# CHANGING FOR THE BETTER

working **together**

caring for each other

always improving

**ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH
BOARD - INTEGRATED MEDIUM TERM PLAN**

**April 2015 – March 2018**

GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

## Foreword



We are delighted to present to you the Abertawe Bro Morgannwg University Health Board Integrated Medium Term Plan for the period 2015 to 2018.

In 2014/15 we agreed our strategic vision and six strategic aims with our partners and within our agreed three year plan we described how we would make progress against these. During the year we have made significant progress against many of these and we are proud of the work we have carried out in this regard.

2014/15 was also a very challenging year for us as a Health Board. We received the outcome of our independently commissioned AQuA report into the quality of care being provided at Princess of Wales Hospital which we instigated through our own internal escalation mechanisms. In May these findings were supplemented with the findings from the Andrews 'Trusted to Care' report which painted a distressing picture about aspects of care provided at that hospital.

Clearly this is unacceptable and our principal priority during the year has been to engage with our staff and work with them to start to put this right. Our dedicated 'Action After Andrews' taskforce has led tirelessly on this work, engaging with over members of staff, patients and leaders to establish the best way to address these shortcomings. This focus on protecting our public and keeping patients safe has been strengthened as the underlying principle of all our actions in 2014/15 and will continue to be the most important part of this Plan. In early 2015 we launched our Values and Behaviour Framework, based on engaging with over 6,000 patients, carers and members of staff, and these values are at the heart of all that we do.

We have strengthened our commitment to improving our standards of care, particularly by investing in our nursing workforce. Recruitment and retention of nursing staff across the NHS in Wales is a significant challenge and we will focus on fully establishing our nursing teams whilst supporting them with complementary skills to allow them to focus on care delivery.

We recognise that our performance has not been as good as it has been in some areas during 2014/15. Much of this was a result of the pressures of unscheduled care during the second half of the year which impacted on our planned care and other services. We are determined to improve on this in 2015/16.

Whilst our hospital-based care is being supported to achieve the highest of standards, we will build on our successes in the development of our primary and community care services. We are committed to supporting patients as close to their homes as possible with local services which promote independence and wellbeing. This supports the strategic direction of the Health Board to develop a whole system of care which is focussed on the wellbeing of its population.

In 2015/16 we will deliver our strategy, embed the learning from the recommendations of the AQuA and 'Trusted to Care' reports and begin to substantially move the healthcare system to a community-based focus. This will be based on the values we have developed with our staff, patients and stakeholders and will underpin how we work as Health Board. Within our hospitals, care will be of the highest quality and will reflect our commitment to quality and safety at the heart of everything we do.

This IMTP is quality and values driven. We are clear on where we want to be and how we want to achieve our goals. Our commitment to quality and safety is unfaltering and has been reinforced by the lessons we have learned in 2014/15.

Through our collaborative ARCH (A Regional Collaborative for Health) programme, developed in partnership with Swansea University and Hywel Dda University Health Board, and the work supported by the South Wales Health Collaborative, the opportunities for the future model of our services are based on sound foundations but also present exciting and unprecedented opportunities for partnership working and genuine health and social care services to support our citizens.

We are realistic that the Health Board faces significant challenges, as do all other health providers across the UK. Our commitment to quality, sustainability and a balanced healthcare system which is built on strong values, quality focus and partnership working, as set out in this Integrated Medium Term Plan, will serve our patients, families, carers and staff in a meaningful, transparent and legitimate way.

**ANDREW DAVIES**
**CHAIRMAN**
**ABM UNIVERSITY HEALTH BOARD**

## Executive Summary

This document describes our plan as a commissioner and provider of health care services to meet the needs of our local population over the next three years, 2015/16 – 2017/18. In preparing this plan, we have:

- Reviewed our earlier Integrated Medium Plan for 2014/15 – 2016/17, (which was approved by Welsh Government in April 2014)
- Considered the key drivers for change, including the needs of our local population
- Reflected on our progress and challenges in 2014/15
- Reflected on the key messages from a comprehensive engagement exercise with patients, carers and our staff
- Reviewed our performance over the past year.

We have concluded that our purpose, vision and strategic aims remain the same for this IMTP. Our purpose is to fulfil our civic responsibilities by improving the health of our communities, reducing health inequalities and delivering effective and efficient healthcare in which patients and users feel cared for, safe and confident." Our vision is to be an excellent healthcare, teaching and research organisation for ABMU and the wider region. This means that:

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

Our six strategic aims are to achieve:

- Healthier Communities
- Excellent patient outcomes and experience
- Sustainable and accessible services
- Strong partnerships
- A fully engaged and skilled workforce
- Effective governance

Our modelling is based and planning assumptions are built from The Strategic Health Needs Assessment (SHNA) produced in 2013. Whilst we have made good progress in delivering our strategic aims, the Health Board, along with all other NHS organisations in the United Kingdom has experienced significant operational pressures in 2014/15, particularly around the provision of unscheduled care.

We deliver high quality care to most of our patients, however, in early 2013 it became clear that there were legitimate concerns about the quality of some care provided, particularly at the Princess of Wales Hospital. This became apparent through ombudsman reports, coroner reports, complaints profiles and police investigations. In response to this, in the summer of 2013 we set up a quality improvement programme and through the work of this programme we engaged the Advancing Quality Alliance (AQuA) to undertake an independent assessment of our services. In October 2013, the Minister for Health and Social Services in Wales also announced an independent review which would be known as the Andrews Report *Trusted to Care* report.

As a result we have put in place a rigorous and robust approach to improving care, with a dedicated Taskforce to lead this work. This is demonstrating clear benefits and improvements in the standards of patient care provided, as shown through improving patient feedback. This focus on protecting our public and keeping patients safe has been strengthened as the underlying principle of all our actions in 2014/15 and will continue to be the most important part of our plan for 2015/16 and beyond.

At the beginning of 2014 we started to develop our Values. The Board set clear expectations of change for the next three years and we have recently agreed our three core values: -

- Caring for each other
- Working together; and
- Always improving

In developing our Values, we have undertaken one of the largest patient, staff, and public engagement exercises in NHS Wales. This has been an enormously rewarding and humbling experience for the Health Board. We are using the information from what our patients, their families, patient groups, the voluntary sector, other stakeholders and the public have told us to fundamentally change how we plan, provide and deliver care.

For the first half of 2014/15 the implementation of our plans set out in the 2014-2017 IMTP began to provide system benefits and improvements in unscheduled care access times, ambulance handover and medical outlying patients were evident. During the second half of 2014/15, changing demands on our unscheduled care services and high levels of staff vacancies meant that we were not able to achieve all of the high standards we set ourselves during 2014/15, across a range of important measures.

We have responded to these challenges by turning surgical beds into medical beds and investing significant additional resource in staffing services over seven days. We have a number of other actions underway: -

- Strengthening organisational level leadership and coordination to manage the unscheduled care pressures
- Developed joint solutions and integrated approaches with the Welsh Ambulance Services NHS Trust (WAST)
- Revised GP Out of Hours (OoH) service models and protocols
- Enhanced inpatient models and discharge planning
- Escalation to and involvement of senior social and community care leads
- Protecting urgent and cancer surgery capacity through a variety of models
- Direct communication and media campaign

We know that these pressures impact on the quality of our care for patients, the experience of our patients and their families, waiting times, staff morale, and finance. We have sought to minimise these wherever possible and will continue to do so through identifying where we can reduce pressures, and focussing on a whole system approach.

We recognise that our planned care patients waiting for routine surgery are waiting longer than we would hope. We have reflected on our experiences in 2014/15 and based on our six strategic aims and informed by the above information we have identified the following priorities.

The significant detail behind each of these priorities is set out in the document which follows, but the priorities circled on the diagram above are the ones which will receive our primary focus in this IMTP. These are listed for ease below as they represent the fundamental essence of this Plan.

- Reduce inequalities in health
- Implement our Quality Strategy
- Embed **Trusted to Care** recommendations
- System shift to primacy care
- Sustainable Unscheduled Care services
- Sustainable planned care services
- Community based models of care
- Reduce sickness absence levels
- Improved recruitment and retention
- Skills development programme and extended roles
- Achieve financial balance

Robust demand and capacity modelling has been completed to estimate the possible patterns and levels of demand for medical beds across the Health Board. Historical patterns of bed consumption have been studied and adjusted for anticipated future demand for demographic change; in addition a provision has been made for patients who were unable to flow from Emergency Departments due to bed pressures, who would, in a less constrained bed environment, have required a modest bed stay. Having considered the historical pattern of bed consumption, it was determined that the years followed a broad pattern of demand where three distinct time periods at distinct bed consumption levels were observed.

- February to September (baseline)
- October to December ("winter" uplift)
- January – in some years exceptional and above the October to December level

The table below sets out the predicted bed demand consumption by hospital.

| | February to September | | October to December | | January | |
|---|---|---|---|---|---|---|
| | Occupancy | beds | Occupancy | beds | Occupancy | beds |
| Morriston | 94% | +21 | 85% | +43 | 75% | +75 |
| POWH | 94% | +26 | 87% | +45 | 82% | +62 |
| Singleton | 97% | +10 | 89% | +25 | 81% | +50 |
| NPTH | 97% | +5 | 95% | +6 | 93% | +9 |
| **Total** | | **+62** | | **+119** | | **+196** |
| | | | | | | |
| **Total @ 85%** | | **+186** | | | | |

These 3 phases of the year have helped us to shape our approach to unscheduled care planning to enable bed capacity and supporting out of hospital services to be prioritised to enable the planned required levels of beds and bed equivalents to be achieved.

Through our planned investment in primary and community care and unscheduled care we anticipate that the baseline level of 62 beds will be achieved and that schemes can be implemented to move to within 15 bed equivalents of the 119 winter level identified. We have also begun to develop contingent plans that could allow for initiatives to provide a further 77 beds (119 to 196) should the exceptional January and February pressures experienced in 2015 repeat in future years. Improvements in unscheduled care and patient flow will allow our planned care activity to increase and will therefore allow us to improve the access standards for RTT and cancer patients.

The financial climate in which we are operating is a challenging one. This IMTP is a Plan for improvement with all of our Tier 1 targets improving performance in year 1. We have set ourselves stretching savings targets and identified a modest level of investment to support our strategic direction. The areas of investment are: -
• Demand on acute services
• Delivering high quality services
• Primary care and community services
• Tier 1 delivery
• Sustaining core services

We have identified savings in the region of £63m, which leaves a financial gap of approximately £35m over the next three years.  Based on our track record of delivering savings achieving a savings target of £63m is ambitious but we feel represents a fair challenge to us.

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

When we combine our cost and funding bases, we get a final assessment of our financial outlook for the next 3 years which shows, year 1 is broadly balanced, £8.85m in year 2 and year 3 is also broadly balanced. The total recurrent deficit for the duration of the plan, at present, is £34.5m.

This IMTP sets out what we aim to achieve, how we will achieve it and the resources required to support it.

# Contents

**Appendices C1 - C26 Mandated appendices**

# 1      Progress in delivering 2014/15 Plan

This section of the Integrated Medium Term Plan provides a summary of our progress in delivering the 2014/15 IMTP.

## 1.1    Introduction

In 2014/15 we set out our six strategic aims: -

- Healthier Communities

- Excellent patient outcomes and experience

- Sustainable and accessible services

- A fully engaged and skilled workforce

- Strong partnerships

- Effective governance

Significant progress has been made against each of these aims, with some examples set out below:

**Healthier Communities**

- 40 community pharmacies targeted to provide Level 3 stop smoking services based on areas of greatest need

- Hospital based smoking cessation service established

- We have the highest levels of vaccination and immunisation in Wales for certain childhood vaccinations

**Excellent Patient Outcomes & Experience**

- Agreed a comprehensive Quality Strategy

- A number of patient stories tell us the recent investment in Community Resource Teams is providing excellent outcomes for people

- Rolled out the Family and Friends Test across Neath Port Talbot, with other hospitals planned

- Opening a new low secure Mental Health Unit at Glanrhyd Hospital to provide fit for purpose and extended capacity for this highly vulnerable group of patients from across South Wales.

- Invested in infrastructure to properly collect, analyse and report on patient feedback

- Embedded universal mortality reviews in practice

- A single view of patient events is now available following the roll-out of the Myrddin PAS system across the whole of the Health Board

## Sustainable and Accessible Services

- As part of the investment into Community Resource Teams, a common access point has been established in each locality ensuring the public and professionals have one telephone number and contact point

- Further development of the Acute GP Unit for Swansea (AGPU), which offers alternative patient pathways, during an urgent episode of care

- Established the Alcohol and Treatment Centre Help Point to reduce inappropriate attendances at A&E

- Developed specialist advice for GPs in a number of specialty areas

- Established a tele health project which links Welsh Ambulance Services NHS Trust with GP Out of Hours

- Increased the consultant workforce to support care for medical patients

- Transferred Vasectomy services from secondary to primary care, with patients able to access a service closer to their homes and with less waiting times

- Completed a review of the Paediatric Assessment Unit at Morriston Hospital and have visited areas in England offering different models of urgent paediatric care to research potentially improved ways of offering this level of care.

- Continued to support and encourage the development of community networks, through their local cluster plans, developing their own local plans and priorities.

## A fully engaged and skilled workforce

- Invested in a Service Improvement Team to support improvements in our care processes and patient flow.

- Engaged large numbers of staff to develop our values and behaviours.

- Started an ongoing programme of training staff in dementia awareness.

## Strong Partnerships

- Strengthened the Community Resource Teams in each of the three localities as part of the Health board's commitment to working in partnership with local authorities and third sector.

- Common assessment with social services for older people.

- Developed a Memorandum of Understanding and agreed work programme with Swansea University.

- Reviewed our partnership arrangements within Substance Misuse Area Planning Board to bring three localities together.

### Effective Governance

- Reviewed and reconfigured our Board Committee structure to improve governance arrangements

- Started plans to review our organisational operational management arrangements to streamline and simplify governance

- Developed our core values, which will underpin all that we do

At the same time, the Health Board, along with all other NHS organisations in the United Kingdom has experienced significant operational pressures in 2014/15, particularly around the provision of unscheduled care.

We had always planned to strengthen our registered nursing workforce and we committed to invest significantly in nursing resource during the year. What we experienced however was a challenging recruitment and retention scenario where we were unable to substantially increase our contracted nursing workforce numbers whilst the funded establishment increased to reflect the demands on the service. Some key indicators on workforce show that whilst our funded establishment has increased by 226 Whole Time Equivalent (WTE) over the last 2 years, the number of vacancies within the funded establishment has increased from 47 to 217 WTE.

As we were unable to recruit to meet demand we have used agency nursing to fill these gaps. In 2012/13 we spent £1.5m on agency nursing, for 2014/15 we are predicting an annual spend in excess of £9.5m. In addition the number of 1:1 nursing requests has doubled placing further pressure on our contracted workforce. The impact of these workforce pressures has contributed to the pressures we have experienced in unscheduled care.

We deliver high quality care to most of our patients, however, in early 2013 it became clear that there were legitimate concerns about the quality of some care provided, particularly at the Princess of Wales Hospital. This became apparent through ombudsman reports, coroner reports, complaints profiles and police investigations.

In response to this, in the summer of 2013 we set up a quality improvement programme and through the work of this programme we engaged the Advancing Quality Alliance (AQuA) to undertake an independent assessment of our services. In October 2013, the Minister for Health and Social Services in Wales also announced an independent review which would be known as the Andrews Report *Trusted to Care* report.

In May 2014 the Andrews Report, **Trusted to Care** report, was published. Some of the findings were shocking and distressing. Nobody could deny that there were problems and we responded immediately. We immediately undertook a significant engagement and briefing programme with our staff on all sites.  As a result we have put in place a rigorous and robust approach to

improving care, with a dedicated Taskforce to lead this work. This is demonstrating clear benefits and improvements in the standards of patient care provided, as shown through improving patient feedback. This focus on protecting our public and keeping patients safe has been strengthened as the underlying principle of all our actions in 2014/15 and will continue to be the most important part of our plan for 2015/16 and beyond.

At the beginning of 2014 we started to develop our Values. The Board set clear expectations of change for the next three years. We developed a Strategy Bridge which we have recently reviewed and which will support our strategic direction for the next three years. The Strategy Bridge is attached as **Appendix 1** and shows how our strategic aims will support us to deliver our purpose through our values.

The remainder of this Section sets out at a high level where we have made progress in 2014/15, where have had challenges and our priorities for 2015/16 and beyond.

## 1.2    Our Values

The Board has recently agreed our three core values.  These are described below:

**Figure 1 :  Health Board Values**

In developing our Values, we have undertaken one of the largest patient, staff, and public engagement exercises in NHS Wales. This has been an enormously rewarding and humbling experience for the Health Board. We are using the information from what our patients, their families, patient groups, the voluntary sector, other stakeholders and the public have told us to fundamentally change how we plan, provide and deliver care. Figure 2 below provides a sense of the scale and breadth of the co-production. This full involvement has not only been in developing our Values, but also the Behaviours which we expect to see and be demonstrated by all our staff going forward.

**Figure 2 :  Engagement Exercises**



We heard from patients, their families, patient groups, the voluntary sector, other stakeholders and the public about their experiences of our care, good and not so good.  We asked them to describe what their ideal care and services would look like and through these "In Your Shoes" sessions the staff who listened to these patient stories made a pledge of how they would act differently in future.  We had over 60 "In Our Shoes" sessions with staff who talked about what makes a good and bad day for them. We asked them to identify what they could do to improve the situation and what other things need to happen.  This resulted in a list of priorities for action from our patients, and a list from our staff.  Acting on these priorities will be key for the organisation going forward in order to demonstrate its commitment to continue to listen and act on what our patients are telling us, as well as our support for our staff through acting on their issues.  The graphics set out in **Appendix 2** represent the messages emerging from these listening sessions.

**Figure 3 : Engagement Exercise – In Your Shoes, patients ideal health service**



This feedback has provided us with an extremely strong basis upon which to develop our Integrated Medium Term Plan (IMTP) for 2015/16 and beyond. Publication of the Andrews Report **Trusted to Care** has fundamentally changed the centre of gravity for the organisation. We have reflected this at the beginning of the 2015/16 to 2017/18 Plan as it is the foundation upon which we are modifying our future Plan for the Health Board. A copy of the Andrews Report **Trusted to Care** and its recommendations can be accessed by the following link.

http://www.wales.nhs.uk/sitesplus/863/page/73970

## 1.3    In-Year Operational Challenges

For the first half of 2014/15 the implementation of Plans began to provide system benefits and improvements in unscheduled care access times, ambulance handover and medical outlying patients were evident. During the second half of 2014/15, changing demands on our unscheduled care services and high levels of staff vacancies meant that we were not able to achieve all of the high standards we set ourselves during 2014/15, across a range of important measures.

Our previous Plan took our Health Needs Assessment and, along with modelling based on a range of trends for unscheduled care attendances and admissions, planned capacity to meet this. Our analysis shows us that during the period from 10th November 2014 to 22nd February 2015 emergency admissions are up 3.6% on the same period on the previous year and within that, admissions for patients aged 80 or over were up by 5.1%. Similarly,

ambulance conveyances for those over 80 have increased by 6.2% on the same period 12 months earlier. The major impact of this is the increased number of medical patients in our beds, the average age of whom is now over 80. Our demographic mapping had anticipated a population growth in the over 80s, but the pace of the increase and the clinical complexity of this patient group has been higher than anticipated. Our clinical teams tell us that this age group has a high level of complexity and acuity, making them more complex to clinically manage, resulting in increased lengths of hospital stay and greater challenges in facilitating comprehensive discharge plans which is exacerbated by demands on community services.

In addition, we have had substantial difficulties in recruiting sustainably to our ward nursing establishments and so have had to use agency nursing. This is not the position that we want and our workforce strategy is an important part of the overall solution to sustainable unscheduled and planned care.

We have responded to these challenges by turning surgical beds into medical beds and investing significant additional resource in staffing services over seven days. We have a number of other actions underway: -

- Strengthening organisational level leadership and coordination to manage the unscheduled care pressures
- Developed joint solutions and integrated approaches with the Welsh Ambulance Services NHS Trust (WAST)
- Revised GP Out of Hours (OoH) service models and protocols
- Enhanced inpatient models and discharge planning
- Escalation to and involvement of senior social and community care leads
- Protecting urgent and cancer surgery capacity through a variety of models
- Direct communication and media campaign

We know that these pressures impact on the quality of our care for patients, the experience of our patients and their families, waiting times, staff morale, and finance. We have sought to minimise these wherever possible and will continue to do so through identifying where we can reduce pressures, and focussing on a whole system approach.

We recognise that our planned care patients waiting for routine surgery are waiting longer than we would hope. However the total number of patients waiting for our services is reducing, indicating that we are treating increasing numbers of urgent surgical cases. We will factor this change in demand pattern into our plans for scheduled care. The summary of our overall performance position for 2014/15 is set out in section 2 below.

## 1.4      Priorities for 2015/16 to 2017/18 Plan

For the current IMTP we recognised the importance of having clear aims and objectives. We engaged widely and took our time to consider what was important to the people we serve. **These six strategic aims remain the same for this IMTP reflecting our commitment to clear direction and intent as a Board:**

- Healthier Communities

- Excellent patient outcomes and experience

- Sustainable and accessible services

- Strong partnerships

- A fully engaged and skilled workforce

- Effective governance

We have reviewed our objectives within each Strategic Aim and these objectives are set out below.  Table 12 in section 4 takes these objectives and illustrates where they are referenced throughout the IMTP. Further detail against these objectives and other actions is set out in section 4 of this Plan.

The diagram below provides an overview of our priorities.

**Figure 4 : Our key priorities**
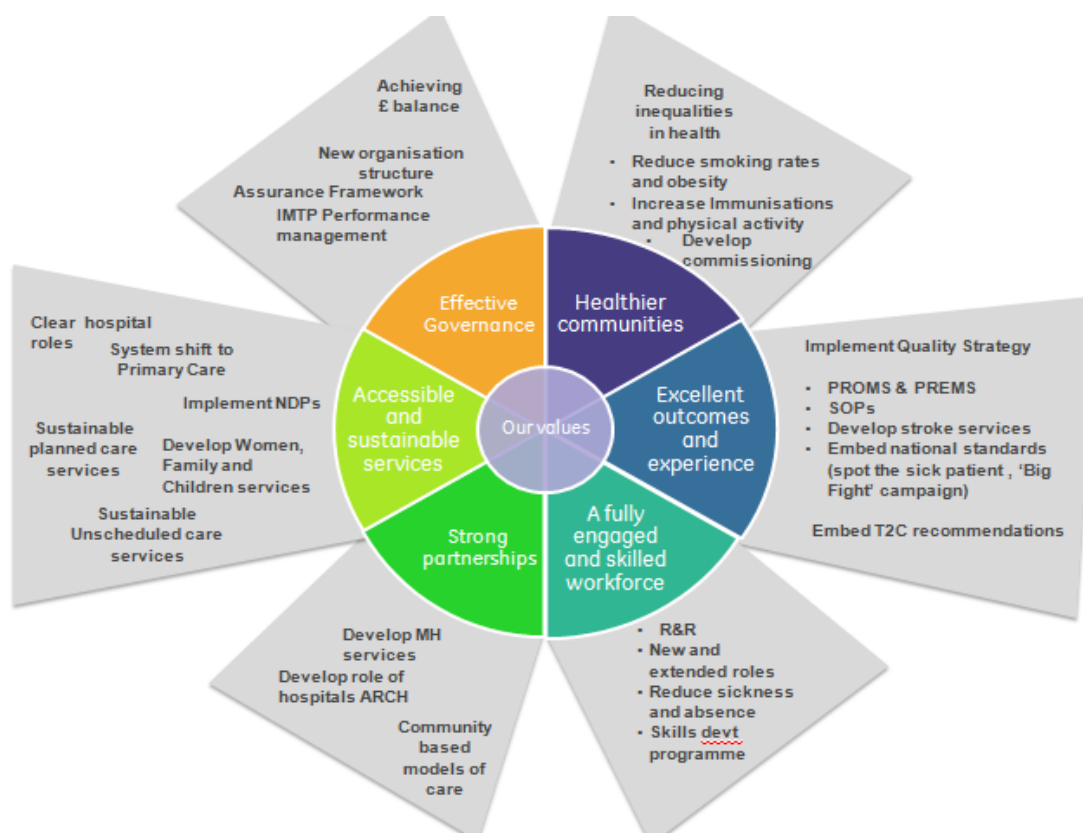


## 1.4.1 Healthier Communities

- Reduce health inequalities by:
  - Reducing smoking rates
  - Reducing unhealthy eating and increasing physical activity
  - Increasing vaccination and immunisation rates
  - Develop our commissioning approach for cancer; mental health; long term conditions; children & young people; planned care; unscheduled care

## 1.4.2 Excellent Patient Outcomes and Experience

- Implement the Quality Strategy:
  - Develop and implement patient reported outcome measures across all major clinical areas
  - Start to replace guidelines with Standard Operating Procedures and automated pathways, in particular implementation of the "Do not Attempt Cardiac Pulmonary Resuscitation Pathway"

- Address the delivery priorities set out by Welsh Government for stroke services
- Embed national and professional standards to reduce inappropriate variation and increase reliability, focussing on:
  - Implement the "spot the sick patient" project
  - Introduce electronic prescribing and medicines administration
  - Roll out the "big Fight" campaign targeting C Difficile infection and antibiotic resistance in primary care.
- Embed the recommendations of the Andrews Report *Trusted to Care*
- Develop our Digital Strategy

## 1.4.3   Sustainable and Accessible Services

- Further develop a system shift to primary and community care:
  - Develop pathfinder initiatives and new organisational models to support GP networks & clusters
  - Improve access to primary care
  - Implement priorities in cluster plans
  - Implement Health Board wide initiatives in respiratory disease and diabetes education
  - Develop programme to improve skills and capacity across primary care workforce (also in A fully engaged and skilled workforce)
- Develop sustainable unscheduled care services across the whole system by targeting opportunities to reduce bed utilisation
  - Improve our patient flow to reduce the numbers of people waiting for unscheduled care and access to care outside hospitals post discharge
  - Continue the implementation of intermediate care initiatives
  - Work with the Ambulatory Emergency Care Network to develop ambulatory care as the default with each of the four hospitals supporting each other as a network
- Have a sustainable plan to meet our planned care requirements
  - Improve the efficiency of our surgical pathways through reviewing standard procedures for the whole patient pathway
- Have clear roles and functions for all of our hospitals
  - Implement the outcomes of the South Wales Programme consultation in Princess of Wales Hospital
  - Further develop and implement service models for the South Central Acute Care Alliance
  - Implement outcomes of the South Wales Programme in Morriston Hospital

- Establish the South West Acute Care Alliance as a formal programme and develop models of care to support agreed priorities
- Open HVS1 at Morriston Hospital and complete further works
- Improve our services for Women, Children and Families
- Implement the priorities from the National Delivery Plans
- Optimise benefits of investment in the Community Resource Teams to support frail older people

### 1.4.4 Strong Partnerships

- Develop proposals for the future role of Morriston and Swansea hospitals as part of a network of care and innovation – ARCH (A Regional Collaboration for Health)
- Implement seamless community based models of care with partner organisations
  - Fully exploit benefits of Community Resource Teams
  - Develop anticipatory care in Community Networks through risk stratification of the most vulnerable in our communities
- Develop a comprehensive and joint mental health service and estates strategy with our partners
- Develop managerial and clinical leaders across the UHB in partnership with education providers.
- Develop UHB wide links with partner organisations across the health economy to develop consistent and common goals.

### 1.4.5 A fully engaged and skilled workforce

- Develop a joint strategic approach to the recruitment and retention of those staff groups where recruitment is a challenge
- Develop new and extended roles to support service redesign
- Continue to reduce sickness absence levels and support the health and well-being of our workforce, through a range of support services such as joint care, protect and respect, emotional wellbeing
- Provide a skills development programme to ensure staff have the skills to deliver safe quality care that matches the needs of our citizens, and supports the development of clinical leadership
- Develop an overarching People Strategy that will reflect our values and create a culture for people to achieve their full potential

### 1.4.6  Effective Governance

- Develop our organisational strategy to set out a clear 10 year vision with clear outcomes, milestones and performance measures to ensure all plans are aligned and consistent.
- Implement the new management arrangements and new ways of working outlines in "Changing for the Better".
- Continuing to deliver financial balance

## 1.5  Summary

We have welcomed and embraced the three year planning process. Our approved IMTP has enabled us to tangibly deliver strategic change, which is improving services across primary, community, secondary and tertiary care. We have strengthened our organisation, through our engagement work and through the development of our core values.

We have faced significant in-year challenges in delivering this strategy, but remain confident that our strategy is taking us in the right direction to deliver our vision.

The remainder of this IMTP now builds on this summary introduction and sets out what we aim to achieve, how we will achieve it and the resources required to support it.

# 2     Health Board Profile

This section of the Integrated Medium Term Plan provides a summary picture of the Health Board's health economy, its service composition and describes the Health Board's current service and performance profile.

## 2.1     Health Community Overview

Abertawe Bro Morgannwg University Health Board assesses the health needs and subsequently commissions, plans, and delivers care for a resident population of approximately 500,000 people. The Health Board has a budget of £1.3 billion. At the end of Quarter 3 we had a planned workforce of 13,347 Whole Time Equivalent (WTE), 70% of whom are involved in direct patient care.

We are responsible for improving the health of our communities as well as the commissioning, planning and provision of both primary (General Practitioner, Optometry, Pharmacy and Dental services), community based services and secondary (Hospital) care services. We provide mental health and learning disability services and also provide a range of very specialist (tertiary) services such as Burns and Plastic Surgery (for South Wales and the South West of England), Forensic Mental Health Services (for the whole of South Wales) and Learning Disability Services (Swansea, Cardiff and the Rhondda Cynon Taf and Merthyr Tydfil areas

The map below shows the geographical area covered by the Health Board and the location of some of our services.

**Figure 5 : Map showing ABMU catchment area**
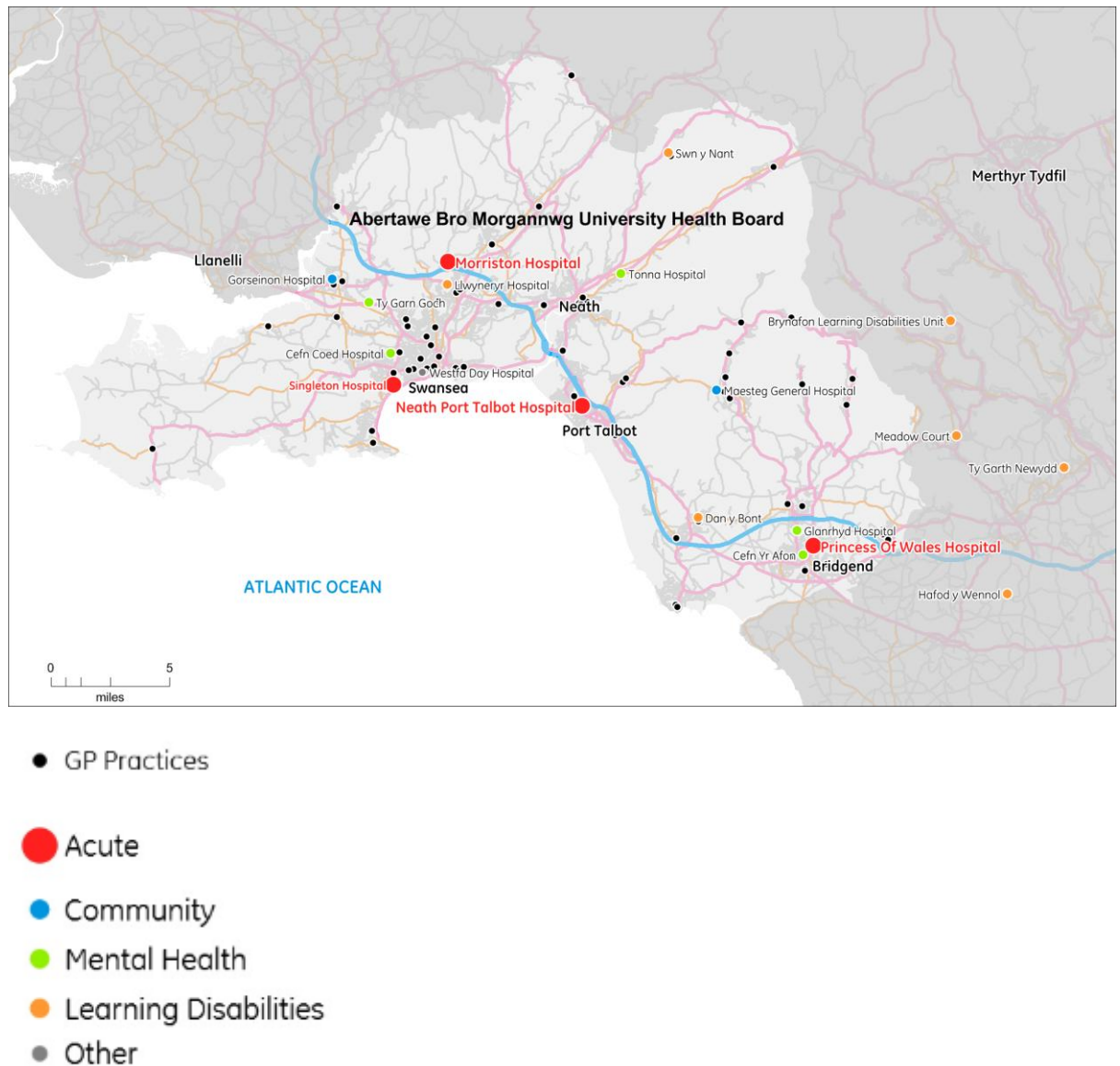


A profile of our services is attached at **Appendix 3**

## 2.2 Activity Summary for 2013/14

An overview of our activity during 2013/14 is set out below. In addition, activity was also provided by independent contractors in primary care, and through other commissioned services (including those provided by the independent and third sector). Nationally, over 90% of peoples' contact with the NHS takes place in primary care settings.

| | |
|---|---|
| **215,235** | New outpatient appointments |
| **425,962** | Follow up appointments |
| **65,598** | Day cases |
| **20,317** | Elective admissions |
| **65,289** | Emergency admissions |
| **188,793** | A&E attendances |
| **6,074** | Births |
| **83,024** | GP Out of Hours Contacts |
| **379,606** | District Nursing Contacts |
| **220,470** | Health Visiting Contacts |
| **372,200** | Home and Community based Therapy Contacts |

## 2.3 Overview of Progress in 2014/15

### 2.3.1 Quality

In Section 1 we referred to concerns about the care of older people at the Princess of Wales Hospital. This led to a review being carried out by the Advancing Quality Alliance (AQuA). Their final report was received in May 2014.

We recognised that the findings of the AQuA report were equally applicable to all of our hospitals and so in 2014/15 we took action to address the AQuA recommendations and started to redesign our systems to ensure consistent delivery of high quality care 24 hours a day 7 days a week. As set out in section 1 above, we received Professor June Andrews', **Trusted to Care** Report and immediately began to implement the recommendations within that report.

In our Annual Quality Statement, published at the end of September 2014, we acknowledged that there are big challenges to overcome, if we are to meet the health needs of our local population and deliver person-centred, safe, caring and compassionate care in the future. We know that to succeed we must work with those living in the communities we serve and our partners to provide more care in a community, primary care or home-based setting. We also want those living and working in the community to help us plan and

deliver primary and community services, because they are best placed to understand local needs and opportunities.

Through our engagement events, we reviewed with our staff, patients and carers, the values we want to see in ABMU. These events also helped us identify clear steps to create a culture of care, which is built on involving our patients in:

- Setting and monitoring of standards

- The resolution of issues

- The practical choices that arise from the need to make prudent decisions within limited resources.

We have developed a behavioural framework for all those who work for us and on our behalf, which was launched in February 2015. This framework will help us to genuinely 'put local residents at the heart of everything we do' and embody the principles of 'Prudent Healthcare'.

Our Quality Strategy (which was agreed by our Board in January 2015), sets out clear objectives for taking forward our quality agenda over the next three years. This is described in Section 5.

### 2.3.1.1 Trusted To Care

In June 2014 we established seven work streams to address the recommendations set out in the **Trusted to Care** report. The table below provides an overview of progress to date against each of these work streams.

**Table 1 : Progress by Trusted to Care Work stream**

| Trusted to Care | |
| --- | --- |
| **Work stream** | **Progress in 2014/15** |
| **Care Standards** | We have: <ul><li>Carried out an extensive staff communication exercise on 'never events' in relation to medication, hydration and toileting practices and provided clear instructions about the good practice we expect to see.</li><li>Introduced a zero tolerance to "never" events across all our services and sites</li><li>Introduced regular unannounced visits to wards to ensure that standards of care are being adhered to.</li><li>Worked with staff, patients and voluntary groups to develop 12 standards of care for older people in our hospitals.</li><li>Developed the "Ideal Ward" assessment toolkit to assess how well each ward area meets minimum standards relating to –Leadership,</li></ul> |

| | |
|---|---|
| | High standards of care, Staff behaviours and culture and environment.  Awards will be able to work towards achieving bronze, silver and gold status.  The aim will be to achieve gold status for all wards.  Baseline assessments are currently being carried out.<br><br>• Developed, consulted on and implemented a new Flexible Visiting Policy across all our main hospitals in all acute areas, meaning that visiting is open from 11am to 8pm every day with families and friends being actively encouraged to spend time with and support their loved ones while they are in hospital.<br><br>• Recruiting jointly with Swansea University a clinical professor in older care.<br><br>• Applied the all Wales acuity tool and increased ward staffing levels in key areas.<br><br>• Worked with patients to improve aspects of food, including options and taste of pureed food. |
| **Environment** | We have:<br><br>• Identified £200k funding in 2014-15 to carry out improvements in ward areas such as call bell systems, signage, ward layouts and noise reduction measures.<br><br>• Hosted a Design School supported by Stirling University with clinical staff, estates project managers and members of our Disability Reference Group to agree the key priorities for environmental change in our hospitals<br><br>• Agreed key priorities for improvements to the environment across our sites<br><br>• Agreed a range of plain English terms for departments which will be rolled out on all signage across our sites along with appropriate pictograms |
| **Learning, skills and knowledge** | We have:<br><br>• Developed and rolled out a compulsory dementia awareness training for all our staff – over half our 16,200 staff have already gone through this programme<br><br>• A multidisciplinary skills programme has been developed for frail older people which is now in place at one of our hospitals and is being rolled out to the others.<br><br>• Training is being delivered by palliative care clinicians in partnership with CRUSE on communicating effectively about end of life care and dying in hospital. |
| **24/7 services** | We have:<br><br>• Worked with frail older people's doctors to agree better ways to support clinical decision making at weekends, and how one clinician will care for a patient throughout their inpatient stay.<br><br>• Made it easier for staff to access out of hour's pharmacy.<br><br>• Developed and implemented swallow screening training for staff in |

| | |
|---|---|
| | priority areas |
| | • Working towards services being available for emergency and urgent patients 7 days a week |
| **Medicines Management** | We have:<br>• Revised our medicines management policy and produced simplified guidance on key issues.<br>• Developed guidance on the appropriate use of antipsychotic medication<br>• Carried out training by pharmacists on every ward regarding registrants responsibilities regarding medication |
| **Integrated Quality** | We have:<br>• Introduced a new approach to complaints, which is more responsive and less defensive<br>• Developed a Patient Liaison Advisory Services at Princess of Wales Hospital which is being evaluated with a view to expansion to other hospitals as new management arrangements are implemented<br>• Developed a quality strategy and overhauled our complaints system, through our Patient Safety and Patient Experience Strategic Change Programmes. |
| **Values and Leadership** | We have:<br>• Held 66 staff *in our shoes* and 18 patient *in your shoes listening* workshops.  We also held events for younger patients and families to understand what was important to them.<br>• Delivered sessions for our managers and leaders to understand their views and what was important to them.<br>• We carried out staff and patient surveys which has had over 3,100 responses.<br>• Used these listening events and surveys to develop a draft set of values and behaviours for the organisation.<br>• Held a series of workshops with staff and stakeholders to finalise our core values.  These values will underpin all that the Health Board does and the behaviours we expect from staff. |

Work is ongoing to plan how these work streams are embedded within the new governance and management arrangements.

## 2.3.2    Performance

The table below sets out the Health Board's performance against the delivery framework outcome measures for February 2015.   A more detailed commentary on performance in 2014/15 is set out in **Appendix 4**.

These measures are routinely reported to full Board meeting of the Health Board, which receives its assurance through the newly established Health Board Performance Committee. More detail on these arrangements is provided in section 10 under Effective Governance.

The hyperlink below links to the March 2015 Health Board performance report and illustrates the detailed level of reporting available to the Board meeting through the report card system developed in 2014/15 to assist with monitoring the implementation of the IMTP. An example of a typical report card is presented as **Appendix 5**.

http://www.wales.nhs.uk/sitesplus/863/opendoc/260183

*Changing for the Better: Integrated Medium Term Plan (IMTP)*
*2015/18*

## Table 2 : Delivery Framework Profile 2015-18

**STAYING HEALTHY -**

| Measure | | | Target | 2014/15 Baseline (month 11 unless specified) |
|---|---|---|---|---|
| Monthly | Number of emergency admissions for basket of 8 chronic conditions | | Reduction | 1203 |
| Monthly | Number of emergency readmissions for basket of 8 chronic conditions | | (rolling 12 | 192 |
| Monthly | Reduction in the number of emergency hospital admissions for pts aged 85+ | | PROJECTIONS | 640 |
| Annual assessment | % uptake of the influenza vaccine in the following groups: | Over 65's | 75% | 65.2% |
| | | Under 65's in at risk groups | | 44.1% |
| | | Pregnant women | | 38.6% |
| | | Healthcare workers | 50% | 41.0% |
| Quarterly assessment | % uptake of childhood scheduled vaccines up to the age of 4: | 5 in1 age 1 | 95% | 96.8% |
| | | MenC age 1 | | 97.8% |
| | | MMR1 age 2 | | 96.8% |
| | | PCV age 2 | | 95.3% |
| | | HibMenC Booster age 2 | | 94.7% |
| Quarterly assessment | % estimated LHB smoking population treated by NHS smoking cessation services | | 5% (end of fin year) | 1.43% |
| Quarterly assessment | % smokers treated by NHS smoking cessation services who are CO- validated as successful | | 40% (end of fin year) | 42.7% |
| Annual assessment | % of reception class children (aged 4/5) classified as overweight or obese | | Reduction | 26.9% |

**EFFECTIVE CARE - I**

| Measure | | Target | 2014/15 Baseline (month 11 unless specified) |
|---|---|---|---|
| Monthly | Crude Mortality | Reduction | 1.87% |
| Monthly | RAMI 2014 | | 100 |
| Monthly | % valid principle diagnosis code 3 months after episode end date - monthly | 95% | 78.9% |
| Monthly | % valid principle diagnosis code 3 months after episode end date - rolling 12 months | 98% | 89.6% |
| Annual assessment | Number of NISCHR clinical research profile studies and Commercially Sponsored studies | Improvement | 99 |
| Annual assessment | Number of Audits the organisation is participating in against the national clinical Audit | 35 | 35 |
| Annual assessment | % people aged 45+ who have a GP record of blood pressure measurement in the last 5 yrs. | Improvement | 87.3% |

**TIMELY CARE - I**

| Measure | | | Target | 2014/15 Baseline (month 11 unless specified) |
|---|---|---|---|---|
| Annual assessment | % GP practices offering appointments between 17:00 and 18:30 at least 2 days a week | | Improvement | 96% |
| Annual assessment | % of GP practices open during daily core hours or within 1 hour of the daily care hours | | | 76% |
| Monthly | % of patients waiting less than 26 weeks for treatment – all specialties | | 95% | 3437 |
| Monthly | Number of 36 week breaches – all specialities | | 0 | 5203 |
| Monthly | % of patients waiting less than 8 weeks for diagnostics | | Improvement | 996 |
| Monthly | % of new patients spend no longer than 4 hours in A&E | | 95% | 77.5% |
| Monthly | Number of patients spending 12 hours or more in A&E | | 0 | 683 |
| Monthly | % of Cat A Ambulance responses within 8 minutes | | 65% | 52.8% |
| Monthly | Number of over 1 hour handovers | | Reduction | 554 |
| Monthly | % of patients referred as non-urgent suspected cancer seen within 31 days | | 98% | 93.0% |
| Monthly | % of patients referred as urgent suspected cancer seen within 62 days | | 95% | 74.0% |
| Annual assessment | Patients treated by an NHS dentist in the last 24 months as % of population | | Improvement | 62.45% |
| Monthly | % compliance with acute stroke bundles: | 1 - First hours bundle | 95% | 86.0% |
| Monthly | | 2 - First days bundle | | 25.0% |
| Monthly | | 3 - First 3 days bundle | | 52.0% |
| Monthly | | 4 - First 7 days bundle | | 64.0% |

| INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities | | | |
|---|---|---|---|
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | % of assessments by the LPMHSS undertaken within 28 days from the date of referral | 80% | 88.8% |
| Monthly | % of therapeutic interventions started within 56 days following assessment by LPMHSS | 90% | 84.1% |
| Monthly | % of LHB residents (all ages) to have a valid CTP completed at the end of each month | 90% | 96.6% |
| 6 monthly assessment | % of hospitals with arrangements to ensure advocacy available to qualifying patients | 100% | 100.0% |
| Annual assessment | % of over 65 registered as having dementia with their GP practice | Improvement | 2.9% |
| DIGNIFIED CARE - I am treated with dignity & respect & treat others the same | | | |
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | % procedures postponed on >1 occasion, had procedure <=14 days/earliest convenience | Improvement | 57.0% |
| SAFE CARE - I am protected from harm & protect myself from known harm | | | |
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | DToC delivery per 10,000 LHB population - mental health | Reduction rolling | 5.40 |
| Monthly | DToC delivery per 10,000 LHB population - non mental health +75y | 12 months | 50.70 |
| Monthly | Number of healthcare acquired pressure sores in a hospital setting | Reduction | 20 |
| Monthly | Number of cases of C Difficile per 100,000 of the population | 31 per 100,000 | 27.54 |
| Monthly | Number of cases of MRSA per 100, 000 of the population | 2.6 per 100,000 | 7.51 |
| Quarterly assessment | % compliance with patient safety solutions - alerts | Improvement | 87.5% |
| | % compliance with patient safety alerts - rapid response notices | | 100.0% |
| Monthly | Number of new Series Incidents | Reduction | 9 |
| Monthly | Number of new Never Events | | 0 |
| OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful | | | |
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | % staff absence due to sickness | Reduction | 5.69% |
| Annual assessment | % of total medical staff undertaking performance appraisals | Improvement | 60.0% |
| Annual assessment | % of total non medical staff undertaking performance appraisals | Improvement | 32.5% |

## 2.3.3 Delivering Service Improvements – Our Strategic Change Programmes

The Health Board has seven strategic change programmes, which are described in the figure below:

**Figure 6 :    Changing for the Better (C4B) Strategic Change Programmes**

**C4B Patient Safety**

**C4B Patient  Experience Programme**

**C4B Clinical Services Programme**
**(9 Projects)**
• **Staying Healthy**
• **Community Services**
• **Hospital Services**
• **Rapid Access**
• **Pre hospital Services**
• **Trauma Centre Development**
• **Outpatient Modernisation**
• **Women, Children and Families**
• **Elective Procedures in Primary and**
**Community Care**

**C4B Surgical Pathway Efficiency**
**Programme**

**C4B Patient Flow Programme**

**C4B Effective Use of Information**
**Systems  and Technology**
**Programme**

**C4B Commissioning Development**
**Programme**

Patient Safety and Patient Experience have now been subsumed into the Health Board Quality Strategy.

We have made good progress against each of these programmes. Examples of progress include:

- Established a tele health project which links Welsh Ambulance Services NHS Trust with GP Out of Hours

- Merging our work on patient safety and patient experience under Action after Andrews to produce a new **Quality Strategy** for the Health Board which will coordinate all quality activities under one strategy. This will ensure that patient safety and quality is central to all that we do and that we monitor clinical outcomes and patient experience in order to check how effectively we are achieving this.

- Setting clear standards of care required for services by setting up **Commissioning Boards for cancer, Children and Young People and Planned Care** by the end of March 2015, with a further 3 coming on line in the summer. These Boards will help us to plan services which meet need, have clear outcomes and use resources prudently.

- Having our **Information Management & Technology (IM&T) Strategic Outline Programme** (SOP) approved by Welsh Government and we are now developing business cases to implement the components of this programme, particularly those which support issues highlighted in the Andrews Report "Trusted to Care" such as e-prescribing.

- Working practices and processes have changed to focus on **Patient Flow**, with a particular focus on rolling out Board rounds across all wards. A number of specific improvement projects have been supported which have demonstrated measurable benefits – medicines reconciliation, Emergency Department (ED) minor injury streams, therapy input to weekends, triage capacity in GP Out of Hours (OOH).

**Appendix 6** provides a more detailed description of progress by Strategic Change Programme.

During 2015/16 the Changing for the Better Delivery Board is overseeing the transition, from the current structures (for developing, managing and monitoring progress in the delivery of our Strategic Change Programmes), to a structure which is initiated through the Commissioning Boards, refined and developed through a programme management approach, with progress against delivery monitored as part of the organisations performance management structure

## 2.3.4   Developing primary and community care services

A key focus for the development of primary and community services in 2014/15 has been the implementation an action plan, which responds to the recommendations set out in the report entitled 'Learning for the Future' . This report was produced following the inquiry into the death of Robert Powell. Good progress has now been made in taking forward the individual recommendations, for example, redesigning the visiting programme for General Practice and the development of an internal dashboard about quality and effectiveness.

2014/15 has also marked the start of a shift in the provision of primary and community services across ABM and we will be looking to build on this progress over the next three years.

During the year we have invested significantly in expanding community based services for older people through the Intermediate Care Fund and also have made good progress in developing community networks. A list of key achievements in 2014/15 is set out in **Appendix 7**. Some of the high level actions against each theme are set out below:

Planning care locally

Supporting the testing of new organisational models within primary care – e.g. federations, social enterprises

- Developing new models of integrated care with social services and third sector

Improving access and quality

- Reducing the levels of Do no Attends (DNAs) within primary care
- Supporting practices to extend the scope for nurses to support access to urgent primary care
- Improving access to primary care by promoting later afternoon appointments

Equitable access

- Improving end of Life Care
- Tackling respiratory disease
- Taking forward actions from the Local Eye Care Plan and Local Oral Health Plan

Skilled local workforce

- Upskilling the practice and community nurses by developing a plan to extend the number of independent prescribers
- Extend the role of community pharmacists to support Networks

Strong leadership

- Develop a leadership programme to support the development of network working
- Continue to support the development of practice managers

## 2.3.5     Prudent Healthcare

We have made good progress in determining how we take forward the principles of Prudent Healthcare. We have carried out a review of our current position and identified the impact of imprudent healthcare.  We have used this information to develop a proposed approach, describing how we will work collaboratively with local stakeholders and setting out a number of specific actions.  This is described in **Appendix 8**.  These actions include:

- Continuing to train clinicians in:

    – Supporting patient self- management

    – Interventions to affect health behaviours such as smoking, obesity, alcohol and physical activity

    – Implementing the co-creating health framework (**See Appendix 8**)

- Ensuring that all patients with chronic conditions are referred to the Educated Patients Programme

- Incorporating the principles of Prudent Healthcare into our approach to Commissioning.  This is described more fully in Section 4

- Expanding the work of our current Prudent Health Care Programmes i.e. Living life well; Expert Patient Programme (EPP); Time Credits; Psychological Therapies; Health and Housing Collaboration; Open access Audiology, Physiotherapy and Podiatry;  Lymphoedema including Surgery and Garments; Enhanced Recovery After Surgery (ERAS) and developing Psychologically Minded Organisations.

- Developing an IT infrastructure to support the delivery of Prudent Healthcare.

We have also, as part of the National Prudent Healthcare initiative, led a project to apply the principles of Prudent Healthcare to the delivery of Audiology services.  The outputs of this project are summarised below.

A Prudent Healthcare Workshop was held in Swansea to test out the prudent principles in Audiology and see how they could be applied.  At the Workshop participants identified five main areas for improvement:

1. Walk in open access clinics for the public who have hearing loss or tinnitus.
2. Rapid access models with the more appropriate use of technology, linking primary and secondary care better using telephone virtual clinics.
3. A treatment pathway for patients with ear wax problems to provide a single consistent service, manage referrals across primary and secondary care, reduce inappropriate referrals to ENT, and improve access and outcomes for the patient.

4. A one stop clinic for managing balance disorder and dizziness including routine balance rehabilitation provided by audiologists with referral mechanism for complex cases. implemented
5. Applying a co-creating health framework that supports clinicians to engage patients in making decisions about their own options. Implemented

Plans for implementing ideas 1-3 are being developed. The fourth and fifth ideas have been implemented.

Audit had shown that around 25% of patients seen by ENT Consultants should have been seen instead by an audiologist. Following strong collaboration between ENT surgeons and Audiologists, the Action on ENT pathway for adult hearing loss has now been fully implemented in ABMU and an Audiologist led clinic for patients with dizziness and balance disorder will start in the New Year. This will reduce ENT outpatient activity by around 20%, giving ENT more capacity to provide expert care to patients requiring medical or surgical treatment and allowing Audiologists to 'work at the top of their licence'.

## 2.3.6 Workforce

We currently employ over 15,000 members of staff as set out below:-

**Table 3 : Health Board Workforce**

| Workforce as at December 2014 | Headcount | WTE |
|---|---|---|
| Add Prof Scientific and Technical | 463 | 409.39 |
| Additional Clinical Services | 2,965 | 2,539.66 |
| Administrative and Clerical | 2,533 | 2,176.39 |
| Allied Health Professionals | 953 | 820.28 |
| Estates and Ancillary | 1,696 | 1,373.48 |
| Healthcare Scientists | 339 | 311.79 |
| Medical and Dental | 1,341 | 1,264.02 |
| Nursing and Midwifery Registered | 5,001 | 4,436.42 |
| Students | 16 | 16.00 |
| **Total** | **15,307** | **13,347.43** |

The movement in Whole Time Equivalent (WTE) over the past two years is shown in the Figure below.

**Figure 7 : Health Board Workforce – Contract WTE Aprl 2013 - Dec 2014**
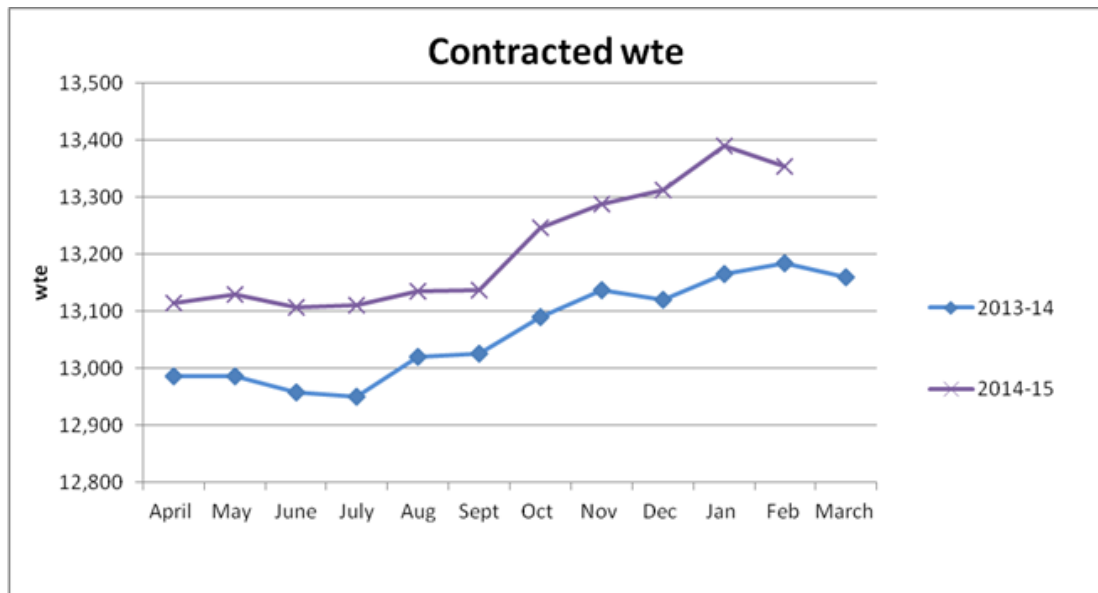


The graph shows that the contracted WTE has risen in recent months and the Workforce Plan shows a further increase. This increase reflects the planned investments in nurse staffing to improve patients experience and quality of care, based on the implementation of the All Wales Staffing guiding principles for nurse staffing levels on acute wards. This in itself has caused difficulties at times recruiting nurses with the right skills.

The Health Board is urgently considering a range of initiatives to help alleviate the recruitment situation  including rotation  and mentorship for newly qualified staff, more focused induction and clear plans  in terms of training and development, better supervision,  based on the therapy model, the reintroduction of  clinical tutors and a review of financial incentives. Further detail is provided in Section 7.

Retention issues are also causing increasing concern. Turnover within nursing has increased from 5% to 7%. Some early indicators based on pulse surveys and exit interviews, suggests that the following issues are important to our workforce.

- Work life balance

- Working patterns

- The effect of excessive workloads and overtime

- Capacity shortfalls

- Inadequate preparation of newly qualified staff to cope with the pressures of working on busy wards

- A perception of lack of leadership when staff are new to the NHS

- The attraction of working in the Community

- An ageing workforce

The Health Board might need to consider applying recruitment and retention premiums in certain specialties in order to be able to recruit and retain staff going forward and this will be addressed through our Workforce Strategy.

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

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

In terms of our nursing and therapy workforce the recruitment situation is complicated by unscheduled care pressures. This means that increased staffing levels to cope with these pressures has meant that Health Boards are selecting from an ever diminishing pool. This has in some areas caused acute shortages e.g. Care of the Elderly. There have been problems in maintaining the supply of bank nurses throughout this period due to unprecedented demands. Coupled with this is the impact of the difficulties in the recruitment of medical staff. Increasingly we are extending the roles of nurse and therapists to compensate for the lack of doctors. These are seen as permanent changes and this is exacerbating the recruitment pressures to these staff groups. As we increase Community care this is also putting pressures on staffing within secondary care. We are currently looking at overseas recruitment as a short to medium term solution but it is critical that at an all Wales level that commissioning numbers for nurses and therapists are increased immediately to cope with demands for the future.

### 2.3.6.1 Workforce Sickness

We recorded 17,000 sickness occurrences in the last 12 months, resulting in 324,000 lost days, 887 WTE. Whilst long term sickness clearly has an impact, over 60% of sickness absence occurrences are 7 days or less. The figure below shows the sickness absence performance of the Health Board on a rolling 12 month basis.

**Figure 8 : Health Board Sickness absence performance – rolling 12 months**
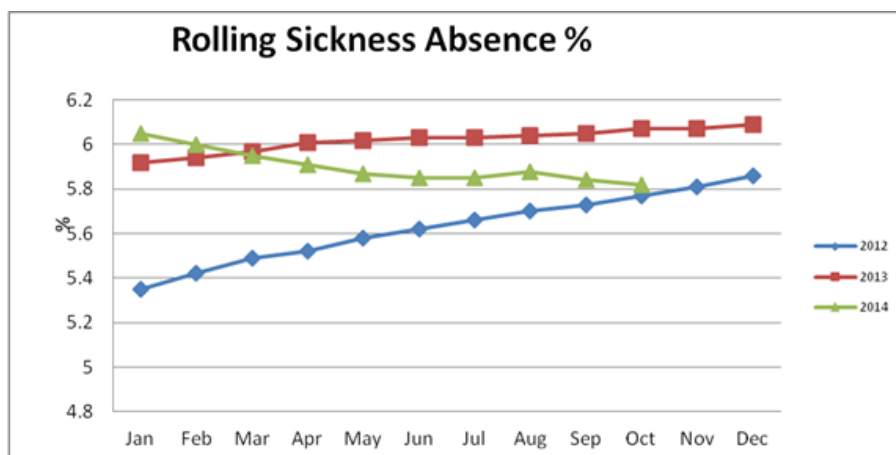


The rolling 12 month sickness absence rate for ABMU as at the end of January 2015 was 5.68%. The sickness absence rate has reduced consistently from 6.10% in November 2013 to 5.68% in January 2015.

On average daily employee attendance at work has improved by approximately fifty staff per day. Long term sickness is around 4.3% and short term sickness 1.4  We are currently slightly off trajectory to achieve the IMTP target of 5.5% by end of March 2015.  The 12 month cumulative differential between ABMU and the all Wales performance has reduced consistently since Dec 13 by 0.32%.

## 2.3.7   Finance

The IMTP set out a financial framework for 2014/15 which required £59.5m of costs against which £33.4m of savings were identified.  This resulted in a £26m funding requirement which was approved by Welsh Government.

At month 11, the Health Board reported a £5m overspend.   The key components of this overspend are:

- Non-delivery of Cost Improvement Programmes £4m – 50% of this relates to the planned variable pay savings which have not materialised due to recruitment difficulties and service pressures

- Variable Pay £3m – despite plans to reduce variable pay costs the Health Board has seen variable pay costs increase in 2014/15.  This has been due to reduced availability of clinical staff, resulting in escalating costs of covering services.

- Prescribing £1m – increasing demand and costs have seen prescribing costs rise above planned levels.

- Continuing Health Care – increasing demand and complexity of patients being cared for in the community has increased costs above planned

levels.  This linked with rising prices, is placing significant pressures on resources.

The Health Board has implemented a range of actions to reduce the level of overspend and is forecasting a breakeven financial year end position.  The unprecedented demand pressures experienced in recent months is making this delivery increasingly challenging.

It must be highlighted that the financial position for 2014/15 is currently being supported by a range of non-recurrent actions and the Health Board has assessed the underlying carry forward deficit for 2015/16 to be £10m.

## 2.3.8    Estates

Our estate covers an area of over 152 hectares and covers a total floor area of over 330,000m$^2$.

We operate four acute hospital sites these being the Princess of Wales Hospital in Bridgend, Neath Port Talbot Hospital in Port Talbot and the Singleton and Morriston Hospital sites which are both in Swansea. Details of our other hospital sites (mental health and community hospitals) along with learning disability facilities and community facilities are published on our website.

We also provide services from 77 General Practices across a range of property models including GP owned, Health Board owned and joint estates models with third party developers and local authorities.

We have reduced the percentage of properties that were built pre-1948 from 24% to 14%.

### 2.3.8.1    Developments

The Health Board is currently completing the delivery of Health Vision Swansea buildings on the Morriston site along with developments in Cefn Coed Hospital and Glanrhyd Hospital. These developments will enable us to rationalise our existing estate. Significant progress has been achieved in 2014/15 on all of these major capital schemes.

We have recently acquired land adjacent to Morriston hospital, which will enable us to move forward on our plans to redesign acute hospital services.

### 2.3.8.2    Performance

The table below provides an overview of our performance against the six condition appraisal criteria.

**Table 4 : Showing estates performance**

|  | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2017/18 |
|---|---|---|---|---|---|
| Physical Condition | 81% | 86% | 86% | 88% | 90% |
| Statutory and Safety Compliance | 73% | 92% | 88% | 88% | 92% |
| Fire Safety Compliance | 100% | 100% | 100% | 100% | 100% |
| Functional Suitability | 93% | 93% | 90% | 91% | 95% |
| Space Utilisation | 98% | 98% | 97% | 97% | 98% |
| Energy Performance* |  | 461 | 413 | * | 411 |

*Performance criteria for energy changed in 2012

Note: The figures in the table below include, Hill House, Garngoch, and Gellinudd all of which have been disposed of within 2013/14.

Despite some slippage on Health Vision Swansea scheme, which has affected our timescale for demolishing older estate on the Morriston site, we still anticipate hitting our projected targets for 2017/18.

### 2.3.8.3 Backlog maintenance

At April 2014 the estates backlog maintenance cost for our estate was £39,753,537. These costs are broken down against four categories of risk. The table below details the breakdown of costs against the four criteria for assessment.

**Table 5 : Showing the risk category for ABMU estate**

| Risk Category | Hospitals |
|---|---|
| Cost to eradicate High Risk Backlog | £1,515,000 |
| Cost to eradicate Significant Risk Backlog | £8,931,383 |
| Cost to eradicate Moderate Risk Backlog | £25,502,334 |
| Cost to eradicate Low Risk Backlog | £3,804,820 |
| **Total** | **£39,753,537** |

The risk-adjusted backlog maintenance figure for the estate is £ 16,474,382. The Health Board has prepared three outline business cases, which propose infrastructure investment, which would address the majority of our backlog

maintenance. Section 8 provides more information on our proposals for capital investment.

The backlog maintenance costs within primary care facilities are detailed in the table below.

**Table 6 :  Showing backlog maintenance costs for primary care facilities**

| Risk Category | Cost |
|---|---|
| Cost to eradicate High Risk Backlog | - |
| Cost to eradicate Significant Risk Backlog | £ 1,559,398 |
| Cost to eradicate Moderate Risk Backlog | £613,914 |
| Cost to eradicate Low Risk Backlog | £1,174,441 |
| **Total** | **3,347,753** |

The Health Board has established a primary care premises steering group to support the planned shift in the balance of care towards the delivery of more care in community settings. This Steering Group is in the process of developing a Primary Care Estates Strategy.

## 2.3.9  Partnerships

The Health Board places an extremely high priority on collaboration and working with other organisations, both within the local health economy, across Wales and beyond. We expect to strengthen this in future years through our focus on developing the strategic direction of the UHB. We will develop and embed our external relationships with partner organisations and ensure as an organisation we both impact upon, and reflect the priorities of, other organisations. Developments with local authorities through the Western Bay Partnership and our strengthening links with Swansea University are set out below. Further information on partnership arrangements is set out throughout the document as it is fundamental to all that we do, and also in Section 10 Building Capacity and Delivery.

### 2.3.9.1  Western Bay Partnership

Within the ABMU health economy the Western Bay Partnership is our key forum for driving forward the integration of health and social care services. This has a comprehensive work programme focused on improving services to people in the communities within which they live, and the Health Board plays an active part in the planning and implementation of these service models. We have strengthened the governance arrangements of the Partnership and elected members and health board Non Officer Members are now included in the governance structures. We have also established a Partnership Forum which also has the Leaders of the local authorities, appropriate Cabinet members and Directors of the local Councils for Voluntary Services as well as the Chair of the Health Board. The Chief Executive attends the Leadership Group which has Chief Executive

Membership of the representative organisations, and Executive Directors and other senior managers attend the Programme Team.

The Western Bay Programme has established two "Tiers" of activity, with all of the activities aligned to supporting implementation of the Social Services and Well Being (Wales) Act 2014. 'Tier 1' consists of six key transformational projects which were identified as priority areas by the Western Bay Leadership Group. The six 'Tier 1' projects are:-

### 2.3.9.2 Learning Disability Services

The project has agreed a set of overarching principles and values, described in the 'Joint Commitment for Learning Disability Services' document, which was drawn up by partners across the Western Bay region. The Statement sets out a number of Key Commitments which help shape the project's strategic direction. These include:

- To work with partners to consider innovative ways of engaging service users in the planning and development of services.

- To develop a joint strategy for an integrated joint process and response to need.

- To develop a joint strategy to address the needs of carers.

- To develop joint strategy for managing transition to adulthood.

A 'Draft Learning Disability Commissioning Strategy for Adults' has been consulted upon, and the outcomes will be used to inform commissioning of services from 2015/16 and beyond.

### 2.3.9.3 Prevention and Wellbeing

This is the newest project to feature as part of the Programme's 'Tier 1' activity and will focus on the implementation of the Social Services and Wellbeing (Wales) Act 2014. As the new Act places a strong emphasis on wellbeing and person-centred care, the project aims to support consistency of prevention and wellbeing services across the Western Bay region. Its scope will incorporate three key areas of work.

- **A Wellbeing Resource** – Working with the third sector to ensure advice and support services are available to those who need them. Bridgend, Neath Port Talbot and Swansea Councils for Voluntary Services will work together to map existing prevention and wellbeing resources.

- **Local Area Co-ordination (LAC)** – This innovative model promotes strong, inclusive communities and gives those accessing services greater control over how their care is delivered (see www.inclusiveneighbourhoods.co.uk for further information). Recruitment of staff to facilitate LAC implementation across the Western Bay region is currently underway.

- **Advice, Information and Assistance** – This is a specific requirement of the new Act. Three Social Services and Wellbeing Act Implementation Officers have been appointed and will undertake a self-assessment exercise to establish how advice and information services are currently delivered and where improvements can be made.

The Prevention and Wellbeing project is very much in its infancy, so there'll be significantly more detail in future IMTPs.

## 2.3.9.4 Community Services

The aim of the Community Services (or 'Older People's Services') project is to transform care services for older people by moving away from the traditional institutionalised models of care, to community-based support which helps people to live independently in their own homes and communities. Services continue to be delivered at a locality level, but work within an overarching regional framework to ensure good quality care is delivered consistently across the Western Bay area. The plans for developing these services are described in Section 6.

## 2.3.9.5 Mental Health Services

Good mental wellbeing improves outcomes for all manner of physical conditions, so effective support services are not only important for mental health but also for sustainable health and physical wellbeing in the future. The main focus of the work of the Mental Health Project is to promote mental well-being by building individual resilience through less reliance on inpatient beds, and to redesign community support to enable people to live in their communities and establish meaningful service user involvement in service design (together with the third sector).

Work undertaken to date includes a thorough review of current arrangements for unscheduled care and access to acute services, as well as the creation of a 'Commissioning Group'. This comprises representatives from all four Western Bay organisations who work together to join up processes and commission Mental Health services that are better suited to the needs of the individual. The Mental Health Project is currently looking at simplifying the referral pathway for secondary mental health services by piloting new processes for a Single Point of Access and triage system in Bridgend, which will be rolled out to the other areas in 2015. The project is also supporting the current community services to further promote reablement through goal focused interventions so that people receive support from secondary services more quickly but for shorter periods.

Further detail is provided in Section 6.6.2. It has been agreed by the Western Bay Partnership that the Health Board will take leadership for the further development of a comprehensive strategy for mental health services to align with the Commissioning Board being established in the summer of 2015.

There are two other Tier 1 priority areas: Children's Services (Adoption) and Contracting and Procurement which the UHB has less direct involvement in, but are reported through the governance structures.

'Tier 2' relates to collaboration in the following areas:

- Regional Safeguarding Boards (Children and Adults)

- A Supporting People Regional Committee.

- Integrated Family Support Services.

- A Regional Area Planning Board (regarding Substance Misuse).

