Our Health, Our Future
Hywel Dda Integrated Medium Term Plan
2015/16 to 2017/18
DRAFT & CONFIDENTIAL
Building on the foundations of our public consultation ‘Your Health, Your Future’, this is our on-going plan for health and well-being services in Hywel Dda

Version: IMTP Draft Submission
30th January 2015
We are very pleased to present the Hywel Dda University Health Board 3 Year Integrated Medium Term Plan for the period 2015 – 2018.

The message contained in the NHS Wales Planning Framework from the Minister for Health & Social Services, Professor Mark Drakeford, signalled that as part of our passion in delivering the best services we can in NHS Wales, our guiding aims need to be: to improve the health of the population we serve, continue to improve the quality and safety of care we provide; and to ensure we get the maximum from the resources we have.

As a result of continued public sector austerity, the Minister also called for us to not only improve the way we currently do things but to think differently about how we do things in the future, the vision being transformed and high quality services securing those better outcomes, albeit set within the context of significant on-going financial challenge.

These messages are perfectly aligned to the Mission Statement for Hywel University Health Board (the Health Board). Through this plan, we will demonstrate how we are committed to the principles of prudent healthcare using a clinical value-based framework, how an investment in prevention activities which will; enable gains in population health, how we are actively pursuing the systematic improvement in patient outcomes, and very importantly, how we intend to transform strong and resilient primary and community care services where health, social care and the third sector services are demonstrably and seamlessly wrapped around patients and their carers. We call this care ‘Care Closer to Home’ and our plan will show how we are
looking for a stepped-change, actually the start of significant and sustainable transformational change, in this area.

We have always had good partnership arrangements, whether with other Health Bodies or with our Local Authorities, and we see considerably strengthened collaborative arrangements as pivotal in successfully securing co-produced solutions which meet all of our challenges over the coming years. We understand the need to clarify decision-making and performance measures which assure us all that stepped change really does realise the benefits we all want to see.

In Hywel Dda, we do have some challenges which this plan has to presently work within in, whilst endeavouring to ensure that we future-proof our service delivery. Our challenges are our rurality, the fact that we have four hospitals geographically some distance apart, often with onerous staffing rosters when we could attract and sustain more services and staffing and operate within our funded resources if we had only one hospital. Indeed, despite our challenges, the achievement of a sustainable resource plan over the next 3 years of the plan still assumes the 100% achievement of a cash-releasing saving requirement of over £77m.

This Plan realistically looks therefore to make the best of our current configuration by really pushing at some pace the concept of all four hospitals working together as ‘One Hospital over Four Sites’. Our hospitals will need to work very collaboratively together, all providing routine day surgery services but with each one also having an area of specialist interest on behalf of the Health Board.

Wherever the service provision occurs, our community and primary care services will be strengthened to ensure that patients with chronic conditions receive the best possible care at home and within communities and that post-operative care and rehabilitation will be provided as close to home as possible.

We understand that transformational change in all of our services will take considerably longer than 3 years, and that we will need to signal even more change within two successive rolling 3 year plans probably over a 10 year context. Therefore this first 3 year plan needs to demonstrate why and how we need to stabilise our service provision, where we think we can make the steps to deliver really optimal care and which services we can transform. Within this endeavour, we will signal where further change in service configuration can realise even greater benefits and needs to become reality, but this pragmatically represents a decade of substantial planning, notwithstanding the capital funding probably required to achieve this.

Above all, we see the need to bring all of our stakeholders - our residents, patients and carers, our staff, and our partners - with us on this journey. The Plan will show how we have engaged so far, but even more importantly how we see the continual need to communicate, engage and co-design these improvements so that Hywel Dda is seen to be an innovative and progressive organisation, which listens and acts upon the needs of our service users, our clinicians and staff, and our communities in a truly meaningful and transparent way.
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Executive Summary

This draft Integrated Medium Term Plan sets out Hywel Dda University Health Board’s (the Health Board) strategic vision, aims and objectives over the next 3 years.

The greatest single benefit that Hywel Dda can deliver to its resident population is access to the ‘*right care, at the right time and in the right place*’. Significantly improved access to good healthcare is the single greatest driver for improvements in both the quality of services we commission and provide and in the patient outcomes which this secures. Within our current services, we have identified our key quality challenges, which do not always meet best practice and standards, and this plan seeks to address many of these quality issues.

The Hywel Dda Mission Statement encapsulates what we mean by improved access to services through one of its key aims, ‘*We will provide Care Closer to Home*’. What our 3 year Integrated Medium Term plan does is demonstrate what we mean by this, and what resources we will need to shift into primary and community care to deliver this. As this represents a very significant change of service ethos, very importantly, our plan will need to provide the confidence to all of our stakeholders and our public that ‘Care Closer to Home’ really is the best fit service delivery model to address the healthcare needs of our increasingly frail and elderly population. In the absence of robust community information systems, this means that we will need to use, and triangulate evidence collected from a many other sources to realise the benefits. A key pledge in this plan is that this evidence will be widely shared so we can prove that what we think is intuitively the ‘*right service shift to providing Care Closer to Home*’, really is.

Importantly, our Care Closer to Home Planning is built up from the individual service perspectives and experiences of our 3 counties and their 7 Localities, and builds on where they each are now, how they intend to meet the needs of their Localities and the co-delivered services they already have in place with partner organisations, particularly Local Authority Social Services and the Third Sector, as well as with Locality Primary Care Services. Progress against our Locality plans will be transparent and fully track-able, and will be shared.

In addition, in the same vein, our Mission Statement equally has more medium to long-terms aims, which are to improve the overall health of our residents, by ‘*Promoting health and well-being and investing in prevention*’. In this way, our 3 Year Plan where appropriate puts a focus on foundations that the Health Board requires to secure better health outcomes in the future for our children, teenage and adult populations. Essential here, is to combine the efforts of everyone in the delivery of health promoting aims, especially our staff where we need to ‘make every contact count’ with our public, our patient and carers in the widespread adoption of these essential health and lifestyle messages. In relation to this our three priority areas for investment are smoking cessation; obesity; and immunisations and vaccinations.

All of the aims within our Mission Statement need to be delivered within our funded resources, and we are a healthcare system that within our current service configuration, has historically struggled to deliver services which achieve financial balance. Our Mission Statement states ‘*We will eliminate waste, duplication and*
ensure value-for-money.’ Against the backdrop of on-going public sector austerity, it is fair to say we are nearing exhaustion of the traditional approach to savings delivery and cost reduction, and this plan shows how we now need to involve our clinicians in the pursuit of ‘right care, at the right time and in the right place’. Solutions created together, using strengthened clinical leadership, can deliver the 2 objectives we all want which are: quality improvement, and elimination of variation in clinical practice and care pathways which wastes our valuable resources. In this way, we can treat more patients and more importantly, through our planning, ensure our valuable resources are in the ‘right place at the right time and with the right workforce’ to deliver improved outcomes for patients.

In order to secure these aims, so that they become reality, an organisation as large and complex as the Health Service is, needs to ensure the ‘right processes’ are in place throughout the whole patient pathway, in order to capture all opportunities for positive change and eliminate poor processes. We need to draw out the best practice we can deliver for patients by running our hospitals as ‘One Hospital over 4 sites’. Our Plan proposes how we can improve the flow of patients through both planned care and emergency / unscheduled care pathways, and that this is undertaken in such a way as to secure best value in the use of our resources. Through a relentless pursuit in improving our understanding of how variation in clinical and managerial practices and processes can impact on patient care, we will get care ‘right first time’, we will get even more patients through our systems.

These two objectives – to improve patient flow and to ensure wasteful variation is eliminated – will help deliver the ‘right services, at the right time and in the right place’, and these philosophies form the foundation blocks on which the Hywel Dda Integrated Medium Term Plan is founded.

There are some difficult challenges facing healthcare in this time of public sector austerity; particularly if we aim to meet the ever increasing, complex needs of a growing frail elderly population whilst at the same time addressing the general health, and, health promotion needs of our entire resident population, in order to prevent the too early onset of the seriously debilitating effects of long-term chronic conditions on the quality of life. Our plan seeks to address these challenges, driving better outcomes for our patients and residents through systematic improvement in patient flow, so that in whichever setting care is being provided, we recognise where we are causing patient harm, wasting our valuable staff capacity and resources, and, importantly where we need to improve.

Hywel Dda has the ability to plan improvements which fully address our population challenges. Working collaboratively with our partners in Local Government and the Third Sector, there is a good record of collaborative working and service co-design. This plan will build on these foundations. Furthermore, as an integrated healthcare organisation, our 3 year plan demonstrates how and where we intend to effectively influence healthcare delivery and processes across the whole system from primary and community care, into secondary acute care and then into tertiary care.

However, like most health care organisations what we are experiencing at present is system imbalance – too many of our patients attend A&E because they can’t access Primary and Community Care, too many of our patients end up in our hospitals because there are no community alternatives, and too many of our residents cannot
be discharged back home for the same reasons. We have patient flow and system shortcomings which result in the wrong care, at the wrong time and in the wrong place. Our plan addresses this by a fundamental shift of our staff and resources into primary and community care, or ‘Care Closer to Home’ whilst operating our hospitals as ‘One Hospital over 4 sites’.

However, these new ways of working have to be clinically-led, and supported fully by good information and information technology. We appreciate that key enablers need to be in place to improve communication channels – through telemedicine, multi-disciplinary team working and electronic sharing of patient clinical information referral, and discharge - in particular between our clinicians in hospital and primary care. On a national level, a Community Information System is being developed, but locally we need to explore the use of the unique NHS number as the key patient identifier which captures patient activity across all of our systems and how we can share this information to improve patient flow, improved access and improved outcomes.

In this way, our plan establishes care processes and practices which are far more anticipatory, and which helps manage the demand of ‘flow’ into emergency medicine and unscheduled care, demand which when exceptionally high, leads to poor performance and use of resources, as our staff capacity become over-stretched.

The concept of using ‘flow’ to improve care has received increasing traction within healthcare, especially in relation to reductions in patient waiting times for emergency and elective care. As the national policy agenda, and our local delivery plans, focus more strongly on integration between primary care, acute services and social care, the need to understand and improve how patients flow through systems is more important than ever. High profile cases of failures in the timeliness and quality of care serve as warnings as to the painful consequences of poor quality systems and processes. There has already been considerable success in tackling issues of flow in NHS organisations and the National Patient Flow Collaborative Wales is seeking to expand on this and understand what is possible when flow concepts are applied systematically across whole organisations and populations. We are rolling this innovative and powerful methodology out across all 4 hospitals, and, in community and primary care in all 3 of our counties and their 7 Localities.

Using this approach to patient ‘flow’, more considered clinical engagement follows, and we all become much more solution-focused. It allows for determined improvements of our own directly provided services by our clinical teams, whilst identifying where we need to collaboratively plan the shape of care delivery from other partner organisations – including our main Health Board partners Abertawe Bro Morgannwg University Health Board to the east and Betsi Cadwaladr and Powys University Health boards on our North and Mid Wales borders, supported by Welsh Health Specialist Services and Wales Ambulance Services. Working and planning collaboratively together, allows us all to secure improvements in patient flow.

Year 1 of our plan focuses on what we need to do to ‘stabilise’ many of our services, whether in primary and community or in hospital care, but just as importantly is much more about how we intend to do this. However, where our services are already stable, we will equally pursue optimisation and transformation in service delivery. As part of this planning round, we have identified both service optimisation and
transformation plans and these will be progressed as much as possible by our Directorates and Service Teams within resource parameters agreed by the Board.

Our main focus in resource terms, however, will be Health Board wide service stabilisation. We intend to significantly involve our clinicians and our partners in the key decisions and actions we need to take to improve patient flow in an open and transparent way. Through a robust programme management approach, we will share collated information and evidence which supports a more collaborative, and co-designed approach to health care planning and delivery in Hywel Dda. And we will share as much of this with all of our staff and our public, and Community Health Council as critical friends, ensuring that we said we would deliver is delivered.

Improvements in our primary and community services will be clinically driven and supported by a strong collaborative planning discipline, which engages our key stakeholders in their design and implementation. We have always achieved this approach in the transformation of Mental Health Services, and more recently in the transfer of Mynydd Mawr Services into our new Frailty Service as well as the Cardigan Integrated Care Development and Cylch Caron in Tregaron. Such a disciplined approach takes time, is far more rewarding, and, our IMTP plans and their programme management to implementation, will signal and evidence our serious intentions to continue in this way.

Stabilisation will involve an injection of much-needed resources – staff capacity and more expert capability - into primary and community care. We will do this by using our share of £70m All-Wales investment monies. This will allow us to enact step change in the provision of Care Closer to Home – plans which our 3 Counties and their 7 Localities have already collaboratively co-designed in readiness for this shift of resource. These Care Closer to Home plans focus on stabilising unscheduled and emergency medicine by supporting our frail elderly in the community.

Our 3 Year planning ambition is to secure the delivery of care in the right place, namely to shift the equivalent of 25000 inpatient bed days into the community.

Throughout Year 1 we will be also be financially scoping our Planned Care capacity – outpatient, theatres and inpatient beds, in readiness for capacity shifts to deliver improved throughput in Year 2.

Year 2 of our plan focuses on what we need to do to optimise our service delivery, and again is also much more about ‘how’ we intend to do this. As ‘One Hospital over 4 sites’, this is more about efficient and effective delivery of planned care, and this allows us to address variation in patient flow and in clinical practice. It does this by ring-fencing elective capacity, so that we can get more patients through dedicated slots for outpatient, day case and inpatient treatments. We can ensure that our clinicians do not need to cancel operations and we will establish each hospital as a centre of excellence whereby improved access to planned care is delivered to all of our residents. There will be transportation and post-operative rehabilitation issues which we will need to address in order to support discharge home, and these will form part of our planning process in Year 1 with implementation in Year 2.

Our ambition is to secure upper quartile performance across our hospital services by the end of Year 2, with robust plans in place for upper 10% performance in Year 3, in
readiness to roll into the next 3 Year Plan. Halfway through the plan we intend that all patients will wait no longer than 36 weeks for all specialties, with improvements in some, but not all specialties, to 26 weeks by 2017/18.

Therefore, Year 3 is about Service Transformation. Building upon the evidence base in Years 1 and 2, the capacity we really need to run our system will be understood, and hopefully in place as we hone the resources we need to sustain ‘Care Closer to Home’ and more efficient and productive planned care delivery.

Evidently, none of this can be delivered without addressing another aim of our Mission Statement which states, ‘We will ensure that we have a flexible, skilled and motivated workforce’. Throughout Years 1 to 3 using this planning approach, we intend to implement some significant transformational changes in our ‘workforce’ as follows:

- Complete re-focus on promoting health and well-being and investing in prevention - embedding this focus in everything we do and making ‘every contact count’, and our plan will evidence that we are taking a concerted and stepped change in delivering these, and it is our intention that our wider workforce, including partners, primary care and independent contractors will all play a part;

- Strengthening Primary Care – we will help our current practices to stabilise the staffing they need to provide core General Medical Services by investing in enhanced services. Where there are retirements, we will help practice with a salaried doctor scheme and we will also offer choices to our primary care delivery – GPs with specialist interests will be encouraged, and GP Leadership in clinical and managerial Locality Services, whether directly managing Community Resource Teams or helping in the commissioning of Patient Care Pathway Improvements will be resourced;

- Community roles will be expanded – we will ensure that specialist nurse expertise is accessible – either directly through redeployment or through telemedicine and tele-care. This will particularly be the case in qualified nursing, but equally for all Advanced Practitioners, like our Allied Health Professionals;

- With our partners, Local Authorities and the Third sector, we will increase our numbers of generic workers – we expect this to impact on a reduced need for traditional independent sector nursing home provision, as we need to commission alternative services from this sector over the next 3 years.

- In Acute Secondary Care, our main focus is growing workforce solutions from a more networked approach; running our hospitals effectively as ‘One Hospital over 4 Sites’ – we will attract more staff if we can develop more innovative clinical rotation and on-call arrangements

- Stabilising Acute Secondary Care staffing through pro-active recruitment drives, to help in the eradication of expensive agency medical staff. This will grow our core workforce and ensure we establish the professional medical staffing we need to improve quality.
• Our ward nurse staffing ratios will be in line with professional standards. As other professional-based understanding on acuity models evolves, for example, in mental health, health visiting and community nursing, we will assess their application to our current and new models of care.

Workforce planning will concentrate on getting ‘the right number of people, with the right skills for the right costs doing the right jobs’. Through turnover, and the clarification of our service direction and the models required to support this, we will look to reduce our costs by £10m in Year 1. From Years 2 onwards, as flow and variation identify where we are using this will increase by £15m and in Year 3, this will increase to £22m, with cumulative workforce savings of £47m. This will result in workforce costs which are upper quartile but achieved through turnover and the elimination of expensive agency costs.

All of our Mission Statement is built around our aim to ‘Focus on quality, safety and improving outcomes’. We believe that our 3 Year Plan will need to show significant improvement in Waiting Times, as this represents more timely access by our residents to Acute Secondary Care treatment. However, progress in this endeavour now needs to be understood in the context that timely, urgent care and ‘treatments’ also need to be delivered by increasing ‘Care Closer to Home’.

Consequently over the 3 years, we will definitely achieve 36 week waits in all specialities, and we want to deliver this partway in year 2, and £12.5m of resource will be set aside to do this. In addition, during our first year we intend to evaluate whether through flow and variation improvements we can take this further in some specialties to 26 weeks.

In terms of ‘Focusing on quality, safety and improving outcomes’ in emergency care, we are already in the process of developing new unscheduled care models in Prince Philip and Withybush hospitals during the course of this plan. We will invest both capital and revenue resources to ensure that this service stabilisation occurs, and pleasingly, this will involve a very innovative workforce model which we believe is the future of innovative rural healthcare delivery in emergency medicine.

Fundamental to the successful delivery of this plan is an entirely new approach to collaboration and co-design of our services. To truly explore the patient quality and resource benefits from improved flow and understanding variation, we will develop a comprehensive programme of clinical informatics.

We need to develop a more balanced healthcare system, and to do this for the maximum benefit of patients, we need our clinicians to share and develop solutions as to how this can be done. Engagement of our clinical body has never been achieved in a sustained and systematic manner and we intend to rectify this. We have some developed some information source which will help us all on the journey to service improvement. What we want to develop is a clinical forum whereby clinical audit and Healthcare Inspectorate findings are triangulated with Together for Health Plans and from this flow and variation is properly evaluated. In terms of clinical involvement in the associated funding flows, we are rolling out Locality Based Resourcing whereby all of the healthcare resource consumed by each of our 7 Localities can be analysed and also Patient Level Costing that allows for peer review of variation of clinical performance by specialty and procedure.
In terms of resourcing the ambitions of our 3 Year Integrated Medium Term Plan, Hywel Dda will receive initial income of £683.588m from 2015/16 Welsh Government Allocation Letter to commission and provide services for our residents. In addition to this we are expecting to receive an additional £23.513m income issued during the year, giving a total planned income of £707.1m for 2015/16. It is important to realise that the underlying strategy of involving clinicians in flow, variation and Locality Based Resourcing is all about beginning the process of framing the costs of our service delivery to match the income / funding provided.

However, this is a 3 year planning journey, and we have to start with addressing the 2014/15 out-turn deficit of £9.297m so in addition to our allocation letter funding of £707.1m, our plan assumes the following:

- Welsh Government funding of £14.445m to address our configuration issues is made recurrent in our baseline funding and the removal of Transitional Funding of £10m does not occur. In addition, provider (and commissioned services) pay award and pensions costs are funded by Welsh Government over

- In order to deliver the shift to Care Closer to Home, funding from our shares of the £10m All-Wales Primary Care Fund and the £70m All-Wales NHS Monies announced December 2014, £1.212m and £8.540m respectively or £9.752m in total, will be available. We intend to use this to invest in Health Promotion and prevention up to £1.5m, stabilise and develop Primary Care General Medical Services by £2.8m, Dental Services up to £0.600m and Community Pharmacy up to £0.750m and growing our Locality Community Resource Teams with the balance of £4.102m;

- Cost pressures arising from inflation and demand of £63.5m will be met fully by internal cost improvement plans;

- Savings delivery therefore is 10.9% or £77m over the next 3 years, targets of 3.2% or £22.5m in year 1, 3.5% or £24.5m in Year 2 and 4.2% or £30m in Year 3. Within this, through turnover, workforce savings of £10m are required in Year 1, and rising to £15m in year 2 and £22m in Year 3, with cumulative savings of £47m. This will result in workforce costs which are upper quartile but achieved through turnover and the elimination of expensive agency costs;

- The balance of our savings delivery are required to fund £6.272m costs from 2014/15 service developments, mainly Women’s & Children’s of £5.6m, and, Smoking Cessation of £0.242m. It also needs to cover £4.8m of unavoidable local cost pressures mainly being driven by ward nursing bed ratio standards of £2.688m and WHSSC commissioning decisions;

- Our £6.3m investment in Waiting Times will increase to £12.446m over the next 3 years in order to deliver 36 week referral to treatment times again this investment is underpinned by the 10.7% savings requirement;

- The plan is still subject to clarification of All-Wales commissioned services (WHSCC, WAST).
On this basis, subject to agreement by Welsh Government on the resourcing assumptions, and the agreement by the Board of a comprehensive set of savings plans underpinning the £77m savings target, and the phasing of their delivery, the Health Board financial plan is breakeven.

In conclusion, therefore, most importantly, Hywel Dda’s Integrated Medium Term Plan is one which sets out our challenges and our opportunities. We recognise that we need to balance the health needs of our population, with improving the quality and safety of our services, whilst at the same time responding to a challenging financial agenda. With effective leadership and engagement, the plan signals that we see this as a time of great opportunity - to stabilise our services, to achieve more service integration with partner organisations to optimise service delivery, and finally, through our staff and clinicians to transform services.
Chapter 1: Introduction & Context

Reader’s Guide to our Integrated Medium Term Plan
We have tried to make this plan as easy to follow as we can by taking the reader through how we intend to build on our Mission Statement and deliver further improvements in the services we directly provide and commission from others over the next 3 years in terms of the following:

In each chapter we will describe our service objectives in terms of which actions we will need to take in order to:

• Stabilise our services where there may be inherent challenges which need addressing
• Optimise services making them considerably better than they are at present but still on a journey for future improvement
• Transform our services so that they are operating at best in class.

Throughout the plan, these actions – our objectives for the future - will be described in pink tables shown as follows:

<table>
<thead>
<tr>
<th>Type of Development</th>
<th>Change intended</th>
<th>Stabilising</th>
<th>Optimising</th>
<th>Transforming</th>
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In addition in order to succinctly sum up our key messages for change within each service area, messages which we will expect the entire organisation to own and run with during the duration of the plan as well as to provide transparency to our key stakeholders and partners, we have also incorporated blue-outlined key message boxes which describe the nub of what we are trying to achieve and why.

Each chapter has been informed by government and clinical policy guidance, very detailed locality or disease / condition guidance, reports, recommendations and advice received from expert advisory groups such as Royal Colleges and / or established joint planning mechanisms with key partners and stakeholders which we continue to build upon.
Our governance structures will ensure that what we say we are going to do can be readily tracked by the reader through the work of the Board and its committees over time.

Finally, we have described where and how we will continue to engage with our staff, partners and stakeholders on the delivery of our Plan, and of course, should any reader wish to lodge their views, comments and suggestions, then a communication channel has been put in place to support this and this can be accessed via our website. We hope this reader guide proves useful in the understanding of the Hywel Dda IMTP.

1.1 Our Mission Statement and the purpose of this plan

In 2009, the Welsh Government set up Local Health Boards to be ‘responsible for planning, designing, developing and securing the delivery of primary, community, in-hospital care services, and where appropriate specialised services for the citizens in their respective areas. This model will ensure the emphasis remains on co-operation and engagement with local partners, particularly in relation to the Health, Social Care and Well-being Strategies and Children and Young People’s Plans’

The National Strategic Direction encapsulated in Together for Health (2011) said: ‘Our collective aim must now be delivery. We believe we can now make significant improvements over the next five years, including:

- Primary and community care services – such as GPs, community nurses and pharmacists – will play a leading role in transforming the way care is provided closer to people's homes;
- A focus on preventing ill health, to address public health challenges such as obesity and smoking rates;
- All district general hospitals will retain an essential role, although some of the services they currently provide will change as new technology and treatments mean less people need to be admitted to hospital;
- A number of centres of excellence – such as for cancer or stroke care – will ensure the very best skills and equipment are on hand round-the-clock for the most complex, life threatening conditions;
- Clinical networks comprising primary and community service staff will support local hospitals in providing Care Closer to Home after patients' discharge from specialist centres, and a greater use of telemedicine to increase 24/7 access to services in rural areas;
- To drive up quality, information on NHS performance in terms of health outcomes and patient satisfaction will be published, including annual reports on each major service area; and
- A compact with the public – an agreement between the NHS and its patients – will be drawn up, to ensure people have the information they need to take responsibility for their own health’.
From that time to date, Hywel Dda has also encapsulated the essence of these responsibilities and collective aims both in our public consultation ‘Your Health, Your Future’, and, in our Mission Statement which reads simply as follows:

<table>
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<tr>
<th>Datganiad o Fwriad Hywel Dda</th>
<th>Hywel Dda’s Mission Statement</th>
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</thead>
<tbody>
<tr>
<td>Byddwn yn darparu gofal yn nes at gartrefi pobl</td>
<td>We will provide care closer to home</td>
</tr>
<tr>
<td>Byddwn yn canolbwyntio ar ansawdd, diogelwch a gwella deiliannau</td>
<td>We will focus on quality, safety and improving outcomes</td>
</tr>
<tr>
<td>Byddwn yn sicrhau bod gennynt weithlu hybbyg, medrus a bwydfrwydd</td>
<td>We will ensure we have a flexible, skilled and motivated workforce</td>
</tr>
<tr>
<td>Byddwn yn hyrwyddo iechyd a llês ac yn buddsoddi mewn afal</td>
<td>We will promote health and wellbeing and invest in prevention</td>
</tr>
<tr>
<td>Byddwn yn ddiolgu gwastraff, arbed dyblygu ac yn sicrhau gwerth am arsiwn</td>
<td>We will eliminate waste, duplication and ensure value for money</td>
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In terms of how Hywel Dda provides services, this means:

- **Creating a Hywel Dda wide service delivery model** which ensures no hospital works in an isolated way, and instead, will form part of a network in the provision of services, functioning as ‘**One Hospital over 4 sites**’.

- **Clinically sustainable, improving quality and outcomes** able to achieve clinical standards, training standards and rosters expected by the Deanery and European Working Time Directives which should help encourage recruitment and retention. This will include the need to ensure volumes are sufficient to support best outcomes, with activity being directed to the part of our Hywel Dda network to best achieve this outcome.

- **Aligned with the Health Board vision of delivering ‘**Care Closer to Home**’ as appropriate, and working as part of the wider health and social care community to improve opportunity and life chances for the population across Hywel Dda effectively using the best health promotion and prevention measures to achieve these opportunities and life chances.**

- **Services which are affordable and value for money** – enabling us to address the escalating premium workforce costs of the current model to the delivery of more sustainable networked services across Hywel Dda using our own workforce, and ensuring the most effective use of other resources like estates and facilities.

The NHS Planning Framework: *Developing an Effective Planning System in NHS Wales* and the 2015/16 update set out the rationale and purpose for Health Board Integrated Medium Term Plans which is, that they are to remain ‘live’ plans, which should evolve and mature over time. This is the case for the Hywel Dda’s plan on which we will actively engage all of our stakeholders, fulfilling our ‘compact with our public’. In the words of the Minister for Health & Social Services, which we have really embedded in our planning philosophy, ‘*Planning, and the planning system, is*
a mean to this end rather than an end in itself. It offers a way to work through the challenges we face, seize opportunities, and work with the public, staff and partners to determine how our vision for healthcare and the health of the population can be met’.

Our plan seeks to link the commitments and values in our mission statement to a wide range of on-going activities, opportunities and challenges. Some of these are dictated by the national context and some are uniquely local to health care delivery across our 3 counties (Carmarthenshire, Ceredigion and Pembrokeshire), and their 7 localities (Amman/Gwendraeth, Llanelli, The 3T’s - Taf, /Teifi /Towy, North Ceredigion, South Ceredigion, North Pembrokeshire and South Pembrokeshire) and, the differing health needs each experiences.

A key purpose of forward planning is not only to provide assurance on the quality and sustainability of clinical services, whilst ensuring that primary care, prevention and prudent healthcare are at the forefront of all that is undertaken, but also to demonstrate this can be delivered within our current funding. Our plan reflects the unique challenges of the configuration of our services and hospitals which arise from our rurality and geography (we cover a quarter of the landmass of Wales). This is reflected in our ‘structural deficit’ which cannot be brought into balance by good house-keeping, productivity and efficiency improvements alone but requires service redesign.

The plan reviews all of our services, and lays out where and how we intend to improve health, wellbeing, life expectancy and greater quality of life for our residents, an ambition which involves partner relationships which have evolved over many decades, and will undoubtedly evolve further in future. Successful partnership working is a key theme of this plan – with other health boards, independent primary care contractors, local authorities, the third sector and the independent sector. Only through this approach will we achieve the vision for greater integration of service delivery, and, develop sustainable services which survive the backdrop of our particular service configuration challenges. The plan is built on our mission to deliver high quality care as close to home as possible, working together with our partners, to fundamentally shift service provision to Primary and Community based models of care.

The plan builds upon our public consultation ‘Your Health: Your Future’ hence the apt sequel entitled ‘Our Health: Our Future’, which reflects the challenges still ahead for many of our clinical services and which will undoubtedly require further engagement over the coming years.

Finally, the plan explains how we are working through service change and redesign in a dynamic way, showing the ambition in our journey and particularly how we are stabilising, optimising, and, finally transforming services, in order to meet the values in our Mission Statement shown conceptually as follows:
This approach is all about providing a conceptual mechanism that promotes planning as an organisational wide discipline that is embedded in every part of the Health Board, linking up our service objectives, and demonstrating the ambition, transformation and innovation required, and aligning these to actions that need to be taken over each year of our 3 Year Plan.

Each objective is supported by a Comprehensive Planning Template (using the SBAR approach) that articulates the service model, the workforce impact, the quality and performance impact, revenue and capital funding impacts, and the links our plans are making with our partners and stakeholders.

This planning approach has been used by service leads in the production of their plans and as part of the engagement with our key stakeholders.

1.2 Our Stewardship and Governance Framework
Underpinning what we do is a strong stewardship and governance framework. The definition of governance within NHS Wales and Hywel Dda is that it is, ‘A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives’
Effective governance provides a focus on:

| Vision – shared understanding of the organisation’s objectives and the difference it intends to create; | Our Mission Statement |
| Strategy – the planned achievement of the vision; | Our Plans |
| Leadership – the means by which strategy will be taken forward | Our new organisational structures |
| Assurance – confirmation that the strategy is being delivered to plan and that risks are being managed, with the organisation working within the law, delivering safe, quality services and has a proper grip on resources of all kinds for which it is accountable; | Our commitment to bring Regulator feedback into our Local Delivery Planning & Performance Management |
| Probity – behaving according to proper standards of conduct, acting with openness and transparency; | With alignment comes probity & stewardship |
| Stewardship – applying proper care to resources |

The planning, development, scrutiny, approval and delivery of the IMTP is a key governance responsibility for the Board and its Committees, so ensuring that patient care remains at the very centre of all that we do, and that plans are evidence-based.

