery Plan																														
		2a.8	Sign Off Service Model and Plan																														
	Cancer Service Model & Delivery plan	2a.9	Developing ServiceModel	Not Commenced																													
		2a.10	Developing Detailed Delivery Plan																														
		2a.11	Sign Off Service Model and Plan																														
	MH&LD Service Model & Delivery plan	2a.12	Developing ServiceModel	Not Commenced																													
		2a.13	Developing Detailed Delivery Plan																														
		2a.14	Sign Off Service Model and Plan																														
	CYP & Maternity Service Model & Delivery plan	2a.15	Developing ServiceModel	Not Commenced																													
		2a.16	Developing Detailed Delivery Plan																														
		2a.17	Sign Off Service Model and Plan																														
Phase 2b - Developing the Enabling Plans																																	
Development of enabling plans which will need to commence alongside the development of the service plans	Digital Plan	2b.1	Opportunties and Constraints	Ongoing							28-Jul																						
		2b.2	Work with Services to develop Service models																														
		2b.3	Sign Off Plan																														
	Capital Plan	2b.4	Opportunties and Constraints	Ongoing							28-Jul																						
		2b.5	Work with Services to develop Service models																														
		2b.6	Sign Off Plan																														
	Workforce Plan	2b.7	Workforce Plannign Principles developed								28-Jul																						
		2b.8	Work with Services to develop Service models																														
		2b.9	Sign Off Plan																														
	Finance Plan	2b.10	Finance Planning Principles developed	Ongoing							28-Jul																						
		2b.11	Work with Services to develop Service models																														
		2b.12	Sign Off Plan																														
	Procurement Plan	2b.13																															
		2b.14																															
		2b.15																															
	D&C Plan	2b.16																															
		2b.17																															
		2b.18																															
	Commissioning Plan	2b.19																															
		2b.20																															
		2b.21																															
Finalising the plan document and ensuring interdependencies are addressed		3.1																															
		3.2																															
		3.3																															
		3.4																															
		3.5																															
Taking the Plan through appropriate Boards and Committees prior to submission in form of IMTP to Welsh	Approval by Quality & Safety Committee	4.1																											23-Nov					
	Financial Plan Approval by F&P Committee	4.2																											23-Nov					
	Approval by Managemetn Board	4.3																												01-Dec				
	Approval By Board	4.4																															
	Submit to Welsh Government	4.5																															20-Dec	

Plan Section	Product Required	Sub Product	Exec Owner	Lead Author	Deadline	Status	Week																															
							14-Jun	21-Jun	28-Jun	05-Jul	12-Jul	19-Jul	26-Jul	02-Aug	09-Aug	16-Aug	23-Aug	30-Aug	06-Sep	13-Sep	20-Sep	27-Sep	04-Oct	11-Oct	18-Oct	25-Oct	01-Nov	08-Nov	15-Nov	22-Nov	29-Nov	06-Dec	13-Dec	20-Dec	27-Dec				
							1	2	3	4	5	6	7	9	10	11	12	13	14	15	16	17	18	20	21	22	23	24	25	26	27	28	29	31	32				
Strategic Context	Health Board Profile description		MH	FA																																		
	Strategic Objectives	Critical Success Factors	SHG	FA/KB																																		
		3 Year Deliverables	SHG	FA/KB																																		
	Clinical Services Plan		SHG	KB																																		
	Case for Change		SHG	KB																																		
	Population Health Strategy		KR																																		
	Role of Health Board description		SHG	FA																																		
	External Drivers		SHG	FA																																		
Past and Current Performance	Activity Performance		DG																																		
	Financial Performance		DG																																		
	Benchmarking		DG																																		
Quality Plan	Priorities and Actions		CW	ND																																		
Service Development Plans	UEC Plan	ServiceModel Framework	RM																																			
		Detailed Delivery plan	RM																																			
	Planned Care Plan	ServiceModel Framework	RM																																			
		Detailed Delivery plan	RM																																			
	Cancer Plan	ServiceModel Framework	RE																																			
		Detailed Delivery plan	RE																																			
	MH&LD Plan	ServiceModel Framework																																				
		Detailed Delivery plan																																				
	CYP & Maternity Plan	ServiceModel Framework	RM																																			
		Detailed Delivery plan	RM																																			
	Population Health and Wellebing Plan		KR																																		
Financial Plan to Secure Sustainability	Financial Plan	Financial Planning Principles	DG	GN	21/07/2021																																	
			DG																																		
Workforce and Leadership Plans	Workforce Plan	Workforce Planning Principles	DWOD	MD	21/07/2021																																	
		Workforce Priorities (People Plan)	DWOD																																			
		ServiceModel Workforce Implications	DWOD	MD																																		
		Workforce Risks	DWOD	MD																																		
		Workforce IMTP Templates	DWOD	MD																																		
		Education and Commissioning Templates	DWOD	MD																																		
Partnership Arrangements	Outline Arrangements		SHG	FA																																		
Regional & Partnership Plans	C&V UHB Joint workplan		SHG																																			
	HDdUHB Joint workplan		SHG	KS																																		
	CTMUHB Joint workplan		SHG	IL																																		
	ARCH Joint workplan		SHG	SC																																		
	HEIW Joint workplan		SHG	MD																																		
	WAST Joint workplan		SHG																																			
	WHSSC Joint workplan		SHG	HR																																		
	RPB Joint workplan		SHG	JAD																																		
	PSB Joint workplan		SHG	JAD																																		
Enablilng Plans	Demand & Capcity																																					
	Capital		SHG	SD																																		
	Digital		MJ	DR																																		
	Procurement																																					
	Decarbonisation Action Plan		SHG	KB																																		
	Commissioning		SHG	HR																																		
Risk	Risk Management Approach and Organsiatioanl Risks		PW																																		
Governance	Organisational Governance Arrangements		PW																																		
	Internal Commissioning Arrangements		SHG																																		
	Socio-economic Impact Assesment																																				
	Equality Impact Assessment																																				
	Bay Way - Service Change Arrangements																																				

Meeting Date	**21 June 2021**	**Agenda Item**	
Report Title	Draft Planning Principles for the Sustainability & Recovery Plan		
Report Author	Kerry Broadhead, Head of Strategy Ffion Ansari, Head of IMTP Development and Implementation		
Report Sponsor	Sian Harrop-Griffiths, Executive Director of Strategy		
Presented by	Kerry Broadhead, Head of Strategy Ffion Ansari, Head of IMTP Development and Implementation		
Recommendation	Members are asked to: • CONSIDER the proposed planning principles, developed to inform subsequent phases of the Sustainability & Recovery Plan.		

Planning Principles

When developing and making decisions on the Sustainability & Recovery Plan 2022-27 the following planning principles will be considered;

- **Delivering our responsibilities as an Anchor institution**: to improve population health and wellbeing, and a greener, cleaner, fairer more equal Swansea Bay
- **One system of care**: pathways of care beginning with the principle of home 1st
- **Better together**: creating strong partnerships, delivering regional solutions, based on highly engaged approaches with the public, our partners and staff
- **Right Care Right Place:** delivering care that maximise digital, technology, estate utilisation and innovative solutions
- **Prioritisation:** reducing harm, improving Q&S, delivering outcomes that matter to people, delivering value and driving performance excellence
- **Workforce:** prioritising wellbeing, operating within constraints, creating new innovative models and roles that prudently respond to health need
- **Building Resilience**: addressing short term challenges through long term sustainable solutions to enable recovery and future proof our services
- **Responding to COVID**: proportionately enabling escalation responses to be embedded into business continuity

DRAFT

SBUHB Sustainability & Recovery Plan 2022-27

Urgent and Emergency Care Case for Change

Complied June 2021 by;

Kerry Broadhead, Head of Strategy (Kerry.Broadhead@wales.nhs.uk)

Charlie Mackenzie, Head of SLR & External Commissioning (Charlie.Mackenzie@wales.nhs.uk)

BETTER HEALTH | BETTER CARE | BETTER LIVES

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Bae Abertawe / Swansea Bay University Health Board

IECHYD GWELL | GOFAL GWELL | BYWYDAU GWELL

Context

Purpose of this Case for Change;

- To provide a single reference source of available information on the SBUHB Urgent & Emergency Care system/services
- To provide relevant information to draw upon for those, communicating, engaging on and redesigning Urgent & Emergency Care services
- To be a 'live' resource up-dated as new information emerges

What this Case for Change covers;

- Evidence: why we need to change Urgent & Emergency Care services
- Excellent Services: our vision and changes to Urgent & Emergency Care services
- Benefits of improving Urgent & Emergency Care services
- Consequences of not improving Urgent & Emergency Care services
- How we will deliver the changes to Urgent & Emergency Care services

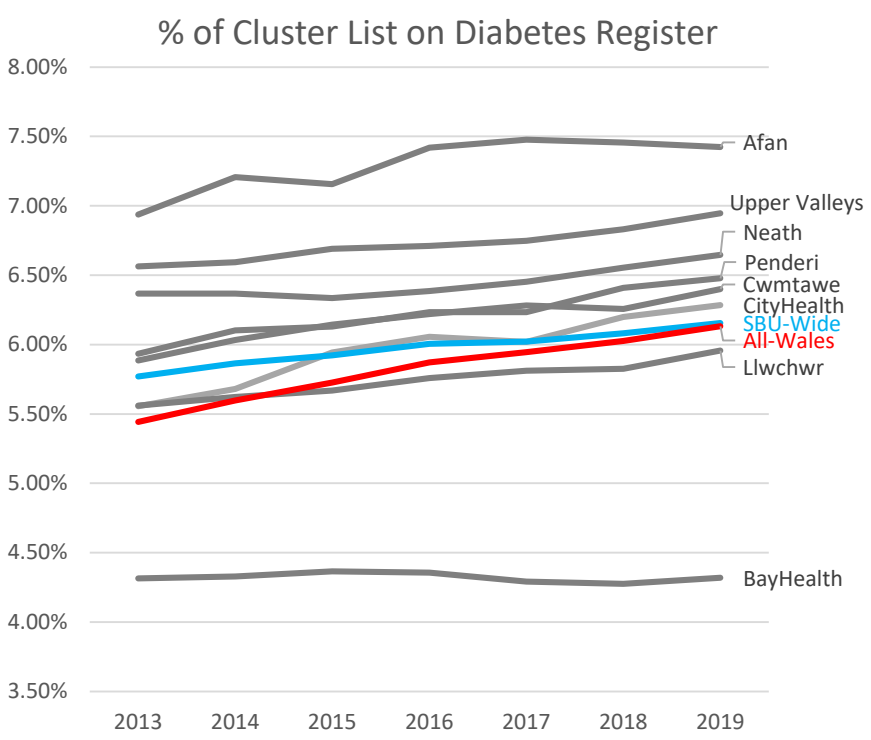
Why Change: Population Health

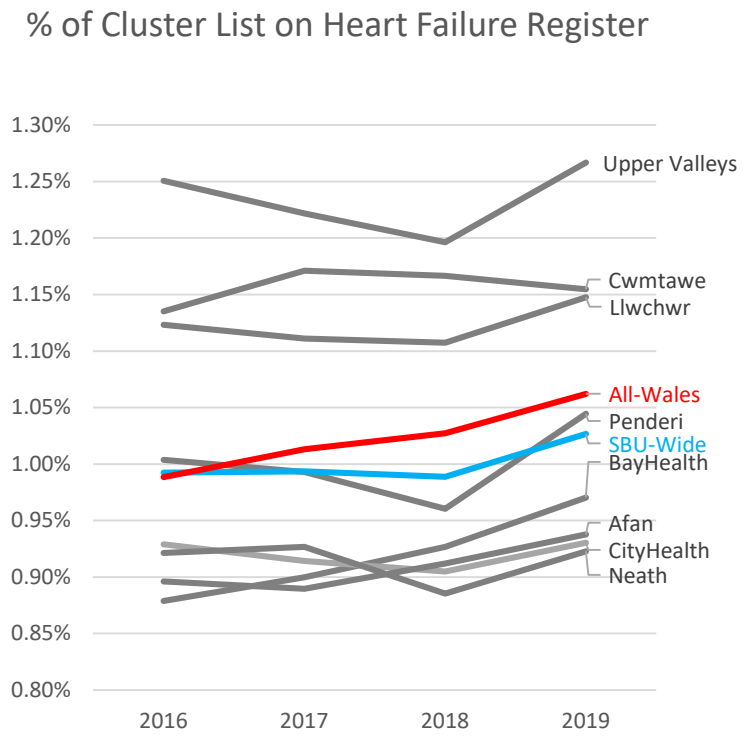
- **Population Changes:**
  - Swansea Bay population forecast to increase by 4.48% by 2035
  - Most substantial rise is in 65-84 year olds followed by the over 85 year olds
  - One quarter of the population has a long-term condition & one quarter of people over 60 have two or more
  - By 2030 11% of our population will be diabetic

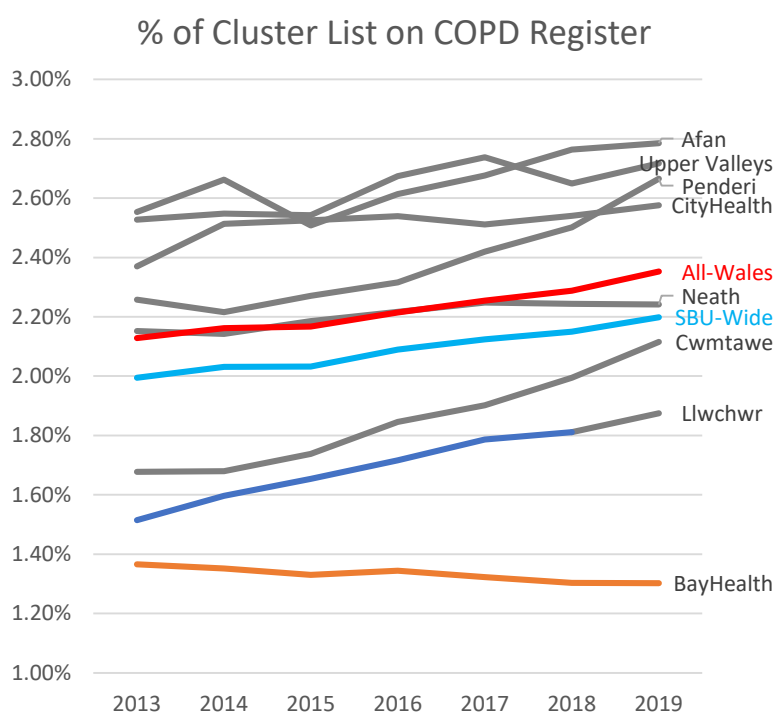
2020 to 2035 Population Change	
Aged 15 and under	-1.80%
Aged 16 to 64	1.42%
Aged 65 and over	19.30%
Overall	4.48%

- **Health outcomes**
  - Living longer increases age-related and long term conditions
  - Diabetes can increase complexity of care needs and is the most common co-morbidity of hospitalised patients in SBUHB
  - Rising frailty increases loss of independence: 45% of over 65's live alone, 1:3 will fall and of these one in 1:3 will move into long term care
  - An ageing population increases use of multiple medicines (polypharmacy) which can have risks associated with unintended incorrect use including risk of falls
  - Between 30-50% of medicines prescribed for long-term conditions are not taken as intended and are a contributory factor to people being admitted to hospital
  - Frail people admitted to hospital are more likely to experience a detrimental impact on their overall health the longer they stay in hospital

Why Change: Population Health







- SBU has more deprived communities than average for Wales with over ¼ of our communities falling into most deprived category
- Areas of deprivation are particularly in urban parts of Swansea, NPT and upper valley communities
- As well as increasing prevalence of chronic conditions there is significant variation within SBU clusters.

A patient perspective - current

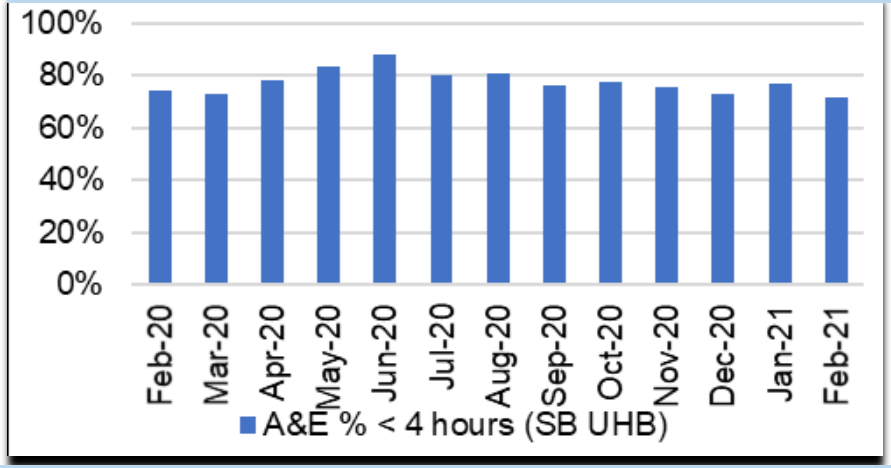
Mary is 68 years old and has bronchitis.

She wakes up in the night coughing with a shortness of breath.

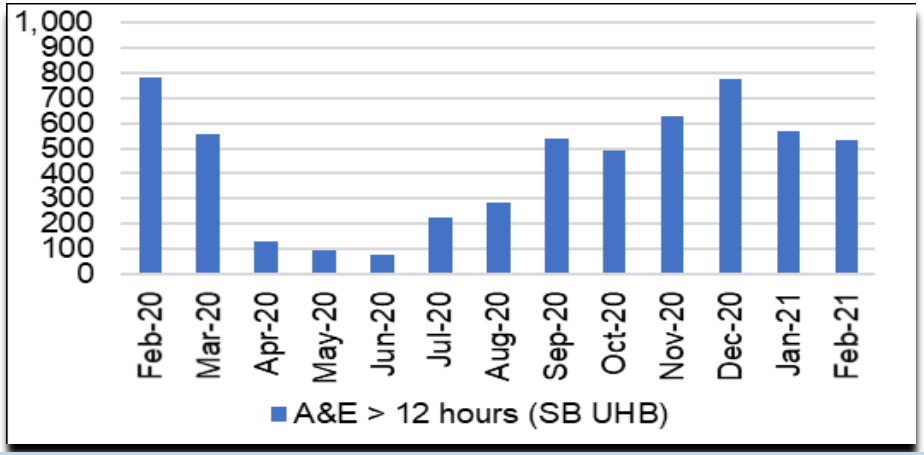
I woke up coughing and short of breath.
I phoned 999.
The paramedics were nice.
They did some tests and calmed me down but thought I needed to go to hospital.
I waited a long time outside A&E and, in the end, I had to stay in.
Unfortunately, I got another infection and stayed in hospital for a week.