- A Regional Youth Offending Service.

The Health Board is mindful of the current discussions which are underway about the options for Local Authority reconfiguration in response to the Williams Commission. Clearly, only Bridgend and the Vale of Glamorgan have formally submitted a proposal from within this area, and the Health Board and local authority have had discussions at the most senior level about the potential impact of this reconfiguration if it proceeds. The Health Board is clear that it is not our preferred approach, which is that the current footprint would remain. We are pleased, however, that the leader of Bridgend Council has reiterated his commitment to the Western Bay Programme if this merger proceeds. There will inevitably be a period of disruption, however, we will continue to work to plan and deliver care to best meet the needs of our citizens.

### 2.3.10 Commissioned Services

Some of our residents access services from outside of the Health Board, particularly those living on the boundaries of our catchment area. Further, we do not provide every aspect of clinical care within our Health Board; as a result we commission services for our local population from other healthcare providers, principally the other Welsh Health Boards and NHS Wales Trusts. The Health Board commissions a number of secondary care organisations across South Wales to provide services for our residents.

Welsh Health Specialised Services Committee (WHSSC) commissions specialised services for all Welsh residents on behalf of the seven Health Boards.

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

manage financial risks and provider pressures and we will commit fully to our partnership role within the WHSSC process.

The Draft Integrated Commissioning Plan for Specialised Services for Wales 2015 - 2018 has been developed by WHSSC in collaboration with the 7 Health Boards to ensure ***equitable access to safe, effective, and sustainable specialised services for the people of Wales***.  The plan highlights the key priorities for specialised services for Welsh patients over the next three years, together with the financial implications, and key risks to delivery.

The table below describes the Local Health Board priorities which were submitted to WHSCC for consideration and inclusion in the WHSSC Integrated Commissioning Plan.  These priorities, along with the priorities submitted by other Health Boards have been risk assessed against agreed criteria and peer reviewed.  The risk assessment criteria are described in the table below.

**Table 7 :  WHSCC risk assessment criteria**

| | |
|---|---|
| Black | Prior commitment by Joint Committee |
| Red | Significant impact – investment required |
| Amber | Moderate impact – investment required / no investment required (provider action) |
| Green | Minor impact - investment required / no investment required (provider action) |

At this stage, none of the schemes have been agreed by the Joint Committee and all of the amber schemes are in the process of being prioritised.

The table below sets out the priorities identified by the Health Board compared to the priorities identified following the risk assessment process.

**Table 8 :  List of ABMU priorities compared to WHSCC priorities following risk assessment**

| Provider | Scheme/Service | | Commissioner Priorities |
|---|---|---|---|
| ABMU | Support for the enhancement of cleft lip and palate services across South | Cleft lip and palate | Amber |
| ABMU | The addition of 3 neonatal intensive care cots or 6 neonatal high | NICU Expansion | Amber |
| ABMU | Developing a sustainable plastic surgery service which supports the redesign of infrastructure and patient care pathways | Review options for reconfiguration of burns and plastic surgery infrastructure and pathways to support | Green |
| | | B&P Backlog | Amber |
| | | Undertake Comprehensive review of complex breast pathways | Green |
| | | Enhance Middle Grade | Green |
| ABMU | Reduce interventions to support prudent healthcare principles and enable patients to access clinical | Sentinel Node Biopsy | Amber |
| ABMU | Development of an electrochemotherapy service that will support the repatriation of Welsh | Electrochemotherapy | Green |
| ABMU | Curative surgical option for | Curing Lymphodoema | Green |
| ABMU | To address the morbidity consequences of obesity | Bariatric Stage 1 | Black |
| | | Bariatric Stage 2 | Red |
| ABMU | Level 1 shared care service for children with cancer | Paediatric Oncology | Amber |
| ABMU | Support for the enhancement of sarcoma services across South West Wales | Sarcoma Nurse Specialist | Amber |
| ABMU | To increase resection rates to improve poor outcomes in lung cancer | Thoracic Surgery | Red |
| ABMU | To ensure service sustainability | Development of CKD Services | Green |
| | | Unit Refurbishment / HVS transfer. | Black |
| | | Consultant Workforce | Amber |
| ABMU | Support a sustainable model for cardiac surgery through the reduction of waiting times and facilitating the capital development at Morriston Hospital | Cardiac Surgery | Green |
| ABMU | ICD risk of growyth | ICD risk of growth | Amber |
| ABMU | Enhanced prosthetics for civilians | ALAC | Amber |
| ABMU | Progress the modernisation agenda for renal services through an enhanced infrastructure which supports equity of access for the resident population of ABMU and Hywel Dda | Renal Service | Black |

The table below describes WHSCC priorities, which are in addition to the list of priorities submitted by the Health Board.

**Table 9 :  WHSSC Priorities**

| Provider | Scheme/Service | | Commissioner Priorities |
|---|---|---|---|
| All Wales | Development of All Wales service. Change in service provider not model. Increased productivity/efficiency should result in savings to NHS Wales | Blood service 3 year profile | **Red** |
| TBC | To host Emergency Medical Retrieval and Transfer Service for Wales | EMRTs | **Black** |
| All Wales | Nutrition at home for Type 2 and Type 3 intestinal failure patients | HPN growth in patient numbers on HPN | **Red** |
| All Wales | | Eculizimab AHUS value | **Black** |
| Unallocated Developments | | SDR | **Black** |
| Unallocated Developments | | SIRT | **Black** |

## Non WHSSC Commissioned Services

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

There are already many areas where we work closely to provide care for our combined communities. In 2014/15 clinicians from our two Health Boards will consider how to plan together better for a number of other services across the South West and West Wales region. These will include radiology, pathology, oncology, dermatology, cardiology, neonatology and neurology. The impacts on changes to these services will need to be carefully considered and the impacts on potential centralisation of more services on patients, particularly those with a disability or another equality dimension, and carers, taken into account prior to decisions being made.

Whilst we have a range of partnership arrangements for local service provision with the Health Board (which are described later in this IMTP) our wider partnership work sees us as a partner in the development and delivery

of the work of the South Wales Programme (SWP) and in future with the South Wales collaborative. We (and therefore our Plan) will need to respond appropriately to the outcome of the planning work of these groups and in particular Princess of Wales Hospital which will be most affected by the final decision which emerges from the SWP.

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

We are also close to finalising the implementation of plans with other Health Boards to place Morriston (and UHW) at the centre of a network of hospitals in South Wales, caring for patients via an enhanced pre-hospital Emergency Medical Retrieval and Transport Service (EMRTS).

## 2.3.11  Teaching and Research – Putting the "U" in ABMU

As a Health Board we continue to put an emphasis on 'developing the U in ABMU'. We have made significant progress during 2014/15 and our priority has been in developing a strategic alliance with Swansea University. As a result we have established a Memorandum of Understanding and developed a governance structure around this work.

It has been agreed that Chairing of the Partnership Board will rotate between the two organisations and the Chair of the UHB will take on this role for 2015/16.

**Figure 9 :   Proposed Governance Structure**
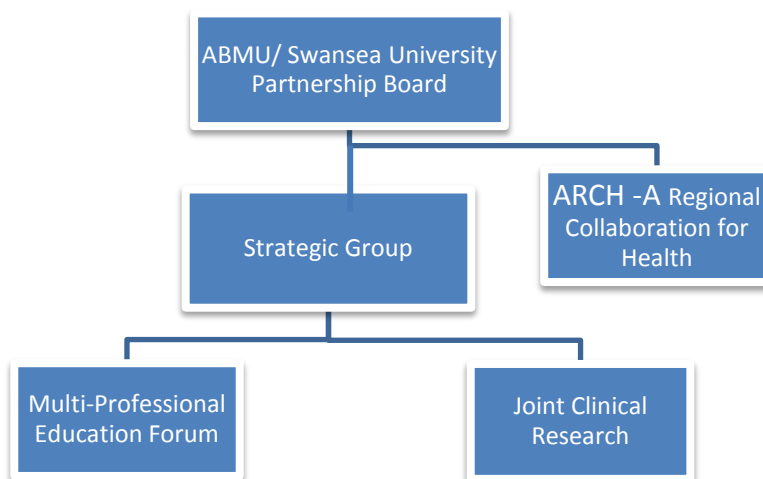


We have also established A Regional Collaboration for Health (ARCH) between the Health Board and Swansea University, and potentially Hywel Dda Health Board.  The aim of the Collaboration is to develop an integrated, open and collaborative health and life sciences regional economy.  This economy will deliver high quality care, whilst also developing professionals working in healthcare and science.  We have developed a Prospectus which describes the many aspects of ARCH and this Prospectus is being finalised ahead of submitting to Welsh Government in April 2015.

At the heart of this collaboration is the redevelopment of the physical estate at both Morriston and Singleton Hospitals. However, this must not be seen as a capital and building based initiative; moreover it is a whole system approach to developing collaborative health and life science models across the whole health economy.

The **ARCH Group**
We are in the process of establishing a Programme Board for ARCH (lead by the Chair of the ABMU Health Board) which will be resourced to drive this Programme forward.

The **Strategic Group** will cover the following areas of collaboration:
- Strategic Planning
- Developing and Enhancing Strategic Partnerships
- Policy

Terms of Reference for this Group are currently being finalised.

The existing **Multi-Professional Education Forum** will cover the following areas of collaboration:

- Education and Training
- Sustainability and Human Resources
- Enhancing Efficiency and Effectiveness

Further detail on some of the work undertaken by this Group is set out in Section 7.2.1. The **Joint Clinical Research** group will cover the following areas of collaboration:

- Economic Development
- Research and Development
- Innovation and Intellectual Property

Further detail on some of the work undertaken by this Group is set out in Section 9.4

We now have concrete examples of where these relationships are influencing and improving changing care.

# 3    Local Needs, Challenges and Assets

This section provides an assessment of our Health Board's strategic and operating environment, especially local need, the demand for services, workforce pressures and opportunities. This section provides an assessment of the overall local context within which we have shaped our strategy and plans to deliver it.

## 3.1    Strategic Health Needs Assessment

The Strategic Health Needs Assessment (SHNA) was produced in October 2013 and sets out the health needs of the population by life course.  It also identifies the priorities for the Health Board and signposts the evidence base for tackling these priorities, through supporting individuals and also through community and environmental interventions.   The key findings from the SHNA and the implications on the health of our population are as follows:

- Rising life expectancy, with a growing numbers of older people.  The number of over 85 year olds set to more than double by 2030.  Frail elderly people are major users of NHS and social care services.  This presents a significant challenge for our services and the need for more integrated out of hospital based approaches to care.

- Increased health inequalities, with the difference in life expectancy between the least and most deprived areas being 10.4 years for men, and 7.3 for women. Designing services which can engage these communities early in preventative services is fundamental to slowing the growth in the inequalities gap.

- Cancer, heart disease and respiratory disease remain the main causes of death in ABM, which are to a large degree preventable, particularly by reducing the prevalence of smoking and other lifestyle risk factors.

- There are variations in smoking rates across the Health Board.  Smoking is a risk factor for all three major causes of death.  It is also a major factor in inequalities in health outcomes.  Smoking is entirely preventable and reductions in smoking are followed by reductions in disease.

- Obesity levels are rising.   Obesity in children aged 4-5 is higher across the Health Board than across Wales and much higher than England.  Obesity is a risk factor for the biggest causes of premature death and also a risk factor for a number of conditions including diabetes and muscular skeletal disorders.

- Rising alcohol consumption is reflected in rising hospital admissions for alcohol related problems.  Alcohol is a risk factor for the biggest causes of premature death. Health issues from excessive alcohol consumption are preventable.

- There is some evidence of higher self-reported mental illness across the Health Board than the Wales average, which is strongly associated with health inequalities.

- Vaccination coverage is not at Welsh Government target levels across the Health Board.  Flu vaccinations are low.  Consequences of low levels of uptake of childhood vaccination are severe.  Effective vaccination levels have the potential to reduce illness levels particularly in frail older people.

Whilst our understanding of inequalities which arise as a consequence of socio-economic deprivation is reasonably well established, we recognise that we have a significant amount of work to do with individuals, communities and other agencies to better understand the inequalities which arise as a consequence of other differences including those identified as protected characteristics (age, gender reassignment, sex, race, disability, pregnancy and maternity, sexual orientation and religion/belief).

A more detailed description of local health needs can be found using the following the link.

http://www.wales.nhs.uk/sitesplus/863/opendoc/259795

We have used the SHNA to inform the development of our IMTP, specifically to:

- Inform health needs priorities for the next three years, and influenced the focus of the Strategic Change Programmes e.g. Staying Healthy and Community Service Programmes.

- Develop a life course approach to support the future commissioning of services aligned to local health needs and priorities.

- Establish a commissioning framework.

- To inform strategic planning a Joint Strategic Health and Social Care Needs assessment will be undertaken in 2015. The JSNA will build on the SHNA with a focus on inequalities and social care needs in our ABMU population

The Public Health Wales NHS Trust have identified the following strategic priorities:

- Adopting and implementing a multi-agency systems approach to achieving significant improvements in our Population's health
- Working across sectors to improve the health of our children in their early years
- Developing and supporting primary care services to improve the public's health

The IMTP focus remains on 4 of the Public Health Wales priority areas, i.e.:

- Smoking cessation
- Obesity
- Immunisation and vaccination
- Frailty

## 3.2    Future demand

A comprehensive modelling exercise has been completed which has taken historical bed use patterns and adjusted these for anticipated future demand and impacts of improved flow for patients who have had long periods of their care provided in Emergency Departments because of bed flow pressures.

The modelling also assessed the pattern of consumption of surgical beds across emergency, urgent elective and routine elective demand to determine what capacity flexibility may exist within the whole bed system at times of acute pressure.

The outcome of the modelling has enabled us to focus and prioritise the service changes and investment initiatives within out IMTP to support the delivery of a whole system of care which either reassigns or reduces demand to enable our hospital systems to cope with unscheduled care demand, our planned care system to function without disruption and primary and community models to support patients and their families with services outside of the traditional hospital model.

The detail of the modelling work outputs is discussed further in section 6 below.

## 3.3    Listening to Patients, Carers and Our Staff

As mentioned in Sections 1 and 2 we have undertaken extensive engagement activities to develop our values.  Over the summer of 2014 we held a series of staff, carer and patient engagement events including

- 66 staff listening events – "*In our Shoes*", involving more than 1650 staff
- leadership events
- 18 patient listening events – "*In Your Shoes*", involving 120 patients
- staff and patient surveys

Several further events were held during November 2014 resulting in **over 6,000 people** being involved in developing our values and behaviours statements.  As part of this, staff and patients told us what they would like to see "more of" and what they would like to see "less of" and what an "ideal" local NHS would look like. The table below describes the outputs from events to identify improvement priorities.

**Table 10 : Patient, Carers and Staff improvement priorities**

| Patient Improvement Priorities | Staff Improvement Priorities |
|---|---|

**1. Re-establish standards of basic human care**

- Humanity and dignity
- Having food and drink
- Medication and pain relief
- Human contact
- Available staff (safer levels)
- Continuous care / After-care
- Bring back Matrons
- Specific needs (disabilities)

**2. A positive, person focused attitude in all staff**

- Welcoming and smiling
- Friendly and caring
- Empathetic and supportive
- Aware of the impact
- Attitude and morale
- Treat the individual
- Putting patients first
- Helpful and time to listen

**3. 'Message recieved and understood'**

- Improved communication
- Information people need
- Inform of waiting times
- Listen and understand
- Be open and honest
- Feedback
- Acknowledge the problems

**4. Staff training and development**

- Training
- Clear expectations
- Values based recruitment
- Role modeling values
- Accountability / consistency
- Able to speak up
- Empower / value staff
- Clear goals / on same page

**5. Specific improvements**

- Quality / nutrition of food
- Calm, healing environment
- Better notes system
- Increased resources
- Decreased paperwork
- Better car parking
- Access
- Discharge / After-care

**1. Improve communication**

- Within and between teams
- Speak up / raise concerns
- Constructively challenge
- Constructive feedback
- Introductions (to other staff and patients)

**2. Align staff workloads to give more time**

- Adjust in particular areas
- Less non-value add tasks
- IT / systems that work
- Sickness / staff levels
- Skill mix / taking breaks
- Time for patient contact
- Less emails, travel, meetings, paperwork, admin, priorities

**3. Hold people to account**

- Values and behaviours
- Clear roles / expectations
- Consistency
- Accountability
- Performance management
- Address attitudes
- Values based recruitment

**4. Improve teamwork and morale**

- Between and within teams
- Patients, family and carers
- Shared goals
- Team building / positivity

**5. Value and recognise contributions and hard work**

- ABC of appreciation
- Respect / say 'thank you'
- Training / improving skills
- Rewards

**6. Listen to and act on staff input**

- Communication / meetings
- Continuous improvement
- Support and feedback
- Better connections between teams and managers
- Trust and empowerment

**7. Leadership development**

- Supportive
- Role modeling
- Visibility
- Talking to staff

We have used the information from these engagement activities to develop action plans to respond to the recommendations of the Trusted to Care Report, Our Values, the Quality Strategy and to support the development of our IMTP.

## 3.4    Key Challenges

The table below provides a summary of our key challenges.

**Table 11 : Summary of key challenges**

| Health Needs | The recent report on the health needs of our population shows that: <br>• Our population is increasing; <br>• The number of older people with one or more long term conditions is increasing <br>• More people are making poor lifestyle choices which have a negative effect on their health. |
|---|---|

| | These challenges will increase demand for healthcare services. |
|---|---|
| **Performance** | **Demand**<br>– Increased acuity of people accessing A&E services.<br>– Increase in the number of attendances at major Emergency Departments of people aged 85 years and above.<br>– Peaks in trauma activity which are 20% above peak activity in 13/14.<br>– The need to support a system shift to enable a focus on prevention, the provision of earlier support in the community and admission avoidance.<br>– Emergency demand pressures have limited the planned shift in resources to support a shift of services into the community.<br>– Local Authority financial pressures have an impact on the demand for health care services.<br>– Increasing population of adults with learning disabilities, living longer with more complex needs.<br>**Access**<br>– Difficulties in meeting our Tier 1 access targets.<br>**Quality**<br>• Recent Quality Reviews have identified variations in the quality and safety of the services we provide.<br>• Difficulties in providing safe staffing levels across a range of professions.<br>• Providing joined up models of care for Child and Adolescent Mental Health services (CAMHS).<br>• Balancing our service provision for dental services.<br>**Service sustainability**<br>A number of services have clinical sustainability issues i.e. neonatal care, Inpatient paediatrics, obstetrics and maternity and Emergency Medicine (A&E). The South Wales Collaborative have been taking a lead on developing an agreed way forward for these services. |
| **Workforce Pressures** | • Difficulties in recruiting and retaining staff, especially for some types of doctors, GPs, nurses and therapy staff.<br>• Maintaining services, such as primary care with an increase trend in the number of GP retirements<br>• High levels of staff sickness<br>• Some unacceptable behaviours, particularly towards older people<br>• Introducing a wide range of new ways of working. This takes time and support to manage change effectively.<br>• Lack of strong clinical leadership in a number of areas<br>• Poor communication mechanisms with our staff. |

| | |
|---|---|
| | • Negative impact of poor job satisfaction, development opportunities, team working and empowerment has on staff engagement. |
| | • Inconsistencies across the Health Board by our workforce in the delivery of basic standards of care Time to reflect on our care share and celebrate improvements while managing the workload pressures. |
| **Internal Operating Environment** | **Finance**<br>• Enduring austerity.<br>• Service improvements are taking longer to deliver anticipated savings.<br>• Limited opportunities to achieve CIP.<br>**Estates**<br>• The design and layout of our acute hospital estate places significant limitations on our ability to meet the needs of our patients and deliver services efficiently.<br>• To support our infection control plans we will need to develop our bed spacing and clinical environments.<br>• Primary care facilities require modernisation.<br>• Our facilities for learning disability patients must be refreshed and reviewed for suitability<br>• Backlog maintenance levels are significant and require a considered programme.<br>**ICT**<br>• Significant lack of investment in ICT to support integrated care and mobile working.<br>**Organisational integration**<br>• Services are not as integrated as they could be which leads to a lack of joined up care and service inefficiencies. |

## 3.5  Our Assets

There are many excellent examples of success and achievement within the Health Board. It is really important to ensure that we build on these and the potential that ABMU has:

- We are one unified organisation, commissioning and delivering whole health care from primary care through to tertiary services
- We have a successful track record of delivering improvement by working in partnership with local communities and organisations
- We are investing in major developments in our community and acute services.
- Our research, teaching and innovation help us continue to improve care, which already includes areas of excellence

- We can only deliver for patients and communities through our workforce – we are a huge employer of committed, enthusiastic and skilled local people in a diverse range of roles

## 3.6    Technological Opportunities

In summary, this section describes local health needs, our patients, carers and staff priorities, our key challenges and our assets. This information provides an insight into the local drivers for change.

Throughout this document we have identified opportunities to use technology as enablers in delivering our strategic aims.  In particular Section 9 sets out our comprehensive plans for implementation of information and communications technology over the next three years.  An example of these opportunities is listed below:

- The design of the new out patient's building, HVS1B, which incorporates self check-in and flow management.

- The business case approved to provide innovative robotic theatre developments linked to minimal invasive in OMFS, ENT, bariatric, urology and colorectal surgery

- A business case is being developed to provide a hybrid theatre for vascular and cardiology services

- As part of the Western Bay Initiative a business case is being developed to support the delivery of ICT enabled integrated care.  The business case sets out proposals to use electronic devices and Apps to support mobile working, pilot initiatives using teleconsultation and also explore the opportunities to share information electronically with service users.

- Introduction of electronic prescribing in outpatients followed by the development of a business case to implement for inpatients in 2016.

- The ability to complete the family and friends test via electronic feedback zones in Health Board settings and via the internet.

- In the future to enable bedside observations to be recorded electronically.

- Through our partnership arrangement with Swansea University and other organisations, encourage our clinicians to develop  opportunities for innovations in how clinical care is delivered and to develop technologies and devices

- Extending access to public wifi on our hospital sites.

- Working with Swansea University and local commercial partners to develop trail blazing technologies to safely and securely tap into the wealth of knowledge in clinical pathway data to help us all understand how we can plan and deliver services together to provide the best outcomes for our population.

# 4    Strategic Context

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

## 4.1    National Drivers

Welsh Government sets out the strategic context and formulates health and social care policy to be implemented by NHS Wales and its partners.  The diagram below presents the Framework of National Planning Requirements and identifies the key drivers for change.

**Figure 10 :  Framework of National Planning Requirements**

### FRAMEWORK OF NATIONAL PLANNING REQUIREMENTS
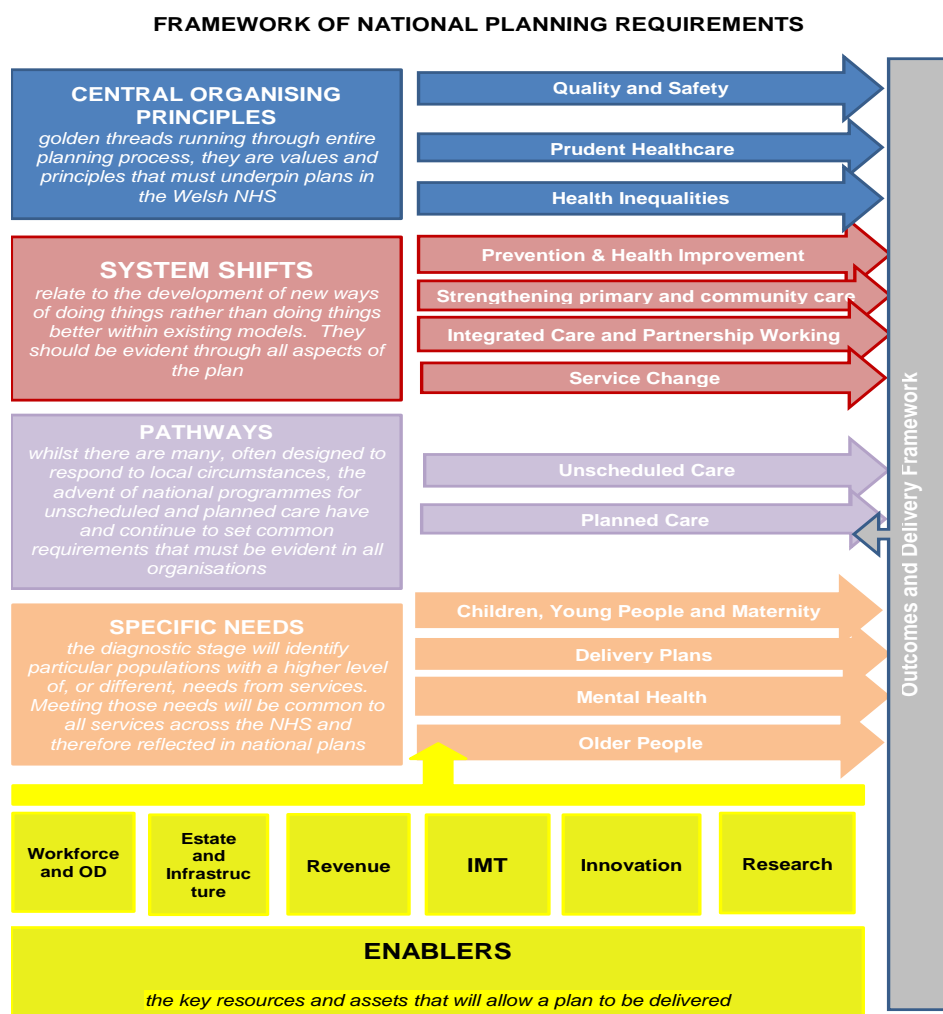
In developing our IMTP we have referred to the framework of national planning requirements, the NHS Delivery and Outcomes Framework and the guidance set out in the NHS Wales Planning Framework 2015/16. We have also made reference to recent national guidance. Where relevant, reference is made to this guidance within specific sections. A list of these references is set out in **Appendix 17**.

## 4.2    Local Context

Our IMTP 2014 to 2017 set out an ambitious transformational service change strategy, to deliver our vision and during 2014/15 we have reviewed this strategy. We have reflected on progress over the past year against our Plan, recent national guidance and the local emerging strategic issues. We have concluded that this is the right strategy to achieve our vision. We have however developed the strategy to provide a greater emphasis for the following:

- Our values will underpin all that we do.

- To make the delivery of quality services a key priority. In 2015/16 we will focus on implementing the Quality Strategy. This strategy will build on our earlier work in addressing the Trusted to Care recommendations and will take forward the priorities, identified by our patients, carers and staff. Given its importance quality has a dedicated section within the IMTP; however it is reflected throughout all of our sections of this Plan.

- To develop a sustainable system for unscheduled care to stabilise and sustain these services, which in turn allows us to develop our planned care system as part of the whole healthcare system.

- To further develop the strategic shift to primary and community care.

- To ensure that our workforce plans support our service delivery aspirations and are values driven.

- To embed our approach to prudent health care.

- To reflect our plans for developing community networks.

- To adjust our planning assumptions and targets to reflect our experience of managing demand and implementing service changes last year.

- To develop Morriston Hospital as a hyper acute centre for the residents of Mid and West Wales which in turn will determine the future role of Singleton Hospital and Neath Port Talbot Hospital and our community and primary care services.

- To recognise the Princess of Wales Hospital's key role in the delivery of the South Wales Programme (SWP).

We have decided that as a Health Board we need to develop a 10 year organisational strategy which will ensure that we have a clear sense of

direction, with clearly articulated outcomes, milestones and performance measures which ensures that all that we do as an organisation is aligned and consistent,  A good strategy will enable us to:

- Evaluate where the Health Board is now across a broad spectrum of measures, and then state **realistic, evidence based goals,** expressed in a way that allows progress to be monitored;
- Design a **patient-focussed** strategy, to improve care quality and patient experience;
- Set out a **clear vision** for improving quality and safety;
- Be based on forecasting and analysing trends in the **local health economy**;
- **Prioritise initiatives**, on the basis of coherence, impact and flexibility;
- Clearly set out **milestones** for achieving specific aims;
- Clearly describe **current problems** (service, quality, workforce and finance); and
- Consider the current and future **organisational culture** required to support implementation of the strategy.

This work will start in late 2014/15 and be completed in 2015/16.

## 4.3    Our Strategy

The diagram below provides an overview of the component parts, which make up our Strategy. This diagram shows that we have described our clinical strategy from both a life course and settings of care perspective. More detailed information can be found on our clinical strategy via the following link.

http://www.wales.nhs.uk/sitesplus/863/opendoc/259796

The figure also shows our principal delivery vehicles, our Strategic Change Programmes and our Underpinning Plans.

**Figure 11 :  Overview of our Strategic Framework**
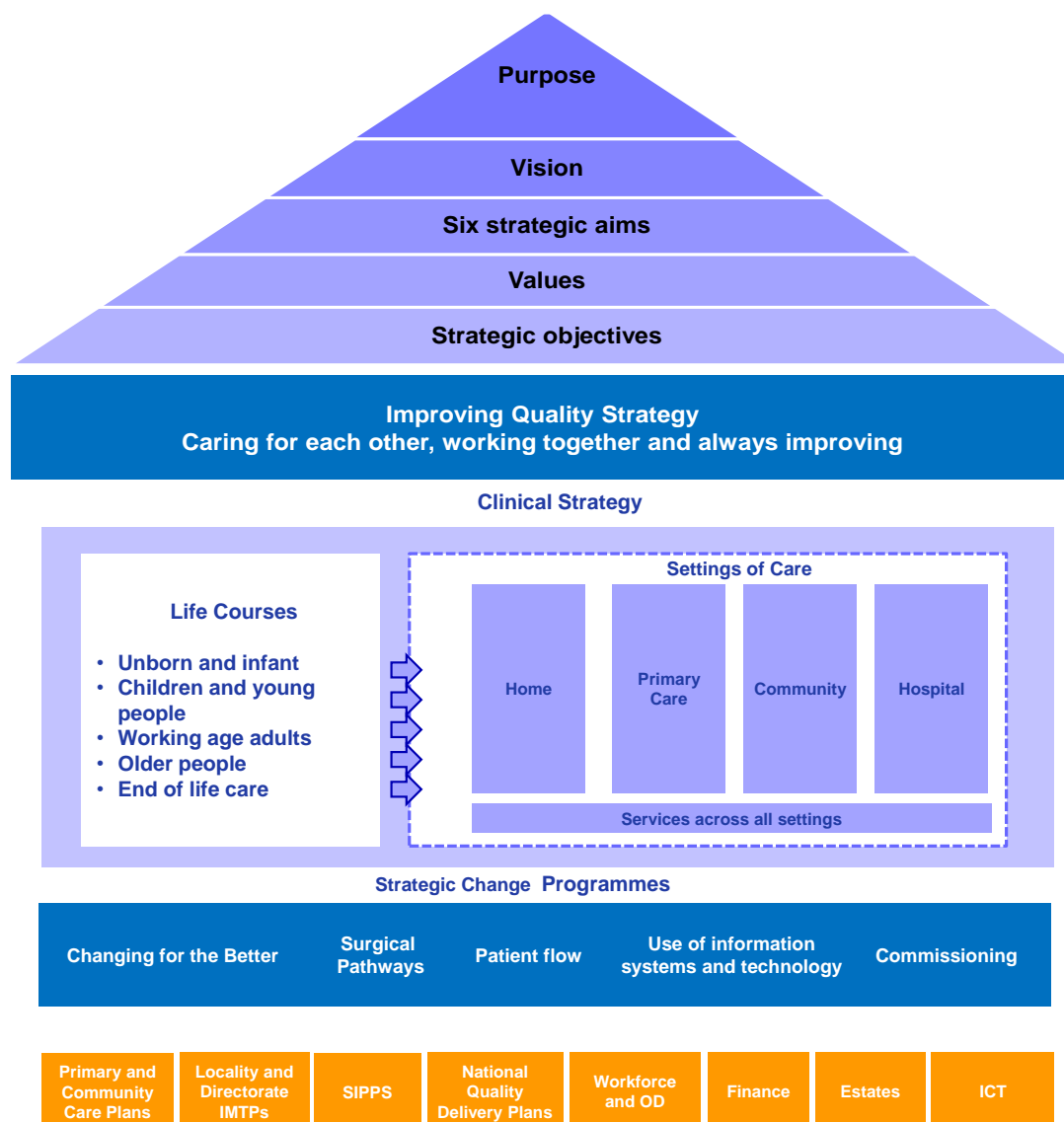


## 4.4    What Does Success Look Like?

The following paragraphs describe our purpose, our vision for the future, our values, our strategic aims and our strategic objectives.

### 4.4.1    Purpose – why we exist

Our purpose is to:

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

## 4.4.2 Vision – Where we aim to be

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

- We will respect people's rights in all that we do and plan our services and their care with them and their carers. Wherever it is provided, care will be delivered to a consistently high quality 24 hours a day, seven days a week. This means that it will be safe and compassionate, meeting agreed national standards, providing outcomes valued by patients and citizens and an experience that is as good as it could be.

- We will make it easy for everyone to get the information and advice they need to be in control of their own health and to live healthier lives.

- We will work in partnership with our communities, our staff and other agencies to meet our citizens' health and social care needs in an integrated way, usually in or near to where they live.

- We will support high-quality research, education and innovation that benefit our patients and staff and we will encourage everyone to share their care experiences with us so that we can learn how we can do even better.

## 4.4.3 Values

We have identified three core values, which were approved by the Health Board in December 2014.

**Figure 12 : Health Board Values**



Having developed these values, we have set out a supporting values behaviours framework.

This will describe the things we need to do (and not to do) to demonstrate our values. Section 7 describes the work to be carried out in driving our organisation development, culture and values.

## 4.4.4 Strategic aims

We have six strategic aims:-

- Healthier Communities
- Excellent Patient outcomes and experience
- Sustainable and accessible services
- Strong partnerships
- A fully engaged and skilled workforce
- Effective Governance

Everything that we do will be aligned back to these six strategic aims.

The table below describes our objectives to deliver these aims.

**Table 12 : The Health Boards Strategic Priorities**

| Strategic Aims | Ref |
|---|---|
| **HEALTHIER COMMUNITIES** | |
| • Reducing health inequalities by:<br>   - Reducing smoking rates<br>   - Reducing unhealthy eating and increasing physical activity<br>   - Increasing vaccination and immunisation rates<br>   - Our Healthy Futures<br>   - Healthy Schools<br>   - Health Care Public Health<br>• Developing our commissioning approach for cancer; mental health; long term conditions; children & young people; planned care; unscheduled care | Section 6 |
| **EXCELLENT PATIENT OUTCOMES AND EXPERIENCE** | |
| • Implement the Quality Strategy:<br>   - Develop and implement patient reported outcome measures across all major clinical areas<br>   - Start to replace guidelines with Standard Operating Procedures and automated pathways, in particular implementation of the "Do not Attempt Cardiac Pulmonary Resuscitation Pathway"<br>   - Address the delivery priorities set out by Welsh Government for stroke services and ensure that services are redesigned around the principles of prudent healthcare.<br>   - Embed national and professional standards to reduce in appropriate variation and increase reliability, focussing on:<br>      - Implementation of "spot the sick patient" project<br>      - Introduce electronic prescribing and medicines administration<br>      - Roll out the "big Fight" campaign targeting C Difficile infection and antibiotic resistance in primary care.<br>• Embed the recommendations of the Andrews Report Trusted to Care<br>• Develop our Digital Strategy | Section 5<br><br><br><br><br><br><br><br><br><br><br><br>Section 9 |
| **SUSTAINABLE AND ACCESSIBLE SERVICES** | |
| • Further develop a system shift to primary care:<br>   - Develop pathfinder initiatives and new organisational models to support GP networks & clusters<br>   - Develop anticipatory care in Community Networks through risk stratification of the most vulnerable in our communities<br>   - Improve access to primary care<br>   - Implement priorities in cluster plans<br>   - Develop programme to improve skills and capacity across primary care workforce | Section 6 |

|  |  |
|---|---|
| (also in A fully engaged and skilled workforce) | |
|     - Develop a step change in respiratory care in line with the national Delivery Plan, using the assets of community networks | |
| • Develop sustainable unscheduled care services across the whole system by improving bed utilisation | |
|     - Improve our patient flow to reduce the numbers of people waiting for unscheduled care and access to care outside hospitals post discharge | |
|     - Continue the implementation of intermediate care initiatives | |
|     - Work with the Ambulatory Emergency Care Network to develop ambulatory care as the default with each of the four hospitals supporting each other as a network | |
| • Have a sustainable plan to meet our planned care requirements | |
|     - Improve the efficiency of our surgical pathways through reviewing standard procedures for the whole patient pathway | |
|     - Address our backlog of long waiting patients, through a mix of local and outsourced solutions | |
| • Have clear roles and functions for all of our hospitals | |
|     - Implement the outcomes of the South Wales Programme consultation in Princess of Wales Hospital | |
|     - Further develop and implement service models for the South Central Acute Care Alliance | |
|     - Implement outcomes of the South Wales Programme in Morriston Hospital | |
|     - Establish the South West Acute Care Alliance as a formal programme and develop models of care to support agreed priorities | |
|     - Open HVS1 at Morriston Hospital and complete further works | |
| • Improve our services for Women, Children and Families | |
| • Implement the priorities from the National Delivery Plans | |
| **STRONG PARTNERSHIPS** | |
| • Develop proposals for the future role of Morriston and Swansea hospitals as part of a network of care and innovation – ARCH (A Regional Centre for Health) | Section 6 |
| • Implement seamless community based models of care with partner organisations | |
|     - fully exploit benefits of Community Resource Teams | |
|     - Develop anticipatory care in Community Networks through risk stratification of the most vulnerable in our communities | |
|     - Further develop business cases to support plans agreed in 2014/15. | |
| • Develop a comprehensive and joint mental health service and estates strategy with our partners | |
| • Develop managerial and clinical leaders across the UHB in partnership with education providers. | |
| • Develop UHB wide links with partner organisations across the health economy to develop consistent and common goals. | |

| A FULLY ENGAGED AND SKILLED WORKFORCE | |
|---|---|
| • Develop a joint strategic approach to the recruitment and retention of those staff groups where recruitment is a challenge.<br><br>• Develop new and extended roles to support service redesign.<br><br>• Continue to reduce sickness absence levels and support the health and well-being of our workforce, through a range of support services such as joint care, protect and respect, emotional wellbeing.<br><br>• Provide a skills development programme to ensure staff have the skills to deliver safe quality care that matches the needs of our citizens, and supports the development of clinical leadership.<br><br>• Develop an overarching People Strategy that will reflect our values and create a culture for people to achieve their full potential. | Section 7 |
| EFFECTIVE GOVERNANCE | |
| • Develop our organisational strategy to set out a clear 10 year vision with clear outcomes, milestones and performance measures to ensure all plans are aligned and consistent.<br><br>• Implement the new management arrangements<br><br>• Continuing to deliver financial balance | Section 10 |

Section 6 describes our Strategic Change Programmes and initiatives, the action plan for developing Community Networks and Mental Health services and the arrangements for taking forward the 18 National Delivery Plans.

**Appendix 9** provides a matrix describing the measures, targets (cross referenced to the NHS Outcomes Framework) and delivery mechanisms for each objective.

The figure below provides an overview of our strategic priorities.

**Figure 13 :  Overview of our strategic priotities**
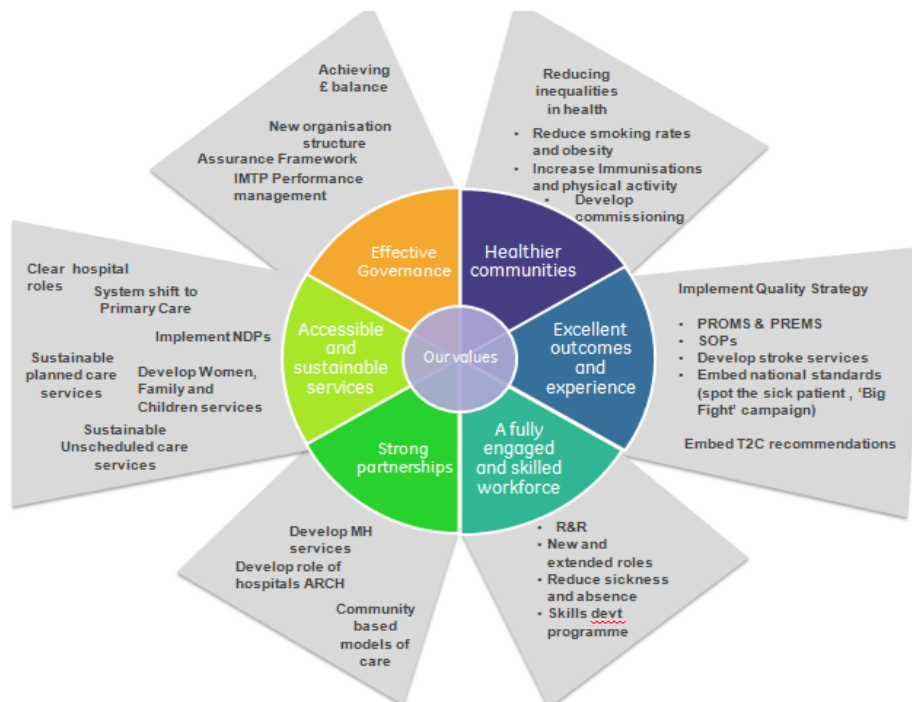


## 4.5   What does success look like for our patients and citizens?

Our clinical strategy describes what success would look like for our patients and citizen's by life course i.e.

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

As part of our engagement activities to develop our values, we asked patients and carers to describe what an ideal health service would look like.

The diagram below identifies the key words used to describe an ideal health service.  The size of the words is proportional to the number of times the work was used.

**Figure 14 : What an ideal health service looks like**



Word sizes are proportional to the number of mentions by patients, family
members and carers

## 4.6    Commissioning Healthcare Prudently

We are developing commissioning to deliver Prudent Healthcare, because it
is a needs lead, evidence based, highly engaged approach to improving
population health outcomes, quality and patient experience. Adopting this
approach will help in involving communities, staff and partners in prioritising
the use of our resources to meet local health needs.

Commissioning supports delivery of our values; 'caring for each other'
through improving experience, 'working together' through involving patients
and staff and 'always improving' through seeking out and using evidence of
best practice. We are also mindful of taking a prudent approach to end of life
care too and our commissioning boards will make these considerations within
their work programmes.

**Table 13 : Commissioning Boards**

| Commissioning Board | Executive Lead | Inaugural Meeting | Clinical Chair appointed |
|---|---|---|---|
| Cancer | Director of Strategy | Held in Jan 2015 | Yes |
| Children & Young People | Director of Nursing | Held in Feb 2015 | Yes |
| Planned Care | Medical Director | Held in Mar 2015 | In recruitment |
| Long Term Conditions | Director of Public Health | Summer | Starting April |
| Unscheduled Care | Chief Operating Officer | Summer | Starting May |
| Mental Health & Learning Disability | Chief Executive | Under review with WBP | Under Review with WBP |

Each Commissioning Board will be co-chaired by clinicians; one each from primary and secondary care or by a doctor and local authority director. Other core members will be drawn from public health, the GP community, nursing, therapies, 3rd sector and local government with additional co-opted members as required

The core purpose of the Commissioning Boards is to;

1. Identify opportunities for re-allocating existing resources within the system to deliver:

   - 'Best bang for buck' where bang = quality, experience, outcome

   - The principles of Prudent Healthcare: -

     – Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;

     – Care for those with the greatest health need first, making the most effective use of all skills and resources;

     – Do only what is needed, no more, no less; and do no harm.

     - Reduce inappropriate variation using evidence based practices consistently and transparently.

2. Propose new models of care & service configurations with partners which shift care up-stream preventing future demand rather than managing existing demand

3. Deliver a highly engaged approach which involves patients and the public as well as clinicians in decisions to change or remove elements of service or pathways in the system

To implement commissioning during 2015, we are establishing 6 Changing for the Better Commissioning Boards. Whilst these gain traction we are also starting several commissioning projects.

**Table 14 : Commissioning Projects**

| Commissioning Projects | Status | Leads | Related Commissioning Board |
|---|---|---|---|
| Upper GI Service Model Commissioning Intention in response to Peer Review findings | Live, steering group in place, process agreed, project underway, due for completion June 2015 | Director of Strategy & Health Board Clinical lead for Cancer | Cancer |

| | | | |
|---|---|---|---|
| CAMHs Service Redesign<br><br>Service specification and standards of care | Live, multi-stakeholder group in place, specification development in process, due for completion summer 2015 | Assistant Director for Strategy | Children & Young People |
| Programme Budget Marginalised Analysis (allocative efficiency) projects in the following areas; | | | |
| MSK | Live, project team in place, intelligence work stream underway, completion date June 2015 | Clinical Director for Orthopaedics | Planned Care |
| Atrial Fibrillation | Live, stakeholder meeting held, intelligence work stream underway, completion date July 2015 | | Planned Care |
| Diabetes | Due to start Feb 2015 | TBC | Planned Care |

We are currently in the process of reviewing and aligning our existing Changing for the Better projects to the relevant commissioning boards.

## 4.6.1  Advancing Commissioning for Prudence

As a Board we have committed to a developmental Commissioning Programme, accepting that commissioning in a Welsh context will require us to be open to testing new ways of working and developing new partnerships.

Working in partnership with Swansea University, Public Health Wales and ABMU, we will test Programme Budget Marginalised Analysis (PBMA) as an ABMU approach for delivering 'bang for buck' and Prudent Healthcare through commissioning.

PBMA is a prioritisation framework accommodating economic analysis, multi stakeholder inputs, values, needs and perspectives within a framework – balancing health services within a total budget and optimising use of resources. A recent report from the *Bevan Commission* suggests PBMA as a rational prioritisation approach that sits comfortably with the notion of prudent health care.

## 4.6.2  Improving Clinical Engagement in Commissioning

The Commissioning Boards will have several senior clinical leaders from across the primary, secondary, nursing and therapies specialities. These leadership positions will play a pivotal role in enabling clinicians to take on key strategic planning roles; working alongside other key decision makers

and our communities it is intended to be a powerful aid to the Board in making decisions based on need, evidence of effectiveness, patient experience and the principles of Prudent Healthcare.

Additionally all of our PBMA work is being driven by a nominated clinical leader and involves clinical staff in scoping, debating and recommending the appropriate commissioning model to improve Prudence within their service areas.

### 4.6.3 Improving use of data and information for commissioning

The Commissioning Analysis Tool (CAT) identifies how the Board currently commits its resources across Acute, Community, Mental Health and Primary Care sectors .This enables users to quantify resource use at Locality, Network, GP Practice and where available, at patient level. Information derived from the CAT will be a key source of information to support the PBMA work of the commissioning boards.

We are working to incorporate Social Services financial and activity data into the CAT to create a better understanding of the patient/client pathway and support future joint commissioning.

Additionally we are working on creating an 'intelligence forum' to support our commissioning and PBMA in particular and grow our future capability. The forum will consist of staff from within and out with the health board.

### 4.6.4 Workforce development and staff involvement

We plan to design a programme of development to assist our commissioning boards and key staff with their roles. This will include review and evaluation processes to reflect upon lessons learned and the effectiveness of the commissioning boards.

Involving key staff in debate and planning to progress our commissioning work continued during 2014/15. The focus of this work will shift in 2015/16 to aligning staff to roles which will facilitate the commissioning function, and supporting their skills development. Work with the Western Bay Partnership Programme will focus on opportunities to align approaches to facilitate joint commissioning,

We are currently planning our end of year commissioning horizon scanning event for March 2015 at the Liberty Stadium. This will be for our staff and partners to inform the next 12-18 months of our commissioning programme.

# 5     Excellent patient outcomes and experience

> Ensuring that we consistently deliver high quality care 24 hours a day, seven days a week is our absolute priority. Our Quality Strategy – caring for each other, working together, always improving, and sets out what we must do to deliver excellent services and become a high reliability organisation.

## 5.1     Introduction and context

The Health Board is committed to delivering the highest quality care that makes genuine and meaningful differences to the people of Bridgend, Neath Port Talbot and Swansea and the communities for whom we provide tertiary services. However, issues identified in the Princess of Wales Hospital showed that we needed to strengthen the processes and systems that we have in place, to ensure improvements to the health of our people and to consistently deliver a high quality service 'every time'.

We have developed a Quality Strategy *which, builds on the foundations put in place nationally by the Welsh Government as well as our local quality improvement and assurance arrangements. Particular regard has been paid to *Achieving Excellence: The Quality Delivery Plan for the NHS in Wales 2012-2016,* which set out the Welsh Government's ambitions for achieving excellence in Welsh healthcare by 2016.

*[http://www.wales.nhs.uk/sitesplus/documents/863/Final%20Quality%20Strategy%20-%20%2013%20February%202015.pdf](http://www.wales.nhs.uk/sitesplus/documents/863/Final%20Quality%20Strategy%20-%20%2013%20February%202015.pdf)

Our Strategy is not just about restating the aims and objectives we have previously set or renewing policies and approaches, it is about bringing real and tangible change to the culture of our Health Board and the way in which we deliver our services.

As part of the work undertaken to agree our values, we completed a baseline assessment of where we were as an organisation. We used this to describe what we will want to achieve over the next three years:

- Put the people of Bridgend, Neath Port Talbot and Swansea and the communities for whom we provide tertiary services at the heart of our services by promoting and encouraging appropriate patient and carer involvement in everything we do ("Working Together")
- Support and enable our staff to deliver high-quality, evidence-based care and prevention compassionately by making it easier for them to consistently do the right thing ("Caring for Each other")

- Make tangible continuous and measurable improvement to the aspects of quality that people have told us are important to them ("Always Improving")
- Ensure vibrant research and education collaborations aligned to help us excel as  a provider of healthcare;
- Learn from when the patient experience is poor or we cause harm so that we do better in the future; and
- Become a 'high reliability' organisation that has consistent quality and improving the experiences of our patients at the core of all our services.

http://www.wales.nhs.uk/sitesplus/863/opendoc/260126

## 5.2    Definition of Excellence

People living in the communities we serve, patients and stakeholders have told us that they understand that, given the complexity of some of our services, sometimes things will go wrong, but they do not expect to be put at risk of avoidable harm and want always to be treated with dignity and respect.  They also expect us to be clear what an excellent service looks like; to know when we fall short of delivering it and to be open about any shortcomings.  They have told us that in terms of quality improvement they would like the Health Board to focus on:

**Table 15 :  Priorities for service improvement**

| **1.    Re-establishing standards of basic human care** | |
| --- | --- |
| • Humanity and dignity<br>• Having food and drink<br>• Medication and pain relief<br>• Human contact | • Available staff (safer levels)<br>• Continuous care / After-care<br>• Bring back Matrons<br>• Specific needs (disabilities) |
| **2. Supporting a positive, person focused attitude in all staff** | |
| • Welcoming and smiling<br>• Friendly and caring<br>• Empathetic and supportive<br>• Aware of the impact | • Attitude and morale<br>• Treat the individual<br>• Putting patients first<br>• Helpful and time to listen |
| **3. Ensuring messages  are understood** | |
| • Improved communication<br>• Information people need<br>• Inform of waiting times<br>• Listen and understand | • Be open and honest<br>• Feedback<br>• Acknowledge the problems |
| **4. Staff training and development** | |
| • Training<br>• Clear expectations<br>• Values based recruitment<br>• Role modeling values | • Accountability / consistency<br>• Able to speak up<br>• Empower / value staff<br>• Clear goals / on same page |
| **5. Specific improvements in relation to** | |
| • Quality / nutrition of food<br>• Calm, healing environment<br>• Better notes system<br>• Increased resources | • Decreased paperwork<br>• Better car parking<br>• Access<br>• Discharge / After-care |

Responding to what people have told us is important to them and recognising the foundations put in place nationally by the Welsh Government we have adopted the following definition of quality:

*'Quality services, care and treatment are safe, effective,*

*person-centred, caring, compassionate and respect people's needs*

*and their right to make informed decisions and choices.'*

We will focus on delivering high quality services by addressing those things that will contribute to the achievement of the strategic quality objectives set out in the next section. Our 2015/16 priorities are highlighted in bold

## 5.3 Our Quality Objectives

Set out below are our four quality objectives, describing what we will do and measures to be used to determine whether we have achieved each objectives. Priorities for action in 2015/16 are highlighted in bold.

### 5.3.1 Quality Objective 1:

*To plan our services with the people living in the communities we serve, so that they are person centred, caring and responsive to need.*

| We will: | We will have achieved this objective when without exception: |
|---|---|
| Support continuous engagement with our communities and patients in planning, service design and development. | – Our public and patients are engaged and actively involved in all our planning and their views and experiences inform our service development and design. |
| Implement approaches for capturing patient feedback in real time and at scale and for using it to ensure continuous and timely improvement. | – We learn when things go wrong so they do not keep going wrong. |
| **Develop and implement patient reported outcome measures across all major clinical service areas**. (2015/16) | – Our learning from patient experiences and feedback forms the cornerstone of all our planning, service development, design and delivery. |
| Develop and implement better ways of identifying patients' care and treatment preferences. | – We measure and talk about the outcomes that matter most to people, patients, carers and relatives. |
| Review how we communicate with citizens, our patients and staff and develop a communication strategy that improves communication (in both directions). | – Our services are easy for people to access when they need them, with reasonable adjustments made for individuals who find it more difficult to use our services than others. |
| Re-establish standards of basic care | |
| Support our staff to deliver excellent | |

| We will: | We will have achieved this objective when without exception: |
|---|---|
| services and have a positive person-focussed attitude | – Our staff give support, advice care and treatment in a way that is compassionate, respects individual needs, values and rights every time. |
| Improve the way we communicate and the information we provide. | – We work in partnership with patients, their families and carers so that they share decision making about their care. |

## 5.3.2 Quality Objective 2:

*To deliver excellent, effective and efficient services, that are based on evidence and standards.*

| We will: | We will have achieved this objective when: |
|---|---|
| Develop and agree PROMs. Introduce Patient Reported Outcome Measures (PROMs) in every major service area by 2017. | – We compare ('benchmark') our services against the very best and continually improve so that outcomes are and remain in the top 25%. |
| Benchmark our services against the very best so that we better understand the quality of the services we deliver and commission. | – We use measures to show that all of our services, wards and departments are consistently delivering high quality outcomes. |
| Develop with our staff an agreed quality dataset based on outcomes and measures of safety for each service which will be used to monitor quality and drive improvement. | – We use the latest evidence and research to guide the advice, interventions and treatment we provide, (and also do not provide) every time. |
| Describe clearly the services we provide, pathways of care and the standards that our public and patients should expect to receive. | – We provide consistent, clinically proven advice and services at the right time, in the right place and to anyone who will benefit. |
| Streamline information and data collection and improve its validity so that we use information to focus on quality outcomes rather than measures of process. | – We no longer provide services that people will be unlikely to benefit from and could be harmed. |
| **Start to replace guidelines with standard operating procedures and automated pathways. will be the implementation of new all -Wales Policy on 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR).** (2015/16) | – We provide advice, support, treatment and care in environments that are clean, safe, accessible and fit for purpose at all times. |
| Establish an annual pro-active quality improvement programme based on national best practice, patient feedback and the outcomes of internal and external reviews. | – Information about outcomes for patients is collected in "real-time", analysed and reported to those accountable for the service, ward and/or patient pathway, used to drive continuous improvement and published openly. |
| **Establish commissioning boards to set the standards and outcomes that we expect our services to meet.**(2015/16) | – We use patient reported outcome measures to show where improvement is |

| We will: | We will have achieved this objective when: |
|---|---|
| | needed. |
| **Address the delivery priorities set out by the Welsh Government and redesign services to reflect the principles of prudent healthcare. We will make improvements to our stroke services**. (2015/16) | |
| Improve documentation and reduce duplication and the collection of data that is of no value. | |

### 5.3.3    Quality Objective 3:

*To make sure that everything we do is as safe as possible.*

| We will: | We will have achieved this objective when: |
|---|---|
| Develop a zero tolerance of safety breaches. | ₋ There is zero tolerance of safety breaches and never events. |
| Review all deaths to ensure that we did the best we could for the patient. | ₋ We consistently use agreed national and professional standards to reduce unjustified variation and practice known to cause harm. |
| Embed national and professional standards to reduce inappropriate variation and increase reliability. **Priorities for 15/16 will be the:**<br><br>₋ **Implementation of the 'spot the sick patient project. Priority for 15/16**<br><br>₋ **Introduction of electronic prescribing and medicines administration.**<br><br>₋ **Roll out of the 'Big Fight' campaign - targeting Clostridium difficile infection and antibiotic resistance in primary care.**<br><br>₋ **Appointment of ward administrators and hostesses to support and free up ward sisters/charge nurses to be supervisory.** | ₋ We act promptly to address concerns and incidents, and ensure a robust and proportionate investigation every time to prevent repeated poor performance, treatment or service.<br><br>₋ We seek actively to learn from and share the experiences of our own and other organisations, safety alerts and research to avoid unnecessary harm to our patients and population.<br><br>₋ We review the care of anyone who was being treated by us when they died to make sure that the care and treatment we provided was the best available.<br><br>₋ We provide information systems that ensure correct pathways are followed. |
| Use a systematic way of identifying, analysing and acting on harm. | |
| Implement a learning approach to addressing errors that does not seek to blame. | |

### 5.3.4 Quality Objective 4:

*To organise the Health Board for excellence and continuous improvement.*

| • We will: | We will have achieved this objective when: |
|---|---|
| Make accountabilities clear. | • The shared values and behaviours that we have adopted are demonstrated by everyone in the Health Board. |
| Address cultural issues | • Accountabilities and responsibilities are clear. |
| Embed quality objectives job descriptions and personal development plans. | • The personal objectives of all our staff are aligned to the Board's Quality Objectives |
| Implement an organisational wide integrated clinical audit, inspection, peer review and spot check programme. | • All our staff are skilled in improvement methods and are empowered continuously to improve the quality and effectiveness of the services they are part of. |
| Develop service level quality improvement plans. | • We are recognised by our patients and staff as being a listening organisation that knows how well we are doing and for being open, honest and transparent in all that we do. |
| Implement a quality impact assessment process. | |
| Establish and support multi-disciplinary team working and the development of improvement skills. | • We have strong and effective leadership at all levels. |
| Strengthen governance arrangements through the development of an annual quality assurance plan. | • We continuously and consistently improve our services so that they deliver high quality today and tomorrow. |
| Create the will and capacity within the Health Board to give people the skills and support for continuous quality improvement and to embed the principles of prudent healthcare. | • We use high quality information, recorded in real time, to highlight exceptions to standards and identify staff compliance with agreed clinical standards in order to target intervention, training and support. |

**Figure 15 : Summary of the Quality Strategy**
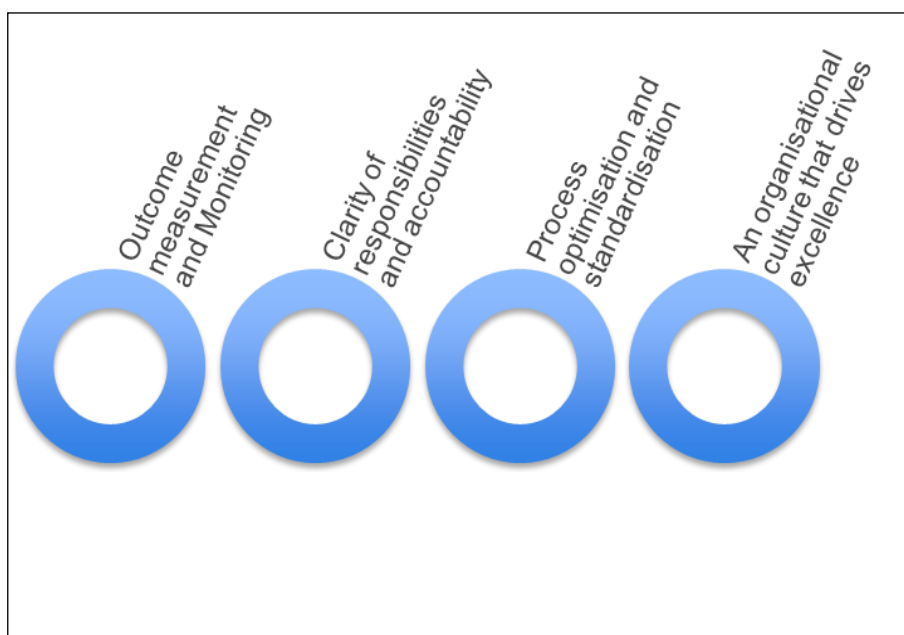


## 5.4    What we will focus on over the next three years.

Over the next three years we plan to deliver significant improvements across our four objectives. We have set an ambitious, but achievable way forward. We want to become the safest Health Board in the United Kingdom and to achieve the highest rates of patient satisfaction by:

- Planning our services with the people living in the communities we serve so that they are person centred, caring and responsive to need
- Delivering excellent, effective and efficient services that are based on evidence and standards.
- Making sure that everything we do is as safe as possible.
- Organising the Health Board for excellence and continuous improvement.

In the months, ahead we will:

- Develop an action plan (including milestones and performance measures) for implementing the Quality Strategy, as part of our Integrated Medium Term Planning (IMTP) process and related annual business plans.

- Continue our work to create a culture of continuous quality improvement and learning, where everyone understands their role in delivering clinical quality and works towards that goal every day.

In the first year we will focus our attention on projects and programmes of work that will reduce harm and mortality, improve patient experience and make the care that we give to our patients reliable and grounded in the foundations of evidence based care.

We have committed £2m to support the implementation of the Quality Strategy priorities in 2015/16. This includes the recruitment of ward administrators and ward hostesses to free up ward managers from non-nursing activities. This figure is shown in Section 8 Table 23 Potential Cost Pressures Assessment 2015/16-2017/18 as £2m Developing High Quality Services.

We will assess our progress against agreed milestones and measures and hold ourselves to account, publicly, during the first year of the implementation of our Strategy. Detailed Annual Quality Plans will be developed and these will set the priorities that we will focus on in each year of the Strategy.

## 5.5   Delivering, Monitoring and Evaluating the Strategy

We value our learning from patient mortality reviews, peer review of clinical services including "spot checks", invited reviews as well as the benchmarking of our services against others through national audits and other quality assessments. From this learning we can identify particular priority areas for improvement. We will deliver this Strategy through a series of projects targeted at these priorities which will also reflect the work of national quality improvement collaboratives. We will set out our priorities in an annual quality plan for the coming year to ensure that the resources and organisation required has been identified.

The Board has overall responsibility for quality, but has delegated responsibility for the regular and detailed scrutiny of this area to the Quality and Safety Committee. The high level objectives and actions and measures set out in this Strategy will be supported by a more detailed Annual Quality Plan in which responsibility for their delivery of each objective, agreed measures of success, milestones and timescales will be described.

As well as developing our Quality Strategy, the Medical Director and Director of Nursing & Patient Experience commissioned a review of the quality assurance and improvement arrangements, in place, at locality and directorate level. The findings of this review (together with the work of the Chair and Chief Executive, to review corporate accountabilities and responsibilities) will be used to inform a new Quality Assurance Framework and Annual Quality Assurance Plan. The Framework and Plan will be designed to give the Board assurances on the quality of care from the 'Patient to the Board' and will ensure that information from various sources is triangulated so that a more accurate picture of quality is built up.

Our Quality Strategy will be reviewed each year as part of the Annual Quality Statement review process. The Annual Quality Statement will report publicly on progress in the priority areas.

# 6       Service Change Plans and Initiatives

> This section describes the key change/transformational programmes and plans that emerged as priorities based on an earlier diagnostic of national and local strategic context and challenges, statutory duties and local ambition. This section also provides an overview of full range of plans and initiatives in place to support the delivery of our plan.

## 6.1      Introduction

In summary this section describes:

- The demand and capacity modelling that underpins a number of the service changes

- The service change plans that we have and are continuing to develop, to deliver new models of care.  These new models of care will reflect population needs, improve clinical outcomes, and support improved efficiency of our services when benchmarked with the best elsewhere to ensure best use of our resources

- Our engagement across South Wales in developing plans for unscheduled care

- Our progress in developing a response to the National Delivery Plans

- Our Locality and Directorate IMTPs, which have informed the development of the Health Board's IMTP

- Our underpinning plans


The priorities of the other, non-clinical, strategic change programmes are set out elsewhere in the Plan:

- Commissioning Development (Section 2 and 4),

- ICT (Section 9)

## 6.2      Demand and capacity modelling

The expectation is that together, these programmes will enable the Health Board to develop and implement new models of care which will support a system shift from secondary to primary and community based care and reduce the number of hospital beds required to support current and projected demand.

Robust demand and capacity modelling has been undertaken to support projected changes in bed requirements. Further comprehensive detail is supplied in **Appendix 10**, which sets out the statistical analysis approach adopted and the reasons for developing a model based on these assumptions. The high level outcome of the modelling work is set out in the following narrative.

We will continue to refine and revisit the assumptions within the model with a clear focus on supporting unscheduled care capacity in unscheduled care beds and increasing the efficiency and productivity of our planned care system through benchmarking and service improvement techniques.

Modelling has been completed to estimate the possible patterns and levels of demand for medical beds across the Health Board. Historical patterns of bed consumption have been studied and adjusted for anticipated future demand for demographic change; in addition a provision has been made for patients who were unable to flow from Emergency Departments due to bed pressures, who would, in a less constrained bed environment, have required a modest bed stay. This demand modelling has been based on our Strategic Needs Assessment published in November 2013.

Having considered the historical pattern of bed consumption, it was determined that the years followed a broad pattern of demand where three distinct time periods at distinct bed consumption levels were observed.

- February to September (baseline)
- October to December ("winter" uplift)
- January – in some years exceptional and above the October to December level

The table below sets out the predicted bed demand consumption by hospital by timeframe.

**Table 16 :  Bed/bed equivalent requiremnts to meet modelled unscheduled care demand**

| | February to September | | October to December | | January | |
|---|---|---|---|---|---|---|
| | Occupancy | beds | Occupancy | beds | Occupancy | beds |
| Morriston | 94% | +21 | 85% | +43 | 75% | +75 |
| POWH | 94% | +26 | 87% | +45 | 82% | +62 |
| Singleton | 97% | +10 | 89% | +25 | 81% | +50 |
| NPTH | 97% | +5 | 95% | +6 | 93% | +9 |
| Total | | +62 | | +119 | | +196 |
| | | | | | | |
| Total @ 85% | | +186 | | | | |

These 3 phases of the year have helped us to shape our approach to unscheduled care planning to enable bed capacity and supporting out of hospital services to be prioritised to enable the planned required levels of beds and bed equivalents to be achieved.

Through our planned investment in primary and community care and unscheduled care we anticipate that the baseline level of 62 beds will be achieved and that schemes can be implemented to move to within 15 bed equivalents of the 119 winter level identified. We have also begun to develop contingent plans that could allow for initiatives to provide a further 77 beds (119 to 196) should the exceptional January and February pressures experienced in 2015 repeat in future years.

Our planning assumption is that by focussing on a sustainable service model to manage the unscheduled care pressures, there will be minimal or no impact on elective planned care beds allowing routine elective flow to continue through the winter. However, if the January pressures seen in 2015 are part of an ongoing future pressure we will need to flex beds in accordance with this above the planned levels.

The table below shows how surgical bed are utilised based on emergency, urgent elective and routine elective cases.

**Table 17 : Surgical bed utilisation**

|  | Total Beds | Emergency Beds | Elective Urgent Beds | Elective Routine Beds |
|---|---|---|---|---|
| Morriston | 287 | 225 | 46 | 16 |
| POWH | 107 | 78 | 14 | 15 |
| Singleton | 22 | 11 | 6 | 4 |
| NPTH | 19 | 1 | 11 | 7 |

The table illustrates that there are only 42 beds which facilitated the treatment of routine elective patients in 2014. In planning to balance the unscheduled care system, the planned care system can flow. Given the relatively small numbers of beds allocated to routine elective operating, any patients outlying in to these beds could significantly affect the flow of the longest waiting patients through our hospitals and presents the risk of increased waiting times. Our plans to support unscheduled care are therefore an important part of the whole system both within and outside of the hospital setting. Further detail on planned care is provided later in this section.

Best practice visits have been undertaken to a number of exemplar organisations to source a demand and capacity modelling tool. The capabilities which could be brought to ABMU, enhancing our current systems, includes the modelling of patient flows in Emergency Departments and assessing the impact of the ageing population and the effects of frailty.

The demand and capacity modelling will provide ABMU with greater insight in planning the most efficient use of resources. This work also supports the Commissioning Development Programme in establishing systems and partnerships to support analysis, evidence review, scenario modelling and service change.

The priorities and actions for the Strategic Change Programmes are set out below. More detail is provided in Welsh Government Mandated Appendix C6.

## 6.3 Service Change Plans

These service changes reflect priorities from three of our strategic aims:

- Healthier Communities

- Sustainable and accessible services

- Strong partnerships

However it is important to note that a number of these changes will have a wider impact. For example the Community Services Project will support both

the development of strong partnership and support the delivery of sustainable and accessible services.

These changes reflect actions being taken forward under our existing Changing for the Better (C4B) Strategic Change Programmes and projects and other national and local priorities.

The table below provides a summary of the service changes described in this section.

| Strategic Aim | Service Change | |
|---|---|---|
| **Healthier Communities** | Staying Healthy (Existing C4B Strategic Change Project)<br><br>• Tobacco<br>• Vaccination and Immunisation<br>• Obesity and physical activity<br>• Our Healthy Futures<br>• Health Schools<br>• Health Care  Public Health | |
| **Strong Partnerships** | • Community Services (existing C4B Strategic Change Project)<br>• Mental Health Services<br>• ARCH | |
| **Sustainable and accessible services** | *System Shifts – Developing Primary and Community Care* | Develop pathfinder initiatives and new organisational models to support GP networks & clusters<br><br>Improve access to primary care<br><br>Implement priorities in cluster plans |
| | | Women, Children and Families (Existing C4B Strategic Change Project) Note: this Project also covers unscheduled and planned care. |
| | *Sustainable unscheduled Care* | Implementing the 111 pathfinder project in ABMU |
| | | Rapid Access  (Existing C4B Strategic Change Project) |
| | | Pre-hospital services(Existing C4B Strategic Change Project) |
| | | Patient Flow Programme |
| | | Hospital Services Project (Existing C4B Strategic Change Project) |

| | | Trauma Centre Development (Existing C4B Strategic Change Project) |
|---|---|---|
| | *Sustainable planned care* | Outpatients Modernisation |
| | | Planned Elective Procedures (Existing C4B Strategic Change Project) |
| | | Surgical Pathway efficiency Programme (Existing C4B Strategic Change Programme) |

## 6.4      Healthier Communities

In drawing up our priorities for the Health Board, we have taken into consideration the priorities set out in the Public Health Wales NHS Trust IMTP (see below).