We have endeavoured to considerably strengthen our governance not only because it’s the right thing to do, but because we see the benefit from getting our planning as right as it can be from the offset, or right first time.

In terms of our overarching approach, our key messages are:

- We are building on our consultation ‘Your Health, Your Future’ and adopting the priorities set out within the Together for Health Delivery Plans
- Our plans and developments use a framework of ‘Stabilise, Optimise and Transform’
- Our acute services will be delivered as ‘One hospital over 4 sites’, and will strive to be clinically sustainable, improving both quality and outcomes
- Our Locality services will be delivered through ‘Care Closer to Home’
- Our services should be affordable and value for money, in line with the principles of prudent healthcare
- We will fully engage on all of our service plans with our partners, staff, stakeholders and our public.

1.3 Promoting Health & Well-being and Investing in Prevention

Pressures, such as increasing demand, our ageing population and public sector austerity will exacerbate NHS challenges over the next few years. As the Minister for Health and Social Services has recently announced, it is becoming increasingly important that we practice *Prudent Healthcare* where we move beyond the “do no harm” principle to one that is focused on the minimum appropriate intervention. This approach, along with developing primary care and prevention, also ensures that people are encouraged and supported to maintain as much ownership of their future health and care.
Together for Health 2011 specifically laid out the following commitments,

- More children will have a good start in life
- The health of the most and least deprived will be more similar
- Obesity, smoking, drug and alcohol abuse will level off or fall
- People will be enjoying more years of high quality life.

One of Hywel Dda’s main challenges is that we have a higher proportion of older people than the Wales average, and that already high proportion is predicted to increase significantly in the coming years. Adding to the challenge in Hywel Dda is rurality, and the associated challenges of physical and social isolation, poor access to transport services, housing and low incomes.

Taking into account local population need, our 3 counties and their 7 Localities work on public health issues including immunization and vaccinations; obesity/overweight initiatives; palliative care and end of life care; and frailty.

A focus on keeping people healthy and protecting good health will help us to tackle the significant variation in health outcomes and life expectancy within Hywel Dda. The Plan targets resources where they are most needed in order to reduce inequalities now and in the future.

In a nutshell, our plan will have the core messaging of significantly shifting our resources into developing more primary and community care, promoting prevention strategies and growing clinical, partner and public understanding of prudent healthcare against an informed understanding of our need to target our resources to those with greatest need. Our workforce will also help embed these principles within our counties and localities, as key ambassadors in this approach.

Key messages:

- Our Population Health Programme is based on health need;
- Priorities focus on early years; chronic conditions; lifestyle factors; and inequalities;
- Our approach links to our strengthened Localities and Care Closer to Home;
- Our approach strongly adheres to the principles of prudent healthcare.

1.4 Providing Care Closer to Home

The health need challenges discussed form the key drivers to providing Care Closer to Home, shifting the focus from in-hospital to primary care and community services, and, involving our partners in this endeavour. This is supported by many of our clinicians who appreciate that without service redesign, greater integration and the development of out of hospital services, we will be unable to provide safe and sustainable services in the future.

Again, Together for Health (2011) encapsulates what Care Closer to Home means in terms of better patient experience from the following

- Access to primary care services will be easier
- More services will be provided through local pharmacies
- More services will be available 24 hours a day, 365 days a year
• A greater range of local services will mean less need to travel
• More information on services and on health issues will be available by telephone and online.

Our Plan shows how, by providing Care Closer to Home, we intend to transform our Primary and Community care services and meet ‘Together for Health’ aims. Specifically, our vision is to build on our existing 7 localities ensuring each has a strong and sustainable workforce which is actively enabled to develop holistic and generic skills and which delivers care focused on the greatest needs of their patients. GPs will become our community clinical leaders, and as such will be enabled and supported to focus time towards the most complex and frail patients directing the community resource teams (CRTs).

Our Local Authority partners, the Police, the Welsh Ambulance Services NHS Trust, the Third Sector and other key stakeholders, all recognise that we can only succeed in delivering sustainable services when we work together. This continues to be a long journey, but progress to date includes:
• Our Foundations for Change work, which alongside the transformation of health and social care services, is trying to pro-actively demonstrate how we intend to meet health needs via bespoke models of care suitable for each locality;
• ‘A Co-Designed Future: The Third Sector Role in Health and Social Care in Hywel Dda’ which is seen as an exemplar of both co-production and sustainable development across Wales, joining up strategic planning, delivery and decisions;
• The development of integrated services which meet the needs of local people, tackling health inequalities, through innovative developments like those of Cylch Caron and Cardigan.

We are committed to continue as full and active members of Local Partnership Boards, Regional Collaborative working on the integration of health and social care, and the many partnership meetings that happen at all levels.

**Key messages:**
• With our partners, we will be considerably strengthening Care Closer to Home, with our 3 Counties and their 7 Localities being fully accountable for how services are developed;
• This will be based around ‘services’ and not ‘beds and buildings’ that meet the needs of the frail elderly demographic, using a considerably increased Primary & Community Care workforce;
• We will be rationalising our community estate and working with partners to do this;
• We will be scoping the number of community beds required and where they are provided;
• IM&T must be a key enabler to the delivery of services;
• Service delivery will be shaped by a comprehensive engagement programme already signed up to by the Board
1.5 Focusing on Quality, Safety and Improving Outcomes

Quality of care is at the very heart of healthcare delivery. We are committed to learning from experiences of people using our services and from elsewhere to continually drive the quality of local care upwards, and to aid this process we have put in place our Quality & Assurance Framework.

### HYWEL DDA QUALITY & ASSURANCE FRAMEWORK

<table>
<thead>
<tr>
<th>How do we improve quality</th>
<th>Standards for Health Services in Wales</th>
<th>Annual Quality Statement</th>
<th>Quality Improvement Plan</th>
<th>Francis Report</th>
<th>Welsh Risk Pool</th>
<th>Putting Things Right</th>
<th>Accounts</th>
</tr>
</thead>
</table>

**Reporting to:**

- Audit Committee
- Board Quality and Safety Committee
- Integrated Governance Committee

**Reporting method:**

- Quality Dashboards
- SBAR Reports
- Action Plans & Exception Reports
- Triangulated Reports
- Patient Experience

**Populating:**

Board/Directorate/County Risk Registers

This responds to the Welsh Government policy, ‘**Together for Health**’ challenging all of the Welsh NHS in ensuring that, health will be better for everyone, access and patient experience will be better, and that better service safety and quality will improve health outcomes, and which in turn reduces harm, variation and waste. Specifically, Together for Health outlined that Health Boards would need, through their planning, to demonstrate that:

- **We will guarantee dignity and respect for patients**
- **Systems for assuring high quality care will match the best in the world**
- **People will benefit more from healthcare - health ‘outcomes’ will improve**
- **Every service will have been put on a solid basis for the long term, with access as local as possible**
- **Specialist hospital care in centres of excellence will match the best**
- **The NHS will work with relevant agencies to ensure people’s transport needs to hospitals are addressed**
- **The best possible communication links will give clinical staff fast, safe and secure access anywhere in Wales to the information needed to help patients**
- **The NHS will publish information on the performance of major services in terms of safety, care outcomes and patients’ views.**

In terms of access, Hywel Dda is not currently meeting all of the Ministerial Tier 1 targets in a sustainable way and if we remain constrained by our current working, then in future, we face the prospect of having to out-source activity in order to try to improve these. Major skill shortages, increased difficulties in recruitment to key specialties, and increasing Royal College and Deanery expectations, combined
with relatively low volumes of activity at individual sites, mean that it is simply no longer viable for our acute hospitals (Glangwili, Bronglais, Withybush and Prince Phillip) to be able to deliver all of their current services, and increasingly our hospitals will need to work as a network which we describe as ‘One Hospital over 4 Sites’.

Consequently, our Quality Delivery Plan tries to ensure better alignment of clinical quality, operational performance and financial goals, whilst ensuring patient safety and quality are integral to all decision making, whether patients are receiving care at home, in primary and community settings, or in our hospitals. Using our Together for Health Local Delivery Plans, this plan triangulates these with results from clinical audit and Tier 1 performance, and outlines how we intend to improve patient care and safety across the system – primary, community and secondary care - through the development of a ‘patient first’ culture.

On quality and clinical sustainability terms, ‘Care Closer to Home’ will help to more appropriately manage, and indeed reduce, what has been a very high level of unscheduled care demand, which all 4 main hospitals have experienced throughout our first 5 years. Throughout this time, we have undertaken numerous audits, and have consistently tracked, that 40% of patients in our hospitals could be in more appropriate alternative care setting and most days there are up to 100 medically fit patients in hospital requiring care which could be provided in the community and / or home.

By stabilising emergency acute medical admissions, we can more effectively deliver elective or planned care, significantly improving performance against Ministerial Tier 1 targets. Our objective is to develop Centres of Excellence for inpatient Gynaecology, inpatient Orthopaedics, complex inpatient Surgery and Ophthalmology in order to improve safety and clinical viability, and significantly improve patient waiting times.

As well as planning our own services, we are also working with our neighbouring health boards to drive in improved outcomes. As part of the South Wales Health Collaborative and the Acute Care Alliance between Abertawe Bro Morgannwg University Health Board and Hywel Dda, we need to align services in order to both meet the overall objectives of the South Wales Health Collaborative and to plan improvements into existing patient flows into Swansea for services which we will never provide locally, for example, Radiotherapy Cancer Treatments, but for which we wish to improve patient experience and access.

Finally, a key outcome of the Mid Wales Healthcare Study (November 2014) is the establishment of the Mid-Wales Healthcare Collaborative which is to be set up to consider the health and wellbeing of the population of North Ceredigion, North Powys and South Gwynedd, and includes membership from Hywel Dda, Betsi Cadwaladr University Health Board and Powys Teaching Health Board. At the time of writing, this is embryonic, but we can state our plan for Hywel Dda will make every effort to strategically align our services with the key recommendations of the Study.
**Key messages:**

- We will ensure that our clinical governance, clinical audit and population health group structures are aligned to Together for Health plan delivery;
- All evidence of quality, safety and improved outcomes are used to test service delivery;
- We will operate as ‘One Hospital over 4 Sites’ and each will have a Centre of Excellence;
- Our strengthened Care Closer to Home strategy should help stabilise our hospital unscheduled care and optimise planned care delivery to make significant improvements in access and waiting times;
- We will work collaboratively with other providers of healthcare to deliver a rural health care model that is sustainable and innovative.

### 1.6 Ensuring a Flexible, Skilled and Motivated Workforce

Health Boards directly employ staff and through primary care contractor services we commission the skills of General Practitioners, Dentists and Pharmacists and their supporting clinical, nursing and administrative teams. We also commission staff and skills from the third and independent sectors, and of course, rely on our local authorities for qualified and experienced social services practitioners. Ensuring a flexible, skilled and motivated workforce, therefore, embraces a much larger workforce concept than just the directly employed.

However, in workforce terms, a population the size of Hywel Dda only requires to be serviced by one acute hospital. The reality of providing acute care to a largely rural area means we have a population equivalent to 93,000 people per hospital, with our hospitals covering between 25% and 50% less population than other health boards. This presents us with the challenge of maintaining safe and appropriate staffing and services across 4 main hospital sites within the funding provided; unfortunately, we have an expensive workforce model arising from disproportionately larger medical rosters than is funded, and which is compounded by excessive agency costs because of our inability to recruit.

Hywel Dda directly employs 9,967 staff, our greatest resource accounting for £330m or 43% of our annual expenditure. Of this, £20m comprises ‘variable pay’, which is spending on temporary medical locum and agency staff, nursing agency staff and nurse bank, in order to fill posts where we have gaps due to the recruitment challenges we face. Evidently, sometimes under exceptional circumstances, these costs will continue to be incurred when for example a patient requires more individual care. This is neither economically sustainable nor does it provide the highest quality of care. This plan aims to significantly reduce our reliance on these premium costs, and indeed demonstrates how we intend to counter them through Care Closer to Home and One Hospital over 4 sites, and importantly further exploration of workforce integration opportunities with our key stakeholders and partners.

In terms of directly employed staff, this plan advocates a full strengthening of our
community nursing and Healthcare Support Worker workforce as both constitute sustainable constants in the delivery of safe patient care, allowing us to grow an effective clinical workforce which can operate at scale and which meets our future demographic needs, and does so safely, as nursing is highly regulated.

However, we also wish to align this sustainable workforce with the strengthening of Primary Care, and will use the new 2015/16 Primary Care Fund to invest in General Practice who will hold the ring in terms of directing clinical care to patients in their localities. Supported by strengthened community roles including nursing, and Allied Health Professional specialist and advanced practice roles, under the auspice of Care Closer to Home, we are planning for a range of innovative staff roles and workforce modernisation encompassing:

- Changes to working practices towards 7 day working, and, different concepts of ‘community services work bases’ enabled by information Technology;
- Developing Health and Social Care worker roles across health and social care, and the Third Sector, looking at multi partner teams to deliver care in the community;
- Developing the workforce to provide psychologically minded services, which promote healthy lifestyle choices, and, using our workforce to embed these principles as part of every patient contact

All of which will be managed through engagement and partnership working with staff and processes defined within the Welsh Government’s Organisational Change Policy.

In terms of our preparedness to deliver this ambitious workforce redesign, in 2014/15, the Health Board reorganised our management structures in order to drive in significant improvement in workforce planning, specifically:

- Our Acute Services Management Re-organisation focused on bringing together the management of secondary care services as “One hospital over four sites”, and, strengthening medical and nursing leadership in order to ensure greater integration of services across the whole Health Board. This provides the necessary managerial support to the development of Centres of Excellence, which allows for the re-organising of inpatient capacity and the associated medical rosters in order to optimise efficiency and meet waiting times targets, both with clinical sustainability and within affordable resources;

- County Directors now primarily lead, and put the necessary focus into, the management of Care Closer to Home within the 3 Counties and their 7 localities. As part of this, they commission acute or hospital services for their localities, support population health programmes driving in longer term healthcare improvement via the locality networks and Foundations for Change, as well as ensuring the benefits of partnership working is optimised with our Local Authority partners and the Third Sector;

- Finally, the restructuring of the Mental Health & Learning Disabilities service in January 2014, has created a single designated Directorate helping us with a more cohesive and sustainable approach to these services, which is no longer fragmented by County boundaries.
Key messages:
- We will pro-actively address our recruitment and retention issues, promoting Hywel Dda has a leader in rural healthcare delivery;
- We will promote networking solutions and the use of IT enablers like Tele-health and Tele-care, as well as considerably improved IT infrastructure to allow our clinical teams to work more effectively together, despite our geographical challenges and travelling distances;
- We will modernise certain roles including Advanced Practitioners and GP Specialists;
- Overall we will need to right-size our workforce over the next 3 years, and we will do this through turnover and relentless attention to skilling our workforce so that we have the right skills in the right place adding the greatest value to patient care.

1.7 Eliminating Waste, Duplication and Ensuring Value for Money

Maintaining the quality and safety of our services in the face of growing financial pressure represents a significant challenge, and even more so when the current operating model is as geographically challenging as it is.

This also means that we will be seeking to redistribute resources to support the model of Care Closer to Home and greater proactive scheduled care aiming to reduce the impact of unscheduled care.

Subject to ongoing discussion with Welsh Government, which assumes income on the same basis as 2014/15, these plans would deliver the following financial out-turns
over the next 3 years:

<table>
<thead>
<tr>
<th>Year</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deficit</td>
<td>£16.881m</td>
<td>£10.448m</td>
<td>£0.371m surplus</td>
</tr>
</tbody>
</table>

It is our intention that our 3 counties and their 7 localities will have greater influence and ownership over the shaping of services in order to ensure more local delivery of services - Care Closer to Home. To this end, building on work already started by our Population Health Programme, we intend to set up a Commissioning Sub-Committee which clearly sets out the expectations for how our Health Board will prioritise resources, how we will shift our planning to promote primary care, prevention and prudent healthcare, and how these endeavours will be monitored and evaluated through key quality and performance indicators.

Alongside this, the Locality Networks will track the realisation of patient benefits, working with partners to redesign our workforce, and ensuring staff roles are more closely aligned to locality need. Specifically our locality commissioning actions and plans, and our acute hospital plans, will be defined as:

- **Stabilisation Plans** – part of normal operational delivery, which involves cost neutral ‘improvement’.
- **Optimising Plans** – requires the Organisational Change Process to be followed and / or very specific inter-agency agreement
- **Transforming** – requires service transfer and / or major service change, and as such full Business Justification Cases will need to be followed and approved by Strategy & Planning Committee, & the Board.

For all plans, we have described what service provision looks and feels like at locality level, what we want to do and why, and how we will engage stakeholders in the prioritisation choices we believe need to be made.

**Key messages:**

- **Our overarching principle is to get the operational systems into balance in workload and workforce terms, improving patient flow and eliminating clinical variation;**
- **By strengthening Care Closer to Home, we will stabilise unscheduled care or acute emergency medical admissions – we are modelling in a significant, phased reduction in premium medical variable pay;**
- **This should allow us to effectively ring-fence elective capacity, delivering improved waiting times within core capacity;**
- **Workforce plans which stabilise expensive premium agency medical staffing, optimise our nursing workforce into new and innovative roles, and using turnover, right-sizing the workforce**
- **Our renewed focus on the provision of services and not beds and buildings means that we will be developing community hubs, which have a greater critical mass of services and staffing, which will be cost effective and represent greater value for money.**
Chapter 2: Health Board Profile

Hywel Dda Local Health Board became fully operational in October 2009 following the NHS Reform Programme which introduced integrated health care for Wales. In December 2013, we were awarded University status and we are now known as Hywel Dda University Health Board.

We are responsible for the health and well-being of our population across Carmarthenshire, Ceredigion and Pembrokeshire and we also provide a range of services for the residents of South Gwynedd and Powys. We cover a quarter of the landmass in Wales, but with a relatively small population of 383,900 people.

2.1 Key demographics

The table below provides an overview of a number of key demographics of Hywel Dda and compares them to Wales.

<table>
<thead>
<tr>
<th></th>
<th>Hywel Dda</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area size in km²</td>
<td>5781</td>
<td>20,779</td>
</tr>
<tr>
<td>Total population</td>
<td>383,900</td>
<td>3,082,400</td>
</tr>
<tr>
<td>Life expectancy at birth in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>77.9</td>
<td>77.2</td>
</tr>
<tr>
<td>Females</td>
<td>82.1</td>
<td>81.6</td>
</tr>
<tr>
<td>% population from ethnic minority background</td>
<td>1.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Live births per 1000 women aged 15-44</td>
<td>60.4</td>
<td>61.2</td>
</tr>
<tr>
<td>% population aged 75 or over</td>
<td>10.1</td>
<td>8.8</td>
</tr>
<tr>
<td>% lower super output are in most deprived quintile</td>
<td>8.3</td>
<td>20.0</td>
</tr>
<tr>
<td>% of adults who are overweight or obese</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>% of adults who smoke</td>
<td>21.3</td>
<td>22.8</td>
</tr>
<tr>
<td>% of adults who drink above guidelines</td>
<td>39</td>
<td>42.9</td>
</tr>
<tr>
<td>Emergency hospital admissions (European age standardised rate per 1,000 population aged under 75 years)</td>
<td>61.3</td>
<td>65.9</td>
</tr>
</tbody>
</table>

The age structure of the population is different to Wales with lower proportions of persons aged 0-4 and 20-44, and higher proportions of persons aged 50 and over.
Population Projections

As demonstrated by the graph below, population projections indicate that if current trends continue, the number of persons aged 65 and over resident in the area will increase by 67 per cent between 2008 and 2033. The proportion aged 75 and over is projected to increase from around 10 per cent at local authority level to around 16 to 18 per cent over this period, the sharpest increases being in Ceredigion and Pembrokeshire. The percentage aged 85 and over is projected to more than double from around three per cent to six to seven per cent by 2033.
2.2 Local Health Needs Assessment and summary of agreed health priorities

Overall health in Hywel Dda, as measured by morbidity and mortality rates, is relatively good with life expectancy for both males and females being similar to the national average. However, there are some important issues around societal ageing, health inequalities and lifestyle choices that need to be addressed if a sustainable health and social care service is to be achieved and maintained over the long term.

Lifestyle indicators in the Health Board area are generally better than, or similar to, the Wales average. However,
- Nearly 6 out of 10 adults are either overweight or obese;
- Around 1 in 4 adults smoke - leading to over 700 deaths each year;
- Over 6,300 hospital admissions annually are caused by alcohol;
- Around 200 patients are admitted to hospital because of drug misuse;
- Only around 2 in 5 people eat the recommended amount of fruit and vegetables;
- Only a third of the population meets physical activity guidelines.

Challenges that we face include:

**Age profile of our communities is an ageing one** – The increase in the number of older people is likely to be associated with a rise in chronic conditions whose prevalence is strongly age-related such as circulatory and respiratory diseases and cancers. In Carmarthenshire; almost 3 in 10 adults report a limiting long term illness, which is higher than both the Welsh average and the other counties in the Health Board. 1 in 16 people over the age of 65 and 1 in 6 people over the age of 80 will be affected by dementia. Census data indicates that the number of elderly single person households is increasing meaning that there is not always family support readily available to help manage minor episodes of illness or enable an early return home from hospital. Also emergency admissions for 65+ years account for over half of total bed days used within Hywel Dda inpatient care across all specialties, and Average Length of Stay for Unscheduled Care hospital admission is 7.2 days, compared to England of 6 days, with significant variability across Hywel Dda.

**Health inequality** – there is a measurable gap between the life expectancy of people living in different parts of the Health Board, especially in our localities with deprivation, namely parts of Cardigan, Pembroke Dock and Llanelli. The map below shows the distribution of inequalities across the wards in the Health Board at the lower super output area (LSOA) level.
Nineteen areas within our Health Board are amongst the most deprived fifth in Wales; alternately, with 17 areas are in the least deprived fifth.

The overall county position is detailed in the Welsh Government Local Area Summary statistics (Annex 1.1-1.3). Some of the County highlights are:

Carmarthenshire - The rate of older people supported in Carmarthenshire has consistently been below the Welsh average since 2005/06 and was at its lowest in 2009-10. In addition Carmarthenshire percentage of looked after children with three or more placements in a year and the levels of adult obesity are above the Welsh average for 2013/14.

Ceredigion - The rate of older people supported in the community was one of the highest in Wales up to 2009/12. There was a sharp drop in 2010-11 and Ceredigion’s rate had remained below the Welsh average since then.

Pembrokeshire - The MMR coverage rate in Pembrokeshire is below the Welsh average while the percentage of looked after children with three or more placements in a year was the highest in Wales in 2013/14. The rate of older people supported in the community steadily increased since 2005/06 and 2010/11 before falling with the rate remaining slightly below the Welsh average.

Rural location – the majority of our population live in a rural environment and this presents challenges in terms of providing transport to enable people to access the right services at the right time. Variability and fragility of the transport infrastructure & rurality creates issues for all partners to achieve their statutory responsibilities.
2.3 How our services are currently delivered

Our acute and community services are currently delivered through:

- Four Acute Hospitals;
  - Bronglais Hospital in Aberystwyth,
  - Glangwili Hospital in Carmarthen,
  - Prince Philip Hospital in Llanelli and
  - Withybush Hospital in Haverfordwest
- Seven Community Hospitals
- Eleven Health Centres
- Numerous locations and settings across our three counties from which Mental Health, Learning Disabilities, and related services are provided; and
- Primary Care Services which are delivered by:
  - 54 GP Practices (main sites) which make up our 7 GP clusters (please refer to chapter 3 for further detail);
  - 67 Dental Practices (49 dental contracts);
  - 99 Community Pharmacies; and
  - 52 Optometry Premises.

**Glangwili General Hospital, Carmarthen:** Has approximately 320 beds to provide inpatient services for patients across the region. The surgical services have access to 7 general operating theatres as well as the specifically designated Obstetric Theatre and Day Surgical Unit. A new Emergency Unit was opened in March 2007 and in late 2011 a new Critical Care Unit and a Clinical Decisions Unit, with a new midwifery led unit in August 2014. The hospital provides a range of general specialties and has visiting specialist Consultants in Paediatrics (Cardiology, Neurology, Nephrology, Endocrinology, Oncology, Haematology, Respiratory Paediatrics and Metabolic disease), Genito-Urinary Medicine, Renal Medicine, Rheumatology, Clinical Oncology, Plastic Surgery, Neurosurgery, Mental Illness and Oral Surgery.

**Withybush General Hospital, Haverfordwest:** Has approximately 260 beds, and provides a broad range of general services and has visiting specialities from ENT surgery, Urology and Ophthalmology with the main centre for the three services based at Glangwili General. Other visiting specialities include Maxillofacial Surgery, Oncology, Plastic Surgery, Genitourinary Medicine and Medical Genetics. The service is supported by 6 operating theatres including new day surgery facilities, a recent endoscopy suite and critical care support with ITU and HDU facilities. A new Emergency and Urgent Care Centre and ACDU (Adult Clinical Decision Unit) opened in 2010.

**Prince Philip Hospital, Llanelli:** Has approximately 225 acute and elective inpatient beds which supports acute and elective General Medicine, elective General Surgery, Orthopaedics, and Urology. The hospital provides surgical day case theatres, endoscopic suite, Radiology and Laboratory support and palliative care facilities, including a hospice facility. This hospital also houses the purpose built **Prince Philip Breast Centre of Excellence**

**Bronglais General Hospital, Aberystwyth:** Bronglais has approximately 153 beds to serve its unique catchment area as the only DGH in the middle of Wales providing
services to around 120,000 people from Ceredigion, Powys and South Gwynedd. The hospital provides the expected range of general medical, surgical and trauma services, consultant led obstetrics, gynaecology and paediatrics, and has a new Emergency Unit and Clinical Decision Unit which was opened in early 2013. The hospital has a range of visiting specialties.

**Mental Health & Learning Disabilities Directorate:** The Health Board provides Mental Health and Learning Disabilities services to people across West Wales. Mental health services include Community Mental Health Team and inpatient units, Assertive Outreach Teams, Crisis Resolution and Home Treatment Teams and Liaison Services. Additionally there are Health Board wide Rehabilitation and Recovery, Substance Misuse, Learning Disability and some Forensic Services. Within Wales the Health Board has a high profile in developing psychological approaches with specialist Personality Disorder Service, Early Onset Psychosis and developing Eating Disorder Community Service. In addition it has a dedicated psychotherapy department, with a consultant psychiatrist and other therapists working in the department. The Health Board also provides a range of services for children across the three counties served, integrating community and acute services and enabling joint working with the specialist Child and Adolescent Mental Health Services. Strong links exist with tertiary centres throughout Wales.

**Specialised and tertiary acute hospital services delivered for our residents by other Health Boards:** Our Health Board is primarily served by Abertawe Bro Morgannwg University Health Board which provides services such as plastic surgery, primary angiography, emergency cardiac services and a range of diagnostic services. Some cancer surgery, paediatric and neonatal intensive care services are delivered from Swansea and Cardiff but also sometimes from hospitals in England. Neurosurgery is provided for our residents in Cardiff.

### 2.4 Education

**Teaching**

The ethos of the Health Board is to provide quality educational opportunities, not only to undergraduate medical students, but also to other undergraduate healthcare professions and to the postgraduate trainees and professional staff in employment within the Health Board. The creation and development of this ethos not only enables the expansion of clinical healthcare professionals within the NHS in Wales, but also meets the clinical governance agenda in relation to continuous professional development and quality and clinical excellence.

It is the intention of the Health Board to develop Medical Education. The increase in multidisciplinary education both at undergraduate and postgraduate levels has helped to facilitate this ideal and consultant staff are required to take a lead in developing multidisciplinary educational opportunities wherever possible.

**Undergraduate Education**

The Health Board provides high quality clinical placements for students. Clinical Placements are sited throughout the four major hospital sites in Hywel Dda.
All doctors within Hywel Dda are required to take a full and active role in undergraduate education. The extent of that commitment will vary in each specialty dependent on need. The Health Board has developed a particularly close association with Cardiff University and Swansea University and honorary lecturer titles are given to consultants within the Health Board who provide a lead in undergraduate medical education.

Postgraduate Education

The Health Board is also very active in facilitating the development of junior medical staff to ensure that the medical service of the future is highly trained and effective. There are four centres for postgraduate education within the Health Board. The central Deanery in Wales is based in Cardiff and is headed by Professor Derek Gallen, Postgraduate Dean. The Health Board enjoys a close relationship with the Postgraduate Deanery and annual commissioning reviews ensure that the postgraduate education taking place across the Health Board is relevant and effective. There are two Faculty Leads in post within the Health Board, one leading on quality and one leading on training.

All consultants take a full and active role in postgraduate education both by the ongoing teaching commitment to their own junior staff and also by participating fully in multidisciplinary educational events across the Health Board.

Nursing & Midwifery Education

Nurses and midwives are predominantly trained through Swansea University under the auspice of commissioning by WEDS. Student midwives and student nurses undertake clinical placements in Hywel Dda and formal responsibility for meeting their mentoring and training needs is facilitated by our qualified nursing and midwifery staff. In addition to undergraduate nursing and midwifery training, all registrant practitioners are required to undertake Continuing Professional Development (CPD) in order to meet professional standards of registration. Currently, this is proving exceptionally challenging against a backdrop of service demands where we cannot release our staff from patient care to attend traditional programmes of education. Therefore, this will require new ways of delivering training to meet these CPD needs in the future.

Enhanced roles for nurses for example advanced practice require Master Level Programme commissioning through Universities, and again, their in-service training to develop key competencies also additionally requires significant support from our wider Health Board professional staff.

Educational Facilities

There are four Education Centres across the Health Board, based at Glangwili General Hospital, Withybush General Hospital, Bronglas General Hospital and Prince Philip Hospital. The Centres provide comprehensive facilities incorporating a number of seminar and lecture rooms which are fully equipped with LCD projection facilities as well as a range of specialist audiovisual equipment to facilitate multidisciplinary team meetings across Wales.
The Library service is of an extremely high standard with professional librarians based at each of the four main sites. The libraries offer access to an extensive range of investigative resources, both in hard copy and electronic formats, including Cochrane Database, Medline, Map of Medicine and Dialogue. All NHS libraries in Wales also work in partnership with Cardiff & Swansea University which allows access to a much wider resource.

The Health Board houses Clinical Skills suites which is available to all medical staff and students for training purposes.

All consultants are expected to take part in Education Centre activities as required.