Why Change: Patient Experience

Up to 30% of patients consistently wait more than 4 Hours to be seen in the ED

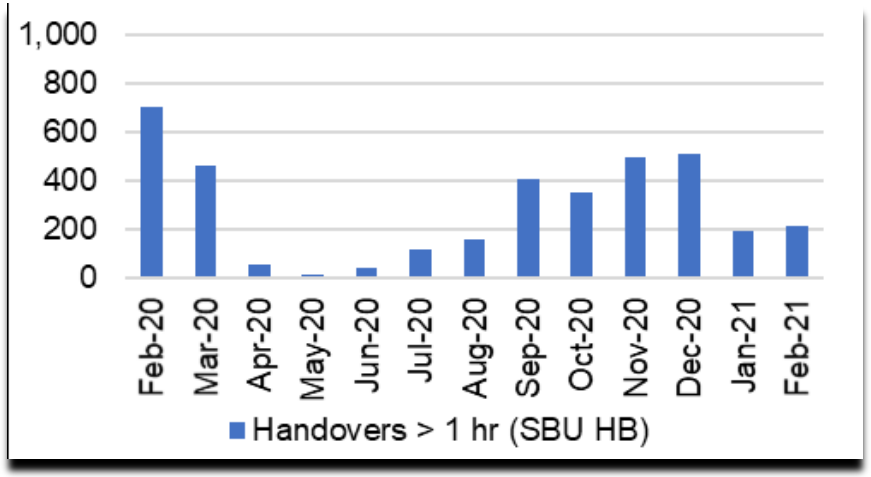


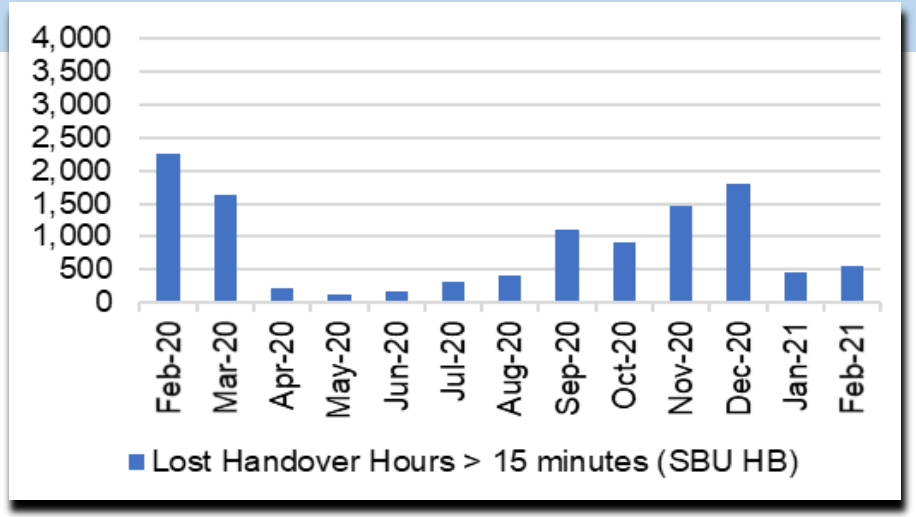
Increasing numbers of patients are waiting more than 12 Hours to be seen in ED



The data suggests this is a return to pre-COVID patient waiting times for Emergency care

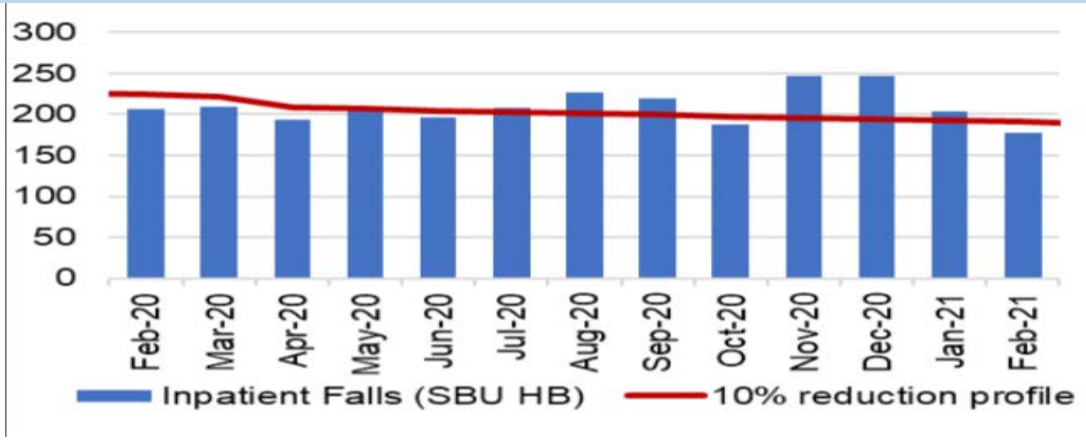
… increasingly ambulance crews spend over 1 Hr handing patient care over to the ED team and as a consequence are delayed in responding to new patient call outs



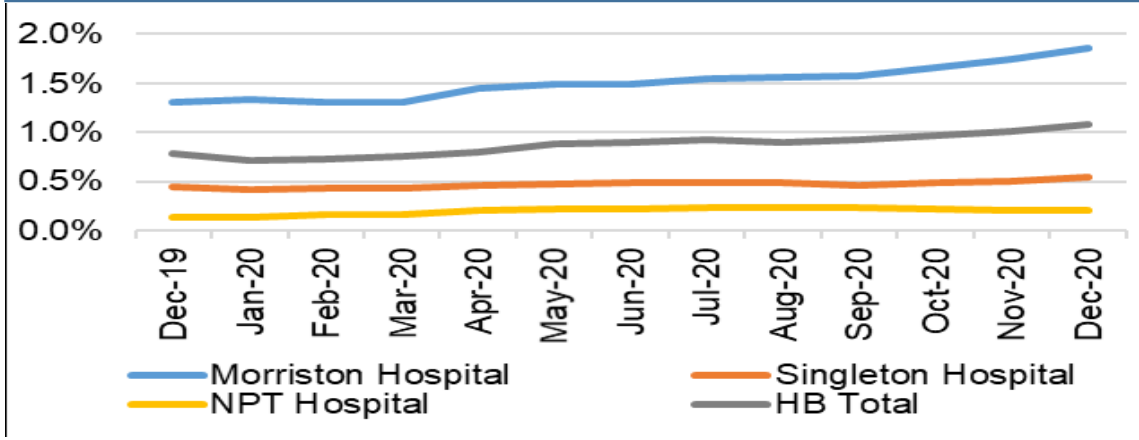


Why Change: Patient Experience

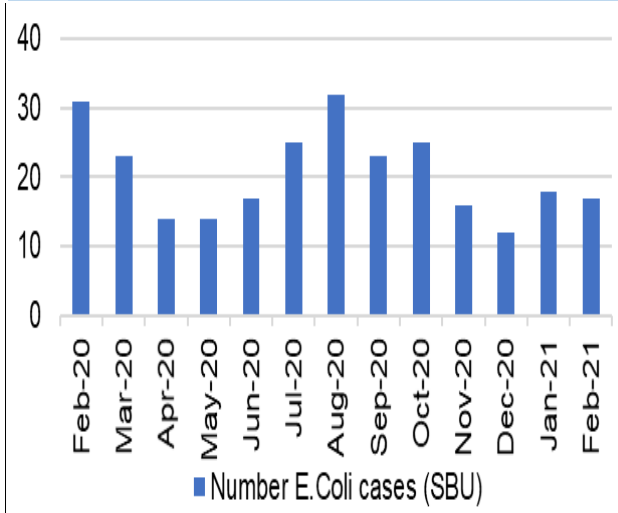
Around 200 inpatients per month fall on our hospital sites

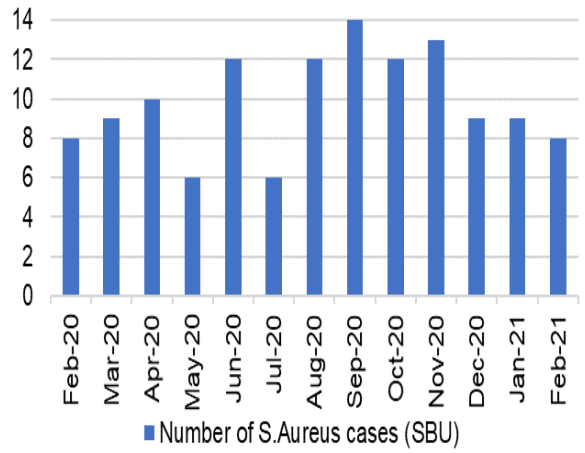


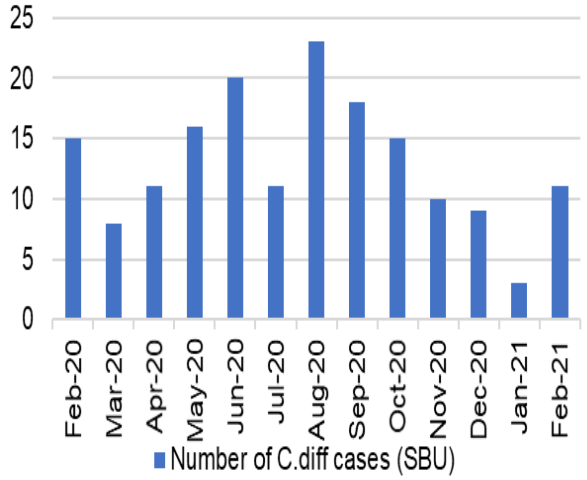
Increasing % of crude hospital mortality rate (74 years of less) in all our hospital sites

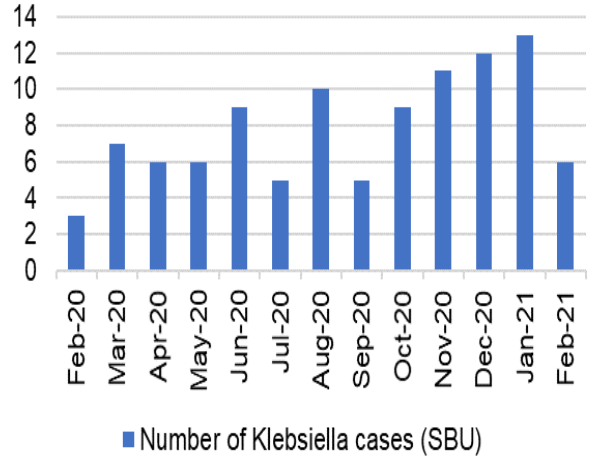


Healthcare acquired infection rates, e.g. E.Coli, S.Aureus, C.Diff and Kiebsiella cases remain high throughout the Health Board









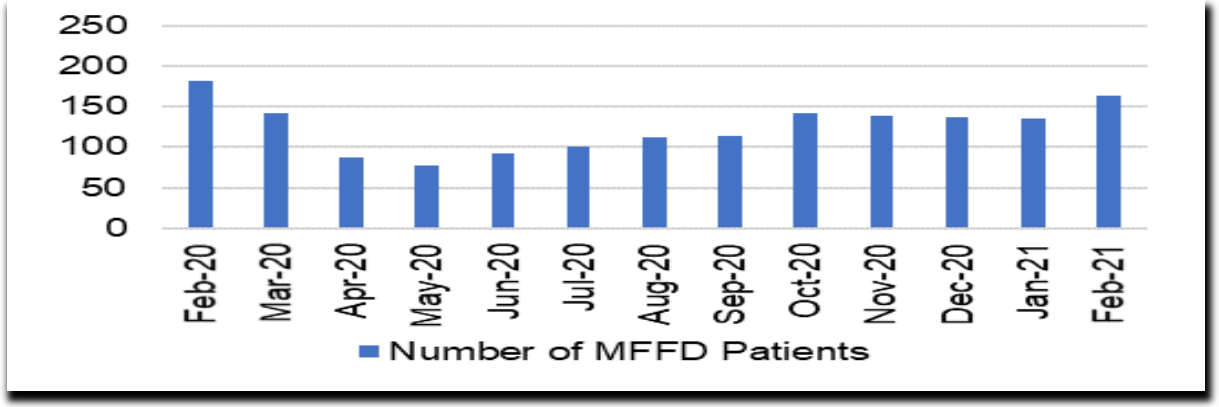
Why Change : Clinical Services Models

- Clinical Services Plan identified system challenges as;
  - Heavy **reliance on hospital** based Urgent & Emergency Care services results in long & unnecessary patient waits
  - Insufficient senior **clinical decision makers** at the front door to assess patients quickly
  - Lack of fully functioning **AEC & AMAU services** to provide same day discharge or short stay care
  - Under developed **integrated frailty & older persons pathway** to respond to levels of need
  - Insufficient level of **community services** and skill mix in workforce to avoid unnecessary admission and support timely discharge
  - Under developed **whole system pathways** across primary/ community services and secondary care to support long term conditions management and reduce patient emergency exacerbations
  - Insufficient **use of available technology** to support patient activated care and provide timely clinical expertise and decision making
  - Overly high **medical admissions & lengths of stay** resulting in delays & cancellations in patient access to elective care
  - Insufficient access to **timely and rapid diagnostics** to support accurate diagnosis and appropriate care first time

Why Change: Clinical Service Models

Evidence indicates excessive bed utilisation compared to benchmark data equating to 250 beds
The variation is being driven by 'Back Door' and 'In Hospital' patient Flow (average lengths of stay)

As of Feb 2021 over 160 medically fit patients were waiting to be discharged home (this is back to pre Covid levels)…



High Levels of Medical Outliers

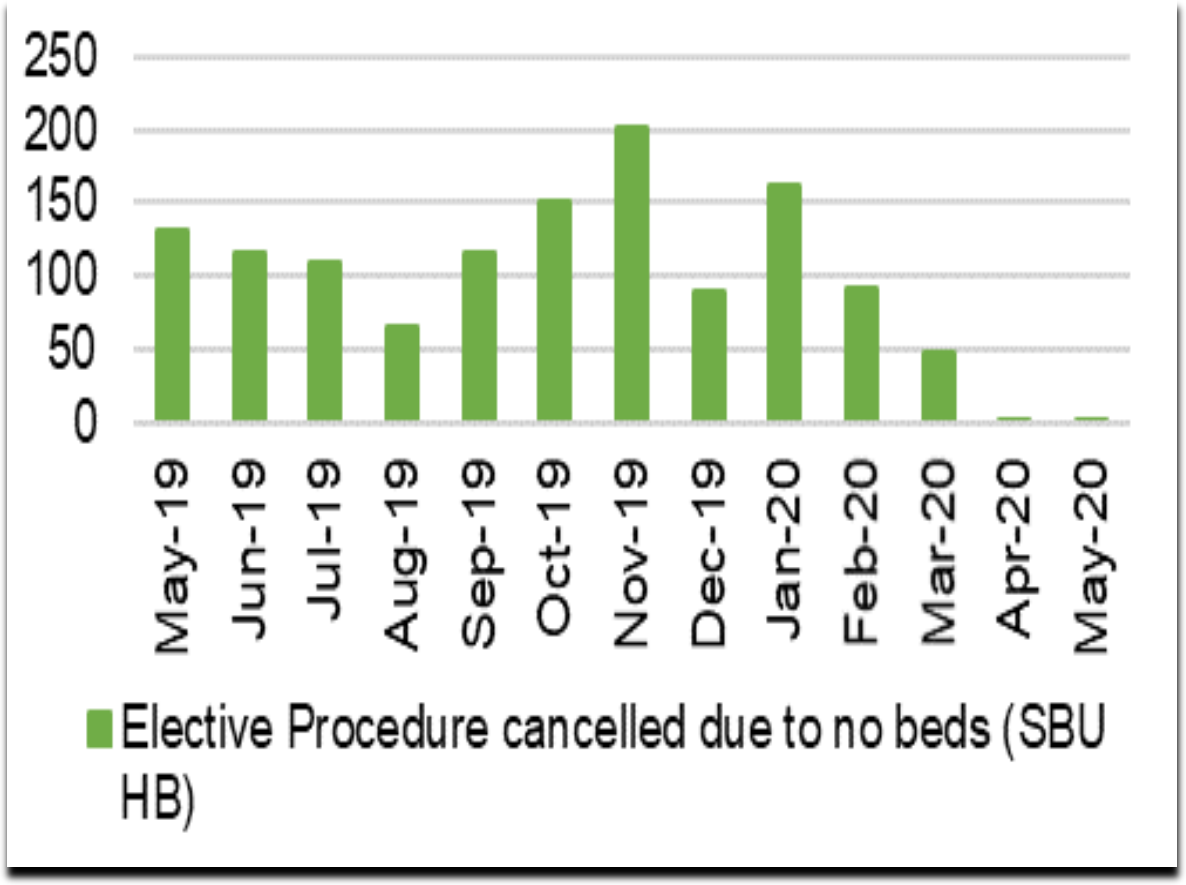
	Funded Beds	1920 Ave Occ	Occupancy %ge
Singleton	196	242	124%
Morrisiton	194	251	129%
NPT	104	114	109%
Gorseinon	36	36	101%
Total	530	643	121%

Variation in in-hospital flow by key pathways expressed as Beds :

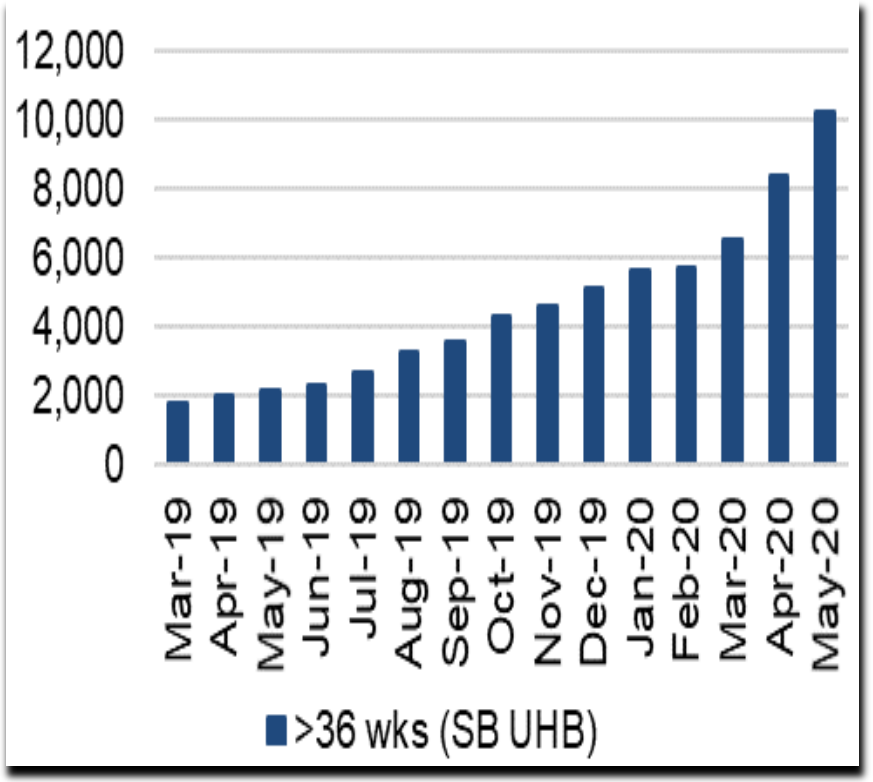
Top 10 HRG Groups - Non Elective	Bed Equivilent
DZ11: Lobar, Atypical or Viral Pneumonia	23.42
EB03: Heart Failure or Shock	12.81
WH09: Tendency to Fall, Senility or Other Conditions Affecting Cognitive Functions	10.50
AA35: Stroke	10.47
FD10: Non-Malignant Gastrointestinal Tract Disorders	8.75
LA04: Kidney or Urinary Tract Infections	8.54
AA26: Muscular, Balance, Cranial or Peripheral Nerve Disorders, Epilepsy or Head Injury	7.04
DZ65: Chronic Obstructive Pulmonary Disease or Bronchitis	6.16
EB07: Arrhythmia or Conduction Disorders	5.81
LA07: Acute Kidney Injury	5.04

Why Change: Clinical Service Models

The variation in acute 'back door' and 'in-patient' flow impacts on elective patient flow through lack of available beds for patients booked to receive planned care (pre-COVID)….



…and contributes to increased patient waiting times for planned procedures (pre-covid)



Why Change : Clinical Service Models

Fragility of Services – there are a number of areas where significant (i.e. high or moderate) risks have been identified either in relation to clinical risks or workforce risks.

Type	Clinical Practice, Clinical Audit, Alerts	Compliance with legislation and Statutory/regulatory inspections	Environment, Estates and Infrastructure	Financial Management	Governance and Assurance	Health and Safety	Health Promotion & Protection	Information Governanace and Communicati on	Medical Devices, Equipment &Supplies	Patient Safety	Risk Profiling of Incidents, Complaints, Claims	Sustainable Services	Workforce & OD	Grand Total
Morriston Hospital Service Delivery Unit	1	4	17	4	5	8		3	49	8	1	52	32	184
Singleton Hospital Service Delivery Unit		11	16	2	6	6		1	10	8		29	18	107
Primary and Community Services		8	2	2	2	2		5	4	5		20	24	74
Mental Health and Learning Disabilities Delivery Unit		2	2	1	1	6		1		7		4	4	28
Corporate Medical Director			4	2	1			13	1			6		27
Operations (previously Planning)		2	10		1							8		21
Neath Port Talbot Hospital Service Delivery Unit		1	1			2			5	3		4		16
Nursing & Patient Experience		6	1			1				7		1		16
Strategy		11										4		15
Transformation					1				1	1		4	3	10
Workforce & Organisational Development							1			2		3	2	8
Finance				2										2
Corporate Governance		1												1
Grand Total	**1**	**46**	**53**	**13**	**17**	**25**	**1**	**23**	**70**	**41**	**1**	**135**	**83**	**509**

Risks associated with Service Sustainability represent a significant proportion (26.5%) of the risks* identified.

**N.B. This percentage is not purely related to Urgent & Emergency Care but the risks associated with Sustainability as a whole system, which could lead to significant impacts on the ability to provision Urgent & Emergency Care*

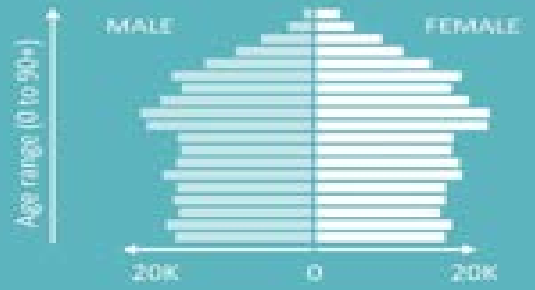
Why Change : Workforce

Population projections suggest that whilst the over 65yr old population increases, significantly so at 85yrs + the adult working age population will shrink.