**Figure 16 :  Public Health Wales NHS Trust IMTP on a page**



IMTP on a page:
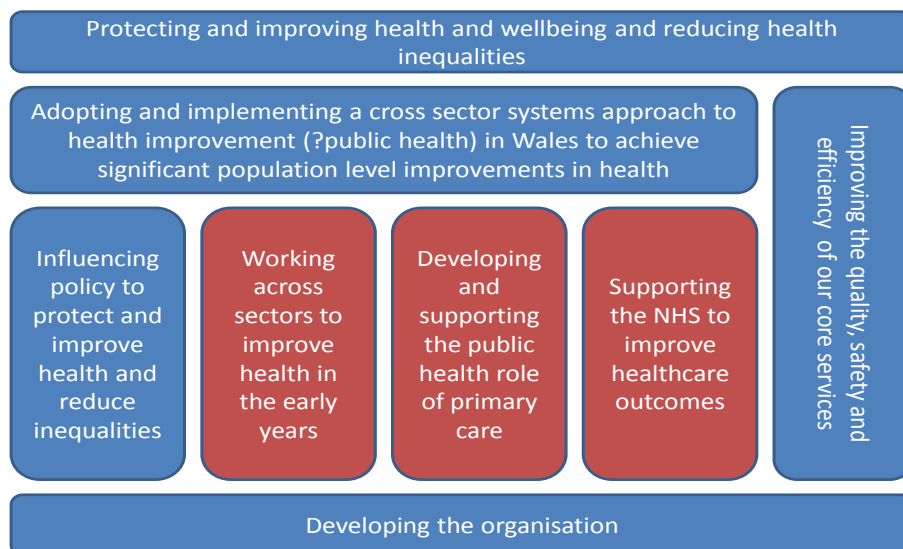
We will remain focused on working towards the delivery of the Welsh Government Tier 1 tobacco and vaccination/immunisation targets. The ABM Public Health Team has set out a work plan, plan, which comprises six programmes i.e.:

- Tobacco

- Vaccination and Immunisation

- Obesity and physical activity

- Our Healthy Futures

- Healthy Schools

- Health Care  Public Health

Each programme will encompass a number of projects that will have a detailed project initiation document, agreed measures and timescale for implementation, to ensure progress can be monitored and performance managed. Work is currently being carried out to develop this information.

The diagram below provides an overview of the content of each of these Programmes.   (Note: Staying Healthy Programme is currently covering Tobacco control, vaccination and immunisation and obesity and physical activity).

**Figure 17 : Publc Health Work Plan**

| Programmes | Projects |
|---|---|
| **Tobacco Control** (using a Large Scale Change approach) | • Level 3 Pharmacy Service<br>• Smoke-free hospital grounds<br>• Hospital Smoking Cessation Service<br>• Smoking in pregnancy<br>• TAG plans<br>• Community based work |
| **Vaccination and Immunisation** | • Flu<br>• Childhood immunisations<br>• 'Light touch' work (e.g. Zostivac, HPV etc) |
| **Obesity and Physical activity** | • Physical Activity Projects<br>• Business Cases (e.g Business Case for CYP services)<br>• Development work pertaining to Obesity programme |
| **'Our Healthy Futures' related work** | • All 'Our Healthy futures' work – including, screening, Sexual Health, mental health, etc.<br>• Plus other work such as Low Birth Weight Babies, and Local authority project work |
| **Healthy Schools Programme** | • Contribution to Team Priorities<br>• Development of Phase 6 Award<br>• Review of School Support |
| **Healthcare Public Health** | • Primary Care (e.g. work with Community Networks)<br>• JSNA<br>• Commissioning<br>• Chronic Disease Delivery Plans<br>• Choose Well |

*(Left vertical label: Life Course Approach. Right vertical labels: Individual's Objectives; Performance Management Framework)*

*Aim: To reduce health inequalities in our most vulnerable and disadvantaged communities.*

| Staying Healthy: | Service Changes |
|---|---|
| (apple icon) | To implement health improvement initiatives on each of the National priorities in order to:<br>**2015/16**<br>**Reduce Smoking**<br>• 40 Community Pharmacies to run Level 3 smoking cessation service, offering smokers motivational support and free nicotine replacement products.<br>• A 'Start Here' marketing campaign, to encourage smokers to quit and to signpost them to the community pharmacy service. |

- An in-house smoking cessation service, focusing on patients with chronic conditions, providing one-to-one intensive support, plus intervention training to various professional groups across the organisation.
- A smoke-free hospital services group to assess compliance against the NICE (2013) guidelines. The group will then make recommendations to the Board to ensure compliance with ABMU Health Board's Smoke-free Environment Policy.

**Reduce unhealthy eating**

- Specialist antenatal clinics for obese pregnant women as part of a maternal obesity care pathway. These clinics would provide early intervention, risk management and healthy lifestyle support from a specialist Midwife and Dietitian to prevent excessive weight gain at this time.
- A targeted level 2 community weight management service to be implemented for adults with a BMI of 30 or over and a history of chronic knee and/or hip pain suggestive of osteoarthritis.
- The establishment of a specialist multidisciplinary level 3 weight management team for adults with severe and morbid obesity.

**Increase vaccination and immunisation rates to target levels**

- Achieve % uptake of the influenza vaccine in the following groups:
- 75% for over 65s, under 65s in at risk groups, pregnant women and 50% health workers
- 95% uptake of childhood scheduled vaccines up to age 4.
- **2016/17 and beyond**
- Reduce health inequalities
- Increase participation rates in physical activity.
- Stop the growth in harm from alcohol and drugs
- Reduce teenage pregnancy rates
- Reduce accident and injury rates
- Improve mental wellbeing
- Improve health at work

| Impact |
|---|

**Reduce smoking**

- 5% estimated LHB smoking population treated by smoking cessation services
- 40% of smokers treated by NHS smoking cessation services are validated as successful
- Reduce the prevalence of smoking to 16% by 2020, with an interim 2016 target of 20%
- Audit/evaluation against NICE (2013) Public Health Guidance 48 – Smoking cessation in secondary care: acute, maternity and mental health services.

**Reduce unhealthy eating**

For all schemes, to demonstrate a % weight loss for participants. To also contribute to:

- Increased use of the midwifery led unit for births.
- Decreased demand in hip/knee replacement surgery.

| | **Increase vaccination and immunisation rates** |
|---|---|
| | • Fewer cases of vaccine preventable diseases, notably flu and measles |
| | **Improvement in our communities health by:** |
| | • Concentrating on key components of the Public Health Strategic Framework and targeting prioritised areas. |
| | • Increased staff knowledge and skills in relation to communicating and promoting health improvement & psychological wellbeing. |
| | • Increased integrated working across the range of organisations and third sector partners. |
| | • Embedding public health objectives in directorate, locality and wider partnership plans and ensuring that Staying Healthy is a very high priority for everyone. |
| | • Raising the profile of public health and ABMU Health Board's Public Health Strategic Framework 2014/2015 and communicating this out effectively. |
| | • Reducing inequalities and inequities in service provision across the ABMU Health Board area. |
| | • Contributing to the outcomes of the ABMU Health Board's Public Health Strategic Framework 2014/2015 and beyond. |

In addition to funding allocated in 2014/15, we have committed a further £337,000 in support of the Weight Management Strategy. This is covered in the following Sub-Section i.e. Primary Care Investments and Implementing Delivery Plans.

## 6.5 Sustainable and Accessible Services

This strategic aim is at the heart of the Health Board's provision of clinical care. We know that we must radically change the way in which we plan and deliver our clinical care if they are to meet the increasing demands being placed upon them, the changing demographics and the necessity of meeting high standards within the available resource – whether that be financial, workforce, estate or equipment. Set out below are the key areas which we are planning to change:

### 6.5.1 System Shifts - Developing Primary and Community Care

Primary and community services are the most frequently used part of our care system and are the bedrock of all that we do. 90% of all interactions with the public are with services delivered out of hospitals and it is only by improving access to a wide range of services in these settings that we will improve the health and well-being of our population, and support maintaining people's independence at home.

The term "primary care" often focuses on primary medical (GP) care and their associated services. Within the Health Board we are focussing our service model changes on the wider primary care team and care provided in community settings by other organisations. We have made progress in

developing our GP Networks and Clusters, as well as integrated Community Resource Teams with local authorities in which the third sectors are also key partners. These will be the focus for ongoing developments outside hospitals and the basis upon which our strategic shift to primary and community based models of care are progressed.

Our focus for developing integrated services will be on prevention, early interventions and avoidance of hospital admission, as well as helping people to return home as quickly as possible when they have had to be admitted to hospital.  We recognise that to make progress we need to develop networks of care, where care is planned and delivered across a continuum which is increasingly focused on care in or near people's homes.

Care needs to be integrated around the person, with all their care needs being recognised and met, rather than focussing on individual elements of need. This is increasingly important for our frail older population who will have multiple co-morbidities. As we develop and introduce new models of care they must be based on outcomes that matter to them as individuals, are based on sound evidence and need, and reflect value for money. Services will be evaluated so that benefits and opportunities for improvement are recognised.

During 2015/16 it is critical that we ensure that key actions for the Health Board and partners within the *Social Services and Well Being Act* $_2$ are taken forward, and aligned with the development of community networks.  In particular the focus on advice, information and assistance, and the range of action required to deliver preventative services all need to be joined with the focus on providing care closer to home.  The community networks will have a key role to play in ensuring that local planning and delivery of care is based on delivering person centred care, and this will be a major thrust throughout our Plan during 2015/16 and beyond. We will build on the changes within the GP contract to put primary care in the driving seat.

Strategic priorities have emerged from GP Cluster Network plans which are attached at **Appendix 7.**

The launch of the Welsh Government's Primary Care Plan provides an opportunity to accelerate progress in shifting the balance of care and support plans and priorities with flexible investment.  This shift forms a cornerstone of our strategy and lies at the heart of the work being undertaken by the Western Bay Health and Social Care Collaboration.

We have developed a Primary Care Plan, which builds on progress made in 2014/15 and is summarised at **Appendix 7.**

### 6.5.1.1    Primary and Community Service Investment

Welsh Government has recently announced a significant investment to support the further development of primary care in 2015/16, which will support the strategic direction of travel for the Health Board as set out above.

The following subsections set out our proposals for investment in primary and community care services, to be funded from the new investment monies, i.e,

- Investment in GP Clusters/Networks - £1.0m

- Investment in Pathfinders – bids against the £3m allocation

- Primary Care Investments and Implementing Delivery Plans - £6.8m

- Community Services Investment - £3.4m

This investment is shown in Section 8 Table 23 Potential Cost Pressure Assessments 2015/16-2017/18 £11.2m for Primary Care and Community Services. We are clear that these figures as working figures only and some of them will be subject to change as part of the business case process to secure funds.

### 6.5.1.2    Primary Care Plan – Investment in GP Clusters / Networks

Networks are currently developing plans for investment of the £1.0m allocation to primary care clusters.   The assurance process will be undertaken by the Primary Care Development Group and will be light touch to ensure that spending proposals:

- Are in line with the aims of the Primary Care Plan and support of their own local cluster plans

- Are realistic in terms of risks and issues to implementation

- Identify contingencies for any slippage

- Are consistent with National Guidance.

### 6.5.1.3    Primary Care Plan – Investment in Pathfinders

ABMU has agreed to become a Pathfinder for the development of pathways to support the introduction of the new 111 model.  A dedicated resource has been made available from ABMU to support both the local and national implementation arrangements.   A local implementation plan is being developed and costed.   To support this initiative, a dedicated local implementation board has been established. The key tasks will be to:

- Establish a comprehensive and robust local Directory of Service

- Establish alternative pathways for key conditions/clients to enable calls from 111 to be diverted or redirected to the most appropriate service to meet their needs

- Technical, communications and local workforce plans to be developed that align with the national implementation project plan.

The Health Board also plans to submit four Pathfinder proposals for consideration against the £3m allocation. These are described more fully in the table below:

**Table 18 :  Proposed Pathfinder Schemes**

| Proposal | Benefits | Delivery Organisation | 2015/16 £000 | 2016/1 £000 | 2017/18 £000 |
|---|---|---|---|---|---|
| **Federated Working (planning and leadership)** to  form a legally recognised body (Social Enterprise Business) representing in excess of 60,000 patients engaging with the Health Board to satisfy WG objectives of community care<br><br>The 6 GP Practices in the East Network of Bridgend will join together to form a Federation / Social Enterprise Business which will provide a platform for the individual independent contractors to legally join together and pool / hold funds, employ staff, and deliver services on behalf of each other for the population served (with scope to also extend service delivery in the community beyond the cluster network, e.g. whole County Borough or ABM footprint) amongst other things. | • Accountability Agreement developed between practices in a network area<br>• Incentive and platform for practices to share knowledge, skills and expertise to improve population health<br>• Ability for cluster network to recruit staff, and hold budgets across the network area<br>• Mechanism to 'scale up' workforce and spread incoming workload across a number of practices<br>• Mechanisms to legally hold and share financial savings from incentive schemes<br>• Assured governance framework in place to mitigate risks to the Health Board to move resources and for devolving budgets down to the Cluster Networks (e.g. Wound dressings)<br>• Ability for network to bid for contracts and secure funding outside of the NHS arrangements (e.g. access to charitable funds, National Charities e.g. MacMillan, Big Lottery)<br>• Mechanism to move services from Secondary to Primary Care – improve access and patient experience delivering | Federated Working (planning and leadership) | £158k | £166k | £150k |

| Proposal | Benefits | Delivery Organisation | 2015/16 £000 | 2016/1 £000 | 2017/18 £000 |
|---|---|---|---|---|---|
| | more services closer to home | | | | |
| **Primary Care Triage and Service Hub (Integrated Access)**<br><br>The development of a primary care hub and individual practice telephone triage.<br><br>Primary Care Hub provide access to an alternative range of professionals / support workers in key patient demand areas related to Musculo Skeletal problems, Mental Health and medication reviews following a telephone triage by the GP. | • Saving appointment time and releasing GP capacity.<br>• Improve demand management and patient access to the 'right service at the right time'.<br>• Single point of access to community integrated health and social care services<br>• Access to a range of well-being services through expansion of the 'Gateway' service. | Neath Cluster Network | £157k (network to contribute) | £203k | £203k |
| **Acute GP Mobile Outreach (access and quality)**<br><br>To advance the Acute GP Unit (AGPU) model at Singleton hospital Swansea and extend into the Community, providing higher levels of care, at home. The service will consist of a GP and nurse practitioner support. | • Offers alternative to admission<br>• Quicker access to higher level of investigation<br>• Offers advice and second opinion<br>• Offers quicker access to specialist advice | Acute GP Mobile Outreach (access and quality) | £173k | £173k | £173k |
| **Alternative Workforce Models- Pharmacist Support to Cluster Networks** (this can be scaled up and down)<br><br>To provide pharmacy support to Network Clusters, specifically developing the following:<br>• Care Home Pharmacist – focussing on managing medicines for the frail elderly | • Improving skill mix, to maximise prudent prescribing outcomes<br>• Maximising benefits and minimising medication risks, which will reduce the demand on unscheduled care.<br>• Improved communications supporting the delivery of integrated care and improved outcomes. | Cluster Pharmacists (skilled local workforce)<br><br>(this can be scaled up and down) | £165k | £220 | £220 |

| Proposal | Benefits | Delivery Organisation | 2015/16 £000 | 2016/1 £000 | 2017/18 £000 |
|---|---|---|---|---|---|
| in care homes across the cluster, building on the GP and Community Pharmacy enhanced services. As part of a cluster hub, with referral to the pharmacist for appropriate review and/or immediate treatment.<br><br>• Managing target medicines/chronic conditions in clinic settings e.g. shared care drugs, cardiac, diabetes, respiratory whilst also considering a holistic view of any other medicines these patients are on, so undertaking a full medication/polypharmacy assessment. | • Maximising outcomes from medicines related QOF targets and enhanced services<br>• Systematic approach to target high risk areas e.g. polypharmacy, multiple chronic diseases, frequent flyers, falls, known high risk medications, antipsychotic use in dementia etc.<br>• Providing proactive advice to patients with respect to their medicines to individualise care in line with co-production principles<br>• Improving cost effectiveness and reducing waste | | | | |

### 6.5.1.4 Primary Care Investments and Implementing Delivery Plans

Primary Care Development Group has identified strategic priorities from the cluster plans for investment against a financial commitment of £6.8m over the next three years. For 2015/16 the priority will be to focus on:

- Commissioning additional services from all networks/clusters that support implementation of the Respiratory Plan (spirometry, patient education and pulmonary rehab)

- Commissioning the roll out of diabetes education across all networks

- Care planning for "at risk" individuals within clusters who would benefit from greater care coordination to prevent hospital admission (linked with Western Bay)

  In addition, to improving access and quality for patients, these priorities would deliver benefits by the end of the year in terms of referrals (RTT) and bed days used (Unscheduled care)

- Accelerate roll out of Ambulatory Emergency Care in line with the strategic shift envisaged by Changing for the Better
  - Joined AEC network in March 15 to help scope work, quantify impact, facilitate clinical engagement and support progress
  - Aim to maximise opportunities across the 49 key conditions
  - Focus on links with Singleton AGPU in first instance. Good clinical engagement, facilities potentially available, nursing skills and expertise - roll out to other three sites over next 24 months
  - Potential for c 75 beds in total to support unscheduled care when rollout is complete

- Support primary care with rapid access to diagnostics roll out to help support unscheduled care and RTT

- Community anti microbial team
  - Address antibiotic prescribing variation, impact on infection etc.

- Dual diagnosis education and training for primary care teams
  - Improve quality of care for patients with dual diagnosis, build primary care skills

- Atrial Fibrillation and anti coagulation in Swansea address current inequalities and safety issues

- Supporting implementation of the weight management strategy

For 16/17 these strategic shift priorities would focus on:

- End of life care

- Early detection of cancer

## 6.5.1.5    Community Services Investment

It has been confirmed that £3.5m will be provided to meet the recurring costs of the Western Bay Community Services Project. This is a joint project with partners and is run through the Western Bay Partnership.  The aim of the Project is to *deliver improved services for frail older people and those with dementia.*

The three key themes are:

- ***Wellbeing and keeping healthy –*** making sure older people who are frail and those with long term conditions are supported to take care of themselves and be independent.

- ***Strengthening community teams*** – ensuring that people receive assessments in the community for assessment and, if necessary care, rather than hospitals or institutional care.

- ***Making services sustainable*** – ensuring community teams have the right support to allow them to be the best they can be for the long term. The planned service changes are summarised in the table below.

| Community Services | Service Changes |
|---|---|
| | **2015/16** |
| | • Localities will continue implementation of Intermediate care, evaluation to begin and benefits realisation framework implemented |
| | • Planning and early piloting of Phase 2 of the project through development of the Frailty Model and in particular Community Network services through identifying the most vulnerable/frail older people and proactively managing  and coordinating their care |
| | • Older People's Community Mental Health work will be further developed as part of the above frailty model |
| | • Detailed service models and potential business cases/funding bids designed and agreed based on planning work carried out |
| | • Roll out community resilience (Time Credits) model to other part of the Western Bay region subject to evaluation of the proof of concept in Upper Amman Valley |
| | • Further strengthening the opportunities through remodelling hospital and specialist services to shift resources into the community |
| | **2016/17** |
| | • Localities continue implementation of Intermediate care, evaluation and benefits realisation reviewed |
| | • Implementation of frailty model continues through community network services - evaluation and benefits realisation reviewed |
| | • Detailed service models and business cases designed and agreed in 15/16 drive the implementation in 16/17 |
| | • Further implementation of innovative community service initiatives ensuring care truly defaults to a community setting. |

| | |
|---|---|
| | **2017-18** |
| | • Further work is being undertaken to determine future actions for this year. |
| | **Impact** |
| | • Rapid Response: 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response. |
| | • Intake: 100% of all potential new homecare clients receive intake intermediate care. |
| | • Planned response: 100% of homecare clients for whom a potential significant change is identified receive review intermediate care. |
| | • Step down care: 100% of post-acute care that is suitable for domiciliary intermediate care is delivered at home rather than in a hospital bed. |
| | • Step up care: Step up care provision is expanded proportional to future change in the frail older population. |
| | • Residential intermediate care: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments. |
| | • Addresses current and potential future capacity issues for community services. |
| | • Minimises the use of long term care home placements. |

## 6.5.2    Women, children and families

***AIM: To review and redesign the full range of services provided in the community.  In order to meet the best standards of care, we plan to transfer maternity, obstetric, neonatal and inpatient gynaecology from Singleton hospital to Morriston hospital.***

Implementing this integrated service will require a significant investment in new facilities and for this reason may take several years to complete.

We want to develop a combined children, young people and family service. This would bring together community and multi-disciplinary teams, therapies, child and adolescent mental health services, sexual health, drug and alcohol services, community paediatric nursing and third sector services in a community setting.

| Women, children and families | Service Changes |
|---|---|
| | **2015/16** |
| | • To develop the case for the relocation of maternity, neonatology and gynaecology from Singleton to Morriston (providing specialist input into Programme ARCH) |
| | • Develop a new paediatric urgent care model and implementation plan, following the recent site visits to centres of good practice which combined PAU and paediatric ED. |
| | • Develop a plan for improved working between paediatric and primary care colleagues to fully maximise skills, experience and relationships. |
| | • Following the implementation of the paediatric continuing care assessment team, |

|  | continue to work with partners across Western Bay to bring improvements in respect of assessment and care planning. |
|  | • Following the development of a new model for providing care to children with disabilities and their families in Neath Port Talbot, develop a phased-implementation plan (revised model includes proposals for joint care co-ordinators, streamlined assessment and co-location of care providers). |
|  | • Support the review into special school nursing provision on behalf of the Welsh Government and make recommendations to the Board in respect of how these schools could be best resourced in terms of nursing support, in the ABMU area. |
|  | **2016-18** |
|  | • A number of the longer term objectives of this project, which relate to the relocation of maternity, neonatology and gynaecology from Singleton to Morriston for the years 2016/18 will be shaped by the work currently underway with key partners including Swansea University, WAST, Public Health Wales following the successful purchase of land next to the Morriston site. |
|  | • Further work in respect of developing commissioning priorities for children & young people's services, will be developed by the Children & Young People's Commissioning Board. The Women, Children & Families Project Board and subsequent workgroups will become specialist stakeholder reference groups that will provide essential forums of engagement and specialist working groups for the commissioning priorities that fall from the Commissioning Board. |
| | **Impact** |
| | A healthier population |
| | • Increased vaccination rates |
| | • Reduction in smoking in pregnancy |
| | • Increase in self-management |
| | • Increase in the take up of breast feeding |
| | • Improvement in morbidity |
| | Better quality services |
| | • Compliance of multi-disciplinary standards/adherence to professional standards. |
| | • Percentage of patients satisfied with their care |
| | • Compliance with waiting time targets |
| | • Achievement of local benchmark targets |
| | • Improvement in RAMI |
| | • Reduced Paediatric ED attendances, referrals to PAU & paediatric outpatients |
| | • Reduced inpatient admissions |
| | • Reduced mortality rates below the national average |
| | • Achievement of the National neonatal audit project measures |
| | • Better patient experience – positive feedback from patient surveys |
| | • Motivated and sustainable workforce |
| | • Medical workforce rota compliance |
| | • Positive feedback from staff surveys |
| | • Reduced sickness and absence levels |

## 6.5.3    Develop Sustainable Unscheduled Care Services across the Whole System

As set out previously, the pressures on the unscheduled care system this year have meant that the final six months of the year will have been spent in a reactive mode which is not a sustainable position for the Health Board, or its partners, to be in. We recognise that establishing a sustainable whole system model, which addresses health improvement and prevention, joint working with our partners in local authorities and the third sector, care across all of our services and joint working with WAST and partnering LHBs is crucial to success. This is the overriding purpose of the ABMU Unscheduled Care Board.

We continue to develop these plans.  Some of our plans are set out below:

### 6.5.3.1    Rapid Access

***AIM: To provide 'one stop' rapid access services for those patients at risk of requiring emergency admission through the Emergency Departments (A&E).***

The priorities include developing:

- Rapid access to specialist advice by phone and email.

- Rapid assessment and treatment services.

- Rapid access to diagnostics / tests.  This will include increasing the access time for testing by extending the working day.

| Rapid Access | Service Changes |
|---|---|
| | **2015/16** |
| | • Swansea Locality to lead  Singleton Ambulatory Unit (Ward 10)  and its implementation against service plans subject to investment agreement |
| | • In line with Hospital Services developments Swansea Locality to finalise model for Cold Site Ambulatory Unit and analyse preferred location, co-location and test the model, e.g. options to locate within the Acute GP Unit (AGPU), Surgical Assessment Unit (SAU) space at Singleton once clinical moves have started or other space on site. |
| | • With support from the AEC Network, Localities and Site Management teams to implement the learning from membership of the Ambulatory Emergency Care Network across the identified acute hospital sites, ensuring ABMU is working towards the model for ambulatory care as a network of hospitals supporting each other |
| | • Interface Group to establish WCCG specialist advice pilot and evaluate advice lines and plan further roll-out to other specialities. |
| | • CSS Directorate to deliver the Radiology service plans subject to investment agreement |

**2016/17**

\*\*this project will transition into business as usual for delivery units and the work of the unscheduled care commissioning board so the following will be monitored via these mechanisms

- In line with acute clinical reconfiguration in Swansea and Neath Port Talbot (movement of Acute Hub/AGPU) Swansea Locality further implement the Cold Site Ambulatory Unit at Singleton in partnership with Swansea University and in line with the long term vision for ambulatory care on site
- Ambulatory Care model implemented in other general hospitals within ABMU as a result of the learning in Swansea approach to hospital provision and learning from the Ambulatory Emergency Care Network
- Roll out of advice lines to remaining specialities where appropriate
- Clinical Support Services Directorate to further refine radiology models and capacity plans based on evaluation of 2015-16 activity and impact

**2017-18**

- Further work is being carried out to determine actions for this year.

| Impact |
|---|

- An ambulatory model in each hospital, supporting admission avoidance.
- Facilitate a change in culture with regards clinical practice and patient management based on the principles of Rapid Access
- Specialist assessment of patients within 4, 12, 24, 48 and 72 hours (depending on complexity and urgency of patient condition) of a possible deterioration of a medical problem, to prevent admission into acute hospital.
- Prevent/reduce admissions and multiple visits to hospital by contributing to a one stop medical, diagnostic workup and multidisciplinary assessment.
- Improve patient satisfaction by keeping services local.
- Enable older people and those with Long Term Conditions to maximise their independence and prevent premature entry into long-term care
- GPs and community staff will have additional routes of access to specialist advice from Consultants and Specialist Nurses e.g. over the phone, email, Skype, etc.
- People will be able to access ward-based assessment where staff know them and are familiar with their condition and medical history

### 6.5.3.2    Pre – Hospital Services

***AIM: To strengthen and develop joint plans with the Welsh Ambulance Service and other partners to provide alternatives to unnecessary attendance, at Emergency Departments and in primary care.***

| Pre hospital services | Service Changes |
|---|---|
|  | **2015/16** |
|  | • Increased focus in this financial year will be on understanding inappropriate demand for Primary Care specifically GP services / time |
|  | • Work that has been established at Emergency Departments such as Frequent Attendee service will be adapted and piloted within the Primary Care setting |
|  | • To develop and strengthen services, with the Welsh Ambulance Service and other partners, to provide alternatives to the public / patients arriving unnecessarily at the Emergency Department and within Primary Care. |
|  | • To  develop new pre hospital pathways with WAST including**: -** |
|  | ‒    Alcohol |
|  | ‒    End of Life |
|  | ‒    Care home conveyance |
|  | ‒    Stroke |
|  | ‒    Fracture Neck of Femur (#NOF) |
|  | ‒    ATMIST – system for patient early alert, pre-alert and handover |
|  | • To link WAST vehicles in the Neath Port Talbot Locality to the GP OOH service, via a secure Tele health service. At the same time and using the same technology we will link 15 care homes to the GP OOH service so residence of nursing homes are able to access a visual assessment by a doctor without having to leave the care home or without the GP having to make a home visit. |
|  | • To identify the numbers of frequent attendees at the Emergency department. Once identified they are contacted by the third sector (Red Cross) who work with them closely for a 12 week period on a behaviour change programme. |
|  | • To continue to inform the public of what unscheduled care services are available and when they should be appropriately accessed. This is being progressed through the "Choose Well Campaign" a priority of this Campaign is to communicate and engage with ABMU staff on the Key messages. |
|  | • To work with Specialities to develop Direct Access Pathways for Patients from the Community and Patients who WAST are conveying. This work is closely linked to the developments of an acute hub. Table 34 below summaries the overall impact of the project. |
|  | **2016-18** |
|  | • The medium to longer term future of this project will be defined through the Unscheduled Care Commissioning Board, which is being established in 2015. |
|  | **Impact** |
|  | • To reduce the numbers of unnecessary A&E attendances |
|  | • To reduce the numbers of unnecessary Primary Care attendances |

The Health Board will also seek to improve the way in which our processes work whilst patients are in hospital, to ensure they receive the right care in the right place at the right time by the right person:

### 6.5.3.3   Patient Flow Programme

***AIM: To ensure the UHB maximises the benefit of effective patient flow to ensure our unscheduled care services are as effective as possible***

| Patient Flow | Service Changes |
|---|---|
| | **2015/16** |
| | This programme will concentrate on |
| | • Embedding Board Rounds on all wards as a way of managing flow effectively |
| | • Redesigning emergency admission pathways for frail older people, using Flow principles to target underlying reasons for delay |
| | • Supporting better access times for 'front door' emergency services at Morriston, Singleton and Princess of Wales Hospitals using Flow principles and by investing in pharmacy, diagnostics and therapists. |
| | **Impact** |
| | • Improved patient experience and outcomes in line with the Health Foundations Flow Cost Quality metrics |
| | • Reduced bed use per 1,000 population and improvements in occupancy levels |
| | • Improved compliance with access times for unscheduled care |

### 6.5.3.4   Hospital Services Project

***AIM: To establish our main hospitals as a network of hospitals, describing a clear role for each hospital.***

The priorities are to:

- Establish Morriston hospital as the only site for acute medicine, for Swansea and Neath Port Talbot.
- Increase the use of Singleton and Neath Port Talbot hospitals as sites for walk in care, low complex diagnostic tests and outpatient care.
- Develop ambulatory care pathways
- Work with Swansea University to develop plans for education and research in Singleton and Morriston.
- Respond to the South Wales Programme's plans for the future role of the Princess of Wales hospital.

| Hospital Services | Service Changes |
|---|---|
| | **2015/16** |
| | <br>&minus; Work with Swansea University and other Partners to develop joint vision and plan for Regional Health Economy<br><br>&minus; Building on year 1 of plan expand the recruitment of additional Medical workforce<br><br>&minus; Implement the Nurse practitioner plan for Medicine<br><br>&minus; Develop and agree the business case for  Hyper Acute Stroke Unit  on Morriston Site<br><br>&minus; Establish an acute hub for medicine for Swansea & Neath Port Talbot (Increase the capacity of the Morriston Acute Medical Unit (Clinical Decision Unit) to enable an increase in acute referrals on the Morriston Site<br><br>&minus; Scope the Implementation of the Singleton Minor Injuries Unit (a consistent model with NPT hospital)<br><br>&minus; Implement the Acute Oncology Scheme<br><br>&minus; Develop existing service to establish Heart Failure Service across Swansea and Neath Port Talbot |
| | **2016/17** |
| | <br>&minus; Reverse the roles of Ward R & Ward C  following a renewal of the Wards<br><br>&minus; Establish decant ward on the Morriston Site to facilitate changes on both Morriston and Singleton sites<br><br>&minus; Recruitment to the medical work force plan will be completed during this financial year |
| | **2016/17 & 17/18** |
| | <br>&minus; The purchase of land at Morriston Hospital is part of facilitating the vision that the Hospital Services Project has described in the past 18months. Detailed work is underway with key partners including Swansea University, WAST, Public Health Wales and other partners to shape this development in the medium term. Work in the first six months of 2015 will shape the nature of the Hospital Services Project between 2016 -2018. |
| | **Impact** |
| | We anticipate the implementation of these moves delivering a wide range of benefits in terms of demand management, access, quality, safety and finance. We plan to: -<br><br>&minus; Increase successful WAST handover completion rate by 15mins by10%<br><br>&minus; Increase the Number of patients that get discharged on the same day of attendance<br><br>&minus; Reduce the number of patients that get admitted with identified medical conditions.<br><br>&minus; Reduce the number of readmissions.<br><br>&minus; Reduction in  Length of stay for patients with identified ambulatory care conditions<br><br>&minus; Reduction in Rate of complications for patients with agreed ambulatory care |

| | |
|---|---|
| | condition Improvement in Risk-adjusted mortality |
| | ‒ Reducing the average length of stay for adult medical admissions by one day. |
| | ‒ Patients avoid unnecessary hospital admissions; |
| | ‒ patient experience is improved by reducing admission and therefore the risk of hospital-acquired infections; |
| | ‒ Support GPs / Primary care to manage patients safely at home once a definite diagnosis has been made (or excluded), and consequent advice on management is given; |
| | ‒ Enhances cost-efficiency by improving the use of resources |

Whilst not a feature of the hospital services project as currently defined, the pressures on critical care at both Morriston Hospital and Princess of Wales Hospital require address. In the first instance we plan to stabilise the workforce which will have a positive impact on quality of care, length of stay and recruitment and retention. In year one of this plan we will commence work on modelling the physical infrastructure requirements and develop plans to enable the expansion of both units to cope with anticipated future demands. For Morriston there is a longer term link to the ARCH project and the opportunities this will bring.

### 6.5.3.5 Trauma Centre Development

***AIM: To develop plans to provide world class care for patients with major trauma in ABMU and across south Wales, by developing Morriston hospital.***

This development is vital to provide appropriate treatment for the sickest and most seriously injured across south Wales.

| Trauma Centre Development | Service Changes |
|---|---|
| | This project will support the development of ideas and a service specification as part of the South Wales Collaborative Major Trauma Network. Specifically, this project has been established to ensure that all actions required to enable ABMU to play a key role, along with the other Health Boards in South Wales, in the provision of Major Trauma services for South Wales. |
| | During 2015/16 the two key aims for the project locally is to implement an improved Osteo plastic service, and to scope the development of unit for the management of acute complex Major Trauma patients |
| | **2016-18** |
| | The Longer term future of this Project will be shaped by the anticipated timeline of the South Wales Collaborative Programme to establish a Major Trauma Network. While the Health Board and the Project members remain committed to improving ABMU services to meet the Major Trauma National Standards, both the requirement for this project and or the work programme of the project will be shaped by the progress made with the wider aims of establishing the Major Trauma Network |
| | **Impact** |
| | • To be developed as part of the process of producing a business case. |

We have committed to invest £4.0m to support the above initiatives. This figure is shown in Section 8, Table 23 Potential Cost Pressure Assessment 2015/16-2017/18 as Demand on Acute Services. We have also committed £2.0m to recruit ward administrators and ward hostesses in order to support ward managers to spend more time on direct patient activities. This is shown on Table 23 as £2.0m Developing High Quality Services.

## 6.5.4    Sustainable Planned Care

The Health Board has acknowledged that our predicted activity to support planned care was not sufficiently robust during 2014/15 and we are determined not to make the same mistakes again. As set out earlier in this section we have undertaken robust demand and capacity planning based on a number of scenarios which will realistically reflect our ability to deliver year on year improvements and also reflect the unscheduled care demands on the system. The bed element of the modelling work is reliant upon our plans for unscheduled care reducing the number of patients outlying into surgical beds

We have worked with our directorates and localities to understand the specific local pressures they are experiencing with the delivery of their planned care access times. Each specialty has its own unique characteristics and has been modelled according to the current waiting times status, the scale of recovery in backlog required and the deliverability of the capacity required to address that backlog in terms of clinical safety and patient governance. This has all been considered against the context of a financial test of value.

In addressing this backlog we have taken the approach that productivity and efficiency are key drivers. The plans are built on the assumption that specialty teams have explored and exhausted as far as possible within the current system the follow opportunities: -

- INNU
- Day case rates
- ERAS
- Pre op assessment
- Surgical pathway redesign
- Benchmarking.

Where specialty teams have indicated that additional resource is necessary to address their backlog we have adopted the principle funding will not be made available until demonstrable gains through the bullet pints above have been factored in to their plans. Once this is established the backlog solutions will differ by specialty and given the scale of challenge we are facing in 2015/16 and beyond these solutions are likely to require outsourcing to alternative surgical capacity though a variety of models which are currently being explored.

Our modelling shows that by utilising efficiency and productivity gains, service model change (see 6.5.4.1 to 6.5.4.3 below) and then by applying a range of sustainable investments and one off backlog removal initiatives it would be possible to arrive at the following RTT position within the span of this 3-year IMTP: -

- 0 stage 1 cases waiting >26 weeks by March 2016 (except ophthalmology)
- All specialties to reach 0 patients waiting > 36 weeks by March 2016, except for MSK, General Surgery, ENT, Oral Surgery, Ophthalmology
- 5 specialties outside of March 2016 delivery will recover within the 3 years of this IMTP

The table below profiles the years during which each specialty will remove their 36 week backlog. It is planned that all of the outpatient waits over 26 weeks with the exception of ophthalmology (which is subject to a specific project to look at clinically based prioritisation of patients) would be removed in year 1 of the plan.

**Table 19 : RTT 36 week wait recovery plan**

| Specialty | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| 7 Medical Specialties | ✓ | | |
| Cardiology | ✓ | | |
| Cardiac Surgery | ✓ | | |
| Vascular Surgery | ✓ | | |
| Urology | ✓ | | |
| Plastic Surgery | ✓ | | |
| Spinal Surgery | ✓ | | |
| Oral Surgery | | ✓ | |
| General Surgery | | ✓ | |
| ENT | | ✓ | |
| Ophthalmology | | | ✓ |
| Orthopaedics | | | ✓ |

Every effort will be made to accelerate the backlog removal and bring these trajectories forward as system efficiencies and the management of the unscheduled care position come in to place.

With regard to cancer services, we have experienced growth in the number of cancer treatments that we are undertaking in 2014/15 and we are rebalancing our planned care system to account for the growth in these volumes and the growth in urgent non cancer cases as referred to earlier in

this IMTP. We have three tumour sites where we are under the most pressure in terms of capacity and demand: -

- Breast
- Lower GI
- Urology

There is a noted increase in Breast USC referrals since the media coverage in November 2014. We have increased the number of new outpatient clinics available to facilitate the diagnostic element of the patient pathway and enable patients with confirmed disease to progress to the treatment stage of their pathway as soon as possible.

In Lower GI we have made very good progress and our 1st appointment waits are now under 10 days for 90% of our patients. Significant progress has been made with the endoscopy element of this patient pathway and now 96% of patients receive their diagnostics endoscopy within 10 days of referral to the endoscopy service.

In Urology significant improvement has been noted in the diagnostic element of the pathway and the Health Board has invested in new capital equipment to speed up diagnostic procedures and increase capacity for these. We have more work to do to ensure that once the diagnostic tests are completed we have sufficient capacity to provide the required surgical interventions within a timely manner.

With regard to diagnostic tests, the Health Board has made significant progress in 2014/15 in addressing its diagnostic test waits and in particular, waiting times for endoscopies, cardiology tests and non obstetric ultrasound. Our plan for 2015/16 is to build on the good progress made and maintain our position as one of the best performing Health Boards in Wales for diagnostic testing.

All of the assumptions around planned care delivery are supported by the initiatives set out below.

In addition to the £6.5m allocation made in 2015/16 we have committed a further £2.5m to cover the cost of the increased backlog of patients waiting over 36 weeks. This figure is shown in Section 8, Table 23 Potential Cost Pressure Assessment 2015/16-2017/18 as £2.5m Tier 1 Delivery.

### 6.5.4.1 Outpatients Modernisation

***AIM: The aim of this project is to transform our outpatient services and reduce the number of outpatient referrals. We will do this by offering different ways for patients and clinical staff to get the specialist advice they need. We will also explore what health technology innovations***

***can be used to transform the way patients are referred and reviewed and how advice and treatment can be provided as close to the patient's home as possible.***

| Out patients modernisation | Service Changes |
|---|---|
| | **2015/16** |
| | • To offer different ways for patients and clinical staff to get the specialist advice they need. |
| | • To explore what health technology innovations can be used to transform the way patients are referred and reviewed and how advice and treatment can be provided as close to the patient's home as possible. |
| | **2016-2018** |
| | • Work is ongoing through the Outpatient Modernisation Project Group to agree the work programme for 2015/16 and beyond |
| | **Impact** |
| | • A preventative model that reduces demand on the service. Reduce number of referrals by 5% in year 2 and 10% in year 3. |
| | • Patients only attend if really necessary. |
| | • More rapid access to diagnostics and better co-ordination of test results |
| | • Alternatives to traditional consultant outpatient appointment provided |
| | • Capacity created to support delivery of national outpatient targets i.e. |
| |     ‒ RTT waiting times |
| |     ‒ 31 and 62 days cancer targets |
| |     ‒ New to follow up ratios |
| |     ‒ Percentage of DNA (Did not attend). |
| |     ‒ Number of FUNB (follow up not Booked Patients) |
| | • A single information system to link services. |
| | • Patient focussed system to allow co-ordination of appointments. |
| | • Standardisation of patient information across the Health Board. |
| | • Electronic referrals from primary to secondary care (100 % compliance) |
| | • Electronic discharge letters from secondary to primary care that is accepted by GPs. (100% compliance) |
| | • Patients should come away from their appointment with relevant information. |
| | • A Direct access model for the patient. |
| | • More One stop shop clinics. |
| | • Early senior review with a clear treatment plan. |
| | • Better follow up management (reduce the numbers). |
| | • Rapid access or hot clinics as needed. |
| | • Junior Doctor Supervision. |
| | • Rapid specialty advice in more specialties. |
| | • Community based clinics/ Network. |
| | • More use of telemedicine / email advice. |

### 6.5.4.2    Planned Elective Procedures

***AIM:  This project will identify best practice in terms of providing more elective procedures in primary and community settings, both to improve patient experience and to reduce waiting times.***

| Elective procedures in primary and community | **Service Changes** |
|---|---|
| | **2015/16** |
| | • To identify minor surgical procedures suitable will be carried out in a primary/community care setting. |
| | • To initially focus on the implementation of vasectomy services in the 2 networks in a primary care setting. |
| | **2016/17 and 2017/18** |
| | • This work will be incorporated within the Planned Care Commissioning Board |
| | **Impact** |
| | • We will perform fewer minor elective procedures in secondary care, therefore freeing up valuable capacity |
| | • Minor Surgery is performed within a Community Network model |
| | • We will see waiting times reduced for minor surgery |
| | • We will see an increase in minor procedures carried out closer to people's homes |
| | • We will see an increase in capacity in secondary care in order to carry out more of the procedures that can only be carried out in a hospital setting |
| | • Patients will have a more convenient service delivered closer to where they live |

Improving our efficiency whilst in hospital will also be key to improving our ability to deliver planned care requirements. The Health Board has established a programme to support this, and it is expected that this will start to reap significant rewards in 2015/16. This will build on benchmarking already completed to inform the capacity and demand modelling referred to earlier in this document, some of which already assumes the gains to be delivered from these programmes. Our experience tells us that it is important to factor in these efficiency gains to support delivery but that we should also be cautious when interpreting the scale of the gain given the complexity of the systems we are applying them to.

### 6.5.4.3 Surgical Pathway Efficiency Programme

***AIM: To improve the quality, safety and efficiency of our surgical pathways and to improve waiting times for patients.*** This is supported by the Health Board's Service Improvement Team.

| Surgical Pathway and Efficiency Programme | Service Changes |
|---|---|
| | **2015/16** |
| | The Surgical Flow Programme will concentrate on: |
| | • Embedding principles of Enhanced Recovery in all relevant pathways |
| | • Improving resourcing of theatres in relation to demand – emergency and elective |
| | • Continuing to improve the pre-operative assessment service as a fundamental plank of the elective surgical pathway – linked to the commissioning of new facilities at Morriston hospital. |
| | • Implementing options to ring fence some bed capacity to support surgical flow as part of capacity plans for 15/16 |
| | • Supporting clinically led specialty based pathway redesign based on "flow" principles, with targeted support in those areas with most significant RTT challenges.  This work will also focus on removing unwarranted variations, (informed by our benchmarking tool Albatross) in line with the principles of prudent healthcare. |
| | • Assess the potential to shift inpatient activity to day case procedures. |
| | **Impact** |
| | • Improved patient experience and outcomes post-surgery |
| | • Reduced bed use per 1,000 population |
| | • Improved theatre utilisation |
| | • Reduced cancellations |
| | • Improved compliance with referral to treatment targets (RTT) and cancer targets. |
| | • Reduced cost of delivering surgical activity overall. |

## 6.5.5    Welsh Government Delivery Plans

The table below provides an overview of our progress in developing and delivering the national delivery plans and mechanisms for delivery. These Delivery Plans incorporate the priorities for 2015/16 as set out in 2015/16 NHS Planning Framework.

**Table 20 :  National Delivery Plan status**

| NHS Delivery plan | Mechanism for Delivery | Executive Lead | Reference to 2015-2016 planning framework priorities | Action |
|---|---|---|---|---|
| Cancer Delivery Plan | Cancer Executive Group | Director of Planning | All five priorities included in original plan. Three of the priorities are to be strengthened in plan to be submitted in March 15. | Delivery Plan submitted |
| Heart Disease Delivery plan | Heart Disease Delivery Plan Steering Group | Director of Public Health | Four of the five priorities are included in the original plan. Remaining priority to be included in plan to be submitted in March 15. | Delivery Plan submitted |
| Diabetes Delivery Plan | Diabetes Delivery Board | Director of Strategy | Two of the six are priorities included in the original plan. The additional four priorities will be included in the plan for submission in March 15 | Delivery plan complete |
| End Of Life care Delivery Plan | End of Life Care Group | Director of Therapies and Health Sciences | One of the three priorities included in the original plan. All priorities will need to be strengthened in the plan to be submitted in March 15 | Delivery Plan Completed |
| Critically Ill Delivery Plan | Critical Care Delivery Board | Medical Director | All three priorities updated for the plan to be submitted in March 15 | Delivery Plan submitted |
| Stroke care Delivery Plan | Stroke Steering Group | Medical Director | All three priorities included in the original plan. | Delivery plan is being finalised. |

| NHS Delivery plan | Mechanism for Delivery | Executive Lead | Reference to 2015-2016 planning framework priorities | Action |
|---|---|---|---|---|
| Respiratory Health Delivery Plan | Local Respiratory Delivery Group | Chief Operating Officer | No priorities set in WG Planning Framework for 2015-16 yet. | Delivery plan to be completed and submitted to WG in **June 15.** |
| Neurological Conditions Delivery Plan | Neurological Conditions Steering Group | Medical Director | Bullet Points 2 and 4 need strengthening in the current plan. | Updated draft to be submitted **October 2015** |
| Liver Disease Delivery Plan | Not yet confirmed | Director of Public Health | WG consultation now closed.  No priorities agreed yet. | Delivery plan completed. |
| Mental Health Delivery Plan | Western Bay Local Partnership Board | Chief Operating Officer | All priorities have been included in the plan | Updated draft submitted **30 Jan 2015.** |
| Substance Misuse | Western Bay Substance Misuse Area Planning Board | Director of Public Health | Draft Commissioning Strategy being developed | Reports submitted quarterly. For follow up in next year's IMTP |
| Maternity | 6 monthly meeting | Director of Nursing and Patient Experience | All priorities (measures) are included in the maternity dashboard, which is reviewed on a monthly basis. | Reviewed monthly. |
| Oral Health | Quarterly Dental Policy and Strategy Group | Director of Strategy | Priority included in original report and delivery plan has been developed | Annual report to be submitted **end Dec 2015.** |
| Eye Health Care Delivery Plan | Eye Care Liaison Group | Director of Therapies and Health Sciences | Four of the six priorities included in the original plan. Remaining priorities to be included in plan to be submitted in April 15 | Delivery plan is being updated for submission to WG in **April 2015.** |

| NHS Delivery plan | Mechanism for Delivery | Executive Lead | Reference to 2015-2016 planning framework priorities | Action |
|---|---|---|---|---|
| National Ophthalmic Implementation Plan | Establishment of working group not yet agreed. | | Plan to be amalgamated into the Eye Health Delivery plan. | Received January 2015. Requirement to establish a working group and develop a plan by April 2015. Plan to be covered by the Eye Health Delivery Plan |
| Organ Donation Delivery Plan | Organ Donation Committee (meets quarterly) | Medical Director | Two of the three priorities are included in the original plan. The remaining priority to be included in the plan to be submitted to WG in March 15. | Delivery plan completed. |
| Rare Diseases | Not yet confirmed | TBC | Final plan not sent out from Welsh Government yet. | No action required as yet. |
| Tobacco Control | Tobacco Control Delivery Board | Director of Public Health | All priorities included | Regular reporting to WG |
| Sexual Health and Well Being | Internally 6 monthly | Director of Public Health | 1 priority in place (LARC LES) others to be included in the plan. | Under review |

**Appendix 11** sets out the priorities for 2015/16 for each delivery plan and our current status against these.

## 6.6    Partnership Working

### 6.6.1    Engagement across South Wales

#### 6.6.1.1    A Regional Collaboration for Health (ARCH)

The Health Board is engaged with a wide range of partners to propose a transformative plan for an integrated healthcare service that reflects the current and future demands of the region. Whilst this programme is being led by the Health Board and Swansea University, Hywel Dda Health Board will also be a partner in the development. Whilst the development will focus on the development of Morriston Hospital, Singleton Hospital and the Swansea University Singleton campus from a capital perspective, the model and vision

of ARCH is far broader than buildings and links a number of key elements together as per the figure below.

**Figure 18 : The ARCH ecosystem**
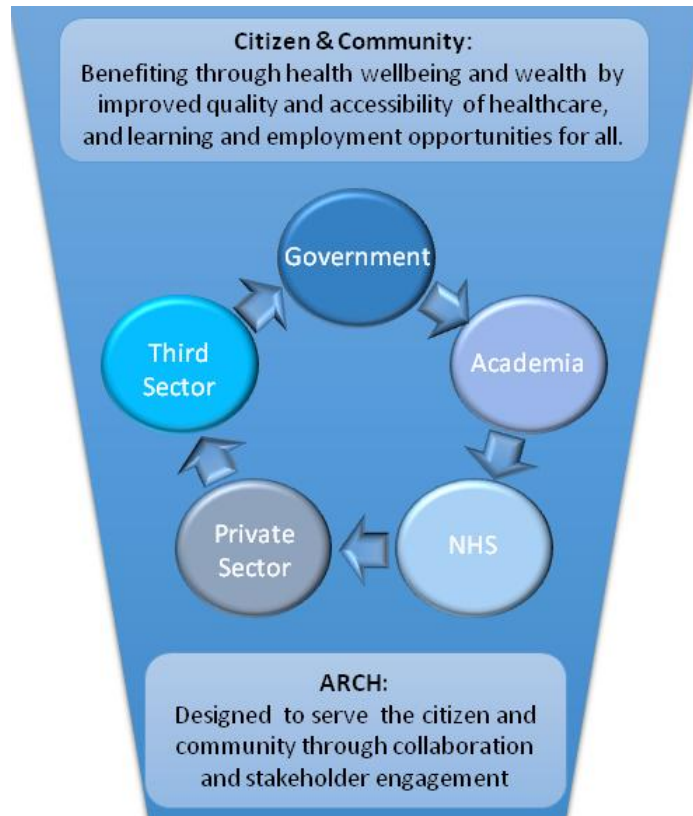


A detailed prospectus is being developed for consideration by Welsh Government which sets out the vision, goals and scale of the project. This not just a health based development as the figure below illustrates.

**Figure 19 :  ARCH model**
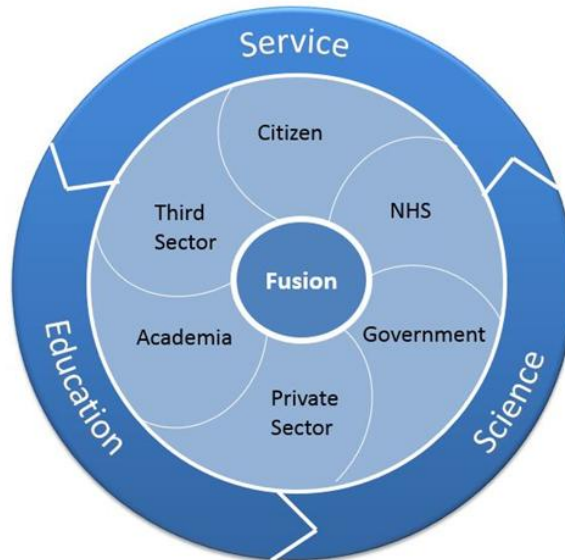


Further detail on the capital impact of the ARCH plan is set out in the capital section of section 8 which follows. ARCH is key element of supporting the Health Board to deliver its long term strategy for out of hospital care, integrated services, links to academia, partnership working and making Morriston and Singleton Hospital modern and fit for purpose for future healthcare delivery.

### 6.6.1.2    South Wales Programme

The South Wales Programme was a joint programme of work between five health boards providing health care services in South Wales and South Powys – Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf and Powys – and the Welsh Ambulance Services NHS Trust. The Programme initially focussed on four fragile services:

- Paediatrics
- Consultant led Maternity care
- Neonatology
- Emergency medicine

Following the most comprehensive public engagement and consultation exercises undertaken in NHS Wales the outcome of the consultation was considered by Boards in February 2014 and the collective position of all partner organisations was confirmed in March 2014. This included the following:

The Programme Board has made a number of recommendations for consideration and agreement by LHBs and endorsement by WAST. The detail of

these was reported to the Board in February 2014, and in essence it has been agreed that:

- Three Acute Care Alliances should be established for the wider South Wales area (including Hywel Dda) based around three "major acute" centres at Morriston Hospital, University Hospital of Wales(UHW) and the Specialist and Critical Care Centre(SCCC) (when built).

- Following the engagement and consultation exercise, Option 3 (University Hospital of Wales Cardiff; Morriston Hospital, Swansea; the planned Specialist Critical Care Centre, Cwmbran; Prince Charles Hospital, Merthyr Tydfil and Princess of Wales Hospital, Bridgend) is the recommended starting point for the transition to three alliances. This represents the start of a process of closer joint working across Health Boards to deliver new models of care that create sustainable services in the longer term. In order to develop a transition and implementation plan, our planning assumptions include the following:-

- The Royal Glamorgan Hospital, Princess of Wales Hospital and Prince Charles Hospital (and their host Local Health Boards) will work closely together and with Cardiff and Vale University Health Board, to ensure services for patients are appropriately staffed and developed in a safe and sustainable way.

### 6.6.1.3    South Central Acute Care Alliance

The South Central Acute Care Alliance (ACA) has been established, with the aim of ensuring that no hospital works in isolation but instead work more closely together as part of networks providing care to patients. Arrangements for the establishment of these Alliances were agreed by the Board in September 2014. There are three levels to the governance structure: ACA Chief Executives Delivery Group; ACA Implementation Team and ACA Clinical Implementation Groups.

The focus of the South Central has initially been on paediatric services, as we know that there will need to be changes to the pattern of service provision from March 2015. The Health Board is ensuring that in-patient paediatric services will continue to be provided from the Princess of Wales Hospital – as agreed through the outcomes of the South Wales Programme consultation.

Changes to emergency medicine services will also need to be agreed before changes to junior doctor's rota come into effect in August 2015.

Further work is also underway to review surgical services and particularly ENT care across the South Central Alliance, the outcomes of which will be considered during 2015/16.

### 6.6.1.4 South West Acute Care Alliance

An Executive led group has been established to agree prioritisation of the services to be reviewed under this alliance. The priority areas are listed below. These have been determined based on the current status of existing projects and service imperatives.

**Running – active groups in place**
- Cardiac
- Histopathology
- Vascular

**Established – and will be reconstituted**
- Neurology
- Stroke
- Oncology
- Radiology

**Next Phase**
- Neonates
- Dermatology
- Spinal

A project manager has been identified and the development of the Alliance is ongoing. The Alliance builds on the strong working relationship between the Hywel Dda and ABMU Health Boards and to a large extent provides some welcome structure and governance to service planning and operational change which is already working well in the region.

### 6.6.1.5 South Wales Health Collaborative

In addition to the Acute Care Alliance, the South Wales Health Collaborative undertakes work programmes with a regional focus as directed by Health Board Chief Executive Officers. This is being extended to have a national remit; however, the following programmes of work will impact upon the Health Board's during 2015/16 and beyond:

- **Major trauma network development** – Health Boards have confirmed that a major trauma network should be established across South Wales, as the clinical outcomes are clearly much better for patients. A business case to support this development is due to be completed early in 2015/16, and will impact particularly on Morriston Hospital.
- **South Wales Pathology Collaborative** – a number of strands of work are addressed in this programme: Andrology; Cellular pathology; Transport and Microbiology – the outcomes of all of these reviews are likely to impact on the Health Board and will impact on plans and services.

- **Sexual Assault Referral Centre (SARC)** – work has been undertaken to review services across South Wales, and there are particular issues around the fragility of the various funding mechanisms. The out of hour's service for children is currently provided from Cardiff and funded through Regional Collaborative Funds, which have been significantly reduced for 2015/16 and beyond. The impact of this is being worked through.
- **Acute Medicine** – the Clinical Reference Group has developed proposals on the levels of care to be provided at different hospitals – whether they are "local" or "regional". The Group continues to refine the service pathway and an audit is underway to determine the potential impact of the new models.
- **Emergency surgery** – whilst not part of the initial South Wales Programme it became clear that these services also needed to be addressed. The following specialties are included within the review:
  - General surgery
  - Vascular surgery
  - Urology
  - ENT
  - Ophthalmology
  - Oral and maxilla-facial surgery
  - Trauma and orthopaedics

Draft services models have been prepared, and data modelling work is underway. The Health Board needs to work closely with Hywel Dda Health Board to understand their proposals for the provision of emergency surgery services, as this will impact upon Morriston Hospital.

Chief Executives have also agreed that the pathway and model for spinal surgery should also be reviewed.

Taking into consideration all of the above, we have developed a. clear vision for our main hospital sites within the overall continuum of care across the Health Board and wider health economy.

During 2015/16 the key drivers will be around ensuring we are ready to implement the outcomes of the South Wales Programme public consultation, and continuing the change programme which is already in place across the Health Board.

## 6.6.2    Mental Health

We have made significant progress in developing our mental health services in recent years – both in terms of joint planning with partners and also in improving the facilities within which we care for people with mental health problems. We recognise however, that we need to bring all of the elements of care together into one comprehensive and integrated strategy for the service, and developing this will be priority for 2015/16.

Our aim is to deliver advice, support and care that avoids the unintended development of dependence, reduces reliance on in-patient services, places an emphasis on early intervention and promotes self -determination and independence. We see to take a whole system approach that starts with health promotion and self-care, and extends through to the delivery of more specialist services.

The Health Board works in partnership with Local Authorities to provide a range of adult and older people's mental health services across the Swansea, Neath Port Talbot, Bridgend, and the Ystradgynlais area of South Powys. Substance Misuse Services are provided within Swansea, Neath Port Talbot and Bridgend. Forensic Mental Health Services are provided for the South Wales population from the Caswell Clinic Medium Secure Unit in Bridgend.

The service model for this Partnership is based on working together to achieve a culture of positive mental health and well-being, which promotes social inclusion and provides mental health services which are accessible and responsive to individual need.

Our key objectives fall into four areas of work, which reflect the National Mental Health and Wellbeing Strategy Together for Mental Health:

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

We share a common objective with partners to shift our focus for delivery to population wellbeing and prevention, to enable people to take greater control of their own mental wellbeing at an earlier stage than at present. At the same time we must not lose sight of the need to deliver safe, quality based interventions and support for those who are most in need and particularly vulnerable due to severe mental illness.

Whilst the range of support will continue to be very broad we need, in general terms, to progress to a situation where the number of people receiving the most complex secondary mental health services at any one time is reduced although people may access such service more frequently.

The length of time for which people receive support in all parts of the service should be the minimum required to enable people to function effectively in what they choose to do which will be achieved by health and social care services becoming much more goal focused and recovery based.

This will ensure that there is greater throughput for all parts of the system which in turn enables services to be more responsive to individuals in times of crisis.  Our priorities for mental health services are set out below:

| Strategic Changes | Actions | Impact |
|---|---|---|
| **Centralise Adult Mental Health Acute Assessment Admission Beds on the Neath Port Talbot Hospital Site** (WG Priority – Crisis response by services) | Replace outdated hospital estate at Cefn Coed Hospital accompanied by the establishment of sustainable and consistent unscheduled care services together improved locally delivered assessment within community services. | Improved service user experience.  Improved service quality and efficiency |
| **Mental Health Triage** (Single point of access)  (WG Priority – Crisis response by services) | **2015/16** Implement a single point of access for all referrals into secondary adult mental health services to the remaining localities (NPT and Swansea). **2016/2017** Evaluate the pilot to consider the potential for triaging all referrals into mental health services including those currently being received by the LPMHSS. | People receiving the right assessment by the right service to meet their needs in a timely and efficient manner. |
| **Implement approach to deliver better outcomes for people experiencing a First Episode of Psychosis** (WG Priority – Crisis response by services & improving access to psychological therapies) | Develop a focused approach to delivering evidence based interventions to people experiencing a first episode of Psychosis. **2015/16** <ul><li>Establish appropriate footprint for hub across ABMUHB area</li><li>Establish additional service in hub format</li><li>Deliver training programme</li></ul> | Earlier identification of people with first episode of psychosis increased access to psychological and psychosocial interventions reduced admission rates to in-patient care and length of stay for this cohort reduce detention rates under the 1983 Mental Health Act for this cohort improved engagement in meaningful educational or vocational activity Improved general/social functioning and user satisfaction. |
| **Re-provision of the Swansea Older People's Inpatient Acute Assessment Services** (WG Priority - Dementia across hospital and community (dignity and safety agenda and | Develop a business case to replace out dated hospital estate at Cefn Coed Hospital accompanied by continuation of a locally delivered assessment service supported by Integrated Community Teams. | Improved service user experience. |

| Strategic Changes | Actions | Impact |
|---|---|---|
| timely diagnosis)) | | |
| **Further development of "Emotional Wellbeing Services"** in response to Social services and wellbeing Act 2014 (WG Priority – Improving access to psychological therapies) | • Develop a psychological therapy service bid for bridging funds through the wellbeing bond. <br> • Expand available evidence based self-management resources | Increased range of options/choice for general public <br> Better management of demand for psychological interventions due to availability of alternatives. |
| **Develop general hospital liaison psychiatry service in Morriston Hospital** (WG Priority - Dementia across hospital and community (dignity and safety agenda and timely diagnosis)) | Develop a business case for the establishment of a comprehensive integrated liaison psychiatry model for Morriston Hospital including Adult, Old Age Psychiatry and Substance Misuse (RAID Model). To be developed jointly with the Morriston Hospital management team. | Decreased number of admissions amongst frail elderly. <br> Lower rates of care home placements on discharge. |
| **Redesign of working relationship between integrated older people's community mental health teams and community resource teams** (WG Priority - Dementia across hospital and community (dignity and safety agenda and timely diagnosis)) | • Establish joint working arrangements between CRT and mental health services on a locality footprint, looking for co-location where possible. <br> • Establish a clinical forum to bring together psychiatrists, acute physicians and GPs with the goal of clarifying and agreeing the interface and language of generalist/specialist roles and to guide the development of an appropriate CRT based service model. <br> • Establish an operational group to plan and co-ordinate the implementation of the service models | Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies |
| **Transfer of Mental Health Services for Residents of the Western Vale of Glamorgan to Cardiff and the Vale University Health Board** | • Develop and agree final transfer arrangements for residual services. <br> • Develop an effective liaison and discharge planning model for this patient cohort. | Improve patient experience |
| **Commission the new 28 bed Low Secure Service at Glanrhyd and the reconfiguration of existing rehabilitation services.** | Following the opening of the new unit in March 2015, patient transfer and ongoing repatriation from independent sector Mar – Sept 15 to bring patients closer to home. | Reduced lengths of stay for individuals in a secure setting. <br> Improved quality of care and increased opportunities to move through care settings back |

| Strategic Changes | Actions | Impact |
|---|---|---|
| | | into community living. |
| | | Better value for money |
| | | Life style benefits of being cared for in a more local setting closer to friends and relatives |
| **Partial decommissioning of Cefn Coed Hospital** | The ISIS low secure ward in Ward F will be decommissioned in April 2015. The Health Board is considering an investment in the heating system and the remaining four wards which will permit the full decommissioning of the western wing of Cefn Coed Hospital in 2015/16. | Commission of modernised services for Rehabilitation & Recovery Programme of modernisation complete in Rehabilitation & Recovery. <br><br> Provision of a reliable heating system with improvement patient environment whilst the necessary elements of the modernisation plan are put in place. |
| **Development of a community Dialectical Behavioural Therapy (DBT) team for women with complex mental health needs** | To pilot a project in the Swansea locality linking a Dialectical Behavioural Therapy team with the women only ward, Ward 4, in Cefn Coed Hospital. | Development of a multi-tiered approach for the care and treatment of women with complex needs. This would help such patients live independent lives within the community rather than be placed within secure inpatient settings. |
| **Development of a medium and high secure gatekeeping and case monitoring service for mid and South Wales** | Develop a business case for submission to the Welsh Health Specialist Services Commission | A significant reduction in the number of high and medium secure patients from the south and mid Wales areas. |

We recognise that Child and Adolescent Mental Health Services (CAMHS) CAMHS services are a vital part of wider continuum of services for children and young people in preventing mental ill health as well as providing early intervention aimed at maintaining and improving children's health and well-being. The Health Board with partner agencies has established a CAMHS planning group to develop and agree a service model for CAMHS to ensure that seamless care is provided from primary or direct contact services through to the most specialist interventions in inpatient units, residential schools and specialist social care services.

The group has also identified the need to address immediate operational issues impacting on the provision of CAMHS services for the ABMU resident population in order to make an immediate, tangible improvement. A workshop was held recently where several actions were identified to be addressed immediately including the need to provide training at Tier 1, agreeing crisis assessment/admission pathways for children and young people, inappropriate admissions of children and young people to adult wards; and addressing staffing levels that are adversely impacting on timely access to the CAMHS service. The planning group is acutely aware of the need to move with pace and set timescales of May 2015 to have developed the service model and addressed the afore mentioned actions.

In developing the service model and associated service specifications, the group recognises the key importance of measureable outcomes and focused on ensuring robust performance metrics are in place to ensure all young people can quickly and easily access appropriate emotional and mental health services that meet their needs; that there is an effective treatment and support system in place for children and young people with emotional and mental health needs; and that the effectiveness of the service can be evidenced through specific cases and service user feedback. Specific expected quality indicators have also been developed with reference to the Quality Network for Community CAMHS (QNCH).

### 6.6.3    Single Integrated Partnership Plans

Our three Localities (Bridgend, Neath Port Talbot and Swansea) will work with local partners to support the development and implementation of local Single Integrated Partnership Plans (SIPPs). The SIPP priorities (see **Appendix 12**) form part of the Locality IMTP and again, progress is monitored through the Local Service Boards (LSB) and also as part of the regular performance review meetings

## 6.7    Locality and Directorate Integrated Medium Term Plans (IMTPs)

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

As part of the planning process, Localities and Directorates have submitted proposed service improvement initiatives.  The approval process involves senior clinicians and managers ranking initiatives against a list of agreed weighted criteria. The proposals are currently being reviewed and ranked.

Once this process is completed, the outputs will be used to inform Executive Group decision making on investment in service improvements.

The cost of funding local service improvement initiatives has been factored into the overall financial plan for the Health Board. If approved the service improvement forms part of the Locality/Directorate IMTP and will progress in implementing the service improvement will be monitored as part of the regular performance review meetings.

## 6.8 Underpinning Plans

The diagram of our Strategy in Section 4 identified a number of Underpinning Plans, which also support the delivery of the IMTP. Delivery of the above Programmes, Strategies and Plans will not be achieved without support across a number of disciplines. Listed below are the Underpinning Plans that support delivery of the overall Plan. The content of these Plans is described in sections 7-10.

- Workforce and OD
- ICT
- Estates
- Finance

# 7 A fully engaged and skilled workforce

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

## 7.1 Introduction

Effective workforce planning is more than getting the numbers of staff right. It is about getting the staff with the right skills to meet our future demands combined with the right values and behaviours. Our need to working more collaboratively with our partners and stakeholders to support the development of integrated services has never been greater.

In developing our strategic workforce plan, we recognise that our staff have a vital role in creating safe and effective care for our community. However, we also recognise the immediate challenges we face:

- Workforce supply - Recruiting and retaining staff and the impact this has had on delivering existing services and taking forward strategic change initiatives especially in some areas where there are now national shortages e.g. nursing

- Skills - Our current workforce needs more development to best care for frail older people in the right settings

- Leadership- Our senior clinical leaders have not always felt empowered to lead change

- Structures - Our staff often work in individual professional communities of practice rather than effective multi-disciplinary teams driving change

- Staff Engagement – Surveys indicate we do not create the best staff experience and well-being services to support a more engaged workforce

2014 has seen ABMU develop its Values in response to more than 6000 contacts with staff, patients and stakeholders. What they told us they want includes:

- Better communication
- Improved team working
- Visible supportive leadership
- Consistent performance management of people and tasks

Clearly our workforce plans must align with our Values: ***Caring for each other, Working together, Always improving***

Therefore, our **People Strategy** will reflect these Values and focus on the following priorities to create a culture for people to achieve their full potential:

- **Caring for our staff –** How we will focus on staff experience, developing leaders to manage talent and support the well-being of our staff

- **Managing our staff effectively –** fair and transparent HR systems, and processes making better use of IT. Creating capacity and expertise in patient experience and service improvement to better support frontline staff. Reward and Recognition will be key.