2.5 Our Journey So Far

We are a dynamic organisation, which has been continually improving our services, consequently, since our inception and further as part of our Public Consultation ‘Your Health Your Future’, our journey so far is shown below and which informs the basis of our next efforts in this 3 year planning cycle:

<table>
<thead>
<tr>
<th>Your Health, Your Future</th>
<th>Personalised, promoting health, equitable, realistic, sustainable, affordable, free at the point of need and promoting independence, interdependence and self care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Ensure the NHS Delivers world class health and the highest quality healthcare for the people of Hywel Dda by operating as a world class health system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aim</th>
<th>Objectives</th>
<th>Since 2010, what have we done to achieve this (Published within our Annual Reports since 2010/11)</th>
</tr>
</thead>
</table>
| 1. Improve the health and wellbeing for all of the Hywel Dda population | 1. Ensure people live longer | • Mind Your Heart Health Promotion Programme  
• Health Screening Programmes: Breast, Bowel, Cervical & Newborn hearing  
• Creation of the Clinical Research Unit to support Research & Development  
• Increased provision of childhood, Influenza & Pneumococcal immunisations  
• Foundations 4 Change Programme  
• Healthy Ageing Action Plan  
• Development of smoking cessation services |
| 2. Reduce the impact of illness on people’s quality of life | | • Rollout of the Educational Programme for Patients Cymru  
• Armed Forces Covenants  
• Tackling overweight and obesity by level 1 – community based prevention and early intervention, Level 2 – community and primary care weight management services, Level 3 – specialist MDT weight management services & Level 4 – specialist medical and surgical services |
| 3. Reduce lifestyle related illness | | • Introduction of the Designed to Smile programme  
• Healthy Pre-school scheme/Healthy Schools Scheme  
• Integrated Family Support Service  
• Hywel’s House and Healthy Wednesday |
| 4. Delivering quality health and health | General Practice/Community Initiatives | • Upgrading and relocating General Practice facilities in Meddygfa Tywi, Adfer, Winch Lane, Saundersfoot, Fishguard, Ystwyth & |
| Optimise the delivery of quality health and social care in the most appropriate setting | Manchester Square  
• Development of the Cardigan Integrated Care Centre  
**Bronglais Initiatives**  
• Front of House Development  
• Digital Mammography machines  
• Dexa Scanner upgrade  
• Replacement of obstetric ultrasound  
• Replacement of phaeo machine  
• Replacement of arthroscopic shaver  
• Replacement of anaesthetic machines  
**Glangwili Initiatives**  
• New mortuary facilities  
• Critical Care Unit  
• Acute Clinical Decisions Unit  
• Review of Women and Children’s Services – Special Care Baby Unit and Consultant Led Unit  
• Replacement of ophthalmology theatre  
• Replacement of obstetric and antenatal ultrasound  
• Replacement of phototherapy machines  
• Replacement of neonatal monitors  
**Prince Philip Initiatives**  
• Breast Care Centre  
• Rheumatology Day Unit  
• Sterilisation and decontamination unit  
• Integrated Urgent Care Centre  
• Mynydd Mawr Rehabilitation Unit  
• Replacement of echocardiograph  
• Replacement of phototherapy machines  
• New ENT equipment  
**Withybush Initiatives**  
• Emergency and Urgent Care Centre and Theatres  
• Renal Dialysis Unit  
• Refurbishment of Midwife Led Unit Digital Mammography machines  
• Multi Modal Scanner  
• Replacement of ICU patient monitoring system  
• Replacement of day surgery endoscopes  
• Replacement of obstetric and antenatal ultrasound equipment  
• Replacement of theatre equipment  
• New ophthalmology laser  
**Health Board Initiatives**  
• New MRI and CT Scanners at all 4 General Hospitals  
• Implementation of E-rostering  
• Replacement of EEG Machines  
• Infection control management systems  
• Implementation of the Choose Well Campaign  
• Upgrading Pharmacy robots  
• Provision of ophthalmology cameras  
• Provision of telemedicine carts  
• Upgrading patient/ward accommodation and facilities  
• Blood bank automated IT system  
**Mental Health Initiatives**  
• Development of a Psychiatric Intensive Care Unit
<p>| | |</p>
<table>
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</table>
| 5. Identify health and social care needs better and respond creatively | • Development of a Low Secure Unit  
• Development of a therapeutic day service  
• Upgrading patient/ward accommodation and facilities  
• Review of our Mental Health and Learning Disability Services e.g. Llys Y Bryn and Maes Llewellyn  
• Development of residential convalescence beds  
• Volunteering for Health Scheme  
• Aberaeron Health and Social Care Project  
• Initiation of the Population Health Programme  
• Street Triage Project  
• 1000 Lives Improvement Service |
| 6. Balance collaboration and new ways of working in the delivery of health and social care | • Co-location of premises/facilities for our citizens such as the  
  o Crymych Primary Care Resource Centre  
  o Milford Haven Primary Care Resource Centre  
  o Aberaeron Primary Care Resource Centre  
  o Bro Preseli Community Resource Centre  
• Investors in Carers Scheme  
• Therapeutic Day Service for Mental Health  
• ‘A Co-designed Future’ Framework |
| 7. Improve the efficiency of the health service and value for money | • The increased use of telehealth and telemedicine  
• Non Emergency Transport  
• Community Virtual Wards  
• Energy Centre Development at Bronglais  
• Achieving International Environmental Management Standard ISO14001  
• CMATs |
| 8. Secure the necessary skills and lead by example | • Development of Community Resource Teams  
• Development of ‘Free to Lead; Free to Care’  
• Development of Welsh Language Training  
• Prevention and Management of Violence and Aggression  
• Leadership Academy  
  o Consultant Leadership Programme  
  o Medical Leaders Development Programme  
  o Empowering Healthcare Leaders  
  o Improving Quality Together  
  o ILM Coaching Certificates  
  o Managers’ passport |
| 9. Work closely with partners to ensure delivery of health, social and community services | • Development of resource centres e.g. Upper Gwendraeth  
• Encompassing community services e.g. Whitland Surgery; Tregaron/Cylch Caron  
• Community Pharmacies including smoking cessation services  
• Community Opticians and Optometry including Glaucoma Referral Refinement Scheme and Cycloplegic Refraction Scheme  
• Substance Misuse Services  
• Feeling Fine – Healthier Homes Initiative  
• Cardigan Integrated Care Centre |
| 10. Manage our reputation and communicate what we are doing | • Siarad Iechyd/Talking Health; ‘Your Health Your Future: Consulting our Communities’  
• Development of our bi-lingual service  
• Development of our social media presence through Facebook and Twitter  
• Stonewall - commitment to equality  
• Hywel’s Voice  
• Putting things Right  
• Citizen’s Panels |
Chapter 3: Promoting Health and Well-Being And Investing In Prevention

3.1 Our Public Health planning journey so far

Overall health in Hywel Dda, as measured by morbidity and mortality rates, is relatively good with life expectancy for both males and females being similar to the national average. However, there are some important issues around societal ageing, health inequalities and lifestyle choices that need to be addressed if a sustainable health and social care service is to be achieved and maintained over the long term.

Since our inception, Hywel Dda has acknowledged the need to move towards a wellness service that helps people stay healthy and prevents sickness, rather than a pure focus on a sickness service, treating people when they become ill.

The Hywel Dda Public Health Team produced our first Public Health Strategic Framework in 2011, which created an opportunity to review service delivery and outline what had to be achieved across a range of health issues at every stage of life. The approach adopted, in the business plan, has allowed the Health Board to start creating a modern, more efficient healthcare service to meet the challenges of the future which places greater emphasis on Care Closer to Home and prevention to reduce inequalities and improved quality of life. As a result, this approach remains robust, and so the business plan was simply refreshed in 2012/13 in the light of the requirement for Local Service Boards to prepare Single Integrated Plans (SIPs) for the health, well-being and prosperity of their populations.

The 2013/14 Strategic Framework represented a transition document as the Public Health work plan moved from the traditional life course approach towards a population health group approach and in support of the wider Hywel Dda Population Health Group work.

In 2014/15, as per ‘Welsh Government Planning Framework’, Hywel Dda’s Public Health Plan is now aligned to the following overall requirement, which is that, ‘Health Boards have responsibility for population health. Working collaboratively with public and third sector partners is essential to fully addressing the health needs of localities’. As such, our Public Health Plan is population based, works in partnership with those who contribute to the health of the population and supports and fosters a collective responsibility for health.

All of the aforementioned is very much responding to the Welsh Government policy directives for public health. However, very early on, we recognised that in order for Hywel Dda to tackle the social and economic challenges it is facing, new ways of connecting and delivering services had to be developed. Our public health vision for Hywel Dda has been to create “a sustainable healthcare system ... which has a greater focus on Care Closer to Home, prevention and well-being to improved quality of life with an increasing focus on creating a wellness service rather than a sickness service.”

In an effort to achieve this vision, in 2010, we made ‘10 pledges’ to help people live healthier lives. The 10 Pledges are divided into 3 delivery periods: 3, 5 and 10 years and focus on those key lifestyle issues that have the biggest impact on morbidity and mortality, specifically; reducing obesity, smoking prevalence and alcohol
consumption. Through making progress in these areas improvement can also be achieved in the 5 and 10 year pledges through reducing the incidence of cancer, heart disease, stroke and increasing life expectancy.

For those with chronic conditions and life limiting illness, the Health Board has pledged to improve service delivery by increasing the number of people treated in community settings who would have previously been treated in hospital and reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions (ACSCs). For these service pledges to be achieved, in the short to medium term, better management of ACSCs in primary care is needed to reduce emergency hospital admissions. In the longer term, there is a need to tackle the underlying causes of ACSCs, for example, reducing prevalence of chronic diseases, such as diabetes, through public health and preventive measures.

Through the 10 Pledges, we are committed to working with the public to raise expectations in relation to individual health and wellbeing, and highlight the importance of the simple things that can make a difference. To support this vision Hywel Dda has not only committed to the 10 Pledges but has also started the process of developing clinical and commissioning structures to support delivery. This includes the development of Population Health Groups (PHG’s) and our Foundations 4 Change Programme (F4C). The remit of PHG’s is to systematically improve population health outcomes and the patient experience; and to ensure sustainable services. Key elements of F4C will tackle cardiovascular risk factors including smoking, physical activity and obesity.

Progress against each of the 10 Pledges has been mixed and reflects the effort still required to drive improvement in population health. (See Hywel Dda’s Director of Public Health Report 2013/14 for detail on progress). To this end, our 3 County Teams are developing their 7 Locality Plans, with the aim of responding to PHGs and F4C in order to ensure on-going improvement against the 10 Pledges and in the 9 priority areas of our Public Health Plan which is discussed next.

During 2014/15 we focused on 9 priority areas of public health plan covering our children, our working aged adults and our older adults. These 9 areas were as follows:

- **High level Priorities** – Smoking/Tobacco Control and Immunizations and Vaccinations (Both with Ministerial Tier 1 objectives)
- **Medium Level Priorities** – Obesity, Alcohol and Mental Health
- **Low Level Priorities** - Frailty, Sexual Health, Substance Misuse and Physical Activity, Integrated Lifestyle/Wellbeing Training, Dementia

Detailed individual work-plans supported the 9 priority areas, and a monitoring framework has been established to ensure progress throughout 2014/15 and the tracking of key deliverables.
3.2 Our Public Health Planning Focus for the next 3 years

Our Plan sets the necessary foundations for a more ‘preventative’ focus in future years, and aims to reduce the risk associated with lifestyle choices, the risks associated from the demand for health care services through improving access, and improving the management of chronic conditions in primary care, and specifically to support the Health Board’s work on tackling inequalities.

Our Public Health Team works across three areas or domains - Health Improvement, Health Protection – supported by Health Intelligence and Improving Services – working in partnership, to influence across the whole system, and from cradle to grave. The Team also works to promote action in the factors that determine health and well-being – the determinants of health. The public health team supports work across the HB, and in addition lead a number of key areas of health improvement. The first Directors of Public Health Annual report (2012-13) report by the current Director of Public Health in Hywel Dda highlighted the work of Professor Marmot on inequalities. As a result the Proportionate Universalism approach underpins the team work-plan (i.e. action that is universal, but proportionate to the level of need).

For the 2015/16 plan, we have also worked closely with Public Health Wales (PHW) planning colleagues, to ensure that the Health Board plan fully benefits from the central support delivered by PHW. As a Public Health System in Wales we have agreed three core areas which are joint/shared priority areas for the HB and for PHW. On the 17th September 2014, three areas were agreed and these have been further developed during October, November and December 2015. The three areas are listed below and also the specific descriptors:

1. Integrated lifestyle/wellbeing – descriptor: developing and supporting the public health impact of Primary Care.
   a. Leadership
   b. Making every contact count
2. Healthy early years – descriptor: improving health in the early years by working across sectors.
   a. Smoking in pregnancy (reducing exposure to tobacco smoking in pregnancy and early years)
   b. Childhood and maternal obesity
   c. Early years settings framework (healthy pre-school scheme) – population level
   d. Improving data collection and surveillance
   e. Large scale change across sectors
3. Amenable to health interventions – descriptor: supporting NHS Wales to improve health outcomes.
   a. Prevention as a treatment
   b. Patient safety
   c. Planned care
   d. Population health
   e. Unscheduled care
   f. Improvement capability
   g. Systemise getting evidence into practice
Also at this event, the Public Health system agreed 4 shared principles. These are that in working on our public health priorities, we must:

- Be outcome focused
- Reduce inequalities
- Be informed by (or add/contribute in a planned way) best evidence
- Follow all of the principles of prudent healthcare.

These are already features of the Public Health work across the Health Board however we will continue to refine and develop these principles in our work.

For this next iteration of the three year plan, we continue to refine our priority areas: Based on need, and priority activity across the Health Board these are:

**High Level Public Health priorities:**
Tobacco Control (Smoking Cessation Tier 1 area)  
Promoting Immunisations and vaccination (Tier 1 area)  
Overweight and Obesity

**Medium Level Public Health Priorities**
Alcohol and Substance Misuse  
Mental Health and Wellbeing  
Dementia prevention

This is shown diagrammatically as:

Further information on these 6 areas is outlined as follows:
1. Tobacco Control and the Tier 1 Smoking Cessation Target

Smoking places a significant burden of illness on the health of the Hywel Dda population, the effects of which place an unprecedented demand on Hywel Dda’s Health and Social Care services across community, primary care and secondary care; and on the services provided by its partner organisations across statutory and voluntary sectors. The full impact of tobacco use on the health of individuals, communities and the population, and its impact on health services is wide-reaching. While overall death rates from smoking are falling, it still continues to be the largest single preventable cause of ill-health and premature death.

Reducing smoking prevalence is a key action in the Tobacco Control Action Plan for Wales (Welsh Government, 2012) which sets out the aim to decrease adult smoking prevalence rates in Wales to 16% by 2020. Welsh Government indicates that reaching the prevalence target by 2020 will require a significant change in efforts to motivate and assist smokers to quit. Despite smoking rates showing a downward trend across the counties of Hywel Dda over the last decade, the smoking prevalence rate remains high.

Twenty one percent of the adult population of Hywel Dda report smoking (23% of men and 21% of women) (Welsh Government, 2013a). That is approximately 66,100 people who are smokers. Pembrokeshire exhibits a higher smoking prevalence rate of 23% compared with rates of 20% in Ceredigion and Carmarthenshire (Welsh Government, 2013a).

Our 3 year objectives are to:
To reduce smoking prevalence to 20% by 2016 and to 16% by 2020.

Our 3 year objectives are to:
- Support 5% of smokers to make a quit attempt through our smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks.
- Implement environmental measures to make non-smoking the norm across our Health Board sites and across the population
- Prevent young people taking up tobacco use in the first place (smoking prevention)

Our 3 year implementation plan will include:
- An ongoing review of the universal smoking cessation provision provided by Stop Smoking Wales to ensure it meets the needs of the Hywel Dda Population.
- Implementation of the Community Pharmacy Level 3 Smoking Cessation Service in 25 pharmacies in 2014/15 with additional recruitment of 10 pharmacies per year in 2015/16 and 2016/17.
- Extending the existing Carmarthenshire based in-hospital smoking cessation service to Pembrokeshire and Ceredigion. This will ensure that the following is achieved:
  - Equitable provision of cessation services to protect the health of, and promote healthy behaviour, among people who use or work in the service.
  - Support the enforcement of environmental measures to promote smoke free sites.
    - Provide specialist cessation support to all pregnant women who smoke – and all those who are planning a pregnancy.
    - Provide specialist cessation support to all pre-operative patients to ensure optimum outcomes are achieved.
- Work in partnership with the third and community sector to support the development and long-term sustainability of bespoke cessation services. These services will ensure the needs of hard to reach groups such as those with mental health problems, young people and those living in some of our more deprived communities are met. Support local implementation of all policies to reduce exposure to environmental tobacco smoke, including smoke free sites policy as well as smoking in cars.
- Work with partners, through a regional Tobacco Control Forum, to ensure a consistent approach to prevention is adopted.
2. Immunisations and Vaccinations and the Tier 1 Target

**Immunisations and Vaccinations and the Tier 1 Target**

Immunisation saves lives and is one of the safest and most effective ways of protecting people’s health. The health board is committed to promoting and providing the comprehensive immunisation and vaccination programme to ensure the population is protected.

**Our three year objectives are to:**

- Develop a new service model for the delivery of immunisation in schools
- Support and promote immunisation and vaccination through primary care and community settings
- Ensure robust and accurate collection and reporting of uptake rates

3. Overweight and Obesity

**Overweight and Obesity**

Obesity is regarded as the most challenging public health priority of the 21st century. Its increasing prevalence makes it one of the main risks for shortened life expectancy and greatly increases the risk of type 2 diabetes, cardiovascular disease and some cancers. At a cost of £73 to the Welsh NHS (estimated at £8.4m to Hywel Dda) obesity places a significant burden on healthcare resources.

As a Health Board we aim to increase the proportion of adults and children at a healthy body weight and reduce the physical and mental health risks resulting from overweight and obesity.

**Our three year objectives are to:**

- Reduce adult obesity by:
  - developing a business case for the implementation of a Level 3 weight management service that meets the new all Wales service specification and common access policy.
  - developing primary and community weight management provision
- Reduce childhood obesity by developing and implementing a comprehensive childhood obesity pathway
- Increase levels of physical activity and reduce sedentary behaviour by adopting a collaborative approach to Large Scale Change
4. Alcohol and Substance Misuse

**Alcohol and Substance Misuse**

Alcohol and Substance misuse has a significant impact upon the quality of life of individuals, families and communities across the Hywel Dda area. The return on investment for the NHS is significant. The King’s Fund and the Local Government Association suggested (2014) that every £1 spent on drugs treatment saves society £2.50 in reduced NHS and social care costs and reduced crime.

**Alcohol**

Hospital admission data for the year 2012/13 show that over 5,000 bed days in Hywel Dda hospitals were taken up by patients with alcohol related conditions costing the Health Board over £5.2million per year in inpatient treatment alone. Referrals to specialist alcohol services in Hywel Dda in 2012 /13 were 2,007 which show a 15% increase in the last two years.

**Drugs**

Whilst drug misuse referrals to specialist services have fallen by nearly 25% over the last four years, concerns remain in respect of the increased incidence of Blood Borne Virus infections (in particular Hepatitis C) in the Hywel Dda area and the impact of new psychoactive drugs on the pattern and presentation of problematic drug users to health services.

**Our 3 Year objectives are to:**

- Encourage people who drink to do so sensibly in line with guidance, so as to avoid alcohol-related problems
- Protect individuals and communities from anti-social and criminal behaviour related to alcohol misuse through work in the night time economy and domestic abuse arenas
- Provide information and education to the population we serve in order to highlight the risks and harms from alcohol misuse
- Reduce the harm to individuals and the population from Blood Borne Virus infections
5. Mental Health and Wellbeing

Mental health and wellbeing
The burden of disease from mental ill health is an increasing factor in presentations to health services in the Hywel Dda area and has a significant part to play in a number of physical health problems that require treatment. The Hywel Dda Local Mental Health Partnership Board has been established to oversee the delivery and implementation of Together for Mental Health, Single Integrated Plans (SIPs) and Communities First plans.

Our 3 year objectives are to:
- Improve and support good mental health and wellbeing, focusing on sustainable recovery and preventing mental health problems and illness through:
  - Promoting mental wellbeing
  - A new partnership with the public
  - The provision of age appropriate information to ensure that people of all ages are better informed about mental wellbeing
  - A well designed, fully integrated network of care
  - Promoting one system for mental health

For the next three years it is therefore our aim that the services across Hywel Dda work actively with communities to minimise, as far as reasonably possible, the development of mental health problems and work, together with individuals, communities and partner organisations, to achieve our aims:
- Promote and sustain good mental health and wellbeing using such frameworks as the 5 Ways to Well Being
- Build individual and community resilience,
- Engage with primary care to further develop an enhanced service provision (planned 2015/16)
- Evaluation of new service delivery (planned 2016/17).

6. Dementia Prevention

Dementia Prevention
Dementia is a major public health problem in Wales with approximately 42,000 cases. Prevalence and incidence projections show that the number of people with dementia will continue to grow, especially in the oldest age group (85 years and over) with the prevalence doubling with every five year increment after the age of 65. Over 10% of deaths in men 65 years of age and older and 15% of deaths in women in the same age group are attributable to dementia. Dementia is also one of the major causes of disability in later life and accounts for 12% of years lived with a disability.

While dementia usually affects older people it is not an inevitable part of the ageing process and may, therefore, be amenable to primary prevention with a focus on lifestyle risk factors. The evidence suggests that a physically active and a socially integrated lifestyle can delay the onset of dementia.

Aim:
To raise awareness of the modifiable risk factors associated with dementia.
Our 3 year objectives are to:
- Raise awareness of the potential to reduce risk through population wide initiatives such as promoting physical activity, healthy eating and smoking cessation.
- Target those in middle-aged, or those with certain chronic conditions, and focus on individual risk assessment and clinical intervention (management of hypertension, lipids, diabetes)
- Build capacity through training in brief advice / interventions
- Map the gap in diagnosis

Our 3 year implementation plan will include:
- Work in partnership with the Dementia Development Group, Carmarthenshire Dementia Development Board and Dementia Friendly and Supportive Communities Working Group to promote PANDA’S
- Lead the Implementation of PANDA’S ‘Conversations about Healthy Choices training.
- Work in partnership to develop local pathways for referral, screening, assessment to ensure that those with risk factors are identified at an early stage.
In addition, work from 2014/15 which is ongoing includes:

**Sexual Health Services:**
Hywel Dda are currently in the process of reviewing sexual health services with the aim to deliver a safe, high quality, fully integrated sexual health service for the population of Hywel Dda. The Public Health team do not lead this activity for the Health Board however, given the importance of a robust service to maintain public health the team have provided significant support to the future planning of services. Engagement has been undertaken with key stakeholders to ensure that views are incorporated in developing the sexual health strategy to ensure it is sensitive to local circumstances and needs. The current proposal relates to developing a ‘Hub’ and five ‘Spokes’ to deliver sexual health care to the population in a timely manner. The 3 Year objective is to provide a safe, effective, high quality, fully integrated and equitable sexual health service for the population of Hywel Dda through development of a hub and spoke model of care, complemented by primary care.

**Large Scale Change Approach – Physical activity and tackling sedentary behaviour**
Our work on a Large Scale Change approach to increase physical activity will continue in 2015/6 and we currently predict onwards for 2016/17 and 2017/18. We acknowledge that physical activity has the potential to significantly improve the physical and mental health of the population; increasing levels of physical activity would reduce the incidence of many diseases, all cause mortality and associated costs to the health service. Rather than be a standalone work area - this work will now fit within the obesity priority work area to ensure maximum alignment. The three year objectives will be to:
- Increase levels of physical activity, and reduce the levels of sedentary behaviour among the whole population of Hywel Dda
- Increase the proportion of the population who achieve the recommended amounts of physical activity as set out in *Start Active, Stay Active* and *Creating an Active Wales* to reduce the adverse health effects associated with low levels of physical activity in the population.

**Behavioural change**
In Hywel Dda, we also acknowledge that every interaction between health and social care staff and patients is an opportunity to promote healthier lifestyles and encourage behavioural change, in order to reduce lifestyle related illness. To support this thinking, the Hywel Dda Public Health Team has been developing staff competency to deliver brief behaviour-change interventions, which enables discussion of lifestyle and wellbeing to become firmly embedded in the role of health and social care employees. Health promotion competencies have been included within Hywel Dda’s Competency Framework, and a generic, evidence-based training package (‘Talking with Patients about Healthy Lifestyles’) and associated resources (‘Hywel’s House’ and ‘Hywel’s Handbook’) have been produced to support these competencies.
Our three year objectives are to:
- Further develop the integrated ‘Hywel’s House’ Brief Advice lifestyle/wellbeing training package.
- Deliver and evaluate (and provide follow up support) to cohorts of Health Board, Primary Care, Social Care and Third Sector teams.
Tackling Poverty and Inequalities

As a directorate and as a Health Board, we acknowledge that health inequalities are unacceptable. They start early in life and persist not only into old age but into subsequent generations. Tackling health inequalities is a priority for the Welsh Government who state in their Programme of Government that their aim is: ‘reducing poverty, especially persistent poverty amongst some of our poorest people and communities, and reducing the likelihood that people will become poor’. A paper on the Tackling Poverty agenda is due to be presented to Board before the end of the 2014/15 financial year to ensure that the Board is aware of the wide ranging work which occurs across the organisation on this agenda and in readiness for the commencement of the new financial year.

As a Health Board we will therefore continue to work with key partners (including Communities First, Flying Start and Families First and Local Authority colleagues) to tackle this agenda, and we will maintain our focus on this agenda through our work in our Population Health Groups (thus strengthening both primary and secondary care links to this agenda) and in support of our Local Authority Single Integrated Plans through the Local Service Board activity.
<table>
<thead>
<tr>
<th>Carmarthenshire</th>
<th>Ceredigion</th>
<th>Pembrokeshire</th>
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</thead>
<tbody>
<tr>
<td>People in Carmarthenshire are healthier</td>
<td>Supporting Families</td>
<td>Children, young people and families have the opportunity to fulfil their learning potential and to live healthy and happy lives</td>
</tr>
<tr>
<td>People in Carmarthenshire fulfil their learning potential</td>
<td>• Families in Ceredigion have the opportunity to thrive and reach their potential</td>
<td>• Pembrokeshire has a competitive, productive and sustainable economy</td>
</tr>
<tr>
<td>People who live, work and visit Carmarthenshire are safe and feel safer</td>
<td>Economy and Place</td>
<td>• People in Pembrokeshire enjoy an attractive, sustainable and diverse environment</td>
</tr>
<tr>
<td>Carmarthenshire's communities and environment are sustainable</td>
<td>• People in Ceredigion have the skills and support to secure employment</td>
<td>• People in Pembrokeshire are healthier</td>
</tr>
<tr>
<td>Carmarthenshire has a stronger and more prosperous economy</td>
<td>• Ceredigion’s communities are resilient and its natural environments are valued</td>
<td>• Children and adults are safeguarded</td>
</tr>
<tr>
<td></td>
<td>Independent Living</td>
<td>• Communities in Pembrokeshire feel safe</td>
</tr>
<tr>
<td></td>
<td>• People in Ceredigion live in safe and affordable homes and communities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• People in Ceredigion are able to live fulfilled lives.</td>
<td></td>
</tr>
</tbody>
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http://www.thecarmarthenshirepartnership.org.uk/English/ICS/Pages/integratedcommunitystrategy.aspx


http://www.pembrokeshire.gov.uk/content.asp?nav=101,126,2182
Our key areas of health improvement focus in terms of this agenda relate to the reducing smoking activity, and tackling low birth weights. During 2015/16 we will be mindful of the findings which arise from the Inverse Care Law pilot strategy projects being run by 1000 Lives Plus with Cwm Taf and Aneurin Bevan Health Boards. This will build on the Health Board work which uses the local authority peer group mortality comparison tool to compare all cause age standardised and age specific mortality rates for Welsh local authorities with the equivalent rates in the most alike local authorities in the UK. This information is being shared with our GP clusters and Population Health Groups.

3.3 Resourcing our Public Health Plan
Our Public Health Plan for the Health Board will not be achieved in full without investment in prevention and an ongoing review of service delivery/implementation where the focus is on Care Closer to Home, prevention activities to reduce inequalities and an improved quality of life. In England, the health regulator Monitor published a report, ‘Closing the NHS funding gap’, which said investment in public health along with greater innovation in clinical care was the key to helping keep the NHS sustainable in the long-term. The evidence for expenditure on public health is ever increasing. Taking steps to prevent problems before they occur or deteriorate is value for money. As the Early Action Taskforce (England) has argued, the approach offers a ‘triple dividend – thriving lives, costing less, contributing more’.

The Health Board acknowledges that public service austerity is a challenge for health and social outcomes, but also that Public Health can be part of the solution to this challenge. It is clear that prevention is cost-effective and can save money, hence the clear statement in the mission statement.

During 2014/15, the Health Board invested in the first year of a smoking cessation service (Level 3 pharmacy) and the Health Board acknowledges that public health investment can show short, medium and long term benefits for the population, for the NHS and the wider economy. As a result, the public health team have worked closely with planning colleagues to detail the key investments required during the coming three year period to deliver our main ambitions. These are detailed in Annex 1.

Not all the investments are costed as further work is needed to form the Business Cases. Where the financial information is already known this has been provided in the plan. All the actions linked to specific priority areas have a significant evidence base behind them. In terms of Value for Money, public interventions show value for money in both the short and long term, for instance,

- Most of the smoking interventions recommended by NICE are considered highly cost effective and some are even cost saving – that is they are cheaper and more effective than the alternative.
- In terms of obesity, NICE suggests that in general, the cost of taking action to prevent obesity will usually be small in comparison with the future health benefits and the long-term cost savings from reductions in type 2 diabetes cardiovascular disease and some cancers.
In addition, we are recommending two key strategic Board proposals which signal a change to this agenda.

1) That the Counties should have access to a dedicated PH budget for the first time. This will need to be spent by the County teams with the agreement the Director of Public Health, in conjunction with the County Public Health teams, and in keeping with the priorities set by the Health Board’s Population Health Board to deliver on the prevention agenda. This is in keeping with the Mission statement of the Health Board and the 10 pledges approach, and will allow a real shift in resources within the Health Board towards the prevention agenda, and will ensure that the work commenced through the Foundations for Change Programme can continue but at scale for the first time. Alongside this work, further work is required on the data analysis in relation to health improvement actions and health inequalities. This approach will also ensure that the strategic actions of the Population Health Group will maintain a focus on prevention type activities in addition to the core work on pathways. We believe that this sum will need to increase during Years 2 and 3 of the plan. This expenditure will support the Health Board’s Mission statement. For the first time not only indicate support for this work but enable investment so that the work can start to flourish.

2) That the Director of Public Health has a senior member of the Health Board staff directly responsible to her – to enable better links to planning within the Health Board and to enable cross-fertilisation of prevention and public health activity across the Three Counties and through the Population Health Groups.

3.4 Our next steps

In terms of the Public Health work-plan, we will follow our normal business calendar to develop and refine the work plans to deliver the Hywel Dda Public Health ambitions. We will work closely with Public Health Wales to ensure that the shared priority areas remain pivotal within our workplan. The team will continue to support Health Board wide activity to ensure that prevention, primary care leadership and prudent healthcare are key approaches within the Health Board.

In terms of the Health Board’s 10 Pledges, the required next steps are:

- To ensure that robust indicator definitions exist for each of our 10 pledges to enable consistent measurement over time.
- To develop an indicator definition for the following pledges:
  - Increase by 20,000 a year the number of people treated in a community setting who would have previously been treated in hospital
  - Ensure, whenever possible, that no-one with a known long term condition is admitted unexpectedly to hospital with that condition.
  - Provide annual updates that are linked to the release of national secondary care data sets.
Chapter 4: Providing Care Closer to Home

4.1 Introduction

The demographic, strategic and current operational context, detailed in chapter 2, within which Hywel Dda operates, is driving the need for change. To bring about the necessary change to meet the challenge, the Health Board will focus on delivering Care Closer to Home. Within this context, priorities will be set based upon the need to improve patient flow, stabilise core General Medical Services whilst meeting access targets and addressing variation in services.