This will impact the available adult carer and health and social care workforce to care for the aging population

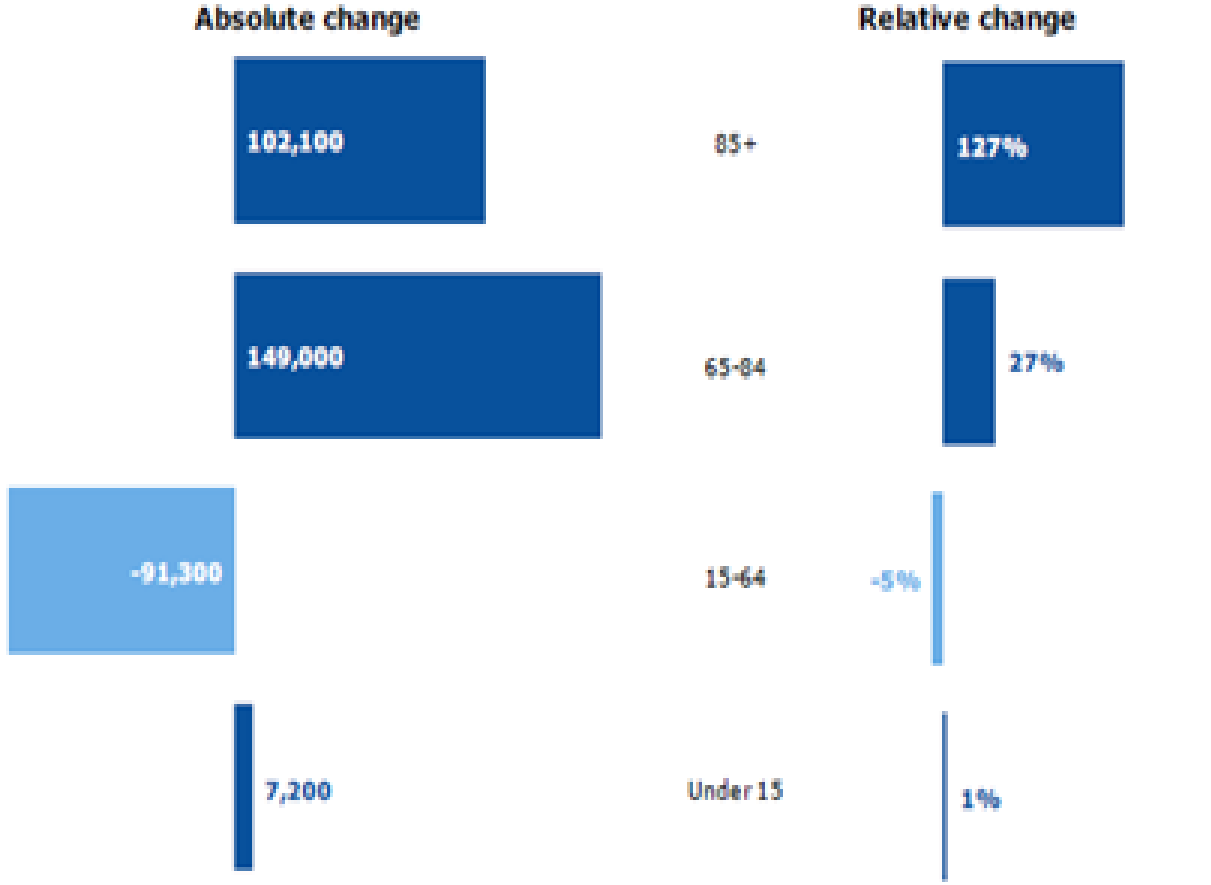
POPULATION OF THE HEALTH BOARD

386,000
APROX. POPULATION



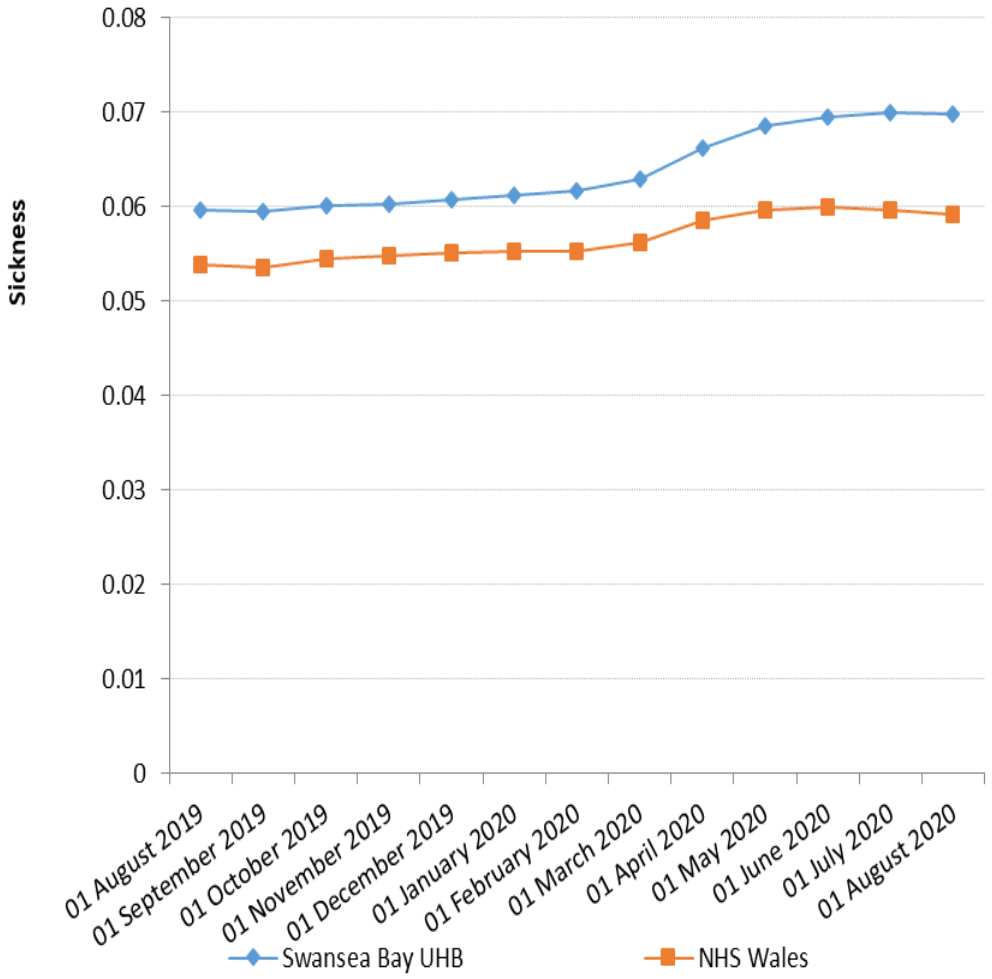
Projected increase in population including +9% in Swansea (the third largest increase in Wales). The Welsh population structure is projected to change, with substantial rise in the older population and a projected fall in working-age adults.

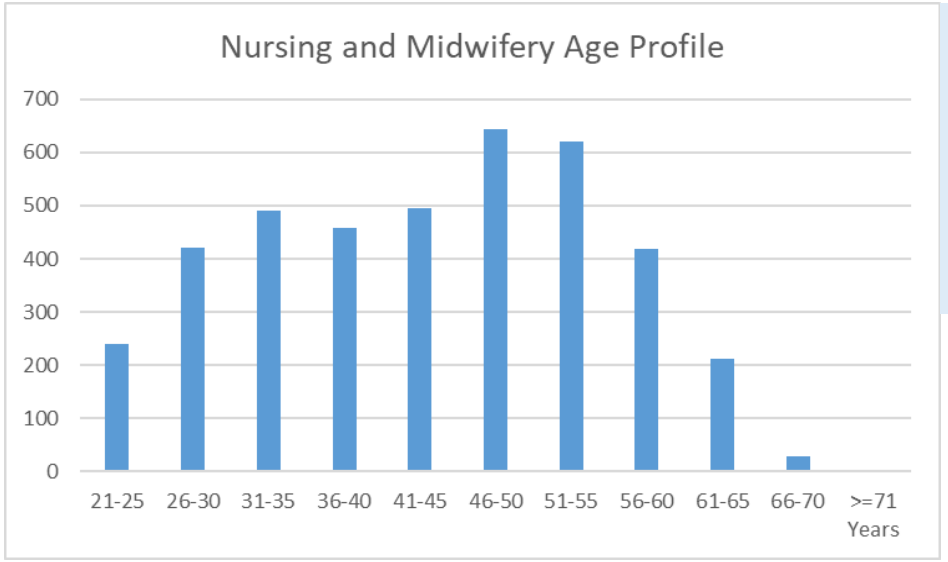
Population projections by broad age group, absolute (count) and relative (percentage) change since 2016, Wales, 2039
Produced by Public Health Wales Observatory, using MYE & 2014-based population projections (ONS)



Why Change : Workforce

Sickness rates are higher than NHS Wales average
There will be an ongoing impact from Covid





Aging workforce with significant proportion approaching retirement

Particularly high vacancy rates for Medical & Dental and Nursing Staff

Position as at December 2020

Staff Group	Budgeted WTE	2020 / 12	Vacancy wte	Vacancy %
Add Prof Scientific and Technic	402.45	389.92	12.53	3.11
Additional Clinical Services	2430.61	2,392.41	38.20	1.57
Administrative and Clerical	2220.22	2,170.79	49.43	2.23
Allied Health Professionals	854.80	804.53	50.27	5.88
Estates and Ancillary	1147.35	1,073.13	74.22	6.47
Healthcare Scientists	322.26	302.98	19.28	5.98
Medical and Dental	1192.57	1,005.84	186.73	15.66
Nursing and Midwifery Registered	3872.05	3,566.07	305.98	7.90
Students	0.00	7.00	-7.00	0.00
Grand Total	**12442.31**	**11,712.67**	**729.64**	**5.86**

Why Change : Learning from COVID

Service Delivery

Digitally Enabled Care : improves patient triggered care, rapid access to urgent care, maximises estate use & increases access to non-site based care options.

Integrated Care Hubs : consolidates skills & expertise, streamlines clinical decision making and improves access.

Single Points of Access : increases planned care response to otherwise traditionally emergency care. Supports management of flow, queues and waiting times.

Scheduling Unscheduled Care : streamlines & simplifies access into UEC services, reduces patient & staff confusion, increases timely access and improves clinically coordinated care & outcomes for patients.

Ways of Working

Change empowerment : clinically led service change can be rapid when governance processes are lighter touch.

Integrated Intelligence : timely & effective decision making is better with integrated intelligence, systems & teams.

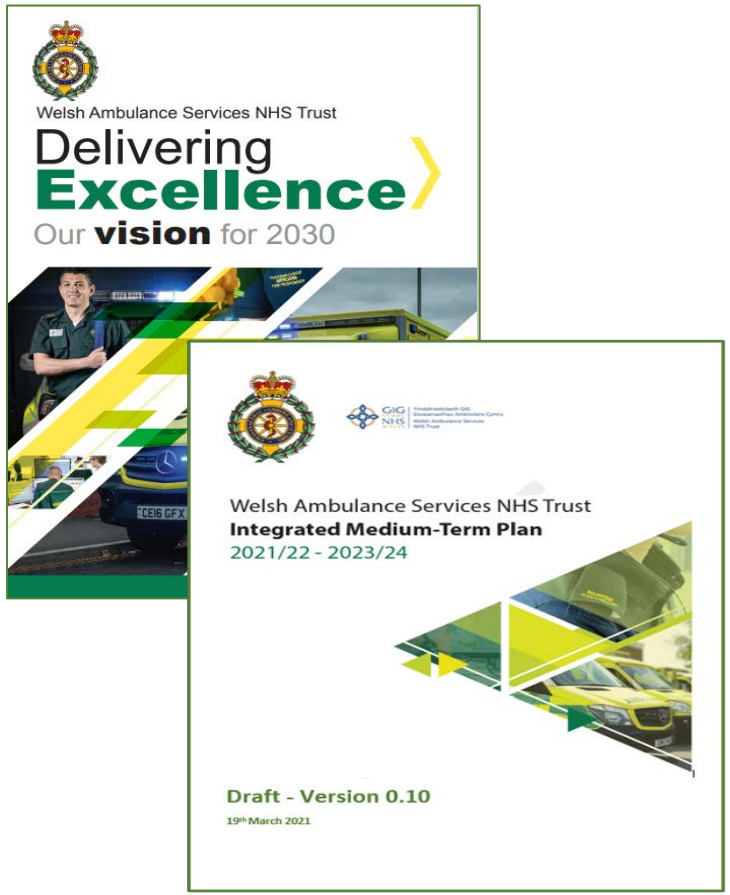
Single System : staff working across services & teams or in MDTs can increase collaboration across pathways and services to deliver service change; staff reported closer team working and collaboration.

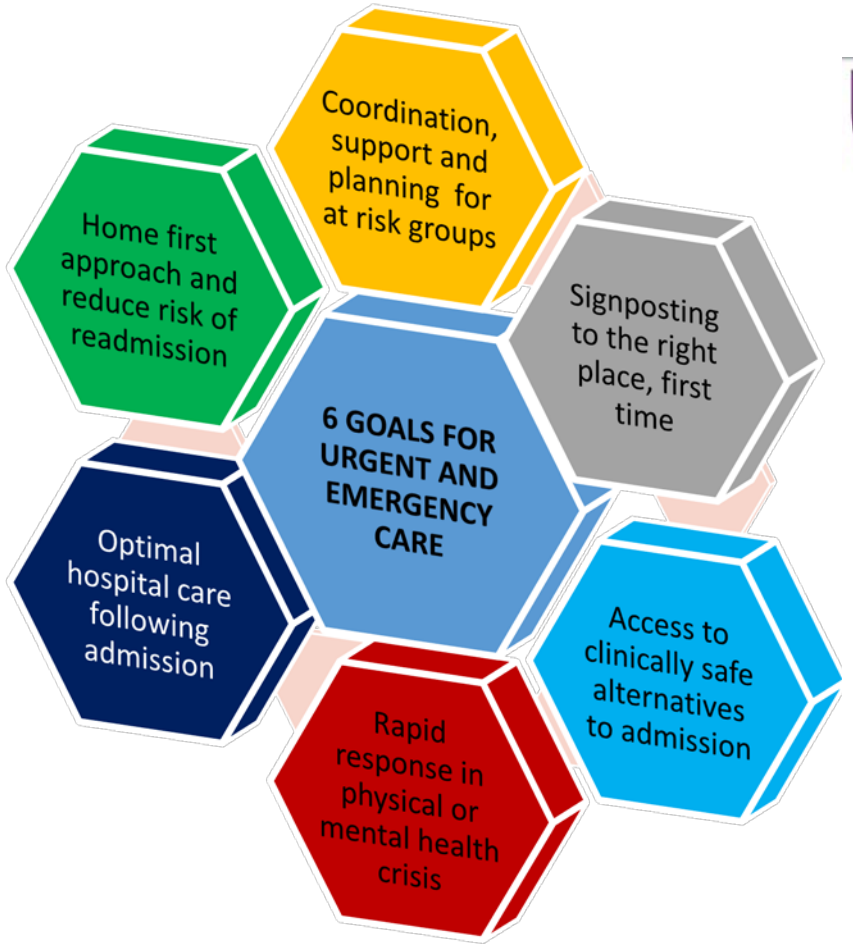
Agile Workforce : redeployment of staff with training /service orientation can create a more diverse workforce, help upskilling and development, improve spread of good practice and deliver a flexible response to demand.

Digital & Remote working : staff reported digital increased feelings of flexibility, engagement with colleagues, partnership working and attendance at meetings, greater inclusion in discussion and improved decision making.

Why Change : National Policy

- A Healthier Wales and Well-being & Future Generations Act : co-producing solutions with individuals, families and communities to prevent ill health and build resilient communities
- National Clinical Framework: whole system pathways of care





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Patron: HRH Princess Royal
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London
EC4A 1DT
Tel +44 (0)20 7404 1999
Fax +44 (0)20 7067 1267
www.rcem.ac.uk

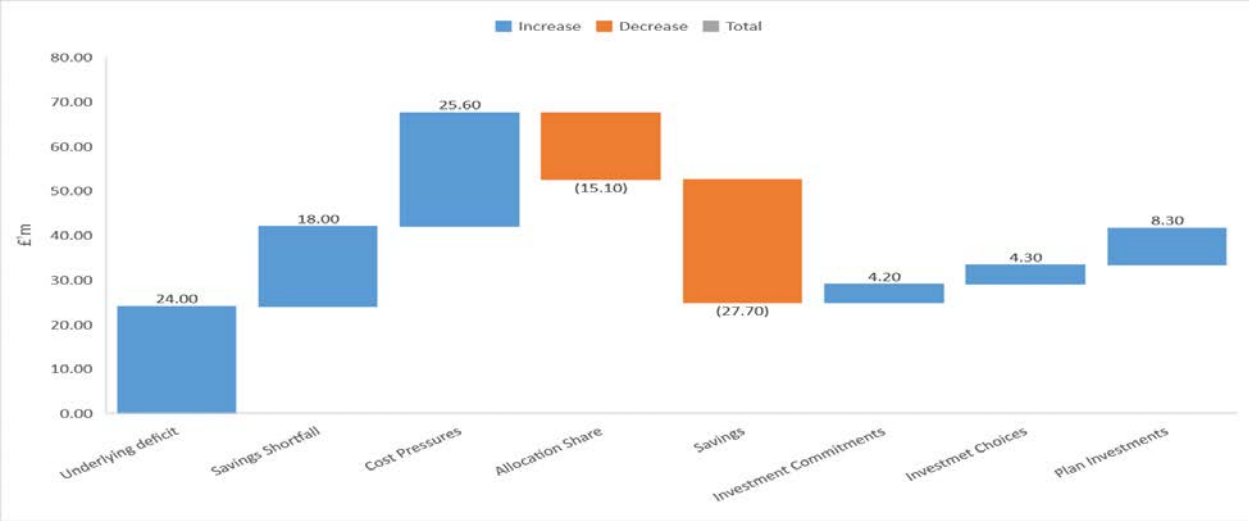
The recommendations support these five fundamental aims:

1. Emergency Departments must not become reservoirs of nosocomial (hospital or healthcare acquired) infection for patients
2. Emergency Departments must not become crowded ever again
3. Hospitals must not become crowded again
4. Emergency care must be designed to look after vulnerable patients safely
5. Emergency Departments must be safe workplaces for staff.

Why Change : Financial Sustainability

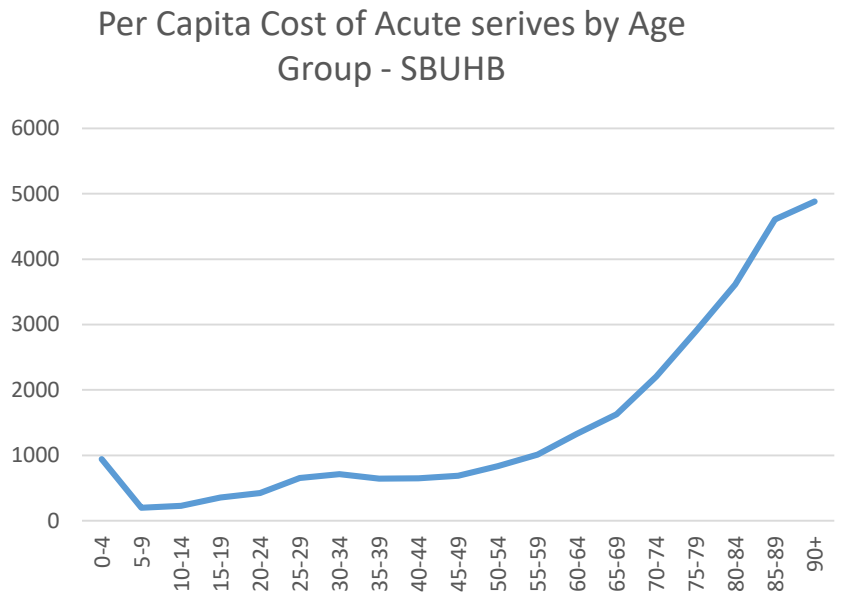
- £42m underlying deficit
- Almost 50% of service related financial deficit driven by UEC
- £17m savings required to stand still in 2122.

Evidence from multiple sources suggests 250+ beds could be released or recommissioned .