- **Developing our staff to reach their full potential –** development of our clinical workforce, growing innovative roles, better support in supervision, mentorship and improved evidence based practice. We play a key role as an employer to ensure future employability of all our staff**.**

In the first year we will:

| Key Priorities for 2015/16 | Impact |
|---|---|
| <ul><li>Develop a joint strategic approach to the recruitment and retention of those staff groups where recruitment is a challenge.</li><li>Develop new and extended roles to support service redesign.</li><li>Continue to reduce sickness absence levels and support the health and well-being of our workforce.</li><li>Provide a skills development programme to ensure staff have the skills to deliver safe quality care that matches the needs of our citizens, and supports the development of clinical leadership.</li><li>Develop an overarching People Strategy that will reflect our values and create a culture for people to achieve their full potential.</li></ul> | <ul><li>Our workforce have the education and training to care for frail older people</li><li>Maximises team performance and productivity through effective clinical engagement and values based leadership, aligned with associated behaviours</li><li>Increase staff engagement through greater staff involvement in decision making; improved management and leadership; personal development and training; promoting a happy, healthy and safe working environment; and ensuring every contact counts</li><li>Different roles, different skill mix, different working practices and different recruitment strategies to support the delivery of the IMTP and its change programmes</li></ul> |

| | |
|---|---|
| | • Better recruitment and retention training of staff to deliver existing services and take forward strategic change initiatives |

## 7.2    Workforce Picture 3 Years Ahead

The impact of implementing our 3 year Plan on the profile of Whole Time Equivalent (WTE) shows the overall workforce numbers are not expected to change significantly, but we will be shifting the workforce focus more into the community, redesigning roles and delivering safe standards of care. Over this period of time, workforce numbers will move from 13,347 to13, 958. Appendices B11 - 15 sets out in more detail how the workforce change is distributed between staff groups, in terms of WTE and also set out the recruitment challenges and education requirements arising from the full range of changes planned to date.

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

• Significant role redesign with new roles and joint roles between health and social care, as a result of service changes and the need for more care delivered closer to patients' homes, illustrated by our *C4B – Service Improvement Programme*.

• Relocation of staff and the times we work, related to proposed changes to care settings, which are aimed at improving and accelerating access to and quality of care.  These changes are reflected in our **Surgical Efficiency Pathway, Patient Flow and C4B Service Improvement Programmes.**

• Changes to posts and headcount related to the introduction of new technology; management and administrative restructurings; investment and reconfiguration of the workforce to meet nationally agreed standards for safe numbers, skill mix and different ways of working. Focus on training and development so that staff are equipped with the right skills and competencies to deliver safe, quality care. Concentrate on reducing variable pay through better ways of working and reducing sickness absences as outlined in Section 8, Finance.

We have also considered the age profile of our workforce as part of our overall consideration of the plan. Figure 20 below illustrates the current profile. This shows that we have 32% of our workforce over 50, an increase of from 28% in 2012 and 25% in 2009.

**Figure 20 : Workforce age profile – headcount**
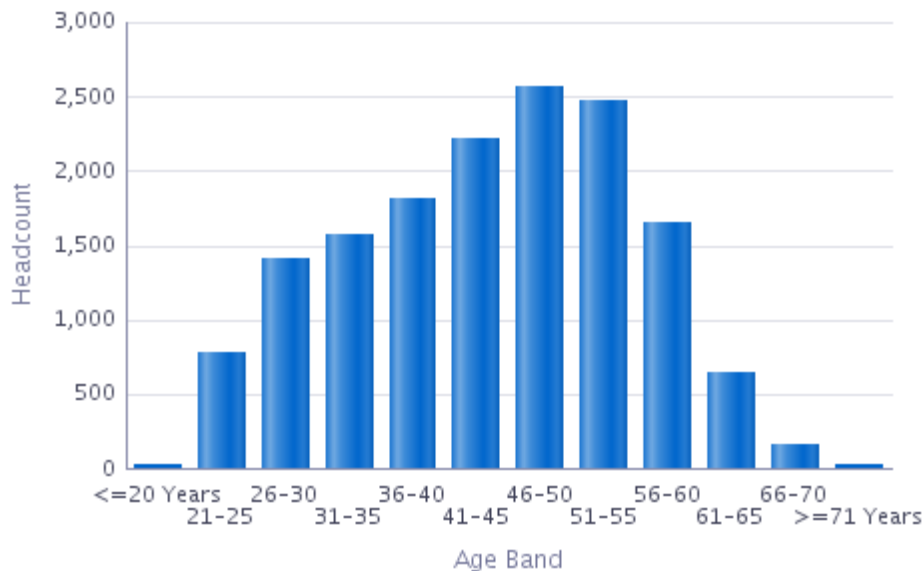


## 7.2.1    Workforce in General

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

In addition to raising the profile as a University Health Board, the Collaborative Workforce Development & Education Committee provides a mechanism for discussing the education priorities arising from the ABMU Clinical Strategy to ensure that the education requirements of the future workforce are met, in line with policy and strategy. For 2015/16 the priorities are to:

| Priorities for 2015/16 | Impact |
|---|---|
| • Develop a joint strategic approach to recruitment and retention for all professional groups, such as increasing the number of honorary appointments across professional groups; developing guiding principles for joint recruitment posts<br>• Improve local educational placements in areas of recruitment shortages and provide innovative routes and solutions for establishing overseas links/international recruitment with | • Improved recruitment and retention<br>• Development of new roles<br>• Leadership development as |

| | part of the Leadership Faculty |
|---|---|
| <ul><li>conversion programmes facilitated locally by the university.</li><li>Lead developments to support non-traditional roles e.g. physicians assistants</li><li>Work jointly with the University and Local Authorities to develop our leaders as part of a Leadership Faculty across health and social care systems to maximise access and opportunities.</li><li>Strengthen work based learning from Health Care Supporters through to Advanced Practice roles</li></ul> | <ul><li>Work based learning strengthened</li></ul> |

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

## 7.2.2    Nursing Workforce

The majority of our workforce and consequently the majority of care is provided by our nursing staff. Our workforce plan illustrates the:

Recruitment and retention of nursing staff is a priority for the Health Board. Despite intensive recruitment being undertaken the recruitment of band 5 registrants in acute adult areas remains a challenge.   The number of vacancies coupled with a turnover rate of 7.26% requires the development of a number of options to recruit retain and effectively utilise our nursing workforce.  We also need to develop the skills of our Health Care Support Workers to ensure that nurses work at the top of their license in line with the principles of prudent healthcare.

The key workforce actions for 2015 -2018 are listed below:

| Workforce actions for 2015/18 | Impact |
|---|---|
| <ul><li>Actively recruit to all nursing vacancies.</li><li>Initiate different recruitment campaigns to address the difficult to recruit areas, such as block/centralised recruitment campaigns, a series of recruitment open days, partnership working with the Universities and overseas recruitment.</li><li>Introduce different ways to attract applicants, through social media, succession planning, staff rotational programmes, providing access to improved career pathways and by providing rewarding careers for staff.</li><li>Achieve full compliance with all-Wales Nurse Staffing Principles Guidance (2012) to include making Ward</li></ul> | <ul><li>Revised workforce profile</li><li>Improved recruitment and retention</li><li>Performance management arrangements aligned to the Quality and Safety Accountability Framework</li><li>Capacity and skills of nursing staff developed in primary and community care</li><li>Nursing Leadership strengthened</li></ul> |

| | |
|---|---|
| Sisters/Charge Nurses supervisory to practice. | • Research and innovation embedded into staff and teams |
| • Systematic review of our nursing workforce numbers in against the All Wales Adult Acute Nursing Acuity and Dependency Tool for all adult acute ward areas using a triangulated approach. | • Development of the HC support worker role |
| • Develop a project plan to support the implementation of the NMC Revalidation process which will ensure that our nurses and midwives remain up to date and fit to practise. Revalidation will be introduced in December 2015. | • Improved training and education for nurses |
| | • Reduction in the use of agency staff |
| • Manage performance through the Quality and Safety Accountability Framework. | • Improved resource utilisation through the use of e-rostering |
| • Build further the capacity and skills of staff to deliver safe, quality care and invest in new skills and redesigned roles for primary care and community settings. | • Improved succession planning |
| • To strengthen nursing leadership at all levels. | • Improve governance through the Advanced Practice Framework |
| • Continue to promote the embedding of research and innovation into the roles of staff and teams through our collaborative approach with the Swansea University College of Human and Health Sciences | |
| • Implementing national training and education initiatives that ensure future sustainability for Wales. | |
| • Further development of the Healthcare Support Worker (HCSW), utilising the All Wales Code of Conduct, and Delegation Guidelines, Guidelines of Delegation to ensure HCSW roles are utilised to full potential and support skill mix in clinical areas. | |
| • Reduce the use of high cost nursing agencies through effective recruitment to vacancies and continuous recruitment to the Nurse Bank. | |
| • Develop further training for those delivering care to frail elderly people and especially those with dementia | |
| • Drive the effective utilisation of e-rostering functionality in nursing areas to deliver maximum benefits realisation and ensure better use of staffing at nights and at weekends. | |
| • Invest in the development of aspiring ward managers through good succession planning, nurturing talent, and supportive management frameworks. | |
| • Fully embed the Advanced Practice Framework (NLIAH 2010) ensuring good governance exists for all nurses working at this advanced level of practice | |
| • Ensure robust preceptor ship arrangements are in place to support and develop new registrants, thus | |

| | |
|---|---|
| enhancing recruitment and retention | |
| • Utilise the NHS Skills and Career Development Framework for Clinical Healthcare Support Workers when it is available to support HCSW careers and increase the professionalism of this core workforce. | |

## 7.2.3    Consultant and Junior Doctor Workforce

In Section 2 we referred to the significant workforce challenges for this Health Board from 2015 onwards, caused by the current deficit in consultant and junior doctor numbers. Other factors, including pension and tax changes which are beyond the control of NHS Wales, are also likely to impact on the demand/supply of the future consultant workforce.

Our service and then workforce plan includes redesigning roles to help support the consultant and junior doctor supply gap. Following on from last year this work has accelerated and there are now many examples of extended roles where they undertake tasks traditionally carried out by doctors. Critically a number of these roles where nurses and therapists support gaps on the junior and increasingly the middle grade rotas. This is challenging Agenda for Change pay frameworks and we will continue to raise these strategic issues on an all Wales basis.

In addition, we continue to work closely with the Wales Deanery where the key actions for 2015-2018 are:

| Workforce actions for 2015/18 | Impact |
|---|---|
| • Pursue overseas Medical Training Initiatives (MTIs) in a number of specialities, with the support of the respective Royal College and the Deanery. These doctors can only work for the NHS for a maximum period of 2 years and there can be a long lead in time to secure these doctors in post. However, once established MTIs can provide a useful supply of junior doctors. <br><br> • Adopt different ways of promoting training in Wales which will radically change the way training is configured. The Health Board is currently working with the Service Reconfiguration Leads appointed by the Deanery in relation to Anaesthetics, Paediatrics, Neonatology, Obstetrics and Gynaecology, Core Medicine and Core Surgery. <br><br> • Ensure that our young doctors have the knowledge and skills to support the delivery of excellent care, especially for the frail elderly <br><br> • Optimise links with Swansea University to establish | • Improved recruitment of junior doctors <br><br> • Increase local opportunities for training <br><br> • Increased training and support for junior doctors <br><br> • Establishment of Clinical Academic posts <br><br> • Improvements in working practices and experience |

| | |
|---|---|
| Clinical Academic posts at consultant and junior doctor level. | |
| • Continue to engage fully with junior doctors to listen to their feedback and work together to deliver improvements in working practices and experience. This should help improve feedback to the GMC to ensure positive messages flow from their experience of working in ABMU which will in turn help attract further young doctors to work in Wales and this Health Board. | |
| • The supply problems of certain medical staff will require the Health Board to attract and recruit Physicians Associates in the future. The Post Graduate Diploma required by Physicians Associates is currently being developed by Swansea University. | |

In addition, short term international recruitment of medical staff will need to continue, but this is not seen as a longer term sustainable solution.

Undoubtedly, our work with the Wales Deanery provides us with a number of specialty challenges, specifically where the number of training grade doctors are being reduced and also the number of doctors required on a rota is being broadened from a 1:8 to a 1:11.  This will concentrate the training grade doctors on fewer sites and raises concerns for the sustainability of existing clinical services. As a consequence our IMTP has identified an expansion of Advanced Practitioners to mitigate some of these risks to service sustainability. This has also led to the development of the Hybrid Consultant role. Due to the need to concentrate trainees  on fewer sites where we know there is an excess of  CCST holders we are attempting to recruit newly qualified consultants who will both work on the middle grade rota out of hours and at consultant level.

We have allocated £3.0 m to cover the cost of maintaining the junior doctor rotas in Women and Children's services and General Surgery. This is shown in Section 8, Table 23 Potential Cost Pressure Assessment 2015/16-2017/18 as Sustaining Core Services.,

As a result of the South Wales Collaborative the Health Board is participating in the work of the South West Wales Alliance. Here neighbouring Health Boards are jointly planning their medical workforce to create greater flexibility to increase capacity and flows across traditional organisational boundaries.

The Health Board has been reengineering its consultant recruitment process, which is in the process of being implemented. This aims to attract high quality candidates and the revised process will allow the Health Board to ensure we are selecting candidates with the most appropriate qualities.  We are also working to ensure the effective utilisation of our current medical staffing

resource. There are important national initiatives underway which may help the Board including maximising the outputs from the current amended Consultant Contract in Wales. A new Junior Doctor Contract is also being negotiated on a UK basis which will simplify the contract and link pay to competence. Locally we will continued to focus on improvements to the consultant job planning with plans to encourage more team job planning to allow greater flexibility, increased capacity and the development of service sensitive outcomes.

Finally, on the horizon is the reshaping of junior doctor training as laid out in the Greenaway Review. This will produce a medical workforce to meet the changing needs of the population. Timescales are not yet known but some of these changes may begin to impact during the life of this 3 year plan.

### 7.2.4    Primary Care Medical Workforce

A joint report produced by the Wales Deanery and the National Leadership and Innovation Agency for Healthcare (NLIAH) in July 2012 summarised work undertaken to model the anticipated future supply of new GPs in Wales and to compare it against the most likely levels of future demand. The conclusion of the review indicated that there is likely to be a shortfall in the supply of GPs in the near future, mirrored in ABMU and referred to in Section 3.

The forecasting work took account of the current supply and also a range of 'demand' factors that are likely to impact on the overall number of GPs. The paper noted that the future demand/supply of doctors is influenced by many different factors which can change over time and that forecasting exact requirements is not a scientific process.  As a result of the national review, ABMU undertook its own analysis of the workforce position and our initial assessment has highlighted:

*A potential shortfall in the number of GPs, given predicted retirement patterns and on the basis of the 'known' shortfall in the number of GPs being trained.*

 Earlier retirement patterns could result in a markedly worse situation.

At the same time, demand for a strong and robust workforce within primary care is needed to address some of the demand factors including the impact of an ageing population, an increase in the number of people who have complex medical conditions, as well the transfer of services from secondary to primary care.

Since the Deanery report was published, the factors described under consultants around pension and tax changes that are beyond the control of NHS Wales are also likely to impact on the supply of GPs. Other factors that are relevant include:

- An increasing proportion of the workforce who wish to work part time

- Changing models that mean that there are a different range of options from the traditional, equity sharing partnership model, including salaried doctors, doctors working on a session basis in a variety of settings, as well as salaried (non-profit sharing) partnerships.

A number of scenarios using different retirement profiles have been developed to help to assess where shortfalls are likely to occur.  Localities will continue to risk assess their areas and consider other factors that may impact on the sustainability of general medical services (for example, factors such as the condition/suitability of premises).  The impact of a shortage of GPs could have a number of different impacts:

- Growing list sizes – Our current ratio of GPs per head of population is consistent with the national average.  However this masks variation across the 11 Community Network areas and a reduction in the number of GPs will worsen the overall ratio.  Growth in the number of older people, and an increase in patients who have multiple chronic conditions will place additional demands on primary care.

- Pressure on access – growing list sizes will inevitably result in pressures around access arrangements with a potential for the improvements in access were secured post 2004 being eroded.

- Closed Lists – with pressures on both list sizes and access arrangements, there is potential for practices to feel that the only way of managing demand is to consider 'closing lists'.

- Quality – sustained workload and service pressures could impact negatively on the quality of service provision and standards of care, which in turn, could impact on other parts of the healthcare system, and also restrain the wider objective of population health improvement

- Sustainability – in some cases, factors may combine to make independent general practice unsustainable in some parts – particularly if there are poorer premises.  Unforeseen issues (for example, ill health) may force premature retirement leading to an increase in the number of practices that the Health Board will have to step in and manage which would expose the Health Board to increasing clinical and financial risk.

In 2015/16, the Health Board will be considering a range of options to tackle the issues as in reality, no single approach is likely to produce benefits.  The following is an initial set of options that will be worked up over the coming months and appraised in terms of feasibility and costs/benefits.  The options span short, medium and long term actions:

| GP workforce - actions | Impact |
|---|---|
| Short to medium term<br><br>• Initiatives to encourage and support doctors to work in the Health Board including more proactive recruitment/retention plans, flexible working opportunities and exploring ways of securing added value through our University Health Board status.<br><br>• Supporting practices to work together more effectively – using existing network structures to consider other models including federated working<br><br>• Employing GPs in supernumerary roles<br><br>• Developing our own 'managed' GP provision, building on the OOH/AGPU services to help address particular workforce challenges<br><br>• Maximising skills across the wider primary care team including practice nurses, specialist nursing roles, pharmacists to help address some of the workload. Using GPs more effectively to manage complex conditions by freeing up their time<br><br>Longer term<br><br>• Considering new radical models of care that move away from traditional professional based models to more locally defined and driven solutions, learning from the experience from elsewhere e.g., NUKA model in Alaska which has a strong foundation of being 'customer owned' and driven<br><br>• Creating new roles that enable us to vertically integrate primary/secondary care provision , working alongside the Deanery<br><br>• Addressing other factors that impact on recruitment, including premises, estates issues and addressing issues that impact on GP workload that are within Health Board control.<br><br>• The Health Board is looking to support the Development of the roles of Practice Managers and Practice Nurses to enhance skills for triage and minor illness  in order to support the role of GPs'<br><br>• Reviewing the model of primary care can help support the capacity of primary care whilst tackling the pressures on the service.  Currently the Bridgend East Network is in the process of developing a Federated model of care, which involves GP's coming together to share responsibility for the delivery of services.  This model of working has the benefit of providing a mechanism to move services from secondary to primary care improving access and patient experience. | • Improved recruitment and retention<br><br>• More effective use of GPs across networks<br><br>• Use of  other roles across the primary care team and development of new roles |

## 7.2.5    Integrated Pharmacy & Medicines Management Workforce

The Health Board has experienced some difficulties in recruiting to junior posts to address the service changes in this 3 year plan. The majority of the service change initiatives will require recruitment to more junior posts to backfill those already in specialist roles to take on additional tasks. The Health Board has also supported Medicines Management following on from The Trusted to Care report and the report by the Older Person's Commissioner "A Place to Call Home'.  It is felt that this may be due to the specific window of opportunity (May – Sept) for recruiting newly qualified pharmacists and technicians as they complete their studies and enter the employment market.

The increase in pharmacist graduates has allowed the directorate to appoint to junior pharmacist posts at lower bands compared to five years ago. Providing a strong foundation on which to build the extended roles of pharmacists including speciality and advanced practitioners supported by junior colleagues, technicians and others.

Our plan is to work towards further development of a career structure, improved integration between areas and further integration of pharmacy into direct patient care.  The structure aligns with the Your Care, Your Medicines ambition to integrate the pharmacy team in all stages of patient care.

The Health Board will be working in collaboration with the **Modernising Pharmacy Careers (MPC) Wales** work streams to ensure the ongoing development of the pharmacy profession and to ensure that ABMU continues to influence and develop the future delivery of pre and post registration education and training.  that supports the development of career pathways for pharmacists, pharmacy technicians and dispensing/pharmacy assistants.

Reconfiguration of services will impact on both the undergraduate and postgraduate training structures, not only within our Health Board but across Wales.  Consideration will be given to rotational training posts, based on future configuration, to ensure robust and comprehensive training. Changes in the delivery of training will provide greater opportunity for further development of roles and allow for further integration of the pharmacy workforce within services.

ABMU has been successful in gaining one of the first Consultant Pharmacists posts in Wales, which will support the retention of senior staff, enhance the contribution of pharmacists to patient care, to strengthen leadership and support new models of care. Our Consultant Pharmacist in Renal Medicine will be involved in innovation of new drugs and therapies, innovative ways of using current licensed drugs and research into service changes.  Establishing Consultant Pharmacist posts in Wales will help to promote and support the retention of senior, leading edge practitioners and gives opportunities too. The Health Board will be looking for further opportunities, to develop Consultant Pharmacists posts to take the workforce forward and to enhance

and advance patient care, e.g. Cancer, Cardiovascular, A&E/Medicine, Frail Elderly.

Pharmacy staff taking on new roles such as prescribing requires an increase in overall headcount but is cost effective in terms of the clinician duties they are replacing and providing a holistic view on all elements of medicines management in patients. A number of the service change initiatives require **non-medical prescriber** pharmacists; a significant number of our workforce already hold this qualification but ongoing consideration will be given with regard to additional staff undertaking the course. A comprehensive Health Board strategy will be developed around Non-Medical Prescribers (not just relating to pharmacists) to ensure there is a consistent approach based on the wider aims and objectives of the Health Board as a whole.

The Health Board continues to be involved in an All Wales Resource Mapping exercise which was completed in 2013 and is due to be repeated towards the end of 2014. The exercise provides the directorate with a raft of information on resource and activity to allow review of skill mixing and the identification of gaps in the service. One area where gaps have been identified is Medication Safety & Governance; a new post has been created to support this significant area of work; once the position has been appointed to work will commence to develop the role and the wider support network around it.

A number of other areas have been highlighted as requiring further assessment of the resource requirement:

- The introduction of a standardised electronic discharge system will require a review of process and subsequent resource to ensure the system works as effectively and efficiently as possible.
- An NVQ lead within the Health Board is required to coordinate and support the training requirements and capacity within the directorate. In community settings, an increased multidisciplinary head count will be required to deliver new and extended services aimed at supporting the frail elderly with their medicines in community and domiciliary care settings. Without such support, delayed transfers of care, hand offs between health and socials care and increased admissions are likely to be common place and so undermine elements of the C4B Clinical Strategy.

## 7.2.6    Therapies, Healthcare Science and Psychology Workforce

**Therapists** play a key role in providing a wide range of community, outpatient and inpatient services. They are autonomous practitioners who take clinical responsibility for patient care, increasingly in roles previously performed by medical staff. All of our therapy services remain under pressure across all life courses. The growing therapies waiting lists are reported as

amongst the highest level of risk on our ABMU risk register and can have a system wide impact on patient flows. The causes of these increasing risks include:

- Increase in demand and patient activity as described in Section 2, together with the need to provide more intensive therapy to reduce stay in hospital while at the same time providing quality, safe care

- The need to support new ways of working to meet services needs and the move towards providing services 7 days a week and closer to people's homes, creating pressures in therapies input to core services

- A reduction in new graduate application numbers as training places are reduced.

- Difficulties to recruit into a number of specialist posts, particularly in dietetics, paediatric, occupational therapy and speech and language therapy.

- The development and expansion of patient self-referral alongside the service changes planned in the IMTP.

Recommended therapies workforce levels have been developed to help service planning, reflecting patient complexity and levels of rehabilitation to meet predicted caseloads. The key workforce actions for 2015-2018 to address the above pressures are listed below:

| Therapies | Impact |
|---|---|
| - Prioritise developments that support the Health Boards priorities, such as frail elderly, unscheduled care and intensive therapy. Progress will require cost improvements to be offset and investment to be made over 3 years to build the staffing capacity<br>- Invest more in therapies and 7 day working as part of the Intermediate Care Services with our Western Bay partners, recognising the requirement our commitment to care for people closer to home<br>- Develop an Early Supported Discharge team for redesigned stroke services, which will be a key element of the Health Boards ability to deliver these Tier 1 responsibilities and to deliver prudent healthcare.<br>- Launch a recruitment strategy to ensure core therapies resource is appropriate and flexible, directed at our Health Board priorities<br>- Develop use of technology, hot clinics, supplementary prescribing, diagnostics and advanced practitioner | - Increased workforce numbers and development of new services<br>- New roles developed improving workforce flexibility<br>- Expanded clinical expertise and the development of clinical leaders through education, training and development |

| Therapies | Impact |
|---|---|
| roles as part of the Clinical Service Programme, exploring workforce redesign as well as service redesign. | |
| • In addition, we will continue to invest in education, training and development of advanced practice and consultant therapists to deliver clinical expertise and leadership, including supplementary prescribing across appropriate therapy professions as part of the development of advanced practice. Our planned developments of advanced practice include: | |
| • Speech and Language Therapy to deliver services for patients with swallowing disorder, head and neck cancer and autistic spectrum disorder to release medical staff capacity in ENT and Community Paediatricians | |
| • Physiotherapists and Podiatrists will increasingly take on expert practice in musculo-skeletal disorders, releasing orthopaedic surgeons time | |
| • Orthoptists will increasingly manage patients with glaucoma and other eye conditions, releasing time of ophthalmic surgeons | |
| • Imaging services where a number of initiatives will be taken forward to increase capacity, support sonographer services and release time for radiologists | |

**Healthcare Scientists** play a key role in diagnosis and increasingly in managing patients as autonomous practitioners. Research and development skills underpin their training. Similar to the picture described for Therapies, Scientific Services are under pressure due to the increase in patient activity as described in Section 2. In addition, there are:

- Pressures on our diagnostic and imaging services with the increase in demand for scientific support (such as MRI scanning)

- Specific capacity constraints in radiotherapy treatment to be addressed within the IMTP

- Increased requirements to deliver evidence base practice through research and development

- Needs to support new ways of working to meet services demands. For example, the increasing use of audiology services and cardiac physiology in delivering prudent healthcare; the future development of STP roles within Neurophysiology

Modernisation of the scientific workforce will, therefore, continue with new training arrangements for assistants, practitioners, scientists and consultant scientists. Development of the latter is in partnership with the Royal Colleges.

Consistent with the principles of Prudent Healthcare, the transfer of patients with hearing loss balance disorder and tinnitus from ENT surgeon clinics will require significant increase in Audiology staffing, equipment and clinic space. Notably, this will include the growth of the assistant practitioner workforce, supported by the development of an educational programme at Swansea University.

**Practitioner Psychologists** are employed in a wide variety of autonomous practice roles throughout the Health Board, with a Doctoral level of basic training. They make particular contributions in helping people understand their mental health issues and in behavioural change. There are pressures across the Health Board, but these are particularly acute in Neuropsychology and in Psychological Therapy for common mental health disorders. It is intended to increase Neuropsychology provision in stroke and to invest in Psychological Therapy to reduce costs of prescription medication. These initiatives will support the delivery of prudent healthcare.

## 7.2.7     Workforce Flexibility

We continue to operate a redeployment policy as part of our approach to achieving a sustainable workforce. This is designed to maximise opportunities for staff who are displaced following service change. It provides a framework in which suitable alternative employment is sought for staff, balancing the skills and experience of staff with service requirements.

We will also continue to make good use of a wide range of flexible employment practices to support our staff and any requirement they have in terms of work/life balance, including Voluntary Early Release (VER) Scheme and Voluntary Reduced hour's contracts

We are committed to managing changes in service using the All-Wales Organisational Change Policy, where those changes impact on our staff. The sensitive management of staff surpluses is a core component of our commitment to staff, captured in the ABMU Joint Statement signed by the Chief Executive and Staff side in 2012. In that statement it was made clear that the protection of employment was an important guiding principle in how we meet our financial challenges.

We have agreed that redundancy would only be a measure of last resort. We have also developed in partnership a VER Exchange scheme, which would provide for a broader opportunity for staff to make use of VER where there were known surpluses within the Health Board. This will be a key pre-redundancy measure put in place to avoid wherever possible the need to

enter discussions on voluntary or compulsory redundancy should this prove necessary.

## 7.2.8    Workforce Modernisation

Redesigning our workforce is a core component of our integrated workforce planning cycle.   The Health Board is redesigning the workforce to ensure that we have the right level of staff with the appropriate skills to deliver services in the most appropriate setting:  The development of our workforce to support service redesign is a priority for the Health Board as is working with primary care and third sector providers.   A number of service developments are being implemented as follows:

- The recruitment of a Community Geriatrician in Bridgend to manage and support frail older people and older people with chronic disease in the community.

- Integrated Community Network Teams which are co-located with single management and a single point of access have been developed within the Health Board.

- Increases in the number of Nurse Practitioners in the CRT and the ENP in the Minor Injuries Unit in Neath has increased the access for patients to highly specialist skills and helped address the challenge in recruiting to the medical workforce.

- Expansion in the provision of Marie Curie Home Visiting Service working in partnership with the Continuing Care Team has increased the level of care available to terminally ill patients.

- Development of the "Chest Help" advice line has enabled access for GPs to specialist respiratory opinion, providing support to primary care in the treatment of respiratory patients and preventing unnecessary referrals to outpatient services.

- Investment in therapy staff has allowed the introduction of 7 Day working of the Community Resource Teams in Bridgend.

- A key strategic change to the delivery of GP Out of Hours services will be the introduction of Phone First which is scheduled to be introduced in 2015.

- There are early plans to develop the Frail Elderly service at the Princess of Wales Hospital, with a Frail Elderly Assessment Unit; nurse-led services and joint working between the hospital and community services. The frail elderly ward will host the practice development unit which has been accredited the receive Nurse Practitioners who are in training.

- The skill mix will be reviewed on the rehabilitation wards at the Princess of Wales Hospital to include the development of a Band 3 Team Leader role.

- Following the Wales Audit Office review of community services, there is a need to review the skills mix of the community workforce to ensure that phlebotomy is being carried out by the appropriate level of staff.

- Investment in District Nursing services to provide a 24 hour service consistently across the Health Board.

- ABMU has agreed to be the pathfinder site for the development of the 111 service in Wales. This is a key priority within the urgent care transformation programme. The 111 service will effectively integrate currently separate services provided by NHS Direct Wales, and GP out of hours services by providing a single portal for callers requiring urgent help or support during the out of hours period as well as a source of information, advice and assistance across the 7 day period. In the longer term, the 111 service provides a platform for wider transformational change of out of hospital services.

## 7.2.9    Partnership working

We highly value our strong relationship with Trade Unions and Professional Organisations. The Health Board includes a Non-Officer Member representing Staff Organisations to maintain openness and involvement at the most senior level of the organisation, and to provide assurance to the Board on matters relating to the effectiveness of partnership working arrangements and staff involvement.

The Partnership Forum is the formal mechanism for consultation, negotiation and communication with accredited and recognised Staff Organisations. A Health Board Partnership Agreement has been developed which sets out a framework for managing the relationship in accordance with Agenda for Change Principles of Best Practice, the TUC Principles of Partnership Working and the Welsh Government Partnership Advisory Forum and Operating Arrangements.

In addition, we meet separately with Local Medical Committee (LMC) where strategic medical issues are discussed. The LMC operates within secondary and primary care and deals with matters relating to terms and conditions and medical and dental employment issues.

We will continue to work closely with our Local Authority and third sector partners in Bridgend, Neath Port Talbot and Swansea, and importantly under the Western Bay Programme. As part of this over-arching work-stream a workforce development sub group of the Western Bay Programme has been formed to enable a more cohesive approach to developing workforce plans across health and social care, with particular emphasis on the development of Community Services

## 7.3    Driving our Organisational Development, Culture and Values

There are many excellent examples of success and achievement within the Health Board. However, it is also clear that we face some significant challenges. Many of these are evidenced throughout this Plan, such as the independent reports into services within the Health Board (AQUA and Trusted to Care) and through mechanisms such as the NHS Staff Survey. Others have been highlighted through the recent listening events we have held across the organisation – where we have collected views from over 6,000 people – both staff and patients. Some of the themes are:

- Our values and behaviours

- Better communication

- Improved team working

- Visible supportive leadership

- Consistent performance management of people and tasks

As a result we believe that in order to deliver the vision for the Health Board we need to change the operational structures of the Health Board. In 2015/16 and onwards we will implement our Organisational Redesign plan, based on Divisional structures.

Our Organisational Development plan will **support the People Strategy** over the next 3 years will focus on achieving our aim "A fully engaged and skilled workforce" by developing a citizen-centred organisational culture which maximises team, individual and organisational potential through valuing and engaging our staff and excellent leadership. In doing so, we will enable our 7 strategic change programmes including our patient experience and patient safety programmes. Over the next 3 years we will focus on:

- Living our shared values and associated behaviours

- Prioritising, creating and delivering sustainable staff experience

- People management, particularly the health and well-being of staff

- Leadership and management development at all levels

- Individual staff training and development

- Service  improvement

### 7.3.1 Living our shared Values and Behaviours

Our starting point is having a set of clear, concise, local and shared values that everyone understands. This underpins all the work we are doing around Action after Andrews, which is the need to transform the culture of ABMU. We need to ensure our values, aims and priorities thread through all that we do and behave, reflecting the "ABMU Way".

Our medium term Framework will cover:

- Patient experience and involvement

- Staff experience and improvement

- People processes and

- Governance

In 2015/16, we will pay particular focus to values based recruitment and induction, starting the year with a big internal and external communication campaign incorporating a launch.

### 7.3.2 Prioritising, Creating and Delivering Sustainable Staff Experience

Staff experience describes what happens when people think and act in a positive way about the work they do, the people they work with and the organisation that they work in. Better staff experience means better patient outcome and when we talk about staff we are including all staff groups, all primary care and community contractors, and all volunteers along with those on a secondment or training placement.

Using feedback from the NHS Staff Survey 2013 and 'In Our Shoes' listening events as an available baseline measure, we will be implementing a Staff Experience Framework, which include:

- Ongoing Staff recognition schemes and celebration events, including the Chairman's Awards

- Continuing to drive the Chairman's Challenge, expanding to other types of challenges particularly supporting staff well-being

- Continuing to introduce 'listening to improve' concepts. This will include a staff ideas 'Let's Just do it' programme, linked to the spread of Improving Quality Together training to all staff.

- Embedding team based working.

- Implementing an ABMU wide staff survey as part of the values campaign for use then by every department across the Health Board as a local survey, which feeds into the appraisal process and the nursing metrics so

that we have a 2015/16 base line from which to measure patient quality and improvements

- Continuing to have an open approach to two way communication with a focus on listening, using a range of methods, such as 'big conversation' style events, smaller staff focus group events, using social media, Team Briefing and other conversation concepts;

- Developing an ABMU Staff Experience Toolkit, building on the All Wales Toolkit to crystallise the approach to staff experience for use by line managers

We will also continue to work in partnership with Trade Unions and professional groups and involve and listen to our Junior Doctors more in service change.

### 7.3.3    People Management

Focus on staff health and well-being, promoting a happy, healthy and safe working environment. ABMU has placed a significant focus on staff health and well-being based on the 'Health Work and Well-being Action Plan for Wales'.   The specific objective is to enhance the lives of the workforce through the provision of preventative, health improvement information and advice; providing support for those who may go off work due to sickness, long term illness, stress or other reasons, as well as support for those required to cover for absentees. A programme of work has already begun to improve information, advice and access to provision by gaining a better understanding of workforce needs and proactive management of workforce issues.

To support the increased focus on staff health and wellbeing additional occupational health nursing and medical staff are in the process of being appointed. This will build more resilience within the team, the benefits of which will be seen during the 2015/16 operational year.

As part of Health Vision Swansea, there will be a new Occupational Health Department at Morriston Hospital. This should be ready late Summer 2015. One of the main benefits of this will be the centralisation of the Occupational Health administrative function, thereby creating a single point of access for all occupational health referrals and enquiries.

An Occupational Health Medical Network is being piloted across ABM and Cwm Taf with the ABM Consultant Physician in Occupational Medicine taking the role of Occupational Health Clinical Director across both organisations. This is proving beneficial in relation to the development of consistent Occupational Health policies and processes across the two sites. This will gain momentum during 2015/16

The Partnership Agreement between ABM, Remploy and the Welsh European Funding Office to deliver WtW ends on 31st March 2015. The

Welsh Government has formally written to the HR Director to request that ABM becomes a partner in a new European Social Fund project. This will secure a further four years funding for the WtW team. There is a financial risk from April 2015 if this new project does not move forward and discussions are ongoing with stakeholders regarding contingencies.

There is a renewed focus on emotional well-being at work particularly in relation to building resilience and managing stress amongst staff. During 2015/16 the Staff Psychologist, Staff Counsellors and Well-being through Work team will implement a plan which focuses on prevention and early intervention. The Lighten Up Programme will be rolled out across the organisation and these staff will play a key role in the selection and training of Staff Well-being Champions in order to build capacity within the organisation

The ABM Head of Staff Health and Well-being is jointly leading on this work on an All Wales basis with a colleague from the Welsh Ambulance service

Welsh Government has approved the ABMU Lighten Up project and posts are currently being advertised. The project will run until at least September 2015. This team, led by a Workforce Programme Co-ordinator, will include Occupational Therapists, Physiotherapists and Call Handlers to offer staff within sickness hot spot areas support from day one of sickness absence. The project will also include training and support for managers tailored to address their individual needs.

ABM will continue to have good representation on the All Wales Staff Health and Well-being Project Group which has recently reviewed its terms of reference and work plan for 2015/16.

During 2015/16 the Changing for the Better Staying Healthy Project and ABM Employee Well-being Group will work together more closely to identify projects/areas of work which they can develop and implement jointly. This will include developing a plan to work towards achieving the Platinum Corporate Health Standard.

Finally, working with Locality Primary Care colleagues, during 2015/16 a Service Level Agreement will be implemented to deliver Occupational Health services to staff who work within NHS dental practices. This has been welcomed by the Local Dental Committee.

### 7.3.4 Leadership and Management Development

Leadership and management capability has never been more important as we strive to create a system with teams that can respond to the challenges ahead and as we plan to embed our values we must challenge the way we want our leaders and managers to behave.

Leadership development and culture are interdependent and we must enable our leaders to adopt coaching styles to improve staff experience and well-being plus create a climate conducive to improve patient experience at every opportunity. In doing so we will:

* Provide a wide range of development programmes that help leaders and managers at all levels better understand how to support their teams and improve staff experience. There will be a strong focus on service improvement techniques in all leadership programmes. In particular we will develop a senior leaders' programme with Swansea University that will be the most significant development programme for the new appointed Divisional leadership teams, bringing operations management, nursing and medical leadership learning together.

* Work with leaders and managers to identify successors and future talent to develop our future leaders. We should then have the opportunity to build leadership capability particularly in clinical roles. As a priority we will focus on team development and improvement methodologies.

* Further develop staff support systems and self-care packages to help build resilience plus create a Coaching framework providing greater access to support to staff who may be struggling to meet the changing demands of healthcare.

The Consultant Development Programme will continue to be delivered to support newly appointed consultants to develop their leadership and management skills. We will also develop Alumni events to keep our future clinical leaders abreast of the changing NHS.

The Leadership Connections Master Class Programme, launched in October 2013, will continue as a mechanism for providing leadership development and networking opportunities for all clinical leaders and general managers at all levels in the organisation.

## 7.3.5 Staff Development and Training

For Wales it is recognised that 80% of our workforce will be employed by us for the next 10 years and beyond, it is imperative that we continually develop our staff to match the needs of the Health Board and the individual to deliver safe, quality care that matches the needs of our citizens. It can increase effectiveness, provide opportunities for individuals to progress and can help staff to feel valued by the organisation.

We will identify and provide development and training to suit the needs of individual staff based on our ABMU priorities. This will be generated in part by the Performance Appraisal Development Review (PADR) and medical appraisal process and delivered with support from our Medical, Nursing and

Therapies Corporate Directorates. A suite of programmes designed to support the care of the frail elderly in hospital will be delivered. This will include:

- Intensive training for those delivering care to frail elderly people and dementia 'awareness' training for all staff and at induction

- Training for clinical staff in the identification and treatment of delirium in older people and delivery of fundamental aspects of clinical care such as continence care training, management of nutrition , hydration, mobility, pain

- End of Life Care training to ensure our patients and families receive the best possible care at this most critical time

In addition, Statutory and Mandatory Training is fundamental to the delivery of high quality patient care and to the overall success of ABMU. Our plan is explained in Section 7.5.

Linking the learning outcome of Improving Quality Together (IQT) training and the need to undertake continuous service improvement as a core knowledge and skills component of the role (explained under ISIS below) will allow staff time to and help believe their ability and responsibility to improve the system in which they work.  Also in the process, there will be explicit questions within the documentation to promote discussion around the values and behaviours are being enacted.

We will also improve the engagement of our staff on our organisational objectives and citizen - centred culture, values and behaviours through our PADR processes. In doing so we will be adopting in 2014/15 the national guidance 'Supporting Citizen - Centred Development Reviews in NHS Wales – a Simplified KSF' and its accompanying documentation, to ensure consistency, further simplification and reinvigoration of the PADR process

The monitoring of staff having an annual appraisal or performance appraisal development review (PADR) is outlined in Section 7.5.1.

Enhanced Clinical Leadership will play a pivotal role in transforming our services and practice to deliver the clinical strategy as set out in 'Changing for the Better'.  Clinicians will lead the process of change and therefore the engagement, leadership skills and behaviours of our clinical leaders are critical. In conjunction with Swansea University we will develop a bespoke Leadership Programme to help embed our new clinical management structure.  During 2015/16, our Talent Management Framework will be in place across the organisation helping us to identify our future leaders, assess the ability and capability of our staff and help us plan for future development interventions to ensure that we invest and retain our talent for the future.

In addition, we will maximise the resources available to us via Academi Wales to support our current and future clinical leaders and managers. This includes opportunities such as attending Academi Wales Summer School,

their Medical Leadership and Senior Leadership Development Programmes as well as such programmes that focus on developing women aspiring to leadership roles. In addition we will tap into external development routes, such as the army's Exercise Medical Stretch events and training events with the Territorial Army to develop staff leadership skills and team building.

Providing opportunities for our local population into employment is an important role for the Health Board. The LIFT project is currently supported by the organisation and aims to offer training or employment opportunities to people living in workless households. Two candidates have recently completed the programme and are well placed to access employment with another 6 placements expected to start soon. We also support a traineeship at the Princess of Wales Hospital and a Work Ready programme in the Swansea area.

Later in the year it is anticipated that we will provide entry level apprenticeships for the unemployed in the areas of health and customer care, supporting the development of our local community and possibly providing employment at the end of the programme.

## 7.3.6   Service Improvements

Service improvement is a planned and systematic quality improvement programme following an evidence based approach to embedding sustained organisational performance. At its heart is the belief that frontline staff understand their own work best and what needs to be done to improve it. Our purpose is to develop mass engagement of frontline staff, to develop their skills and support them in their endeavours to drive continuous service and process improvement.

Focussing on 'A fully engaged and skilled workforce, the Health Board's People Strategy will seek to join improvement under one banner – Changing for the Better. To improve patient outcomes and the patient experience. We will: -

- Create an improvement culture inspired and energised by a leadership style compassionate to staff wellbeing and engagement that is united by one purpose - a future in which everyone has the best care and health possible

- Support clinical teams to create new and innovative ways of doing things united in delivering our purpose

- Build the confidence and capability within the workforce to constantly adapt and improve our services

From 2015/16 and onwards we will:-
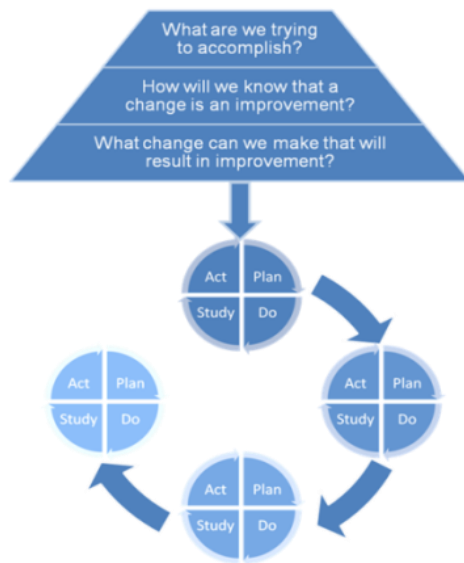
Use Improving Quality Together (IQT) and its Model for Improvement as the bed rock for developing our quality improvement skills and continue to build on the number of staff trained at an IQT Bronze, Silver level and in the Foundation of Improvement Science for Healthcare (FISH), applying their knowledge to delivering improvements in line with our strategic objectives.

We will continue to: -

- Support team and leadership development to improve capability, productivity and performance
- Drive the use of measured outcomes and processes across ABMU using run charts, variance and root cause analysis as standard improvement tools.
- Generate an improvement culture using our own 'ABMU Change Day' and appraisals to generate small change improvements.
- Drive the Model for Improvement as out standard improvement tool, ensuring we start with identifying the real issues using improvement methods.
- Create an improvement environment using Health Board space and technology to showcase, recognise/register and celebrate improvement work, feeding into the Chairman's Awards, NHS Awards and others
- Value frontline staff contribution by offering their support to other teams and to our strategic programmes, recognising their input and creating an ISIS movement
- Organise improvement learning events then support by applying the learning across the board
- Sign up and work with Swansea University on improvement science to bring challenge, research and test different improvement approaches, creating additional resource, innovative practice, academic papers, articles and award submissions at the same time
- We will drive the improvement culture (the ABMU way of working), develop the clinical leaders, and provide support to teams in a learning environment where sustainable improvements will arise from the frontline staff.

In doing so we have a small team made up of a clinical lead, improvement facilitators with data analysts input supporting frontline staff who are making improvements to patient outcomes and the patient experience. The Teams purpose and role is explained in Section 9.

## 7.4    Equality

Our Strategic Equality Plan 2012-2016 set out our corporate vision and commitment to delivering equality and human rights.  Our three Equality Outcomes are: -

- Better Health Outcomes
- ABMU to be a First Choice Employer
- Improved Patient Access and Experience

Our annual Quality Statement and Public Health Annual Report are seen by the Health Board are as key components of its annual Equality Report, although stand separate in their own right.

Our approach for 2014 onwards will be to build on work already started and rollout the 'Treat Me Fairly' eLearning resource for all staff as part of their statutory and mandatory duty. This learning will help staff think about their day-to-day role and what they can do to promote equality in the NHS.

The Equality Act 2010 requires us (as a public body), to undertake Assessments of Impact on existing and proposed 'business activities' (i.e. policies, practices, procedures and service improvements/developments). We will continue to use our Assessment of Impact Toolkit to help us make fair financial decisions and to improve the equality and equity of our health care services.  We will achieve this by ensuring that we think carefully about the potential impact of our work on different communities, groups, staff and service users.

### 7.4.1    Welsh Language

We will support the delivery of the Welsh Government's Welsh Language Framework 'More Than Just Words' by raise awareness amongst line managers of the 'Active Offer' principle as part of performance appraisal development reviews (PADRs); ensuring staff surveys are also available in Welsh, and promote the Welsh Language Strategic Framework in development programmes, which fosters a supportive ethos which empowers patients to speak to staff in their own language.

## 7.5    NHS Wales Delivery Framework

The Framework tells us about the NHS Wales priorities and the expected performance targets year on year to drive up standards and outcomes in

Wales. This section describes where we are and where we want to be in relation to engagement and managing our workforce as part of the Framework.

### 7.5.1 All staff to have an annual appraisal or performance appraisal development review (PADR)

Performance appraisal is an opportunity for individual employees and line managers, to engage in a dialogue about their performance and development, as well as the support required from the manager. To be successful they should also be used as a basis for making staff development and improvement plans.

The plan for 2015/16 is to understand the quality of the PADR process. This will then determine subsequent plans as a result.

The introduction of Employee Self Service within the Electronic Staff Record (ESR) system in 2014/15 and its roll out over the next 2 years will improve the recording, monitoring and measurement of PADR activity across the Health Board. The Health Board is on course with medical appraisal arrangements and revalidation in primary and secondary care. Work is also continuing both nationally and locally to reach agreement on appropriate medical appraisal arrangements for clinical academic colleagues and how this information can best be presented for revalidation recommendations. An initial assessment of the Health Board's performance against the draft Appraisal Quality Management Framework standards will be undertaken both to test the suitability and practicality of the standards themselves and to assess further work needed within the Health Board in 2015/16.

### 7.5.2 Statutory and Mandatory Training

The training and development of staff is fundamental to the delivery of high quality patient care and to the overall success of ABMU. Driving this is the Health Board mandatory training framework based on the UK Core Skills Training Framework. The first priority of the plan is to ensure that staff is competent to do their job, identified in the PADR and corresponding development plan. This will include adequate provision for the training requirements identified to meet statutory and mandatory responsibilities in health and safety and risk management.

Supporting the delivery will be the UK Core Skills Training Framework to standardise the key statutory and mandatory requirements, to deliver level one compliance indicators for all staff, adopted by NHS Wales in April 2014.

From January 2014 all staff will have had access to e-learning mandatory training material via Learning@NHSWales. For us, staff will be able to undertake level one mandatory training electronically. The advantage being that release from the workplace will be reduced which should help with compliance. Work is ongoing to continuously improve the e-learning user

interface in accordance with the WfIs National Action Plan ensure level 2 training

In addition the plan to move towards Employee Self Service for all staff within Electronic Staff Record (ESR) system over the next three years will mean that the staff record will be updates as soon as the e-leaning module has been completed. This will give managers real time access to mandatory training compliance for their area.

### 7.5.3 Staff Surveys

In 2015 we will be implementing a Health Board wide staff survey. This then will be used by every department across the Health Board as a local 'pulse surveys' linked to our patient experience survey and conducted regularly to measure staff satisfaction and feelings at various times throughout the year. Completion rates will improve year on year with staff responses collected electronically. The information will help our Divisions to focus on specific actions and/or particular topic areas, feeding back to staff on the actions taken.

The 'pulse' survey questions will be based on specific measurement of engagement levels covering Involvement, Advocacy and Motivation, monitored nationally as the 'Overall measure for organisational climate' Tier 1 Target. Pulse surveys will also be used to identify short term evaluation criteria to assess the success of the Staff Experience Framework.

The Health Board also uses the Annual Fundamentals of Care Nursing Staff Survey and National Training Survey GMC to help understand 'staff experience' and take action to improve its approach and leadership. In addition, ABMU will be participating in the All Wales NHS Staff Survey, planned for March 2016 and hosted by NHS Employers.

### 7.5.4 Exceed annual local Sickness and Absence workforce targets

The Health Board recognises it has had the highest sickness absence level of all Health Boards in Wales. As a result, we have developed a Sickness Absence Improvement Plan that:

- Supports sickness absence management through clear and consistent reporting and visibility of sickness absence trigger points and trends.

- Provides intensive support to hotspot areas, linking sickness absence to other key clinical, quality and financial indicators.

- Provides a clear governance and performance management framework to help deliver and sustain improvements.

- Up-skills managers to ensure they have the necessary competencies to manage sickness absence with compassion to improve overall people

management skills to support the strategic aim of a fully engaged and skilled workforce**.**

- Contributes towards the achievement of a 20% reduction in total variable pay as identified in Section 8 of the Plan.

Our aim is to further build on the positive work already done within the Improvement Plan. This has resulted in a reduction in sickness absence levels over the last 12 months from over 6.1% to just above 5.8%.

Our overall aim is to reduce sickness absence levels to 5.0% by the end of 15/16 and aim to reduce to 4.5% in 2016/17, particularly focusing on the management of Long Term Sickness.

## 7.5.5    Staff Flu Vaccination

Building on the increased take up amongst staff during the 2013/14 Flu Campaign, for 2014/15 a communications plan has been implemented to ensure there is a focus on immunisation of frontline staff during the whole period of the flu season (October – January). Senior staff are holding regular meetings with managers to remind them of the need for robust leadership to encourage take up. Occupational Health and the Corporate Nursing Team are working in partnership to recruit and train staff flu champions to make vaccinations widely accessible to staff, including evenings and weekends.

Plans for the Integrated Staff Health and Well-being Service are progressing.

## 7.5.6    Conclusion

One year on from the publication of the Andrews' Report we have made great progress and we must continually check our culture for raising concerns ensuring our staff are always supported to 'See It Say It'. In addition we know we must continually check our nursing skills' mix to provide robust assurance to our communities and the Health Board.

The workforce supply is no longer guaranteed from centrally commissioned programmes and we must update our current workforce to meet the changing demands of healthcare.

Given these challenges we need to continually adapt and develop our workforce.  Going forward the Health Board is exploring the recruitment of new roles such as Physicians Associates, and investing in Advanced Practitioner roles. Going forward the Health Board is reviewing how it can also support the development of parts of the primary care workforce.

Wider service developments such as the development of the 111 service for example provide opportunities to align our existing service delivery to enable patients to be referred directly from the 111 service into community nursing services, community resources teams and with local developments (e.g.

Single Points of Access/Gateways).  There is a need to understand fully the on-going impact the development of this service will have on our workforce.
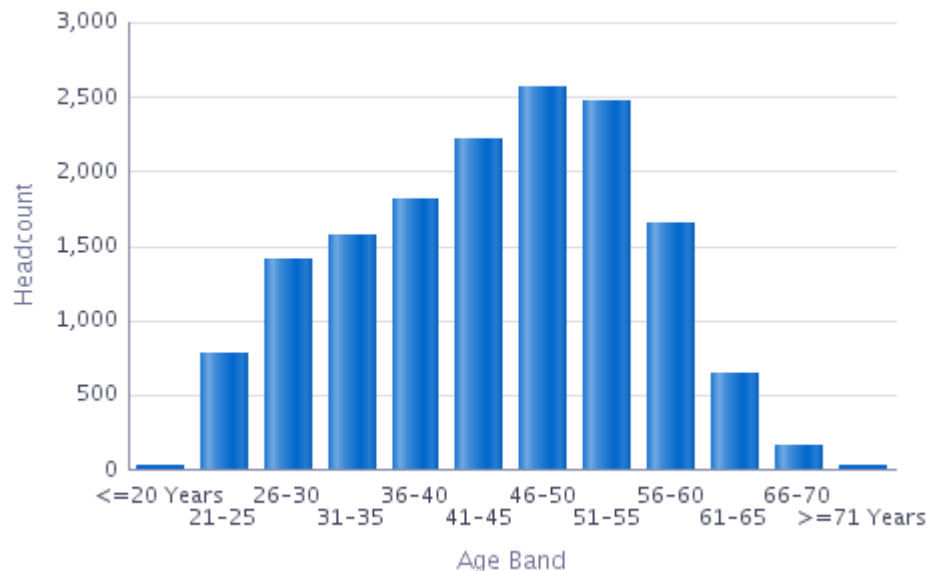


Our workforce is ageing. The above graph demonstrates that 32% of our workforce is over 50, which is an increase from 28% in 2012 and 25% in 2009.

Given this position, going forward the Health Board will need to undertake further analysis of its workforce to identify those parts which have an older profile than the welsh average, and develop strategies to retain and support the health and well-being of the older workforce, whilst continuing to attract younger workers into the Health Board.

Our staff have told us they are dealing with increased acuity of our patients and greater expectations from families. We must respond to ensure they are resilient to meet these challenges.

Our expectation of managers and leaders is clearly changing – they must focus on creating the conditions for staff to succeed in delivering high quality care by ensuring the best staff experience.

Yet we know these challenges will demand investment therefore cannot be seen in isolation of the financial pressures we face. Prudent Healthcare will require greater innovation and creativity.

We now make a commitment to all our staff to develop and deliver our **People Strategy** making ABMU a great place to work.

# 8      Finance

This section of our Integrated Medium Term Plan sets out, in detail, the financial structure of the Plan. Building on the projected position for 2013/14 set out in section 2, consideration is made of the financial outlook for the three year period of the plan and the opportunities which exist to contribute savings and efficiency gains to the plan. Our plans around capital expenditure are referenced here although they are introduced in section 5 above and workforce considerations are also factored in. Finally a Financial Risk profile is provided.

## 8.1      Current Revenue Position and Financial Context

This is described in detail in section 2.5.3 above.

## 8.2      Income, Cost and Investment Assumptions

### 8.2.1      Income Assumptions

The Revenue Allocations from Welsh Government for 2015/16 were issued on 31st December 2014. These confirmed a further year of zero % inflationary uplift across Health Board allocations. The revenue allocation, however confirmed the recurrent distribution of the £200m additional funding announced by the Health Minister in October 2014.

The Health Board income assumptions for 2015/16 to 2017/18 are set out in Table 21 and are consistent with the baseline planning scenario within the Welsh Government planning assumption guidance.

**Table 21 :  Summary Income Assumptions**

| ABMU – Summary Income Assumptions | 2015/16 £m | 2016/17 £m | 2017/18 £m |
|---|---|---|---|
| Revenue Resource Limit | 968.0 | 988.3 | 1,012.20 |
| Other Income | 241.0 | 241.0 | 241.0 |
| 2% Allocation Growth | - | 19.7 | 20.1 |
| Primary & Community Care | 7.1 | - | - |
| Pay Inflation Funding | 4.7 | - | - |
| Performance Delivery Support | 8.5 | 7.0 | 7.0 |
| Employers Cost Contribution Changes | - | - | - |
| **Total Income** | **1229.3** | **1,253.20** | **1,277.50** |

The key assumptions are:

- 2% annual allocation growth on revenue resource allocations in 2016/17 and 2017/18.This reflects flat cash in real terms and is consistent with the baseline scenario in the Welsh Government planning assumption guidance.
- Primary and Community Care reflects the Health Board is notified allocation share of the £6m allocated for Primary Care cluster plans, £30m Primary and Community Care and £20m Intermediate Care Fund. At this point no costs or funding have been included relating to Delivery Plans.
- Pay inflation of 1% in 2015/16 will be met by the pay inflation funding allocation agreed in February 2015.

The planning assumption guidance suggested two further scenarios:

- Scenario 2 – Flat Cash – 0% cash increase per annum
- Scenario 3 – Flat Cash in real terms plus funding to cover the ending of the Employers' contracted out 3.4% rebate for salary related pensions.

The impact of the three scenarios on the total income of the Health Board is set out in Table 22.

**Table 22 :   ABMU Total Income Comparisons**

| ABMU Total Income | 2015/16 £m | 2016/17 £m | 2017/18 £m |
|---|---|---|---|
| Scenario 1 - Baseline | 1,224.9 | 1,244.7 | 1,264.8 |
| Scenario 2 | 1,224.9 | 1,224.9 | 1,224.9 |
| Scenario 3 | 1,224.9 | 1,252.6 | 1,272.8 |
| **Movement from Baseline Scenario** | | | |
| Scenario 2 | - | -19.8 | -39.9 |
| Scenario 3 | - | 7.9 | 8.0 |

## 8.2.2   Cost Assumptions

The continuous rising demand for health services in terms of demographic changes, volume and complexity increases the cost pressures upon the NHS in Wales.   The key factors that drive these demand cost pressures are

increasing numbers of frail older people, lifestyle factors, new technology and new drug therapies.

The impact of pay increases in terms of wage awards and incremental progression along salary scales also introduces annual cost pressures into the NHS. They, along with inflationary costs of the consumables used in delivery services, can add a substantial new cost each year.  The following tables are based on estimates and do not reflect the actual Pay Awards that are yet to be agreed.

Along with other Health Boards in Wales we also have substantial cost pressures arising from the demand for fee increases for patients cared for in Care homes. Given the scale of the costs supported by Health Boards, any stepped increase in fees generates a substantial additional cost pressure to our overall bottom line expenditure plans.

The NHS Wales cost pressures experienced in previous years and envisaged for the 2015/16 period can be utilised to produce a local potential cost pressure assessment for a further 3-year period. The application of the National Cost Assessment has produced the forecast cost analysis as outlined in Table 23.

**Table 23 :  Potential Cost Pressure Assessment 2015/16-2017/18**

| | Forecast | | |
|---|---|---|---|
| | **2015/16 £m** | **2016/17 £m** | **2017/18 £m** |
| **Pay** | 7.00 | 4.50 | 4.30 |
| **Employers Cost Contributions** | 1.20 | 7.90 | 3.70 |
| **Non Pay** | 2.60 | 3.80 | 3.80 |
| **Statutory Compliance & National Policy** | 0.6 | 1.40 | 2.50 |
| **ChC/FNC** | 4.70 | 4.90 | 5.30 |
| **Welsh Risk Pool** | 0 | 1.50 | 1.00 |
| **NICE** | 2.50 | 2.50 | 2.50 |
| **WHSSC** | 2.00 | 2.50 | 2.50 |
| **Primary Care Drugs** | 5.00 | 4.50 | 4.50 |
| **Inflationary/Service Growth Pressures** | **25.60** | **33.50** | **30.10** |
| **Demand on Acute Services** | 3.40 | 4.10 | 4.50 |
| **Delivering High Quality Services** | 2.00 | 3.00 | 3.00 |
| **Primary Care and Community Services** | 4.10 | 3.00 | 0.00 |
| **Tier 1 Delivery** | 2.50 | 0.00 | 0.00 |
| **Primary Care Contracts** | - | 2.50 | 2.50 |
| **Demand/Demographic Growth** | **12.0** | **10.1** | **7.50** |
| **Contingency** | 4.00 | 5.00 | 5.00 |

| | Forecast | | |
|---|---|---|---|
| | 2015/16 £m | 2016/17 £m | 2017/18 £m |
| **Sustaining Core Services** | 3.00 | 2.00 | 2.00 |
| **Local Costs** | **7.00** | **7.00** | **7.00** |
| **Underlying Carry Forward Deficit** | 10.00 | - | - |
| TOTAL | 54.60 | 50.60 | 44.60 |

The inflationary and service growth cost pressure assumptions for the Health Board have been validated against the outcome of the National Cost Assessment undertaken for NHS Wales.

The demand/demographic growth cost pressure assumptions include:

- Demand on Acute Services – this supports the challenges within acute services including Unscheduled Care. 2014/15 has seen unprecedented demands for Health Board services. This investment will support service stabilisation and enhancement within Secondary Care to enable demand increases to be met. This growth assumption is in line with the National Cost Assessment Demographic Growth.

- Primary Care Contracts – this reflects the assumed cost growth based on the 2% income allocation growth assumptions.

- Service Quality – the Health Board is committed to ensuring our services offer safe, high quality care for patients. To support this, it is essential that services are fit for purpose and adequately resourced. There are a number of areas where recruitment issues are challenging the sustainability of the service provision and these will need to be supported with alternative models of care.

- Primary and Community Care – this supports enhancements to Primary and Community care services, in line with Welsh Government investment. This increase in expenditure has been profiled over two financial years which reflects likely expenditure pattern.

- Tier 1 Delivery – 2014/15 has seen deterioration in Tier 1 delivery, a further £2.5m has been identified to support the achievement of Tier 1 delivery plans. This is in addition to the £6.5m investment included within the 2014/15 financial plan. This is targeted at reducing the backlog of patients awaiting treatment within the Health Board.

In addition to the inflationary and service growth pressures and the demand and demographic pressures, the Health Board has also identified local costs and initiatives.

- Contingency – this is required to provide the Health Board with the ability to deal with unexpected events, unforeseen circumstances and also

provides an element of coverage for plan slippage. Given the size and complexity of the Health Board, a contingency of £5m (0.4%) is considered reasonable. This has been reduced to £4m for 2015/16.

- Sustaining Services – this is required to resource the necessary staffing implications of changes to Medical staff numbers as a result of Deanery post reconfiguration, medical staff recruitment shortages and requirements to increase on-call rota numbers.

It can be seen that, even with only a reasonable expectation of annual cost pressures and key investment increases during the 3-year period, the total cost impact continues to require a substantial savings requirement.

Table 24 below sets out a potential range of how the costs may vary over the short to medium term.

**Table 24 : Potential Range for Costs 2015/16 to 2017/18**

|  | 2015/16 £m | 2016/17 £m | 2017/18 £m |
|---|---|---|---|
| Optimistic | 44.6 | 40.6 | 34.6 |
| Calculated range | 54.6 | 50.6 | 44.60 |
| High End | 64.6 | 60.6 | 63.1 |

There is a significant range of costs that could emerge in the forecast period under consideration. There is, however, a 'floor' below which it is difficult to envisage costs falling below and this floor is materially above what can reasonably be managed through savings, whilst delivering the service aspirations of the NHS in Wales.

## 8.3    Achieving the Savings Required

Given the scale of the challenge, our Directorates/Localities are working to produce Integrated Service, Finance and Workforce plans that bring together service plans, access delivery plans, workforce plans and finance and savings plans into one coherent Integrated Plan. These plans will identify the measurable targets on a month by month basis to allow clear comparison with delivery. Much of this work is complete at the end of March 2015, but we continue to refine these plans to ensure that they are aligned to our strategies; our programmes and that they represent value for money.

### 8.3.1    **Performance Benchmarking - All Wales Cost Index**

In setting the context of the financial overview it is important to note that the cost efficiency of the services provided by the ABMU Health Board compares favourably with the cost of services provided by other Health Boards in Wales. The latest Welsh Assembly Government produced analysis on the

20011/12, 2012/13 and 2013/14 cost statements shows the ABMU Health Board with a cost index that is significantly below the All Wales average service cost of a 100. This cost index ranks first in Wales, and represents a service cost performance that has consistently been ahead of other Health Boards. Figure 21 below shows the relative position of the Health Board in the All Wales Cost Index.

**Figure 21 : All Wales Cost Index**
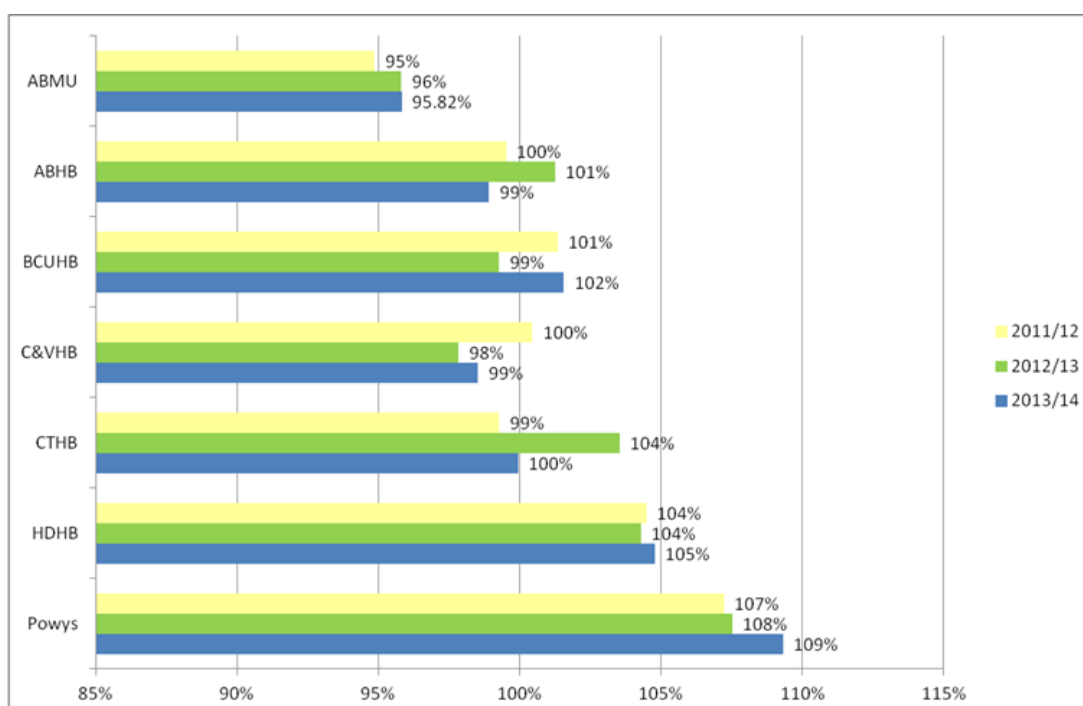


Figures presented on a like for like basis excluding Primary Care

It should however be borne in mind that, whilst the Health Board compares favourably with regard to its cost efficiency, opportunities still exist to improve service productivity and efficiency.

In addition, the Health Board has benchmarked services with English Providers through a range of mechanisms described in **Appendix 13**. These exercises have evidenced the cost effectiveness of the Health Boards services against the average, whilst also identifying opportunity for improvement and savings against higher performers. This benchmarked performance gain has been included within our savings plans with the IMTP.

## 8.3.2    Financial Framework 2015/16 to 2017/18

Table 23 sets out both the forecast Investment and Costs. It is proposed that the means of funding these investments and costs is achieved over 4 levels:-

- • **Level 1** - Welsh Government
- • **Level 2** - National/ Health Board Collective Effort
- • **Level 3** – Health Board wide
- • **Level 4** - Directorates/Localities

### 8.3.2.1    Level 1 - Welsh Government

The Health Board has assumed a level of additional funding allocation from Welsh Government as set out in Table 21. In addition, there may, however, be further opportunities to consider policy changes whereby income can be received.   This may not result in allocation uplifts, but in income/cost reductions in Health Boards.

### 8.3.2.2    Level 2 - National/Health Board Collective Effort

There is considerable scope for Health Boards to work collectively to agree action that would produce savings or income to the benefit of individual Health Boards. The collective effort would encompass:-

- • Pay and Terms and Conditions negotiations

- • Savings in Non Pay through Better Procurement

- • Savings in ChC costs through national strategy

- • Self-funding decisions through WHSSC Prioritisation Strategy

- • Savings in Primary Care drugs costs through national Strategy

These savings will be progressed through a range of national groups or sub groups of the standing national committees.

### 8.3.2.3    Level 3 - Health Board Wide

An exercise promoted by the Welsh Government some three years ago identified 14 High Value opportunities across Wales. Our potential share of these opportunities (estimated at our allocation share of 17%) is shown in Table 25 below:-

**Table 25 :  ABMU Potential Share of All Wales Opportunities**

| | All Wales Opportunities | ABMU Health Board Potential | ABMU Savings in last 3 years | ABMU Savings Planned for next 3-years |
|---|---|---|---|---|
| **Capture the Opportunities of Integrated Care** | | | | |
| Care Pathways and Settings | £m | £m | £m | £m |
| | 100-170 | 17-29 | 4.4 | 3.5 |
| ChC | 40-50 | 7-9 | 11.1 | 6.0 |
| Unscheduled Care | 50-100 | 9-17 | 3 | 0 |
| I.T. | 20 | 3 | 0 | 0 |

| | All Wales Opportunities | ABMU Health Board Potential | ABMU Savings in last 3 years | ABMU Savings Planned for next 3-years |
|---|---|---|---|---|
| **Improve Quality and Financial Stability by reducing harm, waste and variation** | | | | |
| Wasteful Interventions | 100-200 | 17-34 | 0 | 3.5 |
| Acute Performance | 150-250 | 26-43 | 12.5 | 10.5 |
| Non Acute Performance | 65-100 | 11-17 | 1.5 | 4.0 |
| Mental Health | 30-50 | 5-9 | 5.7 | 4.0 |
| Medicines Management | 70-100 | 12-17 | 19.8 | 13.0 |
| Procurement | 100-170 | 17-29 | 12.8 | 15.0 |
| Prevention | NYQ* | NYQ | 0 | 0 |
| **Empower the Front Line** | | | | |
| Streamline the Centre | NYQ | NYQ | 2 | 2.30 |
| Streamline Management | NYQ | NYQ | 2.7 | 3.5 |
| Workforce | NYQ | NYQ | 3.4 | 32.0 |
| **TOTAL** | | **124 - 207** | **78.9** | **96.30** |

*Note this excludes the contribution from other income.