Within this section we will set out what we mean by Care Closer to Home and the Integration and Partnership working framework, which has set the context within which we will continue to develop services. The chapter will then cover in turn Primary Care Services, Community Services and Community Mental Health Services (please also refer to Annexes 2-7). Further detailed consideration of the wider context of Mental Health is set out with delivery plans in Chapter 5.

Component Services detailing both the current position and challenges and how the Health Board proposes to move forward in delivery of Care Closer to Home is detailed within this document. Further sections consider the support services including Estates, Information Management and Technology, Transport and Carers in their role as critical enablers for sustainable care. The table on page 71 sets out the priorities with associated workforce and financial consequences which the Health Board will require to deliver its objectives for Care Closer to Home.

4.2 What we mean by Care Closer to Home

We are clear about the need for change in how we deliver services, particularly the need for increased integration in health and social care, placing the individual at the centre with care services becoming increasingly accessible in local areas. To this end, our core aims are:

- To ensure patients and their families receive community services that are safe and of the highest quality and provide the best experience and outcomes as cost effectively and as locally as possible. As part of prudent healthcare, we want to develop community services which encourage a culture of self management whilst helping and supporting people to optimise and maintain their own health, well-being and independence.
- To work with our population, our partners and our staff to deliver care that is responsive to local needs and addresses inequalities.

Our intention is to achieve a plan for service transformation which results in a significant shift in the way services are provided across hospitals and the community, with some provision moving from hospitals to the community where safe and effective to do so. Delivering care in this way will support Care Closer to Home for our frail and elderly population, whilst allowing our hospitals to concentrate on what they do best - providing both planned and emergency care when it is needed. In planning to deliver Care Closer to Home, the Health Board will need to better
manage the significant pressure on healthcare provision due to the increased prevalence of chronic conditions and level of frailty. Care Closer to Home will place Primary Care Teams at the centre of the care provider network. The delivery of community services are increasingly focused through enhanced Community Resource Teams (CRT) these provide a multidisciplinary approach to the management of patients in the community. CRTs objectives are to prevent unnecessary attendance at hospital through recognition and early identification of acute illness which can be managed in the community avoiding the consequent potential for admission to hospital. Complementary to the CRTs will be the development of enhanced facilitated discharge services, which will similarly provide a team approach to discharge facilitation. The CRT and discharge liaison will improve patient flow through the health and social care system.

The Health Board emphasis on providing Care Closer to Home can only be achieved through ensuring that we have robust sustainable community services which include Primary Care Services.

As part of the ‘Your Health Your Future’ consultation, we agreed we would need to strengthen primary and community care services, demonstrating ‘what good looks like’ as follows:

| Hospital in-reach and early discharge – Rehabilitation and Acute Response Team | Early identification of high risk patients and preventive management | Introduce Rural Health Practitioner role and specific training programmes |
| Diabetes – over 50s casefinding | Enhanced Recovery – Orthopaedics | Dementia and serious mental illness – early diagnosis; monitoring and prescription of medication |
| Improve access to dental services | Single assessment process | Extend access - for Primary & Community Services |
| Integration of health and social care teams (Community Resource Teams) | Mental Health – shared care for stable patients and prescription of dementia drugs | End of life – increase number of people dying in their place of choice/home |
| Locality networks and GP clusters | Community pharmacy – targeted medicines use reviews | Unscheduled Care – patients to be referred for assessment earlier in the day to avoid admission |
| Communications hub – Single point of access (MAVIS) | Women and Children – Shared care for ante-natal and postnatal care. | Scheduled care – Specialist GPs; first and follow up outpatient appointments; |
| Falls Assessment and falls service to be expanded | Develop Clinical Assessment Services in Dermatology; MSK; Urology; Chronic Conditions | Scheduled care – optometrists to provide follow up care; direct listing for routine conditions |
| Access – Explore ways to improve in-contract access to GPs. | Ophthalmology - Direct referral from Optometrist to Ophthalmologist (not via GP); Glaucoma | Dental - Introduce minor oral surgery in primary care |
| Telehealth – pilot telehealth service from GP surgery to secondary care | Cancer – Improved early investigation and diagnosis in primary care | Mental Health - Learning disability and dementia services to be community based |
This analysis was developed during the ‘Your Health Your Future’ planning stage. It reflected a considered view at that point in time of either implementation (green), work in progress (amber) or work still to be done (red). Whilst services have moved on, we may wish to undertake a refresh of the grid. The investment plans embodied in the IMTP link clearly to those areas flagged in red and demonstrate the links in planning processes from ‘Your Health Your Future’ to now. Today, the Health Board view of Care Closer to Home is described diagrammatically as follows:

**Hywel Dda Strategic Vision for Care Closer to Home**

- **Acute hospitals**
  - Dedicated to those who are acutely unwell and need specialist care

- **Community Resource Hubs**
  - Reflect the needs of their local population; with local GPs and community teams integral to the model
  - Dedicated to support local communities, acting as a hub for wider community based care
  - Work together as a network of facilities to provide some specialist community services

- **Community Resource**

- **Community health social care & 3rd sector services**

- **Primary Care**

- **Supporting community services**
  - Locality based Community resource teams (CRTs) including nurses, therapists, social workers, support staff & 3rd sector working across interface of community resource centre and people’s homes with some ‘in reach’ into acute hospitals. The CRT helps people to manage their health & wellbeing and maximise their independence by:
    - Supporting effective transfer home from hospital or community bed, providing packages of home based rehabilitation, ensuring no patient stays in hospital longer than necessary.
    - Supporting patients with long term conditions and frail older people to manage their condition
    - Providing acute response in cases of crisis to stabilise patients quickly, either through short stay admission to a mixed economy of beds or by managing patients in their own home.

- **The range of networked services will include:**
  - Ambulatory care with supporting diagnostics
  - Medical and surgical day units
  - Range of Primary care services (GP, dentistry, pharmacy) etc.
  - Integrated Multi-disciplinary team (MDT) providing local, comprehensive assessments for frail/elderly people and Direct access to a network of community beds and 24/7 care for:
    - Frail people requiring stabilisation or treatment but not specialist acute hospital care
    - High quality packages of planned residential rehabilitation
    - Support for vulnerable adults in effective recovery and re-ablement
What good looks like: Community Resource Teams

Menu of services:
- Community Nursing Services
- Community Specialist Services:
  - Heart Failure
  - Stroke
  - Podiatry (maintenance 3rd Sector)
  - Palliative care
  - Etc.
- Signposting for meal / food delivery to the home
- Assistance for washing and other personal care
  - Social Care
- Home cleaning – 3rd Sector
- Therapeutic Service following the patient
- Signposting to social and support groups
  - 3rd Sector
- Befriending – 3rd Sector
- Community Transport Links – 3rd Sector
- Adaptations to the home
  - Statutory and 3rd Sector
- Equipment
  - Statutory and 3rd Sector
- Respite care
  - Private, Social Care and 3rd Sector
- Short term bed based care – joint care

Process:
- Assessments:
  - Medical
  - Nursing
  - Specialist
  - Social
  - Therapeutic
  - Wellbeing
- Multidisciplinary
- Co-ordinated care planning
- Anticipatory
- Monitoring and review frameworks
Care Closer to Home will be based on the following operational principles:

Each Locality will include a partnership of health, local authority, third sector, independent sector and local mainstream services that deliver an individual service to care and meet the needs of people who are likely to benefit from an integrated approach. These are based around:

- Prevention
- Anticipatory care
- Enhanced preparation for scheduled care
- Rapid community response to provide unscheduled care;
- Rehabilitation & enablement including supporting early discharge;
- Long term conditions management;
- Palliative and end of life care; and
- Long term care (including continuing healthcare).

To build on our existing 7 localities to ensure each has a strong and sustainable workforce which is actively enabled to develop holistic and specialist skills to deliver care focused on the local priorities and needs.

Within the context of the CRTs, GPs will undertake a co-ordination and care planning role for people who are at greatest risk of deteriorating and losing independence. GPs will be supported by the Community Resource Team which includes a range of professions by working collectively to deliver integrated care. This will include effective transfer of care for those admitted to hospital and/or residential care and facilitating return to their own home wherever possible.

Clinical intelligence held by GPs in relation to the local population will be used to assist risk stratification for a locality in order to target community resource appropriately, which will be undertaken by effective commissioning at a local level.

Each Community Pharmacy will offer a range of over the counter and consultation based advice to support self care for the community as well as lifestyle and chronic disease monitoring advice. Pharmacies will be part of a broader network accessing additional integrated community team support when they identify the early signs of patient deterioration.

Local community facilities will provide a base from which integrated services will operate and provide information and access to services supporting self management, health promotion and increasing community resilience. It is envisaged that community facilities will also work as a network across the Health Board to provide an increasing number of specialist services.

There will be access to beds within a range of community settings for people who need 24/7 care but not requiring the level of care provided within an acute hospital setting, or those not able to be safely managed within their own home. These will either be directly provided or commissioned with a range of partners including the independents or third sectors. These services will provide:

- Rehabilitation during a period of intermediate care between acute hospital and home e.g. post operative trauma or rehabilitation after acute medical episode (usually < 30 days),
Clinical care and observation supported by specific diagnostic services and social care during a short period of illness or acute functional decline (usually <72hrs).

Convalescence where care is required and active rehabilitation is limited by condition.

Palliative care where appropriate and according to individual choice and circumstances

Respite care to support the carer and the patient

Assessment beds to determine the future care needs of the patient

Specialist care will increasingly be available within the CRT model and include access to a range of specialist services including specialist rehabilitation, specialist nurses / therapists, low vision, community mental health, specialist palliative care, drug and alcohol services, learning disability services. This will enable the model to work effectively by delivering care closer to people’s homes.

Primary and Community services will support our acute hospital services by providing as much care locally as is appropriate and safe to do so. Services will:

- Reflect the needs of the local population
- Support local communities, linking closely with community teams and providing as a hub for wider community based activity
- Work together as a network of facilities with provision of specialist community services across our population.
- Support effective and timely transfer from acute hospitals. The CRTs will provide home based rehabilitation, or supportive care to enable a return to optimal independence, with reductions in inpatient length of stay avoiding delayed transfer of care
- Deliver integrated ‘twilight’ services providing responsive transport home from hospital and commissioned support services to assist discharge.
- Provide a range of services from the Third Sector that will enable individuals to maintain their independence and improve their quality of life.
- Utilise Care and Repair services to speed up minor adaptations and provide practical support services to maintain people in their homes
- Extend telecare support - Hywel Dda has been engaged for a number of years in piloting the use of new technologies, such as telehealth and telemedicine initiatives. This will support care within rural areas recognising particular areas of interest and taking into account the demography, geography, and health needs of our older population.
- Increase equipment provision to support people in their homes, to assist manual handling and care needs including bariatric and other specialist equipment

In addition, by strengthening our frailty models, multi-disciplinary teams (MDT) including partner organisations, will provide local, comprehensive assessment and diagnostics services for frail and elderly patients. These include:

- Services for elderly patients requiring stabilisation or treatment including access to medical and surgical day units.
- Packages of planned inpatient rehabilitation care, supporting vulnerable adults in effective recovery and re-ablement, including improving therapy input
A greater range of outpatient services, with supporting diagnostic services to help clinicians make quicker diagnoses
- Improving psychological care for patients with chronic conditions
- Appropriate and timely access to Mental Health and Learning Disability services
- Palliative and End of Life pathway implemented.

Our approach to integrated planning can be demonstrated by the Cylch Caron project. Cylch Caron is a new centre being designed for Tregaron. It is a partnership scheme between Ceredigion County Council, Hywel Dda and Housing Associations to create an innovative rural model of community based care to meet health, social care and housing need in the area.

A Strategic Outline Case articulating the case for change has been approved by Welsh Government and subsequently an Outline Business Case has been submitted which identifies a preferred service model. The core physical components are:
- 34 Extra Care Units (mixture of 1 and 2 Bedroom Units)
- 6 Integrated Health and Social Care Flexible Units e.g. Step up Step Down, Respite and Time to think
- Integrated Health and Social Community Care Hub
- General Medical Services and Primary Care Hub
- Pharmacy

The project will provide the following range of integrated services including in-reach, out-reach community services.

A similar scheme has been developed in Crymych with further Community Resource Centres proposed for Ceredigion and Carmarthenshire.
4.3 Integration and Partnership Working

Foundations for Change

Since the ‘Your Health Your Future’ consultation we have embedded into service delivery, initiatives which would also meet Health Promotion and Prevention requirements. Through a Foundations for Change Framework and taking into account local population need, each of the three counties have selected five specific priority areas for their localities for which they have also developed performance targets. To address health inequalities and life expectancy the following table sets out priority areas for each County:

<table>
<thead>
<tr>
<th>Carmarthenshire</th>
<th>Ceredigion</th>
<th>Pembrokeshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations &amp; Vaccinations</td>
<td>HPV vaccination</td>
<td>Immunizations &amp; Vaccinations</td>
</tr>
<tr>
<td>Obesity/Overweight</td>
<td>Obesity/Overweight</td>
<td>Obesity/Overweight</td>
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<tr>
<td>Palliative &amp; End of Life Care</td>
<td>End of life care</td>
<td>Palliative &amp; End of Life Care</td>
</tr>
<tr>
<td>Frailty</td>
<td>Stroke - Improved outcomes</td>
<td>Frailty</td>
</tr>
<tr>
<td>Dependent behaviour (smoking, Drug and Alcohol)</td>
<td>Inappropriate admissions</td>
<td>Smoking</td>
</tr>
</tbody>
</table>

National Strategic Direction

Localities have been determined that serve natural geographical populations of approximately 50,000. Clusters of GP practices and integrated Community Resource Teams (CRTs) will be central to delivery of services for these populations. Our model for community care has been developed in line with key Welsh Government policy objectives including:

- Strategic delivery programme for primary and community services; “Setting the Direction, 2009”
- Welsh Government strategic framework ‘Together for Health’.

And more recently the model has been reviewed to ensure alignment with:

- Single Integrated Plans for each county
- Delivering Local Health Care Plan’ Accelerating the pace of change’ 2013
- A Framework for Delivering Integrated Health and Social Care – For Older people with complex needs’ 2014
- Social Services and Well-being (Wales) Act 2014

Following the Mid Wales Healthcare Study, a Mid Wales Healthcare Collaborative will be established and will lead to even more integration of patient pathways in community and Local Authority services between Hywel Dda, Powys and South Gwynedd. This detailed work will commence in 2015/16.
Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs

A Regional Collaborative was established in 2013. This includes Hywel Dda, Carmarthenshire County Council, Ceredigion County Council, Pembrokeshire County Council, Powys Local Health Board and Powys County Council. A Statement of Intent (January 2014) has been produced and approved by the partner organisations with statutory responsibility for health and social care services in Mid & West Wales.

The Statement reflects a long standing strategic commitment between the organisations to develop and deliver Health and Social Care Services, including those for older people, in an integrated way. This also includes services for older people with dementia and other mental health conditions. The assessment of our current position in relation to integrated services for older people with complex needs and our commitments for the future have been informed by ongoing dialogue between our organisations and with other partners.

The focus of the Framework is the implementation of integrated services, care and support for older people, particularly frail elderly people or those with complex needs, including dementia. Local objectives are:

- Deliver sustainable services
- Improve outcomes
- Improve patient flow
- Reduce long term care costs (NHS & Social Care) per head of older population
- Key features being embedded in County (community) Plans

The above are addressed within the Statement of Intent and are being delivered through integrated working and programme management.

Governance arrangements to support regional cross-sector planning and working have been established principally through an Older People’s Programme Board, comprising senior representatives from local government, the NHS and third sector. This has provided a strategic forum for:

- Sharing learning and outcomes from the new approaches being funded through the Intermediate Care Fund (for a time limited period)
- Identifying opportunities and risks and agreeing appropriate responses to each
- Monthly monitoring of programme delivery and achievement of objectives and milestones
- Developing a shared performance management framework which will enable us to monitor the overall impact of new services developed through the Fund and compare outcomes from different approaches
- Considering how the changes being made through the Fund can be consolidated to effect whole system change in health and social care across the region

These regional arrangements are also replicated at County level through integrated
forums which oversee the local delivery of Intermediate Care Fund initiatives. Partners across different sectors have assumed responsibility for the delivery of individual work-streams, with the third sector in particular leading on a number of initiatives.

The Older People Planning Board (OPPB) Programme oversees the work programme, implementing the ‘Assessment, care management and review for older people’. The Regional Work Programme is set out below:

- Delivery plan to be approved by Older People’s Programme Board in January 2015
- Awareness raising and skills development programme identified
- Initial audit of existing arrangements to check compliance with guidance to take place early 2015
- The following work-streams have been confirmed or are being considered currently for management under the Collaborative Board:

The table below describes the key elements in more depth.

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Broad Objectives</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modernising Learning Disability Services in Mid and West Wales</td>
<td>Delivery of modernised LD services across the region, based on a ‘progression’ model and informed by collaborative improvements to commissioning and practice</td>
<td>Regional Collaboration Fund 2013/14 to 2015/16</td>
</tr>
<tr>
<td>Regional Children with Complex Needs, Transition and Vulnerable People Service</td>
<td>The development and delivery of transformed and sustainable complex needs and transition services across four local authorities and two health boards across Mid and West Wales</td>
<td>Regional Collaboration Fund 2013/14 to 2015/16</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>70 projects across the 4 County areas aimed at improving intermediate care as a key driver for the prevention and wellbeing agenda</td>
<td>Intermediate Care Fund 2014/15</td>
</tr>
<tr>
<td>Regionalisation of Children’s Safeguarding</td>
<td>Introduction of regional arrangements for children’s safeguarding, providing strategic coordination and complementing County-level mechanisms</td>
<td>Delivering Transformation Grant 2013/14 and 2014/15; contribution of partner agencies</td>
</tr>
<tr>
<td>Regionalisation of Adult Safeguarding</td>
<td>As above for adults</td>
<td>Delivering Transformation Grant 2013/14 and 2014/15</td>
</tr>
<tr>
<td>Regional Adoption Service</td>
<td>Implementation of regionalised services to complement those at local level, as part of an agreed model for the National Adoption Service</td>
<td>Delivering Transformation Grant 2013/14 and 2014/15; contribution of partner agencies</td>
</tr>
<tr>
<td>Implemented assessment, care management and review for older people</td>
<td>Implementation of 2013 Welsh Government Guidance supporting new pathways to promote prevention and wellbeing</td>
<td>Delivering Transformation Grant 2013/14 and 2014/15; contribution of partner agencies</td>
</tr>
<tr>
<td>Regional Commissioning Strategy</td>
<td>Identification of opportunities for joint health and social care commissioning on a regional basis and delivering a regional programme</td>
<td>Regional Collaboration Fund 2013/14</td>
</tr>
<tr>
<td>Regional Workforce</td>
<td>Review of workforce plans of partner agencies</td>
<td>Contribution of partner</td>
</tr>
<tr>
<td>Workstream</td>
<td>Broad Objectives</td>
<td>Funding</td>
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<tr>
<td>Strategy</td>
<td>to ensure alignment with strategic priorities and objectives of the region and adoption of collaborative approaches where appropriate</td>
<td>agencies</td>
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<td></td>
<td>Review of workforce capacity across the region</td>
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<tr>
<td>Preventative approaches in services to older people</td>
<td>Proposed project to identify, share and support the implementation of best practice across partners</td>
<td>Contribution of partner agencies</td>
</tr>
<tr>
<td>Performance management for outcomes</td>
<td>Proposed project to develop a common performance management framework for the Collaborative to monitor delivery and outcomes across the region</td>
<td>Contribution of partner agencies</td>
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</tbody>
</table>

### 4.4 Primary Care

**Core General Medical Services - Capacity, Capability and Challenge**

The 54 GP Practices have over 2 million patient interactions each year, both in the surgeries and in patient homes. As generalists, GPs are often the first port of call and ensuring a sustainable, high quality and consistent General Medical Service is a key enabler to the whole health and care system. Effective primary prevention, risk stratification, early identification of deterioration, case management and integrated team working are essential components in managing patients safely outside of hospital.

Shifting resource, addressing recruitment challenges and building integrated teams are vital components to ensure a sustainable and strong General Medical Service for the future. To support this agenda, the Health Board has established **7 Locality Networks** defined around a cluster of GP Practices and their registered populations, whereby existing services based within Primary Care will come together with other community health and social care teams who serve the same locality.

The age profile of the workforce in Primary Care; GPs, Practice Nurses and Nurse Practitioners across the 7 localities is a huge risk over the next five years in terms of sustaining services New GPs from training are now 70% female and choose practice work partially to fit with work life balance. The anticipated retirement position is as follows:

- The projected potential GP retirements over the next 5 years indicate that 29.2% (around 63 GP posts) of the total workforce could retire, and of this 39.8% are currently within South Ceredigion & Teifi, 38.8% the 3 T’s, 30.8% Llanelli and 27.9% South Pembrokeshire. There is a national shortfall across the UK in terms of the GP's in training and the service needs which is already impacting upon our success in recruitment locally.
- The projected potential Practice Nurse retirements over the next 5 years indicate that 29.9% (around 30 posts) could retire and of them 68.4% are all based in North Ceredigion, 35.3% in the 2 T’s and 34.1% in Amman Gwendraeth - which have to date proved to be challenging from a recruitment perspective. The Practice Nurse posts are often filled by locally based district nurses, but the same age profile risks apply with within community nursing – either way, regardless of education commissioning this is a risk to service
provision.

In April 2014, we undertook a Locality Sustainability Assessment, looking at 7 key areas, to understand the challenges faced by General Medical Services / General Practitioner that will need addressing as part of Locality Planning. These assessments are an initial ‘starter for 10’ and although updated in October 2014 they will be further developed and reviewed with contractors as part of the new Quality Outcomes Framework locality / cluster network development domain. The ‘criteria’ are briefly outlined as:

- **Stabilise**: Stabilising actions taken for these practices will need to address real and daily challenges faced by the practice that occupy a significant amount of time and concern.
- **Optimise**: Optimising actions taken for these practices will need to address practices which whilst no longer being challenged on a daily basis, nonetheless experience some underlying problems that require dealing with or some barriers which prevent the practice moving toward innovation.
- **Transform**: This denotes those practices which have core service delivery well managed and are actively seeking ways to work differently and develop.

The 7 key areas which were used to assess the GP practice in our Localities are:

<table>
<thead>
<tr>
<th>Perception &amp; access</th>
<th>Co-ordinate &amp; integrate</th>
<th>Professional prestige</th>
<th>Infrastructure</th>
<th>IM&amp;T</th>
<th>Incentives</th>
<th>Reduce variation</th>
</tr>
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<tbody>
<tr>
<td>Accessible high quality comprehensive services for all communities</td>
<td>Generalist led integrated services to deliver personalised cost-effective care</td>
<td>Promote a greater understanding of the value that the generalist brings to the whole system &amp; expand the capacity of the general practice workforce to meet population needs</td>
<td>Investment in suitable community based premises for delivering care, teaching, training &amp; research</td>
<td>Greater use of information &amp; technology to improve health &amp; care</td>
<td>Align incentives and priorities to enable strategy and more holistic community based outcomes</td>
<td>Enhance the skills and flexibility of general practice workforce to provide complex care</td>
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</table>

And these were scored as follows:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>Stabilise: The majority of practices within the locality are at “Survival”</td>
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<tr>
<td>Stabilise: There is a mix of practices between “Survival” and “Sustainable”</td>
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<tr>
<td>Optimise: The majority of practices within the locality are at “Sustainable”</td>
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<tr>
<td>Transform: There is a mix of practices between “Sustainable” and “Innovative”</td>
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<tr>
<td>Transform: The majority of the practices within the locality are at “Innovative”</td>
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</tbody>
</table>
And by locality, our assessment of their challenges is as follows:

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<thead>
<tr>
<th>Locality</th>
<th>Perception &amp; access</th>
<th>Co-ordinate &amp; integrate</th>
<th>Professional prestige</th>
<th>Infrastructure</th>
<th>IM&amp;T</th>
<th>Incentives</th>
<th>Reduce variation</th>
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Evidently, depending on where each Locality is in terms of the assessment of their current challenges, this will dictate the pace at which the kind of changes to working practices we need to achieve can be delivered. It is our expectation that as part of the wider Locality Teams, our Primary Care workforce will need to deliver the following innovation as part of ‘what good looks like’, described under the headings of stabilising, optimising and transforming. It is our intention that this is measurable as per red narrative, as follows:
### The Way Forward for Core GMS

<table>
<thead>
<tr>
<th>Locality Development Change required</th>
<th>Stabilising</th>
<th>Optimising</th>
<th>Transforming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of Locality Leadership by GPs that embraces multi-agency working</td>
<td>Locality planning development – targeted facilitation and development of the locality to enable rapid move to delivery</td>
<td>Targeted high impact support to delivering change for local communities around prudent healthcare, and in line with aims and objectives of Together for Health Plans</td>
<td>Extension into planning of services provided at Locality level by our acute and tertiary care providers</td>
</tr>
<tr>
<td>Maturing plans will evidence this</td>
<td>Salaried Primary Care Model - demonstrator funding in Year 1 to test model and funding process</td>
<td>More resilient primary care services able to cope with seasonal pressures</td>
<td>Step change in core GMS resilience delivered</td>
</tr>
<tr>
<td>Workforce stability in GMS will evidence this</td>
<td>Target clinical staff in other sectors to receive training to enable shift to primary care</td>
<td>Clinical staff trained and ready to work across system / key pathways</td>
<td>Step change in transferable clinical skills across pathway delivered</td>
</tr>
<tr>
<td>Lack of joined up locum support for Primary Care and succession planning</td>
<td>Frailty / Co-morbidity training required on acute management of the complex frail deteriorating patient</td>
<td>More confident clinical teams capable of holistically managing risk and care of complex patients within the community.</td>
<td>Step change in risk management of the complex frail elderly in the community for as long as possible</td>
</tr>
<tr>
<td>New primary care service delivery will evidence this</td>
<td>Aston Based Team Development – ‘team development’ undertaken for Primary Care Teams</td>
<td>Robust, strong primary care teams capable of collaborative working and fit for future and service improvement</td>
<td>Step-change – no demarcation between teams regardless of the sector / and their independent status</td>
</tr>
<tr>
<td>Sub-specialisation has reduced the confidence of staff to manage holistically the complex frail patient at home / in the community. Reduced re-admissions &amp; increased patients being looked after by CRTs</td>
<td>Clinical Assessment Services – to support pathway development to enable implementation of specialty specific CAS to manage patient flow</td>
<td>Clear and timely advice Full development of Hot Clinics in key specialties providing timely and expert advice to Primary Care</td>
<td>Step change – admission avoidance tracked and GPwSIs encouraged as part of the growth of CAS</td>
</tr>
<tr>
<td>Fragmenting teams within primary care leading to destabilisation of service provision</td>
<td>Community Engagement – to facilitate the process of more effectively engaging with local communities about prudent healthcare and priorities</td>
<td>Provide training for patient engagement champions Provide grant funding for establishing PPGs Support Patient Participation Group network events</td>
<td>Informed and fully engaged patients understanding the service investments being made by Localities</td>
</tr>
<tr>
<td>Reducing the number of practice vacancies</td>
<td>Independent Prescribing Training – to develop a broader clinical workforce including pharmacists, nurses and paramedics</td>
<td>Provide training and mentoring opportunities for new prescribers</td>
<td>Step change in plurality of Primary Care professionals</td>
</tr>
<tr>
<td>Referrals often going to the wrong location or waiting for Outpatient when advice and guidance to Primary Care would have been the better option. Evidenced in T4H Plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localities have limited engagement with their local communities to plan service improvement or engage in prudent healthcare discussions Increased Patient Participation Groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP recruitment is challenging leading to concerns about GMS sustainability Evidence other skill-mix being developed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locality Development</td>
<td>Stabilising</td>
<td>Optimising</td>
<td>Transforming</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Change required</td>
<td>Lifestyle Champions – support &amp; training on brief intervention, motivational interviewing and can focus on the smoking, obesity, activity and alcohol programme for the provider – all primary care</td>
<td>Training of champions</td>
<td>Full embedding of Health Prevention in Locality</td>
</tr>
<tr>
<td>Inequitable focus and delivery of preventative schemes.</td>
<td></td>
<td>Resources for providers</td>
<td></td>
</tr>
<tr>
<td>Evidenced by increased number of Lifestyle Champions</td>
<td></td>
<td>Working groups / facilitation for developing robust programmes within practice that can then be sustainable</td>
<td></td>
</tr>
<tr>
<td>Inconsistent and inequitable skills in primary care to deliver quality improvement</td>
<td>Quality Improvement skills – to deliver purse silver Improving Quality Together packages to whole practice/provider teams</td>
<td>Pure Improving Quality Together silver in provider organisations</td>
<td></td>
</tr>
<tr>
<td>Number of completed Bronze &amp; Silver Percentage</td>
<td>Managing Workload – supporting GMS to review workload and demand to achieve better outcomes for teams and patients</td>
<td>Programme of capacity and demand and service change for practices aimed at improving workload and aligning to broader workforce skill mix.</td>
<td>Step change in core GMS resilience delivered</td>
</tr>
<tr>
<td>High levels of activity and workload in primary care resulting in burnout of some teams</td>
<td>Behavioural Change – targeted training to support clinicians to work proactively with people dependent on services or not coping with managing their co-morbidities.</td>
<td>Training for clinical staff/teams Psychological support, advice and guidance</td>
<td>Informed and fully engaged patients understanding the service investments being made by Localities</td>
</tr>
<tr>
<td>Unscheduled Care Dashboard</td>
<td>Lifestyle Champions – support &amp; training on brief intervention, motivational interviewing and can focus on the smoking, obesity, activity and alcohol programme for the provider – all primary care</td>
<td>Training of champions Resources for providers Working groups / facilitation for developing robust programmes within practice that can then be sustainable</td>
<td>Full embedding of Health Prevention in Locality</td>
</tr>
<tr>
<td>Inequitable focus and delivery of preventative schemes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidenced by increased number of Lifestyle Champions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Community Dental - Capacity, Capability and Challenge**

There are currently 67 Dental Practices (49 Dental Contracts) across the Health Board. It is the intention of the Health Board to have a networked dental service offering an accessible and safe service to our population with routine care delivered as close of home as possible. We also have an employed Community Dental Service, offering care to those patients who may find it difficult engaging with a traditional high street dentist. They work from 12 clinical locations across the Health Board and also deliver the Designed to Smile education programme for our children. It is critical that historic inequitable patterns of commissioned activity are addressed over the next three years. This is a priority for our population and there is a particular focus from the Community Health Council and Welsh Government, given that we have the lowest routine access to high street dental care in Wales.
The Way Forward for Community Dental Services

As a Health Board we will be seeking over the next three years:

- Equitable access to routine primary dental care for 55% of the population within the next 3 years (currently 45%), addressing first the localities with the lowest levels of commissioned Units of Dental Activity.
- Holistic care for patients with the highest need through a modernised Community Dental Service which will offer a full spectrum of care in safe and compliant estate.
- Minor oral surgery and sedation services will be repatriated within Hywel Dda in premises closer to the patients.
- Waiting times for orthodontic treatment will be reduced.
- Focus on prevention and maintaining good oral health will be maintained and extended.
- Our population will receive timely clinical advice and treatment for their urgent care needs.
- Our population will have access to single courses of routine treatment where they do not have a usual dentist.
- The Health Board teams will work together to ensure evidence based, multi-disciplinary care is available to all patients diagnosed with oral cancer.