Underlying Deficit - by Service Area	Underlying Deficit
	£000
Primary Care	-3,400
Mental Health	-2,661
Continuing HealthCare	-2,300
Commissioned Services	-1,170
Scheduled Care	-5,270
Unscheduled Care	-15,402
Children & Women's	-1,420
Community Services	-1,555
Specialised Services	
Executive / Corporate Areas	-8,205
Support Services (inc. Estates & Facilities)	-694
Total	**-42,077**

Ageing population making greater demands on acute services will be a risk to future financial sustainability



Excellent Services: Looking Forward

UEC Summary of Opportunity Messages

System : expand Signal to a ‘control tower’ solution, empower the frontline, metric management (key measures = health of system), mental health, pharmacy

Primary & Community : patient activation, ‘integrated SPoA’, care co-ordination, triage for clinical & wellness services. Expand; self care, social prescribing, behaviour change, LTC management community consultants, faecal calprotectin testing. Redesign; rehab model, rapid response, community paramedics, discharge planning, ACTs. Review; role Neath ‘Day Hospital’

Front Door : Acute Frailty, Centralised Acute Admissions, AEC (COPD, Falls, Nerve disorders, Gastro, Pneumonia) ACPs, extended days/hours, Cardiology Hot Clinic, GP Acute Clinics, Navigators, Heart Failure, Respiratory, Asthma & Gastro pathways

In Hospital : (LoS) Heart failure, Orthopaedics/Hip fracture, Vascular, Pancreatic Disorder

Back Door : Hospital2home, Social service with Nursing support

Re-admissions : Abominable pain, paediatric minor infections & acute broncilitious, gastro

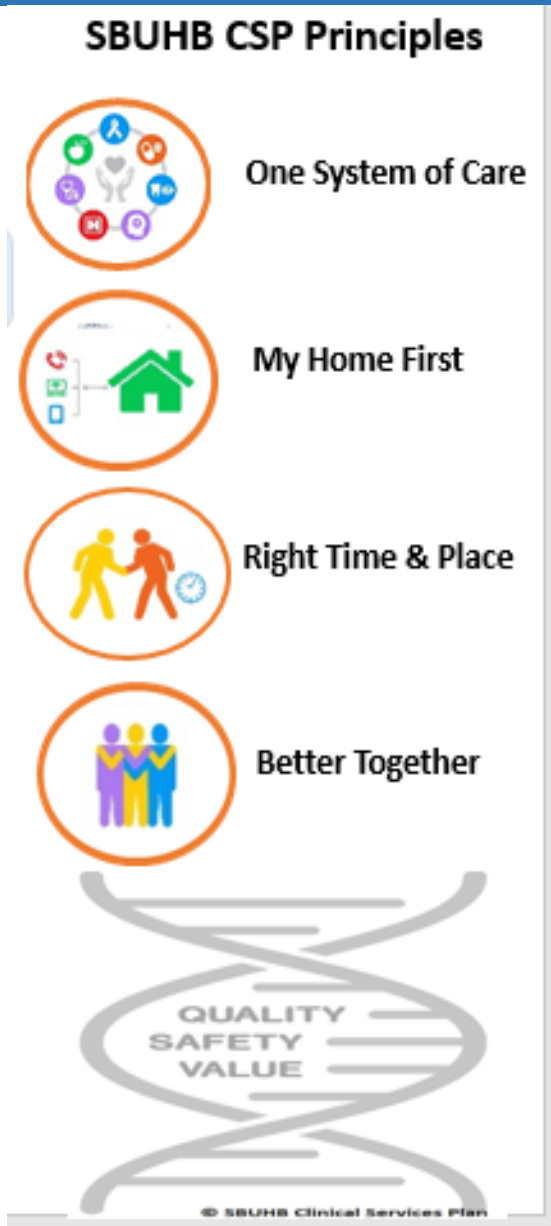
Excellent Services : Looking Forward

Mental Health Services Opportunities include:

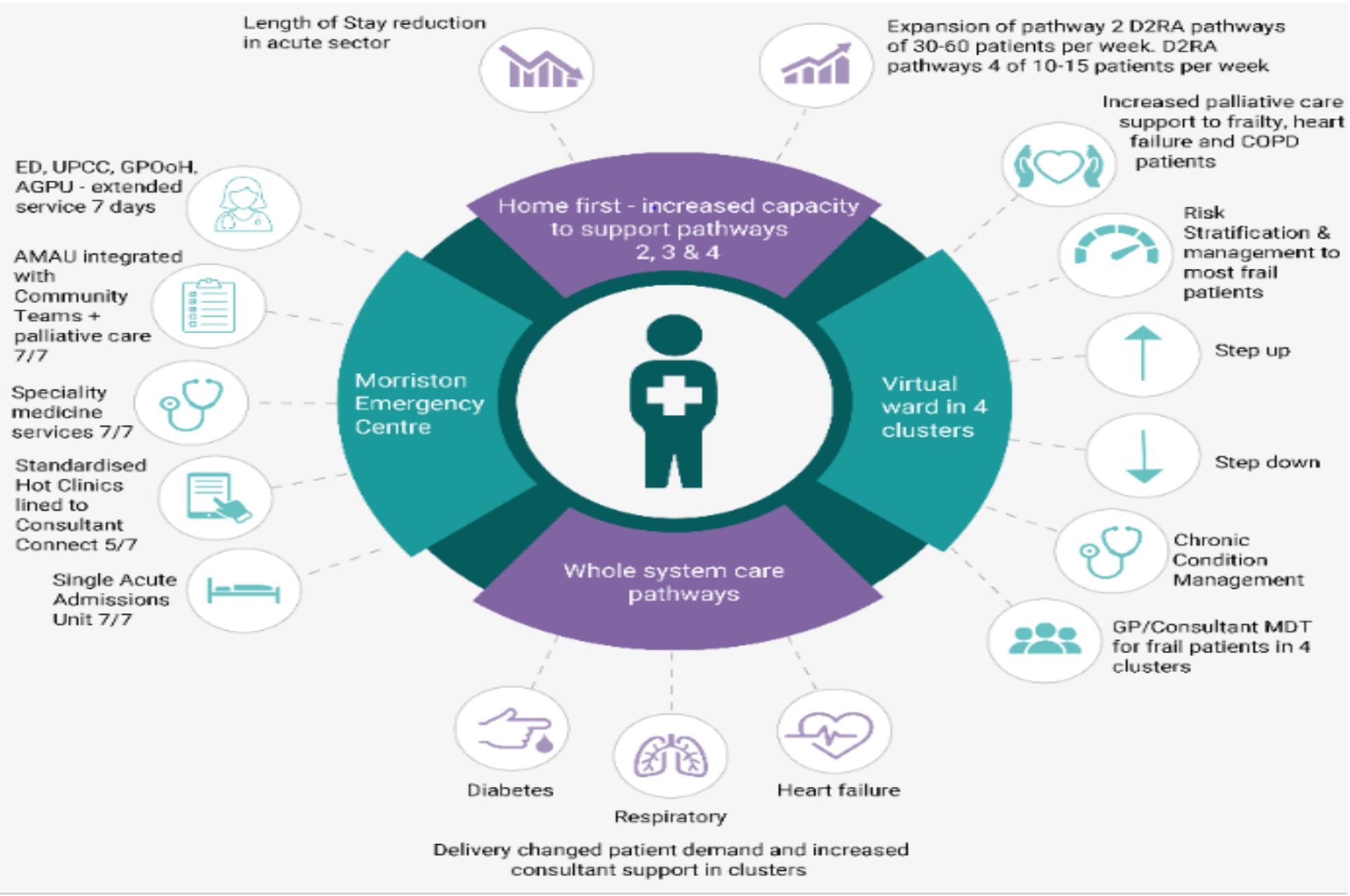
- Expanding role of Integrated Clusters in delivering Mental Health services
- Embed Sanctuary Model supporting people in crisis
- Redesign Adult Acute In-patient Services to improve access and quality of care
- Redesign of Older peoples acute in-patient services redesign to quality of care

Pharmacy Services Opportunities include pharmacists / pharmacy technicians:

- Located in ED and AEC to provide early medication reviews
- Seeing patients in hospital clinics to enable consultants to review new patients
- Managing high risk drugs eg DMARDS in rheumatology, DOACs in anticoagulation, clozapine and lithium for Mental Health & Learning Disability patients, heart failure, COPD, Diabetes.
- Elderly and falls prevention through pharmacy review of polypharmacy and drug choices, including follow up and review of patients post discharge to prevent re-admission.
- Prevention of admission through review of medicines in community settings
- Support for Advance Care Planning to enable patients who wish to die at home



Excellent Services : 2021-22 delivery



SBUHB CSP Principles

Excellent Services : Clinical Services Plan UEC

Urgent and Emergency Care System 3-5 year Vision

Secure a Sustainable Urgent & Emergency Care System
- Single Frailty Model
- Integrated Services – e.g. Acute Care and Home First Teams
- Falls Prevention
- Whole System Response
- Single Acute Medical Assessment Unit
- Ambulatory Emergency Care
- Hyper Acute Stroke Unit

Goals

- Reduce negative impact of avoidable hospital admissions and long stay on older people's physical and mental wellbeing
- Improve quality of care and outcomes for acutely unwell patients through rapid access to medical assessment, investigation, treatment and, where appropriate, admission to hospital
- Optimise outcomes for stroke patients

Methods

- Frailty Pathway Services available 7/7
- Increase in Consultant Care of the Elderly capacity and link to Integrated Clusters
- Increase in Home First service capacity
- Standardise model for 7/7 working for Acute Care Teams
- Dedicated Ambulatory Medical Assessment Unit
- Single specialties created for older people, gastroenterology, respiratory, cardiology
- Invest in key therapy and other services to improve discharge and reduce length of stay
- Develop a Hyper Acute Stroke Service

Outcomes

- Reduction in frailty admissions
- Increase Home First case load
- Reduction in admissions from ACTs
- Reduction in emergency admission numbers
- Reduction in Medically Fit patients in Acute beds
- Removal of 12hr waits

SBUHB CSP Principles

One System of Care

My Home First

Right Time & Place

Better Together

Benefits : patient experience

Increased Patient Access to;

- Timely information and advice
- Activation of their own care
- The right care giver and service at the right time first time
- Early intervention to prevention services

Reduced patient time spent:

- Waiting for an ambulance
- Waiting to be seen in the emergency department
- Waiting for diagnostic tests
- Waiting to be treated
- Waiting to be discharged

Reduced patient harm from:

- Risks of infection
- Physical, emotional and/or mental deteriation from long hospital stays

A patient perspective - future

Mary is 68 years old and has bronchitis.

She wakes up in the night coughing with a shortness of breath.

I rang 111 and a nurse spoke to me and assessed me via video. I was able to give him some information about my heart rate and temperature because my smart watch measures this. After he read some of my medical history the nurse arranged for an advanced paramedic to visit me that same day. The advanced paramedic was lovely and was able to prescribe me some antibiotics and I was able to stay at home.

Benefits: Efficiency

Key Messages Service Transformation Urgent & Emergency care

Admission Avoidance - Opportunity quantified as 58 Beds (Capita)

- Ambulatory Care Model – @10 Beds
- Community Based Care - @48 Beds

Length of Stay
Opportunity quantified as 245 Beds (1920 CHKS HRG analysis)

- 'Back Door' - @120 Beds MFFD
- 'In Hospital' - @125 Beds

Top 10 HRG Groups - Non Elective	Bed Equivilent
DZ11: Lobar, Atypical or Viral Pneumonia	23.42
EB03: Heart Failure or Shock	12.81
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DZ65: Chronic Obstructive Pulmonary Disease or Bronchitis	6.16
EB07: Arrhythmia or Conduction Disorders	5.81
LA07: Acute Kidney Injury	5.04

Key Pathways;

- Respiratory
- Heart Failure
- Gastro
- Stroke
- Diabetes
- Falls (#NoF)
- Cognitive Function
- UTIs
- Nerve Disorders

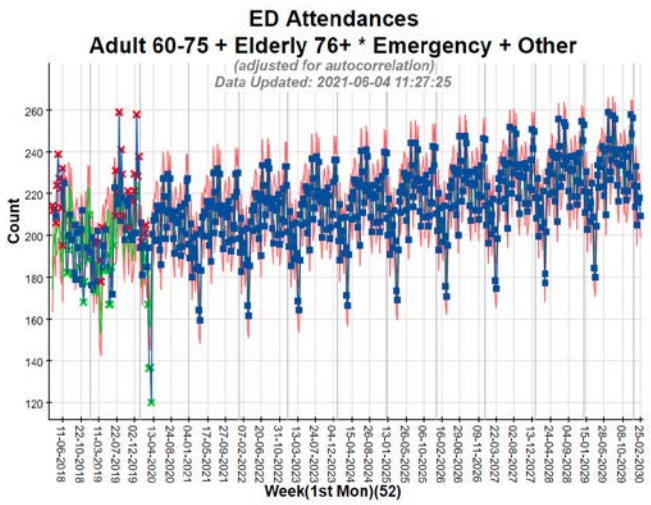
Opportunity by patient Cohort

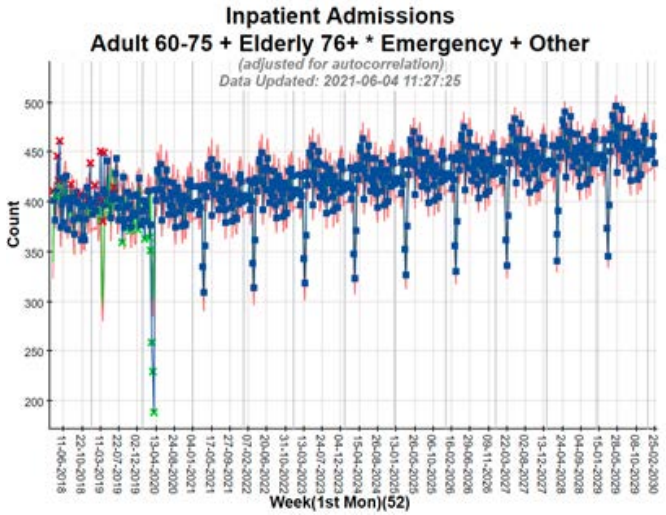
EoL Care
80 Admissions per week of patients in last year of life & died in hospital – occupying 150-250 beds

Frailty
80% medical beds occupied by 60+ yr olds (pre frail / frail)

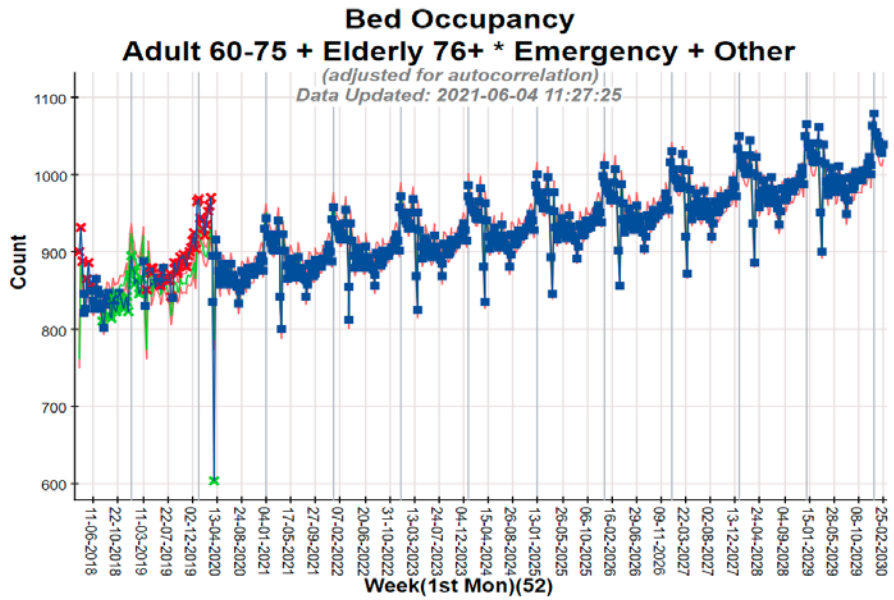
Frailty
50% 60+yr olds admitted in Gen Surg / Uro do not undergo a procedure = ALoS 8 days

Consequences





Without any change the aging population will drive up ED attendances and Emergency Admissions.



Increased admissions and within the Frail Elderly cohort will increase pressure on beds – potentially driving a requirement for 200 extra beds in 10 Years time with consequences for Patient Flow , Workforce and Financial Sustainability

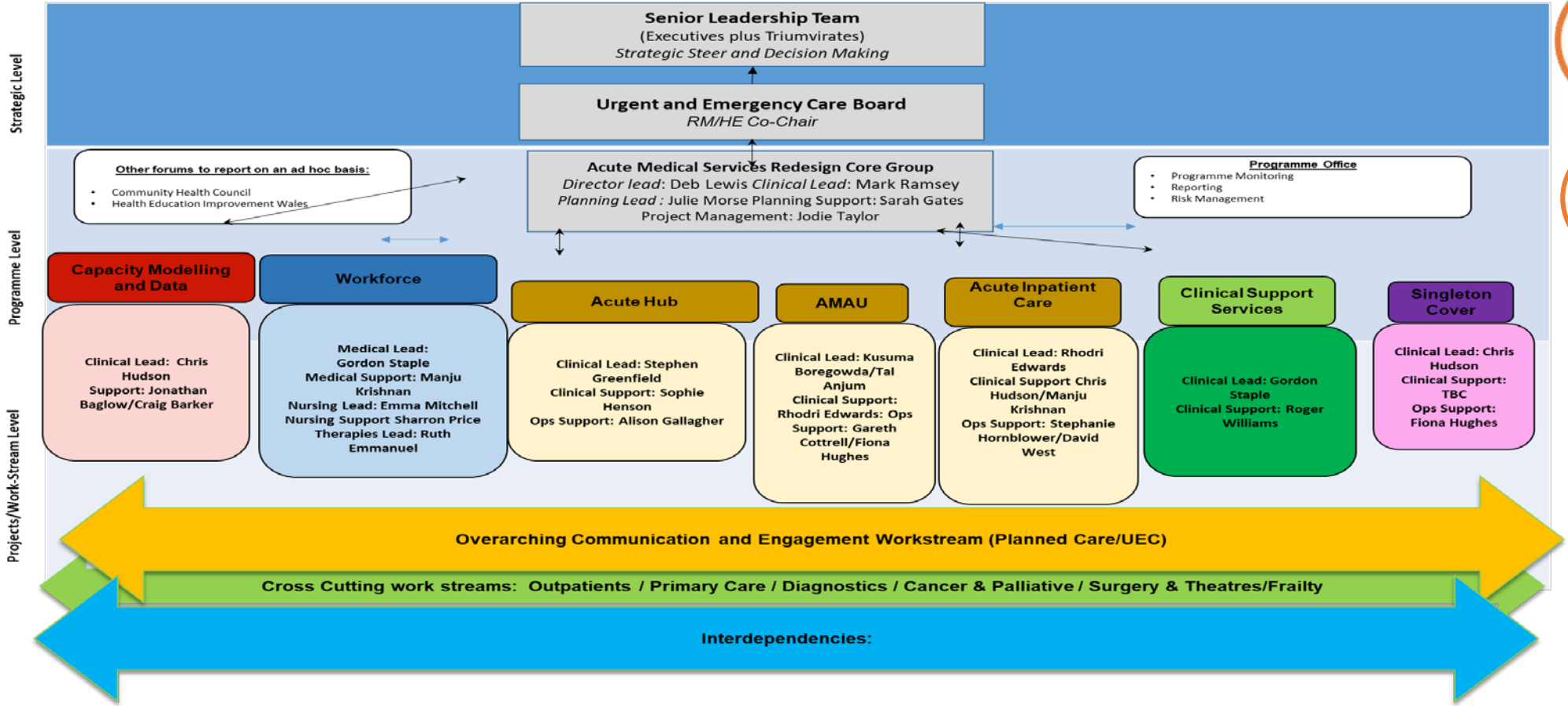
How we will deliver the changes

Patient and Staff Engagement and Consultation

CYNGOR IECHYD CYMUNED COMMUNITY HEALTH COUNCIL | BAE ABERTAWE SWANSEA BAY

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board

Clinical Leadership and the Emergency and Urgent Programme



SBUHB CSP Principles

One System of Care

My Home First

Right Time & Place

Better Together

Information accurate at time of publishing

DRAFT

SBUHB Sustainability & Recovery Plan 2022-27

Planned Care Case for Change

Compiled June 2021 by;

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BETTER HEALTH | BETTER CARE | BETTER LIVES

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Bae Abertawe / Swansea Bay University Health Board

IECHYD GWELL | GOFAL GWELL | BYWYDAU GWELL

Context

Purpose of this Case for Change;

- To provide a single reference source of available information on the SBUHB Planned Care system/services
- To provide relevant information to draw upon for those, communicating, engaging on and redesigning Planned Care services
- To be a 'live' resource up-dated as new information emerges

What this Case for Change covers;

- Evidence: why we need to change Planned Care services
- Excellent Services: our vision & changes to Planned Care services
- Benefits of improving Planned care services
- Consequences of not improving Planned care services
- How we will deliver the changes to Planned care services

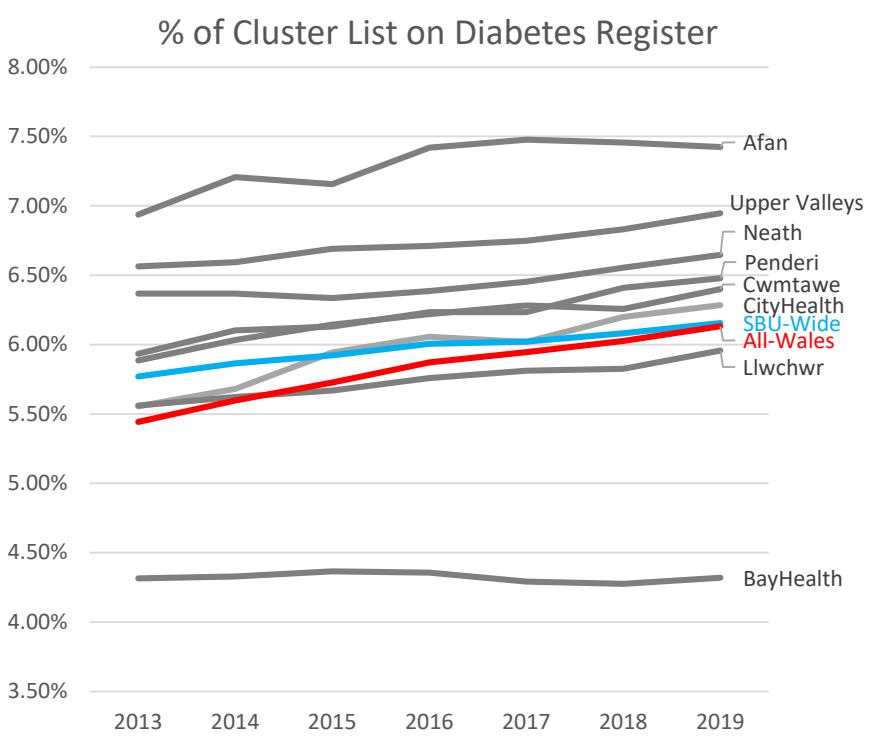
Why Change: Population Health

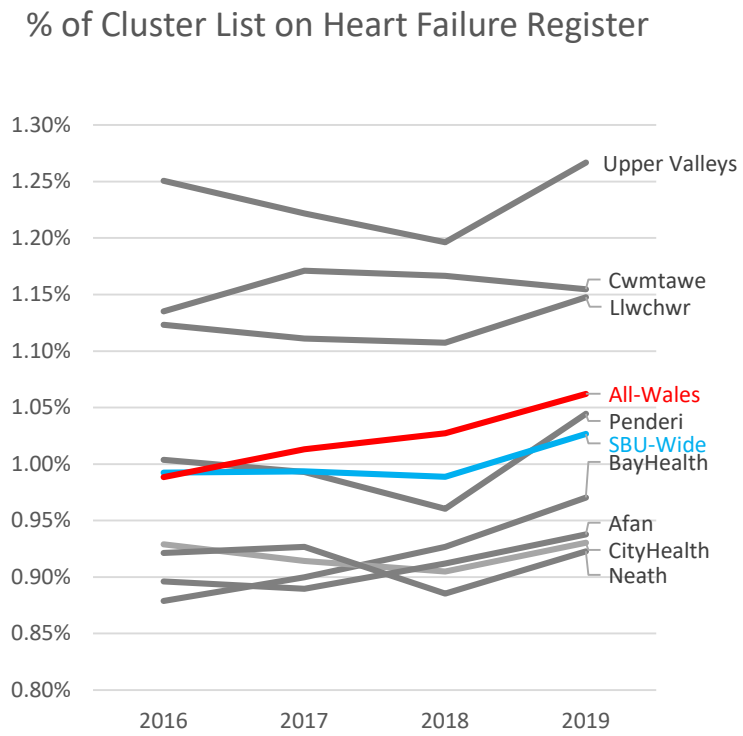
- **Population Changes:**
  - Swansea Bay population forecast to increase by 4.48% by 2035
  - Most substantial rise is in 65-84 year olds followed by the over 85 year olds
  - One quarter of the population has a long-term condition & one quarter of people over 60 have two or more
  - By 2030 11% of our population will be diabetic