Whilst we will strive to make progress over time against the required efficiency and productivity targets in the areas identified in the table above, it is likely that we will not be able to achieve the target levels in all areas. However, it is evident that whilst good progress has been achieved in some notable areas, more needs to be achieved in others. It should also be borne in mind that our services have already been demonstrated to be some 6% more efficient than the Welsh average, and that would equate to a savings achievement of some £40m.

It is also important to note that the efficiency gains shown in Table 25 may not be cash releasing, but capacity releasing allowing service demand growth to be managed. Throughout this 3 year planning process, efficiency is being pursued as core business for the Health Board, and the means have been identified to ensure that cash savings or cost avoidance opportunities are maximised through productivity and performance improvements. Specifically we anticipate that the Patient Flow, Surgical Pathway and C4B Clinical Service Programmes will be demonstrating significant efficiency gain as part of their overall benefits realisation.

As described throughout this document, we are implementing major service change through a range of Programmes and Projects that are already underway. The Strategic Change Programmes and allied Projects report to our Changing for the Better Delivery Board. They are managed through the

Use of Managing Successful Programmes approach and each one is led by a designated Executive Lead. The Programmes and Projects have been evaluated for their savings contributions in the 3 Year period ahead and these are shown in Table 26 below and the savings contributions included in Table 27. The Patient Experience and Patient Safety programmes have been incorporated into the Quality Strategy.

**Table 26 : Potential Savings Contributions**

|  | 2015/16 £m | 2016/17 £m | 2017/18 £m |
|---|---|---|---|
|  |  |  |  |
| Workforce Benefit Initiatives | 0.2 | 0.3 | 0.3 |
| Variable Pay | 2.3 | 1.5 | 0.4 |
| Sickness | 1.5 | 1.0 | 1.0 |
| Energy | 0.25 | 0.50 | 0.50 |
| Corporate & FBC Management Costs | 0.75 | 0.75 |  |
| Clinical Efficiency/Productivity | 0.25 | 1.00 | 2.00 |

Our overall assessment is that our Strategic Change Programmes will support the delivery of the clinical efficiency and productivity cost reduction target alongside producing significant other benefits realisation for demand management, quality improvement and reconfiguration of services

### 8.3.2.4    Level 4 - Directorates/Localities

Having identified the savings contributions to be made by plans at Welsh Government, National and ABMU Health Board level, it will be important to ensure that savings targets established to be delivered by Directorates/Localities do not 'double count' the savings that are planned to be achieved.

The following savings categories will need to feature in all Directorate and Locality plans:-

- Service Location/Facility Rationalisation – realignment of services to enhance service quality and improve efficiency of service delivery. It is recognised that the Health Board will progress some of the large scale schemes, which will require consultation and will form part of our longer term plan. However, there are many smaller issues which may be able to be actioned by Directorates and Localities more quickly.

- Service Performance – the Health Board is not performing optimally and there are many areas where improvements can be made in patient pathways to improve efficiency.

- Service Reduction – given the current economic climate, all services must be reviewed for clinical effectiveness and robustness of service model. This must be clearly linked to LTA requirements to fully understand the impacts of any service changes or reduction.

- Housekeeping schemes – identifying areas for further cost efficiencies.

- Medicines Management – review of all drug/prescribing opportunities. This will be supported by the Medicines Management Team, and could be in addition to the Integrated Medicines Management Savings Strategy being pursued at Health Board level.

- Procurement – reviewing all areas of non-staff expenditure to identify opportunities to reduce costs through improved purchasing arrangements and standardisation of product lines.

- Workforce Redesign – it is imperative that opportunities are fashioned that allows the workforce to adapt and respond to changing circumstances and new ways of working.  Some schemes will be progressed through the Workforce Modernisation Plan at Health Board level, but there would also be opportunities that arise for Directorates/Localities to take action in changing the skill mix and roles of their staff.

## 8.3.3 Savings Plans for 2015/16 to 2017/18

Table 23 above, set out the forecast cost base for us for the 3 year plan. The overall impact of the four levels is that cost containment and savings will deliver £22.65m in year 1, £20.85m in year 2 and £20.3m in year 3. The savings equate to between 2.5% to 3% each year. Table 27 below sets out our anticipated aggregate position when pulling together all of the four levels of funding and savings described above.

**Table 27 :  3 Year Financial Plan (Savings and Net Position)**

| Total Projected Cost Base (as per Table 23) | 54.6 | 50.6 | 44.6 |
|---|---|---|---|
| **Funding** | **2015/16** | **2016/17** | **2017/18** |
| **1.Additional WG Allocation** | (30.0) | (23.9) | (24.3) |
| **2.National/ HB Collective Effort** | | | |
| Pay Restraint | (2.2) | 0 | 0 |
| Non Pay/Procurement | (2.0) | (3.0) | (3.0) |
| ChC/FNC | (0.3) | (0.3) | (0.3) |
| **3. ABMU Health Board** | | | |
| | | | |
| ChC | (1.9) | (1.5) | (1.8) |
| Primary Care Drugs | (1.0) | (1.0) | (1.0) |
| **Projects** | | | |
| • Workforce Benefit Initiatives | (0.2) | (0.3) | (0.3) |
| • Reduce Variable Pay costs | (2.3) | (1.5) | (0.4) |
| • Reduce Sickness costs | (1.5) | (1.0) | (1.0) |
| • FBC Clinical Administration (Morriston)/Devolved Management Costs | (0.75) | (0.75) | 0 |
| • Energy Savings Strategy | (0.25) | (0.50) | (0.50) |
| • Clinical Efficiency/Productivity | (0.25) | (1.0) | (2.0) |
| | | | |
| **4. Directorate/Locality Savings Target (2%)** | (10) | (10) | (10) |
| **Total** | **1.95** | **5.85** | **0** |
| **5.Non Recurrent Technical Adjustment** | **(1.0)** | **1.0** | **0** |
| **SHORTFALL** | **0.95** | **6.85** | **0** |

The graph below identifies the scale of the challenge set down by this Plan in terms of savings delivery.  It can be seen that the total planned savings for each of the three years of this Plan are at a similar level to those achieved in the current year and past two years.

It should be highlighted that the projected cost base in 2016/17 includes £7.9m of additional National Insurance Contributions following the end of National Insurance Rebate.

**Figure 22 : CIPs**
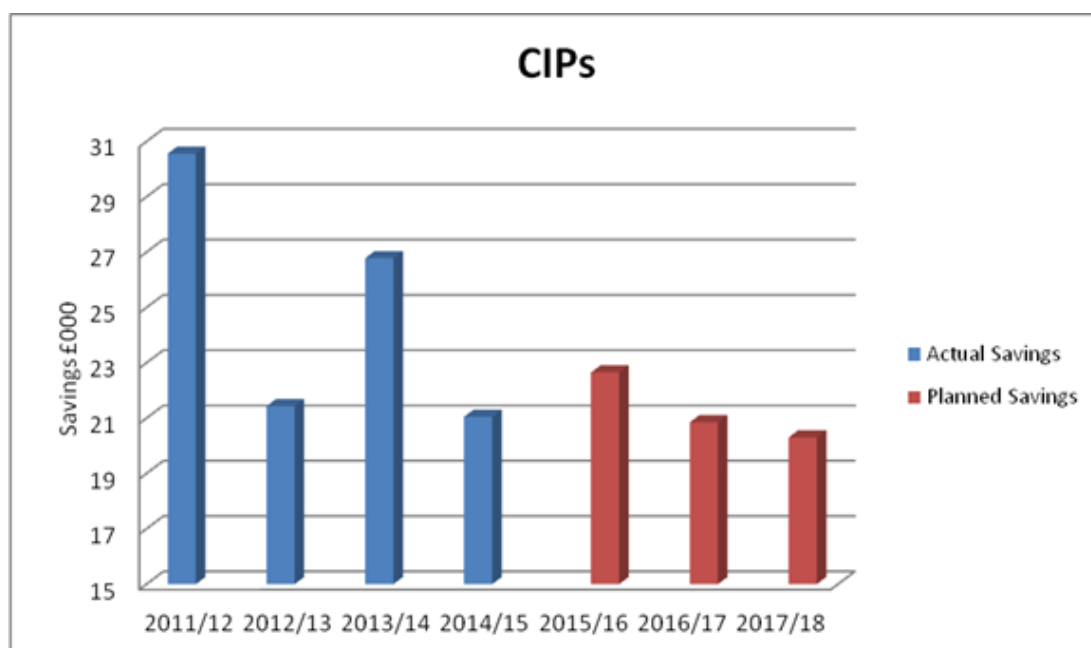


When we combine our cost and funding bases, we produce a final assessment of our financial outlook for the next 3 years. The last row of Table 27 shows this shortfall as being £0.95m in year 1, £6.85m in year 2 and a balanced position in year 3. The total recurrent deficit for the duration of the plan, at present, is £7.8m assuming all allocation assumptions are met.

## 8.3.4   Summary of Financial Projections for 2015/16 to 2017/18

Given the scale of the challenge, Directorates and Localities are working to produce Integrated Service, Finance and Workforce Plans for 2015/16 the 3-year period 2015/16 to 2017/18 that bring together service plans, access delivery plans, workforce plans and financial and savings plans into one coherent plan. These plans must identify the measureable targets on a month by month basis to allow clear comparison with delivery.

Funding the anticipated costs for the period 2015/16 to 2017/18 will require an approach that includes Welsh Government, National Strategies and collaborative working by all Health Boards, ABMU Health Board wide saving strategies and savings programs developed at the Directorate/Locality level.

It is clear that given the financial challenge, significant savings will need to be made through reductions in workforce costs. Based on the current pay/non pay expenditure ratio, it would not be unreasonable to anticipate over half of savings being delivered through workforce efficiencies and changes to Pay Costs.

At this stage, the integrated planning process has not identified a balanced plan and therefore the financial schemes that are available do not meet the full savings targets established. The Board considers that it will not be possible to deliver a balanced Plan and deliver the service targets set down by the Welsh Government.  .

It is clear that the Health Board has a shortfall on its recurrent cost improvement programme (CIP) plans for 2014/15 and that, along with the significant workforce and service pressures resulting in the use of high cost agency staff,  this will translate into a material underlying recurring shortfall carried forward to the commencement of 2015/16. Efforts are continuing to:-

- Review schemes currently identified

- Identify additional schemes to meet CIP target

- Seek additional savings to address any carry forward deficit.

The starting budgets have been established as a result of working through the methodology and assumptions outlined earlier in this report.

## 8.4    Health Board Wide Savings Projects

Table 27 above sets out a number of Health Board Wide Projects for which savings are assigned to Directorate and Locality financial plans for delivery. Described below is the detail of the work undertaken to identify the savings figures profiled in our Plan.

### 8.4.1    Workforce Benefits Initiatives

We are engaging in a number of salary benefit schemes which will benefit staff and also provide a cost saving to the Health Board,

### 8.4.2    Variable Pay

2014/15 saw the Health Board expenditure on variable pay costs increase from around £26m per annum to around £36m per annum.  Elements of this variable pay are not paid at premium rates, as it relates to bank. Similarly the full £36m could not be identified as a saving as the costs are incurred covering vacant posts, the 'premium' element could however be reduced significantly.

The most significant agency cost growth is within nursing which has increased from £1.5m in 2012/13 to £9.5m in 2014/15.  This increase reflects the Health Board's commitment to increase nurse staffing levels to the Chief Nursing Officer's Guiding Principles and the measures to increase operational capacity to manage the demand growth, which have resulted in a significant increase in registered nursing vacancies.

The Health Board is actively recruiting to vacancies, through recruitment days, social media campaigns and overseas recruitment, which is planned to reduce the reliance on agency staff and other premium cost options.

We are actively engaging in benchmarking activity to identify opportunities to maximise the skill mix and efficiency of the workforce, using All Wales Skill mix Analyser and iView data

We are also exploring the opportunities to reshape the workforce, supporting efficiency and productivity improvements through 7-day working, with a number of pilot schemes about to commence. The results of these pilots will be used to further refine and understand the impact on service models.

The Medical and Dental Workforce is a fundamental part of the workforce modernisation project, with greater emphasis on job planning and outcome measures and use of alternative workforce roles to support reductions in available medical staff.

The delivery over 3 years reflects 12% reduction in total variable pay which is considered to be achievable

## 8.4.3    Sickness Absence

Detailed information on sickness absence is included in section 7.5.4, however, it clearly has significant financial impacts for the organisation, and therefore the cost pressures are included here.

Table 29 below is also referenced at the end of our workforce section 7. Our aim is to reduce sickness absence levels to the 5.08% target within two years and aims to reduce to 4.5% in 2017/18. Table 28 below identifies the potential cost benefit available through reduction in sickness absence rates.

**Table 28 :  Projected Sickness levels to 17/18**

|                    | 2015/16 | 2016/17 | 2017/18 |
|--------------------|---------|---------|---------|
|                    | %       | %       | %       |
| Sickness Rate      | 5.0     | 4.5     | 4.5     |
|                    | £m      | £m      | £m      |
| Estimated Saving   | 1.5     | 1.0     | 1.0     |

### 8.4.4 Devolved Management Costs and Clinical Administration

The Health Board is currently reviewing its management arrangements for service delivery and discussions are ongoing to determine revised arrangements for implementation in 2015/16.  The revised arrangements will enhance the delivery capability of the Health Board and its ability to deliver its strategic vision. This along with planned efficiencies within clinical administration has been targeted with generating £1.5m of recurrent savings over a 2 year period.

### 8.4.5 Energy Strategy

The Health Board has targeted further improvements in energy efficiency across its estate and this is aligned with spend to save investment in the Capital Plan.

### 8.4.6 Clinical Efficiency and Productivity

We are committed to utilising a service improvement methodology to improve the efficiency and productivity of our clinical services.  The Strategic Change programmes of Patient Flow, Surgical Pathway, Changing for the Better, Commissioning, Effective Use of ICT and the Quality Strategy all support the ongoing drive for efficiency and productivity improvements.  Much of the benefit realised will support demand management, quality improvement and service redesign, however we will be targeting some elements of cash releasing savings through improved efficiency.

## 8.5 Capital

In light of the opportunity presented by a three year planning framework we have taken the time to consider the objectives of our Service Change Programmes and to reflect this in our capital planning assumptions. We have therefore developed the Capital Programme to support service modernisation and the service sustainability agenda within the physical estate.

The capital programme needs to support the delivery of the Health Board's statutory requirements in terms of the estate performance and maintenance and capital requirements within this 3 Year Plan.  It also needs to support the significant clinical equipment and clinical technology replacement programme to ensure the safety and efficiency of service delivery.

Our capital plan supports the rationalisation of the Health Board estate at a time where alternative clinical models are being implemented, particularly within our Localities to provide care closer to patients' own homes.  This programme of work enables the focussing of more specialist services onto the main acute hospital sites as community based models reduce the requirement for services to be provided in traditional hospital settings.

Our overall plan is made up of two elements.

- Discretionary Capital Allocation
- Capital funding from the All Wales Capital Programme for specific schemes.

Along with other Health Boards, we have a considerable and growing problem with the amount of capital required to eradicate our backlog maintenance problem, replace and maintain our medical and IMT equipment to the recommended replacement standards. It is estimated that the replacement cost for just these three elements is considerably in excess of £100 million.

## 8.5.1 Discretionary Capital Programme 2015/16 – 2017/18

Our discretionary Capital Allocation is £7.673 million for 2014/15 but is anticipated to increase by £2m in 2015/16. A number of factors may improve the position through the year such as additional capital in the form of the Health Technology Fund and other Welsh Government initiatives.

We know that we will face significant demand for Discretionary Capital from 2014/15 onwards, with particular emphasis on the expected requirements for major clinical equipment replacement (including imaging), ICT, and statutory/fire safety expenditure.

It would be unrealistic to assume that the Discretionary Allocation can contribute in any significant way to facilitate major service redesign or reconfiguration as it is insufficient to discharge maintenance and replacement obligations. In light of the comments made above, we have decided that priority will be given to the following categories of capital: -

- To review how well ward accommodation supports care for those with dementia, delirium, cognitive impairment or dying covering physical design of the clinical spaces and equipment available
- To maintain service continuity – particularly replacement equipment including evidence of risk assessment
- Statutory requirements
- Spend to save investments.

Our work to rationalise our estate means that the investment is required to focus on the three acute hospitals accepting that Neath Port Talbot Hospital has a different funding regime as it has a PFI contract. Without the investment identified, the risk of a systems failure which would compromise patient care increases and also the considerable rise in backlog maintenance costs.

It should be noted that there are also plans for the rationalisation of the Health Board estate leading to capital receipts from property sales and these are outlined in Table 31 later.

Maintenance of existing technology and refresh of aging ICT devices and components is a key component of the Health Board's capital priority to maintain service continuity. The clinical risks associated with failure of this vital infrastructure are recognised in the Health Board's assessment of risks. It should also be noted that we are unlikely to make any additional capital investment for additional ICT to support development and modernisation based on our discretionary allocation.

## 8.5.2 All Wales Capital Programme

The main elements for the All Wales Capital Programme relate to the approved plan for the Redevelopment of Morriston Hospital and the Modernisation of Mental Health Services across the Health Board. Once the demolition packages are agreed this will signal the closure of the Health Vision Swansea programme.

We are currently working with University and other partners to develop a unified strategy for healthcare and academic systems for Swansea. A Regional Collaborative for Health (ARCH) project has been set up to produce a prospectus for consideration by the wider Welsh Government. This hugely exciting potential strategy will see a range of partners working together in a truly collaborative structure. Some elements of our existing plan, Cardiac Centre, Maternity services etc, could form part of this ARCH programme but for now these remain as individual schemes. The development of the ARCH work over coming months will enable us to streamline and clarify the overall strategic intent as it relates to the capital programme and the presentation and groupings of the capital plan will need to be revised to reflect this.

Our overall presentation of the plan in table 30 has been categorised to capture our main capital themes. These are: -

- Approved programmes
- Changing for the Better programmes
- ARCH enabling programmes
- Infrastructure enabling programmes
- Regional services

Strategic programmes for ongoing maintenance of Morriston Hospital, Princess of Wales Hospital and Singleton Hospital have been submitted to Welsh Government for environmental infrastructure.

An ambitious strategic programme for Information Technology, both within and outside the hospital environment has been approved and the relevant business cases to underpin this programme are being developed. We are also developing a considered programme for the replacement of existing medical equipment.

Table 30 below sets out the current indicative 5 Year All Wales Capital Programme for 2014/15 to 2019/20 and the range of facilities that the indicative programme affects.

Table 30 also sets out the range of capital requirements to fulfil all of the ambition of the Health Board. It is understood that capital resource is scarce and we accept that once preliminary discussion are held regarding capital, prioritisation will need to be undertaken to allocate scarce resource to the projects and programmes which deliver the critical path of this 3 year plan.

In terms of priorities the capital programme must strike a balance between maintaining the fabric of the existing estate (hence the infrastructure projects) and supporting the strategic development of our services to improve the quality of care we provide. This must be seen in the context of our main hospitals, but also in the context of Mental Health facilities and our primary care estate. The schemes identified in the current All Wales capital programme need to be progressed and the improvement of the Cardiac Intensive Care Unit is a key quality and safety issue for the Health Board and is a high priority.

A small number of schemes remain to be confirmed and quantified and these will be discussed and developed with Welsh Government over the first half of 2015/16 as further clarity becomes available on the national picture for capital availability and the structure and detail of ARCH.

**Table 29 : Indicative All Wales Capital Programme Requirements – ABMU**

| | Scheme | 2015-16 £m | 2016-17 £m | 2017-18 £m | 2018-19 £m | 2019-20 £m |
|---|---|---|---|---|---|---|
| | Discretionary Allocation | 8.120 | 9.745 | 9.745 | 9.745 | 9.745 |
| **Approved Programmes** | **Mental Health - Disposal of Old Cefn Coed** | | | | | |
| | RMHSS Acute Mental Health Unit | 0.500 | 10.000 | 8.900 | | |
| | RMHSS Older Persons Mental Health Assessment Unit | 0.500 | 10.000 | 5.700 | | |
| | RMHSS Mental Health Day Facilities | 0.300 | 2.353 | | | |
| | Cefn Coed Reconfiguration & Enabling Phase | TBC | TBC | | | |
| | Cefn Coed Land Disposal & Demolition | | | | TBC | TBC |
| | **Health Vision Swansea** | | | | | |
| | HVS 1B, Main Entrance & Outpatients, Morriston Hospital | 11.900 | | | | |
| | HVS 1B, Clinical Accommodation & Diabetic Centre | 15.828 | | | | |
| | HVS 1B, Demolition & Car Park | 0.400 | 2.000 | 4.172 | | |
| | HVS 1A External Road & Car Park | | | 15.191 | | |
| **Changing for the Better Programme** | **Cardiac Centre, Morriston** | | | | | |
| | Increasing Cardiac Capacity | 6.409 | | | | |
| | Cardiac Centre | | 4.000 | 30.000 | 30.000 | |
| | Replacement of Catheter Laboratories | 4.000 | 2.000 | | | |
| | Provision of Integrated Theatre | 0.100 | 2.900 | | | |
| | **Centralisation of Medical Model at Morriston & Increase Unscheduled Care Capacity** | | | | | |
| | Phase 1 - Reprovide Physiotherapy off site | TBC | TBC | TBC | TBC | TBC |
| | Phase 2 - Transfer 2 wards from Singleton Hospital | TBC | TBC | TBC | TBC | TBC |
| | Phase 3 - Expand the Acute Hub and 2 additional wards | TBC | TBC | TBC | TBC | TBC |
| | Development of Major Trauma Centre | TBC | TBC | TBC | TBC | TBC |
| | **Women & Child Health** | | | | | |
| | Transfer PAU Morriston to Fracture Clinic, Morriston | TBC | TBC | | | |
| | Transfer Sapphire Suite from Singleton to Current PAU Morriston | TBC | TBC | | | |
| | Reconfiguration of Maternity Services from Singleton to Morriston | 0.300 | 6.000 | 20.000 | 30.000 | 13.700 |
| **Ward Improve** | **Programmed ward improvements** | | | | | |
| | Decant Ward and flexible ward accommodation, Morriston | TBC | TBC | | | |
| | Decant Ward and flexible ward accommodation, POWH | TBC | TBC | | | |
| **ARCH Enabling** | **ARCH - Enabling Phases** | | | | | |
| | Land Purchase | TBC | TBC | | | |
| | Relocation Pathology from Singleton to Morriston | TBC | TBC | | | |
| | Reprovide HSDU (allow increase in CC capacity) | TBC | TBC | | | |
| | Increase Critical Care Capacity. Morriston Hospital | TBC | TBC | | | |
| | Unscheduled Care Capacity | 3.000 | TBC | TBC | | |
| | Reconfiguration of Ophthalmology, Singleton | TBC | TBC | TBC | | |
| **Infrastructure Enabling Programmes** | **Informatics Modernisation Programme** | | | | | |
| | Informatics Strategic Change Programme | 7.150 | 6.400 | 6.400 | 2.000 | 2.000 |
| | **Environmental Modernisation Programme** | | | | | |
| | Environmental Modernisation Morriston | 2.000 | 2.000 | 2.000 | 2.000 | 2.000 |
| | Environmental Modernisation POW | 2.000 | 2.000 | 2.000 | 2.000 | 2.000 |
| | Environmental Modernisation Singleton | 2.000 | 2.000 | 2.000 | 2.000 | 2.000 |
| | **Primary Care Development Schemes** | | | | | |
| | Primary Care Development Schemes | 2.000 | 2.000 | 2.000 | 2.000 | 2.000 |
| **Regional Services** | **Renal** | | | | | |
| | Renal Ward Refurbishment | 3.434 | 1.931 | | | |
| | **Pharmacy Asceptic & Radiopharmacy** | | | | | |
| | Asceptic Unit, Singleton Hospital | 1.000 | 6.881 | 1.000 | | |
| | **Radiotherapy** | | | | | |
| | Replacement programme for Linear Accelerators | 3.000 | 3.000 | 3.000 | 3.000 | |
| | Expansion of Linear Accelerator Capacity | TBC | TBC | TBC | TBC | TBC |
| | **Implications of the South Wales Plan** | | | | | |
| | Implications of the SWP | TBC | TBC | TBC | TBC | TBC |
| | Increase Neo Natal Capacity | TBC | TBC | TBC | TBC | TBC |
| | **NWIS** | | | | | |
| | National EDCIMS | 0.844 | 0.128 | | | |
| | **SWARU** | | | | | |
| | Development of SWARU | TBC | TBC | TBC | TBC | TBC |
| | **Total** | **74.785** | **75.338** | **112.108** | **82.745** | **33.445** |

We are also considering how our ward refurbishment programme can be scheduled to support delivering the required bed spacing which will assist in the delivery of improvement in infection rates. Our current ward templates, if refreshed to required standards for bed spacing and cubicle ratios will only be able to accommodate around 60% of the current bed numbers per ward.

We are committed to our infection control agenda and whilst we modernise services to reduce demand on hospital services and hence beds, we must be mindful that physical capacity will be an issue and planned accordingly.

We have established a primary care estate development group and allocated a notional sum of £2m in the capital table above to recognise the need to develop our out of hospital estate to support our strategic direction of supporting the system shift to primary and community services. As this group develops we will refine the plans into specific programmes to support the development of our community networks.

### 8.5.3 Land and Property

As a consequence of our extensive service modernisation programme, there has already been a considerable rationalisation of our Estate. The future disposals set out in Table 30 below have been approved by the Health Board.

**Table 30 : Health Board approved disposals**

| Site | 2015/16 £m | 2016/17 £m | 2017/18 £m | 2018/19 £m | 2019/2020 £m |
|---|---|---|---|---|---|
| Cefn Coed Hospital | 2.700 | 8.125 | 10.200 | | |
| Briton Ferry Health Centre | 0.100 | | | | |
| Resolven Health Centre | 0.050 | 0.050 | | | |
| Glynneath Health Centre | 0.040 | 0.040 | | | |
| Residences Morriston | | TBC | TBC | | |
| **Total** | **2.800** | **8.215** | **10.200** | **0.000** | **0.000** |

### 8.5.4 Delivering Successful Capital Programmes

The Health Board has a successful track record in delivering capital programmes to time and cost, and also utilising the investment to lever service improvement. Well established and effective Capital and Finance team working is key to this level of performance and both teams share information on Projects in real time on a single information Portal. The quality of the working with agents and service partners is also an important factor in the quality of capital governance.

We welcome the useful guidance recently issued by the Welsh Government and believe these further changes will enhance further the quality of capital governance within NHS Wales.

## 8.6 Cash Flow Forecast

The forecast cash deficit for 2014/15 is as per that submitted with the month 11 monitoring returns. The cash receipts included for each year for revenue are the totals as per the RRL in the SCNE reduced for the depreciation amount as this is non cash

The cash payments are based on the expenditure in the SCNE less depreciation which is non cash with an additional £2.3m of cash payments each year included each year to reflect the forecast deterioration in working balances due to cash payments for provisions.

The overall worsening deficit is directly linked to the forecast I & E Deficit each year. In addition, it should be noted that 2014/15 assumes that capital creditors for major schemes will be fully discharged to the approximate value of £4m. At this point, no cash inflow from Welsh Government has been assumed to cover these payments.

The "Other (incl Non Cash Limited)" line includes anticipated disposal receipts up to £0.5m which is the current limit for Health Boards to retain.

The overall scale of cash deficits each year are significant and are broadly equal to one month's salary payments, totalling £28m, rising to the equivalent of three months by year 2016/17 at £102m.

**Table 31 :  Cash Flows Forecast 2014/1 to 2017/18**

|  | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
|  | £'000 | £'000 | £'000 | £'000 |
| **Receipts:** |  |  |  |  |
| WG Revenue Funding | 945,152 | 983,997 | 1,003,697 | 1,023,797 |
| WG Capital Funding | 59,137 | 37,548 | 32,098 | 24,345 |
| Other (incl Non Cash limited) | 249,367 | 241,000 | 241,000 | 241,000 |
|  |  |  |  |  |
| **Total Receipts** | **1,253,656** | **1,262,545** | **1,276,795** | **1,289,142** |
|  |  |  |  |  |
| **Payments:** |  |  |  |  |
| Revenue | 1,192,636 | 1,234,697 | 1,261,597 | 1,282,097 |
| Capital | 62,236 | 37,548 | 32,098 | 24,345 |
| Other | 0 | 0 | 0 | 0 |
|  |  |  |  |  |
| **Total Payments** | **1,254,872** | **1,272,245** | **1,293,695** | **1,306,442** |
|  |  |  |  |  |
| **Bank & Cash B/F** | **(1,216)** | **-9,700** | **(16,900)** | **(17,300)** |
|  |  |  |  |  |
| **Bank & Cash C/F** | **1,602)** | **(8,098)** | **(24,998)** | **(42,298)** |

NOTE: Requirement to submit Monthly Profile will be met as part of Monitoring Returns Submissions

## 8.7 Risks and Sensitivity

It is important to emphasise that the assessment of our financial challenge for 2015/16, as described above, is based on the latest information available. It is inevitable that even marginal changes on budgets of more than £1billion can have a major impact on our ability to achieve financial targets.

In setting out the financial challenge facing us for the period 2015/16 to 2017/18 the key assumptions and risks built into the financial projections are:

- The Plan assumes additional recurring allocations from Welsh Government.

- The projected annual run rate for CIP savings in each of the following two years exceeds the Health Board's historic delivery pattern.

- The savings target established for the three years amounts to over £80m. This would be a considerable achievement, particularly given the fact that there has already been substantial savings achieved over the recent past for the new configuration of services.

- Our cost performance is significantly better than the average for Wales. This means that it is more difficult for the Health Board to meet all the service and financial targets than other Health Boards in Wales.

- Given the service and financial pressures that are currently present, the Health Board carried forward an underlying deficit of some £10m into 2015/16. Addressing the backlog required to meet access standards will put a considerable strain on financial control and will require a stepped improvement in operational performance. £9m is identified in the financial plan to meet RTT standards.

- The scale of the challenge over the next three years will require a review of clinical services provided to identify their relative effectiveness and priority. It is not envisaged that improved performance alone can deliver the financial savings required.

- The scale of the plans required to be delivered for the period 2015/16 to 2017/18 will inevitably run the risk of slippage in actual delivery, resulting in a risk of an in year overspend.

The Health Board has undertaken a Strategic Risk Assessment of its financial plans to identify 'downside' risk and 'upside' opportunity. This strategic risk assessment is presented in Table 33 below.

**Table 32 :  Financial Scenarios**

| 'Downside' Risk | 15/16 £m | 16/17 £m | 17/18 £m | 'Upside' Opportunity | 15/16 £m | 16/17 £m | 17/18 £m |
|---|---|---|---|---|---|---|---|
| 1.  Demand in excess of Plan | 2 | 2 | 2 | Demand Unlikely to be less than Plan | 0 | 0 | 0 |
| 2.  NICE assessment insufficient to meet costs of new drugs | 5 | 3 | 3 | Mitigation of prescribing costs | (1) | (2) | (2) |
| 3.  Programme Savings Slippage | 2 | 2 | 2 | Rationalisation of Investments with low financial return | (2) | (2) | (2) |
| 4.  Directorate/Locality CIP Slippage | 3 | 3 | 3 | Other Income | (1) | (1) | (1) |
| 5.  Other LHBs Retraction of Services | 2 | 1 | 0 | Growth in service provision to other LHBs | 0 | (1) | (1) |
| 6.  Increased Expenditure to meet Tier 1 targets | 3 | 1 | 1 | Cost mitigation WHSSC Commissioned Services | (1) | (1) | (1) |
| 7.  Additional ChC volume and price growth | 2 | 1 | 1 | Other Partnership Models | (1) | 0 | 0 |
| 8. | | | | WG funding to support Pensions changes | - | (8)- | (4)- |
| | **19** | **13** | **12** | | **(6)** | **(15)** | **(11)** |
| Baseline Plan | 20 | 10 | 5 | | 20 | 10 | 5 |
| | **39** | **23** | **17** | | **14** | **(5)** | **(6)** |

It can be seen that the Baseline Plan has significant 'downside' risk as well as 'upside' opportunity.  Sound financial planning indicates that a Baseline Plan presents a reasonable financial assessment of the position of the Health Board, given these risks and opportunities.  The Health Board's Financial Plan presents such a position.

It is clear that decisions will be required on service priorities, pensions funding support and Health Board investment funding in order to enable the Baseline Plan to be realistically revised towards a balanced position.

## 8.8     Financial Management, Development and Governance

### 8.8.1     Evolving our Finance Future

The evolution of the Finance Function, and the financial management and governance of the whole Health Board, has been the subject of significant

work over the last 12 months.  The issue by the Welsh Government of the "Financial Regime" guidance has informed this work, alongside evidence of best practice across service sectors.

A Finance Future Development Board was established consisting of Senior Finance Officers, Clinical and Service leaders and external representation. The external input of Public Health, Swansea University, the Welsh Government and the Wales Audit Office has enhanced the quality of our work.   The Board is planning to finalise and endorse a medium term development strategy, entitled "Finance Future", in the New Year.  This work builds on the existing Finance Function Management and Development Framework, "Compass".

At the heart of "Finance Future" is the role of Finance as a service partner enabling the alignment of Finance, Patient Experience and Clinical Outcomes throughout the management and accountability structures to enhance value. The organisational, technical and personal development dimensions of this role are explored and a framework for action set down.

'Finance Future' sets the future finance role to support the delivery of the Prudent Healthcare agenda.

Finance Future' has been developed to ensure our Finance Function facilitates the ambition of the Health Board to deliver excellent patient outcomes, experience of service and value, supporting the Integrated Medium Term Plan.  We have developed Finance Future in conjunction with Finance people and stakeholders.   Finance Future describes how Finance will change its focus from being predominantly inputs based to consider value from a patient perspective.

To inform choices and to provide insight into services and opportunities, we need to alter the scope of our financial activities.  We need to develop new financial perspectives on our health services. We have developed a Financial Model for change that assists us in shifting our focus to activities that offer much more value.  In this way we can   support clinical and service decision making from 4 perspectives.

| Inputs | Outputs | Outcomes | Health Gain |
|---|---|---|---|

High performing NHS organisations are able to demonstrate Clinical and Finance teams working together.  There is an understanding that cost reduction without maintaining or improving outcomes may lead to a 'false saving and have a detrimental impact on the delivery of care'. (Department of Health: Effective Clinical and Financial Engagement Nov 2013).

Finance Future needs to fit alongside the complementary work of other clinical and professional groups within the Health Board, and a part of Finance Future is ensuring these relationships grow and strengthen.

Our Finance Future should enable the Health Board's Clinical Services Strategy to be realised.  It should also do so in a way that promotes the values of the Health Board and the positive behaviours demonstrated by those values, engaging the workforce in the use of resources to deliver healthcare of quality and value

# 9 Building Capacity and Delivery

> This section captures more detail on our plans to build the organisation's capacity and capability to deliver our IMTP

## 9.1 Service & Process Improvements

Our ISIS (Innovation, Support and Improvement Science) programme will support the Health Board's Organisational Development agenda. One element is 'People/Staff development' in improvement and systems methodology, enabling the workforce to lead improvement in their daily working processes and increasing understanding that our staff have two jobs; to do their job and continuously improve what they do. ISIS will implement a programme of service improvement and best practice, using tried and tested methodology which is understood by all.

## 9.2 ICT strategy

### 9.2.1 Context

In order to effectively align the use of technology as a key enabler to change, we have established Effective Information Systems and Use of Technology (EIST) as one of the Strategic Change Programmes. Details of how each of the projects within the EIST Programme enable and support the individual service improvement projects are available together with a breakdown of costs with sources of funding. **Appendix 14** provides an overview of how these ICT projects align with each of the Strategic Change Programmes.

The aim of the informatics strategy is to provide clinical staff with an electronic, patient-centred view of information in order to support high quality care. Clearly, this information needs to be up-to-date, accurate, and available wherever care is being delivered. Making this a practical reality for our clinicians is a significant challenge in light of the continued reliance on the paper health record, the number and variation in IT systems in use across the organisation, and the level of investment in technology required to enable and sustain change and modernisation.

We continue to support the development and delivery of national IT products and services working in partnership with NWIS. In the short to medium term, the approach will be to identify opportunities that maximise the benefits of investment in existing information and technology in order to provide more joined-up clinical information. This approach will support prioritised service improvements and ensure the workforce become familiar with more electronic ways of working in order to fully exploit the benefits from national products when these become available.

In addition to a focus on more integrated information, easy access to information will need to be addressed. We have continued to invest significantly in ICT infrastructure. With greater reliance on electronic information, levels of investment will need to increase significantly, not only to maintain a robust and resilient infrastructure that is highly available, but also to provide access for increasing numbers of clinicians as we move away from the paper records.

The approval of the Health Board Strategic Outline Programme (SOP) for Informatics provides the vehicle for business cases to be submitted for individual projects over the next three to five years, ensuring that there is a sustained long term period of Informatics investment to support the Health Board's service improvement strategy.

The Informatics plans describe a radical change over the next 3-5 years as we move from paper to electronic records with effective electronic workflow. During this transition period the Informatics Directorate will require additional resources in both Clinical Coding and Health Records in order to maintain/improve existing performance with the paper-based legacy whilst in parallel creating and adopting new ways of working. Details are included in the financial spreadsheet.

In summary this programme is aimed at delivering:

- Quicker and easier access
- An Improved ability to manage patient flow
- Efficiencies at a departmental level
- ICT integration with Mental Health and Social Services
- Information on patient experience
- Improved performance data

## 9.2.2   Service Change

The table below describes out list of actions for the next three years.

| Effective use of information systems and use of technology | Service Changes |
|---|---|
| | **2015/16** |
| | • Tech refresh to maintain services and enable innovation |
| | • Introduction of a scanning solution to support the transition from paper to electronic records and workflow – and resolve ABMU's significant duplicate record legacy |
| | • Further development and innovation to support patient flow, bed management, clinical work flow and clinical data capture/audit, including: doctor/nursing handover; nursing assessments, VTE assessments, NEWS, PSAG/Board round |
| | • Provision of all pathology and radiology results/reports via the Welsh Clinical Portal (WCP) – including access to all results available across |

|  |  |
| --- | --- |
|  | Wales* |
|  | • Implementation of Electronic Test Requesting for Primary and Secondary Care* |
|  | • Implementation of a patient documents module of the portal to initially provide: referral letters, OP clinic letters, discharge summaries, operations notes, casualty cards and lung function test results |
|  | • Implementation of the WCP IHR across all emergency care settings* |
|  | • Implementation of electronic referral workflow in secondary care* |
|  | • Implementation of ePrescribing in the Outpatient setting |
|  | • Implementation of the National Emergency Department System (Symphony)* |
|  | • Implementation of the National PACS system (Fuji)* |
|  | • Implementation of the National Cardiology PACS system* |
|  | • Development and innovation of mobile applications to further enable service efficiencies |
|  | • Complete implementation of the National Pathology System (LIMS)* |
|  | • Implementation of a pre-assessment workflow solution |
|  | • Implementation of a single Endoscopy system |
|  | • Introduction of self-registration and outpatient flow in Morriston New Outpatients |
|  | • Introduction of digital dictation as part of next phase of Morriston development |
|  | • Introduction of the National Open Eyes Ophthalmology Patient Record System* |
|  | • Submission of electronic discharge summaries and clinic letters to primary care  - replacing the paper* |
|  | • Provision of all pathology and radiology results to primary care* |
|  | • Introduction of further performance dashboards, including: a Ward Dashboard, a Consultant Dashboard, Maternity Dashboard etc. |
|  | • Introduce SharePoint 2013 for clinical and corporate communication, workflow, eforms, document management etc. |
|  | • Organisation wide mobilisation of the workforce including BYOD |
|  | **2016/17** |
|  | • Tech refresh to maintain services and enable innovation |
|  | • Further implementation of the scanning solution to support the transition from paper to electronic records and workflow |
|  | • Further development and innovation to support patient flow, bed management, clinical work flow and clinical data capture/audit, including: infection control statuses, ePrescribing alerts/next actions, patient location e.g. In Theatre |
|  | • Access to more electronic patient documents, including National |
|  | • Access to National Radiology images* |
|  | • Implementation of ePrescribing and electronic drug administration in the ward setting |
|  | • Implementation of an eObservation system |

|  |  |
|---|---|
|  | • Further Outpatient modernisation with the introduction of SMS and email communication for appt booking |
|  | • Further implementation of digital dictation |
|  | • Implementation of the RADIS (Radiology management) system in Swansea |
|  | • Implementation of the National Community Care Information Solution (CCIS)* |
|  | • Further development and innovation to support patient flow, clinical work flow and clinical data capture/audit |
|  | • Further development and innovation of mobile applications to further enable |
|  | • Service efficiencies Wireless infrastructure at Singleton Hospital |
|  | • Introduction of further performance dashboards |
|  | • Further implementation of SharePoint 2013 for clinical and corporate communication, workflow, eforms, document management etc. |
|  | **2017/18** |
|  | • Tech refresh to maintain services and enable innovation |
|  | • Further implementation of the scanning solution to support the transition from paper to electronic records and workflow |
|  | • Introduction of self-registration and outpatient flow across other sites |
|  | • Further implementation of the National Community Care Information Solution (CCIS)* |
|  | • Further development and innovation to support patient flow, clinical work flow and clinical data capture/audit |
|  | • Further development and innovation of mobile applications to further enable |
|  | • Introduction of further performance dashboards |
|  | • Further implementation of SharePoint 2013 for clinical and corporate communication, workflow, eforms, document management etc. |
|  | * Local implementation of the National Programme. |
|  | **Impact** |
|  | • Easier and quicker access to patient information |
|  | • Increased ability to manage patient flow effectively |
|  | • Improved management of patient pathways |
|  | • Improved efficiencies in the use of theatres |
|  | • Improved communications between primary and secondary care, including quicker and better quality discharge summaries |
|  | • Improved ICT integration with Mental Health and Social Services |
|  | • Electronic data sharing across Wales – South Wales Programme |
|  | • Improved information on patient experience |
|  | • Improved performance data |

Over the next 3 years, the successful implementation of the technology solutions listed above will support significant service modernisation and efficiencies across primary, secondary and community care. All are based on the fundamental principle that *high quality care in the 21st century cannot be delivered with paper based information recording and delivery*.

# 9.3 Infrastructure – Capital Estate

## 9.3.1 Primary Care facilities

Development of the Primary Care Estate has presented its own challenges. Approval has now been received to develop Primary Care Centres at Briton Ferry, Vale of Neath and Brynhyfryd. It is anticipated that these facilities will open towards the end of 2015.

A Primary Care scheme for Mayhill is presently being progressed in partnership with the City & County of Swansea.

A baseline mapping of primary care estates issues is underway. An initial assessment, which has not yet been completed, has highlighted a number of issues that will need to be considered in the context of the three year Plan. There has also been a recent change in process for determining priorities and considering how estates developments will be funded by Welsh Government – the impact of which is still being assessed.

A Primary Care Estates Steering Group has been established with the following priorities identified for 2015/16:

- Undertaking a comprehensive review of the Health Board and GP owned estate in terms of its functional suitability and service utilisation to inform a potential investment programme for improvement grants

- Considering strategic options for the location of administrative bases for community based staff, including options for co-locating staff with other areas such as social care, as part of the development of integrated care services

- Establishing a clear review and inspection programme for the primary care estate that reviews the functional suitability and compliance with statutory legislation (within the contract requirements)

- Identifying options for rationalising the estate including the use of branch surgeries, poorly utilised community clinics and minimising the use of clinical space for administrative duties as part of the use of technological solutions for community service staff (Health Technologies Programme)

- Aligning estates plans with the wider development of community networks

- In light of devolution of responsibilities for managing primary care estate, establish clear processes for decision making and providing assurance to the Board on the quality and delivery of the primary care estate.

### 9.3.2    Morriston Hospital

The current redevelopment of Morriston Hospital must be seen in the context of resolving the inadequacies that have been present for a number of decades.  This must be regarded as the start of the remodelling of the hospital and not the end.

It is becoming increasingly clear that Morriston Hospital will need to be continued to be developed in order to enable it to deliver the services of the major acute hospital.  In future, it will be the only hospital within Swansea

with a medical intake and it is ideally situated to support services in Neath Port Talbot and West Wales and the changes that are required are as follows: -

- The need for wholesale demolition of the redundant estate.

- Upgrading and essential engineering work for the remaining part of the hospital built in 1985 and 1997.

- Capacity to support the accommodation requirements of the Hospital Services Project under Changing for the Better

- Increased accommodation for Unscheduled Care.

- Improved and increase physical accommodation for the interim solution for the Cardiac Centre.

- Additional Critical Care facilities.

- Transfer of the Maternity, Neonatal and Gynaecology service from Singleton Hospital.

- Upgrading of Renal facilities.

The Strategic Change programmes set out in section 6 above relate principally to developing increased accommodation for unscheduled care on the Morriston Hospital site. Our priority within the Hospital Services project under Changing for the Better is to commence with this development first as it marks a sequence of events within the Hospital services plan to reconfigure services.

The Health Board has recently acquired additional land around the Morriston Hospital site and is in the process of acquiring more land. As mentioned above, we are developing a scoping prospectus (ARCH) for the potential development of this land which will be submitted to Welsh Government before the end of 2014/15. This provides the Health Board, with partner organisations, the opportunity to develop an exciting, innovative and unique

health campus within will bring significant improvements to the health and broader economy of South West Wales and beyond. It Welsh Government approves the scoping prospectus we will develop a Strategic Outline Programme for further consideration during 2015/16.

### 9.3.3    Singleton Hospital

Over the next 5 years there will be changes in the range of services that will be provided by Singleton Hospital. There will need to be significant investment to remodel the physical accommodation and also investment into the physical and engineering infrastructure of the hospital.

Additionally a robust and realistic replacement programme for the Linear Accelerators needs to be agreed with Welsh Government. See Table 24 above.

ARCH equally applies to Singleton Hospital and indeed, community services within Swansea so as part of the development referred to above at Morriston Hospital we are also working closely with Swansea University to develop joint proposals for the future use of facilities and the site at Singleton Hospital.

### 9.3.4    Princess of Wales Hospital

The outcome of the South Wales Programme was agreed in March 2014. The Princess of Wales Hospital will become a Regional Centre when it is anticipated that significant capital works will be required. This capital requirement cannot be assessed as yet but as the service models emerge more precise assessments can be made.

Irrespective of the outcome of the South Wales Programme it will be necessary for investment into the physical and engineering infrastructure within the hospital.

### 9.3.5    Mental Health Services

Both Cefn Coed Hospital and Glanrhyd Hospital have undergone considerable transformation over the last 5 years. With the approval of the Full Business Case for the Low Secure Unit, only the following elements are outstanding.

- Adult Acute Assessment facilities for the Health Board;
- Older People's Assessment Beds for Swansea;
- Day Care facilities for the West of Swansea;

At the end of 2014/15 we will receive the handover of the new low secure facility (Taith Newydd) at Glanrhyd Hospital which will be commissioned in March 2015. This then leaves 4 wards at Cefn Coed Hospital in Swansea and the outline capital plan set out in table 26 above has provision for an acute mental health unit and an older peoples' mental health assessment unit

which will then enable the closure and disposal of the Cefn Coed Hospital site.

The disposal of the remainder of the old part of the Cefn Coed site can only proceed with the reinvestment of the sale proceeds, which would allow the site to be vacated.

Proposals will be included within the mental health strategy referred to in Section 6.

### 9.3.6 Bridgend

- Development of Maesteg Community Hospital as a primary care resource base with a consequent relocation of Bron y Garn and Nantyfyllon Surgeries

- Porthcawl – development of a new surgery to incorporate Portway and Victoria Road surgeries

- Aberkenfig – redevelopment of existing surgery

### 9.3.7 Neath Port Talbot

- Cimla Hospital – redevelopment into a base for primary and community services has been completed.

- Dyfed Road – strategic solution to accommodate population growth and service pressures in Neath Town Centre

- Cwmavon /Afan Valley– dealing with the poor fabric of the estate

- Upper Swansea Valleys – addressing the security of tenure issues and ensuring a sustainable service solution.

- Partnership development through a third party development to re-provide services from the former Briton Ferry health Centre into a fit for purpose modern facility at Baglan Quays.

- Coed Darcy – meeting the demand for access to primary care as a result of new housing developments

### 9.3.8 Swansea

- Identifying a solution to the constraints within Dyfatty/High Street area

- Finalising proposals for Gorseinon Hospital.

## 9.4 Innovation

We recognise that there are many untapped opportunities for us to be innovative in how we deliver care ourselves and in partnership with others. As a University Health Board, we have both opportunities and responsibilities

to maximise our collaboration with academic partners to benefit our patients, our staff, the academic sector, the local economy and Wales more widely.

We have set out our intentions to innovate through our memorandum of understanding and collaboration agreement with Swansea University and will seek similar agreements with others. These relationships will be not just with direct health related partners but also engineering, mathematics, business, enterprise and entrepreneurship. We will give due consideration to Intellectual Property (IP) protection to ensure that financial benefits flow appropriately to the NHS.

In future we will encourage our clinicians to consider opportunities for innovations in how clinical care is delivered and to develop technologies and devices in partnership with others which could bring inward investment into Wales and technology transfer out of it, whilst benefitting our patients.

We wish to build on our collaboration with the Medical Research Council (MRC) Farr Centre for Health Informatics Research in the Institute of Life Sciences for innovative analysis of the wider impacts and determinants of health for citizens and to understand better the effect of changes of how care is delivered across all sectors of healthcare. Our recent joint award to increase the utility of the SAIL database will bring significant benefit for NHS Wales and makes best use of the integrated approach to health and social care. We are submitting bids to introduce innovation in "out of hospital" settings.

We will also seek innovative solutions to the financial challenges facing us. We will develop different ways of working with others across sectors in Wales to maximise the opportunities for capital investment, external funding grants and loans for the mutual benefit of our patients and citizens.

ABMU will lead the South West Wales Regional hub of the Academic Health Science Collaboration (AHSC). We will seek to build strong partnerships with the life sciences industry to capitalise on our status as an Integrated Health Board with access to outcomes data.

Our 2015-2018 ABMU Research Strategy facilitates regional collaboration and integration across healthcare themes. We will build on the well-established local clinical & academic research partnerships.

ABMU is recognised as an organisation which engages with Industry sponsored research. Our plan is to continuously improve our active engagement with local, national and international Industrial partners (technical & pharmaceutical). Working together with Pharma in this way will ensure full access to novel treatments for our patients. We also recognise our responsibility to generate employment through innovation and deliver regional economic benefits. Equally, collaboration with the Third sector will be a key aspect of our research focus to deliver the improved patient

outcomes from application of the principles of prudent healthcare and co-production.

Our plan recognises the importance of translational research, innovation and effective Intellectual Property management as defined outputs of a vibrant research culture. There will be a focus to ensure, wherever possible, the population of ABMU and our staff gains optimum benefit from our engagement with Industrial partners.

**Our Aims for Innovation are to:**

- Improve & innovate through programmes focussed on principles of prudence and co-production.

- Develop curricula to embed co-creation, innovation, research and development in core practice.

- Make joint appointments of staff between ABMU and University partners and deliver research collaboration from undergraduate to postgraduate level to help attract and retain the very best staff.

- Maximise the potential of an Integrated Health Board to increase participation in research projects and drug trials by improving ability to recruit large numbers of participants, complete studies rapidly at minimal cost.

- Increase the quality and quantity of research generated.

- Embed a system of working where clinical teams generate their own knowledge and use this for continuous improvement

- Widen the active participation in research, development and innovation.

- Increase income from research grant and commercial funding.

- Develop clinical and research networks

- Develop a culture of continuous learning within Health Board staff.

- Develop and embed the co-creating health framework in all of the service provision, service design, education, research, enterprise and partnership work of the Health Board.

- Develop cross-cutting themes to support: knowledge management, integration and sustainability, population healthcare, commercial and non-commercial trials of pharmaceuticals, health technology assessment, and service delivery and organisation, genomics, informatics and technology, and patient and public engagement and involvement in research and innovation.

- Rapidly translate innovation into meaningful outcomes for patients.

- Deploy the financial benefits from full engagement with research programmes.

- Develop effective governance models for the management of R&D.

## 9.4.1 Research and Development

Our aims for Research and Development are to:

- Establish the ABMU area as a leading health economy for Innovation, Research and Development

- Maintain and enhance effective joint research governance and collaboration with Universities

- Actively support innovation maximise benefit from associated Intellectual Property Rights (IPR)

- Maintain current clinical areas of innovation, research excellence and identify and support areas of growth for new activity

- Support the development of a learning culture which actively promotes innovation and research in promoting the 'U' of ABMU

The table below describes how we will achieve these aims.

**Table 33 : Research and Development, strategic aims and objectives**

| Strategic Aim | Objectives |
|---|---|
| **1:**<br><br>**Establish the ABMU Area as a leading health economy for Innovation, Research and Development** | This will be achieved by<br><br>• Employing collaborative and integrated approaches to developing regional research activity, for the benefit of improved patient outcomes, with particular focus on prudence and co-production.<br><br>• Delivering on NISCHR Key Indicators.<br><br>• Supporting implementation of Practice Innovation techniques and involvement in health and social care research programmes.<br><br>• Achieving Centre of Excellence status with Pharmaceutical companies and maintaining preferred site status.<br><br>• Ensuring rapid start up times and completion on target for research programmes.<br><br>• Delivering on target for 1st patient recruitment within 30 days.<br><br>• Increasing primary care involvement in research.<br><br>• Increasing the number of ABMU staff awarded protected time for research via the NISCHR clinical research fellowship programme.<br><br>• Increasing the number of ABMU Chief/Principal Investigators and attraction of research grants across both clinical and non-clinical research programmes.<br><br>• Developing joint research projects and programmes with university staff<br><br>• Enabling staff to develop research portfolios as part of |

| Strategic Aim | Objectives |
|---|---|
| | education qualifications |
| **2 :**<br><br>**Maintain and enhance effective joint research governance and collaboration with Universities including Swansea, Cardiff, University of South Wales, Trinity St David's and Cardiff Metropolitan University** | We will achieve this by:<br><br>• Ensuring operational success of the Joint Clinical Research Facility (JCRF). The JCRF is a joint clinical research initiative between the Health Board and Swansea University, housed within the ILS2 and Morriston Hospital and will offer new opportunities to engage in early stage clinical trials, in partnership with SIMBEC, a Phase 1 specialist clinical research company and other companies where appropriate.<br><br>• Enabling increased capacity for research programmes requiring imaging via the dedicated imaging suite within ILS2, thereby easing the pressure of clinical trial radiology requirements within the clinical service.<br><br>• Maintaining robust collaborative sponsorship and effective governance arrangements with Swansea University through the continued use and development of Joint Standard Operating Procedures and delivery of a consistent approach to research governance management issues.<br><br>• Developing robust collaborative sponsorship and governance arrangements with other Universities through the continued use and development of Joint Standard Operating Procedures and delivery of a consistent approach to research governance management issues<br><br>• Maintaining and enhancing R&D Quality Assurance processes to monitor and govern cross-Organisational R&D activity.<br><br>• Develop a Joint Communications Strategy for Innovation.<br><br>• Develop a Joint Commercialisation Strategy for Innovation<br><br>• Develop plans for new facilities for the JCRF at Morriston: "ILS@Morriston". |
| **3 :**<br><br>**Actively support innovation within ABMU and maximise benefit from associated Intellectual Property Rights (IPR).** | We will achieve this by:-<br><br>• Increasing the Intellectual Property (IP) portfolio of the Health Board, through successful application to national innovation schemes such as the NISCHR INVENT scheme and building on existing collaborations with academic partners.<br><br>• Developing shared JCRF IP management processes with Swansea University to facilitate greater benefits from IPR exploitation.<br><br>• Actively promoting ABMU Health Board as an Organisation "open for business" - keen to engage with the business community on collaborative research programmes and commercial collaborative investigator-led studies.<br><br>• Actively engaging with academic partners to explore and develop collaborative research programmes involving novel technology & service design. |

| Strategic Aim | Objectives |
|---|---|
| **4:**<br><br>**Maintain current clinical areas of innovation, research excellence and identify and support areas of growth for new activity** | We will achieve this by:<br>• Strategically allocating the R&D budget to support health professionals' access to necessary resource to develop areas of research expertise, aligned to NISCHR priorities.<br>• Supporting the development of research through the provision of a research design service provided by our Partner Clinical Trials Unit in Swansea University and the AHSC funded methodology specialist posts.<br>• Delivering an effective research governance sponsorship service for in-house research.<br>• Maintaining a robust scientific peer review process for in-house research, as delivered by the Joint Sponsor Review Committee, a joint Committee with Swansea University.<br>• Providing specialist training opportunities for ABMU staff on research methodologies and good clinical practice.<br>• Supporting researchers with external grants through effective use of networking and membership within various national groups such as MediWales. |
| **5 :**<br><br>**Support the development of a learning culture which actively promotes innovation and research in promoting the 'U' of ABMU.** | We will achieve this by:<br>• Utilising joint appointments with Swansea University Colleges of Human and Health Sciences and Medicine to instil culture of research and evidence-based decision making<br>• Exploring how research and development opportunities embedded with educational courses can be used to address specific organisational 'problems'<br>• Increasing capability and capacity through successful bidding to NISCHR investment schemes and performance management of posts funded via NISCHR.<br>• Supporting NISCHR funded posts using the R&D budget and through the strategic investment of R&D funds according to research priority areas.<br>• Supporting clinicians and managers to collaborate with university colleagues to introduce and evaluate service improvement & innovation initiatives.<br>• Supporting and providing training opportunities for staff to engage in research activity, in particular, by attracting commercially sponsored research to the Health Board, thereby offering opportunities for new Investigators to gain exposure to research and enhance their skills within a structured programme of activity.<br>• Identifying the budget lines for the income generated and cost savings from commercial research activity and actively encouraging clinical teams to utilise this benefit to engage in further research programmes. |

| Strategic Aim | Objectives |
|---|---|
| | • Ensuring all senior medical and non-medical staff job plans have the potential for R&D activity and active University involvement via relevant R&D funding streams. |

## 9.5 Collaboration and Partnership Working

For us to deliver on our priorities and make a real difference to the health and wellbeing of its population, co-production and partnership working are critical principles which need to underpin everything we do.  In particular making sure that all our partners and stakeholders work with us to identify what services need to change and what our priorities should be, and then work with us to design these changes, implement them and evaluate them in order to deliver the best possible outcomes for the public, patients and their carers.

### 9.5.1   Working with the Public, Patient and Carer Groups

In line with the Principles for Public Engagement (signed up to by the Board and based on the NHS Wales Guidance for Engagement and Consultation on Changes to Health Services) we have a well-established and comprehensive approach to continuous engagement with stakeholders, as well as formal public consultation when required.  This is targeted at particular client groups by disease group and age group – for example Children & Young People's Forums, Older Peoples Networks.

In conjunction with the Abertawe Bro Morgannwg Community Health Council, our Health Board works with all its partners and stakeholders on an ongoing basis to involve them in our work and the changes we plan.  We use a variety of mechanisms, some regular, some *ad hoc*; to make sure we involve people appropriately in our work, and in a way which supports their ongoing engagement.

 Our approach is based on the principles of co-production in how we work and introducing this approach throughout the organisation at all levels in order to live our values of "Caring for each other, Working Together and Always Improving".  A key part of this will be about working together with our staff, partner organisations, patients, carers and their families in all that we do, from individual care planning through to significant strategic service change.

The first objective of our Quality Strategy is "To plan our services with the people  living in the communities we serve, so that they are person centred, caring and responsive to need" (section 5.3.1), and this will underpin our approach to all ongoing engagement activities.

## 9.5.2    Working Together with Statutory Partners

It deliver its priorities, our Health Board needs to work increasingly closely with a range of other statutory organisations and sectors. These critically include the Local Authorities within the ABMU area, and those bordering the area. With the three Local Authorities we have formed the Western Bay Partnership, a formalised arrangement for taking the integration of key services forward on a regional basis, particularly focusing on Children and Young People, Mental Health, Learning Disability and Community Services in the first instance. With the emerging picture of regionalisation arising from the Williams Commission, we will work with partner Local Authorities according to the changing organisational structures to ensure that this work continues to progress at pace.

In addition to Local Authorities we work with a range of other statutory Authorities such as the Police, Probation, Prisons, Fire and Natural Resources Wales on particular areas of common interest.

The UHB fully support the development and implementation of the Single Integrated Plans through our local partnership arrangements. We welcome the requirement to make Public Service boards statutory partnerships under the Future Generations Bill, and we will be strengthening our contribution to these arrangements.

## 9.5.3    Working Together with Other Health Organisations

We also work with other Health Boards across South Wales and Wales as well as organisations beyond Welsh borders to deliver a full range of services for our population.

The main areas where we are working together at present are through the South Wales Collaborative and Acute Care Alliances, details of which are included in Section 6.

Through the Welsh Health Specialised Services Committee within Wales we all work together to plan and commission very specialist health services. These arrangements are linked with our partners in England where appropriate.

We also have a key relationship and common work programme with the Welsh Ambulance Services Trust both in relation to their emergency ambulance service and the transition from national to more local non-emergency ambulance services. As the Health Board plans service changes over the three year period, transport and patient accessibility will be key considerations, and implementing the outcomes of the South Wales Programme will have a significant impact on services. The Health Board will work with partners in local authorities, third sector and other health boards and trusts to ensure that improved options for transport to our services are is available for patients, carers and service users where possible. This will

include consideration of innovative ways of developing transportation services to better meet patients and carers needs

Fundamental to achieving a wide range of our priorities is the key alignment of work programmes of Public Health Wales and our Health Board, particularly in relation to the wider determinants of health and reducing health inequalities in our area. The public health priorities of both organisations are completely aligned.

### 9.5.4    Working together with Other Sectors

We have a well-established relationship with the third sector both on a local and national level, with a strong commitment and experience of joint working, partnerships and co-production.  These relationships operate at both a strategic level through the Councils of Voluntary Services and Third Sector Forums across the area, and also operationally as services support the clinical services and other interventions we provide or commission.  We will continue to strengthen these relationships by focusing on joint work around cross cutting strategic agendas such as Child Poverty and Domestic Abuse.

Housing Associations, private and not for profit residential, nursing and domiciliary care providers are also key sectors who we increasingly work with on mutual agendas. We expect to hold a joint Health & Housing conference during 2015/16 to recognise and explore the potential opportunities of working together.

Over the past few years issues of transport, particularly public transport to and from our hospitals and other sites where we provide services has been a constant theme and increasingly one we need to strategically lead with our partners in Local Authorities and Public Transport and community transport providers.  We already have established mechanisms for discussing common issues, but this has in the past tended to be reactive once changes occur and our intention as a Health Board is to move towards more strategic planning for transport services, including building capacity in the system to improve access to our services.  This will include trialling some innovative approaches to transport alternatives in partnership with Local Authorities, transport providers and the University.

### 9.5.5    Working together with Education Establishments

As a Health Board we work with Primary, Secondary schools and Colleges on some issues of mutual interest, but increasingly we recognise the important role these institutions can play in taking some of our priorities forward.  We have learnt a lot from the links we had to establish during the Measles outbreak in particular, and are committed to developing these links in a more ongoing way in future.

We have a formal collaborative arrangement in place for the Universities in our area, including importantly (but not exclusively) the Schools of Medicine,

Schools of Nursing and Health Sciences, as well as well-developed links for Research and Development and partnership working in relation to the Institute of Life Sciences in Swansea. Further detail is included in sections 2.3.13, 7.2.1 and 9.4.

## 9.5.6 Working together with Equality Groups:

We continue to strengthen the ways in which we work together with people who have protected characteristics under the Equality Act. In particular making links with Churches / faith groups, Black and Minority Ethnic groups, older people, disability groups, pregnant women, Lesbian, Gay, Bisexual and Transsexual communities, the homeless, women's groups and developing a range of ways in which we can engage these groups on consideration of our plans, priorities and development is critical to ensuring that we understand any differential impacts of these on these protected groups. The Health Board has specifically set up its Stakeholder Reference Group to make sure that there is representation from each of these protected characteristics on this Group, which has a scrutiny role for any aspect of Health Board work. The Chair of the SRG attends all Health Board meetings, and feeds back on issues and concerns raised by the Group.

# 10 Effective Governance

> This section of the Integrated Medium Term Plan sets out the planning, delivery and assurance model for the Health Board. Set out below are descriptions of the systems we will have in place to ensure that the planning culture is embedded. This should be read in the cognisance that we have committed one of our 6 strategic aims to the delivery of Effective Governance.

## 10.1 Operating Model – planning model and cycle

We are in the final stages of implementing a new planning and commissioning model, which will build on the guidance in 'NHS Wales Planning Framework[1]'. We have engaged with local stakeholders to support us in the development of this model and to ensure that we learn from our collective experience of developing the current IMTP.

The implementation of this model will form part of an overall organisation development programme, to support our staff in adopting new ways of working.

Board Committee structures have been revised and a new performance reporting framework is now in pace.

## 10.2 Delivery/management arrangements

The current structures have been in existence mostly since 2009:

- Clinical Directorates – with the primary objective of joining up "East" and "West" (the former NHS Trusts), and to develop common standards and protocols

- Localities – with the primary objective of integrating medicine, community and primary care services to shift the balance of care, and maintaining a focus on the Local Authority footprint (the former Local Health Boards)

These structures were appropriate at the time and have made good progress on achieving these objectives. Five years on however, other issues have emerged, and new challenges exist as we have set out in the case for change. These issues challenge the appropriateness of these structures to deliver our plans for the next few years.

Particular criticisms of our current structures have appeared in both the AQUA and Trusted to Care reports into quality and safety in our hospital services. They have raised concerns about clarity of accountability in particular – and whether it is clear to patients and staff who is in charge of individual sites and services.

Following the listening events in the summer we decided that any new operational management arrangements should aim to achieve the following:

- Be easier to understand for staff and patients – "does what is says on the tin"

- Accelerate progress on new models of primary and community care, shifting the balance

- Be patient-facing – based on how patients experience our services rather than specialties or professions

- Improved visibility for staff - fewer "layers", shorter lines of communication between senior management and frontline teams

- Create clarity about who is responsible and accountable at all levels and on all sites

- Allow more devolution of responsibility and decision making to local teams

- Be a better framework for joined-up working about service improvement, major operational challenges and performance issues

- Have more local ownership and clinical engagement

We are therefore planning to replace the current Directorates and Localities – 13 in total - with the following 6 delivery units:

**Figure 23 :  Diagram of proposed management structure**
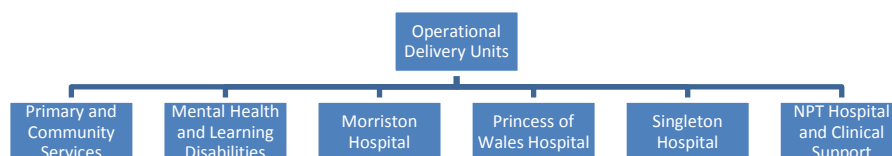


As far as possible, each of these delivery units will be responsible for all of their own services although will be a need for a small number of services to be hosted by one unit on behalf of others as it would not be feasible to disintegrate them – for example, pathology.

Each of these delivery units will be led by a management team comprising a Service Director, Unit Medical Director and Chief Nurse.   .

Corporate departments and functions will need to adjust accordingly to allow the delivery units to work with a high degree of autonomy.

We expect these arrangements to be in place by October 2015.

## 10.3    Corporate Governance

### 10.3.1    The Board

Our Health Board is made up of a Non Officer Chairman and Vice Chairman, with a Chief Executive, Executive Directors and Non Officer Member (NOM) / Independent Members (IM) and Associate members.   Our Board is responsible for:

- **Setting the strategic direction of the organisation within overall policies and priorities of the Welsh Government and the NHS**
- **Establishing and maintaining high standards of corporate governance**
- **Ensuring delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility**
- **Ensuring effective financial stewardship by effective administration and economic use of resources**
- **Ensuring effective communication between the organisation and the community including stakeholders regarding planning and performance and that these arrangements are responsive to the locality's health needs**
- **Appointing, appraising and remunerating executives**

Our Board functions as a corporate decision making body and its principal role is to exercise effective leadership, direction and control.   Executive Directors and NOMs are full and equal members sharing corporate responsibility for all the decisions of the Board.

Our Board meets every other month in public, details of meetings are posted on the Boards internet site. The Board also holds bi monthly development sessions to consider its development needs and discusses future development proposals.

In early 2014 the Chairman and Chief Executive led a review of the governance and management arrangements supporting the determination of the Board to develop a values based organisation which genuinely put the needs of citizens: patients and communities at the heart of the organisation and seeks to free the creativity of staff to deliver better services

The aims of the review was to

- Ensure that the Board strategically leads a system of healthcare in addition  to the short-term operational management of clinical services
- Ensure the continuing development a clear strategic (commissioning) agenda for health and healthcare improvement and develops the capacity and capability to do so.

- Ensure a simpler, easier to understand management structure where there is devolved responsibility and accountability.

- Fulfil the potential for an integrated "citizen centred" service.

Following this review the Board agreed revisions to the portfolios of Executive Directors and proposals for restructuring the operational management arrangements which are due to be consulted on in February 2015.

## 10.3.2 Board Governance

One of the strategic aims recently adopted by the Board is "Effective Governance". Governance is led and overseen by the full statutory Board. The Board governs a large and complex system of healthcare and the expectations of Welsh Government and the public are always increasing, therefore enabling the Board to do its job through the creation of the right accountable committees is seen as a priority. The role of the Board in deciding on strategy, making strategic decisions and holding the executive to account for delivering safe services can only be carried out if discussion of some of the important detail is undertaken by committees. Committees can escalate issues to the Board and the Board can delegate issues to committees. In order to conduct its business efficiently and effectively and particularly given its size and complexity the Board relies on the advice of the committees.

As a result of the review of governance the Board agreed the following committee structure.