This will build on elements of good practice that we have developed particularly through our Designed to Smile prevention initiative aimed at improving the oral health of children, alongside key elements of our oral health delivery plan.

Further, we have identified a number of key enablers that need to be put into place to help support service delivery, these include, the creation of a multifunction business unit to support the management of contracted services and provide operational support to the delivery of clinical services; exploration of opportunities to grow the service and increase specialist skill mix; purchase of a clinical system(s), to allow for the delivery of clinical services within an appropriate clinical governance framework, development performance reporting and to ensure that patient data is held within fit for purpose systems; and the purchase of new equipment.

Community Pharmacy - Capacity, Capability and Challenge

There are currently 99 Community Pharmacies across Hywel Dda, including communities where there is no GP practice. The majority of the Pharmacies have opening hours outside of those in GP practices, are networked electronically and deliver services to peoples' homes that might otherwise not be able to attend a Pharmacy in person. All of these potentially could be used to help shape future services, and as a consequence the Health Board is very clear on its intention to make use of this potentially underutilised resource.

The Way Forward for Community Pharmacy

Prevention & Lifestyle:
- Deliver a range of lifestyle support for smoking cessation, obesity, activity and wellness.
- Deliver a range of immunisations.
• Deliver screening services for cardiovascular and diabetes risk.
• Offer Dry Blood Spot Testing to targeted clients

**Chronic condition management:**
• Deliver targeted medication reviews aligned to GMS poly-pharmacy reviews.
• Deliver an increased number of discharge medication review service to support patients following inpatient stay.
• Deliver phlebotomy services.
• Deliver INR monitoring services
• Deliver networked chronic condition management for hypertension and asthma.
• Deliver Medication Compliance Services for patients identified by secondary care (e.g. TB patients)

**Urgent / Acute Care:**
• Provide a stable core advice, guidance and signposting service for local communities aligned to Choose Well.
• Proactively enable patients to choose over the counter medication to manage minor ailment symptoms.
• Provide Just in Case medication to an increasing number of patients choosing home as their place of care at the end of life.
• Deliver triage and treat services for patients with low level injuries.
• Provide first access services for un-well patients by networked clinical support from Advanced Practitioners, General Medical Services & Emergency Departments.
• Provide locations for community defibrillators.

A number of infrastructure and delivery issues need to be addressed. These include acknowledging that there will be a lead-in time for some services whilst independent prescriber training is undertaken; that appropriate facilities are available within the Pharmacies themselves; that third sector services remain available to support; and that sufficient community pharmacy contractors take up the range of services outlined to achieve the target delivery projections.

### 4.5 The way forward for Community and Primary Care Workforce

The Health Board workforce plan has identified and mapped the risks associated with the age profile of our workforce by staff group and county for many years. Each county/staff group have been working to succession plan and develop staff to support the projected potential turnover through clinical leadership and management programmes and post graduate programmes/modules. The changes to employment legislation have made it more complex to predict the risk but the issue is acknowledged and has informed our commissioning of education across professions.
The specific risks which our plan intends to mitigate are:

<table>
<thead>
<tr>
<th>Risk Area</th>
<th>Stabilising</th>
<th>Optimising</th>
<th>Transforming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ageing profile of the community nursing workforce</td>
<td>Simple local succession plans prioritised</td>
<td>Focus on 50% growth of generic HSCSWs</td>
<td>Full implementation 100%</td>
</tr>
<tr>
<td>Delivery of the future model whilst maintaining service provision</td>
<td>Focus on 25% growth of generic Health, &amp; Social Care Support Workers to help our qualified nurses with simple care duties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing clinical placements available to support the students and capacity to provide effective mentorship</td>
<td>Strengthen roles and responsibilities of team members</td>
<td>Scope contribution of wider resource team members to this provision</td>
<td></td>
</tr>
<tr>
<td>Recruitment issues associated with rurality – reviewing our recruitment strategy to support this</td>
<td>Resource teams to refine and improve further recruitment process, particularly documentation for advertising to strengthen current information making use of ranges of benefits to working in this HB/Wales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for community services investment given the current financial position &amp; workforce savings targets and the impact of social care financial savings targets</td>
<td>Build on work undertaken to develop cross sector support worker role to optimise co-location and co-employment opportunities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead in time to develop Assistant Practitioner and Advanced Practice roles, and backfill to support development of staff for these posts</td>
<td>Develop simple internal competency training plan identifying modules/units of clinical competence required to achieve long term workforce model and scope our time scale which will realistically maintain service delivery/allow for release of staff to develop knowledge and skills.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity/sustainability to deliver to 24/7 service models for prioritised services</td>
<td>Services to review and ensure current roles and job descriptions encompass all activities which are required, and identify and competency development required to inform training plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Expansion will occur based on the following principles:

- Skill-mix savings opportunities in community as per independent analysis undertaken in 2013/14. These need to be scoped and delivered, and will be further informed by subsequent work undertaken by the WAO on District Nursing skill-mix;
- Evaluation of specialist nursing function and job-plans in order to ascertain the opportunity for further re-location from acute sector, as appropriate;
• New Primary Care funding will help to deliver General Practitioner expertise / Locality Management and Services, in conjunction with the delivery of the Primary Care Plan;
• Intermediate Care Fund will be reviewed to evaluate how this is aligned in supporting our Community Resource Teams;
• GP retirement and Practice Nurse retirement – we will work with Localities and the LMC to bring in alternative models to attract GPs and address potential capacity and capability shortfalls in core GMS, specifically:
  o Growing GP portfolios, and / or, GPs with Specialist Interests
  o Expansion of a salaried service in hard to recruit areas.

What this will mean in terms of resourcing

Our Locality Plans are indicating an overall net expansion of just less than 321 WTE, much of which we intend to be resource-neutral in the long-term as we progress upper quartile efficiency and productivity in hospital bed numbers.

In real terms, as we do not have funding at these levels to pump-prime this scale of change, this represents a redeployment of nursing skills in particular from acute care settings to community care, so will probably take much longer than 3 years to implement. However, the long-term shift of resources that has been identified in our Locality Plans would look something like this:

<table>
<thead>
<tr>
<th>CARE CLOSER TO HOME</th>
<th>WTE BY STAFF GROUP</th>
<th>WTE</th>
<th>Revenue Implications - Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing WTE</td>
<td>Therapies WTE</td>
<td>Other WTE</td>
</tr>
<tr>
<td>Community Resource Team/Discharge Liaison</td>
<td>48.15</td>
<td>78.72</td>
<td>11.80</td>
</tr>
<tr>
<td>Palliative</td>
<td>6.00</td>
<td>1.80</td>
<td>1.00</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>74.80</td>
<td>1.00</td>
<td>-</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>31.89</td>
<td>22.16</td>
<td>1.83</td>
</tr>
<tr>
<td>Frailty</td>
<td>-</td>
<td>12.60</td>
<td>-</td>
</tr>
<tr>
<td>District Nursing</td>
<td>11.20</td>
<td>-</td>
<td>0.80</td>
</tr>
<tr>
<td>Psychology</td>
<td>-</td>
<td>-</td>
<td>5.00</td>
</tr>
<tr>
<td>GMS Commissioning Plan</td>
<td>9.40</td>
<td>9.40</td>
<td>9.20</td>
</tr>
<tr>
<td>Community Pharmacy Commissioning Plan</td>
<td>0.50</td>
<td>0.50</td>
<td>-</td>
</tr>
<tr>
<td>Dental Services Commissioning Plan</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>174.04</td>
<td>115.28</td>
<td>31.43</td>
</tr>
</tbody>
</table>

Within our 3 year planning period, we can only progress a proportion of these plans, and this will require Board prioritisation. As fundamental principles, however, our key priorities will fund improvements in ‘flow’ and stabilisation of core GMS. This investment would be expected to be evidenced by:

• Reduction in re-admission into hospital
• Demonstrable evidence of patient’s own management of their chronic conditions
• Demonstrable improvement in GP access
• Phased reduction in surge beds
• Reduction in Delayed Transfers of Care
• Reduction in Continuing Health Care placements
• Increased caseloads for Community Resource Teams and CRT admissions
• Staff reporting improvement in satisfaction from improved, integrated working
• Patient feedback, by annual survey, on increased patient satisfaction

What this means in terms of a shift in Activity to Community from Acute - Creating Capacity in the Service

The following table identifies the potential movement of resources from acute services to community. The method used is based on projected figures for medically fit patients within our four Acute Hospitals. The figures are scoped during the winter four month and summer 8 month periods.

The comparison is made between the winter and summer periods within the current service model and the subsequent periods following the introduction of enhanced primary and community care services.

This comparison provides a formula which identifies the potential release of capacity and revenue.

<table>
<thead>
<tr>
<th>Acute Hospital</th>
<th>Current Services</th>
<th>Future Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Winter</td>
<td>Summer</td>
</tr>
<tr>
<td>Prince Philip</td>
<td>25</td>
<td>18</td>
</tr>
<tr>
<td>Glangwili</td>
<td>45</td>
<td>25</td>
</tr>
<tr>
<td>Withybush</td>
<td>40</td>
<td>18</td>
</tr>
<tr>
<td>Bronglais</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Total medically fit patients per day</td>
<td>131</td>
<td>70</td>
</tr>
<tr>
<td>Potential release of capacity - Equivalent Wards</td>
<td>5.5 x 4 months</td>
<td>3 x 8 months</td>
</tr>
<tr>
<td>Cost</td>
<td>£2.2 m</td>
<td>£2.4m</td>
</tr>
<tr>
<td>Potential Saving</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The impact of the enhanced Community Resource Team has also been scoped in terms of our future anticipated community hospital bed provision and the following reduced provision will be achievable, in a phased manner as the community services come on line:

<table>
<thead>
<tr>
<th>Location</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Llandovery</td>
<td>3 beds</td>
</tr>
<tr>
<td>Amman Valley</td>
<td>8 bed</td>
</tr>
<tr>
<td>South Pembs</td>
<td>20 beds - phased</td>
</tr>
<tr>
<td>Tregaron</td>
<td>13 beds – phased</td>
</tr>
<tr>
<td>Cardigan</td>
<td>12 beds (staffing already factored into new County model)</td>
</tr>
</tbody>
</table>
4.6 A special focus on Mental Health & Learning Disability Services

Whilst Mental Health & Learning Disability services are not organised by Locality, nonetheless the same principles of integrating workforce, estates and pathway opportunity also applies.

The National strategic direction is to move services to more community focused delivery wherever it is appropriate and safe to do so, and recent Welsh Government policy clearly indicates the changes needed in the way we deliver Community based care in Wales. The focus on delivering community based models within Mental Health and Learning Disability services has been the strategic direction for many years following the closure of the historical large institutions. The range of community mental health and learning disability services have extended significantly in recent years and the core values and drivers remain focused on delivering services within and alongside local community infrastructures.

The ‘Together for Mental Health Strategy and Delivery Plan’ in conjunction with the local Mental Health and Wellbeing Strategy 2012 - 2017 have given a clear focus for the Hywel Dda community to work in partnership to improve the health and wellbeing gains for people who are, or have potential to experience mental health problems. The overarching imperative and emphasis of the Strategy is the promotion of mental wellbeing, mental prevention, appropriate and easy access, early interventions and timely treatment. Effective and evidence based treatments and interventions will be accessed and delivered at the most appropriate stage and cohesively across services.

The Local Partnership Board through its focus on strategic collaboration, planning and assurance of delivery is increasing its ownership of mental health and wellbeing across the Hywel Dda geography and aspires to work across its boundaries to make more open and transparent its services and improve access. It has set about doing this by ensuring appropriate engagement with its stakeholders; people with lived experience, service users, families and carers, staff and the wider public, together with public and third sector organisations and the Community Health Council. In so doing, it will encourage a pan organisational approach whilst ensuring the communities and individual voice is represented in the planning and delivery of safe and high quality services.

The Hywel Dda Mental Health & Learning Disability service recognises that the treatment of mental illness is an essential service however it can often be reactive. By taking a proactive and holistic approach, promoting mental health and providing early interventions before mental illness is manifested, it may be possible to reduce the impact of mental illness. It is therefore the aim that the service works actively with counties and localities to minimise, as far as reasonably possible, the development of mental health problems and work together with individuals, communities and partner organisations. Our Mental Health & Learning Disability services are focused on a progression model aimed at improving community resilience and enablement through choice, self direction and control over our own lives, with an opportunity to move away from traditional services such as hospital and residential care.

The Mental Health (Wales) Measure 2010 has provided a great opportunity for services to be delivered differently, and enabled a more flexible and targeted use of
resources ensuring that people receive the most appropriate support at the right time by the most appropriate service.

Within Hywel Dda a major programme of service redesign over many years has enabled the delivery of enhanced community mental health provision, with a resulting reduced reliance on in-patient services. The Recovery Model defines the philosophy of our service. This means that the individual is supported to ‘recover’ their life so that it feels worthwhile; so that they are working towards aspirations and goals that give value and meaning to their lives. Although they may not ‘recover’ fully from their illness, they find themselves living in and contributing to the community. Our service model is underpinned by evidence based psychological interventions, delivered in a timely fashion by appropriately trained, competent practitioners.

Our detailed objectives for each year of the plan reflect an investment in developing our services to focus on prevention, early diagnosis and intervention alongside the consolidation and realignment of our existing portfolio of specialist services. The detailed plans in Annex 7 define the delivery timescales for the service plans and associated efficiencies. There will be an increased focus on service improvement, outcome focused delivery and enhanced training and support to deliver evidence based treatments. Indeed, the delivery of our service model is reliant on engagement with the wider system that supports people with a mental health problem or learning disability and therefore our services are fully dependent on a partnership approach to delivery.

The Together for Mental Health National Strategy has enhanced the opportunities to deliver mental health and learning disability services together in partnership, an example of which being the development of the Mental Health Street Triage service delivered collaboratively with Dyfed Powys Police following a successful bid for funding from the Police Innovation Fund. This experience of a positive approach to service design and delivery has led the Directorate to consider all of our future plans in terms of partnership and joint commissioning.

4.7 Where we are in terms of Mental Health & Learning Disabilities Workforce & Estate

The revised Mental Health & Learning Disability Directorate structure was formed in January 2014, following the integration of the previous county and centrally delivered services into a Health Board wide managed service. The realignment of Mental Health, Learning Disabilities, Substance, Psychological Services, Specialist Child & Adolescent service and Commissioning has provided significant opportunity to implement innovative “whole system” changes to ensure consistency and delivery via agreed pathways. The revised structure has also provided many opportunities for effective and efficient use of our workforce by considering models that make best use of current workforce distribution and the implementation of clear and measurable outcomes against defined performance indicators.

In 2014/15 the Directorate achieved the implementation of revised Management, Psychology and Medical structures and roles to mirror the modern vision for the service moving forward. This focused on the transition from traditional professional and management roles to those defined in terms of new service models and a service improvement focus. Medical Job Planning and Personal Development Reviews reflect the new structure and focus and detail the commitment to transform
the way in which we provide services to our population.

In terms of adult acute inpatient Services, these have undergone significant redesign and restructuring over the past 3 years with the decommissioning of Teilo Continuing Care Unit and the commissioning of both Rehabilitation & Recovery and Psychiatric Intensive Care Units to facilitate an extensive repatriation programme for patients previously placed outside of the Health Board area.

The Rehabilitation & Recovery Unit has been further redesigned in 2014/15 to provide core Low Secure provision. This has enabled a wider group of patients to be repatriated back to their local areas. However, there remains a challenge in terms of the repatriation to designated female facilities, which due to a critical mass is not viable for the Heath Board to provide as core service delivery. Therefore a partnership approach is being utilised to design and commission bespoke repatriation programmes to supported living or residential care locally with a Third Sector, Health and Social Care delivered domiciliary care package to meet individual needs.

Acute and In-Patient Mental Health services are currently delivered across 2 counties, and 3 sites. The flexible management of the staffing resource to meet the demands of these busy acute admission wards is challenging given the geographical spread. Significant expenditure on bank and agency Nursing and Medical staff has become the norm in key areas caused in the main by long-standing recruitment difficulties to the outlying units. Relatively isolated units managing patients with the greatest acuity and a lack of access to a critical mass of staff during periods of increased acuity or when managing individuals with challenging presentations, are often not attractive environments for staff to want to work. The reality is that with the development of enhanced community services in some areas and alternative career pathways on offer staff choose to work in the community.

An opportunity has arisen with the existing acute and in-patient mental health service in Pembrokeshire to consider the introduction of a more innovative model of enhanced community based services to take the place of the existing traditional in-patient provision.

This would facilitate a complete restructuring of Adult Acute In-Patient services to deliver specialist assessment and treatment beds centrally from Carmarthenshire, with the development of enhanced community provision, including robust unscheduled care and liaison psychiatry, to ensure that where possible patients are managed within their local communities.

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

CAMHS provides both mental health services for children, adolescents and their families which are community-based consisting of multi disciplinary teams and the provision of specialist services which are coordinated and provided from a central base. We work in locality-based teams, which cover all areas of the Hywel Dda and service delivery is centrally coordinated from a central resource in Carmarthen (Ty Llewellyn). The clinical governance within the Health Board is assured through the Service and Directorate dashboard. On a National level the strategic direction is via the CAMHS Delivery Assurance Board whose function is to ensure delivery of the high level standards within Together for Mental Health.
Service for children and young people with emotional and mental health problems cannot be the responsibility of one agency alone and therefore Specialist CAMHS within Hywel Dda has developed strong network relationships with local statutory agencies and the Third sector to ensure collaborative multiagency service delivery. Working across key agencies such as Social Services, Education, Youth Offending and Prevention Services and Third sector partners ensures the provision of a seamless service for our most vulnerable population.

The demand for our services shows that in 2013/14 there were 5129 requests for advice and consultation; and 1128 referrals to secondary mental health services. To support this, our service aims are specifically to:

- Provide specialist services to children and young people presenting with mental health needs which include those with a learning disability
- Promote improved mental health and emotional well being of children and young people.
- Ensure the service provision is in line with local and national strategy and best practice.
- Enable families, carers and other professionals to positively support children and young people, by providing them with appropriate strategies and skills to improve mental health.
- Provide timely assessment and intervention appropriate to the needs of each individual child and their family.
- Provide training and consultation for tier 1 professionals to maximise their ability to promote mental health within primary care setting.
- Work collaboratively across the range of agencies and professionals to promote emotional and mental health in the least restrictive environment.

Recent advances that we will be taking forward to support our service delivery include:

- The development of a Community Crisis Assessment and Treatment Team which will ensure that children and young people will receive mental health services in a crisis and which will also reduce/prevent children being admitted into hospital in the local CAMHS Unit in Bridgend.
- The provision of dedicated age appropriate beds to ensure the needs of young people in a psychiatric emergency can be met
- The funding of a CAMHS/Adult Link Practitioner post aimed at improving the interface between services and to improve the transition for young people.

**Estates**

**Primary Care – GP Premises (Accurate at Date of Survey)**

We have reviewed our GMS primary care estate using the following criteria

- Space available per patient and Confidential space to communicate with reception staff
- Type of accommodation – new or older purpose built, or conversion
- Adequate fire precautions including provision for safe exit, and Compliance with DDA requirements
From the above, those practices which operated under significant constraints were classed as Priority 1 moderate constraints were placed in Priority 2, with the remainder in Priority 3 as follows:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Priority 3</th>
<th>Priority 2</th>
<th>Priority 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amman</td>
<td>Pontyberem</td>
<td>Margaret St</td>
<td>Amman Valley</td>
</tr>
<tr>
<td>Gwendraeth</td>
<td>Pontyates</td>
<td>Kidwelly</td>
<td>Brynteg</td>
</tr>
<tr>
<td>3Ts</td>
<td>Teilo</td>
<td>Llandovery</td>
<td>Morfa Lane</td>
</tr>
<tr>
<td></td>
<td>Furnace House</td>
<td>Nantgaredig</td>
<td>St Peters</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>St Clears</td>
</tr>
<tr>
<td>Llanelli</td>
<td>Fairfield</td>
<td>Tywynbach</td>
<td>Avenue Villa</td>
</tr>
<tr>
<td></td>
<td>Ashgrove</td>
<td>Harbour View</td>
<td>Ty Elli</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Andrew St</td>
</tr>
<tr>
<td></td>
<td>Llwynhendy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>Argyle</td>
<td>Narberth</td>
<td>Tenby</td>
</tr>
<tr>
<td>Pembrokeshire</td>
<td>Rhiannon</td>
<td>Saundersfoot</td>
<td>Neyland &amp;J'ston</td>
</tr>
<tr>
<td>North</td>
<td>Barlow House</td>
<td>Winch Lane</td>
<td>Robert Street</td>
</tr>
<tr>
<td>Pembrokeshire</td>
<td></td>
<td></td>
<td>St Thomas</td>
</tr>
<tr>
<td></td>
<td>Solva</td>
<td>Newport</td>
<td>St Davids</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fishguard</td>
</tr>
<tr>
<td>South</td>
<td>New Quay</td>
<td>Bro Pedr</td>
<td>Feidrfair</td>
</tr>
<tr>
<td>Ceredigion</td>
<td>Emllyn</td>
<td>Ashleigh</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Llwyfran</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>Borth</td>
<td>Ystwyth</td>
<td>Church</td>
</tr>
<tr>
<td>Ceredigion</td>
<td>Padarn</td>
<td>Llanhilar</td>
<td>Tregaron</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tanyfron</td>
</tr>
</tbody>
</table>

We have some work currently in progress mapping our community and partner agency premises to see whether there could be some innovative locality solutions which could be applied to Priority 1.

Premises colour coded in green are already being addressed within our capital development plans, and include significant schemes integrating primary and community care, as well with our social care and housing partners, namely the Cardigan Integrated Care Project and Cylch Caron.

Those in amber have to be resolved within this 3 Year IMTP.

**Community Premises**

In addition to our community hospitals, we have 26+ other premises across all 7 localities. We have reviewed their current state and prioritised them using the same concept as with GP premise, but using Estates Department backlog maintenance as the key decision criteria.

Our proposed service and estate intentions are as follows:
- Premises in Green are well-advanced in terms of Business Cases and are lodged in capital programme already
- Premises in Amber represent where there is robust discussion with stakeholders has been significant and / or the service requirements are now significant. Therefore these need to be prioritised and finalised within our capital IMTP planning assumptions
- Premises in red are being seriously scoped for re-designation of their use / requirement as part of our service strategy.

With on-going austerity, we cannot afford to maintain poor estates infrastructure – much of which is denoted by Priority 1 / significant backlog maintenance costs. We are also retaining all 4 main hospitals which cost significant amounts to both run and maintain. Our aim is to grow community services with more community staff providing Care Closer to Home, in people’s homes. To this end, our estate solutions are proposed as follows:

<table>
<thead>
<tr>
<th>Carmarthenshire Locality</th>
<th>Community Site</th>
<th>Total Backlog £</th>
<th>Service action prioritised in IMTP &amp; Link to Capital Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amman Gwendraeth</td>
<td>Amman Valley Hospital</td>
<td>£680,943</td>
<td>With strengthened re-provision of community services, implement reduction in bed capacity</td>
</tr>
<tr>
<td></td>
<td>Swn y Gwynt</td>
<td>£46,593</td>
<td>Re-locate to Amman Valley</td>
</tr>
<tr>
<td></td>
<td>Crosshands Health Centre</td>
<td>£263,565</td>
<td>Disposal &amp; New Build proposed</td>
</tr>
<tr>
<td></td>
<td>Llanelli</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elizabeth Williams Clinic</td>
<td>£64,778</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brynmair Clinic</td>
<td>£53,235</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bryntirion CPU</td>
<td>£332,711</td>
<td>Linked to Outsourcing Food Production</td>
</tr>
<tr>
<td></td>
<td>3T’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Llandovery Cottage Hospital</td>
<td>£403,131</td>
<td>With strengthened re-provision of community services, implement reduction in bed capacity</td>
</tr>
<tr>
<td></td>
<td>Bro Myrddyn</td>
<td>£13,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wellfield Road</td>
<td>£48,369</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Penlan</td>
<td>£1,040</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pond Street Clinic</td>
<td>£339,186</td>
<td>Disposal &amp; Re-location to existing estate</td>
</tr>
<tr>
<td></td>
<td>Hafan Derwen</td>
<td>£445,906</td>
<td>Review required</td>
</tr>
<tr>
<td>Ceredigion Locality</td>
<td>Community Site</td>
<td>Total Backlog £</td>
<td>Service action prioritised in IMTP &amp; Link to Capital Programme</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>North Ceredigion</td>
<td>Aberaeron Hospital</td>
<td>£1,972,750</td>
<td>Disposal &amp; Lease option for community services</td>
</tr>
<tr>
<td></td>
<td>Tregaron Hospital</td>
<td>£3,392,415</td>
<td>Disposal &amp; New Build: Cylch Caron Development</td>
</tr>
<tr>
<td></td>
<td>Gorwelion</td>
<td>£159,978</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ty Helyg</td>
<td>£37,446.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>North Road Clinic</td>
<td>£504,065</td>
<td>Disposal &amp; relocate to existing estate.</td>
</tr>
<tr>
<td></td>
<td>Y Wern</td>
<td>£60,308</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dan y Coed x3</td>
<td>£58,770</td>
<td></td>
</tr>
<tr>
<td>South Ceredigion</td>
<td>Cardigan Hospital</td>
<td>£2,252,925</td>
<td>Disposal &amp; New Build: Cardigan Integrated Care Development</td>
</tr>
<tr>
<td></td>
<td>Cardigan Health Centre</td>
<td>£400,000</td>
<td>Disposal &amp; New Build: Cardigan Integrated Care Development</td>
</tr>
<tr>
<td></td>
<td>Llys Steffan</td>
<td>£93,969</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hafan Hedd</td>
<td>£47,973</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pembrokeshire Locality</th>
<th>Community Site</th>
<th>Total Backlog £</th>
<th>Service action prioritised in IMTP &amp; Link to Capital Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Pembrokeshire</td>
<td>Fishguard Health Centre</td>
<td>£102,908</td>
<td></td>
</tr>
<tr>
<td>South Pembrokeshire</td>
<td>South Pembs Hospital</td>
<td>£616,055</td>
<td>With strengthened re-provision of community services, implement reduction in bed capacity</td>
</tr>
<tr>
<td></td>
<td>Tenby Hospital</td>
<td>£14,300</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bro Cerwyn</td>
<td>£147,155</td>
<td>With strengthened re-provision of community services, implement reduction in bed capacity</td>
</tr>
<tr>
<td></td>
<td>Pembroke Dock Health Centre</td>
<td>£44,223</td>
<td>Disposal &amp; re-locate to South Pembs Hospital</td>
</tr>
<tr>
<td></td>
<td>Neyland Health Centre</td>
<td>£31,551</td>
<td></td>
</tr>
</tbody>
</table>

| Total Backlog (across all localities/counties) | £12,629,656 |

As can be seen, we have undertaken a detailed desk-top estate review exercise on property disposal and service re-location. Detailed estate plans are now being prepared, which will need to be further informed as service plans evolve during 2015/16. From this, we will have clarity on the phasing of staff re-location, property disposal, and the consequent backlog maintenance and annual running cost.
Key messages:

- We need to ensure that all of our 4 main hospitals are fully used. This includes maximizing our bed efficiency and taking the opportunity to re-use space more appropriately. If we are more efficient, we can reduce our inpatient space by up to 4-5 wards. This provides us with huge opportunities to develop new services, such as our Centres of Excellence, which helps improve patient flow and waiting times;

- Where appropriate, we would like to re-focus the use of community hospital space into more Integrated Community Resource Centres and re-locate the services / staff currently working from small, uneconomical and poorly maintained properties into these ‘new’ Community Resource Centres, working as part of the strengthened Community Resource Teams.

4.8 Information Management (Performance) & Technology Enablement

Information Management (Performance) and the production of Dashboards

As already stated, Care Closer to Home will need to capture performance management information on how it will result in the following benefits in terms of improvement in patient ‘flow’ and improvement in patient outcomes:

- Reduction in re-admission into hospital
- Demonstrable evidence of patient’s own management of their chronic conditions
- Demonstrable improvement in GP access
- Reduction in Delayed Transfers of Care
- Reduction in Continuing Health Care placements
- Increased caseloads for Community Resource Teams and CRT admissions
- Staff reporting improvement in satisfaction from improved, integrated working
- Patient feedback, by annual survey, on increased patient satisfaction

We need to bring together, in a more meaningful ‘whole system’ way, the current performance metrics / dashboards being used within our Counties. The Health Board is in the process of developing a consistent performance dashboard, which seeks to meet five standards. These ensure that we keep measuring only those processes which really help us deliver meaningful outcomes for patients, and that robust performance indicators are developed which:

- Reinforce the purpose of community and primary care services & what matters
- Shows variation over time
- Can be used to understand and improve the system
- Can be used by the front-line to control and improve the work
• Can be used by managers to act on the system

Measures are considered as critical in order to understand demand, capacity (leading measures) and capability (lagging measures). These are the measures we are using within the CRTs within the existing service in Carmarthenshire, in order to understand whether purpose is being achieved, and is summarised as follows:

<table>
<thead>
<tr>
<th>Community Resource Teams - Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measures of Demand</strong></td>
</tr>
<tr>
<td>• Number of Calls to Careline+</td>
</tr>
<tr>
<td>• Number of Enquiries (new clients)</td>
</tr>
<tr>
<td>• Failure Demand – repeat referrals</td>
</tr>
<tr>
<td>• Domiciliary Care:</td>
</tr>
<tr>
<td>• New Care Packages</td>
</tr>
<tr>
<td>• Care Packages Ended</td>
</tr>
<tr>
<td><strong>Measures of Capability</strong></td>
</tr>
<tr>
<td>• Time from enquiry to first visit</td>
</tr>
<tr>
<td>• Service Users</td>
</tr>
<tr>
<td>• Staff Skills V Service Requirements</td>
</tr>
<tr>
<td>• Quality Assurance Survey</td>
</tr>
<tr>
<td>• % of Service Users who Die at Location Requested</td>
</tr>
<tr>
<td>• Multidisciplinary Working</td>
</tr>
<tr>
<td>• Service Improvement</td>
</tr>
<tr>
<td>• Appreciative Inquiry</td>
</tr>
<tr>
<td>• Outcomes of Reablement</td>
</tr>
<tr>
<td>• Domiciliary Care Procurement</td>
</tr>
<tr>
<td>• Equipment Delivery</td>
</tr>
<tr>
<td><strong>Measures of Capacity</strong></td>
</tr>
<tr>
<td>• Staff Caseloads</td>
</tr>
<tr>
<td>(range/median/mode/mean)</td>
</tr>
<tr>
<td>• Service Users</td>
</tr>
<tr>
<td>• Length of Stay at Residential Care placements</td>
</tr>
<tr>
<td><strong>Measures of Staff</strong></td>
</tr>
<tr>
<td>• Staff Skills V Service Requirements</td>
</tr>
<tr>
<td>• Staff Morale</td>
</tr>
<tr>
<td>• Appreciative Inquiries</td>
</tr>
<tr>
<td>• Continuous Improvement</td>
</tr>
<tr>
<td><strong>Measures of Customer Satisfaction</strong></td>
</tr>
<tr>
<td>• Quality Assurance Survey</td>
</tr>
<tr>
<td>• Appreciative Inquiries</td>
</tr>
<tr>
<td>• Complaints</td>
</tr>
<tr>
<td><strong>Financial Measures</strong></td>
</tr>
<tr>
<td>• Activity:</td>
</tr>
<tr>
<td>• Residential Care</td>
</tr>
<tr>
<td>• Domiciliary Care</td>
</tr>
<tr>
<td>• Day Care</td>
</tr>
<tr>
<td>• Hot Meals</td>
</tr>
<tr>
<td>• Budget Monitoring</td>
</tr>
<tr>
<td>• Use of Direct Payments</td>
</tr>
</tbody>
</table>

(please refer to Annex 9 for further detail)

**IM&T Infrastructure - The Way Forward**

Effective Information Technology ‘infrastructure’ is essential in delivering Care Closer to Home, and we know we need to develop:

• A good Community Information System - this is being secured nationally
• Mobile devices so that clinical records can be accessed by our community staff whilst ‘on the move’ and community staff will not need to return to base to obtain patient information
• Improved interface between acute and primary care – specifically securing significantly improved the electronic discharge notification
• Improved access to Social Services systems by health – especially in A&E and Unscheduled Care, and within the community integrated care assessment
• Exploring whether we can get all IT systems to ‘talk to each other’.