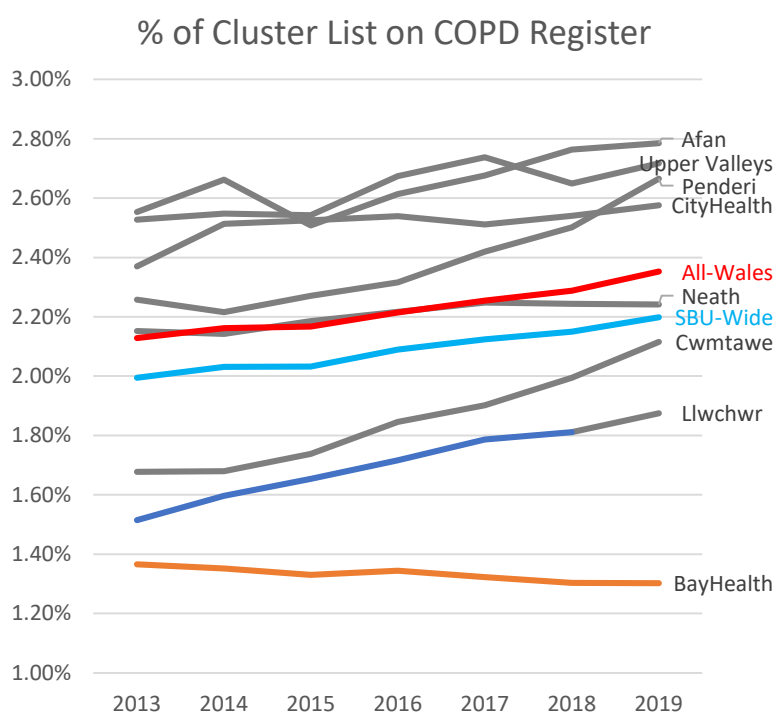
2020 to 2035 Population Change	
Aged 15 and under	-1.80%
Aged 16 to 64	1.42%
Aged 65 and over	19.30%
Overall	4.48%

- **Health outcomes**
  - Living longer increases age-related and long term conditions
  - Diabetes can increase complexity of care needs and is the most common co-morbidity of hospitalised patients in SBUHB
  - Rising frailty increases loss of independence: 45% of over 65's live alone, 1:3 will fall and of these one in 1:3 will move into long term care
  - An ageing population increases use of multiple medicines (polypharmacy) which can have risks associated with unintended incorrect use including risk of falls
  - Between 30-50% of medicines prescribed for long-term conditions are not taken as intended and are a contributory factor to people being admitted to hospital
  - Frail people admitted to hospital are more likely to experience a detrimental impact on their overall health the longer they stay in hospital

Why Change: Population Health

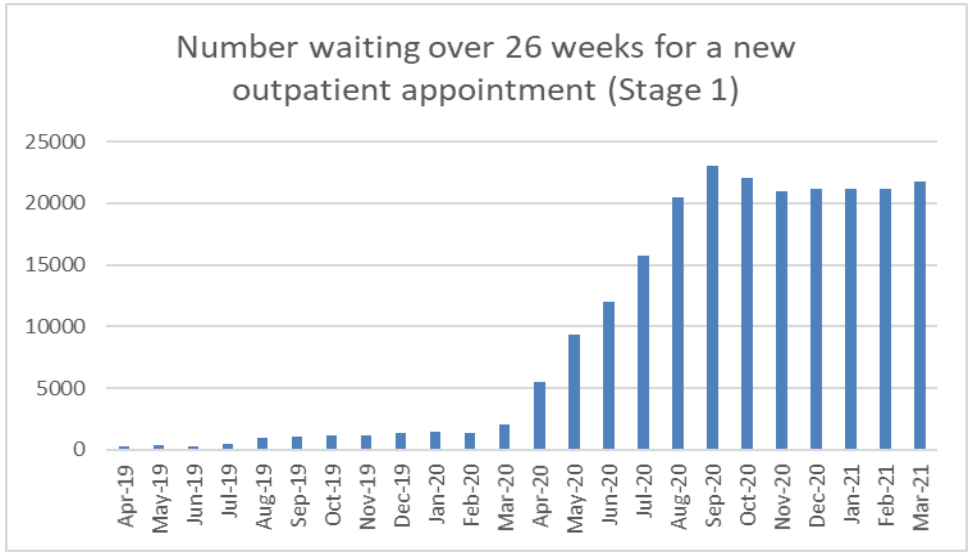


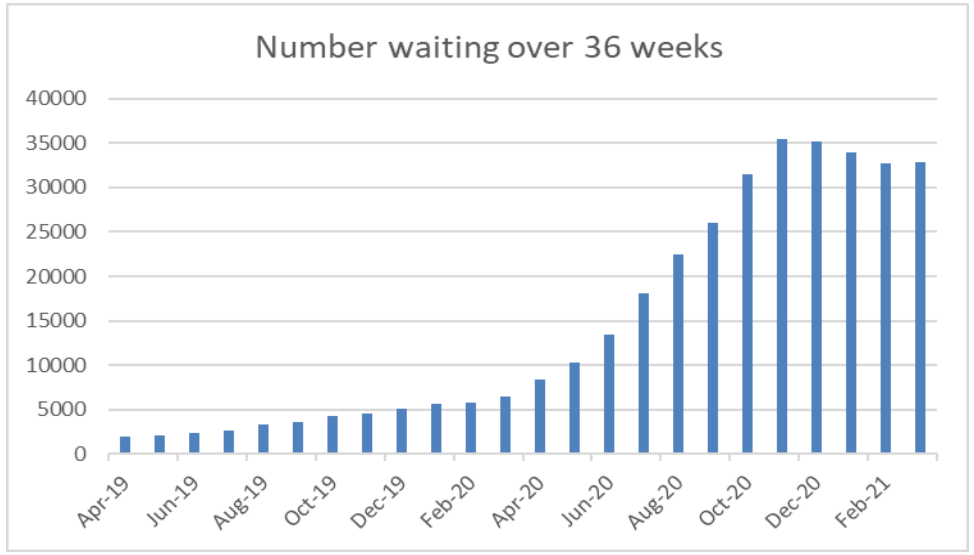


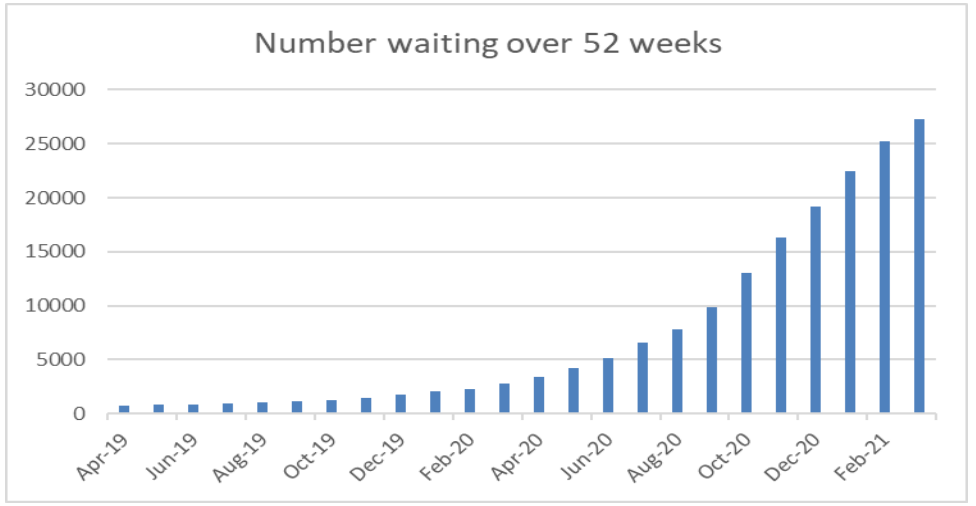


- SBU has more deprived communities than average for Wales with over ¼ of our communities falling into most deprived category
- Areas of deprivation are particularly in urban parts of Swansea, NPT and upper valley communities
- As well as increasing prevalence of chronic conditions there is significant variation within SBU clusters.