**Table 34 : Showing the Health Board Committee Structure**

| Committee | Role |
|---|---|
| Audit Committee | To provide advice and assurance to the Board on issues of effective governance |
| Quality and Safety Committee | To provide assurance to the Board on all matters associated with the quality and safety of clinical services and oversees the Board's clinical governance arrangements |
| Remuneration and Terms of Service Committee | – To advise the Board on the remuneration and terms of service of executive directors and other senior officers<br>– To assure the Board on the remuneration and terms of service for other staff |
| Workforce and Organisational Development Committee | To provide assurance and advice to the Board on workforce and organisational development matters |
| Strategy, Planning and Commissioning Committee | To provide assurance and advice to the Board on the development and execution of the Board's clinical and commissioning strategy and to oversee the continued development of the IMTP |

| Performance Committee | To provide assurance and advice to the Board on the full range of performance indicators adopted by the Board through its strategy and plans and the "balanced scorecard" adopted by Welsh Government. It will refer appropriate matters to other Board committees e.g. the Quality and Safety Committee where they merit closer scrutiny |
|---|---|
| Mental Health Act Monitoring Committee (including the Hospital Managers Power of Discharge Committee) | *Mental Health and Learning Disabilities Committee.*<br>To receive national and local reports that impact on the provision of Mental Health and Learning Disabilities Services and oversee compliance with the Mental Health Act. |
| Pharmaceutical Application Funds Committee | To deal with applications to and changes to the pharmaceutical list for the Board |
| Charitable Funds Committee | - To ensure that the Board's rules on investing charitable funds are followed<br>- To apply charitable funds in accordance with their governance rules |

The Welsh Health Specialist Services Commissioning Committee and Emergency Ambulance Committee are also joint committees of the Board run with the other six Health Boards in Wales as required by Welsh Government.

There are also three forums which allow the Board to seek advice from and consult with staff and key stakeholders; they are the:

- **Local Partnership Forum** - The forum provides a formal mechanism for the Health Board (as an employer) and Trade Unions/Professional Bodies (representing the Health Board employees) work together to improve health services for the citizens of the ABM area.
- **Stakeholder Reference Group** - This group provides a forum to facilitate full engagement and active debate. Its membership includes elected representatives for protected characteristic groups under the Equalities Act. Members also include statutory bodies such as the Local Authorities, Police, Fire and Rescue and Environmental Agency etc. The group has a remit to examine any aspect of the Health Board's work in relation to how it affects stakeholders.
- **Health Professionals Forum** - The role of this forum is to provide balanced, multidisciplinary professional advice to the Board on local strategy and delivery. The forum has responsibility for facilitating engagement and debate amongst a wide range of clinical interests within the Health Board's area of activity

The Chairs of each of the above groups attend Board meetings to ensure that equality issues are central to the Health Board's agenda.

The roles of these forums will become increasingly important as the Board makes transformational changes and decisions on priorities to reflect the challenges it faces.  These arrangements are overseen by the Chairs Advisory Group.

## 10.3.3    Assurance

The Board has a number of ways it receives assurance in addition to that provided through the Board Committee structure. These arrangements are set out in a document (the System of Assurance) which have been updated to take account of the revised arrangements and is subject of regular reporting to the Audit Committee and will be reported to the Board. Some of the key documents that support this process are

- The Annual Report
- The Annual Governance Statement
- The Annual Quality Statement

## 10.3.4    Performance Management and Reporting Framework

The objectives and KPIs in the Integrated Medium Term Plan will form the basis of our performance management and reporting arrangements, which will include a regular review of risks and any actions required to mitigate these. For example:

- Monthly Directorate/Locality Performance reviews chaired by the Chief Operating Officer, supported by key executive colleagues. Half yearly and annual Performance Reviews are chaired by the Chief Executive.

- Each Strategic Change Programme being overseen by the Changing for the Better Delivery Board, which meets monthly and is chaired by the Chief Executive.

- Regular reporting to the Board and Board Committees.

This will provide assurance that the implementation of the Integrated Medium Term Plan will have rigorous governance arrangements. Figure 24 below illustrates how the performance management arrangements support reporting to the committees described in 10.3.2 above with escalation through either the Executive Team or the Annual Plan Implementation Group as required.

**Figure 24 :  Performance management**



Subject to negotiation and agreement
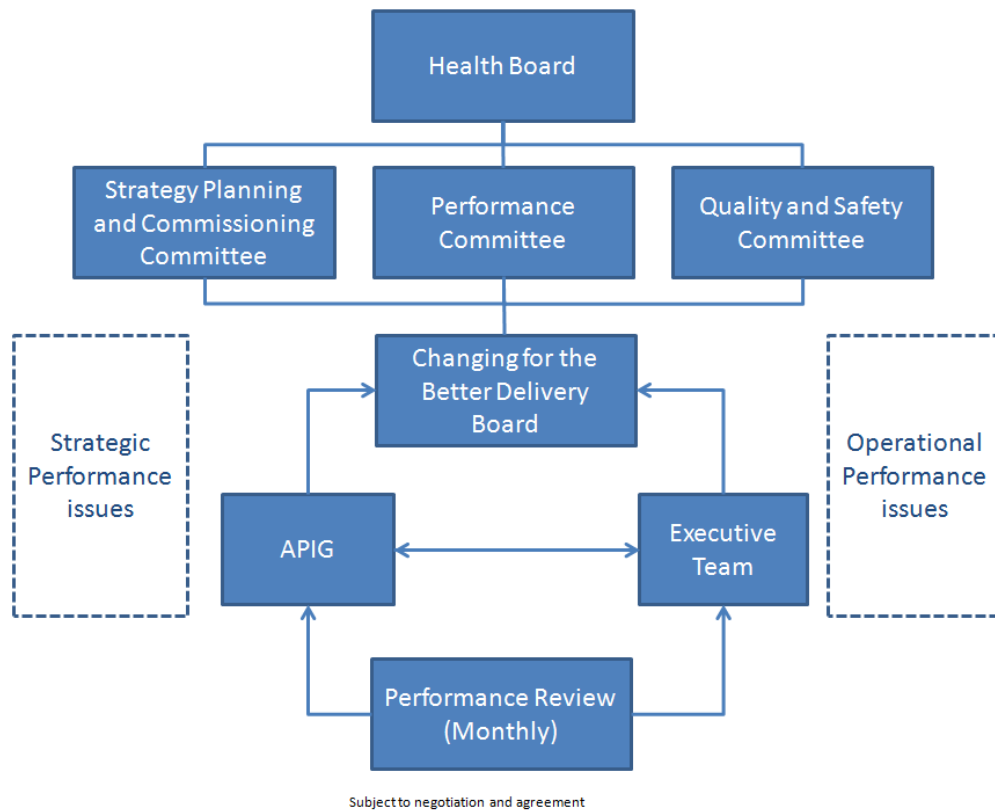
### 10.3.5   Performance Management Framework

A Delivery and Accountability Framework for our Directorates and Localities is in place. This is based on monthly performance review meetings, which feed into our Board Integrated Performance reports.  These reports set out current performance against agreed indicators in the IMTP and are cross referenced to the risk register.

## 10.4   Risk Management

Effective risk management is integral in enabling our Health Board to achieve our objectives, both strategic and operational in delivering safe, high quality services and patient care. We manage risk within a framework that devolves responsibility and accountability throughout the organisation.  The Framework sets out the levels at which staff groups are responsible and can take action and when they have to escalate risks above their agreed tolerance level.  All risks identified, once qualified, which have a risk rating of 16 or more are required to be discussed at the Risk Management Review Group as this has been set for the tolerance limit of high risks when decisions need to be considered as part of a specialist group within the organisation.

We run a Management Training Programme providing training at two levels:

Level 1 is available to all grades of staff and is part of mandatory/statutory training.  The training provides an overview of risk management as well as how to complete a risk assessment and highlights the importance of identifying mitigating actions to reduce and manage those risks.
Level 2 training is provided to managers of band 6 and above.  The training is practical and informative and enables managers to identify and take mitigating action to reduce risks if they cannot be eliminated.  The role of Risk Registers is also included within the training.

We have introduced a revised Risk Management Training Programme, which incorporates local data and analysis of incidents, complaints and claims to enable our staff to prioritise risk assessments and management in their work area.

Performance against risk management training is reported to and monitored by the Risk Management Review Group on a bi monthly basis.

## 10.4.1   Risks

We have grouped our risks, on the Corporate Risk Register under the organisation strategic aims.  The key risks of relevance to the IMTP are attached in **Appendix 15.**

## 10.4.2  Sensitivity Analysis

The upside and downside risks associated with our plan have been explored and quantified in Section 8, para.8.7.

## 10.4.3  Risk Management Strategy

The key elements of the Risk Management Strategy include:

- Risk Management roles and responsibilities;

- Strategy Objectives;

- Significant Risks for the organisation;

- Risk Management Reporting Structure;

- Risk Management process;

- Risk Registers;

- Risk Management Training;

- Standards for Health Services in Wales.

Each of our Executive Directors are responsible for managing risks within their area of responsibility and ensure that:

- There are clear responsibilities for clinical, corporate and operational governance and risk management.

- Our staff are appropriately trained in risk assessment and management.

- There are mechanisms in place for identifying, managing and alerting the Board to significant risks within their areas of responsibility through regular, timely and accurate reports to the Executive Board, relevant Board Committees and the Board.

- There are mechanisms in place to learn lessons from any incidents or untoward occurrences and that corrective action is taken where required.

- Details of the key risks within their area of responsibility are reported to the Board.

- Compliance with Health Board policies, legislation and regulations and professional standards for their functions.

Our Executive Directors are supported in these duties by Assistant Directors, Clinical Directors and Locality Directors.  Together they ensure that robust systems are in place for risk management.  In addition our Director of Nursing has specific responsibility for progressing compliance with 'Doing Well, Doing Better Standards for Health Services in Wales' within the Health Board, as well as specific strategic responsibility for key areas of patient safety. Our Director of Finance also has specific responsibility for financial risk management and for providing regular, timely and accurate financial reporting to the Board in line with requirements and professional standards.

### 10.4.4    Operational Risk Management Arrangements

Our clinical/Locality Directors are responsible for the management of risk within their Directorate/ Locality. They ensure that they have effective arrangements in place to identify and manage risk. When risks are identified outside their control, our Directors are required to communicate this effectively through to the Chief Operating Officer.

Each Directorate/Locality has a clearly defined structure to ensure the appropriate management of risk which has been confirmed within their annual return of their Annual Governance Statements for their specific areas of responsibility. This includes Directorates/Localities maintaining up to date Risk Registers and maintain a log of risks they have mitigated to a risk tolerated level and risks that have been terminated.

As part of the process of introducing new management arrangements, we will revise responsibility for management of risks and the presentation of the risk register to ensure alignment with these new arrangements.

## 10.5    Financial Controls, reporting and audit arrangements

The financial reporting system has continued to be developed during 2014/15 through increasing use of the business intelligence dashboard and further developments to support procurement analysis and charitable funds. This enables budget holders to have greater access to and understanding of their financial performance and provides greater focus on efficiency opportunities. The financial management of Health Board outputs has been developed by the implementation of the commissioning analysis tool and the patient cost benchmarking dashboard. Both of these business intelligence tools enable managers to compare the expenditure on their service areas against other service providers. These benchmarking tools will continue to be rolled out and integrated into the financial management of the Health Board.

We have also developed, in conjunction with HFMA, a bespoke budget holder e-learning resource that has been rolled out across our delegated accountability structure. This e-learning resource sets down the responsibilities of budget holders and the techniques available to them in discharging those responsibilities. This e-learning training is reinforced by face to face training and education by the Devolved Finance Function.

We have been preparing for the implementation of Service Line reporting for a number of regional services, which is planned to go live in 2015/16. This will be accompanied by reshaping of the WHSSC LTA in order to clearly attribute income for work completed to each service. There are cultural as well as technical challenges with the successful implementation of these pilots.

ABMU Finance has engaged with Internal and external stakeholders to produce a financial strategy to underpin the Medium Term Plan entitled "Finance Future". This strategy sets down the direction of travel for financial management and reporting within the Health Board.

## 10.5.1 Internal Audit

NWSSP Audit & Assurance Services provide internal audit, specialist audit and consultancy services to ABMU Health Board. Audit & Assurance is responsible for providing an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, internal control and governance arrangements support the achievement of the organisation's agreed objectives.

NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in Wales, and the Strategy has been approved by ABMU Health Board. The Strategic Audit Plan is largely based on the system of assurance operating within ABMU together with the organisation-wide risk assessment.

An Annual Operational Plan is prepared each year drawn from the Strategic Audit Plan outlining the scope and timing of audit assignments to be completed in the year ahead. Both Strategic and Annual Plans are developed in discussion with Executive Management and approved by the Audit Committee on behalf of the Board.

The risk based plan identifies auditable areas within eight assurance domains that include:

- Corporate governance, risk and regulatory compliance
- Strategic planning, performance management and reporting
- Financial governance and management
- Clinical governance quality and safety
- Information governance and security
- Operational service and functional management
- Workforce management
- Capital and estates management

The Strategic Planning, performance management and reporting assurance domain will include provision for internal audit review of the Integrated Medium Term Plan (IMTP), and it is intended as part of this review to look at the processes established for the management of implementation and execution of the IMTP.

## 10.6    Developing Governance arrangements

Our Board is taking a number of actions to strengthen governance arrangements. These include.

- A review of governance arrangements, led by the Chairman. This includes a review of Board Committee structures and performance reporting arrangements

- A review of executive portfolios led by the Chief Executive to further clarify accountabilities

- An action plan developed in response to the Francis Report and the report into Betsi Cadwaladr University Health Board

- Strengthening clinical governance arrangements, using the methodologies being piloted at the Princess of Wales Hospital

- Working with Academi Wales to define the Board Development programme.

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

# Appendix 1    Strategy Bridge

**Purpose**

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

**Strategic Aims    ...To**
- Healthier Communities
- Excellent patient outcomes & experience
- Sustainable and accessible services
- A fully engaged and qualified workforce
- Strong partnerships
- Effective governance

**By 2017 at latest**

**From ...**
**Today**
**2014**

| Strategic Aim | From (Today 2014) | Actions | | | | To |
|---|---|---|---|---|---|---|
| **Healthier Communities** | Huge variations in patient experience. Data and evidence not collected, reported or acted upon in any systematic way. | Promote self care and well being – engage people in our communities in taking charge of their own health | Co-produce services based on population need. | Manage the whole system to minimise health inequalities | Target action to focus on areas of greatest need | A systems wide focus on the quality of care and health for ABMU citizens, focusing on end-to-end patient health and well being. Citizens are more engaged in their own role in healthy living. |
| **Excellent patient outcomes and experience** | Opportunity to improve levels of staff engagement, visibility of leadership, clinical leadership and connectedness of teams across the organization. | Measure and understand patient experience and outcomes – real time comparative triangulated data to support decision making and improvement. | Embed accountability for patient experience within roles & job descriptions to do the right thing for the every patient/person. | Ensure effective support & concern resolution – evaluate resource/ investment in patient experience/PALS to always put the patient first and learn lessons from experience. | Keep listening to citizens, patients and carers about the outcomes they value. | We understand our citizens' experience and outcomes at a granular level in real time, keep listening, factor in what we hear, and see our experience and outcomes continuous improving. Services are commissioned based on need and improved outcomes for people. We can see tangible improvements in productivity and efficiency. |
| **Sustainable and accessible services** | Beginning to develop a more open culture. Need to consider ABMU as going beyond staff to all citizens in our patch. | Realign and optimise resources through effective commissioning to improve outcomes. | Develop fit for purpose models of care with aligned investment and disinvestment, based on principles of prudent healthcare. | Continuous improvement and better value for money. | Align systems/processes that priorities people's needs. | We have engaged staff at every level who are role models of our values, and who are empowered to keep improving services. We understand our staffing experience. |
| **A Fully Engaged and Skilled Workforce** | Focused on good financial performance, less visibility of quality outcomes, and not always holding people to account. | Review and further develop mechanisms to gather feedback on staff experience. | Develop values-led leadership & management including communication, visibility and role modeling. | Develop appreciation & recognition processes and culture to value everyone's contribution (HB and local level) | Develop teams working in collaboration across the whole system & empower/ skill teams to deliver continuous improvement. | Clear alignment between Health Board and partner organisations values, strategies and plans. People who receive care from different organisations cannot tell the difference. |
| **Strong partnerships** | Compartmentalised approach focused on delivering individual services and on delivering to WG agenda rather than citizen needs. | Further develop Health Board integration with the right balance between primary, community, secondary and tertiary care and movement between different setting supported. | Develop and implement integrated models of care and teams with partner organisations. | Agree shared values with our partners | Integrated strategies and plans with partner organisations. | Everyone is able to describe the ABMU values. Our leaders and staff role model our values and behaviours. Good governance processes based on values and strategic aims. |
| **Effective governance** | | Develop systems that promote safe and appropriate care and agree values based behaviours, clear roles, responsibilities & accountabilities. | Embed shared values across ABMU & measure impact of values on staff & patient experience. | Visible HB leadership, shaping & inspiring culture, listening & connecting to staff, citizens & partners. | Develop HB wide clinical leadership capacity & capability and org structure to empower clinical leaders & teams. | |

**Guiding principles : Our values**

*Caring for each other,* in every human contact in each of our communities and in all of our hospitals

*Working together,* as patients, families, carers, staff and communities so that we always put patients first

*Always improving,* so that we are at our best for every patient and for each other

## Appendix 2      Key Messages from our Listening Events



A good experience In Your Shoes



When it's not so good In Your Shoes

# What makes a good day…

# Appendix 3    Service Profile

## Home based services

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

**District Nursing Services** provide holistic assessment, planning and evaluation of care from engagement in the discharge planning to proactive health surveillance and health promotion for patients with long term conditions. District nurses support the management and treatment of many conditions such as diabetes, continence issues, immunisation and wound care. District Nurses also support medicines management through Nurse Prescribing and medication administration. They have a key role in End of Life Care and post bereavement support.

**Chronic Conditions Management Nurses** are based within primary care, and support people with complex long term conditions who are at risk of episodes of frequent ill health to avoid hospital admission.

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

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

- Nursing

- Therapists

- Community Psychiatric Service

- Community Drug and alcohol service

- Wound care, continence, tissue viability, medicines management and specialist palliative care teams.

- Health Visitors and Flying Start Health Visitors

- Looked After Children's Health teams

- Child Disabilities Health Visiting Service

- Child Community Nursing Services

- Health Care Support Workers

## Primary Care based services

We contract with independent practitioners to deliver primary care services, which are delivered by General Practitioners, Optometrists, Pharmacists and Dentists.  The contracts are determined on a national basis. There are 77 General Practices across the Health Board. There are currently just over 300

GPs, nearly 60 Opticians, 125 Community Pharmacists and almost 300 Dentists in the area. Outside normal practice hours, the Health Board manages the provision of the GP Out-of-Hours Service. We also provide General Medical Services within Her Majesty's Prison (HMP) Swansea, and are responsible for commissioning all health care within HMP Swansea.

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

## Community based services

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

## Hospital based services

We provide hospital services from four acute hospital sites:

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

The Table below describes the services provided at each of these main hospital sites.

**Table 35 : Health Board Acute Hospital Service Composition**

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

## Mental Health, Substance Misuse and Learning Disability Services

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

The majority of Child and Adolescent Mental Health Services are provided by Cwm Taf Health Board. The planning of these services is taken forward by the ABMU Children's and Young People Mental Health Planning Group. Cwm Taf Health Board, the Local Authorities and the third sector are members of this Planning Group which has an agreed action plan to address key issues. Figure 24 below illustrates the geographical basis of the services provided by the Health Board.

**Figure 25 : Health Board Service Provision**

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

## Commissioned and Partnership Services

Some of our residents access services from outside of the Health Board, particularly those living on the boundaries of our catchment area. Further, we do not provide every aspect of clinical care within our Health Board; as a result we commission services for our local population from other healthcare providers, principally the other Welsh Health Boards and NHS Wales Trusts. The Health Board commissions a number of secondary care organisations to provide services for our residents.

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

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

There are already many areas where we work closely to provide care for our combined communities. In 2014/15 clinicians from our two Health Boards will consider how to plan together better for a number of other services across the South West and West Wales region. These will include radiology, pathology, oncology, dermatology, cardiology, neonatology and neurology. The impacts on changes to these services will need to be carefully considered and the impacts on potential centralisation of more services on patients, particularly those with a disability or another equality dimension, and carers, taken into account prior to decisions being made.

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

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

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

# Appendix 4     Performance

The table below sets out the Health Board's performance against the delivery framework outcome measures.

| STAYING HEALTHY - | | | | |
|---|---|---|---|---|
| **Measure** | | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | Number of emergency admissions for basket of 8 chronic conditions | | Reduction | 1203 |
| Monthly | Number of emergency readmissions for basket of 8 chronic conditions | | (rolling 12 | 192 |
| Monthly | Reduction in the number of emergency hospital admissions for pts aged 85+ | | PROJECTIONS | 640 |
| Annual assessment | % uptake of the influenza vaccine in the following groups: | Over 65's | 75% | 65.2% |
| | | Under 65's in at risk groups | | 44.1% |
| | | Pregnant women | | 38.6% |
| | | Healthcare workers | 50% | 41.0% |
| Quarterly assessment | % uptake of childhood scheduled vaccines up to the age of 4: | 5 in1 age 1 | 95% | 96.8% |
| | | MenC age 1 | | 97.8% |
| | | MMR1 age 2 | | 96.8% |
| | | PCV age 2 | | 95.3% |
| | | HibMenC Booster age 2 | | 94.7% |
| Quarterly assessment | % estimated LHB smoking population treated by NHS smoking cessation services | | 5% (end of fin year) | 1.43% |
| Quarterly assessment | % smokers treated by NHS smoking cessation services who are CO- validated as successful | | 40% (end of fin year) | 42.7% |
| Annual assessment | % of reception class children (aged 4/5) classified as overweight or obese | | Reduction | 26.9% |
| **EFFECTIVE CARE - I** | | | | |
| **Measure** | | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | Crude Mortality | | Reduction | 1.87% |
| Monthly | RAMI 2014 | | | 100 |
| Monthly | % valid principle diagnosis code 3 months after episode end date - monthly | | 95% | 78.9% |
| Monthly | % valid principle diagnosis code 3 months after episode end date - rolling 12 months | | 98% | 89.6% |
| Annual assessment | Number of NISCHR clinical research profile studies and Commercially Sponsored studies | | Improvement | 99 |
| Annual assessment | Number of Audits the organisation is participating in against the national clinical Audit | | 35 | 35 |
| Annual assessment | % people aged 45+ who have a GP record of blood pressure measurement in the last 5 yrs. | | Improvement | 87.3% |
| **TIMELY CARE - I** | | | | |
| **Measure** | | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Annual assessment | % GP practices offering appointments between 17:00 and 18:30 at least 2 days a week | | Improvement | 96% |
| Annual assessment | % of GP practices open during daily core hours or within 1 hour of the daily care hours | | | 76% |
| Monthly | % of patients waiting less than 26 weeks for treatment – all specialties | | 95% | 3437 |
| Monthly | Number of 36 week breaches – all specialities | | 0 | 5203 |
| Monthly | % of patients waiting less than 8 weeks for diagnostics | | Improvement | 996 |
| Monthly | % of new patients spend no longer than 4 hours in A&E | | 95% | 77.5% |
| Monthly | Number of patients spending 12 hours or more in A&E | | 0 | 683 |
| Monthly | % of Cat A Ambulance responses within 8 minutes | | 65% | 52.8% |
| Monthly | Number of over 1 hour handovers | | Reduction | 554 |
| Monthly | % of patients referred as non-urgent suspected cancer seen within 31 days | | 98% | 93.0% |
| Monthly | % of patients referred as urgent suspected cancer seen within 62 days | | 95% | 74.0% |
| Annual assessment | Patients treated by an NHS dentist in the last 24 months as % of population | | Improvement | 62.45% |
| Monthly | % compliance with acute stroke bundles: | 1 - First hours bundle | 95% | 86.0% |
| Monthly | | 2 - First days bundle | | 25.0% |
| Monthly | | 3 - First 3 days bundle | | 52.0% |
| Monthly | | 4 - First 7 days bundle | | 64.0% |

| INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities | | | |
|---|---|---|---|
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | % of assessments by the LPMHSS undertaken within 28 days from the date of referral | 80% | 88.8% |
| Monthly | % of therapeutic interventions started within 56 days following assessment by LPMHSS | 90% | 84.1% |
| Monthly | % of LHB residents (all ages) to have a valid CTP completed at the end of each month | 90% | 96.6% |
| 6 monthly assessment | % of hospitals with arrangements to ensure advocacy available to qualifying patients | 100% | 100.0% |
| Annual assessment | % of over 65 registered as having dementia with their GP practice | Improvement | 2.9% |
| DIGNIFIED CARE - I am treated with dignity & respect & treat others the same | | | |
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | % procedures postponed on >1 occasion, had procedure <=14 days/earliest convenience | Improvement | 57.0% |
| SAFE CARE - I am protected from harm & protect myself from known harm | | | |
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | DToC delivery per 10,000 LHB population - mental health | Reduction rolling | 5.40 |
| Monthly | DToC delivery per 10,000 LHB population - non mental health +75y | 12 months | 50.70 |
| Monthly | Number of healthcare acquired pressure sores in a hospital setting | Reduction | 20 |
| Monthly | Number of cases of C Difficile per 100,000 of the population | 31 per 100,000 | 27.54 |
| Monthly | Number of cases of MRSA per 100, 000 of the population | 2.6 per 100,000 | 7.51 |
| Quarterly assessment | % compliance with patient safety solutions - alerts | Improvement | 87.5% |
| | % compliance with patient safety alerts - rapid response notices | | 100.0% |
| Monthly | Number of new Series Incidents | Reduction | 9 |
| Monthly | Number of new Never Events | | 0 |
| OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on its use of resources & I can make careful | | | |
| **Measure** | | **Target** | **2014/15 Baseline (month 11 unless specified)** |
| Monthly | % staff absence due to sickness | Reduction | 5.69% |
| Annual assessment | % of total medical staff undertaking performance appraisals | Improvement | 60.0% |
| Annual assessment | % of total non medical staff undertaking performance appraisals | Improvement | 32.5% |

Set out below is a commentary on how we performed during 2014/15, against a series of priority areas. Although it is important to recognise that this does not cover the entirety of the Health Board's agenda.

- 96.8% 5 in 1 immunisation uptake at age 1

- 97.8% uptake Menn C vac at age 1

- The lowest number of non-mental health delayed transfers of care (50.7 on a rolling 12 month average)

- 57% of patients having procedures postponed on > 1 occasion & had procedure within 14 days/earliest convenience

- 62.1% of Patients receiving care from an NHS dentist > once in most recent 24 months as % of population

For almost all other areas of performance we are showing strong performance which is improving from the position of previous years. The following areas where we have challenges to our performance levels are:

- Flu vaccination uptake in <65 in high risk groups (44%)

- Flu vaccination rates in pregnant women (38.6%)

- GP practices offering appointments between 17:00-18:30 on at least 2 days (96%)

- Patients referred for Urgent Suspected Cancer seen within 62 days (further detail below)

- % compliance with stroke bundle 1 (1st hours) (further detail below)

- % compliance with stroke bundle 2 (1st day) (further detail below)

- % total medical staff undertaking performance appraisals (60% - although this figure is improving)

## Unscheduled Care

Section 1 above explained the context of our performance in respect of unscheduled care delivery which can be described in two distinct parts. For the first half of 2014/15, our plans began to positively impact across all areas of unscheduled care with numbers of people waiting over 12 hours in Accident & Emergency (A&E) reducing and from May 2014 to September 2014 an improvement in the numbers of people waiting over 4. The Figure below shows the overall Health Board performance against 4 hour performance and numbers of patients waiting over 12 hours.

**Figure 26 :  Health Board Performance showing 4 hour and 12 hour waits**
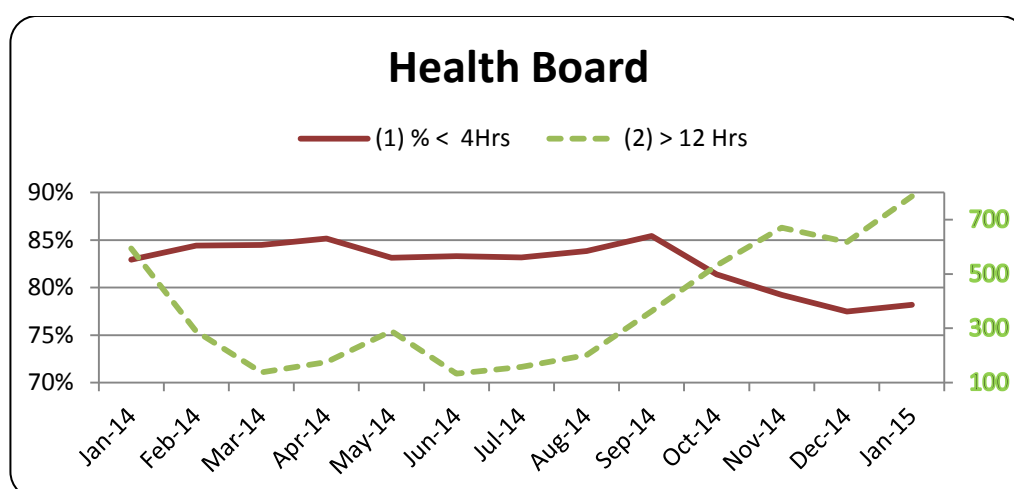


During the same period ambulance handover delays of over an hour reduced and the Health Board, along with the Welsh Ambulance NHS Trust (WAST), was reporting the best Category A 8 minute response time performance in Wales.

The second part of the year has seen a stepped change in performance which can be explained by a number of factors: -

- An increase in emergency admissions from November 2014 to mid-January 2015 of 5.5%;
- For the same time period an increase in admissions for over 80 year old patients of 7.8%; and
- A 9.6% increase in ambulance conveyances for patients over 80 years old.

In addition to this increase in demand, recruiting and retaining staff to fill our nursing establishments has been not been as straightforward as envisaged. We have been unable to recruit to full establishment levels resulting in wards using increased levels of bank and agency nursing to fill shifts. This makes it difficult to develop team working and deliver continuity of care. This is not the position that we want and our workforce strategy is an important part of the overall solution to sustainable unscheduled and planned care.

**Figure 27 : Variable Pay Costs Comparison**
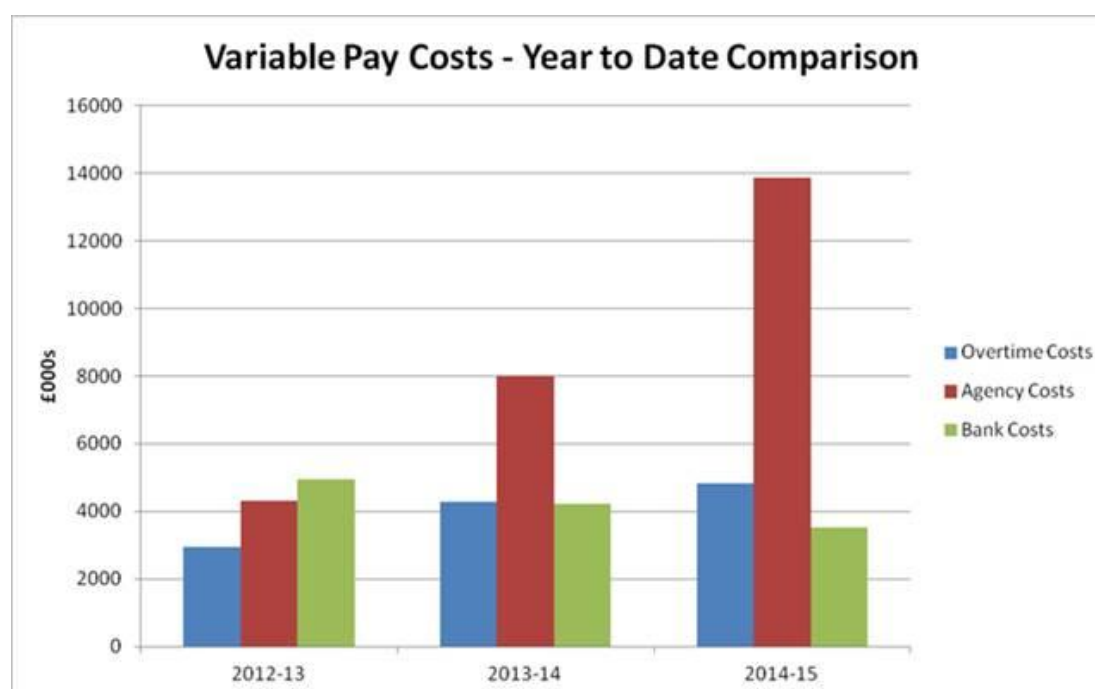


At the same time, attendances at our Minor Injury Units are also higher than last year's levels. This indicates that patients are presenting across the unscheduled care system and that patients are being streamed, wherever possible, to non-Emergency Department clinical services. At the same time our GP Out of Hours services continue to manage a high activity level which has been broadly unchanged year on year.

The immediate impact on performance measures of these increased attendances and the age profile of these attendances has been as follows: -

- Increased delays in ambulance handovers and a consequent adverse impact on Category A response times.
- Longer waiting times in the Emergency Departments
- Patients being cared for  in escalation beds with associated risks of infections and impact on the quality of care
- Longer lengths of stay within the hospitals leading to more medical patients being inappropriately cared for  in surgical beds thus impacting on our ability to undertake planned elective care.
- Delayed transfers of care.

This is clearly our primary operational priority as the whole system of care is affected by these pressures. Later in this IMTP we set out how our patient flow programme (and associated service change projects within the Changing for the Better programme), which are planned to address the pressures within unscheduled care.

## Planned Care

### Referral to Treatment Access Times

Our previous IMTP set out plans to reduce the numbers of patients waiting over 36 weeks for treatment and move towards the target of 95% of patients being treated within 26 weeks of referral.

To achieve this, the IMTP set aside £6.5m within the Financial Plan to provide additional capacity to remove the backlog and to fill workforce gaps where they existed.

At the end of December £4.839m of the proposed RTT funds have been allocated and in summary this has delivered: -

- 6,848 additional new outpatient attendances

- 1,493 new inpatient treatments; and

- 300 new day case and outpatient procedures

However, some of our plans to remove the backlog and achieve sustainability within the financial year were overly ambitious, and despite this extra activity, we have been unable to improve our RTT position this year.

Our prioritisation of unscheduled care has inevitably impacted upon planned care activity and we have cancelled some outpatient activity, particularly in medicine, to enable clinicians to care for ward based patients.

There is currently very little routine elective work being carried out in Morriston, Singleton and Princess of Wales Hospitals, primarily due to the lack of available beds. Emergency surgery, urgent surgery and cancer surgery are prioritised and are being managed daily on a clinical needs basis.

For example, our commitment to treating patients needing Cardiac Surgery within 36 weeks of referral remains on profile as the capacity is protected.

Our year end 36 week projection for RTT is 5,333. However, over the first 9 months of 2014/15 the total numbers of patients waiting has reduced by 4,294 from 73,345 to 69,051 whilst the numbers of patients waiting for surgery has only marginally increased from 18,967 to 20,214. Within this overall picture we have also reduced the numbers of patients waiting for an outpatient consultation from 46,252 to 43,002 (an improvement of 3,250) and patients waiting on an RTT pathway for a follow appointment have also reduced from 5,923 to 3,356 over the same period.

The early analysis of this position is indicating that we are treating more urgent elective cases from the waiting list which is maintaining the total numbers of patients waiting, but is extending waits for some of the more routine patients, particularly in orthopaedic surgery, plastic surgery and general surgery. Our plans for these specialties in particular must rebalance capacity to match the urgent demands as well as provide sufficient capacity to manage the length of time patients are waiting for routine surgery.

### Cancer

For the Non Urgent Suspicion of Cancer (NUSC) target of seeing patients within 31 days the Health Board is routinely achieving, or close to the required 98% target level. At present we are experiencing high demand for breast cancer patients. We believe this may be as a result of more sensitive diagnostic techniques and we are currently investigating this. We are responding by putting on more clinics and we are looking at a more sustainable solution. All other aspects of NUSC performance remain on track. For the first 9 months of 2014/15 we have treated 1,198 patients, 1,163 of them within the required target time.

With regard to the Urgent Suspicion of Cancer (USC) target of seeing patients within 62 days we, along with other Health Boards in Wales are finding this target extremely challenging to deliver. We have been supported for the past 24 months by the Delivery Unit and we have worked through and actioned a wide range of recommendations to improve performance. We are seeing an increase in the numbers of cancer patients we are treating under this measure and we are investigating the reasons for this.

Demand has increased in 2014/15 and in the 9 month period between April 2014 and December 2014 we have treated 61 more cancer patients than in the comparable period for the year before. For the 9 month period we have treated 1,044 urgent cancer cases with 84% of these treated within 62 days.

### Diagnostic and Therapy Access times

The Health Board continues to perform well across diagnostic and therapy access times.

Funding has been received from Welsh Government in 2014/15 to support improvement in endoscopy, cardiology, cardiac MRI and nerve conduction studies. We have implemented our plans in these areas and we have seen improvement in access times for these tests.

Endoscopy remains a challenge but we have seen significant improvements in cancer patient access times (96% of patients seen within 10 days) and cancer surveillance access times which are not reported under this measure. As a Board we have prioritised our most urgent patients first by addressing urgent cancer and cancer surveillance patient waiting times first. Even though we have taken this approach, we are still ensuring that over 90% of our routine endoscopy patients are seen within 8 weeks.

### Follow Up Patients

A significant amount of work has been undertaken in 2014/15 to ensure that patients waiting for follow up appointments are seen in a timely manner.

Our focus has been on all follow up patients and we have been addressing this through a range of actions: -

- Promoting new models of care where a follow up attendance is not required, but alternative support and advice is available and accessible to patients.
- Clinical validation of follow up lists to manage the backlog and ensure that reported follow up lists are accurate.
- Redesign of the Patient Administration System to avoid duplicate records and reflect clinical prioritisation.

At total of over 79,000 patients have either been seen in clinic or validated during the first half of 2014/15 as part of our plans to improve performance and access times for follow up patients. We are seeing steady progress in reducing the number so patients who are waiting beyond their scheduled follow up date. At the end of November 2014, we have reduced the numbers of patients waiting beyond their scheduled follow up date by 23% from April 2014.

### Ophthalmology New Measures Pilot (ABMU Health Board)

The Pilot aims to prioritise all Ophthalmology outpatients (new and follow-up) based on clinical risk and to set individual waiting times for patients in line with their pathway and individual circumstances, adhering to a clinically agreed set of definitions.

- Priority 1. Patients who may suffer serious irreversible harm from delayed appointments
- Priority 2. Patients who may suffer reversible harm from delayed appointments

- Priority 3. Patients who may be inconvenienced or suffer mild and/ or reversible consequences from delayed appointments

The pilot is being implemented at both Singleton and Neath Port Talbot Hospitals. Over the 6 month period of the pilot, the number of higher risk P1 patients waiting over their target date have reduced from 6,500 to 3,500, a reduction of 3,000 (46%). The number of patients who are more than 100% over their target date has reduced from 3,500 in June 2014 to 1,600 at the beginning of December 2014 (54% reduction).

The new system provides a fairer, safer service to patients than one based purely on Referral to Treatment time targets for new patients.

## Stroke

Stroke care performance has been a challenge for the Health Board in 2014/15 and in particular delivery of the first day bundle. The figure below sets out performance against the 4 main measures for a rolling 13 month period.

**Figure 28 : Stroke bundle performance**
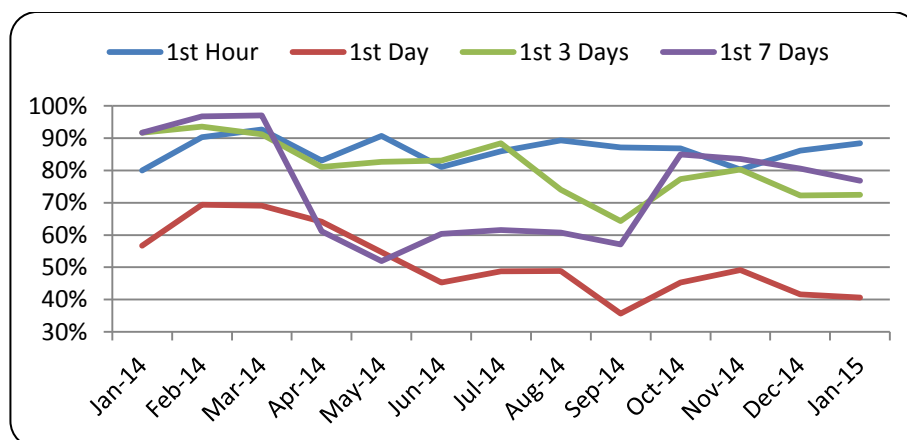


A wide range of operational actions have been implemented at both Morriston and Princess of Wales Hospitals which include the recruitment of 2 new stroke consultants, protection of ring fenced beds with breaching them only an action of last resort and partnership work with the Welsh Ambulance Services NHS Trust to pilot taking of bloods for patients on the stroke pathway.

On a strategic basis, the Medical Director is conducting a strategic review of stroke services so that they are configured to deliver excellent care, consistently and to meet prudent healthcare principles and best practice standards. This will form a priority area in the 2015-16 quality plan for the Health Board. Work is already underway to prepare for this and to define the

precise pathway for different patient groups. There will also be a focus on prevention and early supported discharge.

## Infection Control

### *Clostridium difficile infection*

The total number of *C. difficile* cases in ABM University Health Board between April 2010 and December 2014 is shown in the chart below. In addition to the total number of cases (the black line in the chart below), the blue and grey bar charts show the breakdown of whether *C. difficile* was diagnosed when the patients were inpatients or non-inpatients.

**Figure 29 : Monthly numbers for C.*difficile – Apr 2010 to Dec 2014***
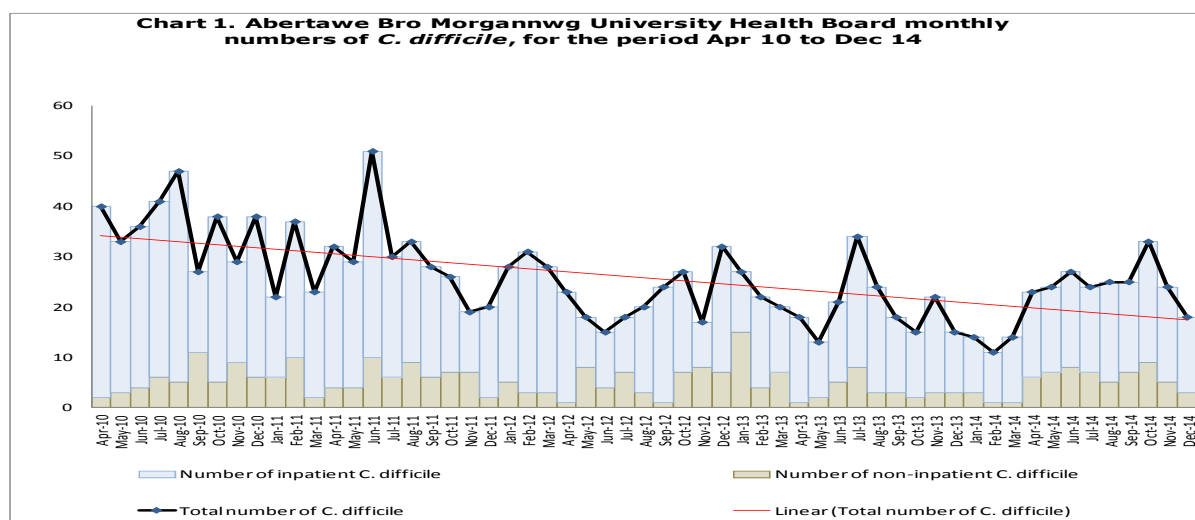


There was an increase in the number of cases seen within the hospitals between April and October 2014 and clinical and managerial staff have been working to reduce this. There has been a decrease in the number of cases seen in the last two months.

In addition to existing infection prevention and control measures, the Health Board implemented new technologies aimed at reducing environmental contamination in June 2014. These technologies include the use of Hydrogen Peroxide Vapour room decontamination, and the use of disinfectant wipes that are specifically for bacteria that produce spores such as *C. difficile*.

### *MRSA Bacteraemia (Bloodstream infection)*

The chart below shows the total number of MRSA bacteraemia cases between April 2010 and December 2014. In addition to the total number of cases (the black line in the chart below), the blue and grey bar charts show the breakdown of whether MRSA bacteraemia was diagnosed when the patients were inpatients or non-inpatients.

This demonstrates that there has been an overall downward trend in the total number of cases of MRSA bacteraemia since April 2010.

**Figure 30 :  Monthly numbers for MRSA – Apr 2010 to Dec 2014**



Chart 2. Abertawe Bro Morgannwg University Health Board monthly numbers of MRSA bacteraemia, for the period Apr 10 to Dec 14
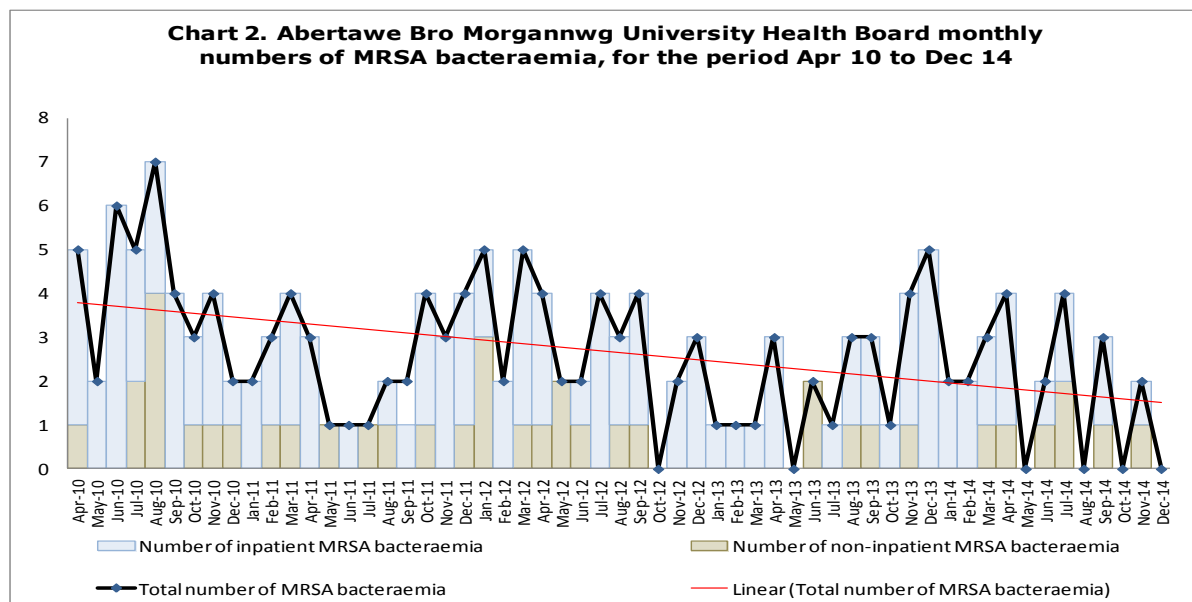
The Health Board has introduced the use of a licensed, single use applicator, skin disinfectant for use before inserting any intravenous line. This new product requires specialised staff training, which commenced in Morriston in April 2014.

### *Comparisons with other Welsh Health Boards and NHS Trusts*

The table below shows the number and rate of C.*difficile* and MRSA *bacteraemia* per 100,000 population by health board, for the period, Apr-Dec 2014.

**Table 36 :  Number and rate of *C. difficile and* MRSA *bacteraemia* per 100,000 population by health board, Apr-Dec 14**

| Health Board/NHS Trust | Number of C. difficile (difference between current and target)* | Rate of C. difficile/ 100,000 population | Number of MRSA bacteraemia (difference between current and target)* | Rate of MRSA bacteraemia/ 100,000 population |
|---|---|---|---|---|
| Abertawe Bro Morgannwg | 223 (+100) | 56.84 | 15 (+5) | 3.82 |
| Aneurin Bevan | 170 (+33) | 38.96 | 16 (+5) | 3.67 |
| Betsi Cadwaladr | 301 (+138) | 57.73 | 24 (+10) | 4.60 |
| Cardiff and Vale | 136 (+23) | 37.69 | 33 (+24) | 9.15 |
| Cwm Taf | 84 (+14) | 37.78 | 13 (+7) | 5.85 |
| Hywel Dda | 112 (+21) | 38.72 | 21 (+13) | 7.26 |
| Powys** | 7 | 7.00 | 0 | 0.00 |
| Velindre** | 8 | N/A | 0 | N/A |
| **All Wales** | **1041 (+315)** | **44.82** | **122 (+61)** | **5.25** |

\*   Difference between current number of cases and number required to be on trajectory to meet the target

\*\* Target not currently defined

## *C. difficile*

The C. difficile target for Wales for Apr 14-Sep 15 is for a rate of no more than 31 per 100,000 population. The Health Board does not compare well and has the second highest rate in Wales.

## MRSA *bacteraemia*
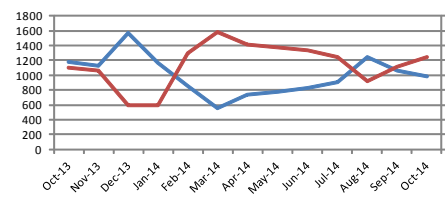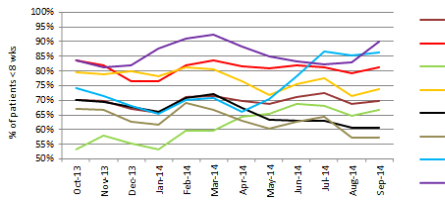
The MRSA bacteraemia target for Wales for Apr 14–Sep 15 is for a rate of no more than 2.6 per 100,000 population. None of the Health Boards meet the target; however we are the second best performer in Wales.

# Appendix 5    Sample Performance Report Card

| Strategic Aim : Sustainable and Accessible Services | | Strategic Change Programme: Patient Flow | | Executive Lead : Darren Griffiths | |
|---|---|---|---|---|---|
| Period : Oct-14 | IMTP Profile Target :<br>(1) NA  (2) 484 | WG Target :<br>Improve | | Current<br>Status : ✖ | Movement : ⬆<br>Improving |
| **Current Trend: Oct 13 - Oct 14** | | **How are we doing ?** | | | |
|  | | • There are 980 patients waiting over 8 weeks as at the end of October against a profile of 484.<br>• Whilst diagnostics continues to be off target, October saw an improvement of 1058 to 980 (an improvement of 78).<br>•Cardiology (Stress Test), Radiology CT, MR, Cardiac CT and MR are all within planned profile.<br>• Deviation to profile mainly relates to Cardiology (echocardiogram), Neurophysiology (nerve conduction studies and electromyography) and non-obstructive ultrasound. | | | |
| **Benchmark** | | **What actions are we taking?** | | | |
|  | | • Improvement plans are now in place based on recent funding approved to deliver a zero position by year end.<br>• Plans include:<br>1. Additional Radiology resource.<br>2. Increased capacity for Cardiology (all diagnostics)<br>3. Additional capacity for Neurology (electromyography and nerve conduction) | | | |
| **How do we compare with our peers?** | | **What are the main areas of risk?** | | | |
| • As at the end of September ABMU performance was 81.3% compared to all-Wales performance of 69.8%. ABMU is  the second best performing organisation excluding Powys. | | • Routine activity being displaced by urgent and cancer patients; however recent investment will support the implementation of improvement plans to year end.<br>• The implementation of Nuchal Translucency (NT) screening may impact on the ultrasound numbers; however this cannot be confirmed at present. | | | |
| Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (October 14) | | | | | |

# Appendix 6    Strategic Change Programmes – Progress in 2014/15

**Table 37 :  Strategic Change Programme improvements and developments in 2014/15**

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| **Patient Safety Programme (to be merged into the Quality Strategy)**<br>– Dashboard to support the identification of potential Hospital Acquired Thrombosis (HAT) cases.<br>– Embedding Universal Mortality Reviews into practice.  Three of the four main hospitals consistently review all their deaths and the fourth has now reached 90% compliance.<br>– Working to promote and embed early recognition and intervention e.g. the Sepsis Care Bundle.<br>– A review of training provision, effectiveness and prioritisation is underway, covering the Resuscitation Training Team and "Last days of life – the Health Board's End of Life delivery plan". | Reducing avoidable harm and mortality through increased awareness in the organisation, enabled by the systems and processes created in specific categories of risk. |
| **Patient Experience Programme (to be merged into the Quality Strategy)**<br>– Invested in infrastructure to enable us to capture, analyse, report and learn from patient feedback, including investment in "SNAP", "I Want Great Care" and DATIX systems.<br>– The Friends and Family Test has been rolled out across Neath and Singleton, with Morriston scheduled for early 2015.<br>– The Patient Feedback Team has been developed with a number of appointments completed; this ensures the Health Board values patient experience, learns and produces a co-ordinated patient focussed approach, in a timely manner. | Supporting how ABMU Health Board is a listening organisation, aligned with Trusted to Care.<br>Real time indication of the quality of care received, learning from when things go wrong to improve patient experience and quality of care and services. |
| **C4B Service Improvement Programme**<br>**Staying Healthy Project**<br>– Smoking Cessation – 40 Community Pharmacies prioritised to provide Level 3 Stop Smoking Service, supporting the delivery of the Tier 1 target. Hospital based Smoking Cessation service established with a view to being operational early in the year.<br>– Adult Weight Management business case  and Children & Young People's business case is in development for 2015/16<br>– Annual calendar of monthly messages development, commencing in October 2014.  Messages communicated via internal mechanisms and externally via partners, signposting to local service provision where appropriate.<br>– The Public Health Strategic Framework 2014-15 was refreshed in May 2014, setting out a clear strategy for how ABMU and our partners could improve population health across the life courses. | Increased public engagement and awareness of the support provided by ABMU Health Board in smoking cessation; including the expansion of services in both the Community and Hospital settings.<br>Reduce smoking prevalence<br>Reduce popn prevalence of obesity<br>Increase engagement in healthy behaviours amongst staff and the general popn. |

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| There are further plans to refresh again for the forthcoming year. | |
| **C4B Service Improvement Programme**<br><br>‑ **C4B/Western Bay Community Services Project**<br><br>• Integrated health and social care Community Resource Teams) has been rolled out across the 3 localities.<br><br>    - Recruitment of 158 staff is 95%complete. Posts range from health care support workers to therapists to acute clinical nurses.<br><br>    Early impact analysis has seen the following:<br><br>    - Bridgend project 115% increase in number of admissions avoided and projected 85% increase in facilitated discharges (14/15)<br><br>    - NPT Acute Clinical Service has provided **232** IV treatments at home which means these people were saved from having to have the treatment in hospital<br><br>    - Reablement Support Workers in NPT equates to an additional 20 service users able to receive Reablement<br><br>    - Swansea, an additional 76 A&E OT patients seen since ICF recruitment and 7 day working was introduced in September 2014<br><br>    - Care and Repair presence in the POW hospital resulted in a total of **343** referrals - the savings in bed days as **892 bed days saved**<br><br>    - Bridgend anticipating an additional 149 Tele care placements by March, which means technology is installed for people at risk within their own homes to allow them to remain at home instead of residential/nursing care<br><br>    - NPT Acute Clinical Service had 452 referrals (Apr to Sept 2014), preventing **370** admissions and earlier discharge of **46** people<br><br>    - Swansea - additional 149 CRT referrals dealt with since ICF funded increase in staff of 3.82 WTE in September<br><br>    - Increased capacity in Swansea's Common Access Point resulted in 23% less referrals and ultimately allocated service<br><br>    - Between April and September, Swansea's services have prevented 54 care home admissions which means these people have been able to stay at home for their care<br><br>‑ Between June and November, **72** people were supported by British Red Cross to return home from hospital and in excess of 1500 people had home adaptations provided by Care and Repair as part of the investment in community care. In addition **50** carers assessments have been undertaken to allow the correct | As recruitment in the first year is nearing completion, the shift of care in the Community away from the Hospital setting is anticipated to build. A detailed impact report is available<br><br>The Community Teams in each Locality have been strengthened, keeping older people well and healthy, with patients receiving joined up services between Health and Social Care. Reduction in demand for inpatient admissions and promote earlier discharge, which would enable a reduction in hospital beds. The planned bed reductions for this Project are scheduled to commence from October 2015. |

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| support for those that care for those coming out of hospital Section 33 agreement has been developed in each locality which is a significant piece of work to ensure CRT services are sustainable for the future.  This is a clear symbol of the commitment of the four organisations working together to improve community services and builds on the joint commitment (Delivering Improved Community Services) signed off by the Board and three Cabinets in 2013.<br><br>‑ Implementation of new service model, incorporating common assessment.<br><br>‑ A comprehensive (£100,000) evaluation of intermediate care has been commissioned with Cordis Bright which is a three year longitudinal evaluation of the investment in intermediate care and how this will benefit service users<br><br>‑ Phase 2 of Community Services has a significant piece of work underway to identify the most vulnerable older people in our communities and provide intensive care management to prevent deterioration and limit the need for institutional care – this has been agreed as one of the main priorities for Western Bay going into 2015-16 and beyond<br><br>‑ A Medical Service Forum has been established for the redesign of Older People's Mental Health Services in line with integrated care in the community<br><br>‑ An overarching Frailty Model has been designed that brings together all the pieces of work related to the care of frail older people into one model – this will be finalised at a large event on 27th March 2015.<br><br>‑ A business case has been completed for the development of Technology for our community teams in terms of the new ways of working within the overarching frailty model<br><br>‑ The project successfully bid for primary care funding to establish 'proof of concept' project in the Upper Amman Valley to tackle loneliness among older people.  The project has had over 100 contacts with older people in the last 6 months and an evaluation report and business case will be provided by the end of March. This is being led by NPT locality | |
| **C4B Service Improvement Programme**<br><br>**-Rapid Access Services Project**<br><br>‑ The Ambulatory Care Unit is being expanded at Singleton Hospital (Ward 10), as a result of the agreement of recruiting the required nursing establishment with recruitment underway. Full planned recruitment is subject to the resultant savings being deliverable by the locality, which is continuing to be developed.<br><br>‑ The project has secured the agreement to join cohort 7 of the | Specialist advice lines will improve access for specific specialties, contributing to an avoidance of inappropriate admissions/appointments, subject to the roll out of WCCG.<br><br>Subject to the investment decisions, the impact of expansion in Ambulatory Care |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| Ambulatory Emergency Care Network (AECN) from March 2015, building on the significant work carried out to identify the key target ambulatory conditions and using the acute hospital sites as a network of hospitals supporting each other to ensure ambulatory care is the default. <br><br> – Detailed plans have been agreed for each element of the Rapid Access to Radiology project.  These will be delivered in line with 2015-16 investment decisions <br><br> – Specialist advice access for GPs has been established in a number of areas with discussions ongoing with further Specialties. | and Radiology is anticipated in 2015-16. |
| **C4B Service Improvement Programme** <br><br> **-Pre Hospital Services Project** <br><br> • An Alcohol Treatment Centre (ATC) has been established, reducing inappropriate attendances to the Emergency Department; and reducing demand for WAST vehicles to attend the night time economy. In first 3 months of operation 426 people treated at Help Point. <br><br>      - Assault victims – 41 (10%) <br>      - Injured persons – 179 (42%) <br>      - Vulnerable persons – 206 (48%) <br>      - Estimated 310 avoided WAST attendances <br>      - Evaluation of service commissioned from Swansea University Health Economics Department <br><br> – The Choose Well Campaign continues to focus messages towards 16,000 ABMU staff. It has expanded to include key message about speaking to  Health Visitors for advice about children before calling Primary Care, and raising profile of community pharmacy as alternative to ED or GP <br><br> – Tele health project underway linking WAST to GPOOH enabling more WAST calls to be resolved at scene as opposed to conveyed to ED <br><br> – Tele health project underway linking 15 Care homes to GPOOH, aimed at reducing number of 999 calls, inappropriate conveyances and admissions and reduce home visits. <br><br> – Established frequent attendees programme targeted high volume inappropriate users of WAST and ED. Identified individuals referred to Red Cross who work with them for up to 12 weeks. Small number of high frequency attendees have been targeted (less than 40 individuals) initial reports are positive – evaluation being completed. <br><br> – It was planned during 2014/15 to expand the hours of operation of the Acute GP Unit at Singleton Hospital, to support  AGPU receiving more red 2 – green 3 WAST calls. Due to pressure on Primary Care workforce it has not been possible to recruit further | The services initiated by the Project are designed to avoid attendances at Hospital. As the services continue to establish, the contribution to avoided attendances is anticipated. <br><br> The profile of recruitment in the medical workforce covers the breadth of the IMTP. The impact on increased capacity is correlative to this investment. <br><br> Recruitment continues to be developed in line with workforce availability and robust operational plans for delivery of planned savings. <br><br> As a 3 year planning process, the impact of this Project was scheduled for later years, with the first year focused on analysis, engagement and planning. <br><br> The recent appointment will support the development of this Project in 2015 and onwards. |

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| Acute GPs to the service and expand operational hours. This will be reviewed in the next financial year. | |
| **C4B Service Improvement Programme**<br><br>**-Hospital Services Project**<br><br>‒ Consultant workforce recruitment has begun. During 2014, 8 Consultants have been recruited across Swansea Locality:<br><br>   - 1 geriatrician<br>   - 2 gastroenterologists<br>   - 2 stroke physicians<br>   - 2 acute care physicians<br>   - 1 respiratory physician<br><br>‒ Five of these posts have been to replace established posts, two have been funded through unscheduled care funding, with one post using the IMTP strategic change funding.<br><br>‒ The posts are already providing increased flexibility to allow opportunity for service improvement for example since October 2014 Gastroenterology have been providing a 6 day a week On Call service which previously was not possible to organize.<br><br>‒ Over the next 2 and half years a further13 additional consultants will be recruited. This will be part of transforming the way medicine is organised for the population for Swansea and Neath Port Talbot Specifically recruitment of the following is planned for later this financial year:<br><br>   - Up to 4 Respiratory Consultants.<br>   - Up to 3 Geriatricians<br>   - And 7  Acute Care Physicians<br><br>‒ Stroke Clinicians have agreed to establish one Hyper Acute Stroke Unit on the Morriston Site. Within Oncology and Haematology, a plan has been developed for co-location of inpatients at Morriston. Future demand for Cancer Services is being modelled over the next 10 years, in partnership with Swansea University.<br><br>‒ Developed a plan to  increase  Medical Nurse Practitioners to support a range of changes that will imporve effciency and quality<br><br>‒ The project aimed to establish Acute Ambulatory Care on the Morriston Site. Plans for the implementation of this have been delayed due to the current capacity within the Acute Care | Enhanced communication and access for patients through working with patients and carers.<br><br>The planned efficiency gains are under review, responding to the pressures faced by the Health Board.<br><br>Patients are cared for in the appropriate setting, providing better access and supporting secondary care capacity. |

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| Physician workforce. Implementation is planned for April 2015.<br><br>• | |
| **C4B Service Improvement Programme**<br><br>    – **Women, Children and Families Project**<br><br>‑ An initial scoping exercise has been completed regarding the proposals to co-locate obstetrics, neonates, gynaecology and inpatient and urgent paediatrics on the Morriston Hospital site.<br><br>‑ A review of the Paediatric Assessment Unit (PAU) at Morriston has been completed. The findings are being worked through in partnership with primary care colleagues; these include the management of certain conditions towards admission avoidance and care in the appropriate setting.<br><br>‑ A new paediatric urgent care model is also in development, following recent site visits to centres of good practice, combining PAU and paediatric ED.<br><br>‑ A number of workshops and engagement events have taken place with partners across the Western Bay, including site visits, to determine a stream lined approach to assessment and care planning.<br><br>‑ Following implementation of the continuing care guidance, a review has been undertaken with partners with a focus on further improvements, particularly following recruitment of a new paediatric continuing care assessment team.<br><br>• Plans were submitted in respect of sapphire suite (secure environment for vulnerable children) for nursing provision, to replace the existing support which is currently provided by school health nursing. This will proceed subject to investment decisions. | As a 3 year planning process, the impact of this Project was scheduled for later years, with the first year focused on analysis, engagement and planning. |
| **C4B Service Improvement Programme**<br><br>    – **Trauma Centre Development Project**<br><br>‑ A Clinical lead has been appointed to represent ABMU in the South Wales Major Trauma Network. | The recent appointment will support the development of this Project in 2015 and onwards. |
| **C4B Service Improvement Programme**<br><br>    – **Outpatient Modernisation Project**<br><br>‑ There is ongoing engagement to understand the opportunities of patients receiving out-patient care in non-hospital based settings. Several pilots have been initiated including telephone and e-mail advice and digital imagery.<br><br>‑ Actions during 2015/16 include:<br><br>‑ Using digital technology for dermatology patients<br><br>‑ Establishing virtual clinics in nursing homes for older people with mental health problems and MSK services<br><br>‑ Physiotherapy and nurse led clinics | Enhanced communication and access for patients through working with patients and carers.<br><br>The planned efficiency gains are under review, responding to the pressures faced by the Health Board. |

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| <ul><li>E-mail advice between consultants and GPs</li><li>Telephone advice</li><li>Development of new shared care pathways for patients on medication</li><li>Due to the early phase of implementation of the initiatives identified and being taken forward by the directorates and localities, it is currently difficult to quantify the impact of the initiatives. This has been identified as a high priority for the work programme for 2015/16 with directorates and localities working closely with informatics colleagues to ensure the impact of the initiatives such as virtual clinics is captured appropriately and robustly evaluated to determine impact on efficiency, patient experience/outcomes and cost savings.</li></ul> | |
| **C4B Service Improvement Programme**<br><br>   – **Elective Procedures in Primary and Community Care Project**<br><br>The project has focused on Vasectomy services  transferring to Primary Care, with a new service model and specification agreed and comprehensive procurement exercise completed, to provide the optimum service as specified by Urologists, GPs and the Surgical Services Directorate.  Two community networks will deliver the service, one in Bridgend and the other in Swansea. | GPs have completed their minor surgical training in Swansea so that Patients are cared for in the appropriate setting, providing better access and supporting secondary care capacity. Bridgend training will be completed shortly. |
| **Surgical Efficiency Pathway Programme**<ul><li>Expertise and support has been secured through the newly established Service Improvement Team, support from the University and "flow" roles within individual Directorates</li><li>Progress has slower than anticipated for a number of reasons including bed pressures, information systems, clinical engagement and investment.</li><li>The focus has been on unblocking some of the major bottlenecks in the pathway – pre operative assessment and theatre resourcing – as these were seen as fundamental planks that need to be in place before pathways are redesigned.</li></ul> | Completion of TOMS roll out in December and implementation of the Service Improvement Team will enable us to measure the impact of the programme going forward. |

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| **Patient Flow**<br><br>– Expertise and support has been secured through the newly established Service Improvement Team and close working with the 1,000 Lives Collaborative<br><br>– Training and education across teams has been developed through good levels of participation in local and national workshops held as part of the 1,000 Lives Programme and over 50 clinical and managerial staff have successfully completed the Foundations of Improvement Science in Healthcare (FISH). Over 1,500 staff are holders of the Bronze Improving Quality Together (IQT).<br><br>• Working practices and processes have changed to focus on flow; with weekly "Big Room" standard meetings are held on each site. A number of specific improvement projects have been supported which have demonstrated measurable benefits – medicines reconciliation, ED minor injury streams, therapy input to weekends, triage capacity in GP OOH. | Individual improvement projects have developed their own specific measurements to demonstrate improvements<br><br>Overall the Flow programme is monitoring impact on mortality and unscheduled care access times<br><br>Next phase is to measure the impact on bed days used more directly<br><br>By the end of the year the Service Improvement Team will have supported the delivery of tangible improvements in inpatient flow on target wards across each of the hospital sites, through consistent implementation of Board Rounds. |
| **Effective Information Systems and Use of Technology**<br><br>– This programme is an integral part of the strategic planning process and will be the enabler to deliver quality and safety improvements as well as many of the service modernisation projects.<br><br>– A Strategic Outline Programme (SOP) for Informatics has been developed to establish an innovative investment strategy, maximising the utilisation of sources of funding. Individual scoping documents have also been submitted to Welsh Government to highlight funding requirements for key projects in the areas of unscheduled care and surgical pathways.<br><br>– The first phase of a Ward Management Portal has been implemented across the Health Board to provide live admissions lists and a standardised process for completing discharge summaries.<br><br>– A single Theatre Management System, TOMS, has been implemented across the Health Board to support process efficiencies and improved clinical and performance information.<br><br>– A Clinic Letter System has been successfully rolled out across the Health Board to provide a standard process for creating and processing OP Clinic Letters. This is a huge step forward towards establishing an electronic patient record.<br><br>– Introduction of a number of key performance dashboards in the areas of patient flow, surgical pathway, HAT, discharge | The implementation of the described innovative technological solutions has provided the organisation with more effective ways of working, and significant advancements towards an electronic, patient centred view of information enabling high quality care and service modernisation. |

| Strategic Change Programmes - Key successes | Impact |
|---|---|
| summaries and outpatients<br><br>&#8211; Significant progress has also been made on ICT projects/initiatives in the following areas: Digitising the Health Record;; Clinical Portal; ePrescribing;; eReferrals; Emergency Department; ,pre assessment Pathology; Radiology; Outpatient Flow: Community and Social Care.  . | |
| **Commissioning Development Programme**<br><br>&#8211; A number of work streams within the Programme have been significantly progressed including:<br><br>&#8211; Joint Strategic Needs Assessment<br><br>&#8211; Planning & Commissioning Framework & Commissioning Boards<br><br>&#8211; Communication & Workforce Development<br><br>&#8211; Improving Clinical Engagement in Commissioning<br><br>&#8211; Improving use of data for Commissioning<br><br>&#8211; Progress includes the creation of several Changing for the Better Commissioning Boards, including associated governance, organisational engagement and establishing Programme Budgeting Marginal Analysis (PBMA) exercises. | The establishment of Commissioning Boards; the principles, approaches and culture of commissioning, will support and inform the strategic planning of ABMU Health Board for the current and future years of the IMTP.<br><br>Allow whole pathways to be designed, including prevention services and the prudent healthcare approach |

## Appendix 7     Progress in Developing Community Networks and Plans

| | |
|---|---|
| **Planning care locally** | • The production of a Community Network Development Plan, to support the development of cluster networks and increase their responsibility and autonomy. We have worked with network leads and partners to identify the actions to be taken forward over the next three years as part of their Cluster Network Plans.<br><br>• Supported cluster networks to develop their own local Plans as part of the GMS contract changes.<br><br>• In response to the launch of the Primary Care Plan for Wales (Nov 14) we have identified actions under each of the five priority areas within the National Plan. These are set out in Section 6.<br><br>• We have led a national piece of work to develop a common set of measures across Wales and it is hoped that these will be introduced in April 2015.<br><br>***Service Developments***<br><br>• A new care homes enhanced service has been developed. The scheme is designed to focus on anticipatory care for vulnerable patients and encourages practices to collaborate. service.<br><br>• A new enhanced service for 'Long Active Reversible Contraceptives (LARC) and more specialised Sexual Health Services has been introduced.<br><br>• Through additional WG funding  - the roll out of a non-medical prescriber continence support service<br><br>• The transfer of vasectomy services from secondary to primary care and we will use this as an exemplar to look at other planned care.<br><br>• North Network in Bridgend has set up a Joint Working Agreement project with a pharmaceutical industry. The aim of the project is to improve outcomes and equity of care of patients with COPD and asthma. |
| **Improving Access and Quality (equitable access)** | **Primary Care**<br><br>• The Primary Care Access Forum (PCAF) has developed an access improvement plan to drive improvements in the tier 1 targets as well as other areas.<br><br>• The Primary Care Foundation are working with a number of practices in one network area to support practices balance capacity and demand. If the model of support is successful, we would look to roll this out to other practices.<br><br>• Telephone triage is being developed in a number of networks.<br><br>• New access guidance is being developed to focus on a number of targeted areas including a reduction in lunchtime opening and improvements in the number of practices offering appointments after |

| | |
|---|---|
| | 5pm on a routine basis. |
| | • Ongoing roll out national ICT programmes – 45 practices migrated to date. |
| | **Dental** |
| | • Some improvement s, with 2% more units of dental activity commissioned in 2013/14 than two years previously. |
| | • In-hours access appointments have also improved as a consequence of the new ABMU service model implemented on the 1st April 2014. |
| | • Community Dental Service will also be able to provide services to bariatric and wheelchair bound patients with the development of a facility at Port Talbot Resource Centre. |
| | **Pharmacy** |
| | Progress has been made in extending the range of services accessed via community pharmacists.  This includes: |
| | • Developing a Level 3 Stop Smoking service from 40 community pharmacies across ABMU |
| | • Extending the number of pharmacies providing seasonal influenza vacation in line with WG guidelines |
| | • Enabling community pharmacies to provide  Medicines Management Service for Domiciliary Care |
| | Medicines Management.  Developments include: |
| | ₋ An agreement to recruit four polypharmacy pharmacists to work in primary care. |
| | ₋ The launch of a Network Prescribing Management Scheme, focusing on respiratory prescribing |
| | ₋  Pain clinics run by a specialist pain pharmacist, which will be rolled out to target networks in 2015. |
| | Engaging community pharmacy in community networks: A project in Bridgend focussed community pharmacy MURs on osteoporosis, linking in with network aims. |
| | **Optometry** |
| | Improving access is described more fully in the local Eye Care Plan.  The national IT Programme is being rolled out across Optometry practices and which will enable practices to refer to secondary care using e-referrals. |
| | Funding to support the transfer of work to primary care optometry practices will be used to facilitate post-operative cataract patients being followed up by optometrists working in the community, as well as enabling ocular hypertension and glaucoma monitoring to be undertaken locally. |
| **Strong leadership** | • Development of Cluster/Network Plans |
| | • The practices in one network have agreed in principle to develop a federated model. An initial Chief Executive conference was held in the summer of 2014. |
| **Skilled Local Workforce** | • Practice management development programme |
| | • Development of advanced skills for practice nurses |

## Primary Care Plan – Priorities for action

The National Primary Care Plan identified 5 priority areas for action:

- Planning care locally
- Improving access and quality
- Equitable access
- Skilled local workforce
- Strong leadership

We have developed a primary care plan, which identifies key actions within these 5 themes.