Our IM&T Strategy (Annex 8) has to fundamentally address the above and align with the service direction being progressed within Care Closer to Home.
Informatics can be a significant enabler and driver of improved information flows so that as a Health Board we can effectively measure what we do now and most importantly, how to improve it; particularly in relation to patient safety, outcomes and patient experience. Our overarching informatics vision is to “Enable every member of staff an additional 15 minutes per week to support patient care locally through the efficient use of information, health records and its supporting technologies”. Our strategy’s main ambitions are clearly articulated as follows:

- Paper light organisation – providing administrative and clinical time savings and reduced clinical risk.
- Information used to drive integrated care across the entire health and social care sector, both within and between organisations;
- Information regarded as a health and care service in its own right for us all – with appropriate support in using information available for those who need it, so that information benefits everyone and helps reduce inequalities;
- A change in culture and mindset, in which our health and care professionals, organisations and systems recognise that information in our own care records is fundamentally about us – so that it becomes normal for us to access our own records easily;
- Information recorded once, at our first contact with professional staff, and shared securely between those providing our care – supported by consistent use of information standards that enable data to flow (interoperability) between systems whilst keeping our confidential information safe and secure
- Real time bed state – enabling improved access and predictability.
- Referral letters, discharge summaries, clinical correspondence and diagnostic results (including images) available whenever and wherever they are needed – efficiency, timely service delivery, quality of care, patient satisfaction.
- Diagnostic and service requests made electronically – quality of care, reduced clinical risk.
- Clinical decision support, electronic prescribing – quality of care, reduced clinical risk.
- Improved handover arrangements for clinical staff – patient safety, quality of care.
- Improved nursing and midwifery systems – observations, documentation and point of care testing (POCT)
- Improved access to care through protocol based referrals – quality of care, reduced patient risk, efficiency
- Improved data analysis
- Improved information to support clinicians and management – service level reporting.
- Improved infrastructure in the rural area making use of the Public Sector Broadband Aggregation service to enable more robust access to technology. Developing the use of Telehealth / Telecare services in the patient home to support Chronic Disease Management through automated monitoring and notification, aimed at reducing direct clinician contact.
- The extended use of video conferencing and tele-medicine to support remote clinical contacts reducing the need for patients and clinicians to travel long distances and enable access to specialist services. This will also support better communication between care providers and improve access to specialist
advice.

In order to deliver this vision we know we need to work closely with the NHS Wales Informatics Programme (NWIS) and its overarching delivery plan.

Specifically one of our key focuses going forward would be to consider the IM&T needs for our nursing workforce. Specifically, we need this to help with the significant nursing observation and nursing documentation requirements, moving away from paper based systems where appropriate and safe to do so. The link to quality and safety benefits from this piece of work is deemed to be immense.

**Tele-health**

Chronic disease is the major cause of disability and accounts for most of our health and social care utilisation. People with chronic conditions need to be supported and enabled to manage their health and wellbeing over a long period of time. Research suggests that telehealth can have a positive effect on patients with chronic disease, such as improved patient experiences, clinical indicators, quality of life, ability to self manage, and reduced use of secondary healthcare.

Hywel Dda is leading the way in Wales using telehealth technology to support the implementation of its clinical strategy. Telehealth supports the following:

- Easier and more timely access by healthcare professionals to relevant information about the patient
- Effective involvement of the patient in the management of his/her disease through education and access to clinical data
- Better interaction between patients and healthcare professionals
- Maximises efficient working practices, minimises wasteful variation, brings about measurable savings and ensure value for money
- Supports people to communicate within the rural settings of Hywel Dda, manage their own health and wellbeing, and to become more active participants in the care and services they receive
- Contribute to care integration and to support people with long term conditions
- Improve the availability of appropriate information for healthcare workers and the tools to use and communicate that information effectively to improve quality
- Provides information and technology in a co-ordinated way to provide clinical and other local managers across the health and social care spectrum with the timely management information they need to inform their decisions on service quality, performance and delivery

Hywel Dda is currently working in partnership with a European funded telehealth project to support the implementation of a telehealth service at scale United4Health (U4H) will validate and strengthen the evidence for chronic disease management by telehealth solutions, especially on effectiveness, cost-efficiency, and transferability of the implementation of the services.

For many years, telehealth solutions have been trialled, seeking evidence that their use can release a number of benefits in terms of both quality and cost of care, and experience shows that if provided appropriately, telehealth can deliver major
advantages The long term impact of the United4Health project is the integration into healthcare systems of a new care model for chronically ill patients in order to improve quality of life, accessibility of care, and efficient use of resources. These improvements are expected to come from a combination of factors:

The core assumption behind the United4Health project is that to make the most of telemedicine solutions, it is essential to adopt innovative health and care service models. These are to increase the personal control and engagement of patients and provide greater independence, so that health and care services can be delivered where patients want them in a cost-efficient and care effective manner.

The project’s driving philosophy is that telemedicine solutions provide value for citizens, providers, and payers by improving access to services (locally or in the home), reducing costs (reduced home visits, fewer emergency admissions to hospital), and increasing quality.

U4H will deliver the next generation of telehealth services supporting the key objectives of the Health Board’s clinical services strategy and the telehealth technologies deployed in Hywel Dda will offer personalised solutions designed to promote treatment compliance, early intervention in response to signs of deterioration and that can be reviewed and adjusted to reflect each person’s ongoing health status and self care and self management capabilities.

4.9 Transport

The Health Board has developed a Non-Emergency Transport Strategy (NEPT) based on the findings of the Griffiths review which was clear in its recommendation for stronger management of non-emergency patient transport budgets and performance.

The Health Board is aware that inefficient patient flow and legacy processes can be problematic for patients and raise healthcare costs. The NEPT strategy has aimed to make the best use of resources including; skilled staff time, the asset maximising opportunities available for cross-sectoral collaboration and opportunities for task focused work with government.

Key stakeholders and working partners have included the Third Sector, Social Care Departments, the Welsh Ambulance NHS Services Trust (WAST), Patient and Family Carers, the Community Health Council and Welsh Government.

The agreed strategic priorities for the Health Board, which have already been agreed and are implemented includes developing the following:

- Single patient booking pathway
- Increase Voluntary Sector involvement in NEPT
- Review the Operational Service Level Agreement with WAST
- Evaluation of Project Support Manager (NEPT)
- Procurement of new services
- Transport Accessibility Group
- Healthcare Planning – understanding impact and refreshing travel plans
- Public and Community Transport Services – supporting public, private and
community transport solutions and considering revenue support for patients
• NEPT – assessing the case for extending the scope of shared vehicle resource between Health Board and local authorities, building on learning from NEPT pilots and working with key partners and stakeholders in the Transport and Health sectors to define the scope for development of a Hywel Dda Central Transport Unit
• ICT Infrastructure developments – maximising access to healthcare in rural areas through appropriate technology

The table below shows progress against each of these priorities:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single patient booking pathway</td>
<td>• Partnership working with Powys Teaching Health Board for Ceredigion patients&lt;br&gt;• Eligibility criteria applied to all outpatient transport bookings&lt;br&gt;• Nursing staff time saved in them not having to arrange transport&lt;br&gt;• Similar arrangements being considered for Pembrokeshire and Carmarthenshire patients&lt;br&gt;• Formal review of service due in December 2014 to ensure links are also made with Powys and South Gwynedd patients.</td>
</tr>
<tr>
<td>Increase Voluntary Sector involvement in NEPT</td>
<td>• Almost 28% of journeys now undertaken by alternative providers including Dedicated Discharge Vehicles at District General Hospital Sites&lt;br&gt;• Specific provision of patient transport for Nurse-led clinics in rural areas, motor neurone disease, palliative care, dialysis units and mental health through alternative providers&lt;br&gt;• Agreement and extension of Twilight Service serving patients at Glangwili and Prince Philip Hospitals&lt;br&gt;• New providers identified including Royal Voluntary Service, Red Cross, St John Ambulance and Community Transport Associations</td>
</tr>
<tr>
<td>Review the Operational Service Level Agreement with WAST</td>
<td>• Work-streams established to review objectives of a long term agreement which now covers 50,000 journeys per annum&lt;br&gt;• WAST liaison officers to access patient administration system to cross check outpatient appointments and transport bookings to reduce cancelled journeys.&lt;br&gt;• Established SLA performance management meetings based on agreed key performance indicators&lt;br&gt;• Review future of Ambulance Car Service and revisit arrival times of 10am and 2pm to meet clinic times.&lt;br&gt;• Introduce new eligibility checklist to support in particular cancer patients attending for Radiotherapy accounting for 1,000 journeys per month.&lt;br&gt;• Text and Voicemail reminders to reassure patients and reduce cancelled and aborted journeys.</td>
</tr>
<tr>
<td>Evaluation of Project Support Manager (NEPT)</td>
<td>• Single point of contact established for all extra contractual referrals&lt;br&gt;• Average of 100 journeys arranged each month for those outside the current WAST contract i.e. journeys to specialist hospitals, QE Birmingham, Royal Brompton.&lt;br&gt;• Saving in nursing time by arranging all additional transport including repatriation of patients&lt;br&gt;• Responsive service to support mental health patients and families to inpatient and outpatient services.&lt;br&gt;• Specialist provision for children, bariatric, oncology, cardiac and nursing home patients.</td>
</tr>
<tr>
<td>Procurement of new services</td>
<td>• Dedicated Discharge Vehicles contracted in order to meet on the day discharges i.e. St John at Bronglais&lt;br&gt;• Shared resources established to cover weekends and bank holidays</td>
</tr>
</tbody>
</table>
between hospitals to support patient flow
- Contractual arrangements in place to support local dialysis units i.e. RVS at Bronglais
- New taxi contract awarded together with new protocol to ensure appropriate usage together with new providers i.e. Blood Bikes, Just Wales.
- Free phone link in Emergency Departments to support staff and ensure adherence to protocol out of hours from January 2015.

| Transport Accessibility Group | • Improved information with only 5% patients attending hospital utilise NHS funded transport.
• Many patients travel substantial distances for health care through family networks etc.
• Greater engagement with Bus providers across the region to meet the needs of rural communities – two new routes established.
• Health changes and improvement will now be taken forward at the same time as transport considerations i.e. Front of House project at Prince Philip.
• Opportunity to begin looking at the zoning of appointments and availability of transport i.e. Cardigan, Tregaron & Teifi Valley. |

Such a spread of key themes has engendered operational improvements and efficiencies, developed the capacity of Hywel Dda staff and partners to deal with continuous change and begun to shine light on future paths of work.

This multi outcome approach: addressing the issues and simultaneously building capacity to promote continuous change is at the heart of Hywel Dda’s Strategic Partnerships strategy for the future. As such the next steps will include:

- Define how any new service model within Hywel Dda region can be made fully accessible through the mixed transport provision now available.
- Influence and determine the future work plan of the Transport Accessibility and Bus Policy Groups by highlighting rurality as a priority.
- Fully engage with the work of the NEPT Transformation Project Board and the work-streams established for Customers, Organisational Development and Finance.
- Contribute to the Health Board’s winter planning ensuring transport forms part of ongoing arrangements and contingency plans.
- Contribute to the consultation on the Healthcare Travel Costs Scheme

4.10 Carers

**Partnership approach to the Carers Measure** - In developing the *Hywel Dda Information and Consultation Strategy for Carers (2012- 2015)* both lead organisations were asked to support the Welsh Government’s vision for Carers and commit to:

- Facilitating the early identification of Carers and Young Carers, and ensuring improved access for Carers to the information and services that they need to help them to care, and to protect their own mental and physical health.
- Ensuring that Carers receive earlier and more planned support, both through local partnerships, and through joint commissioning involving the NHS, local authorities, the Third Sector, independent and private sector.
• Creating cultural change so that Carers are empowered in the decision making processes around care management and at the strategic level in service planning and delivery.

• Ensuring that Carers issues were mainstreamed into the everyday working practices of NHS and Local Authority (LA) staff, and that staff work with Carers in effective partnership to support the Carer, and maximise care for the cared-for.

The Welsh Government recognised that the unpaid care workforce is the single largest provider of care to people with support needs in our communities. However, they saw that there was a sizeable gap between policy and the delivery of support.

Support for Carers was seen as a key element of the Welsh Government’s health and social care agenda and the priorities of social inclusion, reducing health inequalities and building better communities. Priority areas were:

• Ensuring that Carers have access to information
• Earlier and planned support for Carers
• The creation of cultural change in the NHS
• That Carers issues be mainstreamed into working practices of the NHS
• Recognition of the key role of community health services as the first point of contact with statutory agencies

The subsequent Annual Report provided further context, including Hywel Dda’s Clinical Services Strategy ‘Your Health, Your Future’, Passing the Baton and ‘A Co-Designed Future and the Third Sector Role in Health and Social Care in Hywel Dda’. It also shows how the Welsh Government feedback was taken into consideration to develop and deliver and locally sensitive strategy.

The progress to date which has been reported through a robust Programme Board arrangement includes:

**Carer Engagement:** Carers’ issues and questions have featured regularly in General Practitioner Protected Time For Learning sessions, Citizen Panel surveys, Survey of local NHS Staff and in the Health Board’s “Talking Health Programme”.

**Training:** A Carers Training Group was established including key staff from lead organisations and they have been able to instigate and coordinate all training initiatives linked to the strategy.

**Looking After Me Courses:** The Carers Training Group has been working closely with the Health Boards Education Patient Programme (EPP) to promote the Looking After Me (LAM) and “Introduction of Self Management” (ISM) courses for Carers provided across the region.

**E Learning (Carer Aware):** This E-learning programme has been extended to all clinical and non-clinical staff, including Health Board and Scrutiny Committee members. Working across Health Board regions (Mid & West Wales), this approach has seen two Health Boards and four Local Authorities cooperate in taking forward a comprehensive E learning package for Health & Social Care staff enabling them to identify Carers.
The Carers Information Sub Group (ISG) has developed as a work stream that recognises the shift in resources since June. Elements included in this work stream include branding to establish a logotype and corporate imaging for Carers across the region. The rationale for this is that Carers need to be able to identify / recognise / associate with publications, information and events designed or developed specifically for their needs.

Audit of existing information – It is planned to carry out an extensive (and continuous) review of appropriate information across departments, clinics, wards, teams and other relevant areas to establish the current level of carer inclusion. Appropriate personnel from Hywel Dda – PPE, Local Authority Information Officers, third sector Brokers and Commissioned Carer Services will work with the ISG to develop and implement a systematic approach. The outcomes from audit will inform a best practice toolkit and communication / action plans.

Carers Information: A dedicated web page on the Hywel Dda website is under development. The carers section will provide information for carers and signpost to other agencies providing information and support. Other work has also been developed including Carers page in hospital bedside folders, “Say I’m fine and mean it” booklets, information packs and Carers Newsletters distributed across all health settings.

Investors in Carers Scheme: The Investors in Carers scheme is a framework of good practice, which all Hospital and community health settings can utilise to develop their Carer Awareness and ways of working to support Carers. This has a number of work-streams active including work specifically targeting General Practices, Community Pharmacies, Acute Hospitals and Secondary Schools.

Performance Management: A performance management framework has been agreed and entered on to the Local Authority Feynman System in line with the key aims of the Strategy and the Welsh Government Report Card. Ceredigion County Council has taken forward this work on behalf of the Partnership together with Chairing the Performance Management Group.

The initial data from this Group found in the Annual Report outlines the progress that is being made across all the key indicators on which the success of the Strategy will be measured.

To date we have seen an incremental increase in the number of carers identified from 4,882 in June 2013 to 8,131 in September 2014.

Young Carers: A Health Board Senior Officer has been appointed to take forward the Young Carers agenda in partnership with Education and other key stakeholders. Active work streams including:

- British Red Cross initiative to support the key Young Carer aims within the Information & Consultation Strategy for Carers in Ceredigion
- Young Carers Workstream now assumed by Carmarthenshire County Council
- Pembrokeshire Young Carers Project commissioned with Action for Children
• Production of the information booklet ‘Who Cares…do you?’
• Young Carers Charter agreed for each county drawn from Young Carers experiences
• Research projects to challenge the stigma experienced by Young Carers

In moving forward the key aims for 2015/16 follow on from those in 2014/15 and include but not limited to:

• Review Carers information, guidance and signposting for cultural sensitivity and language relevance.
• Review organisational structure in line with Strategy development and adopting a consistent approach to individual Carers and Carer Forums
• Ensure that existing services are in line with increased demand and strategic direction and new jointly commissioned services are in place to meet increased demand.
• Establish a sustainable annual plan for Outreach Services.
• Adopt a national approach on Carer feedback mechanisms through the All Wales Carers Advisory Group (AWCAG)
• Evaluate and evidence impact of planned increased engagement with Carers to gauge any improvement or otherwise in this process across and within groups and work streams across the 3 counties

Health & Social Care Support Worker Project

Health and social care organisations provide overlapping services. The integration agenda is particularly prominent given the dual pressures on services of increasing demand and diminishing resource. A top down approach to integration is important but ensuring this is delivered in practice presents challenges. This project seeks to train a cohort of social care support workers in basic healthcare so that they can provide an integrated and cohesive service. Across Hywel Dda, there are already a number of interface points between social care services, voluntary sector organisations and NHS.

The concept of a multi-skilled support worker, fulfilling a mixture of health and social care related tasks or functions are not new. The Carmarthenshire Carers Forum, representing unpaid carers, is concerned regarding current service delivery and the impact of cuts to both health and social care budgets. They are concerned that, without radical changes to health and social care delivery, support for patients and their carers may decline, while the reality is that it needs strengthening.

This project is linked to the report by the Older Peoples Commissioner for Wales ‘A Place to Call Home’ which focuses on the quality of life and care in care homes throughout Wales. Of relevance this review found the majority of residents in care homes had profound healthcare needs and access to preventative healthcare services was severely limited. It also showed a lack of shared intelligence and joint working between health and social care. This project hopes to demonstrate how these concerns can be addressed to improve health and wellbeing of older people in these environments.
Carmarthenshire Carers Forum Members and many health, social care and third sector personnel believe that a single worker trained in the delivery of both social care and healthcare support functions would impact substantially on service delivery and the development of integrated community services. It would be particularly important for the third sector to have a strategic input in the provision of low level care and wellbeing provision (isolation, loneliness, anxiety, ill health and financial issues).

4.11 Next Steps in delivery of Care Closer to Home

This chapter of the Integrated Medium Term Plan aims to create structured solutions in order to:

- Implement the Community Resource Team model within the context of multidisciplinary, multi professional and multi organisational arrangements.
- Provide a commissioning framework that responds to individual locality profile of need and risk stratification.
- Achieve integration of the locality Cluster plans, Community, Acute, Primary Care, and Mental Health plans, Local Service Board plans that will reflect the priorities and implement the aims and objectives identified.
- Shift the balance between community and acute service delivery, improving access to Community based 24/7 services to impact on patient flow and Tier 1 targets.
- Review service delivery and impact on performance, patient and carer experience, staff satisfaction and reduction in clinical incidents and complaints.
- Benchmarking of resources at locality level.
- Address the Workforce challenges arising from 30% of GPs and Practices Nurses that are due to retire over the next 4 years, in addition to a challenging retirement profile in community nursing. We intend to do this by considerably strengthening Community Resource Teams recognising the leadership role of the GP’s and GP clusters within locality care. Our Plan will need to demonstrate to Primary Care in particular our shift of capacity and resource into this sector, and evaluate these against the baseline assessment of their challenges at Locality level.
- Improve integrated working and address on-going financial pressures by optimising the use of our estate.
- Integration of Mental Health and Learning Disability Services within the CRT development and continued development of specialist Mental Health services as indicated in the plan.
- Ensure that Informatics and IT assist in the integration of services, improving transfer of care, care management and monitoring performance.
Chapter 5: Focusing on Quality, Safety and Improving Outcomes

Introduction

This chapter describes how we are addressing the quality and safety of our services. It looks at the systems we have in place to improve quality and the actions we are taking to deliver improvements in our services delivered through our unscheduled and planned care pathways and the actions we are taking in key specialties. Section 5b details progress and priorities associated with the Together for Health Delivery Plans. All the actions are addressing the key priorities of improving access - delivering tier 1 targets and improving waiting times, improving patient flow, and addressing service variation.

Section 5a – Quality, Safety and Improving Outcomes

5.1 Our Quality System

Quality of care is at the very heart of healthcare delivery. Our plan aspires to achieve the right balance between quality, performance and costs to ensure we are providing clinically safe, appropriate and sustainable services to our 3 counties and their 7 localities.

We are committed to learning from experiences of people using our services, particularly with respect to co-production, and from elsewhere to continually drive the quality of local care upwards, and to aid this process we have put in place our Quality Assurance Framework.

Consequently, our Quality Delivery Plan tries to ensure better alignment of clinical quality, operational performance and financial goals, whilst ensuring patient safety and quality are integral to all decision making, whether patients are receiving care at home, in primary and community settings, or in our hospitals.

As part of the latest Health Board Annual Quality Statement (for 2013/14), the Health Board shared with our population what we wanted to do to improve services moving forward to meet their needs. We identified a number of priorities, outlined in the table below, to improve the quality of patient care and outcomes.
<table>
<thead>
<tr>
<th><strong>We said</strong></th>
<th><strong>We did</strong></th>
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</table>
| **Improve patient experience** | - The butterfly scheme to identify and provide tailored care for dementia patients within hospital has been rolled out, we have trained more than 1,000 staff and we are now appointing Butterfly Champions on each ward  
- Volunteering for Health now has over 250 volunteers in 70 different roles across 59 different healthcare sites, these include patient be-frienders and meet and greeters at hospital. 100% of patients and staff said they had a positive impact on patient experience  
- 91% of patients surveyed said they were satisfied with the level of care provided (internal audit)  
- We’re helping nursing homes to also measure themselves against standards |
| **Increase patient and public engagement** | - We developed a database of patient stories and guidance on their use  
- We launched The Assuring a Positive Patient Experience Strategy to help ensure patients receive a positive experience of care and learn from situations where things have gone wrong: [http://www.wales.nhs.uk/sitesplus/862/opendoc/231291](http://www.wales.nhs.uk/sitesplus/862/opendoc/231291)  
- We now have almost 1,000 members in our membership scheme Siarad Iechyd / Talking Health, which provides opportunities for people to shape services and improve health  
- Patient representatives have been used to plan new services and buildings, from the Renal Unit at Withybush Hospital to new maternity services |
| **Reduce mortality** | - Approximately 97% of in-hospital deaths have been reviewed, with learning points identified and shared to make improvements  
- RRAILS now been implemented across all Community Hospitals and remaining Mental Health and Learning Disability areas. Initial compliance audits have shown an improvement in compliance with most areas achieving 95%. |
| **Reduce harm** | - There has been a year on year reduction on the number of C difficle in patients aged 66+ - 13.5% reduction in 2013/14 since previous year  
- Hand hygiene compliance is better than All Wales average - Varies between 86-91% better than All Wales  
- We’ve increased the number of risk assessments for clots – between 20 and 30 per cent in surgery and orthopaedics and 10-20 per cent in medicine – to assist in prevention)  
- Incidents of pressure ulcers have increased (26%) but this follows work to improve recognition and reporting. We’re continuing to work at reducing them by reviewing and taking action following each case  
- We’ve put new systems in place to share learning – from visual displays to presentations  
- We’ve introduced a Medicines Event Review group to look at incidents and share learning  
- Case study: A smaller range of Warfarin tablet (used to thin blood) strengths are being used to make it safer and reduce the likelihood of human error  
- Case study: Work progressed to introduce the Seeing Red campaign (due for September 2014) to ensure protected quiet time for ward staff when administering medicines |
| **Improve quality assurance** | - We produced an annual plan for quality and safety and formed a working group to drive forward improvements  
- We invited the Good Governance Institute to review what we were doing; they found no serious issues of concern and we are now addressing areas raised for improvements through an action plan  
- A dashboard was developed and is now being aligned with the website My Local Health Service to better share and receive information with the public - [http://mylocalhealthservice.wales.gov.uk/](http://mylocalhealthservice.wales.gov.uk/) |
| **Foster a culture of quality and safety** | - We’ve started the training programme and since its launch: 430 staff have completed the bronze level; 51 have completed silver; and 22 are on the gold network  
- The Improvement Academy is piloting many leadership schemes. Case study: the Consultant Leadership Programme launched and is being discussed with a local university to see if it can be accredited at Masters level  
- Case study: we are using different elements of data to find areas where falls occur on wards and prevent them |
The Health Board is developing a Quality and Safety workplan for the 2015/16 year based on two keys pieces of work, listed below. These revised systems and processes will underpin delivery of actions within this IMTP and, through the Quality and Safety Committee enable the Board to track progress on addressing quality and safety of services. These key pieces of work are described as follows:

- Through our Quality and Safety Committee, developing a consolidated Quality and Safety Action Plan to ensure Board assurance of progress. This plan amalgamates all quality and safety related actions from both internal and external reviews such as Health Inspectorate Wales (HIW), Care and Social Services Inspectorate Wales, the Royal Colleges, Medical and Healthcare products Regulatory Agency, Trusted to Care, and Wales Audit Office.

- Building on our process of risk management improving the process of identifying, assessing, analysing and managing all potential risks. If risks are properly assessed, the process can help the Health Board, teams and individuals set their priorities and improve decision-making to reach an optimal balance of risk, benefit and cost.

- To use our existing quality measures for example Fundamentals of Care to help augment, support and implement practice-related improvements which enhance the patient experience.

This new process ensures Board assurance on understanding and managing risk as follows

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<tr>
<th>Known risk and issues</th>
<th>Forward planning</th>
<th>Board assurance</th>
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<tbody>
<tr>
<td>• Corporate risk register</td>
<td>• Quality and Safety agenda</td>
<td>• Annual Quality Statement</td>
</tr>
<tr>
<td>• Operational risk register</td>
<td>• Sub Committee agenda</td>
<td>• Quality and Safety Annual Report</td>
</tr>
<tr>
<td>• Ownership by Executive and Senior Lead</td>
<td>• Links to other committees (e.g. Workforce &amp; OD)</td>
<td>• Clear ownership of issues</td>
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5.2 Improving Quality – Identifying the Challenges

Whilst significant changes have occurred since Your Health Your Future Consultation, especially in Women’s & Children’s Services, significant challenges still remain. The inability to recruit and retain skilled staff in a number of specialties across our 4 main hospital sites, combined with relatively low volumes of activity at individual site level, is the cause for some of our services facing significant challenge. Also many services are overly-reliant on locum/agency medical staff which does not provide sustainability of services nor is financially sustainable.
This poses a fundamental challenge to many services within the Health Board both as a result of increasing sub specialisation in the training of doctors but also in attracting staff to work in rural areas. There are specific challenges in a number of hospital based clinical specialities including Radiology, Anaesthetics, Accident and Emergency Services, Acute Medicine, and General Surgery. There are also specific challenges for hospitals with single handed specialty consultants in providing cover during periods of leave or other absences.

Additionally, in their drive to improve training, the Deanery is reorganising medical training. This is causing increasing challenges to the provision of doctors’ rotas across junior and middle grade staff. This was a key driver behind the recent changes to Obstetric, and Paediatric services in the Health Board and poses similar challenges for other specialities.

We have previously described the needs of our ageing population and the challenge that this poses to delivering services. Currently, patients aged over 75 occupy 70% of our hospital beds, with chronic diseases, such as diabetes and heart disease being common. We also know from previous studies (2011) that up to 40% of patients in hospital are staying too long and receiving a level of care that is greater than they need. Often, this is because our current community services do not always provide the right care, at the right time in a local setting.

To improve quality and in making our services future-proof, we know we will need to:

- Address the needs of an increasing and ageing population which we know will place exponential demands in some specialties, particularly those in chronic conditions, heart disease and orthopaedics.

- Make our consultant rosters far more attractive by increasing the numbers of consultants employed in certain specialties, and of consultants working ‘out of hours’. To help meet this challenge, we need to ensure “join up” of our hospitals especially at night, as well as growing more innovative advanced practitioner roles;

- We are now also experiencing significant recruitment challenges in nursing and in Allied Health Professionals such as radiographers.

The current configuration of hospital services, spread thinly over 4 district general hospital sites, with the staffing levels available make the achievement of some Tier 1 targets even more of a challenge. The need to plan services as one hospital over four sites is increasingly pressing. This impacts on our ability to improve access, flow and variation and form part of the rationale for supporting the changes we are proposing to our service delivery model across specialties with very high volume waiting times, including Orthopaedics, Gynaecology & Ophthalmology.

This path of travel has also been informed by expert thinking on the safety of services. A selection of the more relevant Royal Colleges reports, their pertinence to where our service issues are, and why and how Hywel Dda is focusing on these areas, is provided in the following section.
5.3 What the experts say

The table below provides an overview of a number of the key external reports that have directly or indirectly either reviewed or shaped our services, along with what action we have undertaken as a Health Board to address them.