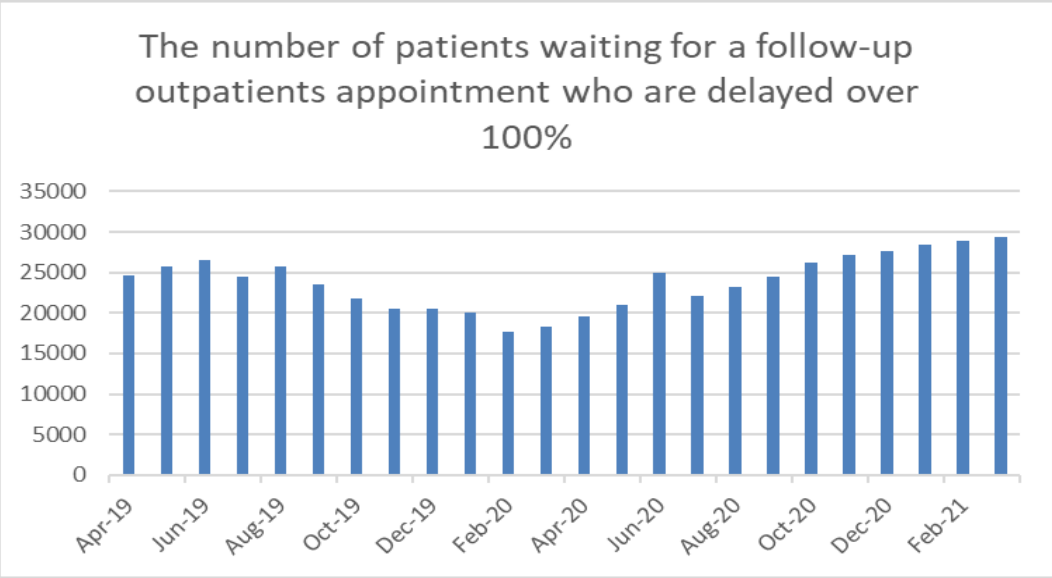
Why Change: Patient Experience

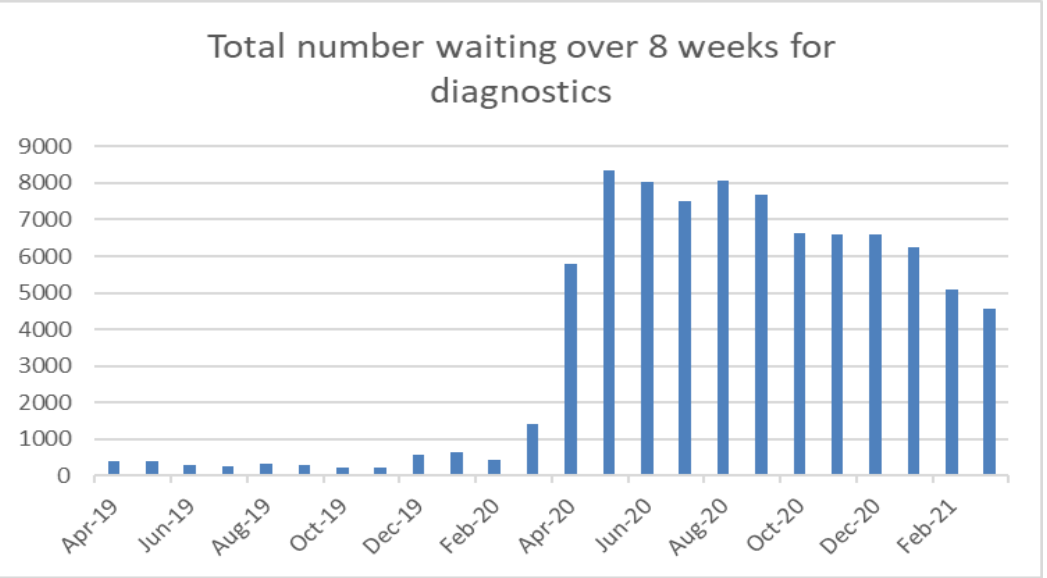






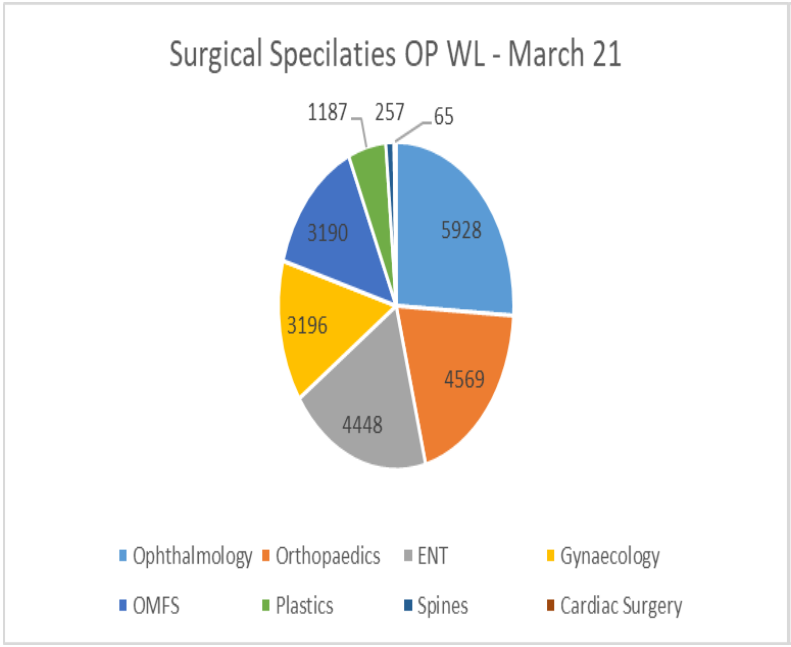
Why Change: Patient Experience

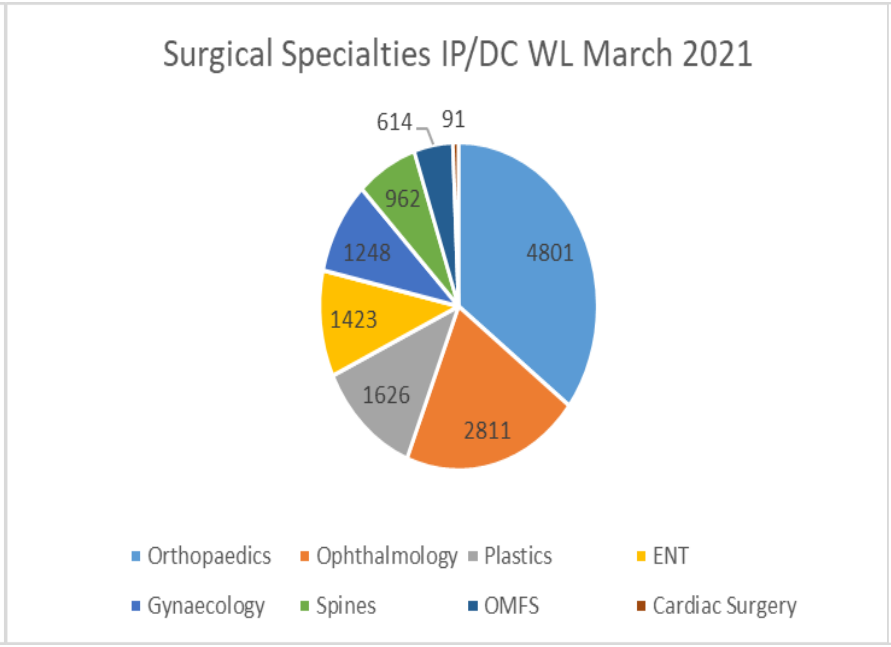


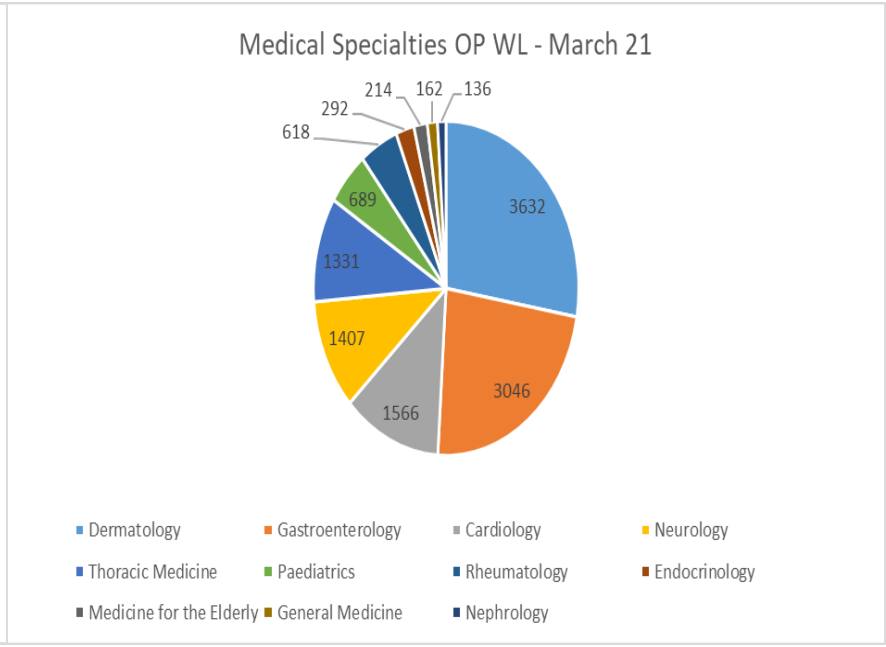


Why Change: Patient Experience

Relative List Size

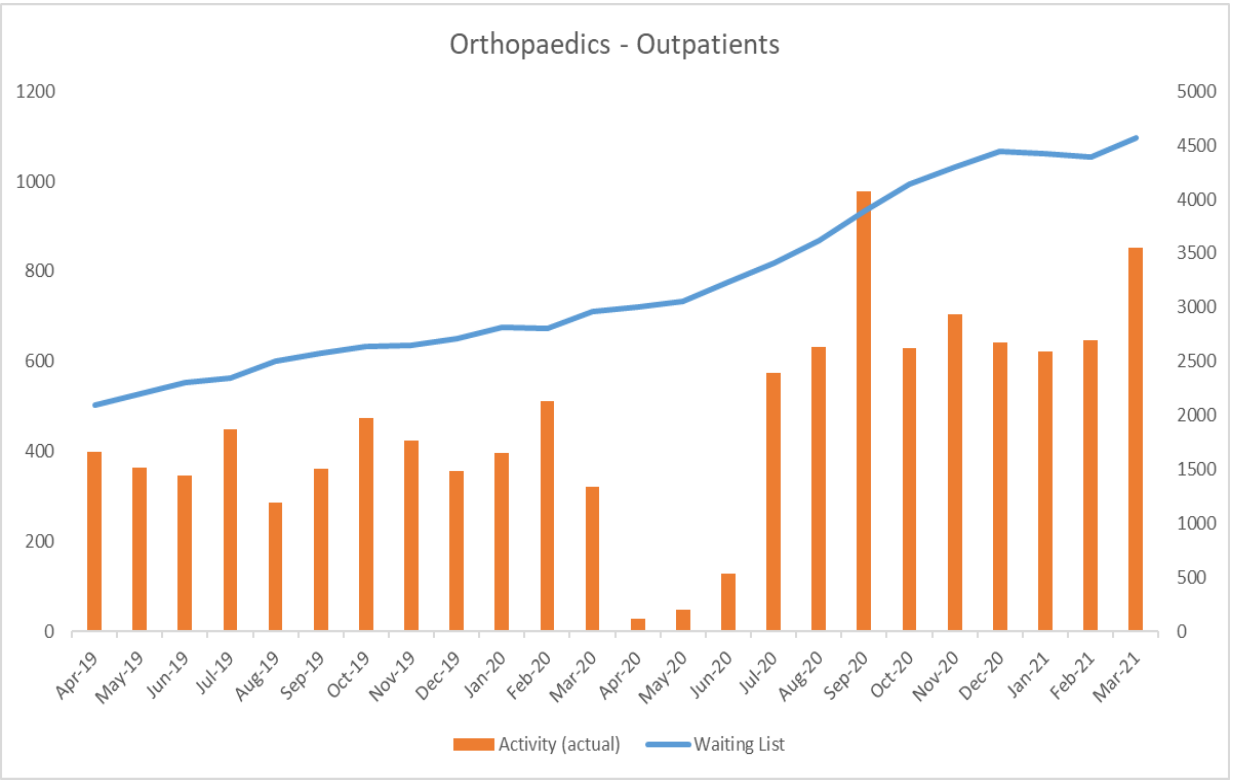


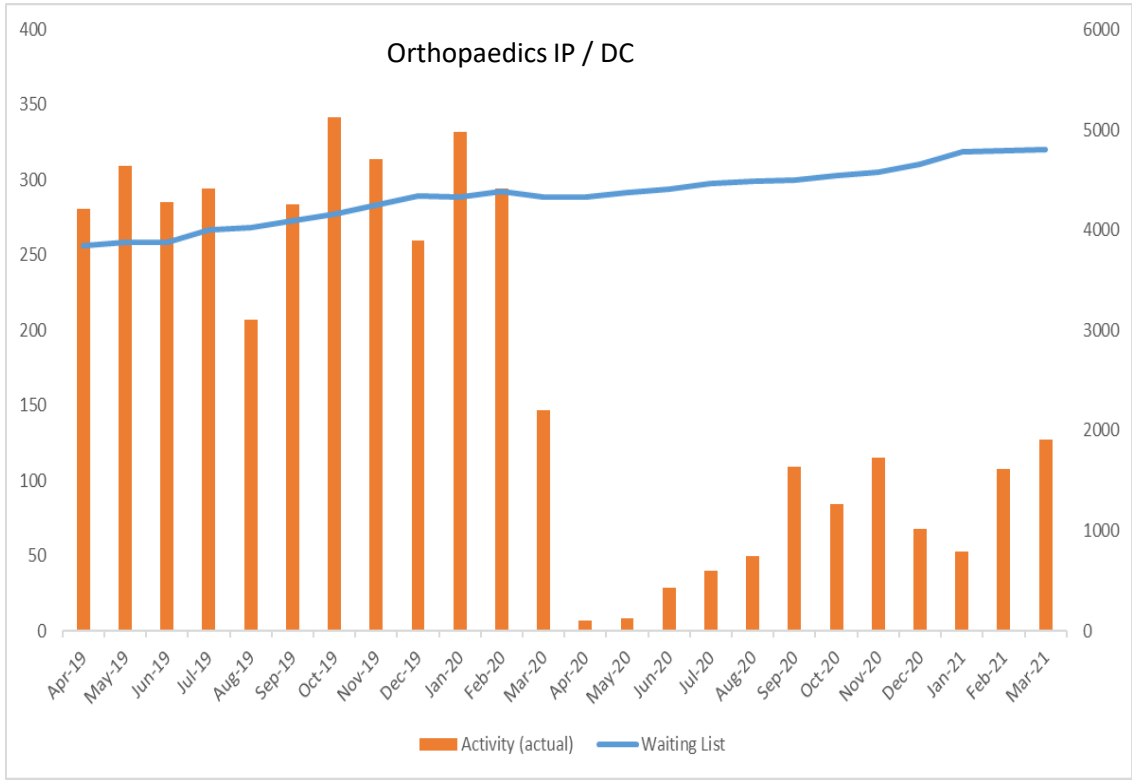




Why Change: Patient Experience

Orthopaedics





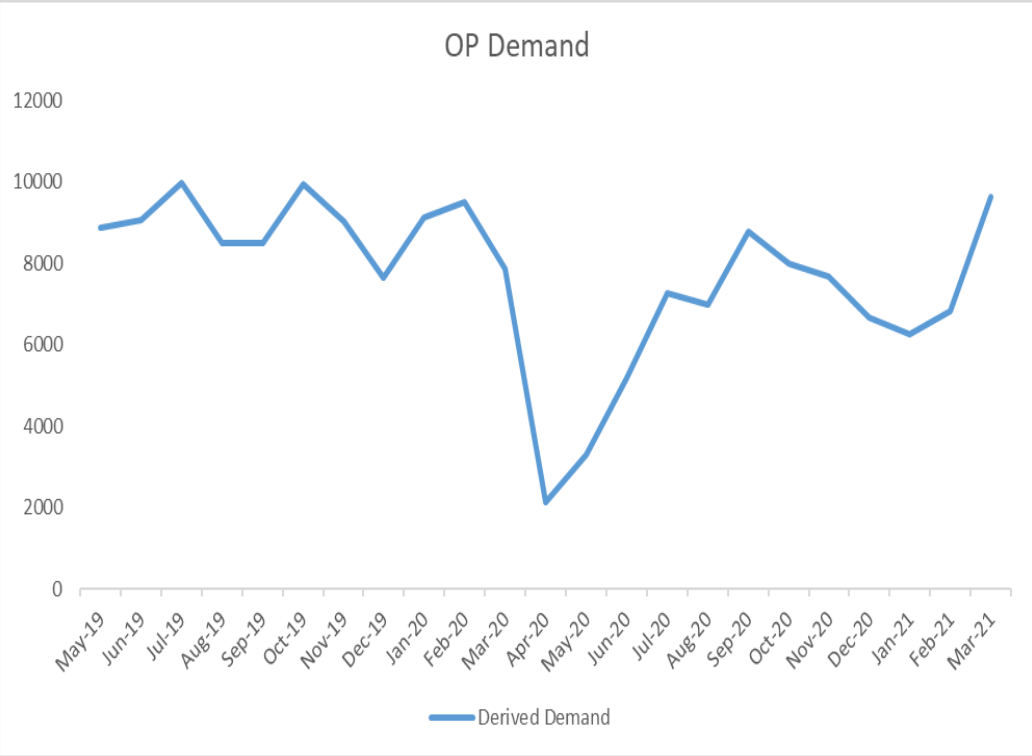
Covid impact has manifested itself initially through growth in OP waiting list , but as OP backlog is addressed patients will convert to the IP/DC list and there will be a significant growth in numbers waiting for treatment.

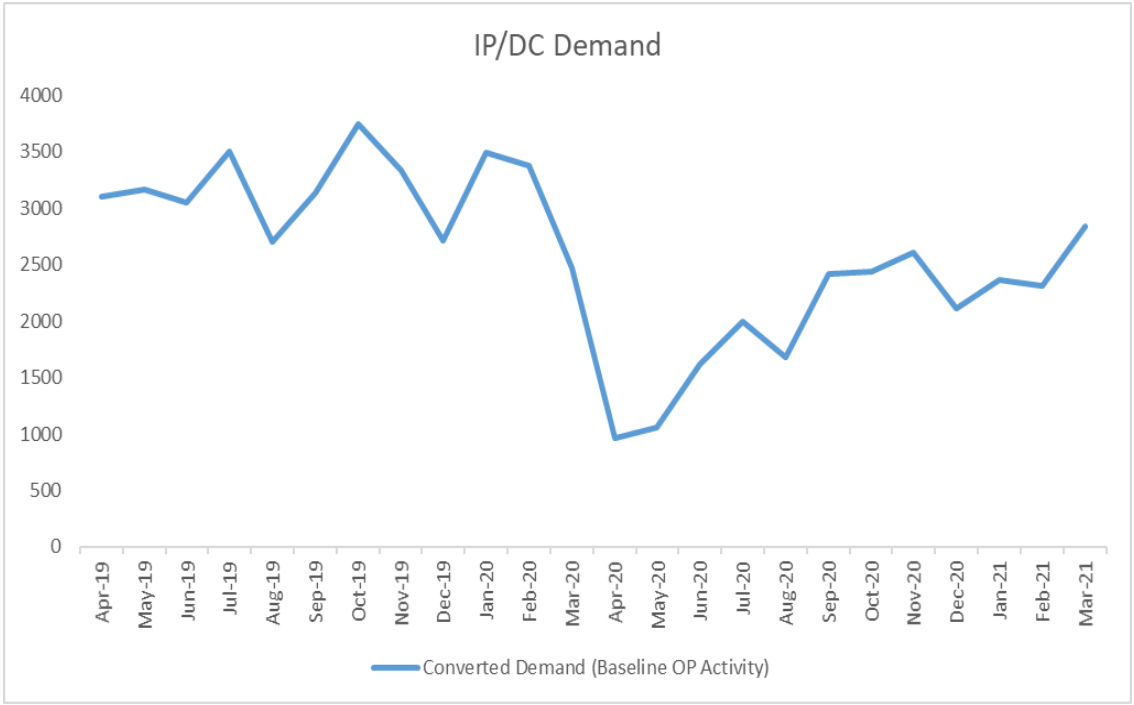
Why Change : Clinical Services Models

- Clinical Services Plan identified system challenges as;
  - Insufficient **access to timely diagnostic** services increasing potential risks to patient health
  - **Inefficient use of surgical capacity** and resource especially in pre & post operative care and for average length of stay rates
  - **Over reliance on Morriston Hospital** to deliver surgical services for patients of all acuity levels rather than optimising surgical services across all of our sites including in primary care
  - **Limited use of Patient Reported Outcome Measures** to prioritise and inform patient care
  - Significant **patient waiting times** for planned care appointments due to medical system pressures
  - **Cancellations** of patients planned care appointments at short notice due to system pressures
  - **Poor quality clinician to clinician** advice leading to unnecessary or delayed appointments
  - **Routine hospital based outpatients** appointments as the default model rather than risk prioritised, patient activated, virtual and/or self care practices
  - **Limited use of Telehealth and telemedicine** approaches to enable patients to manage their care at home

Why Change : Service Demand

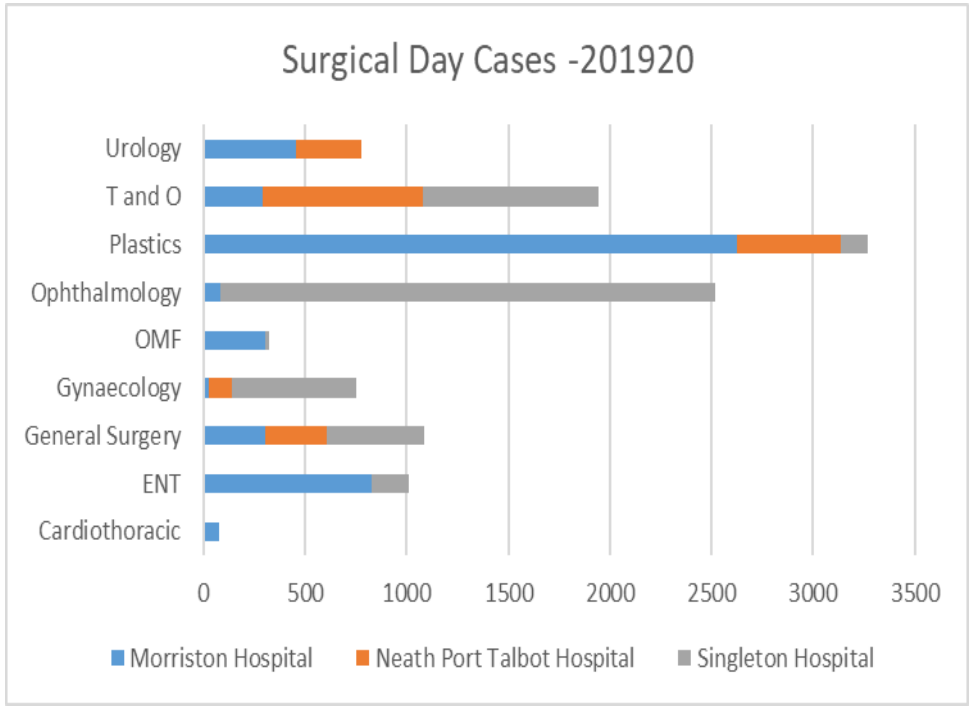
Demand for elective services is returning to pre pandemic levels.

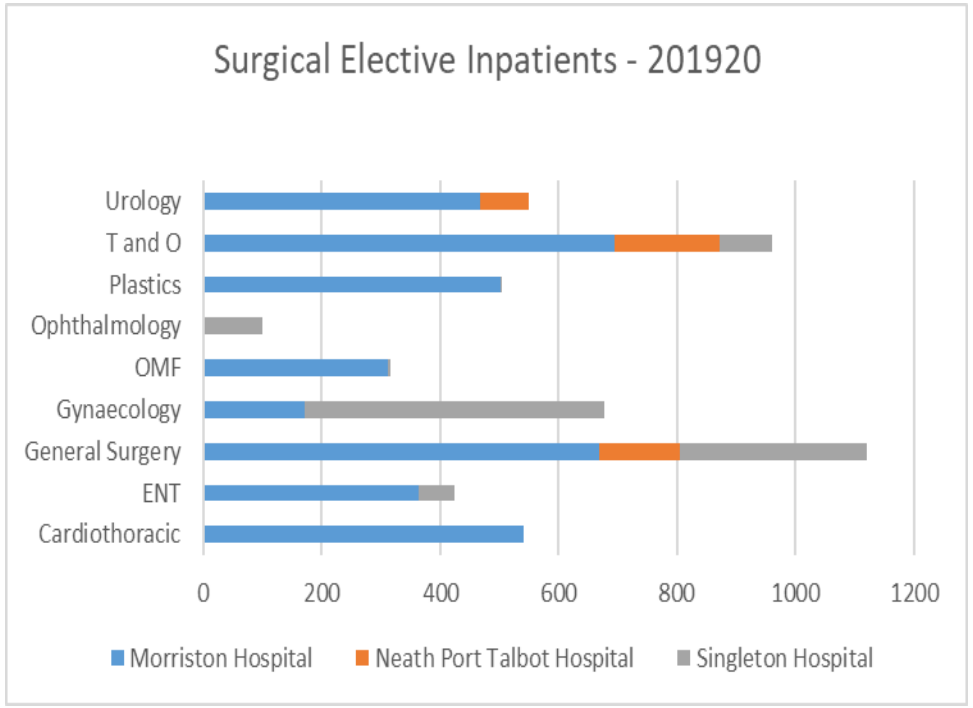




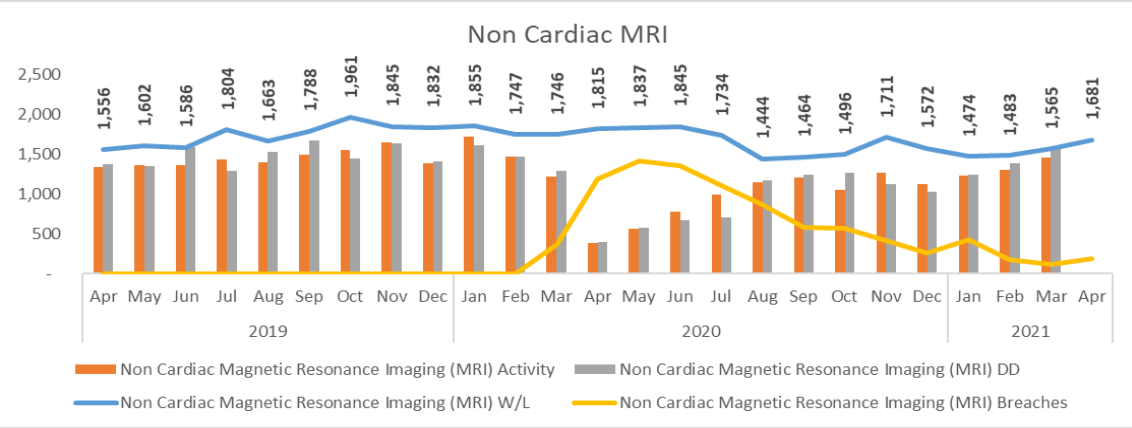
Why Change : Service Demand

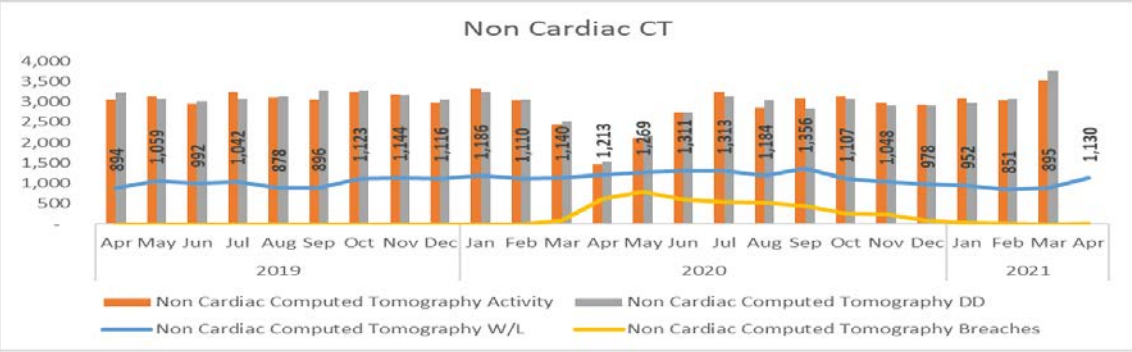
Distribution of elective surgical theatre activity by site (excludes CTM provider activity delivered in NPT)

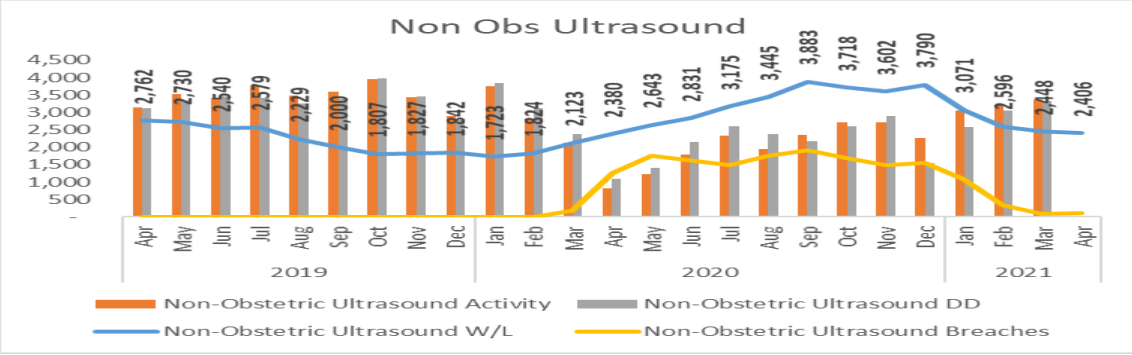




Why Change : Diagnostics - Radiology







- Out patient breaches back under control – but still high volumes waiting and additional pressure anticipated as Outpatient services become re-established.
- Lack of capacity leading to delays in In Patient diagnosis – unnecessary increases in LOS

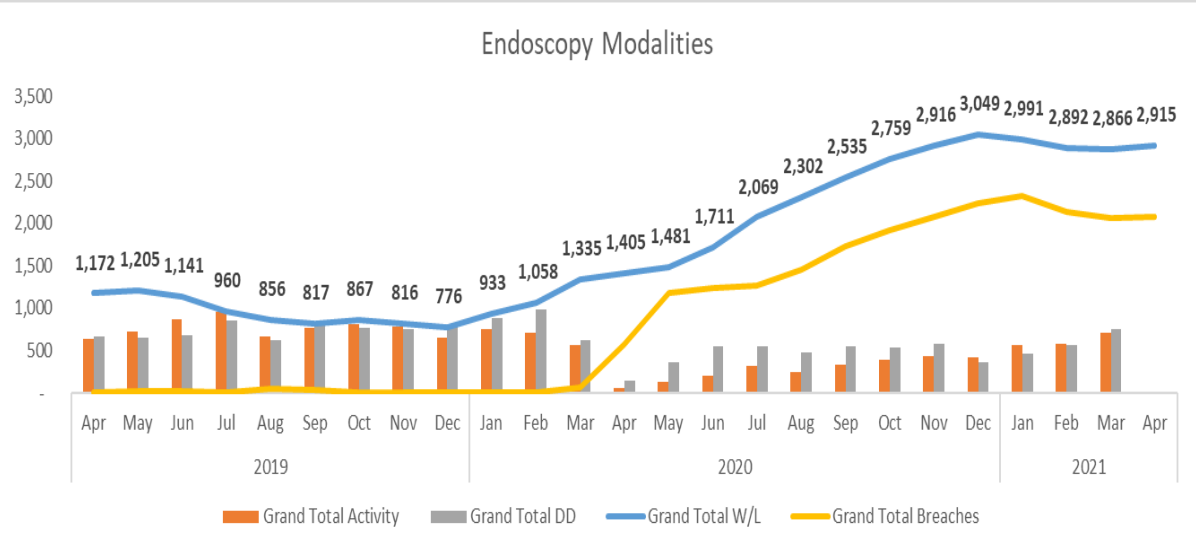
Solutions

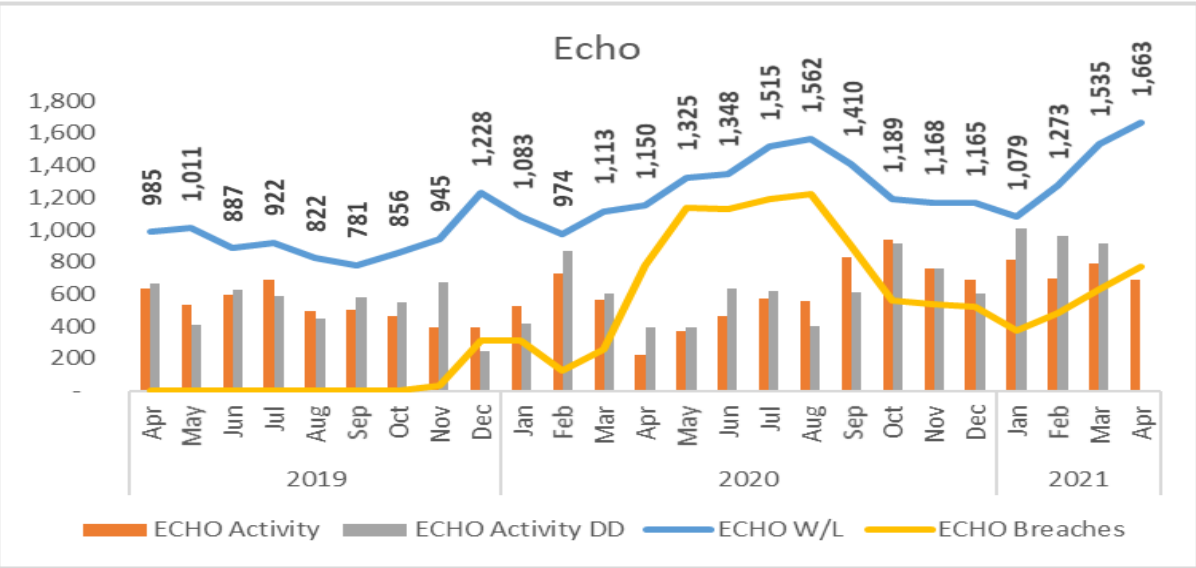
- Rebalancing Outpatient activity away from Morriston
- Extended working on existing equipment.
- Short term mobile capacity brought in.
- Partnership working with Swansea University
- Options around procurement of additional scanners