## Primary Care Planning

We will continue to support networks to mature and develop as the process of developing their 3 year plans matures. We will support a number of Pathfinders which will provide learning on an All Wales level.

| Planning Care Locally | |
|---|---|
| Action | Timescale |
| • Take forward individual priorities identified within the cluster network plans | 2015/18 |
| • Support the development of a small number of priority areas to develop pathfinder initiatives (further detail below) | |
| • Support the testing of new organisational models within primary care – for example, federations, social enterprise, super practices | |
| • Join up, and embed, the delivery of integrated health and social care within the network areas | |
| • Enhance opportunities to develop partnerships with third sector organisations | |
| • Rolling out the work undertaken by the Primary Care Foundation on access improvements within networks | |
| • Implementing plans to extend triage models in primary care | |
| **Impact** | |
| Improved co-ordination of the delivery and development of services across networks | |

## Improving Access and Quality

We will:

- Develop new pathways to support the introduction of the new 111 model.  ABMU have agreed to become the pathfinder from October 2015.  A dedicated resource has been made available from ABMU to support both the local and national implementation arrangements.  A local implementation plan is being developed and to support this, a dedicated local implementation board has been established. The key tasks will be to:
  - Establish a comprehensive and robust local Directory of Service
  - Establish alternative pathways for key conditions/clients to enable calls from 111 to be diverted or redirected to the most appropriate service to meet their needs
  - Technical, communications and local workforce plans to be developed that align with the national implementation project plan.
- Support the introduction of the Social Services and Well Being Act.

Our priorities to improve access to GPs (across the in and out of hour's period) are as follows:

| Improving Access and Quality | |
| --- | --- |
| Action | Timescale |
| • Work with GP practices to test and develop new models of access | 2015/16 |
| • Work to reduce the level of Do Not Attends(DNAs) within primary care – by introducing text messaging | |
| • Support practices to extend the scope for nurses to support access to urgent primary care services by up skilling practice nurses in the management of chronic disease and minor illness | |
| • Promote the use of My Health On line as a tool for patients to be able to request repeat prescriptions and make GP appointments | |
| • Support practices in reviewing and managing workload | |
| • Continuing to work with practices to extend access for patients who work, by promoting later afternoon appointments | |
| • Extend the access during core hours by encouraging all practices (except those who meet our definition of a small practice) to be available to their population for at least 47 ½ hours per week (out of a maximum of 52.5 hours). | |
| • Implement the new GP Out of Hours Standards for Wales. | |
| • Creating a 'triage' hub at Morriston Hospital to provide additional capacity to manage peaks in demand | |
| • Extending the workforce available to support GP OOH with nurses | |

| |
|---|
| • Pilot tele health links with care homes and also the Welsh Ambulance Services Trust (WAST) to enable face to face dialogue with professionals and patients using video-calls<br><br>Continue to test patient experience working collaboratively with the Community Health Council |

| **Impact** |
|---|
| The impact of this these actions will be to:<br><br>• Improve access for working patients<br><br>• Ensuring that GP practice and GP OOH have the necessary capacity to meet urgent clinical need<br><br>• Improve the timeliness of response to out of hours services and improve the quality of service available<br><br>• Assist in managing demand by directing patients to the most appropriate service that can meet their needs by ensuring effective signposting<br><br>• Improve the overall availability of practices within core hours to respond to patient need. |

## Equitable Access

Within ABMU we have significant issues to tackle in terms of health inequalities both across the Health Board and within individual locality areas. Each network has identified initiatives to address key issues within their individual local area.

| **Equitable Access** | |
|---|---|
| Action | Timescale |
| • Improving end of life care<br><br>• Tackling respiratory disease,  diabetes education and anti coagulation<br><br>• Ensuring robust anticoagulation services are in place<br><br>• Targeting atrial fibrillation<br><br>• Care for patients with diabetes<br><br>• Early detection of cancer and the interface between primary and secondary care. Managing patients at risk of deterioration and introducing a new model of care coordination to manage patients who are vulnerable<br><br>• We would target any additional WG funding into these discrete areas to maximise the benefit of additional investment during year 1 of the IMTP.<br><br>• Take forward specific actions to improve access to eye care and dental services in line with our agreed Local Eye Care Plan and Local Oral Health Plan<br><br>• Extend the range of services available within community pharmacies | 2015/18 |
| **Impact** | |

> These seven key areas were common themes across the cluster network plans and are also considered to be areas where targeted investment will have the biggest impact in terms of quality, access, focussing on the specific primary care actions within the NHS delivery plans and where there is likely to be wider system benefit and impact on health inequalities.

## Skilled Local Workforce

The GP practice is at the heart of primary care and will continue to be so in the future.  However, their role will increasingly be to provide overarching leadership to multi-professional teams, made up of advanced practice nurses, community and district nurses, midwives, health visitors, healthcare support workers as well as pharmacists, therapists, social care staff and third sector staff.

As part of Phase 2 of the Western Bay Programme we will take forward the work to develop new service models and the workforce required to support these models.

| Skilled Local Workforce | |
|---|---|
| • **Action** | Timescale |
| • Commit to a longer term programme of up skilling for practice and other community nurses and developing a plan to extend the number of independent prescribers | 2015/16 |
| • Consider opportunities to extend the skills and number of pharmacists working in support of networks | |
| • Build links with community pharmacists so that they become an integral part of network | |
| • Focussing on the provision of skills within care homes – particularly in the management of patients at end of life and working with Macmillan Cancer Care to drive service improvement | |
| • Improve the interface between primary and secondary care and ensuring that Consultant Job plans are aligned with , and in support, of priority areas including frail older people and the management of chronic conditions by identifying specific community sessions within job plans | |
| • Consider other actions to improve the recruitment and retention of GPs locally in line with the all Wales workforce plan and actions set out in 7.2.4 | |
| • Continuing to develop advanced practice nursing | |
| **Impact** | |

The impact of these actions will be:

- A broader skill mix of practitioners working within primary and community settings maximising the role of other professionals working to support core primary care teams
- Improved working across the primary and secondary care interface to provide seamless care, and creating new roles that may help to address recruitment issues

A more sustainable model of primary and community care

## Strong Leadership

| Strong Leadership | |
|---|---|
| Action | Timescale |
| ‒ Continuing to develop a leadership programme for cluster network leads/chairs to support the development of network working<br>‒ Support networks who want to have greater autonomy/freedom to become 'pathfinders' and provide OD support to help networks grow and develop<br>‒ Continue to support the development of practice managers<br>‒ Supporting networks in developmental implementation of effective plans to get best outcomes from cluster investments. | |
| Impact | |
| A robust clinical leadership model for networks and more sustainable primary care models in place. | |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

## Cluster Network Plans

| Strategic Aim | Action | Bridgend East | Bridgend West | Bridgend North | NPT Upper Valleys | NPT Neath | NPT Afan | Swansea Bay | Swansea Penderi | Swansea Cwmtawe | Swansea Llwchwr | Swansea City |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 1: To understand the needs of the population served by the Cluster Network | Finalise detailed network profile of need | . | . | . | . | . | . | Yes | Yes | Yes | Yes | Yes |
| | Improved/increased data sharing, collation and management with partner organisations to inform service developments | Yes | . | . | . | | | . | . | . | . | . |
| | Increase bowel screening uptake | . | . | . | . | | | Yes | Yes | . | . | . |
| | Increase cervical screening uptake | . | . | . | . | | | Yes | Yes | . | . | . |
| | Increase attendance of diabetic retinopathy screening | . | . | . | . | | | Yes | Yes | . | . | . |
| | Undertake alcohol screening | . | . | . | . | | | Yes | Yes | . | . | . |
| | Reduce obesity in children (Adults) | . | . | Yes | . | | Yes | Yes | Yes | . | . | . |
| | Weight Management Scheme | . | . | . | | | | . | . | Yes | Yes | Yes |
| | Asthma Education | . | . | Yes | . | | | . | . | . | Yes | . |
| | Reduce Smoking / Smoking cessation referral | Yes | . | Yes | Yes | Yes | Yes | . | . | Yes | . | Yes |
| | Introduce opportunistic screening for AF and valvular disease | . | . | . | . | | | Yes | Yes | . | . | . |
| | Increase flu immunisation uptake | Yes | . | . | Yes | Yes | Yes | Yes | Yes | Yes | . | . |
| | Roll out diabetic injectables | Yes | . | . | . | | | . | . | . | . | . |
| | Improve community services for frail elderly and Reduce falls | . | . | . | . | | | . | . | Yes | Yes | Yes |
| | Wound Management | . | . | . | . | | | . | . | . | . | Yes |
| | Improve provision of Sexual Health Services with cross referral | . | . | Yes | . | | | . | . | . | . | Yes |
| | Increase access to Pulmonary Rehab Service | . | . | . | . | | | . | . | . | Yes | . |
| | Develop Alcohol/Substance Misuse Service | . | . | . | . | | | . | . | . | . | Yes |
| | Dementia Friendly training | . | . | . | . | | | . | . | . | . | . |
| | Improve access to Tier O Mental Health Services | . | . | . | . | | | . | . | . | Yes | . |
| | Increase uptake of Care Home Enhanced Service | . | . | . | . | | | . | . | Yes | . | . |
| | Consistency of Read coding in data extraction/export | . | Yes | . | . | | | . | . | . | . | . |
| | Monitoring increasing numbers of non-English language speakers accessing the services | . | Yes | . | . | | | . | . | . | . | . |
| | Health Board to develop USC dashboard with 'red flag'/better communication systems | . | Yes | . | Yes | Yes | Yes | . | . | . | . | |
| | Engagement and clinical dialogue with colorectal surgery | . | Yes | . | . | | | . | . | . | . | . |
| | Access to CAB | . | . | . | . | | | . | Yes | Yes | Yes | . |
| | Increase use of Voluntary Sector / Community Connectors | . | . | . | Yes | | | Yes | Yes | Yes | Yes | Yes |
| | Establish patients/carer participation group | . | . | . | . | | | Yes | Yes | Yes | Yes | Yes |
| | Increase the use of Healthy City Directory | . | . | . | . | | | Yes | Yes | Yes | Yes | Yes |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim | Action | Bridgend East | Bridgend West | Bridgend North | NPT Upper Valleys | NPT Neath | NPT Afan | Swansea Bay | Swansea Penderi | Swansea Cwmtawe | Swansea Llwchwr | Swansea City |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 2:  To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients | Discuss/ monitor access arrangements | Yes | . | . | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Pilot new ways of working with different staff skill mix. Analyse data and share with network/cluster | | | | Yes | Yes | Yes | | | | | |
| | Patient education ensuring consist knowledge of communication channels are maximised including the use of standard forms | Yes | . | Yes | . | . | . | . | . | . | . | . |
| | Identify patient prioritisation systems in place within primary care and share good practice with rest of cluster | . | . | . | Yes | Yes | Yes | . | | . | . | . |
| | Re-evaluate model of delivery - telephonen triage/consultations/different skill mix | | | | Yes | Yes | Yes | | | Yes | | |
| | Explore appointment text reminder service / Use text messaging across Network to reduce impact of DNA | . | | | | Yes | | Yes | Yes | . | | Yes |
| | Reception/admin staff training to ensure consistency of message to patients (re: minimising wasted appointments; increasing availability) | . | . | Yes | Yes | | | | | | | |
| | Implement medicines waste management scheme to generate savings for investment in the Network | . | . | Yes | | | | | | | | |
| | My Health Online in all practices | Yes | . | Yes | Yes | Yes | | Yes | Yes | . | . | . |
| | Explore the potential for use of telephone triage | . | . | . | Yes | Yes | | . | . | Yes | . | Yes |
| | Advertise Choose Well Campaign | . | . | Yes | . | | Yes | Yes | Yes | . | . | . |
| | Complete GPC Wales Workload Survey | . | . | . | . | | | Yes | Yes | . | . | . |
| | Address difficulties in recruiting partners and shortages of locums | . | . | Yes | . | . | Yes | Yes | Yes | . | . | . |
| | Ensure primary care estate is fit to deliver services | . | . | . | . | | | Yes | Yes | . | . | . |
| | Explore practices working more closely together | . | . | . | . | Yes | Yes | Yes | Yes | . | Yes | . |
| | Review workforce demographics | . | . | . | . | . | . | Yes | Yes | . | . | . |
| | Peer support and succession planning | Yes | . | . | . | . | . | . | . | . | Yes | . |
| | Workforce vacancy monitor | . | Yes | . | . | | | . | . | . | . | . |
| | Explore establishment of cluster clinics with GPwSI (possibly MSK clinic) | . | . | . | . | | | . | . | Yes | . | . |
| | Consider impact (with planning department) of new housing developments | . | . | . | . | | | . | . | Yes | . | . |
| | Improve Discharge Summaries- 80/90 % to be received within 48 hours | Yes (80%) | Yes (90%) | . | Yes | Yes | Yes | . | . | . | Yes | Yes |
| | Work with secondary care to ensure that patients receive letters for non attendance as well as GPs [ie not just when discharged] | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | Cluster to establish work via the Prescribing Incentive Plus Scheme, within the first year to complete switch from  Symbicort to | Yes | . | . | . | | | . | . | . | . | . |
| | Develop GP Skills Directory | . | . | . | . | | | . | . | Yes | . | . |
| | Agreed data extraction via Audit + to give comparative and trend data to inform local planning | Yes | Yes | . | . | | | . | . | . | . | . |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 3: Planned Care – to ensure that patients needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimizing waste and harm | Ability to cross refer for long acting reversible contraception | . | . | . | . | | | Yes | Yes | Yes | Yes | Yes |
| | Ability to cross refer for shared care/substance misuse | . | . | . | . | | | | Yes | . | . | . |
| | Provide expert management of complex AF patients – clinics in community | . | . | . | . | | | | Yes | . | . | . |
| | Pilot a dementia friendly approach | . | . | . | . | | | | Yes | . | Yes | . |
| | Undertake PMS+ | . | . | . | . | | | Yes | Yes | Yes | Yes | Yes |
| | Increase practices providing care home enhanced service | . | . | . | Yes | Yes | Yes | | Yes | Yes | Yes | . |
| | Review consistency of provision of enhanced services | . | . | . | Yes | Yes | Yes | Yes | Yes | . | . | . |
| | Implement Minor Surgery Network Wide Service | . | . | . | . | | | | . | . | . | Yes |
| | Mental Health – addressing issues around urgent case referrals | . | . | . | . | | | | . | . | | Yes |
| | Improve waiting times for MCAS service | . | . | . | . | | | | . | . | Yes | . |
| | Streamline access to OPD via continuation with ENT clinics and Rheumatology clinics | . | . | . | . | | | | . | Yes | . | . |
| | Pilot triage of referrals to dermatology using agreed dermatology camera | . | . | . | Yes | Yes | Yes | . | Yes | . | . | . |
| | To improve communication loops (possibly via WCCG) around USC with particular reference to downgrades and delays in treatment | Yes | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | To improve patient care for isolated/socially excluded /housebound patients, embedding the chronic disease management role in the community nursing team | . | Yes | . | . | | | . | . | . | . | . |
| | Development of a community based ultrasound equipped musculoskeletal service | . | . | Yes | . | . | | . | . | . | . | . |
| | Work with LHB to develop a one-stop shop for Iron Deficiency Anaemia | . | . | Yes | . | . | | . | . | . | . | . |
| | Agree clinical pathways to be reviewed / developed with identified secondary care directorates and other partners | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | To assess feasibility and test practical/medico-legal issues for improved diabetes management in care homes by routine monitoring via periodic BMs and self/care home administration of insulin | . | Yes | . | . | | | . | . | . | . | . |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 4:  To provide high quality, consistent care of patients presenting with  urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management | Reduce inappropriate visits to ED and 999 calls | . | . | . | | | | Yes | Yes | . | Yes | see 2 |
| | Choose Well Campaign | . | . | . | Yes | Yes | Yes | . | . | . | Yes | . |
| | Improve communication between Primary care and Welsh Ambulance | . | . | . | | | | . | . | . | Yes | Yes |
| | Reduce inappropriate visits/frequent users via exploring use of telephone triaging and effective signposting to Voluntary sector services | . | . | . | Yes | Yes | Yes | . | . | Yes | . | . |
| | Reduce hospital admissions | . | . | . | | | | . | . | Yes | . | . |
| | Proactive/ anticipatory care | . | . | . | | | | . | . | Yes | . | . |
| | Signpost to community based options | . | . | . | | | | | | | | |
| | Secondary Care to ensure timely and consistent feedback to referring GP on USCs so that patient expectations can be addressed. | Yes | . | Yes | Yes | Yes | Yes | . | . | . | . | . |
| | Diabetic reviews and pilot injectables / Explore methods for identifying patients at risk of diabetes with a view to improving management of the condition | Yes | . | . | . | . | . | . | . | . | . | . |
| | Pilot e-mail advice service for rapid access to secondary care advice for diabetes | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | As above for respiratory | . | . | . | Yes | Yes | Yes | | | | | |
| | As above for acute element of CRT | . | . | . | Yes | Yes | Yes | | | | | |
| | Run Vasectomy service | Yes | . | . | | | | . | . | . | . | . |
| | Evaluate FH pilot | Yes | . | . | | | | . | . | . | . | . |
| | Ensure safe and effective availability of rescue medication for COPD patients in care homes, with the collaborative development of guidance for care home staff | . | Yes | . | | | | . | . | . | . | . |
| | Development of algorithm for consistent follow-up of USC referral downgrades | . | Yes | . | Yes | Yes | Yes | . | . | . | . | . |
| | Development of housebound register to inform of service demands/pressures | . | . | Yes | | | | . | . | . | . | . |
| | Promote role of Third Sector in supporting primary care | | . | . | Yes | Yes | Yes | | | | | |
| | CCM role development | . | . | Yes | | | | . | . | . | . | . |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 5: Improving the delivery of end of life care | *Review delivery of end of life care using the after death analysis toolkit / Individual Case Review Audit* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Summarise outcomes and any arising issues and actions | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | . | . | . |
| | *Establish a review cycle to monitor progress / Undertake regular audit sharing results on a cluster basis* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | . |
| | Palliative Care – developing closer relationships with secondary care, address communication | . | . | . | . | | | . | . | . | . | Yes |
| | Use of Principles of End of Life Care | . | . | . | . | | | . | . | Yes | . | Yes |
| | Retrospective individual case review (palliative care deaths) as network learning activity with community nursing colleagues (district; Macmillan) | . | Yes | Yes | . | | | . | . | . | . | . |
| | Audit the use of the 'Just in Case' box and work with the palliative care, medicines management and primary care teams to improve utilisation and re-launch the scheme locally | . | . | . | . | | Yes | . | . | . | . | . |
| | Improve effectiveness of palliative care MDTs in collaboration with District Nursing. Engage with District Nursing pilot in Care Homes to improve end of life care and prevent unnecessary admission to hospital and explore collaborative working with Ty Olwen | . | . | . | Yes | | Yes | . | . | . | . | . |
| | LHB to facilitate information sharing by community palliative care team | . | Yes | . | . | | | . | . | . | . | . |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 6: Targeting the prevention and early detection of cancers | *SEA of all new lung, stomach and upper GI cancers* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | *Summarise learning and actions* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | . | . |
| | *Summarise themes and actions for review* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | . | . |
| | Review USCs downgrades & improve comms between P and S care | . | | Yes | Yes | Yes | Yes | . | . | Yes | . | Yes |
| | Regular audits to be shared amongst networks | Yes | Yes | Yes | Yes | Yes | Yes | . | . | Yes | Yes | Yes |
| | Adopt principles of end of life care | . | . | . | . | | | . | . | . | . | Yes |
| | Use of pathways: Red Flag Symptoms | . | . | . | . | | | . | . | Yes | . | . |
| | Scope the access to diagnostics in Primary Care, particularly in relation to MRI, CT scans and imaging and identify key issues | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | Network approach to promote Public Health Wales Screening programmes | Yes | Yes | . | Yes | Yes | Yes | . | . | . | . | . |
| | Increase locally/practice based Stop Smoking Wales services | . | Yes | . | . | | | . | . | . | . | . |
| | Improve the quality of referral letters using locally available/specialty guidance | . | Yes | . | . | | | . | . | . | . | . |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 7: Minimising the risk of frailty and poly-pharmacy | *Identify the % of patients aged >85 receiving 6 or more medictns* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | *Undertake face to face med reviews using No Tears approach* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | *Identify actions to be undertaken in the PDP* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | *Summarise themes for action & review within Cluster network; action identified within Cluster Network Annual Report* | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Undertake a range of prescribing initiatives / PMS Scheme | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Undertake polypharmacy review and high dose steroid asthma reviews | . | . | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | . |
| | Improve/maintain against prescribing indicators | Yes | . | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Attend educational sessions | . | . | . | . | | | Yes | Yes | Yes | Yes | Yes |
| | Develop pre-diabetes pathway | | | | | | Yes | . | . | . | . | . |
| | Work with Care and Repair on direct GP referral Pilot funded via ICF | Yes | . | . | . | | | . | . | . | . | . |
| | (On-going) Falls/bone health pilot – outcomes to be shared and implemented to all community pharmacies as part of MUR | . | Yes | . | . | | | . | . | . | . | . |
| | Joint med reviews in care homes GP and LHB Pharmacist to review needs and minimise risks of poly-pharmacy | . | Yes | . | . | | | . | . | . | . | . |
| | Develop joint template for care home data recording / reviews | . | Yes | . | . | | | . | . | . | . | . |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 8: Deliver consistent, effective systems of Clinical Governance | Demonstrate governance - completion of the CGPSAT tool | Yes | . | . | Yes | Yes | Yes | Yes | Yes | Yes | . | Yes |
| | To review Significant Event Analysis ongoing learning through community network boards | Yes | Yes | . | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Premises fit for purpose | . | . | . | Yes | Yes | Yes | . | . | . | . | Yes |
| | Practices to review all cancer referrals that have been downgraded | . | . | . | . | | | . | . | Yes | Yes | . |
| | Develop systems to sound process management and effective data capture on antibiotic prescribing | . | Yes | . | . | | | . | . | . | . | . |
| | Refer appropriately into the Alternative Primary Care Provision where patients have been violent and/or aggressive | . | . | . | . | | | . | . | . | Yes | . |
| | Each practice to bring one SEA to each cluster meeting | . | . | . | . | | | Yes | Yes | Yes | Yes | Yes |
| | Continue with effective PLTS programme | . | . | . | . | | | . | . | Yes | . | . |
| | Buddy and support all practices in the network to work towards level 4 of all the Robbie Powell indicators on the GPSAT | Yes | Yes | . | . | | | . | . | . | . | . |
| | Ensure efficient, effective and timely management of OOH care Including a review of the process for providing 'Special Notes' | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | Ensure effective clinical leadership and peer support is available through the Clinical Governance Leads Forum | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | Audit to Ensure Aspirin is no longer prescribed as anticoagulation in AF, in line with latest guidelines | . | . | Yes | . | . | | . | . | . | . | . |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 9: Other Locality Issues | Progress the INR rollout revised service model | . | . | . | | | | Yes | Yes | Yes | Yes | . |
| | Develop a shared education agenda | . | . | . | | | | Yes | Yes | . | . | . |
| | Network to link with establishment of community hub bases | . | . | . | | | | Yes | Yes | Yes | Yes | Yes |
| | Network to inform the establishment and ongoing development of a single point of access (Intake) for the integrated teams | . | . | . | | | | Yes | Yes | Yes | Yes | Yes |
| | Ambulance waiting times – review with WAST | . | | . | | | | . | . | . | . | Yes |
| | Explore publication of - Outpatient waiting times | . | . | . | | | | . | . | . | . | Yes |
| | Discharge summaries – raise common issues | . | . | . | Yes | Yes | Yes | . | . | . | . | Yes |
| | Developing key elements of primary care on a network basis; administration, payroll, recruitment | . | . | . | | | | . | . | . | . | Yes |
| | Plan for impacts of population developments, housing/student | . | . | . | | | | . | . | . | . | Yes |
| | Ensure good working relationships with key colleagues to improve patient care | . | . | . | | | | . | . | . | Yes | . |
| | Raise need for additional investment into Primary Care | . | . | . | | | | . | . | Yes | . | . |
| | Address national level shortage of locums/GP's | . | Yes | . | | | | . | . | Yes | . | . |
| | Systems to ensure that outpatient appointment are appropriately managed through directorate resources and patients are not directed to GP Practices for repeat referrals; review blood tests, results, prescribing requirements through agreed frameworks e.g. Shared Care Services. | Yes | . | . | | | | . | . | . | . | . |
| | Cross Boarder working and patient pathways with Cwm Taf and Cardiff & vale Health boards | Yes | . | . | | | | . | . | . | . | . |
| | Health Board to reintroduce Hospital communication with patient advising receipt of referral and expected wait to avoid wastage of GP consultation time | . | Yes | . | | | | . | . | . | . | . |
| | Health Board to address its systems for outpatient appointments inaccurately coding patients as not having attended where patient either attended or never received an appointment | . | Yes | . | | | | . | . | . | . | . |
| | Health Board to address Estates issues | . | Yes | . | | | | . | . | . | . | . |
| | Review Pt4L provision with a view to exploring practice development opportunities | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | Up skill practice nurses to become advanced clinical practitioners | . | . | . | Yes | Yes | Yes | . | . | . | . | . |
| | Review 3rd sector provision from Marie Curie, Ty Olwen and District Nursing provision to improve equity in relation to cross border patients | . | . | . | Yes | | | . | . | . | . | . |
| | Secure Clinical / GP leadership for NPT Locality | . | . | . | Yes | Yes | Yes | . | . | . | . | . |

# Appendix 8      Prudent Healthcare

Professor Mark Drakeford, Minister for Health and Social Services has defined Prudent Healthcare as, "Healthcare that fits the needs and circumstances of patients and actively avoids wasteful care that is not to the patient's benefit." 'Prudent' healthcare delivers three objectives:

- Doing no avoidable harm

- Carrying out the minimum appropriate intervention that delivers the outcome valued by the patient, and

- Promoting equity between those people who use and those providing services.

The waste in delivering 'imprudent' healthcare within ABMU is significant and unsustainable. In ABMU, common with developed health economies across the world around, 10 per cent of patients admitted to hospital experience some degree of avoidable harm. Similarly, around 20 per cent of all work done by staff in ABMU does not positively affect patient outcomes. We estimate that currently, only 18 per cent of time spent in ABMU hospitals offers any value to patients – the rest is spent waiting for the next step in the process. In addition, we currently do not commission our services on the basis of delivering outcomes valued by patients. Instead, we acknowledge that our services can be arranged around the needs of the system or of those delivering rather than those of our patients.

Imprudent healthcare in ABMU results from:

- Habitual practice of clinicians and patient expectation of 'being fixed'

- The causes of harm are known but complex to eradicate

- Professional autonomy leads to inappropriate variation in outcomes and experience

- High reliability, high quality care takes time and resource to embed in practice

- Response to increasing demand has been to do more of the same or put patients on waiting lists

- Healthcare policy and measurement focuses on procedures rather than outcomes or experience

- Patients are not routinely informed about or engaged in making decisions

- Care is not person-centred

- Policies and rules get in the way of delivering good outcomes and experience

- Management information does not show what is happening 'on the ground'

Our intention is to change what we do to focus on delivering outcomes and experience valued by patients and improving 'flow' through our systems. We will increasingly collect data that measures outcomes, experience and flow to help us make appropriate decisions with citizens about commissioning and performance. This will ensure that ABMU is focused on delivering what really matters to the people we serve.

We recognise that our clinicians training and time must be allocated to deliver better outcomes and experience within a culture of continuous improvement. Our staff are responsible for ensuring that people are fully informed and engaged in making decisions about their health and well- being, that patients receive high quality support and care, based on the best available knowledge.

An important principle is that the people using ABMU services will be give information to understand their personal responsibilities as citizens. This includes being involved in decisions about commissioning and design of services. The people we serve also need training to work with clinicians to set personal goals and expectations of treatment. In emergency circumstances it may not always be possible for people to be fully involved in, or aware of, decisions that have to be made in their care. But for the overwhelming majority of healthcare interactions, there is a shared responsibility between the people receiving and the people delivering healthcare.

We intend to redesign our systems around the principles of prudent healthcare:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;

- Care for those with the greatest health need first, making the most effective use of all skills and resources;

- Do only what is needed, no more, no less; and do no harm.

- Reduce inappropriate variation using evidence based practices consistently and transparently.

This will need us to work collaboratively to:

- Educate Individuals and their Families to manage their own health and well being

- Engage with Communities to support individuals

- Work with the third sector to develop new models of support

- Work in effective partnership across public services around social determinants of health, particularly housing

- Improve the integration and coordination of community, primary, and secondary care

- Work to integrate physical and mental healthcare, particularly for patients with chronic conditions

Some of the specific actions to achieve this will be to:

***Redesign Stroke service to meet RCP guidance***.

Implement the agreed service model for stroke services. In 2015/16 we will develop an early supported discharge team, providing rehabilitation support during days 3-21 of the inpatient stay. We will also develop the business case for a hyper-acute stroke unit. In 2016/17 we will focus on developing support for our longer stay patients.

***Apply Best Practice Surgery in all Surgical Disciplines***. This will require some investment in therapy support

Impact: Major reduction in length of stay for every surgical specialty-both emergency and elective, reduce costs, better patient outcomes

***Deliver LVA surgery to 42 Lymphoedema ABMU patients per year***. This has already had major equipment investment from WG

Impact: Reduce cost of managing lymphoedema, improved patient outcomes

***Deliver additional Physiotherapy Treatments in orthopaedics and in gynaecology***

Impact: Reduced number of patients choosing elective operations

***Continue to train clinicians in co-creating health, implementing the co-creating health framework*** (see below) and in interventions to affect health behaviours such as smoking, obesity, alcohol and physical activity

***Provide EPP training to patients with chronic conditions***

Impact: Reduced number of elective operations, reduced number of patients with chronic conditions being admitted to hospital, better patient outcomes, reduced costs

***Provide Psychological Therapy to patients with both chronic physical conditions and common mental health problems*** such as anxiety, depression

Impact: Reduced admissions for people with diabetes, heart disorder, COPD, reduced cost, better patient outcomes

***Work with local authority and third sector partners on health and housing***-better care of homeless people, reduce fuel poverty, adapt homes

for independent living, secure housing for dementia patients,  adaptations for falls prevention, better coordinate return to peoples own homes to allow them to return more quickly

Impact: fewer hospital admissions, reduced deaths, fewer patient entering social care

We will expand the current Prudent Healthcare Programmes within ABMU including:

- Living life well
- Time Banking
- Psychological Therapies
- Health and Housing Collaboration
- Audiology
- Walk in Physiotherapy
- Walk in Podiatry
- Lymphoedema including Surgery and Garments
- Enhanced Recovery After Surgery
- Psychological Therapies

**Co-creating Health Framework**
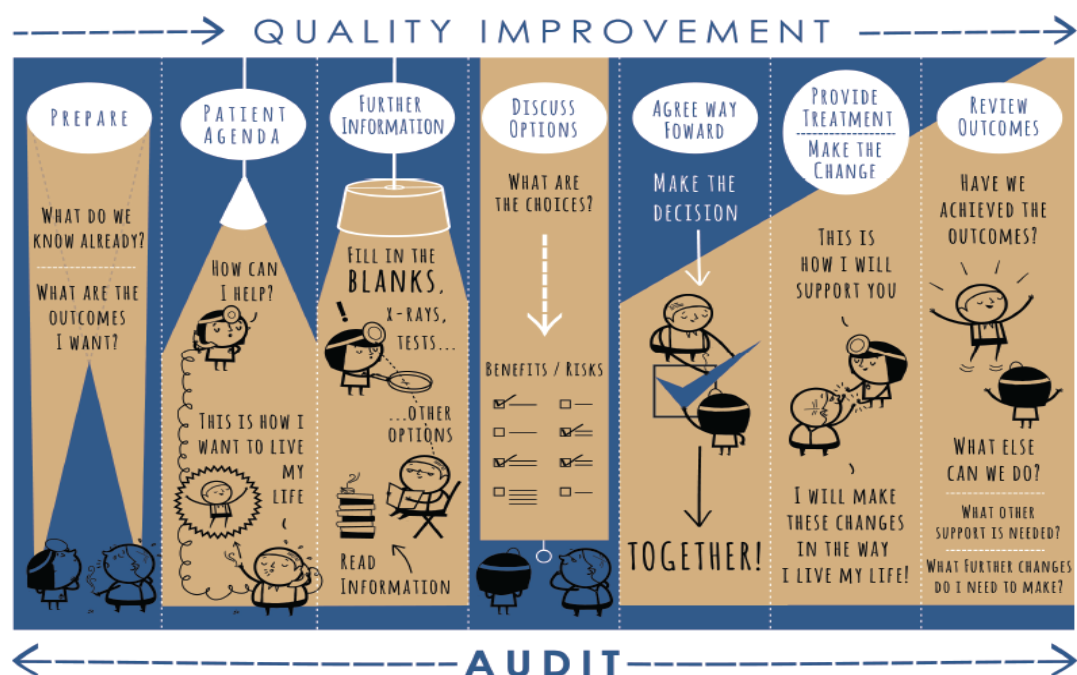
To support prudent healthcare we are developing an IT infrastructure. The prudent healthcare principles for IT are:

- Informational continuity by which people have access to information about their conditions and how to access services and for clinicians to have the right information and records needed to provide the right care at the right time.

-  Management continuity that is a coherent approach to the management of a patient's condition and care spanning different services, with IT supporting people and providers collaborating in drawing up collaborative care plans.

- Relational continuity in supporting a consistent relationship between a person, family, and carers and one or more clinicians over time, so that people are able to turn to known individuals to coordinate their care.

    IT needs to support systems leadership at the following levels:

1. Individual-Educate Individuals/Families to manage their own health and wellbeing e.g. access to own health records, ability to write to own health records, authoritative sources of information about condition, option grids

2. Informal Community-Engage with Communities to support individuals e.g. signposting or directories to community resources

3. Formal community -Work with the third sector to develop new models of support e.g. signposting to third sector services, joint records with third sector services

4. Public Services-Partnership across public services around social determinants of health, particularly housing e.g. joint social care/health care It/records

5. Integrated/Coordinated community/primary/secondary care e.g. joint records with GPs, removal of boundaries, e-referral, e-discussion, e-discharge, e-prescribing etc.

6. Integrated Physical/Mental Health, particularly chronic conditions e.g. care plans drawn up to include all chronic conditions and mental health conditions-records available to all, software to ensure drug-interactions don't happen

7. Research-ensure all data held on individuals is integrated at patient level and e.g. facilitates back-casting – use known data to determine the characteristics of patients that led them to be high users of resource.

## Appendix 9        Objectives, Measures and Delivery

### HEALTHIER COMMUNITIES

| WHY IS THIS A STRATEGIC AIM? |
| --- |
| Differences in life expectancy have widened between the best and worst areas across the ABMU health economy in the last 10 years. We must work to reduce health inequality through ensuring adequate access to services. |
| **WHAT WILL GOOD LOOK LIKE?** |
| We will have a systems wide focus on the quality of care and health for ABMU citizens, focusing on end-to-end patient health and wellbeing. Citizens are more engaged in their own role in healthy living. |

| **Strategic Aim: Healthier Communities** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Action 15/16** | **Lead** | **Timescale Q1/2/3/4** | **Target** | **Measurement** | **Reporting Mechanism** |
| **Reducing** smoking rates.(1)<br>• 40 Community Pharmacies to run Level 3 smoking cessation service, offering smokers motivational support and free nicotine replacement products.<br>• A 'Start Here' marketing campaign, to encourage smokers to quit and to signpost them to the community pharmacy service.<br>• An in-house smoking cessation service, focusing on patients with chronic conditions, providing one-to-one intensive support, plus intervention | DPH / C4B Staying Healthy Project | Q4 | Tier 1 | *Smoking (1)*<br>5% Estimated LHB smoking population treated by smoking cessation services<br>40% of smokers treated by NHS smoking cessation services are co-validated as successful | Changing for the Better Programme Board (C4B Programme Board)<br>Health Board |
| | | | Local target | • Reduce the prevalence of smoking to 16% by 2020, with an interim 2016 target of 20%<br>• Audit/evaluation against NICE (2013) Public Health Guidance 48 – Smoking | |

| Strategic Aim: Healthier Communities | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale Q1/2/3/4** | **Target** | **Measurement** | **Reporting Mechanism** |
| training to various professional groups across the organisation.<br><br>• A smoke-free hospital services group to assess compliance against the NICE (2013) guidelines. The group will then make recommendations to the Board to ensure compliance with ABMU Health Board's Smoke-free Environment Policy. | | | | cessation in secondary care: acute, maternity and mental health services. | |
| • Reducing unhealthy eating and increasing physical activity (2)<br><br>– Specialist antenatal clinics for obese pregnant women as part of a maternal obesity care pathway. These clinics would provide early intervention, risk management and healthy lifestyle support from a specialist Midwife and Dietitian to prevent excessive weight gain at this time.<br><br>– A targeted level 2 community weight management service to be implemented for adults with a BMI of 30 or over and a history of chronic knee and/or hip pain suggestive of osteoarthritis.<br><br>• The establishment of a specialist multidisciplinary level 3 weight management team for adults with severe and morbid obesity. | DPH / C4B Staying Healthy Project | Q3 | Tier 1 | ***Overweight and obesity (2)***<br>Reduction in % of reception class children (4/5) classified as overweight or obese.<br>Prevalence of overweight and obesity in the adult population ceases to rise and then decreases in subsequent years. | |
| | DPH / C4B | Q4 | Local | For all schemes - to demonstrate a % weight | |

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| Strategic Aim: Healthier Communities | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale Q1/2/3/4** | **Target** | **Measurement** | **Reporting Mechanism** |
| | Staying Healthy Project | Q1 | | loss for participants. Further measures agreed | |
| • Increasing vaccination and immunisation rates (3) | DPH / C4B Staying Healthy Project | Q4 | Tier 1 | ***Vaccination and Immunisation (3)*** Achieve% uptake of the influenza vaccine in the following groups. 75% for over 65s, under 65 in an at risk group, pregnant women and 50% health workers 95% uptake of childhood scheduled vaccines up to age of 4. | |
| • Stopping the growth in harm from alcohol and drugs. • Commissioning strategy of WBP APB in draft. | DPH | Q2 | | Monitor decreased admissions associated with Swansea Help Point. Further measures to be agreed in Commissioning Strategy | |
| • Reducing teenage pregnancy rates • Continue the roll out of Long Acting Reversible Contraception for teenagers and young people across ABMUHB. | DPH | Q4 | | Reduction in teenage pregnancy rates | |
| • Reducing accident and injury rates • Develop a multiagency Physical Activity Strategy for implementation of resource neutral elements as soon as possible and with business case/s in 2016/17 IMTP | DPH | Q4 | | Percentage adults meeting physical activity guidelines increase from 28%. | |
| • Improving mental wellbeing | DPH | Q4 | | Measures of mental health and well-being | |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Healthier Communities | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale Q1/2/3/4** | **Target** | **Measurement** | **Reporting Mechanism** |
| • This will be addressed through the Physical Activity Strategy (see above). | | | | under review in Public Health Performance Framework | Health Board Workforce and OD Committee |
| • Improving health at work | DPH | Q2 | | (See A fully engaged and skilled workforce) n | |
| • Developing our commissioning approach;<br>   ‒ Commissioning Boards & Governance<br>   ‒ Establish 6 strategic clinically lead commissioning boards with agreed ToR, reporting, decision making and governance processes and structures, including the Commissioning & IMTP<br>• Develop of a strategy and commissioning framework to include a 'commissioning toolkit' to support the commissioning boards with producing prioritised commissioning plans for the IMTP<br><br>• Commissioning leadership development<br>   ‒ Identify and develop appropriate modules and delivery mechanisms to facilitate the development of commissioning capability for commissioning board members and associated clinical and corporate staff<br><br>• Commissioning Intelligence Recruit additional intelligence and analytical capability and capacity for ABMU | | Q4<br><br><br><br><br>Q3<br><br><br><br>Q4<br><br><br><br>Q2<br><br>Q3 | | • Commissioning boards operational<br><br><br><br>• Commissioning Plans drafted for IMTP<br><br><br><br>• Integration of commissioning into Leadership programme<br><br><br><br>• Intelligence manager in post<br>• Proposal for establishment of Prudent Health Care Centre agreed | |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Healthier Communities | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale Q1/2/3/4** | **Target** | **Measurement** | **Reporting Mechanism** |
| • Work in partnership with Swansea University and NWIS to develop a PHC Centre to support the intelligence needs of the commissioning boards in delivering PHC<br><br>• Commissioning Service Improvement<br>  ‒ Undertake review and options appraisal of UGI service<br>  ‒ Agree and commissioning sustainable UGI service<br>  ‒ Design and agree standards of care for CAMHs service<br>  ‒ Agree and commission CAMHs service specification<br>  ‒ Undertake PBMA in MSK to identify | | Q3 | | • Cancer Upper GI service model finalised<br><br>• CAMHs standards of care finalised<br><br>• MSK PBMA proposal finalised<br><br>• AF PBMA proposal finalised<br><br>• Diabetes PBMA proposal in development | |

## EXCELLENT PATIENT OUTCOMES AND EXPERIENCE

**WHY IS THIS A STRATEGIC AIM?**

Ensuring that we consistently deliver high quality care 24 hours a day seven days a week is our absolute priority. Our Quality Strategy sets out what we must do to deliver excellent services and become a high reliability organisation.

**WHAT WILL GOOD LOOK LIKE?**

We understand our citizens' experience and outcomes at a granular level in real time, keep listening, factor in what we hear, and see our experience and outcomes continuously improving.

| Strategic Aim: Excellent Patient Outcomes and Experience | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| • Develop and implement patient reported experience and outcome measures across all major service areas<br>PREMS<br>- implement 5 day a week PALs model in NPT & Singleton Hospitals<br>- implement 7 day a week PALs model in Morriston Hospital<br>- Have SNAP 11 set up and systematic proactive mechanisms in place to capture the experience across Learning disability & Mental Health services | DoN&PE | <br><br><br>Q2<br>Q3<br><br>Q3<br><br><br>Q4 | Local | • Receiving feedback from at least 40% of our patients/service users by the end of March 2017.<br>• Each of our hospitals being in the top 20% of NHS hospitals for patient experience (as determined by the Department of Health "Friends and Family Test") by the end of March 2016.<br>• Each of our primary care contractor and commissioned services offering their patients the opportunity to provide feedback on their experience and using the information to plan and deliver service | Quality and Safety Committee |

| Strategic Aim: Excellent Patient Outcomes and Experience | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| ˗ Have electronic patient feedback zones in all clinical areas across all hospital | | Q3 | | improvements by December 2016. <br><br> • Achieving a 90% positive feedback score for primary care and commissioned services by March 2017. | |
| ˗ Have patient feedback embedded as an integral component of the patient entertainment system at NPT Hospital | | Q4 | | | |
| ˗ Have systematic patient experience feedback mechanisms in place in GPOOH services & 25% of GP practices | | Q4 | | | |
| ˗ Undertaken 'proof of concept tests' of experience feedback mechanisms in the care home & dental practice settings (electronic if possible) <br><br> PROMS <br><br> During 2014 work began on the development of PROMs for: | | Q2 <br> Q2 | | | |
| ˗ Orthopaedics; and | | Q3 | | | |
| ˗ Maternity services. <br><br> Continue work to develop to implement PROMs This will include: | | Q4 | | | |
| ˗ All MSK services by December 2015 | | | | | |
| ˗ All clinical services where there are national validated tools and databases | | | | | |
| • DNACPR <br><br> ˗ Start to replace guidelines with | MD | Q2 | Local | Deliver WG targets | Quality and Safety |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Excellent Patient Outcomes and Experience | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| Standard Operating Procedures and automated pathways, in particular implementation of the "Do not Attempt Cardiac Pulmonary Resuscitation Pathway" | | | | | Committee |
| • Address the delivery priorities set out by Welsh Government for stroke services (5) | MD | Q4 | Tier 1 | *Stroke Services (5)*<br><br>• 95% compliance with acute stroke bundles<br><br>• Improved levels of stay on stroke unit from 68% to 90% of Patients will have their entire stay on a Stroke Unit when fully functional<br><br>• Improved access to Acute Stroke unit within 4 hours of presentation at ED. From current level of 14% to 75% when fully functional.<br><br>• Reduce number of Hospital Beds in use at any time by stroke patients from 81 to 50 when fully functional<br><br>• Mortality rates will decrease – *amount still to be quantified*<br><br>• Time to see rates for High Risk TIA patients will increase from 35% currently seen within 24hours to 60% once fully functional | Quality and Safety Committee |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Excellent Patient Outcomes and Experience | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| | | | | • % of Patients discharged within 21 days will increase 64% to 75%<br><br>• Stroke Patients will be offered life after stroke assessment within 6 month of discharge – increase from 22% - 90%<br><br>• Detect and manage AF within population via Primary care - *to be quantified* | |
| • Embed national and professional standards to reduce inappropriate variation and increase reliability, focussing on:<br><br>- Implementation of "spot the sick patient" project<br><br>- Introduce electronic prescribing and medicines administration in outpatients (6) | DoN&PE | Q4<br><br>Q4<br><br>Q3 | Local | • 95% patients risk assessed for VTE<br>• 95% compliance in daily senior review by end of March<br>• Maintain 98% compliance for stage 1 Mortality Reviews<br>• 95% compliance with the requirements for full discharge summaries within 24 hours<br>• 100% compliance with requirement for full discharge summaries within 5 working days<br><br>***Spot the sick patient***<br><br>• Indicators developed via primary and secondary care informatics group.<br>• 100% patients with completed NEWS score and appropriate responses actioned – (tolerance 95%) | Quality and Safety Committee |

| Strategic Aim: Excellent Patient Outcomes and Experience | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| – Develop and use our digital systems to report the reduction in and monitoring of INNUs<br><br>– Develop, as part of the Innovation Fund an SBRI technology bid to provide practical decision support tools for our clinical workforce to reduce variation by adhering NICE guidelines | MD<br><br>MD<br><br>MD | Q4<br><br>Q3<br><br>? | | • Further measures are in the process of being agreed.<br><br>***Eprescribing***<br>• Fewer medication errors (targets in the process of being agreed)<br>• Improve the quality of data provided to primary care on discharge<br>• Reduce the % of drugs prescribed off formulary against 14/15 baseline<br><br>***Reducing variation (other)***<br>• Reduction in INNUs against 14/15 baseline<br><br>• Bid supported by Welsh Government | |
| | | | Tier 1 | ***Reduce inappropriate variation(6)***<br>• Improvement in % compliance with patient safety solutions – alerts<br>• Improvement in % compliance with patient safety alerts - rapid response notices<br>• Reduction in the number of new serious incidents<br>• Reduction in the number of new never | Quality and Safety Committee |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Excellent Patient Outcomes and Experience | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| | | | | events | |
| | | | | • Reduction to %  in Crude Risk adjusted scores together with mortality | |
| | | | | • Reduction in RAMI | |
| | | | | • Improvement in the number of audits the organisation is participating in against the national clinical audit Programme | |
| | | | | • 95 % valid principle diagnosis code 3 months after episode end date – monthly | |
| | | | | • 98 % valid principle diagnosis code 3 months after episode end date - rolling 12 month | |
| – Roll out the "big Fight" campaign targeting C Difficile infection and antibiotic resistance in primary care (7). | DoN&PE | Q4 | Tier 1 | ***Reduce infections(7)***<br>31 per 100,000 cases of C. *difficile*.<br>2.6 cases per 100,000 for MRSA<br>Reduction in health acquired pressure sores | Quality and Safety Committee |
| | | | Local | ***Big Fight***<br>• Linked to C.difficile targets<br>• Reduction in antibiotic prescribing (primary care) | |
| • Embed the recommendations of the Andrews Report | DoN&PE | Ongoing | Local | ***Trusted to Care*** Implementation of T2C action plans | Trusted to Care Team |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Excellent Patient Outcomes and Experience | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| | | | | | and |
| | | | | | Quality and Safety Committee |
| | | | | | Health Board |
| • Develop our Digital Strategy | MD | Q4 | Local | ICT Priorities implemented (see Section 9 for list of actions and timescales) | C4B Delivery Board |
| | | | | | Strategy Committee |

## SUSTAINABLE AND ACCESSIBLE SERVICES

**WHY IS THIS A STRATEGIC AIM?**

Developing and implementing new models of care is crucial to us ensuring we have sustainable and accessible services for our population. Care must reflect population needs, support the reduction in inequalities in care, improve clinical outcomes and support improved efficiency when benchmarked with the best elsewhere.

**WHAT WILL GOOD LOOK LIKE?**

Services are commissioned based on need and improved outcomes for people. We can see tangible improvements in productivity and efficiency

**Strategic Aim: Sustainable and Accessible Services**

| Action 15/16 | Lead | Timescale | Target | Measurement | Reporting Mechanism |
|---|---|---|---|---|---|
| • Further develop a system shift to primary care:<br>  - Develop pathfinder initiatives and new organisational models to support GP networks & clusters<br>  - Improve access to primary care (8)<br>  - Implement priorities in cluster plans<br>• Develop programme to improve skills and capacity across primary care workforce (also in a Fully engaged and skilled Workforce) | COO | | Tier 1 | ***Primary care access (8)***<br>Increase the percentage of GP practices offering appointments between 17:00 and 18:30 on a least two nights per week<br>Increase the percentage of GP Practices open during daily core hours or within one hour of daily core hours<br>Improvement in % people aged 45+ who have a GP record of blood pressure measurement in the last 5 yrs<br>Improvement in number of patients treated by an NHS dentist in the last 24 months as | |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| **Strategic Aim: Sustainable and Accessible Services** | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| | | | | % of population | |
| • Develop sustainable unscheduled care services across the whole system<br><br>  - Improve our patient flow to reduce the numbers of people waiting for unscheduled care and access to care outside hospitals post discharge (9) | COO | | Tier 1 | ***urgent and emergency services (9)***<br><br>95 % of new patients spend no longer than 4 hours in A&E<br><br>No patient spends 12 hours or more in A&E<br><br>65% Cat A response times within 8 minutes<br><br>Reduction in the number of over 1 hour handovers<br><br>Reduction in the number of emergency hospital admissions for the basket of 8 chronic conditions (reduction rolling 12 mths)<br><br>Reduction in the number of emergency hospital readmissions for basket of 8 chronic conditions (reduction rolling 12 mths) | Performance Committee |
| - Build Capability - Continue Foundation in Improvement Science (FISH) Training | | | Local | X staff completed Foundations in Improvement Science (FISH) training | Workforce and OD Committee |
| • Have a sustainable plan to meet our planned care requirements<br><br>  - Improve the efficiency of our surgical pathways through reviewing standard | | | Tier 1 | ***Meet planned care requirements (10)***<br><br>95% patients waiting less than 26 wks for treatment<br><br>No 36 week breaches – all specialities | Performance Committee |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Sustainable and Accessible Services | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| procedures for the whole patient pathway (10) | | | | Improvement in % of patients waiting less than 8 weeks for diagnostics<br><br>98% of patients referred as non-urgent suspected cancer seen within 31 days<br><br>95% of patients referred as urgent suspected cancer seen within 62 days<br><br>Improvement in the % procedures postponed on >1 occasion, had procedure <=14 days/earliest convenience<br><br>Reduction in DToC delivery per 10,000 LHB population - non mental health<br><br>Reduction in DToC delivery per 10,000 LHB population - mental health(Rolling 12 mths | |
| • Have clear roles and functions for all of our hospitals<br><br>  - Implement the outcomes of the South Wales Programme consultation in Princess of Wales Hospital<br><br>  - Further develop and implement service models for the South Central Acute Care Alliance<br><br>  - Establish the South Wales Acute Care Alliance as a formal programme and develop models of care to support | DoS | Q3<br><br><br>Ongoing<br>Ongoing<br><br><br>Q1<br><br><br>Q1 | Local | Role and functions for each hospital defined<br><br>• Changes implemented to the emergency medicine rota<br><br>• Model for ENT services implemented<br><br>• As required- reviews of other services completed<br><br>• Formal programme management arrangements and work programmes established<br><br>• HVS opened with improvements to | Strategy Committee |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strategic Aim: Sustainable and Accessible Services | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| agreed priorities al<br><br>- Open HVS1 at Morriston Hospital and complete further works<br><br>-<br><br>- | | Q3 | | patient care<br><br>• New clinical accommodation opened | |
| • Improve our services for Women, Children and Families | | | Tier 1 | | C4B Delivery Board |
| • Implement the priorities from the National Delivery Plans | | | | WG Priorities implemented – as described in Appendix 11 | C4B Delivery Board |

## A FULLY ENGAGED AND SKILLED WORKFORCE

**WHY IS THIS A STRATEGIC AIM?**

As well as having the right numbers of staff in the right roles, we need to make sure that we have the staff with the right skills to meet the future demands on us, combined with the right values and behaviours. Working more collaboratively with our partners and stakeholders to support integrated services, and having the right people to do this has, and will continue to be, increasingly important to us and the people we care for.

**WHAT WILL GOOD LOOK LIKE?**

We have engaged staff at every level who are role models of our values, and who are empowered to keep improving services. We understand our staffing experience

### A fully engaged and skilled workforce

| Action 15/16 | Lead | Timescale | Target | Outcome measure | Reporting Mechanism |
|---|---|---|---|---|---|
| • Develop a joint strategic approach to the recruitment and retention of those staff groups where recruitment is a challenge. | HR Director/Director of Nursing/Director of Therapies Health Science and Psychology/ Medical Director | Q4 | Local | Improvement in the % of staff (excluding medical) undertaking PADR (12)<br><br>Improvement in the % of medical staff undertaking performance appraisal (12)<br><br>Reduction in 0.8 % staff absence due to sickness (12)<br><br>Maintain the labour stability index at 91.34% | Multi-professional Education Forum<br><br>Medical Workforce Board<br><br>Nursing and Midwifery Forum |

| A fully engaged and skilled workforce | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Outcome measure** | **Reporting Mechanism** |
| | | | | | Health and Well Being programme<br><br>Health Board Workforce & OD Committee |
| Develop new and extended roles to support service redesign. | Heads of Profession | On-going | Local | Increase in the number of Advanced Practitioners roles<br><br>Implementation of the NHS Wales Skills and Career Development Framework for Clinical Health Care Support Workers<br><br>Appointment of Physicians Associates | Multi-professional Education Forum<br><br>Medical Workforce Board<br><br>Nursing and Midwifery Forum<br><br>Health Board Workforce & OD Committee |
| Continue to reduce sickness absence levels and support the health and well-being of our workforce, through a range of support services such as joint care, protect and respect, emotional wellbeing | Director of HR | Q3 | | Sickness Absence reduced to 5% | Health Board Performance Committee and Health Board Workforce and |

| A fully engaged and skilled workforce | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Outcome measure** | **Reporting Mechanism** |
| | | | | | OD Committee |
| • Provide a skills development programme to ensure staff have the skills to deliver safe quality care that matches the needs of our citizens, and supports the development of clinical leadership. | Director of HR | On-going | | Implementation of programme | Multi-professional Education Forum<br><br>Medical Workforce Board<br><br>Nursing and Midwifery Forum<br><br>Health Board Workforce & OD Committee |
| • Develop an overarching People Strategy that will reflect our values and create a culture for people to achieve their full potential. | Director of HR | Q3 | | Implementation of Strategy | Health Board Workforce & OD Committee |

## STRONG PARTNERSHIPS

| WHY IS THIS A STRATEGIC AIM? |
|---|
| We cannot deliver our Strategic Aims through working in isolation. We are the major employer in the local health economy and we must work with our partners and stakeholders to secure improved health of the population as a whole and to ensure that all of our services are complementary to meet people's needs. |
| **WHAT WILL GOOD LOOK LIKE?** |
| Clear alignment between Health Board and partner organizations values, strategies and plans. People who receive care from different organizations cannot tell the difference. |

| Strong Partnerships | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| • Develop proposals for the future role of Morriston and Swansea hospitals as part of a network of care and innovation – ARCH (A Regional Centre for Health) | DoS | Q4 | Local | Strategic Outline Programme developed, subject to Welsh Government approval to proceed | C4B Programme Board<br>ARCH Project<br>ABMU Swansea University Partnership Board<br>Strategy Committee |
| • Implement seamless community based models of care with partner | | | | | C4B Programme Board |

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| Strong Partnerships | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| organisations<br><br>- fully exploit benefits of Community Resource Teams<br><br>- Develop risk stratification based on tested frailty models and test in pathfinder networks<br><br>- Further develop business cases to support plans agreed in 2014/15. | | | | | |
| • Develop a comprehensive and joint mental health service and estates strategy with our partners | COO / DoS | Q3 | Local / Tier 1 | Support the achievement of Tier 1 targets and lead to improvements in quality of care for service users across all levels of care. | C4B Programme Board<br>Strategy Committee |
| • Develop managerial and clinical leaders across the UHB in partnership with education providers. | | | | | |
| • Develop UHB wide links with partner organisations across the health economy to develop consistent and common goals | DoS | Ongoing | Local | Plans are aligned and consistent with partner organisations | Strategy Committee |
| - Increase the number of NISCHR studies (11) | Medical Director | Q4 | Tier 1 | Improvement in number of NISCHR clinical research profile studies and Commercially Sponsored studies (11) | |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Strong Partnerships | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| • Develop a joint commissioning model for CAMHS | DoS | Q3 | Local | Services Commissioned based on need and to a consistent level | Strategy Committee |

## EFFECTIVE GOVERNANCE

| WHY IS THIS A STRATEGIC AIM? |
|---|
| Effective governance is crucial to the transparent and efficient management of the UHB. We need to give assurance to our citizens, Board, partners and Welsh Government that we are using the resources allocated to us to best effect. |
| **WHAT WILL GOOD LOOK LIKE?** |
| Everyone is able to describe the ABMU values. Our leaders and staff role model our values and behaviors. Good governance processes based on values and strategic aims. |

## Effective Governance

| Action 15/16 | Lead | Timescale | Target | Measurement | Reporting Mechanism |
|---|---|---|---|---|---|
| • Develop our organisational strategy to set out a clear 10 year vision with clear outcomes, milestones and performance measures to ensure all plans are aligned and consistent. | DoS | Q3 | Local | Vision and outcomes identified | Existing governance and assurance arrangements<br><br>Existing Health Board performance framework. |
| • Implement the new management arrangements | CEO | Q3 | Local | Management structures fully in place enabling clearer and simplified | Health Board |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Effective Governance | | | | | |
|---|---|---|---|---|---|
| **Action 15/16** | **Lead** | **Timescale** | **Target** | **Measurement** | **Reporting Mechanism** |
| | | | | governance arrangements | |
| • Deliver financial balance | DoF | Q4 | Tier 1 | Balanced financial position | Health Board |

# Appendix 10    Demand and Capacity Modelling

## 1. Overview

For the 2015/16 to 2017/18 IMTP a more robust capacity and demand modelling exercise has been undertaken to understand the relationships (in the hospital setting) between unscheduled and planned care, with a particular focus on beds.

From the outset it is important to note that all modelling is based on a complex range of variables which impact the series of assumptions and predictions in terms of future demand and capacity behaviours. This paper sets our anticipated model and the plans to address the challenges within it but the Health Board is realistic that the complexity of the system will require flexible and adaptive approaches throughout the duration of the plan.

The capacity and demand modelling exercise undertaken to inform the baseline projections for the unscheduled care elements of the 3 year plan used the following methodology:

- Analysis by day of all Medical beds used by hospital for the last 4 years of data
- Calculated uplifts by life course (age band specific) based on 2011 census population uplifts
- Calculated bed requirements for patients waiting for a bed in the Emergency Department over midnight, also uplifted for population growth.

The baseline data was then plotted as a run chart and 1, 2, and 3 standard deviations were calculated, along with beds required for average occupancy rates of 100%, 95%, 90% and 85% for each hospital site.  This analysis clearly showed a seasonal variation to the emergency medicine bed requirements peaking during the winter period.

The approach taken by the modelling team was to categorise the demand into 3 distinct periods:
- February – September  = 'In year'
- October  - December  = 'Winter pressure'
- January  = 'Extreme winter'

The rationale behind these categories becomes clear when reviewing the run charts as the 'winter pressure' on emergency medical beds is clearly evident and this January's peak stands out as a 'special cause.

The final stage of the medical bed capacity modelling was agreeing the number of medical beds required to optimise patient flow. In order to achieve this, a series of workshops were held with service leads to work through the process and agree, using the statistical analysis provided, that the optimum

level would be set at 2 standard deviations. This would mean that 95 times out of 100 capacity would meet or exceed demand.

In addition, analysis was also undertaken to quantify the utilisation of surgical beds across all sites. This work again used the actual beds used distributed by emergency, elective urgent and routine. All of the above was plotted as daily run charts by site by speciality and daily bed utilisation was calculated in order to inform the planning assumptions.

## 2. Unscheduled Care

The modelling estimated the possible patterns and levels of demand for medical beds across the Health Board. Historical patterns of bed consumption have been studied and adjusted for anticipated future demand for demographic change; in addition a provision has been made for patients who were unable to flow from Emergency Departments due to bed pressures, who would, in a less constrained bed environment, have required a modest bed stay.

The modelling used standard deviation testing to determine options for potential bed models. As a working principle it was agreed that the second standard deviation point be used to give 95% confidence in the results.

The table below sets out the range of options available based on using the 3 sigma points within the standard deviation approach.

Further, having looked at the historical pattern of bed consumption, it was possible to determine that the years followed a broad pattern of demand where three distinct time periods at distinct bed consumption levels were observed.

- February to September (baseline)
- October to December ("winter" uplift)
- January – in some years exceptional and above the October to December level

**Morriston Hospital**

| | February to September | | | October to December | | | January | | |
|---|---|---|---|---|---|---|---|---|---|
| | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks |
| 1 sigma | 97.0% | 14 | 65 | 88.0% | 36 | 31 | 77% | 70 | 11 |
| 2 sigma | 94.0% | 21 | 22 | 85.4% | 43 | 14 | 75% | 75 | 7 |
| 3 sigma | 91.0% | 27 | 3 | 83.0% | 49 | 4 | 74% | 79 | 1 |
| illustrative | 95.0% | 19 | 28 | 85.0% | 44 | 8 | | | |

**Princess of Wales Hospitals**

| | February to September | | | October to December | | | January | | |
|---|---|---|---|---|---|---|---|---|---|
| | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks |
| 1 sigma | 96.0% | 21 | 113 | 89.0% | 40 | 7 | 83% | 57 | 7 |
| 2 sigma | 94.0% | 26 | 58 | 87.0% | 45 | 4 | 82% | 62 | 1 |
| 3 sigma | 92.0% | 30 | 21 | 85.0% | 51 | 2 | 80% | 68 | 0 |
| illustrative | 95.0% | 23 | 80 | 90.0% | 38 | 8 | | | |

**Singleton Hospital**

| | February to September | | | October to December | | | January | | |
|---|---|---|---|---|---|---|---|---|---|
| | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks |
| 1 sigma | 97.0% | 5 | 116 | 91.0% | 19 | 14 | 83% | 43 | 11 |
| 2 sigma | 95.0% | 10 | 61 | 89.0% | 25 | 8 | 81% | 50 | 9 |
| 3 sigma | 92.0% | 16 | 26 | 87.0% | 30 | 2 | 79% | 57 | 4 |
| illustrative | 95.0% | 10 | 61 | 90.0% | 22 | 11 | | | |

**Neath Port Talbot**

| | February to September | | | October to December | | | January | | |
|---|---|---|---|---|---|---|---|---|---|
| | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks |
| 1 sigma | 98.0% | 2 | 64 | 96.0% | 5 | 21 | 94% | 7 | 1 |
| 2 sigma | 97.0% | 4 | 14 | 94.9% | 6 | 5 | 93% | 9 | 0 |
| 3 sigma | 95.8% | 5 | 1 | 94.0% | 7 | 0 | 92% | 11 | 0 |
| illustrative | 95.0% | 6 | 0 | 90.0% | 14 | 0 | | | |

**Health Board Total**

| | February to September | | | October to December | | | January | | |
|---|---|---|---|---|---|---|---|---|---|
| | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks | Occupancy | + beds | Over line peaks |
| 1 sigma | | 42 | 358 | | 100 | 73 | | 177 | 30 |
| 2 sigma | | 60 | 155 | | 118 | 31 | | 196 | 17 |
| 3 sigma | | 78 | 51 | | 137 | 8 | | 214 | 5 |
| illustrative | | 58 | 169 | | 118 | 27 | | | |

Growth in 2015/16 is estimated to be 15 beds

Discussion required to identify which options of beds, bed equivalents and system balance (planned care) will be implemented to manage this position

**Note**

1 Sigma ( 68% of the data within 1 standard deviation)

2 Sigma ( 95% of the data within 2 standard deviation)

3 Sigma ( 99.7% of the data within 3 standard deviation)

By demonstrating the impact of this modelling visually using the following figures, the Health Board was able to arrive at a considered position which enabled a planning position to be developed for unscheduled care.