<table>
<thead>
<tr>
<th>Report</th>
<th>Our IMTP Response</th>
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<tr>
<td><strong>Royal College of Surgeons: 2013 – Reshaping surgical services</strong></td>
<td>Makes the clinical case for establishing larger centres of excellence to improve outcomes for many specialist services.</td>
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<td></td>
<td>This plan proposes the development of Centres of Excellence for Inpatient elective Orthopaedics &amp; Inpatient Gynaecology.</td>
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<tr>
<td><strong>Royal College of Physicians: 2012 – Hospitals on the edge?</strong></td>
<td>Notes that hospitals are struggling to cope with the change of an ageing population and increasing hospitals admissions, and argues that transforming the care that patients need can only be achieved by challenging existing practice. Organisations involved in health and social care must be prepared to make difficult decisions and implement radical changes where this will improve care.</td>
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<td></td>
<td>Hence our focus on Locality Plans discussed under Care Closer to Home. However, also looking at the roll-out of an innovative approach to acute medical admissions we are piloting at Prince Philip Hospital.</td>
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<tr>
<td><strong>Mid Wales Healthcare Study 2014</strong></td>
<td>Considers the issues and opportunities for providing accessible, high-quality, safe and sustainable healthcare, which is best suited to the specific needs of people living in Mid Wales.</td>
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<td></td>
<td>Collaborative Board to be established.</td>
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<tr>
<td><strong>Cardiology Review 2014</strong></td>
<td>Royal College of Physicians review of Hywel Dda Cardiology Services making a series of comprehensive recommendations to ensure service improvement and sustainability.</td>
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<td></td>
<td>Establishment of Cardiac Services Programme Board.</td>
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<td><strong>Academy of Medical Royal Colleges: 2012 – Seven Day Consultant Present Care</strong></td>
<td>This report recognises that full adoption of standards on seven day consultant present care will not be self-funding in the short term, therefore other interventions, such as changes in work patterns and service reconfiguration onto fewer sites, will be needed, to ensure high quality services and financial sustainability in the future.</td>
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<td></td>
<td>Planning joint on-call rosters between sites in key specialties.</td>
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<tr>
<td><strong>Royal College of Obstetricians and Gynaecologists: 2013 – Reconfiguration of women's services in the UK</strong></td>
<td><strong>Our IMTP Response</strong></td>
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<td>This guidance note sets out the principles that should be adhered to, during the planning and process of, reconfiguring women’s health services. It highlights that a key consideration must include staffing of units and rigorous assessment of a woman’s risk profile. Patient-centred care must be a priority.</td>
<td>Addressed and evidenced as part of our redesign of Paediatrics &amp; Maternity &amp; Neo-natal care in Hywel Dda during 2014. Including community Paediatric services.</td>
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<table>
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<tr>
<th><strong>Royal College of Obstetricians and Gynaecologists: 2012 – Tomorrow’s Specialist</strong></th>
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<tr>
<td>This report argues that obstetric delivery suite needs fully qualified specialists available at all times, 24 hours a day, 7 days a week. The affordability issues that could be a consequence of this requirement may mean fewer acute obstetric units, so that for the more specialised obstetric care, women may have to travel further as the service applies the logic that care should be localised where possible, centralised where necessary.</td>
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<tr>
<th><strong>Royal College of Midwives: 2013 - State of Maternity Services</strong></th>
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<td>Although recognising that overall births in Wales have fallen over the past ten years, this report highlights the increased pressure that maternity services are facing in the UK today.</td>
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<tr>
<th><strong>Royal College of Paediatrics and Child Health: 2013 – Back to Facing the Future</strong></th>
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<td>This report argues the case for providing better consultant (or equivalent) coverage when they are at their busiest. Paediatrics services should be a 24 / 7 speciality with services being organised around the child’s needs.</td>
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<th><strong>Royal College of Nursing: 2007 – Nurse staffing ratios</strong></th>
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<td>The Francis report stressed the need to maintain the correct nurse staffing ratios in wards to ensure patients receive the correct level and quality of care. The recommended staffing ratios are set out in a publication by the Royal College of Nurses in 2007.</td>
<td>Planned in as part of strengthening our nursing workforce.</td>
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<tr>
<th><strong>Royal College of GPs 2013 – 2022 GP: A Vision for General Practice in the future NHS</strong></th>
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<td>Report outlines the aspirations for the future of general practice and patient care, setting out the needed in general practice to deliver the future care for the population. Drawing on an extensive body of national and international research demonstrating how general practice should be the driving force for transforming the NHS over the next decade.</td>
<td>Augmented within our approach to Care Closer to Home &amp; growing Advanced Practitioner roles to support GP care.</td>
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<tr>
<th><strong>Royal College of Psychiatrists: 2009 – New Ways of Working for Psychiatrists</strong></th>
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<td>New Ways of Working is about supporting and enabling consultant psychiatrists, among others, to deliver effective and person centred care across services for children, adults and older people with mental health problems. This is about a big culture change; it is not just tinkering at the edges of service improvement.</td>
<td>Addressed within our Mental Health Plans</td>
</tr>
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</table>
5.4 What our external regulators tell us about our services

We have undertaken a comprehensive review of how our regulators – including Health Inspectorate Wales, Wales Audit Office, Health & Safety Executive, Welsh Risk Pool, Internal Audit, Capital Audit, Community Health Council unannounced visits, Good Governance Institute, Trusted to Care, Royal College of Physicians Cardiology Review, Welsh Government Decontamination Audit, detailed in Annex 10 - have assessed our services, and their overarching themes are as follows:
5.5 Assessing Risk

Importantly, we have also triangulated this against our own risk register with the following results:

- **Performance**
  - Failure to achieve targets and priorities

- **Primary Care**
  - Insufficient project/financial mechanisms to take resource out of existing service and into primary care

- **Service Models**
  - Current service models for pediatrics, obstetrics and gynaecology, trauma and orthopaedics, Emergency surgery, emergency and urgent care do not meet Royal College, College of Emergency Medicine, medical guidelines and have led to a reduction in trainees.
  - Current service models are not sustainable in both clinical and financial terms

- **Business Continuity Plan**
  - lack of updated robust tested resilient plans across the organisation

- **Information Governance**
  - Inscribing in the medical record
  - Lack of integrated record management system
  - Lack of storage

- **Quality and Safety**
  - Patient safety and quality of service compromised due to increasing referral rates, capacity impacting on waiting times, diagnostic and treatment, access to services and follow up appointments in the “oboy” services.
  - Lack of unified processes for clinical policy, guidance, NPSA, Protocols etc

- **Medical Equipment Backlog**
  - The backlog of medical equipment out of service or in need of replacement > £3Millon

- **Funded Nursing Care Judicial Review**

- **Medicines Management**
  - Medicines Management review of oesoptc unit at GGH totally inadequate and in need of urgent upgrade.

- **Clinical Negligence**
  - Delays in the length of time taken to investigate concerns exacerbating the likelihood of reocurrence and lessons not being learned.

- **Estates**
  - Compliance issues with the estates infrastructure
  - Range of infrastructure issues
  - Suboptimal accommodation and physical building defects

- **Medical**
  - Concerns regarding the management of patients across integrated care pathways for Diabetes and Cardiology and multidisciplinary working in cancer services

- **Workforce**
  - inability to release staff to attend training
  - lack of PDRs
  - Recruitment and retention issues
  - Age profile of staff
  - Inadequate staffing levels

- **Informatics**
  - Sub Optimal IT systems

- **Finance**
  - Non delivery of savings targets resulting in breach of financial duties

- **Data Quality**
  - Poor data quality within the UHB

- **Corporate Risk Register**
Among evidence of high quality for the majority of our patients, the Assurance, Safety and Improvement Team (ASI) in the Health Board has consolidated information from the Risk Register looked at thematic areas identified from incidents, together with similar work undertaken by the Complaints Team. Current issues may be summarised as follows:

**Emerging themes from incidents:**
- Medication errors in particular patients being given medication to which they are allergic
- Failure to monitor patients adequately
- No Consultant cover when single handed consultants are away.
- Patient Falls
- Poor transfers between wards/hospitals
- Failure to follow up patients
- MDT cancellations

**Emerging themes from complaints:**
- Delay in diagnosis of cancer
- Delay/missed diagnosis in A&E, failure to engage medical staff; failure to review x-rays prior to discharge
- Discharge arrangements
- Referral arrangements (incorrect referrals being sent outside of HB’s resulting in delays in patient being seen by appropriate provider)
- Shared care – between consultant teams, communication and lack of joint planning of care
- Management of patient expectations – lack of patient information pre admission and post discharge, leading to increased length of stay or re-admission

This information was presented to the Quality and Safety Committee (October 2014) and to the Putting Things Right Committee (November 2014) and from this a Quality Governance Matrix has been developed which reflects known issues and risks within the organisation. This will ensure that all risks from the above process and issues arising from the consolidated reporting of action plans will be included in a collective workplan for the Quality and Safety Committee, related committees and sub-committees and the teams which support this work.

**Infection Control**

The Health Board previously reviewed its Infection Prevention and Control (IP&C) strategy at a Board Development session following a Team Wales event in December 2013. As a result, a revised approach which aimed to extend the work of the Health Boards IP&C team much more into the primary care setting was endorsed at the Infection Prevention and Control Committee and approved through the Strategy and Planning Committee in mid 2014. An investment of £55,000 was made into the IP&C team resource to enable the acute hospital focussed work to continue (as reducing C. difficile and MRSA bacteraemia remains a priority for the Health Board) but at the same time to enable some of the senior and experienced IP&C team member time to refocus on preventative work outside of the hospitals in an effort to reduce the E.coli and other gram negative infections that constitutes a much higher number of the infections that patients are admitted to hospital with. The aim is to also focus on reducing these infections and thus avoid the infections which in turn will reduce the number of bed days associated with infection as the primary...
diagnosis causes. Whilst the wider discussions required to take forward this strategy have commenced during 2014/15, the full rollout has been slowed by the preparatory work required to ensure preparedness for the Ebola risk. However, the full quota of additional human resource within the IP&C team (medical as well as nursing) will have been recruited and be in post by April 2015 and this together with the appointment of 0.5 WTE antibiotic pharmacist based in each of the four acute hospitals will ensure that the strategy can be pursued vigorously in the coming year. The success of the strategy will be monitored by the Health Board not only through the Welsh Government Tier 1 HCAI related targets but also through monitoring of E.coli bacteraemia infections.

5.6 Your Health Your Future and the Mid Wales Healthcare Study

During the clinical engagement process as part of ‘Your Health Your Future’ our clinicians described the key challenges that we are facing in regard to delivering high quality, safe and sustainable hospital based services. Despite the service changes successfully managed since the publication of that clinical strategy, there are still a range of challenges to be overcome.

On 23 October 2014 the Welsh Institute for Health and Social Care published the findings from its independent study of healthcare in Mid Wales. The findings provide a clear account of the challenges associated with delivering accessible and high-quality healthcare in Mid Wales - longer travelling times to access key services; the difficulties retaining skilled staff and developing resilient services. A series of recommendations were made by the report authors, namely:

- The three Health Boards (Hywel Dda; Betsi Cadwaladr; and Powys) should establish a joint governance mechanism (working title: The Mid Wales Healthcare Collaborative) as described in the report, in order to implement many of the recommendations below.
- Public engagement in Mid Wales should be established on a new basis, and coordinated by The Mid Wales Healthcare Collaborative.
- The three Health Boards should re-double their efforts to address the pressures facing local primary care, developing complementary services, creating new models, sharing functions and providing business support, looking at new organisational models for general practice, and where possible providing targeted financial support. There is traction to be gained by the Boards coordinating their efforts to meet the specific circumstances of Mid Wales, and considering shared solutions where appropriate.
- The Welsh Government national Primary Care Plan should address the many common and systemic challenges facing primary care, which lie beyond the scope of the Health Boards.
- Hywel Dda University Health Board, supported by the other two Boards, should confirm publicly its vision of the future strategic role of Bronglais General Hospital and the strategic direction that it intends to pursue. The Health Board’s submission to this study provides a good basis for such a vision. It will require subsequent detailed consideration of pathway and service options, but should be sufficiently specific to reassure potential and current staff and the public that the hospital will remain an acute
centre, and that urgent and non-urgent provision will address the challenges of remoteness. It should state explicitly the criteria that must be met, based on the Six Key Service Criteria set out in this report (see Table F3.1, Section F).

- Clinical staff in all the specialties should now be actively engaged in clinical discussions with their colleagues about how services should develop. This process will require active leadership and facilitation by the Hywel Dda University Health Board, working on behalf of the Mid Wales Healthcare Collaborative. It must address the difficulties in the relationships between the hospitals, and should include representatives from primary care, the Royal Colleges, the Deanery and service providers from Scotland and elsewhere who have successfully addressed some aspects of rural acute care provision. This process, including reviews by professional bodies, should address the specialty-specific issues (see below), but also their interdependencies, and the linkages with pre-hospital care and between hospitals, along the patient pathways. It is important that the medical Royal Colleges are all engaged in this work, along with the learned bodies drawn from the other professions.

- A further examination of the options for providing cardiology services in Bronglais General Hospital should now be started, which takes full account of the broad range of presenting conditions at this hospital, and evaluates alternative ways of constructing the sort of clinical network support that is needed. This should build upon the initial discussions held as part of this study, and the submission to this study from the Royal College of Physicians both of which offer some grounds for optimism that alternative solutions are worth exploring.

- A similar process should take place in relation to general surgery, building on the discussions initiated by this Study and scheduled for October 2014, and for maternity and obstetric services in Bronglais General Hospital.

- Unnecessary journeys to access care should be eliminated, with a coordinated and comprehensive examination of relevant pathways to ensure care is actually provided closer to home, clinics and

- Mid Wales Healthcare Study for Welsh Government · September 2014 Page xi other provision is organised to reflect travel difficulties, patient’s are encouraged to choose options which suit their needs, and patients and visitors are provided with information to help them access remote services. This will require a coordinated effort crossing hospital and Health Board boundaries.

- Plans to develop more advanced skills in the ambulance service in Mid Wales should be supported and expedited.

- There should be a coordinated effort by all three Health Boards to identify the opportunities for much greater use of telehealth capacity and a determined drive to hasten its implementation.

- The three Health Boards, working with local universities and others, should develop and support a centre of excellence in rural healthcare, with a particular focus on research, development and dissemination of evidence in health service research which addresses the particular challenges of Mid Wales. This has great potential to carry out work of
relevance internationally. A high-profile conference on Mid Wales healthcare as described in the report should be organised immediately.

The Health Board has already commenced work on engaging with staff and the public on the recommendations contained within the study. These events mark the start of a series of events which will continue throughout the next year to allow staff and local people to express their views on healthcare services. Once the Mid Wales Healthcare Collaborative has been established then work will commence at pace to develop detailed plans to implement the findings from the review. The Health Board’s response to the Mid Wales Healthcare Study can be found in Annex 11.

5.7 Acute Services Plans

This Plan describes how we need to optimise our acute services to improve access and meet tier 1 targets, to improve flow and reduce variation.

- For Unscheduled Care this plan seeks to stabilise our emergency and acute medicine services. We believe that there will be a co-dependency to Acute Surgery going forward but it is not our intention to redesign this service at this time without further supporting evidence from the South Wales Planning process.
- An essential enabler for the future of our emergency services footprint is the phased implementation of the Emergency Medical Retrieval Transportation Service (EMRTS).
- For Planned Care, it is our intention that this plan applies best practice across the Health Board area to create networked provisions, particularly in securing planned or elective capacity to meet waiting times.

5.8 Unscheduled Care and Improving Flow

Our Challenge & Ambitions for Unscheduled Care to deliver Tier 1 Performance

Tier 1 performance standards are a key measure to define how effective emergency care is being delivered. Joint working with public health, scheduled care and mental health is essential in ensuring all pathways are developed and work in parallel with each other and all patients receive timely and quality care.

What will Good Unscheduled Care Look Like?

- Patients will understand how to access the Urgent and Emergency Care services and be confident in its ability to meet their needs.
- Professionals working within the Urgent and Emergency Care services will understand his or her specific role and the part this plays in the context of the whole system.
- Every service within the Urgent and Emergency Care system will be responsive and adaptive to the other services that make up the whole system.
- Service development will become progressively more embedded within the new county commissioning process.
- The commissioning process will be completely aligned with the whole system development plan for urgent care.
- The winter planning process, along with the demand and capacity management systems it requires to be successful, will be incorporated into the yearly planning cycle.

### Aligning Priorities: Patients, Care Delivery and County Commissioners

<table>
<thead>
<tr>
<th>Perspective:</th>
<th>HYWEL DDA UNSCHEDULED CARE PRINCIPLES</th>
<th>Stakeholder Alignment</th>
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<tbody>
<tr>
<td>Based On:</td>
<td>Experience and Values</td>
<td>Process, Organisation and Leadership</td>
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<tr>
<td>Key Themes:</td>
<td>Be ‘joined up’ and responsible for my care</td>
<td>Always network, but integrate where possible</td>
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<td>Priorities</td>
<td>Help me understand the urgent care service</td>
<td>Education &amp; Publicity</td>
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<td></td>
<td>Let me access it appropriately</td>
<td>Patient Navigation</td>
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<td>Assess and treat me promptly and in the right place</td>
<td>Reduce A&amp;E attendance</td>
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<td>Admit me to hospital only when necessary</td>
<td>Professional navigation</td>
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<td>Make my stay in hospital short, safe and effective</td>
<td>Networked or integrated assessment &amp; treatment</td>
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<td>Reduce hospital admissions</td>
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<td>Improve hospital systems</td>
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<td>Better discharge processes</td>
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<td>Try to care for me at home, even when I’m ill</td>
<td>Develop and integrate community services</td>
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Improving Accident and Emergency services

In terms of strategic direction, Hywel Dda will continue to provide 24 hour A&E services on 3 sites and redesign services in Prince Philip Hospital to provide a 24 hour medical emergency model with enhanced minor injuries and integrated patient pathways. This is deemed the optimal configuration to enable both sustainability and local healthcare access to the community. Our key focus remains on ensuring pathway improvements in order to provide a robust and resilient service to all patients.

As an outcome of the consultation process on the Hywel Dda Clinical Service Strategy it was decided to establish a rigorous project framework to identify and implement the future model for the current Accident and Emergency Department in Prince Phillip Hospital (PPH). A clinically led process has developed a new model for PPH so that patients presenting to the hospital will be seen by the most appropriate clinician in the timeliest manner. The Unscheduled Care system developed will be sustainable and will ensure that the current patient groups continue to be seen within the hospital and will therefore not impact on neighbouring hospitals.

The key change will see 999 and GP arranged patients being taken straight into the redesigned acute medical unit. A resuscitation area will be created in the Clinical Decision Unit along with a stroke/FAST positive bed. This area will also now house an ambulatory care area to maintain appropriate patients without need for a bed.

Walk in patients will arrive at the current A&E front door where they will be triaged as appropriate to an ENP or GP. Patients needing the Frailty service will be directed to the multidisciplinary team. Patients needing mental health services will similarly have access to acute assessment within the department. All patients presenting will have a rapid alcohol assessment through a modification planned to our patient administration system.

The GPs within the unit will further be able to provide advice on appropriateness of admission to colleague GPs working in Practice. Patients presenting with minor illness will be directed back to primary care daytime or Out of Hours with referral in place.

In all instances the co-locating of community based care providers within the department will serve to provide enhanced range of options for care for patients outside the acute environment.

The Emergency Department at Withybush Hospital has faced particular pressure and challenges. Work is underway to stabilise the service through introducing enhanced physician rosters and evaluation of models of care using alternative clinical models whilst long terms solutions can be put in place including the recruitment of additional physicians to ensure a sustainable acute medical rota for the longer term.
Improving Patient Flow

Managing patient flow is key to reducing variation and achieving tier 1 targets. As evidenced by the graphs below there is significant variation in the daily activity in our hospitals. Interestingly there is more variation in daily discharges which the Health Board should, together with our partner organisations, have more control over.

The concept of using flow to improve care has received increasing traction within healthcare, especially in relation to reductions in patient waiting times for emergency and elective care. As the national policy agenda focuses more strongly on integration between primary care, acute services and social care, the need to understand and improve how patients flow through systems is more important than ever. High profile cases of failures in the timeliness and quality of care serve as warnings as to the painful consequences of poor quality systems and processes.

As part of the National Patient Flow Collaborative Service Improvement and Business Intervention team established a “Big Room” on one DGH site. The Big Room is a weekly multi-agency and multidisciplinary meeting utilising a robust problem solving methodology supported by pertinent timely analysis to evidence and develop needed changes / improvements to the system to unblock flow constraints. The members of the big room have received training in Foundations of Improvement Science for Health Care.

Through the problem solving methodology it was identified that the greatest impact for improvement of patient flow would be achieved by focusing on the frail, elderly pathway and investment in Care Closer to Home services.

The graph below illustrates the outcomes of A&E attendances over an 18 month period. It is evident from this graph that for the older age group population of over 75 years that A&E attendance is more likely to result in an admission to a hospital bed than discharge home.
Prudent healthcare aims to reduce waste, harm whilst improving collaboration. The problem solving methodology utilised through the Big Room with multi-agency and multi-disciplinary team input has enable important work streams to develop improvement projects which are evidenced based to improve flow and variation in A&E. The future state map below is the vision for the Health Board which brings together the different work streams under the IMPT in order to achieve this vision through the project below.
Objective: a left shift of activity across the system. As a function of time; yesterday's urgent cases are today's acute cases and tomorrow's chronic cases.

The Health Board plans to roll out the big room methodology to all acute sites during 2015 and establishing a Patient Flow Programme Board.

**Key Actions for the Patient Flow Programme Board**

- Improvements to Discharge planning by developing the role and function of Multidisciplinary Teams
- Processes for Mental Capacity assessment and the utilisation of assessments across the multidisciplinary team
- Joint Records and record Sharing – links to effective information-sharing
- Comprehensive Frailty Assessment at the Front Door
- Discharge summaries to GPs
- Comprehensive nursing assessments in the Emergency Department
Improving Our Frailty Pathway

Across the Health Board there is significant focus on meeting demographic pressures through implementation of specific frailty work to support frail elderly in a community setting with reduced propensity for admission through acute unscheduled event. A frailty pathway has been developed and specifically a Rapid Access Frailty Service has been piloted in the South of Carmarthenshire (SCRAMS). SCRAMS works through analysis of the population being served and identifying people most at risk using risk prediction models. The service assesses which admissions are potentially avoidable and targets people with conditions that can be treated more effectively in the community, along with supporting a programme of self care and self management functioning through a model of MDT co-orientated care.

We have reviewed nursing and residential home attendances and will be working to address the homes with high A&E and acute care usage not only to reduce pressure on acute care but to ensure patients wherever possible are cared for in their usual place of residence.

Working with our Partners, Local Authorities & Welsh Ambulance NHS Services Trust

Welsh Ambulance NHS Services Trust (WAST) performance is key to ensuring all residents have access to emergency care when needed. Significant improvements have been made to ensure timely handover performance but there are still further improvements that need to be achieved. Processes have being reviewed and a Health Board wide offload policy is underway based on the Draft NHS Wales Hospital Handover Guidance, November 2014. Hywel Dda works closely with other Local Health Boards and WAST to support increases in demand and will take ambulance diverts from other hospitals when they are under significant pressure.

The Health Board has escalation plans in place to address increases in demand and times of peak pressure which includes community and social care partners. Winter plans are in place ensuring the learning from previous years are incorporated to provide resilient and robust plans. There are twice daily Health Board conference calls to manage emergency and planned demand which are increased during times of increased activity.

The Heath Board continues to work with specialist centres ensuring the residents of Hywel Dda have access to specialist services. We have joint consultant contracts with ABMU for many specialties to provide follow up Care Closer to Home. This also supports consultant recruitment which has proved challenging in certain areas by facilitating more attractive posts and experience.

The formation of the Mid and West Wales Acute Care Alliance (ACA) as part of the South Wales Health Collaborative is opportune as it builds on the developing and maturing relationship between our two Boards over the last 18 months or so.

This work is feeding into both health Boards IMTPs therefore is aligned. A number of service areas have been prioritised for joint working. These are set out below:
Community Health Councils work closely with the Health Board ensuring effective communication with residents about access to the range of health care services. They perform patient surveys in A&E Departments especially in times of peak demand and out of hours the findings are reviewed and agreed actions implemented to improve services to Hywel Dda residents.

Unscheduled care & Care Closer to Home

Unscheduled Care has a critical interface with Community proposals. Across all three counties work is focused on admission avoidance and discharge facilitation. There is very close working with community partners to ensure patients receive the appropriate care in the right place at the right time. The community teams work closely with acute care and will review and provide care for patients who need supported discharge. As already discussed in chapter 4, Community Resource Teams (CRTs) are the key enabler of providing Care Closer to Home and avoid unscheduled care presentations.
### Actions to Improve Unscheduled Care

<table>
<thead>
<tr>
<th>Unscheduled Care Service Improvement to ensure Tier 1 target Delivery</th>
<th>Key Messages from ‘Your Health Your Future’</th>
<th>Stabilise</th>
<th>Optimise</th>
<th>Transform</th>
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<tbody>
<tr>
<td><strong>Unscheduled Care: Emergency Departments</strong></td>
<td><strong>Unscheduled Care Service</strong></td>
<td><strong>Improvement to ensure Tier 1 target Delivery</strong></td>
<td><strong>Key Messages from ‘Your Health Your Future’</strong></td>
<td><strong>Stabilise</strong></td>
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<tr>
<td>Long waiting times at busy times</td>
<td>Closure of Minor Injury Units and staff redeployed to Withybush Emergency Department to support staffing difficulties</td>
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<td>Delayed access to senior clinical opinion and decision making</td>
<td>Minor Injury Unit Tenby Summer service</td>
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<td>Clinical governance challenge e.g. key specialty backup not available on all sites, with inconsistent assessment processes</td>
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<tr>
<td>Lack of clarity of service provision</td>
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<tr>
<td>Chronic recruitment and retention challenges</td>
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<tr>
<td>Too many patients waiting too long in ambulances</td>
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<tr>
<td><strong>Acute Medicine</strong></td>
<td><strong>In addition to current A&amp;E services, we will have fully scoped the applicability of the “PPH Medical Model” to Withybush and Bronglais – this means that we can</strong></td>
<td><strong>Stabilise</strong></td>
<td><strong>Optimise</strong></td>
<td><strong>Transform</strong></td>
</tr>
<tr>
<td>Inability to meet Royal College Guidance &amp; Standards</td>
<td>Sustain high quality acute medicine on all 4 sites with direct access to the CDU</td>
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<td>Single handed practitioners</td>
<td>Deliver a frailty model integrated with community, primary and social care</td>
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<tr>
<td>Recruitment &amp; retention challenges</td>
<td>Keep all of our “front doors” open 24/7</td>
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<td>Over-reliance on in-hospital and bedded models of care</td>
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<td>Too many patients staying too long in hospital</td>
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<tr>
<td>Current model cannot meet future demand</td>
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<tr>
<td>Sub-specialties require network solutions</td>
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<tr>
<td><strong>Emergency Surgery</strong></td>
<td><strong>For Bronglais, this will be part of the emerging Mid Wales Study Collaborative Board</strong></td>
<td><strong>Scoping as per South Wales Health Collaborative planning work</strong></td>
<td><strong>Networked emergency surgery rosters, providing emergency sub-specialisation expertise which could effectively allow us to operate as ‘One Hospital over 4 Sites’.”</strong></td>
<td><strong>Networked emergency surgery rosters, providing emergency sub-specialisation expertise which could effectively allow us to operate as ‘One Hospital over 4 Sites’.</strong></td>
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<tr>
<td>Inability to meet Royal College Guidance &amp; Standards</td>
<td>For Withybush, we will need to recruit 8+2 Consultant Physicians to stabilise the acute medical roster</td>
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<td>Single handed practitioners</td>
<td>For PPH – see above</td>
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<tr>
<td>Recruitment &amp; retention challenges</td>
<td>For Bronglais, this will be part of the emerging Mid Wales Study Collaborative Board</td>
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<td>Sub-specialties require network solutions</td>
<td>For Glangwili, service as is now</td>
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<td>Too many patients staying too long in hospital</td>
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<td>Current model cannot meet future demand</td>
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<tr>
<td>Sub-specialties require network solutions</td>
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<td><strong>Women and Children’s Services</strong></td>
<td><strong>Consolidation of 2014/15 service transfers for Women’s &amp; Children’s</strong></td>
<td><strong>Phase 2 development on GGH site for SCBU, Obstetric unit &amp; Paediatrics</strong></td>
<td><strong>Develop sustainable service model for Bronglais that meets standards</strong></td>
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5.9 Improving Planned Care – Improving Access, Meeting Tier 1 Targets and Reducing Variation

Within Planned care, we see this ambition being achieved by implementing five simple changes which will improve integration, quality and productivity as follows:

1. Treat day surgery (rather than inpatient surgery) as the norm for planned procedures and increase theatre efficiency.
2. Improve referral and diagnostic pathways.
3. Actively manage admissions to hospital.
4. Actively manage discharge and length of stay.
5. Actively manage follow ups.

Our plans will focus on work activities that will progress Tier 1 targets for planned care, in order to deliver:
- 90% of planned activity on a day-case basis.
- Average new to follow up ratio of 1:1.5
- 85% of planned surgical admissions on the day of surgery.
- In the first instance, 26 weeks for a first out-patient consultation or between OP and admission for any subsequent treatment with subsequent improvement.
- Maximum wait of 8 weeks for endoscopy.

The improvement work will be achieved by implementing the five simple changes which will improve integration, quality and productivity.

Our Challenges & Ambitions against our Baseline position

Referrals: The challenge of increasing demand for diagnostic and treatment services is leading Hywel Dda to evaluating how we can meet demand on the basis of need rather than on unmanaged expectation. This philosophy underpins the improvement work of the planned care IMTP that are outlined and exemplifies the principles of “prudent healthcare” in Wales.

Day-cases: Rates in Hywel Dda compare favourably with other acute Hospitals in Wales. The current day-case rate within Hywel Dda is 85%; however, changes in service organisation and delivery are needed alongside thorough and systematic data recording to move towards the target of 90%.

Preadmission assessment: During 2014/15, over 1000 patients were diagnosed unfit on the day of surgery, and 500 day-case patients were admitted the night before their day-case procedure. In addition to reducing the DNA rate and patients unfit on day of surgery, pre-assessment is integral to achieving the target of 85% of patients to be admitted on the day of surgery. An increase of 5% is required over the next three years to meet this challenging target.

Length of stay and discharge planning: Hywel Dda is in the top quartile for a number of specialties in relation to length of stay for surgical specialties. In 2014, a decision was taken that all patients entering our system should be given an estimated discharge date, and this is being implemented.
New to follow up ratio: For surgical specialties, this is 1:1.9 for the eight month period April 2014 to November 2014. However, since September 2013 follow-ups have increased by over 6,520. Work is underway to reduce this backlog.

RTT management: We are working on the delivery of the 36 week target. Sustainability requires redesign and modernisation, which includes adopting best practice principles for managing the queue. Service Delivery Managers need to have access to timely and accurate data on demand, capacity and activity to support performance management and to be able to identify potential problems or areas for development.

Patient-focused booking: Partial booking has been implemented in the majority of out-patient specialties. Patients are seen in out-patients, are then pre-assessed and offered a date for surgery.

On the basis of this baseline position, we are establishing the following 7 projects to significantly improve planned care

Project Area 1 Improve Referral and Diagnostic Pathway
- **Objective 1:** Develop primary care based referral management system at practice level
  The aim of the project is to influence the referrals from primary care, to ensure the appropriate pathway for care is achieved.
- **Objective 2:** Develop the capacity of community based minor surgery by 5%
  Minor surgery services need to be well established in all three counties. Discussions are already underway over the development of the minor surgery capacity within primary care. The aim of the work is to maximise the extent of community based minor surgery, to release capacity in the acute sector.
- **Objective 3:** Sustain the management of musculoskeletal referrals
  A key strategy of redesign in Hywel Dda is the development of intermediate tier services. Hywel Dda needs to further develop its plan to develop a primary care gate keeping function for musculoskeletal, pain and rheumatology problems. Our aim has always been to create a central referral point within primary care for GPs and health professionals to refer all MSK problems not requiring an orthopaedic surgical opinion.

Project Area 2 Treat Day Surgery as the Norm
- **Objective 4:** Increase overall day-case rate by 5% from 85% to 90%
  A baseline assessment has been undertaken which has highlighted areas for improvement, focusing on day-case rates by consultant and procedure, and those patients staying one day either post or pre their day-case surgery. From this, in addition to the work around ‘basket’ procedures, it has been identified that theatre utilisation requires improvement.