Constraints

- Workforce
- UK wide supply chain issues

Why Change : Diagnostics – Endoscopy and Cardiology



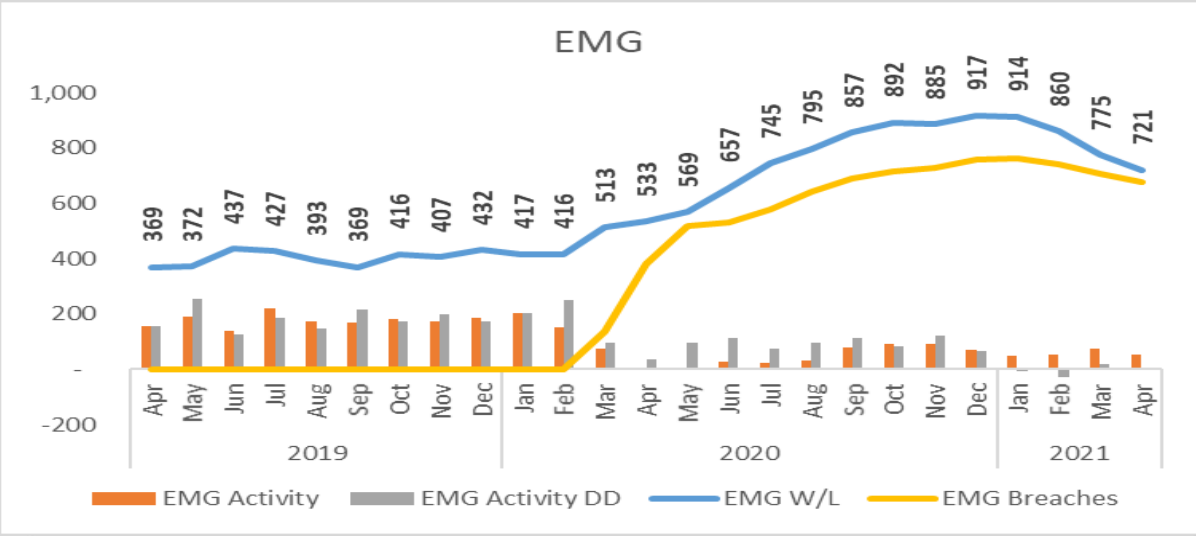


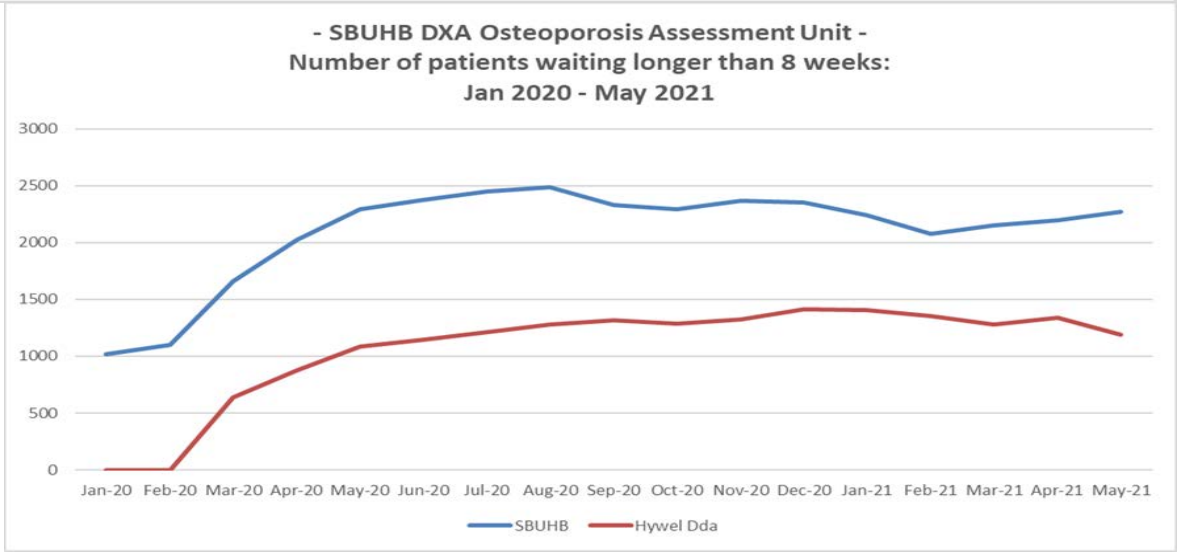
- Restricted working practices due to COVID have given rise to significant growth in patients waiting and waiting time breaches.

Plan to eliminate breaches includes
- Short term Waiting List Initiatives
- Insourcing
- Longer term recruitment to increase core capacity to 48 weeks.

Plan to eliminate breaches and reduce overall waiting :
- Short term
  - Overtime
  - Insourcing
  - Partnership working with Swansea Uni
- Longer term
  - Additional staff recruitment
  - 6 Day Working

Why Change : Diagnostics – Neurosphysiology and DXA





- Restricted working practices due to COVID have given rise to significant increases in patients waiting and waiting time breaches.
- Plan to eliminate breaches includes :
  - Waiting List Initiatives
  - Outsourcing
  - Workforce redesign
  - Consultant Recruitment

- Plan to eliminate breaches includes :
  - Additional Recruitment to enable extended working days and Weekend Working.

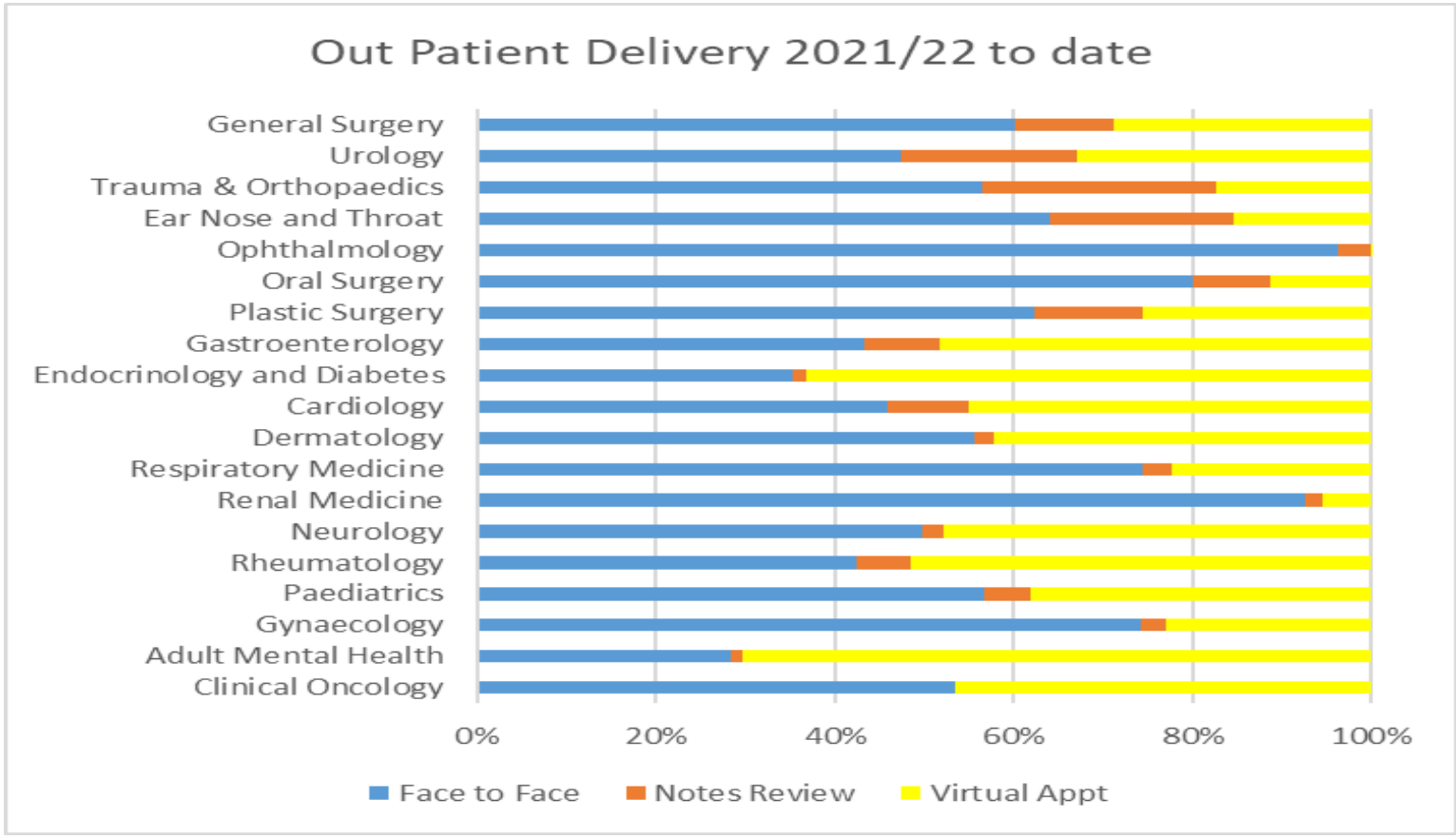
Why Change : Diagnostics – Pathology

Key Objectives :
Maintain Core Services
Increased demand generated from recovery related activity – estimated 25% increase
Cancer Pathway Optimisation – reduced turnaround time .

Enhanced Demand and Capacity modelling
Workforce Resilience – Recruitment and Retention
Phlebotomy Service Redesign.
Digitalisation

Long Term working with HDHB , PHW , Swansea University to develop regional pathology service (OBC to Welsh Govt mid 2022)

Changing models for OP Delivery



Why Change : Clinical Service Models

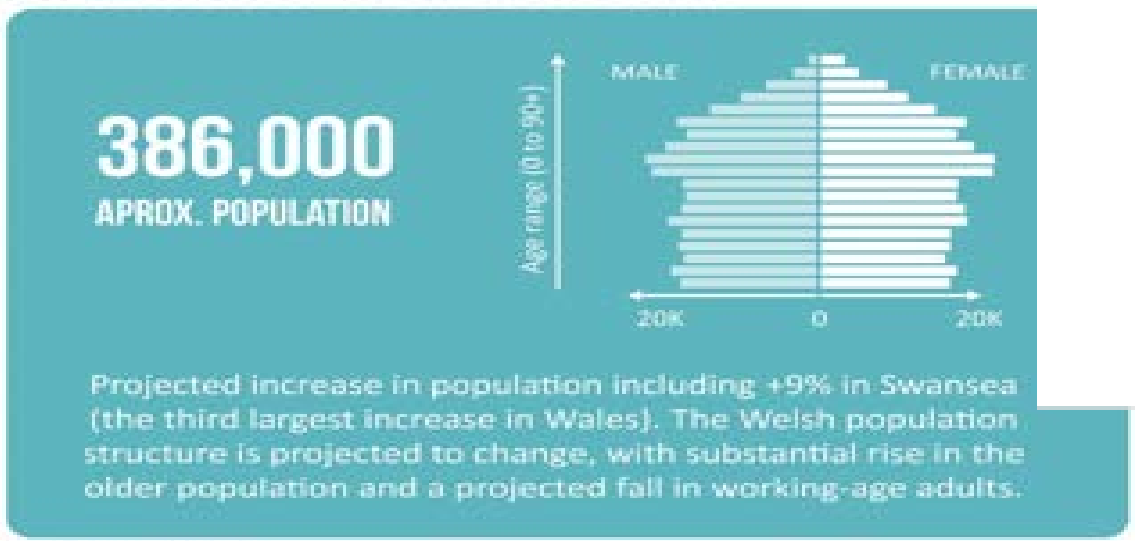
Fragile Services i.e. those services where significant clinical and/or workforce risks have been identified

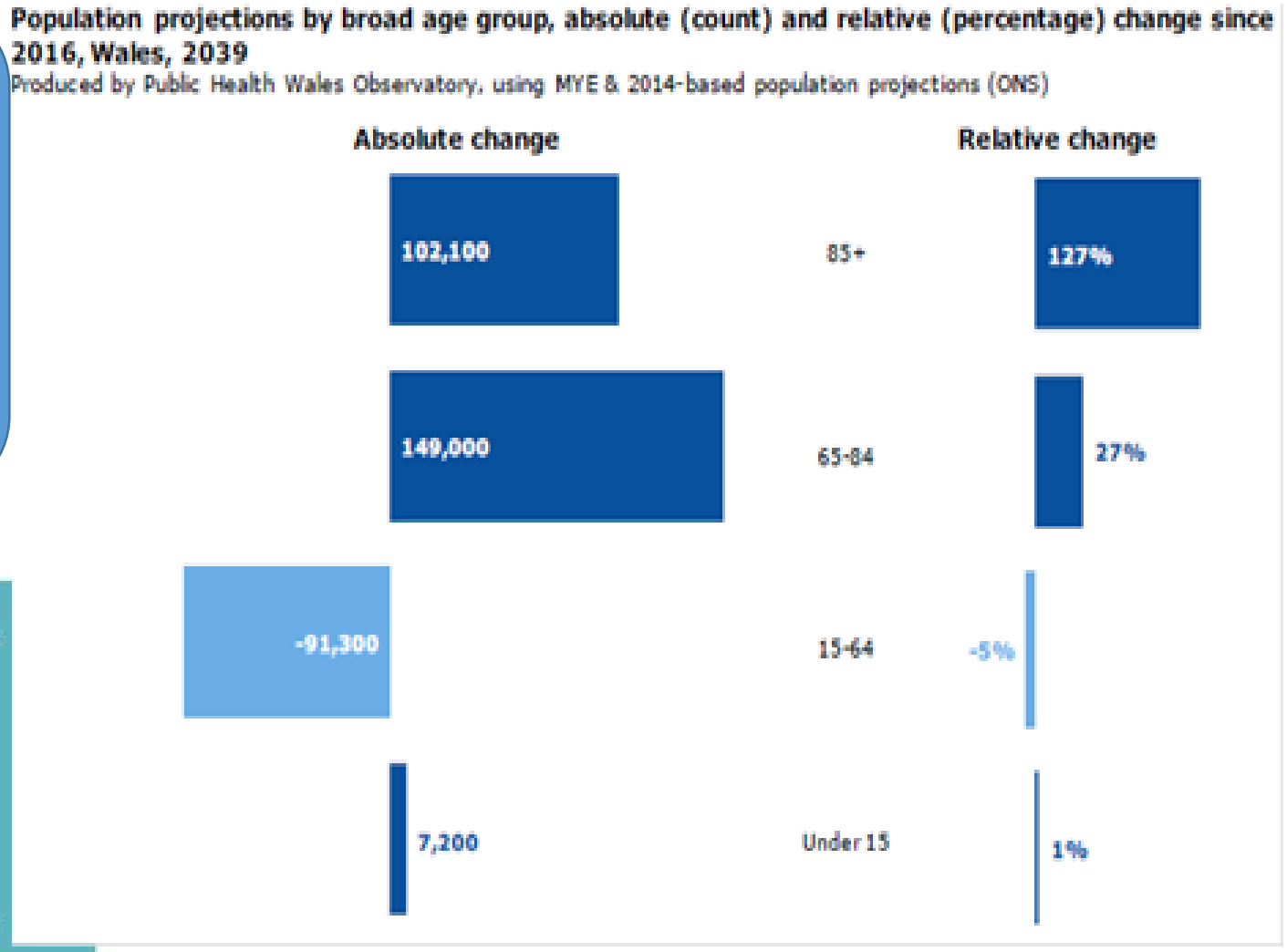
??

Why Change : Workforce

Population projections suggest that whilst the over 65yr old population increases, significantly so at 85yrs + the adult working age population will shrink.

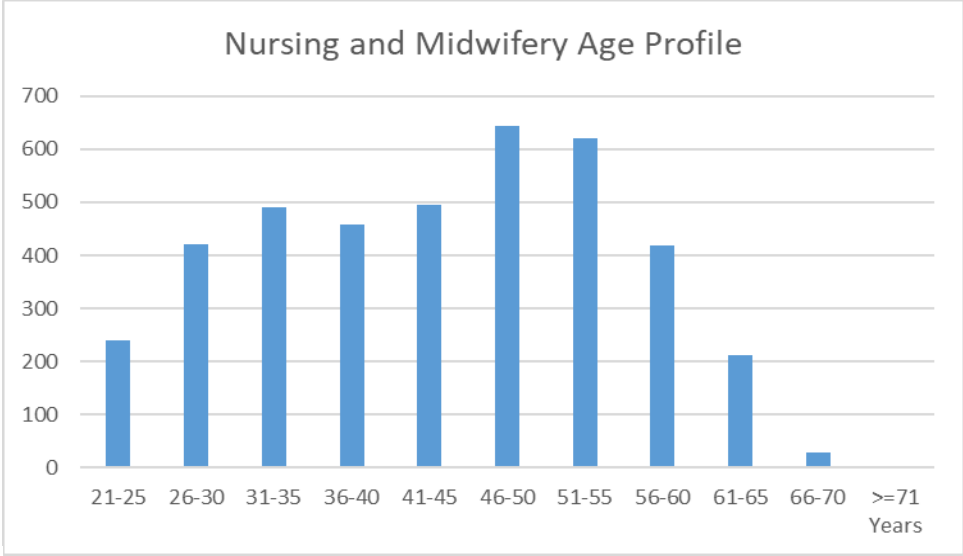
This will impact the available adult carer and health and social care workforce to care for the aging population



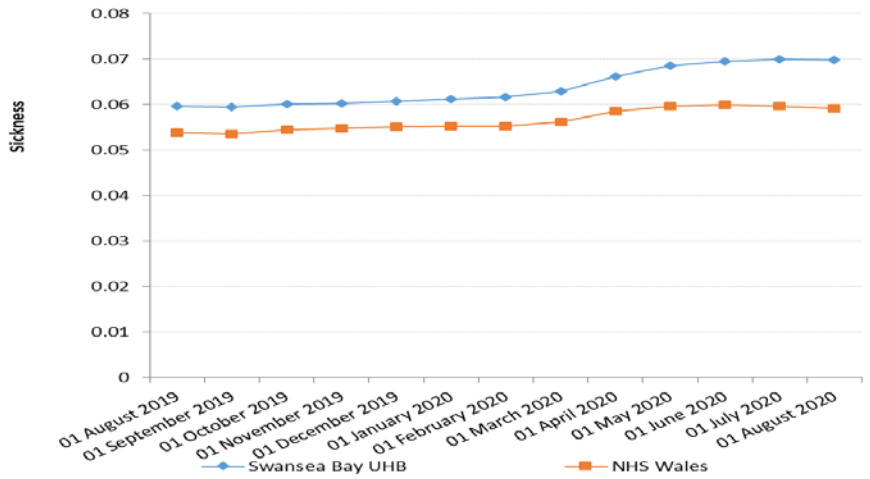


Why Change : Workforce

Position as at December 2020				
Staff Group	**Budgeted WTE**	**2020 / 12**	**Vacancy wte**	**Vacancy %**
Add Prof Scientific and Technic	402.45	389.92	12.53	3.11
Additional Clinical Services	2430.61	2,392.41	38.20	1.57
Administrative and Clerical	2220.22	2,170.79	49.43	2.23
Allied Health Professionals	854.80	804.53	50.27	5.88
Estates and Ancillary	1147.35	1,073.13	74.22	6.47
Healthcare Scientists	322.26	302.98	19.28	5.98
Medical and Dental	1192.57	1,005.84	186.73	15.66
Nursing and Midwifery Registered	3872.05	3,566.07	305.98	7.90
Students	0.00	7.00	-7.00	0.00
Grand Total	**12442.31**	**11,712.67**	**729.64**	**5.86**



Particularly high vacancy rates for Medical & Dental and Nursing Staff



Aging workforce with significant proportion approaching retirement age

Sickness higher than NHS Wales average – Ongoing Impact of Covid

Why Change : Learning from COVID

Service Delivery

Digitally Enabled Care : improves patient triggered care, rapid access to urgent care, maximises estate use & increases access to non-site based care options.

Integrated Care Hubs : consolidates skills & expertise, streamlines clinical decision making and improves access.

Single Points of Access : increases planned care response to otherwise traditionally emergency care. Supports management of flow, queues and waiting times.

Scheduling Unscheduled Care : streamlines & simplifies access into UEC services, reduces patient & staff confusion, increases timely access and improves clinically coordinated care & outcomes for patients.

Ways of Working

Change empowerment : clinically led service change can be rapid when governance processes are lighter touch.

Integrated Intelligence : timely & effective decision making is better with integrated intelligence, systems & teams.