## Morriston Hospital, bed day model



Morriston Hospital Medical Beds Consumed
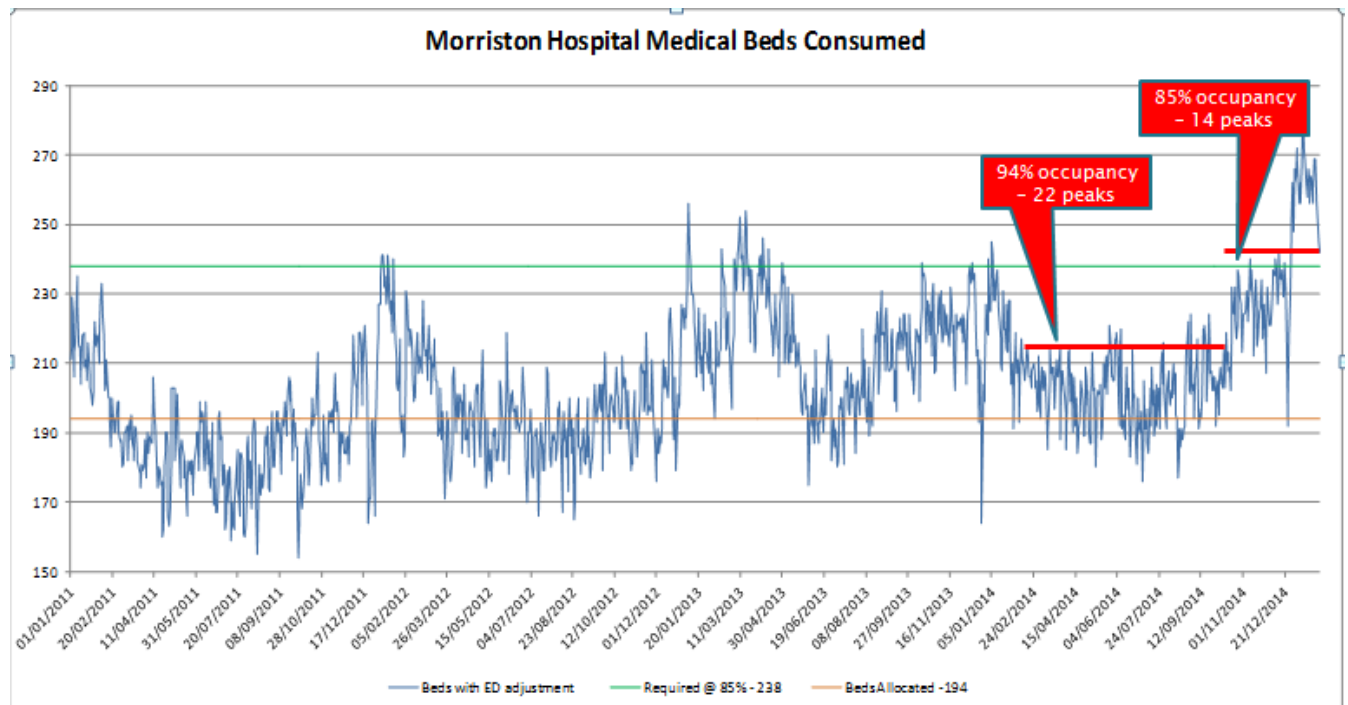
## Princess of Wales Hospital bed day model



Princess of Wales Hospital Medical Beds Consumed
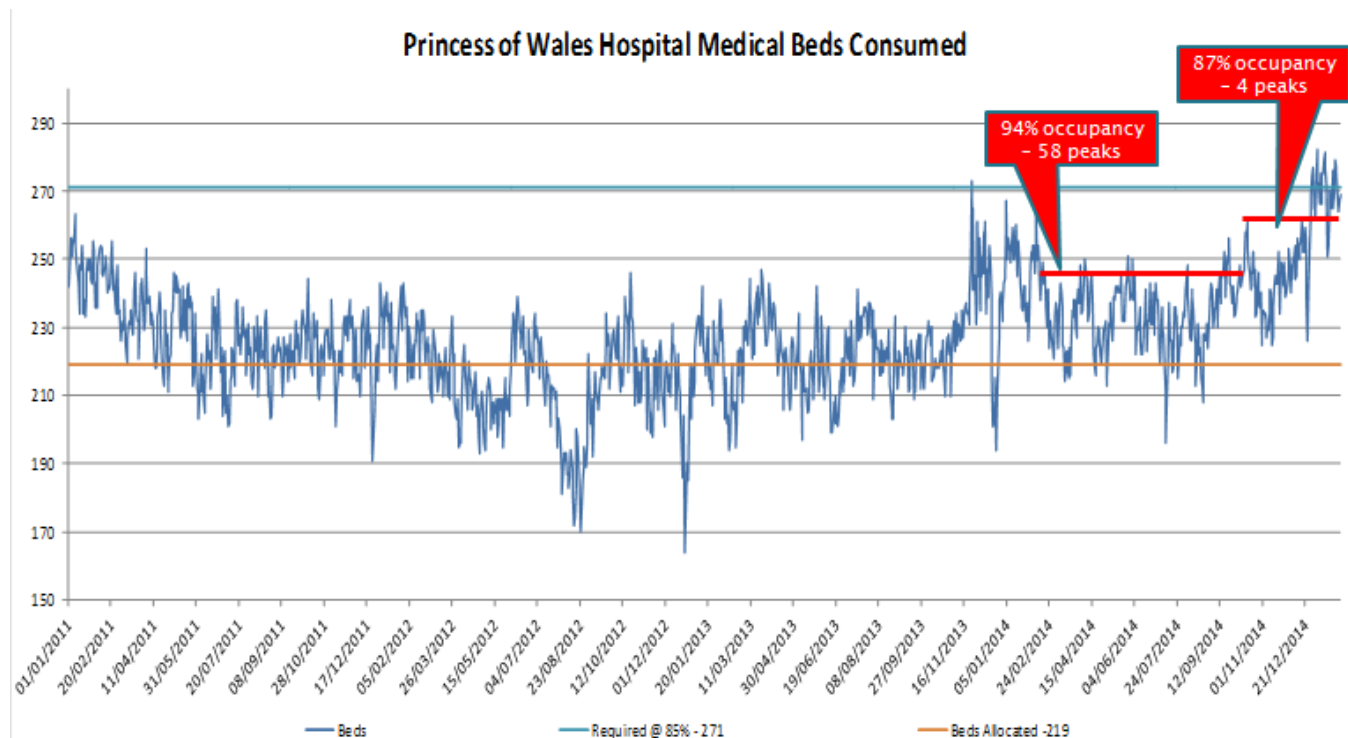
Includes patients in AMU Assessment who are subsequently admitting into a bed from the time that they were admitted into AMU Assessment.

Includes patients in AMU Assessment who are admitted and discharged from AMU Assessment (without being admitted) that stay in AMU Assessment for 24hrs and over

## Singleton Hospital bed day model



### Singleton Hospital Medical Beds Consumed

Please Note: There are currently on average 10 patients per day waiting to be transferred into Singleton Hospital
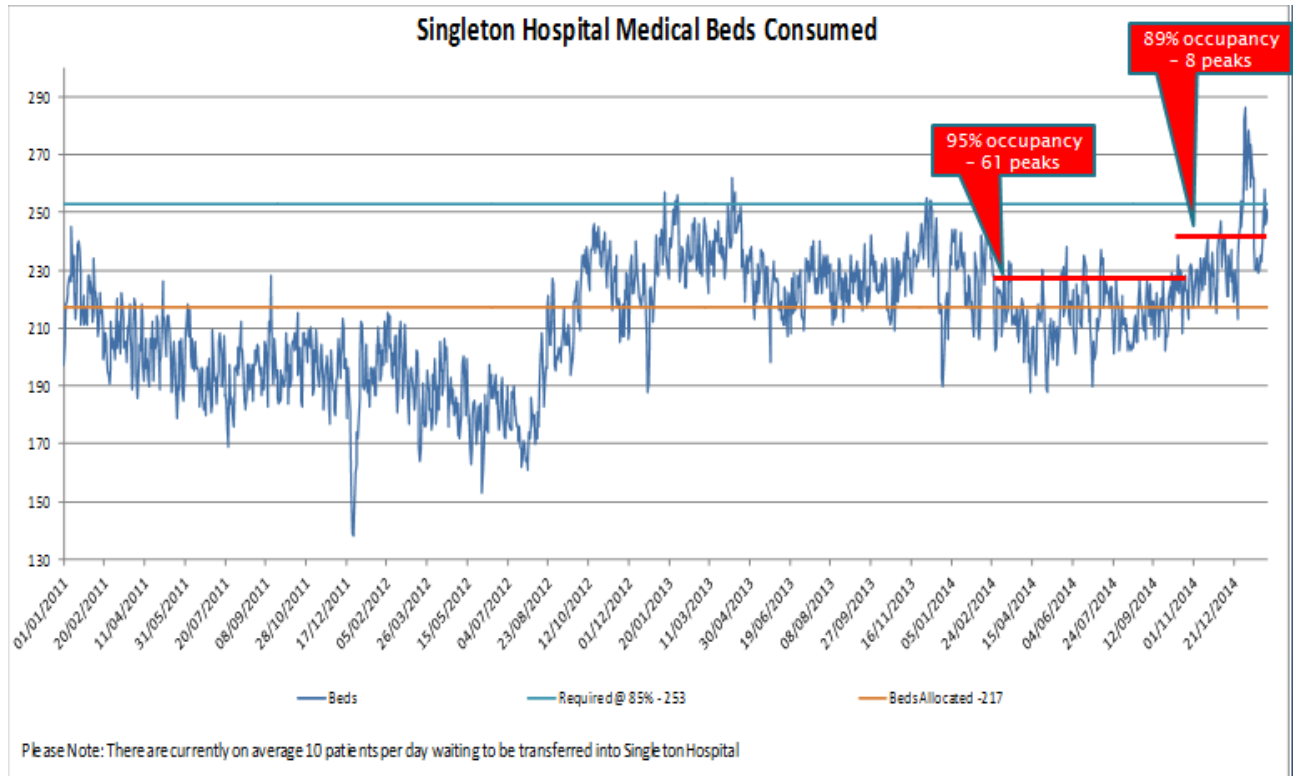
## Neath Port Talbot Hospital bed day model
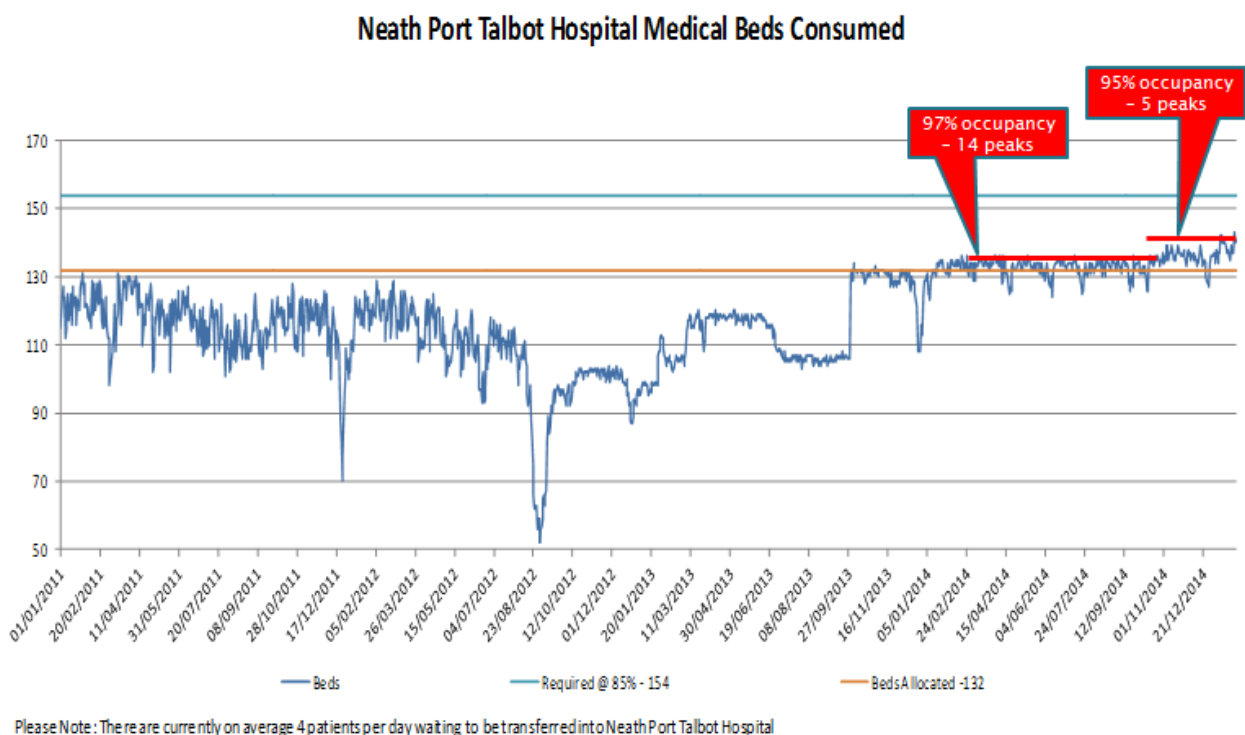


### Neath Port Talbot Hospital Medical Beds Consumed

Please Note: There are currently on average 4 patients per day waiting to be transferred into Neath Port Talbot Hospital

Based on a balance between practical delivery, capital constraints, workforce constraints and timeliness a staged picture of the bed profile required across the year was developed.

The table below sets out the predicted bed demand consumption by hospital by timeframe.

| | February to September | | October to December | | January | |
|---|---|---|---|---|---|---|
| | Occupancy | beds | Occupancy | beds | Occupancy | beds |
| Morriston | 94% | +21 | 85% | +43 | 75% | +75 |
| POWH | 94% | +26 | 87% | +45 | 82% | +62 |
| Singleton | 97% | +10 | 89% | +25 | 81% | +50 |
| NPTH | 97% | +5 | 95% | +6 | 93% | +9 |
| **Total** | | **+62** | | **+119** | | **+196** |
| | | | | | | |
| **Total @ 85%** | | **+186** | | | | |

The table shows that:-

- In order to meet baseline demand levels the Health Board is 62 beds short of predicted consumption levels across all hospitals.
- 119 additional beds needed to manage demand "winter" demand.
- If the January peak of 2015 is experienced again across all hospitals a total of 196 extra beds would be needed.

Whilst the modelling work was ongoing the 70 schemes identified as unscheduled care were prioritised. This prioritisation has been carried out based on agreed service criteria and in clear cognisance of the constraints in year of the 3 year plan around availability of workforce and capital (in particular timing of capital solutions).

To support the strategic direction of the Health Board to strengthen and develop primary and community care services, and in recognition of the physical estate constraints at our hospital sites (all surge capacity and previous winter ward capacity remains pen) the principle of bed equivalents has been used as a technique to assess how new ways of working support patients out of the hospital setting, prevent admission and facilitate early diagnosis and discharge (where necessary). This enables the prioritised schemes to be assessed for their impact on the bed gaps above. After completing this prioritisation we have found that the list of unscheduled care schemes includes schemes that will deliver bed equivalents of 104 against the winter projected requirement of 119 beds.

The current iteration of the IMTP therefore plans to deliver baseline levels of bed numbers as soon as possible (62 beds) and then continue to move towards the 110 bed number to reduce the potential impact on elective beds of medical outlying patients.

## 3. Planned Care

Directorates and Localities were asked to model their projected stage 1 26 week RTT position and all stage 36 week profiles as part of the IMTP process. Important assumptions were included in this modelling which were that teams were to assume no additional income above their funded directorate baseline and to also assume activity levels similar to those experienced in 2014/15. By adopting these assumptions, a worst case scenario based on 2014/15 activity levels and 2014/15 cancellation levels has been determined.

This approach is identical to the approach taken for unscheduled care which takes a worst case, unfunded, pre service change scenario and then applies proposed solutions to manage improvement in the performance.

The outcome of this initial assessment (which has been completed on a specialty by specialty basis is set out in the table below: -

|  | March 2013 | March 2014 | March 2015 (proj) | March 2016 (proj) | 2015/16 impact | March 2016 (rev) |
|---|---|---|---|---|---|---|
| >26 weeks stage 1 | 4 | 2,241 | 4,966 | 15,934 | (14,819) | 1,115 |
| > 36 weeks all stage | 378 | 2,079 | 5,670 | 10,503 | (6,157) | 4,346 |

The shaded column sets out the potential impact of solutions identified by directorates and localities as at 17th March 2015. Within the impact figures, we have emphasised that specialty plans are built on service improvement and efficiency gains including: -
- INNU
- day care rates
- ERAS
- pre op assessment
- surgical pathway redesign, and
- benchmarking.

The principle which has been adopted is that specialty solutions which require additional funding will not receive any funding until demonstrable gains through the bullet pints above have been factored in to their plans.

Once this is established the backlog solutions will differ by specialty and given the scale of challenge we are facing in 2015/16 and beyond these solutions are likely to require outsourcing to alternative surgical capacity though a variety of models which are currently being explored. Based on the current planning assumptions, our projected RTT position is as set out below: -

- 0 stage 1 cases waiting >26 weeks by March 2016 (except ophthalmology)
- All specialties to reach 0 patients waiting > 36 weeks by March 2016, except for MSK, General Surgery, ENT, Oral Surgery, Ophthalmology
- 5 specialties outside of March 2016 delivery will recover within the 3 years of this IMTP
- Improvement in 52 week total waiting number

The table below profiles the years during which each specialty will remove their 36 week backlog. It is planned that all of the outpatient waits over 26 weeks with the exception of ophthalmology (which is subject to a specific project to look at clinically based prioritisation of patients) would be removed in year 1 of the plan.

| Specialty | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| 7 Medical Specialties | ✓ | | |
| Cardiology | ✓ | | |
| Cardiac Surgery | ✓ | | |
| Vascular Surgery | ✓ | | |
| Urology | ✓ | | |
| Plastic Surgery | ✓ | | |
| Spinal Surgery | ✓ | | |
| Oral Surgery | | ✓ | |
| General Surgery | | ✓ | |
| ENT | | ✓ | |
| Ophthalmology | | | ✓ |
| Orthopaedics | | | ✓ |

Every effort will be made to accelerate the backlog removal and bring these trajectories forward as system efficiencies and the management of the unscheduled care position come in to place.

To accompany this analysis, an exercise has been undertaken to test how surgical beds have been consumed over the last 12 months. The table which follows shows how the beds have been consumed across 3 important classifications: -

- Emergency surgery beds
- Urgent elective beds
- Routine elective beds

| | Total Beds | Emergency Beds | Elective Urgent Beds | Elective Routine Beds |
|---|---|---|---|---|
| Morriston | 287 | 225 | 46 | 16 |
| POWH | 107 | 78 | 14 | 15 |
| Singleton | 21 | 11 | 6 | 4 |
| NPTH | 19 | 1 | 11 | 7 |
| Total | 434 | 315 | 77 | 42 |

The table shows that only a modest number of beds (42 in total) were used to provide capacity to treat the longest waiting elective patients out of a total bed stock of 434.

Our plans for planned care will rely on our solutions for unscheduled care working in such a way as to strictly limit the occasions where a medical patient outlies into surgical bed. The tale below shows how the two systems could come in to conflict of our plans around unscheduled care are unable to consume the demand we have planned for.

| | February to September | October to December | Winter Increase | Elective Routine beds available |
|---|---|---|---|---|
| | beds | beds | beds | beds |
| Morriston | +21 | +43 | +22 | 16 |
| POWH | +26 | +45 | +19 | 15 |
| Singleton | +10 | +25 | +15 | 4 |
| NPTH | +5 | +6 | +1 | 7 |
| Total | +62 | +119 | +57 | 36 |

The diagram which follows illustrates how the two solutions are planned to work in tandem. Our planning assumption is that by October we will have implemented sufficient bed equivalent schemes to address the 119 bed gap which has been modelled.

**Whole System – Demand and Capacity Modelling**

**Unscheduled Care**

**Outsourced capacity (Oct – Jan)**

Nursing home beds

Dec to Jan
Require 77
Demand Surge

Oct to Dec
Require 57 beds

Routine elective
15 beds

42 beds

Feb to Sept
require 62 beds

62 beds

Routine elective
15 beds

**Bed equivalent schemes**

Adult
Unscheduled care beds

762

**Planned Care**

Routine elective
42 beds

**Summary:**
Unscheduled care require
762 + 62 + 57 beds
(plus surge capacity)

Planned Care require
315 + 77 + 42 beds

Routine urgent
77 beds

Require
435 beds

53 CRT
25 – Flow
26 - Other

Emergency surgery
315 beds

The diagram shows that plans are in place to provide 104 bed equivalents to support unscheduled care: -
- 53 from CRT
- 25 from flow improvements including 7 day working, discharge initiatives etc.
- 26 from a variety of schemes such as rapid access diagnostics, redesigned assessment services and ambulatory emergency care models

The current planning assumption is that the 15 bed equivalent gap will be identified in year through the refinement of the plan. If there remains a gap the illustration shows that the first impact will be to swing medical capacity into elective surgical beds of which there are 42 available across the Health Board.

Exceptional pressures above the anticipated 119 bed gap will be managed through a series of alternative measures such as utilising closed capacity in the community setting, care homes, the short stay unit model in POWH being revised and additional medical staffing levels being explored.

## Appendix 11    Delivery Plan Details

| Plan | Lead Director | Priorities 2015/16 | Plan submission deadline | In existing plan | To be included in plan by submission deadline |
|---|---|---|---|---|---|
| Cancer | Siân Harrop Griffiths (Melanie Simmons) | Organisation of cancer support services to ensure improved services, delivery, planning and performance | 31st March 2015 | Yes | Yes |
| | | Primary care oncology (project initiation focus for this year) | | Being made more explicit | Yes |
| | | Develop and pilot a single urgent cancer pathway | | Nationally led and no clear steer as yet | Clarity from WG will not be received in time for the revised plan. No but reference will be made. |
| | | Patient experience (delivery of consistent key worker policy and improving patient information) | | Yes | Yes |
| | | Lung cancer – national focus | | Yes | Yes |
| Heart Disease | Dr. Sara Hayes | Delivering the cardiac waiting time target through putting in place effective pathways | 31st March 2015 | Yes | Yes |
| | | Developing and piloting component or differential waiting time targets | | Yes | Yes |
| | | Develop a consistent model for the delivery of cardiovascular risk assessment | | Yes | Yes |
| | | Review workforce capacity and consider new models of delivery that release capacity | | Yes | Yes |
| | | Improving participation and case ascertainment in National Clinical Audit | | Yes | Yes |
| Diabetes | | Focus on improving outcomes in paediatric care for children with Type 1 | | Yes but being updated | Yes |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Plan | Lead Director | Priorities 2015/16 | Plan submission deadline | In existing plan | To be included in plan by submission deadline |
|------|---------------|--------------------|--------------------------|------------------|-----------------------------------------------|
| | Siân Harrop Griffiths (Carl Verrecchia) | Prevention of Diabetes – evidence review and supporting General Practice | 31st March 2015 | Yes but being updated | Yes |
| | | Improving Structured Education and self-management | | Yes but being updated | Yes |
| | | Introduce Patient Management Information System | | No | Yes but not yet nationally agreed |
| | | Focus on foot care for inpatients | | Yes but needs updating | Yes |
| | | Focus on inpatient insulin management | | No | Yes |
| End of Life Care | Andrew Phillips | Repatriation of hospice funding to LHBs | 31st March 2015 | No | Yes |
| | | Encouraging more open conversations and focussing on improving communication skills | | Yes but needs strengthening | Yes |
| | | Improved identification in General Practice of patients in last 12 months of life | | Mentioned but needs strengthening | Yes |
| Critically Ill | Hamish Laing (Dai Roberts) | Delayed transfers of care – expectation of a 10% reduction quarterly | 31st March 2015 | No | Yes |
| | | Consideration and action to improve the configuration of services in line with other service change programmes | | Yes but needs updating | Yes |
| | | Improved Public and Professional awareness and use of advance decisions | | No | Yes |
| Stroke | Andrew Phillips | Identification of individuals with Atrial Fibrillation and awareness Campaign for Atrial Fibrillation | 31st March 2015 | Yes | Yes |
| | | Reconfiguration of stroke services in Wales including the development of hyper-acute Services in Wales | | Yes | Yes |
| | | Improve access to Community Rehabilitation | | Yes | Yes |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Plan | Lead Director | Priorities 2015/16 | Plan submission deadline | In existing plan | To be included in plan by submission deadline |
|---|---|---|---|---|---|
| Respiratory | Alex Howells (Jan Worthing) | Establish governance arrangements and systems for the plan implementation | 30<sup>th</sup> June 2015 | Group established and developing a plan | No priorities set by WG yet |
| Neurological Conditions | Hamish Laing (Tersa Humphries) | Raising awareness of neurological conditions among the public and healthcare professional. | 31<sup>st</sup> January 2015 | ?Yes | Yes |
| | | Undertaking a comprehensive population needs assessment | | Yes but needs strengthening | Yes |
| | | Providing clear information and support to patients and their families | | ?Yes | Yes |
| | | Developing consistent and coherent neuro-rehabilitation services | | Yes but needs strengthening | Yes |
| Liver | Dr Sara Hayes | Establish governance arrangements and systems for implementation of the plan | TBC no date proposed | Plan is drafted and out to consultation | WG plan not issued yet |
| Mental Health | Alex Howells (Robert Goodwin) | CAMHS Service Improvement | 31<sup>st</sup> January 2015 | Yes | Yes |
| | | Dementia across hospital and community (dignity and safety agenda and timely diagnosis) | | Yes | Yes |
| | | Improved access to psychological therapies | | Yes | Yes |
| Mental Health Con't | | Crisis response by services | Jan 2015 | Yes | Yes |
| | | Roll out of Mental Health core data set | | No but to be added to current plan before submission | Yes |
| | Dr Sara Hayes | LHBs to establish alcohol specialist nurses in A&E Departments | | Yes | In Morriston, Singleton and POW |
| | | Establishing clear protocols and integrated pathways for | | Yes | Dual diagnosis |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Plan | Lead Director | Priorities 2015/16 | Plan submission deadline | In existing plan | To be included in plan by submission deadline |
|---|---|---|---|---|---|
| Substance Misuse | | those with co-occurring substance misuse and mental health issues in line with revised Welsh Government guidance | 31st January 2015 | | strategy and care pathways to be discussed at APB 2 April |
| | | Implement the NHS related activity set out in the Substance Misuse Treatment Framework 'Improving access to the substance misuse for older people' | | Yes | Designated Older Persons worker in voluntary sector, NPT |
| | | Consider and respond to the rise in deaths relating to Tramadol, other prescription only medicines and over the counter medicines | | Yes | CDAT work with pain management teams to manage clients whose addiction has developed via this route. Liaison nurses work with locality officers to identify GP practices where high rates of such prescribing is identified |
| | | Reduce drug and alcohol related deaths | | Yes | Maintenance, recovery and reablement |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Plan | Lead Director | Priorities 2015/16 | Plan submission deadline | In existing plan | To be included in plan by submission deadline |
|---|---|---|---|---|---|
| | | | | | important aspects of the strategy |
| | | Reduce the harm associated with substance misuse | | Yes | Maintenance, recovery and reablement important aspects of the strategy |
| Maternity | Rory Farrelly (Malcolm Thomas) | Public Health of pregnant women | | No plan but priorities recorded and monitored on Maternity dashboard | *Yes but on dashboard only* |
| | | Reducing caesarean section rate (to below 25%) | | | Yes recorded on the Maternity Dashboard |
| | | Improving breast feeding rates | | | |
| | | Focussing on safe staffing levels | | | |
| | | Early direct access to a midwife | | | |
| Oral Health | Siân Harrop Griffiths (Lindsay Davies ) | Work with dental teams and all other relevant stakeholders, to support the ongoing development and delivery of Local Oral Health Plans | December 2015 | Yes | Yes |
| Eye Health | Andrew Phillips | Roll out of IT for eye care – optometry referrals and Open Eyes | 30th April 2015 | Yes | Yes |
| | | Reduce the Follow-up Backlog in Ophthalmology and rollout of Focus on Ophthalmology Pathways | | Yes | Yes |
| | | Demand and capacity data Collection and Outcome Measures (including Certificate of Visual Impairment) | | Yes | Yes |
| | | COMMS Strategy | | No | Yes |
| | | Workforce | | Yes | Yes |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Plan | Lead Director | Priorities 2015/16 | Plan submission deadline | In existing plan | To be included in plan by submission deadline |
|---|---|---|---|---|---|
| (plus ophthalmology Plan) | | Patients being seen in an appropriate setting | | No specific reference in plan | Yes |
| Organ Donation to 2020 | Hamish Laing (Peter Matthews/Anne Biffin) | Consistent application of best practice and donation pathways | | Yes but needs updating | Yes |
| | | Performance management and escalation arrangements | | No | Yes |
| | | Education and communication | | Yes but needs updating | Yes |
| Rare Diseases | TBC | Establish governance arrangements and systems for implementation of the plan | TBC No date proposed | | WG plan not sent out yet |
| Tobacco Control | Dr Sara Hayes | Work with Public Health Wales to: Increase the percentage of the smoking population treated by LHB funded smoking cessation services such that the target in the Delivery Framework is achieved | April 2015 | Yes | Yes |
| | | Implement the findings of the MAMMS smoking in pregnancy pilot in order to significantly increase cessation support for pregnant women | | | Yes |
| | | Provide support for NHS staff to quit smoking | | | Yes |
| | | Work with GP practices so that they either refer smokers to a smoking cessation service or provide their own service with CO-validation | | | Yes |
| | | Develop local smoke free homes projects to decrease exposure to second-hand smoke | | | Yes |
| | | Consider the impact e-cigarettes are having in the LHB area on quit attempts by smokers | | | Yes |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Plan | Lead Director | Priorities 2015/16 | Plan submission deadline | In existing plan | To be included in plan by submission deadline |
|------|---------------|--------------------|--------------------------|------------------|-----------------------------------------------|
| | | Look at options to introduce evidence-based programmes, e.g. ASSIST, aimed at preventing young people from taking up smoking. | | | Yes |
| Sexual Health and Wellbeing | Dr Sara Hayes (Nina Williams) | Raise awareness of Long Acting Reversible Contraception (LARC) and increase the referrals for LARC for under 18s from maternity services | | Covered within Empower to Choose and reported nationally.<br><br>Included in sexual health and wellbeing plan 2015 (reporting unclear) | Yes |
| | | Ensure sexual health services are available to teenagers | | Integrated adult sexual health services via WCH/primary care LES, 3<sup>rd</sup> sector – yes in Sexual health and wellbeing plan 2015 ( reporting unclear) | Yes |
| | | Provision and delivery of LARC within substance misuse services in Wales | | National work being promoted through APB structure. | Yes |

## Appendix 12    Summary of priorities within Single Integrated Partnership Plans 2012-18 area

| Population outcome | Measure | Bridgend | Neath Port Talbot | Swansea |
|---|---|---|---|---|
| **Health** | | | | |
| Children have a good start | Low Birth Weight | | • | • |
| | Domestic Abuse/reported incidents/repeats | | • | • |
| | School readiness | | | • |
| Children and Young People are physically and emotionally healthy (0-18 year olds | % reception year children who are of a healthy weight | | • | |
| | % uptake of MMR2 | | • | |
| | % uptake of HPV  vaccination | | • | |
| | Decayed, missing, filled teeth score(5 Year olds) | | • | |
| Adults are physically and emotionally healthy | Reducing number of people who are overweight/ | • | | |
| | %adults 65+ | • | • | |
| Older people are independent and enjoy a good quality of life | Increasing the number people helped to live independently/Older people's independence | • | | • |
| | Reduce excessive alcohol drinking/ | • | | |
| | % Adults 65+ | • | • | |
| | Improving people's emotional wellbeing and mental health | • | | • |
| | % adults currently being treated for any mental illness | | • | • |
| | Reduce smoking rates/ | • | | |
| | % adults 65+ | | • | |
| | Increase the number of people taking exercise/ | | | |
| | Adults reporting being physically active on 5 or more days in the past week/ | • | | |
| | Adults 65+ | • | • | |
| | Preventable early deaths | | • | • |
| | Life expectancy | | • | • |
| | Crime | | | • |

# Summary of priorities within Single Integrated Partnership Plans 2012-18  area

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Population outcome | Measure | Bridgend | Neath Port Talbot | Swansea |
|---|---|---|---|---|
| | % working age population economically inactive (excluding students) | | ● | |
| | % uptake of influenza vaccination (under 65's, at risk) | | | |
| | % uptake bowel screening | | | |
| | Breast Screening - % resident and eligible women screened | | ● | |
| | % adults currently being treated for any mental illness | | ● | |
| | % adults (aged 65 and over) with a limiting long term illness | | ● | |
| | Emergency hospital admissions with diagnosis of fractured neck of femur | ● | ● | |
| **Learning** | | | ● | |
| Engaged and empowered to achieve full potential | Reducing the number of NEETs | ● | ● | |
| | Increase the number of 15 year olds achieving 5 GSEs Grade A*-C | ● | ● | |
| | Reduce Teenage pregnancies/ | ● | | |
| | Conception rates 13-15 years | ● | ● | |
| | Reduce the number of people who are homeless | ● | | |
| | % of all potentially homeless households for whom homelessness was prevented for at least six months | ● | ● | |
| | % of private sector dwellings that had been vacant for more than six months as at 1st April that were returned to occupation during the year through direct action by the Local Authority | ● | ● | |
| | Increasing the number of people with NVQ level 3 | ● | | ● |
| | Improving support for families affected by unemployment | ● | | |
| | Increasing the number of people who they can contribute to decision making | ● | | |

# Summary of priorities within Single Integrated Partnership Plans 2012-18  area

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Population outcome | Measure | Bridgend | Neath Port Talbot | Swansea |
|---|---|:---:|:---:|:---:|
| People learn successfully | School attendance/primary and secondary | | ● | ● |
| | School achievement | | | ● |
| | Improving employment opportunities | ● | | |
| | Number of permanent exclusions | | ● | |
| | Days lost through fixed term exclusions | | ● | |
| **Economy** | | ● | | |
| Strong & more prosperous economy | Increasing support for businesses | ● | | |
| | Reducing the number of empty properties in town centres | ● | | |
| | Increasing support for people to improve their household income | ● | | ● |
| | Increasing the number of visitors to town centres | ● | | |
| | Improving support for people claiming job seekers allowance | ● | ● | |
| Decent Standard of Living(S) | Personal Debt | | | ● |
| | Child Poverty/ | | | ● |
| | Proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60% of median income. | | ● | ● |
| Young People & Adults have good jobs(S) | Youth unemployment | | | ● |
| | Economic inactivity | | | ● |
| | Average earnings | | | ● |
| | Economic performance | | | ● |
| (NPT) | % working age people (aged 16 – 64) who are employed | | ● | |
| | % working age people (aged 16 – 64) who are economically active | | ● | |
| | Number of newly opened | | ● | |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Population outcome | Measure | Bridgend | Neath Port Talbot | Swansea |
|---|---|---|---|---|
| | enterprises | | | |
| | Number of enterprises closing | | • | |
| **Place** | | | | |
| Great place to live, work and visit | Further reducing violent crime | • | • | |
| | Reducing drug misuse | | | |
| | Number of people presenting to drug treatment services | • | • | |
| | Further reducing domestic burglary | • | • | |
| | Reducing reoffending rates/ | • | | |
| | young people | | • | |
| | IOM | • | • | |
| | Improving street cleanliness | • | | |
| | Improving opportunities for play and leisure for young people | • | | |
| | Increasing the number of people who feel part of their community | • | | |
| | Increasing the amount of household waste that is recycled, reused or composted | • | | |
| | Increasing the range and choice of housing available | • | | |
| | Improving the water quality of our lakes and rivers/ | • | | |
| | Water quality/ | • | | • |
| | European legislation on air quality, contaminated land and water quality met | • | • | |
| | Increasing tourism | • | | |
| | Public Transport | • | | • |
| | Carbon Emissions | | • | • |
| | Housing quality | | | • |
| | Rate of total recorded offences per 1,000 people. | | • | |

# Summary of priorities within Single Integrated Partnership Plans 2012-18 area

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Population outcome | Measure | Bridgend | Neath Port Talbot | Swansea |
|---|---|---|---|---|
| | Number of first time entrants into the youth offending system | | • | |
| | Number of reported incidents of anti-social behaviour | | • | |
| | % of all fire incidents categorised as 'deliberate fires' | | • | |
| | % of all fire incidents categorised as 'accidental fires' | | • | |
| | Number of A&E Attendances (Assaults) | | • | |
| | % reported fly tipping incidents cleared within five working days | | • | |
| | % total length of public 'Rights of Way' which are easy to use by members of the public | | • | |
| | % of road casualties killed or seriously injured | | • | |

## Appendix 13    Benchmarking tools

To date the Departments of Informatics and Finance have worked together to make available a range of benchmarking materials and tools. Performance can be compared based on Cost, Length of Stay and Theatre Time and analysis undertaken at HRG, Procedure and Diagnosis level.

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

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

Where we were performing below average, the ten organisations immediately above the average.

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

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

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

Develop the dashboard to compare performance across numerous dimensions with either a specific comparator Trust or an appropriate peer group.

Enable users to drill down into data to identify factors potentially influencing variation such as a patient's age, residence, consultant or clinical classification.

Plot performance on a quarterly basis to assess trends and the impact of service changes.

Support local teams in developing skills in using the dashboard to support continuous service improvement.

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

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

The benchmarking tools in use within our organisation are:

**NHS Benchmarking:** ABMU is a member of the NHS Benchmarking Network. The NHS Benchmarking Network works with its members to understand the wide variation in demand, capacity and outcomes evident within the NHS and define what good looks like. This supports providers in delivering optimal services within resource constraints, whilst also allowing commissioners to achieve the best balance from available commissioning resources. The Benchmarking Network newsletter is available on Portal and there are more than 40 individuals set up to access a wealth of benchmarking information via the website.

**CHKS:** In order to quantify the potential for further efficiency savings as a service provider, the Health Board commissioned CHKS to benchmark service level costs with efficiency and outcome measures, comparing the Health Board with high performing providers in England. The aim of the exercise was to identify outlying services; provide insight into the drivers of variance and to produce an action plan where there look to be opportunities to generate savings without sacrificing quality of care.

**CHKS Signpost:** Signpost is used at different levels across the Health Board, providing easy access to user-specific information for consultants, clinicians, managers and information analysts. Signpost is a user-friendly 'dash-board' which enables access by all designated users.

**National Clinical Audits:** ABMU has participated in a number of clinical audits in 2012/13. Details of these audits and links to the published reports are embedded in the attached document.

**Reference Costs:** Welsh health Boards are required to submit reference costs to WG on an annual basis. These are incorporated into a specialty cost statement (WCR1) breaking down fully absorbed costs and activity by specialty and point of delivery and generating average unit costs and an HRG cost statement (WCR2) breaking down the costs and activity for admitted patient care by Healthcare Resource Group (HRG)

And cost driver. Welsh Government incorporates this into an All Wales average. For each Board, activity is costed at HRG level (for APC) or specialty (for non APC) using the All Wales average costs. The resultant derived cost is compared to the cost reported by the Board to generate a cost Index. The cost index for ABMU was 95.69 demonstrating the relative cost efficiency of ours services within Wales. Detailed working papers are made available to drill down into this variance to specialty, POD and HRG level.

**Commissioner Reference Group:** The Health Board is a member of the Commissioner Reference Group within the NHS Benchmarking Network. The Group is in the process of creating a programme of work for 2014/15, including a proposed enhancement of the Total System Benchmarker toolkit. This toolkit presently contains activity, financial, quality, mortality and disease prevalence data for a large of number of English Healthcare bodies and provides a modelling functionality. The opportunity is for inclusion of the Health Boards of Wales, whilst expanding on the outcome measures, though a collaborative work programme. Additional work programmes include Acute Reconfiguration, Pathways (proposed Diabetes), Children's Services and Medicines Management.

In addition, Finance and Informatics colleagues have been working to acquire, implement and rollout two new benchmarking dashboards that can assist the Health Board in their Service Improvement and performance work.

These are Albatross and Comparative Health Knowledge System (CHKS) Insight:

**Albatross:** A Patient Cost Benchmarking Tool that will enable ABMU to compare costs for admitted Patient Care treatments with other similar Health Service providers, enable drilling down into the component parts of HRG costs, enable sharing / accessing of variance reports and ensure easy extraction of data from existing costing systems. In December we provided information to Directorates on where there are opportunities for them to improve performance.

> Each Directorate/Locality/Programme have addressed action/ savings/ benefits from the information in their plans. We will open up access to Albatross to a wider audience in the New Year with appropriate support and training.

**CHKS Insight:** A healthcare intelligence programme that combines expert analysis and benchmarking advice with an online monitoring and reporting system. We plan to tailor the Insight programme to match our specific priorities and objectives and use the variety of presentation formats and bespoke reports to engage all stakeholder groups in more informed decision making. CHKS Insight will allow us to focus on the indicators that are most important to our organisation, to directorates and to specialties.

Recent work by Public Health has developed an NHS Expenditure and Health Tool (SPOT in England). This should be useful to us from a Commissioning perspective going forward.

## PATIENT COST BENCHMARKING WITH ENGLISH PROVIDERS

Albatross (Patient Cost Benchmarking) collects patient level clinical, demographic and cost information and enables access to this information through a business intelligence dashboard. The dashboard facilitates the

presentation of comparative analysis of data in a flexible and effective manner.

In order to undertake the comparative analysis, we have identified specialty "improving performance" Peer Groups against which to benchmark Cost, Length of Stay and Operating Theatre Time.

Using the dashboard to compare performance with these Peer Groups, it has been possible to scope the potential for performance improvement with resultant productivity improvement and cash releasing saving.

Access to the Albatross Dashboard has been arranged for all Directorates and Localities, and Programmes and Project leads, and a series of meetings have been arranged to provide familiarisation and to explore the potential opportunities.

Specialty specific performance Indices and Impact Statements have been developed and utilised to underpin the IMTP.

## Appendix 14    Effective Use of Information Systems Programme

### Easier and quicker access

Through a combination of a scanning solution, the use of electronic forms and a patient documents/diagnostic results module of the clinical portal, easy access to electronic information will increasingly become more available to clinicians in all secondary care settings, with a diminishing need for paper records. This will include access to the GP Summary record.

### Improving the ability to manage patient flow

Further development of ward management functionality through the clinical portal to provide electronic workflow for test requesting, ePrescribing and drug administration, doctor/nursing handover, nursing assessments, NEWS, PSAG/board rounds, live patient location statuses etc., will have a significant impact on patient safety and flow and the timeliness of discharge information to primary care.

The next phases of the TOMS Theatre system development and the introduction of an electronic solution to support the pre-assessment process will enable safety improvements and process efficiencies across surgical pathways.

In the outpatients setting, the Implementation a patient flow system at the new Morriston Outpatient building, will allow patients to self-register upon arrival and help coordinate their journey through the department. During the consultation their doctor will have access to all the electronic information available in the clinical portal. It is anticipated that this new Outpatient flow model will be a huge success, and has the potential to be taken forward to the other sites.  Also ePrescribing will firstly be implemented in the Outpatient settings across ABMU during 15/16, helping to reduce errors and further improve patient flow.

### Improved efficiencies at departmental level

New systems to be implemented across a number of departments/services will provide the huge opportunity for efficient working and contributions to a high quality electronic patient record, these include:

- Procure and implement a single ED system across the organisation (ABMU are leading the development of a national framework contract for an ED system for NHS Wales).

- Implement the National Laboratory Information Management System (LIMS) to support the workflow of the pathology departments within the national model, and provide the platform to allow the introduction of electronic test requesting in both primary and secondary care.

- Implement the National RADIS (Radiology Information System) and PACS solutions across ABMU, allowing clinicians to work with images and reports across the organisation, and share with the rest of Wales.

- Procurement and implementation of a single Endoscopy system for ABMU.

- Introduction of the National Ophthalmology Patient Record System – Open Eyes.

## Improved communications between primary and secondary care

In the primary care setting, all GP Practices in the ABMU area will have migrated to one of the two National Systems in 2015/16. This is a significant step forward, not only for the standardisation of the information produced within the practices, but it also simplifies the sharing of electronic communication between primary and secondary care.

Working with practice colleagues, ABMU plans on increasing the use of eReferrals to 100% to reduce the need for paper. Also, clinical patient documents that are sent to primary care, such as discharge summaries and clinic letters, will be sent electronically and easily embedded into the patient record at the practice end.

The National GPTR solution will also be taken forward in ABMU in 2015/16 to deliver pathology and radiology results/reports and also introduces pathology electronic test requesting.

## Improved ICT integration with Mental Health and Social Services

In the Community / Mental Health / Social Services space, the work to provide an integrated service for patients and service users across health and social care is well advanced from an operational perspective in ABMU HB. Whilst the integration of staff and services is progressing well, there is still much to be done to integrate information. During 2015/16 work will commence on the implementation of the national integrated Community and Care information System (CCIS). As plans develop to roll this product out nationally, business cases will be developed to support technical enabling work, such as populating the NHS Number in social care systems, and short-term tactical ICT solutions. This work will be progressed by the WBP ICT Leads Group. In addition, a business case will also be developed in order to provide mobile access to information by HB staff, with the aim of enabling the whole workforce with mobile access.

## Improved information on patient experience

We are putting in electronic tools to capture patient experience in both an inpatient and outpatient setting. This will be available to patients via dedicated kiosks and also widely available using the free public wi-fi access using their personal mobile phones, tablets or laptops. This system will be further enhanced in order to collect information from patients following an

operation or in patient stay for example. This information will be made available for patients to see how departments are performing from a patient perspective.

**Electronic data sharing across the South Wales Programme**.

The implementation of electronic systems described above will allow information to be shared electronically across organisations. Key elements of this will be the implementation of the laboratory, PACS, and emergency department national systems.

**Improved performance data**

The introduction of Information Performance Dashboards during 2014/15 has provided a rich and valuable source of information to clinicians and managers across the Health Board, This work will continue to ensure the organisations performance is effectively reported.

ICT Enablers improvements in our technical infrastructure and increased access devices will need to underpin the above innovations. In particular there will need to be significant investment in mobile enablement of the workforce, providing a wireless infrastructure at Singleton Hospital and strengthening the infrastructure and 24/7 support to sustain the increasing reliance on electronic information.

**Remote mobile working** in hospital and community care through the development of simple/intuitive health "apps" on mobile devices.

## ICT Plans aligned to the Strategic Change Programmes

| # | Product / Service | | 14/15 | 15/16 | 16/17 | 17/18 | Patient Safety | Clinical / Clinician Efficiency | Direct Patient/Carer Experience | Patient Flow | Surgical Pathway | Diagnostic & Therapies | Outpatients | Primary Care | Community | South Wales Patient Flow |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Digitising the Health Record | Scanning solution to support the transition from paper to electronic records/workflow and resolve ABMU's significant duplicate records legacy | | dev/pilot? | ph1 | Scan? | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| 2 | | ENPI - The ENPI is the foundation of the electronic patient/citizen record. A combined Local and National Administration Model is required to ensure patient' ENPI records are managed effectively | | | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3 | Clinical Portal — WARD | Live Admissions, Discharges, Transfers | ✓ | | | | ✓ | ✓ | ✓ | ✓ | | | | | | |
| 4 | WARD | Transfer of Care / Discharge Summaries workflow | ✓ | | | | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | |
| 5 | WARD | Electronic workflow/forms: Junior Doctor / Nursing Handover, nursing assessments, VTE assessments etc | | Iterative product releases | | | ✓ | ✓ | | ✓ | | | | | ✓ | |
| 6 | WARD | Patient/bed mgt Dashboards - Building on live ADTS: PSAG/board round, NEWS scores, infection control statuses, ePrescribing alerts/next actions, patient location e.g. In theatre, live bed states | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| 7 | ALL | Radiology Reports & Images (East data only) / Access to Pathology Results | ✓ | | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 8 | ALL | Radiology Reports & Images (West) | Reports: Mar | Images: Dec | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| 9 | ALL | Pathology Electronic Test Requesting (ETR) | | Phased | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| 10 | ALL | Patient events summary, discharge lists, patient labels/wristband labels, Therapy Mgt module, MH Act Administration (only implemented in East) | ✓ | | | | ✓ | ✓ | | ✓ | ✓ | | | | ✓ | |
| 11 | ALL | Clinician View (eDocs) - first phase: Discharge summaries, OP letters, Scanned images of prioritised referrals, operation notes, Cas Cards, lung function test results (West). Second phase to include ECG, EEG etc | Phase 1 Mar | Phase 2 | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | | |
| 12 | ALL | Access to the GP Summary Record (IHR) | | | | | ✓ | ✓ | | ✓ | ✓ | | | | ✓ | ✓ |
| 13 | ALL | Access to National diagnostic results | | | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| 14 | ALL | Access to National clinical documents | | | | | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | |
| 15 | REFERRALS | Electronic prioritisation of referrals | | | | | ✓ | ✓ | | | ✓ | | | | ✓ | |
| 16 | ePrescribing (JAC) | Electronic prescribing (OP / IP) and administering (IP) of medication | | OP? | IP? | | ✓ | ✓ | | ✓ | ✓ | | ✓ | | | ✓ |
| 17 | eObservations | Electronic recording and management of patient observations - including escalation alerting/notification | | ??? | ??? | ??? | ✓ | ✓ | | ✓ | ✓ | ✓ | | | | ✓ |
| 18 | Document Management System (DMS) | A Bolt-on to Microsoft Word to create and make available electronic clinical documents - underpins the Clinical Portal presentation of documents and the WCRS | ✓ | | | | ✓ | ✓ | | ✓ | ✓ | | ✓ | | | ✓ |
| 19 | ED System (Symphony) | Electronic workflow and clinical information recording in EDs, MIUs, CDUs, PAUs, FEA, SDNU, MAU, AMUA, AMUO | | East:Aug West:Oc | | | ✓ | ✓ | | ✓ | ✓ | | | ✓ | ✓ | ✓ |
| 20 | Major Trauma Centre Management System | Implement a Major Trauma Centre Management System e.g. Blue Spier | | ??? | ??? | ??? | ✓ | ✓ | | ✓ | ✓ | | | | | |
| 21 | National PACS (Fuji) | Single PACS system across ABMU | | East:Jun West:Dec | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| 22 | Radiology Information System (RADIS) | Single RADISZ instance across ABMU. The system is already in PWH and NPT. | | Readiness | Implement | | ✓ | ✓ | | | | ✓ | | | | |
| 23 | National LIMS | Single Laboratory Information Management System for Wales | Micro / Blood Sc | Histo | | | ✓ | ✓ | | | | | | | | ✓ |
| 23 | Cardiology PACS | Single National Cardiology PACS System across ABMU | | | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| 24 | Theatre Mgt System (TOMS) | Single Theatre Management System across ABMU, including investment in new devices and wireless in Singleton Theatres | ✓ | Phase 3 | Apr/May | | ✓ | ✓ | | | ✓ | | | | | |
| 25 | Pre-assessment workflow | Electronic workflow and clinical information recording to support an effective pre-assessment model | | | | | ✓ | ✓ | | ✓ | ✓ | | | | | |
| 26 | ERAS clinical data capture | Electronic workflow and clinical information recording to support ERAS | | ??? | | | ✓ | ✓ | | ✓ | ✓ | | | | | |
| 27 | Endoscopy System | Single Endoscopy system across ABMU | | | | | ✓ | ✓ | | ✓ | ✓ | ✓ | | | | |

**Key**

| | |
|---|---|
| ✓ | Implemented |
| (green) | Implementation period is scheduled - dependencies / constraints not withstanding |
| (orange) | Implementation period is scheduled - dependencies / constraints not withstanding |
| (red) | Further activites required to prioritise and establish an implementation plan |

# Effective Use of Information Systems Programme

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| # | Product / Service | 14/15 | 15/16 | 16/17 | 17/18 | Patient Safety | Clinical/ Clinician Efficiency | Direct Patient/Carer Experience | Patient Flow | Surgical Pathway | Diagnostic & Therapies | Outpatients | Primary Care | Community | South Wales Patient Flow |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 28 | **Modernising Outpatient services** — Outpatient self registration and patient outpatient flow | | Morriston | ??? | Other Sites | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | |
| 29 | Utilise text messaging and email to improve patient appointment communication and booking, and reduce the need for paper letters | | ??? | ??? | | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | |
| 30 | **Ophthalmology Patient Record System** — The National OpenEyes Ophthalmology Patient Record System | | (orange) | | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| 31 | **Diabetes Management System** — The National Diabetes System - SCI Diabetes | | ??? | ??? | ??? | ✓ | ✓ | | | | | ✓ | ✓ | ✓ | ✓ |
| 32 | **Single Audiology System** — Merge 3 instances of the Auditbase Audiology system into 1 | (orange) | | | | ✓ | ✓ | | | | ✓ | ✓ | ✓ | ✓ | |
| 33 | **Sexual Health System** — Enhance Sexual Health System to provide additional functionality and increase departmental efficiencies such as automated patient SMS texting from Pathology feeds | | ??? | ??? | ??? | ✓ | ✓ | | | | | ✓ | ✓ | ✓ | |
| 34 | **Primary Care Clinical Communication** — WCCG Electronic GP referrals - GP Surgeries to use the WCCG eReferral solution for all referrals when their GP system is upgraded | | July | | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ |
| 35 | Electronic transfer of Discharge summaries & OP Clinic Letters to Primary Care via WCCG - stop sending paper letters | Feb pilot | | | | ✓ | ✓ | | | | | ✓ | ✓ | | |
| 36 | Primary Care access to Radiology Reports (East data only) and access to Pathology Results | ✓ | | | | ✓ | ✓ | | | | ✓ | | ✓ | | |
| 37 | Primary Care access to Radiology Reports (West) | Pilot: March | Rollout | | | ✓ | ✓ | | | | ✓ | ✓ | ✓ | ✓ | |
| 38 | Primary Care Pathology Electronic Test Requesting (GPTR) | | Phased | (orange) | | ✓ | ✓ | | | | ✓ | ✓ | ✓ | | |
| 39 | **Community, Mental Health, Social Services** — Mobilising community staff | | ??? | | | ✓ | ✓ | | | | | | | ✓ | |
| 40 | Implementation of the National Community Care Information System (CCIS) across Health and Social Care | | Bgd LA | ??? | ??? | ✓ | ✓ | | ✓ | | | | ✓ | ✓ | ✓ |
| 41 | **Patient & Staff Feedback System** — Electronically capture patient and staff feedback to monitor performance and inform service improvement | (orange) | | | | ✓ | | ✓ | | | | | | | |
| 42 | **Patient Entertainment System NPT** — Replace patient entertainment system at NPT | (orange) | | | | | | ✓ | | | | | | | |
| 55 | **ICT Enablers** — Implement wireless network in Singleton. Theatres and some wards already wireless. | | ??? | ??? | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| 56 | Digital Dictation | | Mar Admin | ??? | ??? | | ✓ | | | | | ✓ | | | |
| 57 | Sharepoint 2013 - Clinical & corporate communication, workflow, eForms, document management etc | (orange) | (orange) | (orange) | (orange) | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 58 | Invest in Mobile Device Management Solution (MDM) to provide organisation wide opportunities for Bring Your Own Device (BYOD) | ??? | | | | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 59 | Invest in wireless/integrated comms to enable voice, video and instant messaging comms. Desk/wireless phones, tablets securely integrated into one comms system. Replace bleep system with integrated comms system to provide efficiency savings. Mobile devices to support further use of remote care and support e.g. Doctor and Care worker communicating over Skype | ??? | ??? | ??? | ??? | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 60 | Migrate ABMU Clinical Portal from an Ingres Database to a Microsoft SQL Database. Benefits: revenue saving, staff recruitment/retention, better integration opportunities | Mar | | | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | |

**Key**

- ✓ Implemented (green)
- Implementation period is scheduled - dependencies / (orange)
- Further activities required to prioritise (red)

| # | Product / Service | 14/15 | 15/16 | 16/17 | 17/18 | Patient Safety | Clinical/ Clinician Efficiency | Direct Patient/Carer Experience | Patient Flow | Surgical Pathway | Diagnostic & Therapies | Outpatients | Primary Care | Community | South Wales Patient Flow |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Reporting / Secondary Uses of Information** | | | | | | | | | | | | | | | |
| 43 | Patient Flow Dashboard (including Capacity Planning) | ✔ | | | | ✔ | ✔ | | ✔ | | | | | | |
| 44 | Theatre/Surgical Pathway Performance Dashboard | ✔ | | | | ✔ | ✔ | | | ✔ | | | | | |
| 45 | HAT Dashboard | ✔ | | | | ✔ | | ✔ | | ✔ | | | | | |
| 46 | Outpatient Performance Dashboard | ✔ | | | | | | ✔ | | ✔ | | ✔ | | | |
| 47 | Discharge Summary Performance Dashboard | Dec | | | | ✔ | ✔ | | ✔ | ✔ | | | | ✔ | ✔ |
| | Primary Care Dashboard | Jan | | | | ✔ | ✔ | ✔ | | | | | ✔ | | |
| | Infection Control Dashboard | | | | | ✔ | ✔ | | ✔ | ✔ | | | | | |
| | Mortality Dashboard | | | | | ✔ | ✔ | ✔ | | | | | | | |
| 48 | Maternity Dashboard | | | | | ✔ | ✔ | | | | | | | | |
| | Mental Health Dashboard | | | | | ✔ | ✔ | | ✔ | | ✔ | | | | |
| | Community & Therapies Dashboard | | | | | ✔ | ✔ | | ✔ | ✔ | ✔ | | | | |
| 49 | Ward Dashboard | | | | | ✔ | ✔ | ✔ | ✔ | ✔ | | | | | |
| 51 | Consultant Dashboard | | | | | ✔ | ✔ | | ✔ | ✔ | | ✔ | | | |
| | Planned Care Dashboard | | | | | | | | | | | | | | |
| 52 | Board/Exec/Performance Dashboards | | | | | ✔ | ✔ | | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | |
| 53 | Junior Doctor Dashboard | | ??? | | | ✔ | ✔ | | ✔ | ✔ | | | | | |
| | Service Line Reporting | Mar | | | | | | | | | | | | | |
| 54 | Improve clinical coding timeliness | Team | Expand | | | ✔ | | | | | | | | | |

**Key**

| | |
|---|---|
| ✔ | Implemented |
| (orange) | Implementation period is scheduled - dependencies / constraints not withstanding |
| (red) | Further activites required to prioritise and establish an implementation plan |

## Appendix 15    Key Risks

| Ref | Objective for 15/16 | Risk | Current context | Controls in place | Risk Rating | Action Plan | Action Lead | Progress |
|---|---|---|---|---|---|---|---|---|
| 1 | **Excellent Patient Outcomes & Experience** | **Compliance with Tier 1 target - Unscheduled Care** | Non compliance with Tier 1 target - Unscheduled Care which will have an impact on patient and family experience. . | ABMU and partners Unscheduled Care and Patient Flow Improvement plan developed via USC and Patient Flow Programme board , chaired by CEO.  This is supported by individual Directorate and Locality plans. Daily Health Board wide conference calls escalation process in place.  Weekly meetings at POWH and Morriston Hospital. New monthly performance meetings being introduced regarding ambulance performance. Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee. External reporting to Welsh Government. | 25 | 2 main areas of focus  'Front Door' and 'Flow' Support from new Service Improvement Team to improve patient flow as part of 1000 lives collaborative. | Chief Operating Officer/Deputy CEO and Director of POWH | Demand from increasing 80 year old age group in last 6 months combined with workforce problems in healthcare and social care have led to a deterioration in performance which has had a whole system impact. Additional actions and measures have been put in place to try and address the signifincat scale before medical outliers. A revised improvement programme will be agreed by the end of March 2015. |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Ref | Objective for 15/16 | Risk | Current context | Controls in place | Risk Rating | Action Plan | Action Lead | Progress |
|---|---|---|---|---|---|---|---|---|
| 3 | **Sustainable & Accessible Services** | Deliver services effectively through trained competent staff and develop new roles as services change over time. **Workforce Planning** Compliance with Mandatory and statutory training | National shortages of numbers in some areas can lead to: Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites Unable to attract non training grades to complete rotas Unable to fill Consultant grade posts in some specialties with adverse affects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff. | Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board. Specialty based local workforce boards established to monitor and control specific issues. The new HB Workforce & OD Committee will seek assurance of medical workforce plans to maintain services. Engagement of the Deanery about recruitment position | 20 | HB Workforce & OD Committee to be established. Medical workforce issues are seen as a lever for service planning and factored into C4B and South Wales service plans. Ongoing discussions and communication with Deanery about recruitment position. Recruitment campaigns for additional non training posts to fill gaps. Specific Medical Workforce Group for Integrated Medicine and Paediatrics to develop short term workforce plans. Medical Workforce Board to consider current and future shape of medical workforce. Review of primary care in terms of recruitment and retention | Director of Workforce and OD Medical Director, Director of Nursing, Director of Therapies & Health Sciences | Workforce and OD Committee meetings on a quarterly basis to provide assurance on WF and OD issues including staffing levels and recruitment. Focus of Changing for the Better and South Wales Programme is to redesign services and roles that take account of recruitment difficulties in key specialties. A number of medical training initiatives are being pursued in a number of specialties to ease junior doctor recruitment. Medical Workforce Board continues to monitor recruitment and junior doctors rotas. |

| Ref | Objective for 15/16 | Risk | Current context | Controls in place | Risk Rating | Action Plan | Action Lead | Progress |
|---|---|---|---|---|---|---|---|---|
| 11 | **Excellent Patient Outcomes & Experience** | **All 6 Domains ……………… ….. Focus on improving Dignity in Care and the needs of older people** | Increasing challenge of providing healthcare models for aging population. Over next 20 years care resident population will see a 24% increase in people of a pensionable age and 15% increase in people of non working age. Providing services to enable citizens to live independently at home is a major challenge. | Action plan in place and monitored through the Older Persons Group.  Full implementation of the Butterfly Scheme and Dementia Training in Place across the Health Board. | 16 | Being taken forward as part of the Action after Andrews. • Twelve standards of care for older people in hospital have been drafted jointly by clinical staff, patient groups and voluntary sector organisations • The 'See It Say It' campaign established to make it easier for staff, patients and visitors to raise concerns – anonymously if they wish – by phone, text or email • We've introduced the '15 Step Challenge' to improve the first impression patients and visitors get when they enter a ward | Chief Executive | *  ABMU Values launched in February 2015. • Work is well under way to reduce paperwork so clinicians can spend more time with patients • To ensure wards run smoothly and efficiently we are developing an 'Ideal Ward' concept, which explores factors like processes, environment, staffing and training. This is being rolled out across ABMU • More than 2,700 surveys have been completed by staff and patients/families capturing views on what's good and bad |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Ref | Objective for 15/16 | Risk | Current context | Controls in place | Risk Rating | Action Plan | Action Lead | Progress |
|---|---|---|---|---|---|---|---|---|
| 9 | **Excellent Patient Outcomes** ………….……. **Sustainable & Accessible Services** …………. | **Access** ……………….……….. | Insufficient bed capacity to meet demand at peak times can have a major impact on service delivery around access particularly. | Patient Flow Programme.• Board Rounds • 7 day working. • Analysis of < 15 day LOS • Community capacity increase • Increased staffing levels • Improved operational provisions | 16 | Additional investment in these initiatives through the Integrated Medium Term Plan. Dedicated Service Improvement Team in place from September. | Chief Operating Officer and Director of POWH | Bed capacity has deteriorated and is exacerbated by staffing issues. Plans are being developed to further reduce delays and increase bed availability. |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

| Ref | Objective for 15/16 | Risk | Current context | Controls in place | Risk Rating | Action Plan | Action Lead | Progress |
|---|---|---|---|---|---|---|---|---|
| 4 | **Excellent Patient Outcomes** ……………. ……………….. …. | **Safety Domain** …………… …………… Infection Control Reducing Healthcare Acquired infections | Healthcare acquired infection (HCAI) causes patients harm. HCAI also results in increased costs, length of stay and bed losses. Insufficient isolation and negative air pressure facilities make it difficult to adhere to recognised evidence based pratcice standards for the management of patients with a suspected or actual transmitable infection. Environments of care that have sufficient estates risks that compromise the ability to defend any evidence of increased HAI and patient experience perception. No approved bed spacing standard and incidents of increased bed capacity with extra trolleys on wards resulting in a greater than 85% bed occupancy. Difficult to achieve required decontamination programme and full adherance to requirements of norovirus tool kit. | Comprehensive Control of Infection Policies & Procedures / SOPs in place. HB wide ICD appointed. Comprehensive programme of action via the 1,000 Lives Programme being actioned including hand hygiene, antibiotic stewardship, dress code, cleaning standards. Regular monitoring of compliance with standards and the identification of hot spots. Operational engagement of infection control in site management processes. Clear escalation process in place. Operational Infection Prevention Board established chaired by the Director Nursing and Patient experience. Setting of upper controll triggers for hospital sites. Initiation of hospital management iCC meetings to pomote a widescale enagement with decontamination programme and response to surveillance alerts. | 16 | Improved real time surveillance alets and trends by ICC team. Set hospital and ward upper controll triggers for promt reaction to increasing trends. Devise risk based decontamination programme for all wards across all hospital sites to implement a proctive opportunistic approach to decontamination. Continue with Root Cause analysis to ensure monitoring and lessons are continued to be learned from HAI. Support all hospital sites in setting upa hospital based ICC forum so there is ownership of local improveme nt and management of risk. Provide all management teams with a trajectory against current performance to required performance for tier one targets so this forms part of the senior management teams quality improvement plans. Continue with roll out HPV, UV utlising capital allocation to infection prevention and controll agenda. Finalise business case for negative pressure isolation facilities. | Director of Nursing and patient Experience Chief Operating Officer Medical Director & Director of T&HS | •Progressis being made in agreeing an option appraisal for the location of negative pressure fcailities within the HB - The HB is off trajectory against its tier one targets but all directorate/locality/hospital management teams have been advised of their individuall trajectory and target to be met. All hospital sites and wards have been issued with upper control triggers so that hospital management ICC groups are able to take proactive measures to reassess controls and implement further requirements. The management group are multiprofessional in their terms of reference wihich is supporting a team based approach to problem solving and mangement of risks and solutions. Performance is being monitored |

*Changing for the Better: 3 Year Integrated Medium Term Plan (IMTP)*

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| 34 | **Excellent Patient Outcomes & Experieince** | Princess of Wales | Increase in complaints relating to care and treatment at the PoWH. | PoWH Quality & Steering Group established, chaired by Chief Executive. | **16** | * 15 wte nurses recuited, 26.43 wte Band 5's to be recrutied to in April. 4 wte Advanced Nurse Practitioners appointed for the ED, full time Continence Specialist Nurse to be appointed.  Specialist and advanced practice workforce within the site.  A Specialist Nurse and Advanced Practice Forum and Steering Group has been established. • 2 Consultants in Emergency Medicine appointed on 4th April 2014.<br>• Interviews for an Acute Care Physician has been arranged for the 15th May 2014 and at present there are 2 appointable applicants.<br>• An advert will be placed imminently for 2 Consultant Cardiologists and the interviews will be held in the middle of June 2014. Two wards have been piloting the Ward Hostess service with excellent results in terms of patient experience, compliance with nutritional standards and food waste.  * All complaints reviewed by the Director of Princess of Wales Hospital and Head of Patient Experience and decision made.  * review of the condition of the maintenance of the Princess of Wales Hospital - priotiy areas identiifed as Ward 7, Ward 9 and Maternity Unit.  * Hospital management Committee estalbished first meetign 16th May. | Director for PoWH | Q&S Committee receive a report on the work undertaken to progress the actions identified during each meeting. The action plan incorporates actions identified within the AQuA report and this is being addressed to include the Andrews Report to develop a consolidated Quality & Safety Plan. |

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| 35 | **All objectives** | Changing for the Better programme. | If the programmes set up to deliver C4B are not managed effectively then they will have an impact on all of the Health Boards objectives. | C4B Board established to oversee all programmes and an Assurance Group set up to review the programmes. | 16 | Contained within the C4B Risk register for all the risks identified. | Director of Planning | A number of risks for each programme are identified with the C4B Risk Register and plans to manage these risks within the embedded excel document.<br><br>C4B Risk Register - Master Copy.xlsx |

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| 33 | **Excellent Patient Outcomes & Experience** .................... **.. Sustainable & Accessible Services** | Cardiac Services - Access | Delay in access to Cardiac Surgery. | Patients are admitted and treated according to clinical need.  Patients are advised to discuss their condition with their GP should they have concerns recording their condition. Patients are formally pre-assessed prior to elective surgery. Emergency admissions are retained until a date for surgery can be provided. Options assessment with architect new build required have been explored for the development and expansion of CITU/CHU unit to increase capacity and flexibility. | 12 | Discussions are ongoing with WHSCC and WG about options to extend Cardiac ITU. Cardiac Action Plan in place. • A Cardiothoracic Directorate has been established.<br>• Appointment of a Consultant Cardiac Intensivists<br>• Clinical leadership has been enhanced for CITU with the appointment of a Director of CITU.<br>• Regular communication with staff has continued through fortnightly staff briefings led by the Chief Executive and Chief Operating Officer.<br>• Workforce plans to address gaps and deficiencies have been developed and costed.<br>Revised operational processes in place regarding team briefing and Board rounds which are maximising throughput. | Chief Operating Officer/Deputy Ceo | Cardiac Action plan in place and reviewed by the Q&S Committee quarterly.<br>On track to deliver revised trajectory this year as a result of the actions taken and therefore the risk has reduced to 12 |

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| 26 | **Effective Governance** | Effective Governance ……………. …………... Patient Feedback team | Prolonged period of reduced resourcing within the department, arising through high staff turnover resulting in limited knowledge levels within the team.  Increased volume of work entering the department - 50% increase in complaints over past 3 years / continual increases in volumes of incidents reported / increasing Serious incidents and Never Events / increasing litigation / increasing numbers of cases progressing to Ombudsman / NHS Redress requiring far greater input to achieve compliance / changes to HM Coroners requirements demanding greater co-ordination. | Interim Complaints strategist recruited to review complaints arrangements and progress devolvement of work.  Interim Operational Manager for Complaints assisting within department to progress backlog complaints and resolve complaints capacity issues through the next 3 months. Former departmental staff assisting undertaking work as external contractors.  Executive oversight of Ombudsman correspondence. | 12 | Progress restructuring and redesign of corporate functions provided by the existing department to ensure ownership is appropriately allocated to increase awareness and likelihood of improvement actions being realised and more effective in reducing recurrence. | Director of Nursing and Patient Experience | Reduced number of compliants for 2014/15 compared to 2013/14, reduced number of Ombudsman referrals and compliants upheld by the Ombudsman. Serious Incidents investigated and report submitted to the Clinical Director within 4 weeks since January 2015. |

## Appendix 16    National Guidance

Specific guidance referred to in developing the IMTP:

- NHS Wales Planning Framework 2015/16
- The Bevan Commission Report 2008-2011
- NHS Wales – Forging a Better Future 2008-2011
- Setting the Direction - 2009
- The 1000 Lives Plus programme - in 2010
- Together for Health - Nov 2011
- Working Differently – Working Together  - May 2012
- Children's Rights Bill - 2012
- Delivering Local Health Care – 2013
- The NHS Wales Delivery Framework 2013-14 and future plans - May 2013.
- Delivering Safe Care, Compassionate Care NHS Wales - August 2013, the Government's response to the Francis Report.
- The Williams Commission – Jan 2014
- Social Services and Well Being (Wales) Act - 2014
- Planned Care National Framework - Planned Care Ophthalmology Plan, Implementation of a standard MSK referral service
- Together for Health, Eye Health Care, Delivery Plan for Wales 2013-2018
- Implementation of the Human Transplantation (Wales) Act and Taking Organ Transplantation to 2020 action plan.
- Welsh Health Circular –WHC/002/14 Prudent health care-making prudent healthcare happen.  Aylward M, Phillips C, Howson H. Simply Prudent Healthcare – achieving better care and value for money in Wales – discussion paper. 2013
- Welsh Health Circular – Prudent Healthcare One Year On, 11 Feb 2015
- Future Well Being and Generations Bill - 2014
- Improving unscheduled and out of hours services
- Primary Care Plan for Wales -Nov 2014
- Children's Rights Bill - 2012
- Innovation – the driving force for prudent Healthcare, Chris Martin, Member of the Bevan Commission, Chair of the Prudent Prescribing Implementation Group, Former Chair, Hywel Dda Health Board, Ifan

Evans, Deputy Director, Healthcare Innovation, Welsh Government – Dec 2014