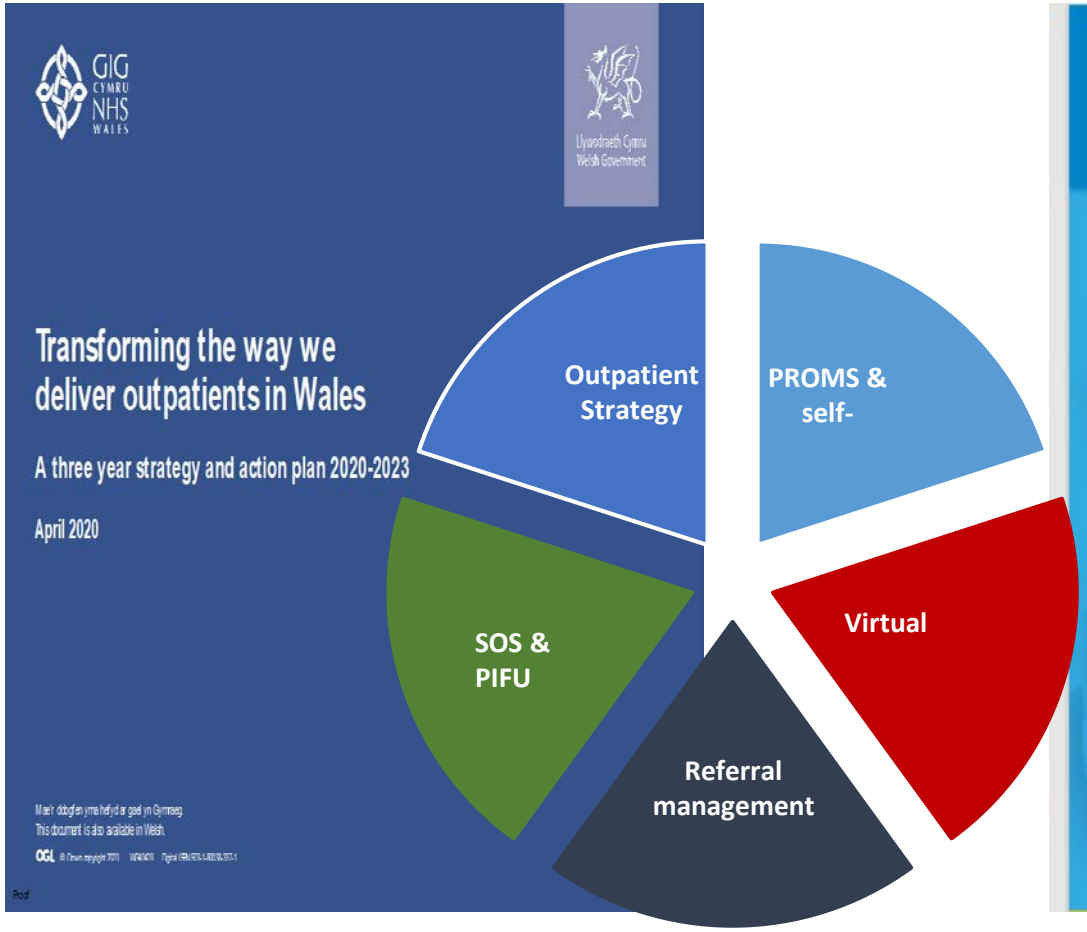
Single System : staff working across services & teams or in MDTs can increase collaboration across pathways and services to deliver service change; staff reported closer team working and collaboration.

Agile Workforce : redeployment of staff with training /service orientation can create a more diverse workforce, help upskilling and development, improve spread of good practice and deliver a flexible response to demand.

Digital & Remote working : staff reported digital increased feelings of flexibility, engagement with colleagues, partnership working and attendance at meetings, greater inclusion in discussion and improved decision making.

Why Change : National Policy

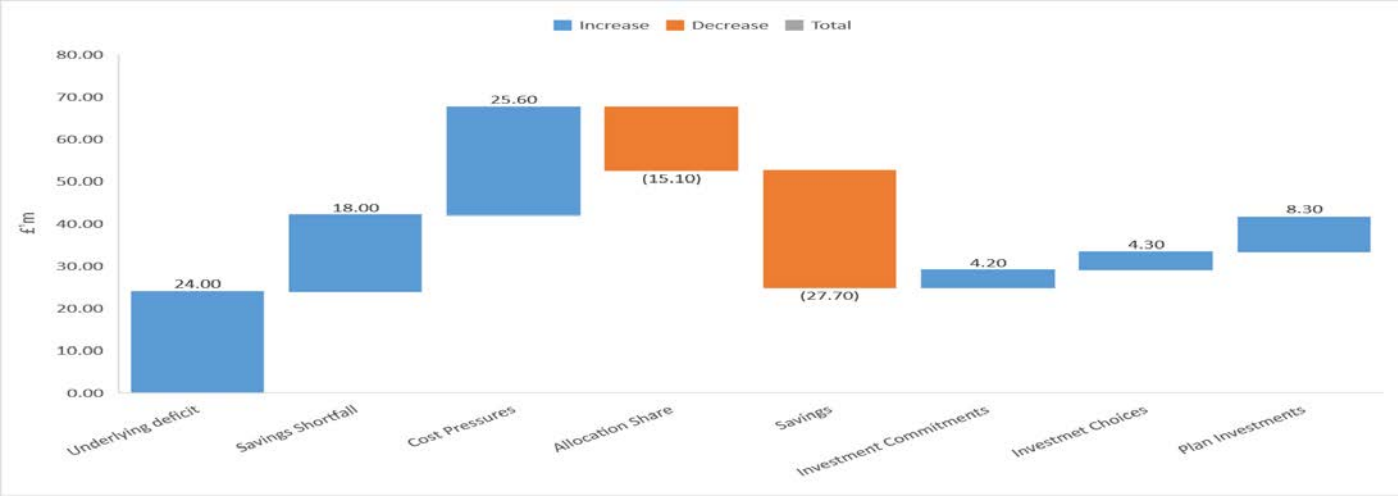
- A Healthier Wales and Well-being & Future Generations Act : co-producing solutions with individuals, families and communities to prevent ill health and build resilient communities
- National Clinical Framework: whole system pathways of care

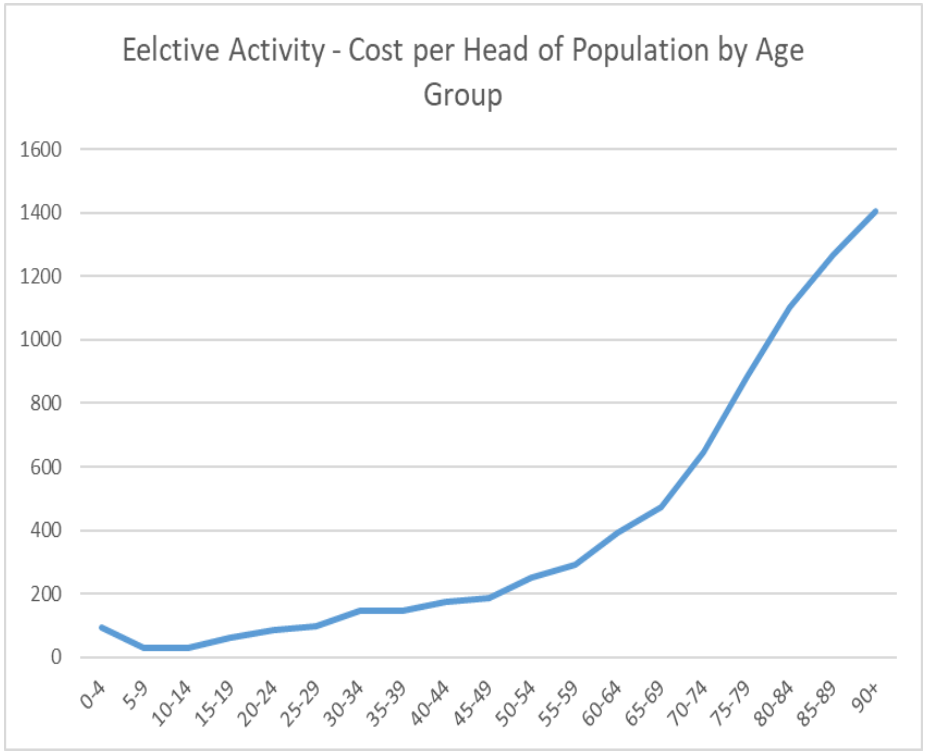


Why Change : Financial Sustainability

- £42m underlying deficit
- £17m savings required to stand still in 2122

Ageing population making greater demands on elective services will be a risk to future financial sustainability





Underlying Deficit - by Service Area	Underlying Deficit
	£000
Primary Care	-3,400
Mental Health	-2,661
Continuing HealthCare	-2,300
Commissioned Services	-1,170
Scheduled Care	-5,270
Unscheduled Care	-15,402
Children & Women's	-1,420
Community Services	-1,555
Specialised Services	
Executive / Corporate Areas	-8,205
Support Services (inc. Estates & Facilities)	-694
Total	**-42,077**

Why Change : Pharmacy Services

Current Challenges;

- Fragile Pharmacy IP Services
- Over-reliance on single individuals – e.g. Oncology, HF
- Diabetes & Respiratory – largest areas of spend

Improvement Opportunities;

- IP Pharmacists in Outpatient clinics and GP practices – providing follow ups, counselling, ongoing monitoring, prescribing and patient pathway management to improve capacity of Consultants;
- Newly qualified Pharmacists will become IPs in acute settings;
- Virtual / telephone appointments;
- Utilise Homecare Medicines Services;
- Clinical Technician role to be trialled and expanded in LTC;
- Pharmacy Service to Surgery;
- Further engagement with speciality teams – i.e. respiratory, diabetes, cardiac (HF)
- Frail Elderly – investment in Pharmacy team has been agreed for Care Homes and Domiciliary Care

Why Change : Pharmacy Services

Improvement Opportunities;

- Frail Elderly – vanguard approach from acute front door to Primary Care;
- Embed Clinical Pharmacists in CMHTs.

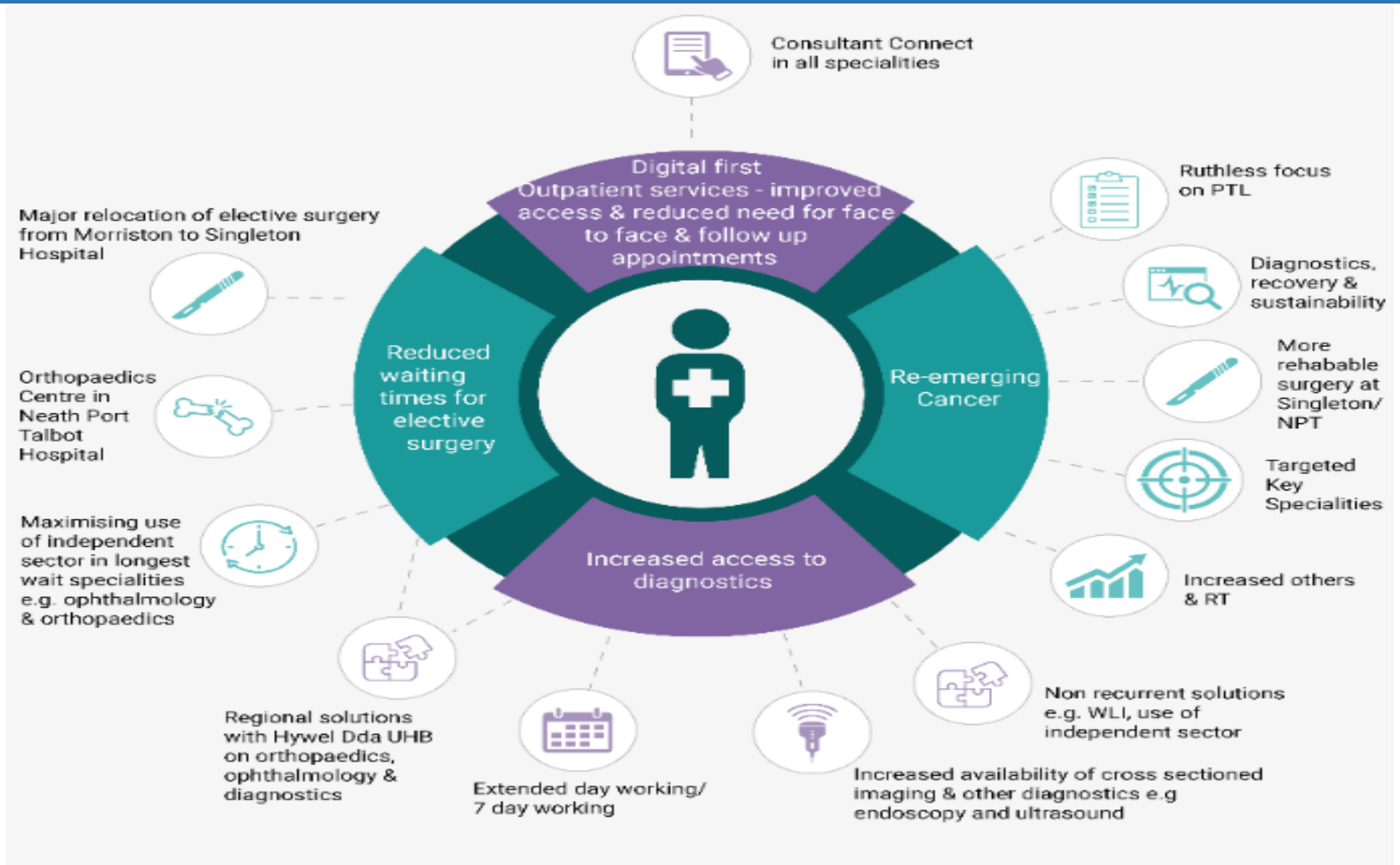
Reduced patient time spent:

- Positive impact on Patient Flow – targeted 7/7 services, timely Medication reviews on admission, Medication optimisation, 7/7 discharge
- Reduction in acute site footfall – allowing more serious cases to be seen

Reduced patient harm from:

- Reduce variation / inappropriate prescribing within MH
- Pain management support
- Substance misuse support
- Delays in diagnosis and treatment
- Physical, emotional and/or mental deterioration from longer than necessary stays in hospital

Excellent Services : 2021 -22 Delivery



SBUHB CSP Principles

One System of Care

My Home First

Right Time & Place

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Excellent Services : Clinical Services Plan

Planned Care System Vision

Excellent Services : Looking Forward

Looking Forward : Further Opportunities to explore in Planned Care

Goal	Method - service change evidence suggests	Outcomes
Maximise timely access through efficient use of estate and workforce; where appropriate provide non-surgical management;	**Theatres & Surgical** Relocation of surgery by complexity across sites, Pooling of waiting lists, Primary care demand management scheme, Enhanced Recovery After Surgery, Therapeutic assessment and non-surgical management of patients, 7 day working, discharge planning	Reduction in aLoS by equivalent of 13 beds *Reduction of equivalent of 3 beds by increasing day case rate Reduction in Outpatients appointments equivalent to XX
	Peripheral Vascular Disorders diagnostic assessments close to home & enhanced discharge planning, Pancreatic disorder education, self help and community MDT services, Post Op LoS; Spinal, Hip and Knee fracture	
	Out Patients Slot utilisation, DNA policy, patient initiated, virtual, self booking, intelligent automation, Community appointments	
	***Day case 0 LoS** : Ophthalmology, Breast Surgery, Head & Neck, ENT, Urology, Gynaecology,	

**Note: at present these opportunities are limited when considered within context of overall service improvement programme*

Excellent Services : Looking Forward

Looking Forward : Digital Opportunities

Digital Primary Care transformation through technology to transition care from Secondary to Primary and Community care settings through scaling up and embedding existing solutions such as:-

- AskMyGP
- Consultant Connect and Welsh Clinical Communications Gateway (WCCG) Connect
- Virtual consultations

The impact can be further enhanced through the introduction of new Digital solutions, including:

- Welsh Community Care Information System (WCCIS) –
- E-scheduling
- Swansea Bay Patient Portal (SBPP)
- Welsh Clinical Portal
- Business intelligence

Delivering a Digital primary care will enable the transformation of our care pathways, support the creation of additional capacity and provide our citizens

Excellent Services : Looking Forward

Looking Forward : Pharmacy Opportunities

Excellent Services : Looking Forward

Looking Forward : Integrated Cluster – workshop July 2021 tbc

Benefits : Patient Experience

Increased Patient Access to;

- Timely information and advice
- Ways to manage and activate their own care
- The right care giver and service at the right time, first time
- Virtual appointments
- Diagnostics including at home and in the community

Reduced patient time spent:

- Travelling for outpatients appointments
- Waiting for diagnostic tests
- Waiting for surgical procedures
- Waiting to be discharged from hospital

Reduced patient harm from:

- Delays in diagnosis and treatment
- Physical, emotional and/or mental deteriation from longer than necessary stays in hospital

Benefits: Efficiency

Key Messages Service Transformation Planned Care

Patient Flow - Opportunity quantified as 16 Beds

Theatre Utilisation (Pre Covid)

Out patient Modernisation

Elective LOS opportunity– @13 Beds

Day Case Rates Opportunity - @3 Beds

'Wasted' sessional time equates to 623 sessions – dependent in part on resolution of patient flow

- Reduction in DNA rates
- Enhanced Slot Utilisation
- Reduced Follow Up
- Non F2F contacts
- Patient activation & PROMS
- Process Automation

Equivalent bed opportunity in total suggests comparatively low return at an individual pathway level

Optimising Acute Care will in part improve theatre utilisation

Consequences

- Do nothing scenario 10yr trajectory

How we will deliver the changes

Patient and Staff Engagement and Consultation

CYNGOR IECHYD CYMUNED COMMUNITY HEALTH COUNCIL | BAE ABERTAWE SWANSEA BAY

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board

Clinical Leadership and the Planned Care Programme

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Information accurate at time of publishing

Meeting Date	**21st June 2021**	**Agenda Item**	
Report Title	Sustainability & Recovery Plan Workshop Outlines		
Report Author	Kerry Broadhead, Head of Strategy SBUHB Carolyn Gullery, Specialist Healthcare System Advisor Lightfoot Solutions Group Ltd		
Report Sponsor	**Sian Harrop-Griffiths,** Executive Director of Strategy		
Presented by	Kerry Broadhead, Head of Strategy SBUHB Carolyn Gullery, Specialist Healthcare System Advisor Lightfoot Solutions Group Ltd		
Recommendation	Members are asked to: • Endorse the proposed workshop outlines • Endorse the proposed dates for delivery		

1. INTRODUCTION

To describe the proposed approach to delivering two engagement workshops to inform development of the SBUHB Sustainability and Recovery Plan (S&R plan).

2. BACKGROUND

The HB is developing a 3-5 year S&R Plan to set out what clinical service excellence looks like for the HB to enable improved financial health. Two workshops are proposed to inform R&S plan development;

1. **The role of Integrated Clusters 2022-27** defining the future of integrated clusters in delivering system sustainability and how to deliver this.
2. **Developing a Sustainable SBUHB System**: answering some of the key system wide questions to achieving sustainability.

2.1 The role of Integrated Clusters 2022-27 Workshop Outline

The workshop will define the future role of clusters in the context of 'hospitals only doing what only a hospital can do' and will deliver the following outputs;

- A vision for Integrated Clusters 2022 - 27
- A summary of the enablers required to achieve the vision;
    - Novel pathways.

    - Workforce solutions.
    - Technology requirements.
    - Health Board infrastructure support.
    - Investment/ disinvestment
- 4 outline delivery model visions and key actions required to achieve these for;
    - Mental Health
    - MSK
    - Diabetes
    - Frail elderly

The choice of the four models is based on clinical areas identified by primary care as offering the greatest opportunities to 'rethink' existing system/service models. The session participants will include;

- Integrated Cluster leads
- Delivery Group Clinical Directors and managerial leads
- A National lead for primary care (Sue Morgan/Alan Lawrie/Alastair Roeves)
- A small number of secondary care clinicians
- RPB representation

A detailed programme will be developed by the Strategy Directorate and Lightfoot Solutions working with Anjula Mehta, Medical Director for the Primary and Community Service Group, who has agreed the approach and will chair the workshop supported by facilitation from Lightfoot Solutions Ltd. The date for the workshop is scheduled for 28th July 2021 at Singleton Chapel.

2.2 Developing a Sustainable System Workshop

In the context of the SBUHB Case for Change evidence and the emerging visions for integrated clusters and acute medicine models the workshop will build on the outcomes of the first workshop and consider the following questions;

- What would the system look like if it was better integrated and patient centred?
- How can we shift system focus to a wellness and prevention model and reallocate resource accordingly?
- What are the priority actions to deliver the CSP in the next 3-5 years?
- Do the change programmes address our highest areas of risk?
- What is the best practice we need to adopt?
- What are the top "vital priorities" to improve leadership and performance
- How can we use data to drive change?

The workshop will implement a 'world café' approach; asking participants to share their ideas based on their experience and areas of expertise to deliver the following outputs;

- System vision / direction of travel
- Priority changes required to deliver sustainable service models
- Improvement opportunities (service, leadership, performance)

The session participants will include representives from;

- Primary, Community and Hospital clinical leaders (nursing, medical and therapies)
- Executive Directors
- Community Health Council
- Social Care Leadership
- Service Group Directors

A detailed programme will be developed by the Strategy Directorate and Lightfoot Solutions working with the Executive Director for Strategy. Facilitation will be provided by Lightfoot Solutions Ltd. The date for the workshop is proposed as 12th August 2021 at Singleton Chapel.

3. GOVERNANCE AND RISK ISSUES

Attendance: securing appropriate attendance to deliver the required outputs
Mitigation: early agreement of participants and circulation of invitations

4. FINANCIAL IMPLICATIONS

There are no financial implications associated with delivering the workshops.

5. RECOMMENDATION

Members are asked to:

- Endorse the proposed workshop outlines
- Endorse the proposed dates for delivery