Project Area 3 Actively Manage Admission to Hospital
- **Objective 5:** Increase pre-assessment activity by 25%
- **Objective 6:** Increase day of admissions for surgery by 20%
Objective 7: Reduce number of patients being admitted with ‘no procedure performed’ by 25%
The main focus will be the development of pre-admission assessment. It is anticipated that this will also impact on the number of patients admitted on the day of surgery.

Project Area 4 Actively Manage Discharge and Length of Stay
  - Objective 8: Reduce variation in length of stay
  - Objective 9: Introduce estimated discharge date for 100% of elective patients
In 2014, Hywel Dda introduced a policy thereby ensuring every patient has an estimated discharge date on admission to the hospital. Progress with implementation within the planned care setting is positive. Work is already underway on developing the pathway so that all patients are given an estimated length of stay for their forthcoming procedure at out-patient appointment.

Project Area 5 Actively Manage Follow Up
  - Objective 10. Achieve 1:1.5 new to follow up ratios for chosen specialties.
Although Hywel Dda is starting from a very good position with new to follow up there is still potential for improvement. A key focus of the work will be the testing of alternatives to face to face follow up with a consultant e.g. telephone follow up, patient generated follow up, nurse led follow up.

Project Area 6 Patient Focus Booking
  - Objective 11: Evaluate patient focus booking
In order to inform the change strategy for roll out of booking systems, an evaluation of existing practice is required. This will include a reflection on the definitions of Patient Focus Booking

Project Area 7 Queuing theory and performance framework
  - Objective 12: Improvement on the 26 week out-patient and in-patient target
Management responsibility for the delivery of the 26 week targets lies within the acute operational management structure. In order to deliver this target, managers require the tools and techniques to help with this work. Hywel Dda also has to adopt best practice methods for waiting list management across all specialties. Additional Theatre capacity will be required in order to meet the referral demand.

Improving Waiting Times

The table below shows the additional activity that we will put in place to achieve referral to treatment times across all specialties.
The Centres of Excellence that we intend to establish will need to work within these improvement projects, and services will undoubtedly change over time to support the objectives. We anticipate that, in terms of the full range of services, the shaded areas in the table below are service issues where significant amounts of further scoping will need to be undertaken given known and emerging service and workforce pressures, and in order to deliver our planned care objectives already outlined.

The above table provides the total cohort that requires patients to be treated to achieve 36 weeks by March 2016 and the additional capacity requirements. The Planning Templates are per Annex 17 demonstrate the operational requirements from the anticipated demand and capacity for the months. The profile 36 week figures by speciality highlight the monthly position in terms of how the Health Board will operationally manage its services.
<table>
<thead>
<tr>
<th>Planned Care Services</th>
<th>GGH</th>
<th>PPH</th>
<th>WGH</th>
<th>BGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Surgery &amp; Day Attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy Day Unit</td>
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<td>√</td>
<td>√</td>
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<tr>
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<td>√</td>
<td>(Amman Valley)</td>
<td>X</td>
</tr>
<tr>
<td>Gynaecology Day Cases</td>
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<td>(scope one only?) √</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>General Surgery Day Cases</td>
<td>√</td>
<td>(scope one only?) √</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Endoscopy (JAG Accreditation)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Orthopaedic Day Cases</td>
<td>√</td>
<td>(scope one only?) √</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Inpatient Electives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td>√</td>
<td>(scope one only?) √</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Orthopaedics &amp; Rehabilitation</td>
<td>√</td>
<td>(scope one only?) √</td>
<td>(include extra capacity as Centre of Excellence)</td>
<td>√</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Cardiology</td>
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<td>(Hub &amp; Spoke)</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Gynaecology</td>
<td>√</td>
<td>(scope one only)</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Note: The table entries are marked with ‘√’ for availability and ‘X’ for non-availability.
### Planned Care Gynaecology

- Too much variation in Provision, Waiting Times & Access, Poor productivity
  - Compliance with Standards
  - Not maximizing sub specialisation potential – in line with modern practice
  - Privacy & Dignity
  - No emergency / elective separation
  - Patient experience challenges e.g. High Cancellation rates

- Consolidation of 2014/15 service transfers for Women’s & Children’s
- Improved Gynaecology pathways between GGH and WGH

- Phase 2 development on GGH site for SCBU, Obstetric unit and Paediatrics will create capacity which will allow us to optimise Gynaecology services

- Develop elective inpatient centre of excellence in Gynaecology to:
  - Split planned and unplanned
  - Create critical mass to support sub-specialisation
  - Improve Efficiency through theatres
  - Improve Infection control Hospital Out-patients, diagnostics and day-case surgery to remain local as current.

### Planned Care Orthopaedics

- Developing dedicated facilities so that more people will have their operation on a day or short stay basis and not need to stay so long in hospital
- Separating planned from unplanned care and will allow investment in pre-operative assessment services, delivered by GPs or community team, and minimising cancellations and reducing significantly the risk of cross infection

- Community led MSK triage service – including Pain Services
- Hywel Dda Orthopaedic network to maximize sub specialization potential – in line with modern practice
- Repatriate out-sourced work into Withybush

- To maximize all efficiencies in outpatients, theatres and bed utilisation to All-Wales best in class

- In addition to existing inpatient Orthopaedics on all 4 sites, we will strengthen capacity and facilities on 1 site to create an elective centre of excellence to accommodate increasing elective inpatient demand and workload.
  - Otherwise inpatient Orthopaedics and Day-case surgery to remain local as current. With Follow up Trauma Fracture Clinics in each county

### Planned Care Ophthalmology

- Delivering in dedicated facilities to improve efficiency and reduce waiting times
- Step improvement to deliver RTT

- To maximize all efficiencies in outpatients, theatres to All-Wales best in class

- Strengthen capacity on two sites

### Planned Care – Cancer / Oncology & End of Life Care

- Inability to meet Standards
- Do not consistently meet the Tier 1 targets
- Not all our Cancer MDTs are linked
- Diagnostic Services are often a rate limiting step

- Introduction of a short-term service & workforce solution for Oncology
- Re-establish the T4H Cancer

- Achieve clarity on variation
- Fully functioning MDTs
- Improved ‘unbundling’ of parts of the pathways as Cancer services – a major piece of work which needs to be scoped is transformation of surgical Cancer Services, and this will need to be
5.10 Women’s & Children’s Services

From August 4th 2014, all obstetric deliveries and neonatal services in Carmarthenshire and Pembrokeshire were centralised on the Glangwili General Hospital (GGH) site, with Midwifery Led Units (MLU) at GGH and Withybush General Hospital (WGH). Gynaecology services continue on both sites with a consultant “safety net” back up in WGH at all times. Subject to independent evaluation all outpatient clinics, diagnostic investigations, early pregnancy clinics, day assessment and day surgery services continue on both sites.

To comply with the Post Graduate Deanery requirements for training all paediatric junior doctors and obstetric and gynaecology junior doctors are based on the GGH site for their on call work and they cover both sites during the day.

From 20th October 2014, there is a 12 hour 7 day/week paediatric ambulatory care unit at WGH, led by consultants. All inpatient paediatric services are located on the GGH site in an expanded ward, together with a new dedicated paediatric high dependency unit and paediatric ambulatory care unit. All community based paediatric services, our patient clinics, diagnostic investigations and day case services continue as before on both sites.

A Monitoring and Evaluation Group has been established, chaired by the Medical Director. This group has developed a Monitoring and Evaluation Framework that has been approved by the Women and Children’s Services Programme Board.

The service changes are being evaluated against the benefits criteria that the Health Board specified as part of their decision. In particular the new service models are intended to improve the services by addressing the difficulties in the old service
models. These include the need to
- Meet Royal College and Neonatal standards
- Stabilise medical rotas
- Improve and ensure that we maintain medical training within the Health Board
- Keep children and babies in the Health Board and transfer them back to the Health Board when they have been in units elsewhere
- Have a dedicated paediatric high dependency unit

Flying Start
There are multi-professional Flying Start team across the 3 Counties of Hywel Dda. The Health Board provides Flying Start Health Visitors within each of the three partner local authority areas, as part of the integrated, multi-professional team response. Challenges exist in establishing a proportional budgetary contribution of the universal health visiting caseload as the Flying Start scheme is based on postcode areas. In addition over the past few years Welsh Government have continued to expand the Flying Start programme and there remain on-going dialogues between the Health Board and Council’s to ensure that the full complement of Flying Start Health Visitors can be provided.

Challenges exist in ensuring that the families outside of the geographically targeted Flying Start areas can access the intensive support that they need, and in this context health professionals have a key link into the Team around the Family approaches which have developed as a result of Families First funding described later in this report.

During the summer the Health Board was asked to participate in a Welsh Government Task and Finish Group, which had been established to consider how a shared outcomes framework for the 3 key tackling poverty programmes, Flying Start, Communities First and Families First could be developed. It was envisaged that a new framework would be issued by Welsh Government in the autumn 2014, however the joint Outcomes Framework has not yet been finalised. From a Health Board perspective it is likely that the outcomes will remain focused on low birth weight, obesity, teenage conception rates, smoking and immunisations. Whilst these are key public health priorities at present the Welsh Government outcome measures focus on pregnant women and under 4’s. Representation has been by the Health Board through its involvement in the Task and Finish Group for the inclusion of appropriate outcomes for older children and young people to be included, especially given the relationships between engagement with education (and the work which is being undertaken to reduce the number of NEETS – not in education, employment and training) and health issues such as emotional mental health and substance misuse.

Families First
The key objectives of the Families First programme are to:
- Reduce the numbers of families living in workless households;
- Improve the skills of parents/carers and young people living in low-income households, so that they can secure well-paid employment; and
- Reduce inequalities that exist in health, education and economic outcomes for children and families by improving the outcomes of the poorest – with a focus on supporting families to achieve better outcomes for children.
Hywel Dda currently receives funding for a number of services which are delivered as part of the Families First programme. Some examples are provided below:

**Team around the Family (TAF)**
The Health Board is expected to play a key role in supporting the work of TAF e.g. through the early identification of families who would benefit from additional support to address welfare or parenting issues (these are early intervention issues rather than child protection/safeguarding issues or concerns).

TAF uses a process of holistic assessment called a Joint Assessment Family Framework, which has a number of domains to ensure that the health and wellbeing needs of all the individuals within the family are considered. Alongside this the strengths of families are also assessed and recorded so that these can be used to support positive change. Any health professional who identifies and individual family who they feel would benefit from additional support can submit a request for a TAF service. There has been wide engagement from universal health professionals such as school nurses and health visitors, however, it is acknowledged that there is more work needed to support GPs and their practice teams to understand their local TAF approach, how to make referrals and how the service could benefit both individual patients and the wider family. The framework provided by TAF supports a public health approach to health improvement through the consideration of the wider influences and determinants that impact on good health. The JAFF is key to the development of a Family Plan that helps to draw in the input of other professionals or services that can help to support the family to address each of the individual needs. Rather than working in isolation each family has a team of professionals supporting them who come together to review their input an each professional leads on their element of support for the family.

Given the importance of this approach to improving health and supporting the reduction of health inequalities it is essential that Health Board staff working across a range of primary, community and secondary care services are fully cognisant of the TAF framework and approach within their locality so that they can actively contribute to improved outcomes for individual patients and their families.

**Youth Health Team (Carmarthenshire and pilot in Ceredigion)**
The Youth Health Team facilitates 1:1 intervention work with vulnerable young people who are often hard to reach, including those who are looked after, care leavers, those educated in wider curriculum settings, or who are supported by the Youth Offending & Prevention Service. Additionally, the Team provides early intervention health workshops and community events on subjects such as substance misuse, sexual health and emotional health. The Team is commissioned to work with Carmarthenshire young people who are not in mainstream education, and who may be particularly vulnerable and hard to reach, contributing to the poverty agenda by targeting those who are least likely to engage with mainstream services, and who are therefore at increased risk of poorer health and employment outcomes. The success of the long-standing Youth Health Team has resulted in the role out of a pilot project in Ceredigion, funded from the Substance Misuse Action Plan fund.

The Health Board hopes to be successful in receiving continued funding for a part-time service in Ceredigion from 1st April 2015. In Pembrokeshire work has been on-
going to consolidate a number of funding streams, in order to provide a similar service, as described below.

**Emotional Health and Wellbeing Service (Pembrokeshire)**
Up until the end of 2013/14 the Health Board received funding for a number of individual projects e.g. Sandy Bear Loss & Bereavement Service, Emotional Wellbeing Nurses, Dynamic Family Psychotherapist, each of which were delivering services in isolation of each other. As a result of partnership discussions, latterly through the Pembrokeshire Children and Young People’s Executive Group, a proposal has been developed (and approved) to re-configure the existing services and establish a comprehensive multi-disciplinary service that will deliver early intervention and prevention activity to vulnerable young people in Pembrokeshire with the aim of improving the physical and emotional health and wellbeing. The service development is being lead by Specialist CAMHS and the aim is to provide child and family focused services that engage earlier in a non-stigmatising way and are delivered in partnership with other agencies e.g. education service, youth service, youth offending and prevention services. The new service specification will be implemented during 2014/15 and will be closely monitored by commissioners, including the Pembrokeshire Children and Families Group to ensure that it achieves the intended outcomes.

**Tim Teulu (Ceredigion)**
Tim Teulu is a multi-agency team providing co-ordinated family support services, working with families or a time limited period to provide bespoke parenting interventions and on-to-one support including practical assistance to prevent the escalation to statutory services. The Team which is managed by Children’s Services within the local authority also includes a specialist Health Visitor who can provide a key link with other health professionals.

**Families First Grant**
Carmarthenshire CYPP was the first local area to commence a formal review and this has resulted in the formal de-commissioning of two existing services provided by the Health Board – Sure Start Health Team and PINS (Pre-School Intervention Service). The local authorities’ decision to formally re-commission some services provided by external partners is a significant departure from the previous culture of joint and collaborative working in the development and provision of services. However, it has provided an opportunity for the Health Board to reflect on how best to contribute the skills of health professionals to the wider family support agenda, and work is on-going to strengthen the Youth Health Team to meet the increased demand for emotional and mental health support being identified through the Team around the Family process. The de-commissioning process has introduced financial risks for the Health Board which are currently being managed carefully to reduce the impact both for staff and for families currently receiving services. Pembrokeshire Children and Families Executive Group have just begun a Families First review but have given their commitment to continue to work collaboratively, through partnership governance arrangements, to agree priorities for future use of Families First funding.

The revised Healthy Child Programme over the next 3 years, The Health Board is fully engaged in the WG implementation agenda for the Healthy Child Wales Programme (HCWP). The inaugural Healthy Child Wales Programme
(HCWP) sets out the intention to support families to ensure their children attain their health and developmental potential. The overarching aim is to ensure families are resilient and children are healthy, secure and ready for school at school entry and beyond.

Work will be completed early January to illustrate the Health Visiting workforce requirements for the Healthy Child Wales programme to be launched April – September 2015 as requested by the Welsh Government Project officer for the Healthy Child Wales Programme.

A one Wales Health Visiting acuity tool is being developed to ensure a consistent approach to allocation per caseload built upon levels of deprivation and health inequalities. In the current absence of the same a calculation the Health Board will utilise that equates with 250 children per 1.0wte (as per RCN/CPHVA GUIDANCE). This calculation will be applied across the 3 Counties that will aim to illustrate requirements but initially will not take into account of local levels of high need that exists in many of our communities but provides a reasonable indication of workforce requirements. This work will be completed once the All Wales Acuity Tool and Resilience Measurement Tools are completed.

Include updated programme to achieve delivery of NSF standards for children, young people and maternity services by September 2015. Demonstrate how the delivery of integrated services for disabled children and children in special circumstances will be delivered; demonstrate how the organisation will integrate with the national CAMHS service change programme evidence an integrated planning approach with WHSSC in the delivery of children’s specialised services, for children with acute or chronic.

**Future Priorities for Maternity & Gynaecology Services**
There are a number of key priority service issues facing the Health Board. These include:
- Review of the ministerial ‘safety net’ cover arrangements at WGH.
- Review inpatient gynaecology service provision.
- The urgent need to commence service and capital planning in respect of ‘phase 2’ of the capital scheme at GGH to enable provision of an optimal estate solution for Maternity and Gynaecology services at the hospital, thereby addressing the service quality and efficiency challenges associated with the current interim solution in place.

**Future Priorities for Neonatal Services**
The key development priority facing Neonatal service will be progress in respect of planning towards ‘phase 2’ of the neonatal development at GGH, implementation of the neonatal transitional care service and supporting outreach service.

Activity and demand assumptions in respect of neonatal service provision will need to be planned in partnership with the Neonatal Network.
Future Priorities for Paediatric Services

There are several key development priorities facing Paediatric services. These include:

- Progress in respect of planning towards ‘phase 2’ of the paediatric development at GGH
- Completion of the consultant recruitment initiative to enable achievement of the target establishment identified as part of the reconfiguration model
- Full capacity and demand review of community paediatric service provision including services available to support the assessment and treatment of children with Autistic Spectrum Disorder and ADHD. (Services are currently provided in partnership with separate local authorities and assessment pathways vary in each local authority area)
- Review and improvement of Paediatric Diabetic Services in line with recommendations to be received as a consequence of the recent Peer Review visits undertaken across the Health Board.
- Review of Health Board services provided in partnership with Local Authorities as part of overarching WG policy priorities to address poverty and deprivation and their impact on child and family development

Improved outcomes for health improvement strategies targeted at children and young people and maternal health will be achieved by

1. Improving childhood and maternal immunisation rates

There are current ongoing initiatives:

- plans for a nurse led immunisation service within the Health Board
- Post has been agreed to support child health departments with data cleansing commenced
- Communication/tools/posters have been developed and have been distributed widely across the Health Board
- Focus has been on children’s flu programme supporting and delivering in the short timescale and managing vaccine supply issues
- Routine monitoring immunisation uptake by practice, identifying “queues” and troubleshooting and problem solving local issues and problems.
- There is a Childhood vaccination sub group of the Health Boards Immunisation and Vaccinations Committee in place that is established to focus on childhood work plan to ensure monitoring of uptake and action plan
- A new post of immunisation coordinator is progressing to recruitment early this year

2. Plan to deliver substantial improvement in maternal smoking rates
3. Families First and Flying Start programmes will be enhanced
Section 5b – Together for Health Delivery Plans; Alignment of Planning Priorities; and Research and Innovation

5.11 Involving our Clinicians in Together for Health Planning

Together with our clinical leads we have undertaken a maturity assessment of each of the Together for Health Delivery plans. The table below shows the stage of delivery of the actions within each of the plans with the supporting detail shown in Annex 12 – green indicates we are currently complying the action within the delivery plans; amber indicates that an initiative is underway to ensure compliance and red indicates that we are currently unable to comply. This paints a picture of variability in terms of compliance with the recommendations of the Plans. The intention is to put this at the centre of service planning during 2015/16 by establishing a governance mechanism to ‘map and gap’ compliance more accurately, establish greater clinical ownership and develop transparent plans for the areas of service which do not yet meet the recommendations set.

<table>
<thead>
<tr>
<th>Name of Delivery Plan</th>
<th>Total Number of Actions Within Delivery Plan</th>
<th>Number of Green Actions (Currently Comply)</th>
<th>Number of Amber Actions (Initiative Underway to Comply)</th>
<th>Number of Red Actions (Cannot Comply/Decision or Investment Required)</th>
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</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>92</td>
<td>37</td>
<td>38</td>
<td>17</td>
</tr>
<tr>
<td>Critical Illness</td>
<td>38</td>
<td>9</td>
<td>24</td>
<td>5</td>
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<td>Diabetes</td>
<td>38</td>
<td>16</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>End of Life</td>
<td>31</td>
<td>13</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Eye</td>
<td>20</td>
<td>4</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
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<td>Mental Health</td>
<td>103</td>
<td>79</td>
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<td>0</td>
</tr>
<tr>
<td>Neurological</td>
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<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Oral</td>
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<td>11</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Organ</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory</td>
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<td>12</td>
</tr>
<tr>
<td>Stroke</td>
<td>15</td>
<td>7</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Unscheduled Care</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

In the next steps, we will map the All Wales priorities listed in each area of the plan and the stage of delivery of that priority. However, to do this effectively, even if we need to keep structures separate in organisational terms, we know we will need a ‘planning alignment’ of our Together 4 Health Delivery Plans, Clinical Audit & the Population Health Programme, in order to optimise and transform clinical service delivery.

The 2015/16 Planning Guidelines make clear that ‘NHS Wales will provide the necessary headroom for service change and improvement to happen at the same time as ensuring an unrelenting focus on delivery’. It is clear therefore that to deliver this, we need to align the ownership and implementation of our Together 4 Health
Plans, Population Health Groups & Clinical Audit. This will ensure both tighter governance and help make the right planning connections, as all form key contributions to service scope and quality, set the direction for major service areas and are the subject of national priority setting.

Our 3 Year Plan seeks to:

- Ensure clear governance arrangements are in place for both the Delivery Plans and Annual Reports and updates
- Ensure clear clinical ownership
- Better understand the risks to the delivery of the plans and alignment with the wider ‘Quality’ agenda
- Better align financial and workforce requirements to the achievements of the priority areas established by WG and the Health Board

5.12 Population Health Programme

The Population Health Programme (PHP) was developed for Hywel Dda in 2013 to drive improvements in Health, Wellbeing and Healthcare for the population served by the Health Board. Clear principles were agreed from the outset promoting multi-professional leadership, whole system improvement, evidence based decision-making based on need and value which involves public, patients, carers and employees.

The Programme was launched in 2013 with support from Professor Nigel Edwards from the Nuffield Trust and Professor Sir Muir Gray from “Better Value Healthcare”. Multi-professional clinical Health Group Chairs were appointed in October 2013 and the programme was supported by the Better Value Healthcare team.

This paper outlines the progress so far, and the proposed next steps for the Population Health Programme to best support the Health Board to meet its objectives. Our progress so far is as follows:

**MSK Health Group**
- Support in progressing the MSK pathway and implementation of CMATs

**Elderly & Neurological Health Group**
- Supporting the development of the Hywel Dda’s approach to frailty & dementia
- Development of Hywel Dda’s Neurological delivery plan and partnership working with ABMUHB
- Supporting opportunities for optometrists to take a greater role in Eye care

**Head, Neck, Eye & Skin**
- Development of pathway for childhood eczema
- Progress on skin cancer pathway
Mental Health Group
- Progressing health board priorities from the Statutory Mental Health Partnership Board including reducing stigma & discrimination, reducing suicide & self harm

Digestive & Urological Health
- Progressing the development of work-streams for inflammatory bowel disease, nutrition and obesity

All Health Groups have multi-professional and third sector membership and some work programmes are co-chaired by service users. All Health Group Chairs have been part of the “Improving Quality Together” (IQT) programme, for promoting systematic improvement. Links have been made with local Universities and Health Group Chairs are meeting with the Director for Economic Reform’s team to explore progressing programme budgeting, and the programme has maintained strong support and direction from the Director of Public Health and her team.

Challenges

Whilst significant progress has been made towards its original aims, and it is the only clinically-led programme of work that spans the system, the programme has faced challenges due to Health Board support and resource often being required by other urgent activities. These include relocation of obstetrics, neonates and paediatric services, cardiac surgery outsourcing, the Cardigan Integrated Care, Cylch Caron and other major projects.

Next Steps

It is important that the Population Health Programme support the Health Board in meeting its objectives for improving the Health & Wellbeing of the population, and support the development and implementation of its strategy.

It is proposed that the Population Health Programme evolves to more closely align to key Health Board objectives including Delivery Plans and other key strategic priorities such as for example improving its services for those with frailty, dementia and musculoskeletal problems.

Importantly, it will also bring together programmes of work within the three County locality teams, the chronic conditions teams and the GP cluster work to ensure that there is strategic linkage. In this way the work of the localities and cluster development, and the work of the Health Groups will inform each other and be supported and informed by the clinical audit programme.

To enable this it is proposed that there is a restructure to the Health Groups and that the programme management function will be resourced to ensure that the Population Health Programme will deliver on its expected objectives. The original principles of the Population Health Programme remain integral to its work. Each Health Group will have clear deliverables and The Population Health Programme will report into the Strategy & Planning Committee.
5.13 National Audits

The Health Board participates in National Audits. These are both organisational and outcomes based and we aim to map these across both Delivery Plans and Population Health Groups. The National Clinical Audits are reported to the Clinical Effectiveness & Audit Committee. Listed is the current mapping to the management central structure which is being developed to strengthen the tracking of actions. In addition, it is our intention that Local Audits and the Clinical Audit Programme will be better aligned to Health Board priorities and more clearly linked to delivery objectives.

The attached chart lists the Delivery Plans issued to date, the current management arrangements, and the Population Health Programme Group alignment for future ownership and management and the National audits and their reporting structure. This is incomplete at this stage of the IMTP development, but is illustrative of the direction of travel for the
- realignment of the Population Health Programme.
- the focus on delivery plans for service improvement
- the better alignment between key enablers to progress agreed service priorities

This section of the Plan will then go on to describe in more detail the current status of Together 4 Health Delivery Plans and the Research and Development Programme being progressed within Hywel Dda.
<table>
<thead>
<tr>
<th>T4H Delivery Plans</th>
<th>T4H Current Control Group</th>
<th>Population Health Group (PHG)</th>
<th>National Clinical Audit (NCA)</th>
<th>NCA Current Control Group</th>
</tr>
</thead>
</table>
| Heart Disease     | PHP (Cardiovascular Group currently lack clinical lead) | Cardiovascular               | National Heart Failure Audit  
National Audit of Cardiac Rhythm Management Devices  
Myocardial Ischaemia National Audit Project (MiNAP)  
National Audit of Cardiac Rehabilitation (NACR) | Cardiac Network Group                        |
| Diabetes          | Diabetes Network         | Metabolic                    | National Diabetes In-patient Audit  
National Pregnancy in Diabetes (NPID) Audit  
National Diabetes Audit (Paediatrics)  
National Audit of Diabetes (Primary Care) | Diabetes Planning & Delivery Group  
Women & Children’s Quality & Safety Group  
Diabetes Planning & Delivery Group |
| End of Life       | End of Life Group        |                               |                                                                                             |                                           |
| Critical Care     | Critical Care Network    |                               | Comparative Audit of Critical Care Unit  
Adult Patient Outcomes (ICNARC) | Critical Care Network                        |
| Respiratory       | Respiratory DP Task & Finish Group | Respiratory     | Chronic Obstructive Pulmonary Disease (COPD) | Respiratory Planning & Delivery Group                       |
| Neurological Conditions | PHP                    | Neurological                  | National Dementia Audit | Project Leads                                              |
|                   |                          | Musculoskeletal               | National Hip Fracture Database (Part of FFFAP)  
National Joint Registry  
National Pain Database  
Rheumatoid Arthritis and Early Inflammatory Arthritis | Project Leads                                      |
| Liver (consultation document) | PHP                    | Digestive & Urological        | UK Inflammatory Bowel Disease (IBD) Programme – Inpatient Care Audit |                                           |
| Maternity         | Women & Children Quality & Safety Group | Women & Children | National Neonatal Audit Programme Audit  
National Childhood Epilepsy Audit  
UK Obstetric Surveillance System (UKOSS) | Women & Children’s Quality & Safety Group                        |
<table>
<thead>
<tr>
<th>T4H Delivery Plans</th>
<th>T4H Current Control Group</th>
<th>Population Health Group (PHG)</th>
<th>National Clinical Audit (NCA)</th>
<th>NCA Current Control Group</th>
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| Mental Health               | PHP                       | Mental Health                 | National Audit of Psychological Therapies  
National audit of Schizophrenia                                                             |                           |
| Substance Misuse            |                           |                               |                                                                                               |                           |
| Stroke                      | Stroke Network            | Neurological                  | Sentinel Stroke National Audit Programme (SSNAP)                                               | Stroke Steering Group    |
| Cancer                      | Cancer                    |                               | National Bowel Cancer  
National Lung Cancer  
National Head & Neck Cancer Audit  
National Oesophago-gastric Cancer Audit  
National Prostate Cancer Audit (NPCA)  
All Wales Breast Cancer Audit (WBCCA) | Cancer Clinical Group     |
| Oral Health                 |                           | Head, Neck & Skin             |                                                                                               |                           |
| Eye Health                  |                           | Eye                           |                                                                                               |                           |
| Rare Disease                |                           |                               |                                                                                               |                           |
| Tobacco Control             |                           |                               |                                                                                               |                           |
|                             |                           |                               | National Emergency Laparotomy Audit (NELA)                                                      | Project Leads            |
|                             |                           |                               | Trauma and Audit Research Network (TARN)                                                        | Unscheduled Care Collaborative |
|                             |                           |                               | All Wales Fundamentals of Care                                                                | Project Leads            |
|                             |                           |                               | Serious Hazards of Blood Transfusion (SHOT)                                                     | Transfusion Committee    |
|                             |                           |                               | National Comparative Audit of Blood Transfusion (NCABT)                                         | Transfusion Committee    |
|                             |                           |                               |                                                                                               |                           |
|                             |                           |                               | Chronic Kidney Disease (Primary Care)                                                          | Project Leads            |
5.14 Together for Health Delivery Plans

A) Diabetes

Key Strategic Drivers
The prevalence of Diabetes is increasing year on year. Within Hywel Dda 5.49% of the population have diabetes compared to all Wales figure of 4.87%. Spend on diabetes care across the UK accounts for 10% of all NHS expenditure, in Wales equated to £500 million in 2009-10. Diabetes among adults in Wales is predicted to rise to 10.3% in 2020 and 11.5% by 2030.

Together for Health – a Diabetes Delivery Plan was published in September 2013. In response to this, the Health Boards Diabetes Planning and Delivery Group has developed a local Diabetes Delivery Plan which sets out the vision and required action for the organisation and its partners over the next three years.

Priorities
Hywel Dda’s Diabetes Planning and Delivery Group have prioritised five key areas for focus over the first two years of implementation of the plan. The priorities are aligned to those identified at an all Wales level

i. Targeting the high risk population
- Continue to work with Public Health Wales and partners to understand key population risks throughout the life course and then find when changes in behaviour occur (e.g. people stop taking physical activity, become overweight or take up smoking).
- Continue the Diabetes and CVD screening programme (Iechyd Hywel Health)
- Reduce smoking prevalence and inequality
- Reduce the proportion of the population who are overweight and obese
- Increase physical activity levels especially in older population groups.
- Reduce alcohol consumption and binge drinking.

ii. Improved education for individuals living with diabetes
Hywel Dda will continue to focus on improving access to structured education which is provided in line with the relevant NICE guidance to ensure individuals with diabetes have the necessary information, tools and techniques to manage their condition.

Specifically the Health Board will:
- Continue to develop and implement a model of delivering education to patients within primary care which complements existing structured education programmes which ensures equity of access across Hywel Dda. E.g. X-pert, DAFNE
- Increase the number of people with Diabetes referred to the Education Programme for Patients including the Diabetes Self Management Programme (DSMP), Chronic Disease Self Management Programme (CDSMP) and the Looking After Me programme (LAM)
- Complete evaluation of self management e-digital films and plan rollout across the Health Board in primary care
- Support secondary care diabetes services to improve access for people with Type I to structured education programmes.
iii. Improved education for all young people with diabetes

The Health Board will prioritise the following actions within Paediatric services

- Review current provision of education for children, young people and their families with a view to improving access both in traditional NHS venues and in the community and schools. This includes working with the Brecon group to develop an agreed All Wales educational plan.
- Identify opportunities to educate staff within schools

iv. Improved integration across the pathway

Further integration of diabetes services across the patient pathway is a key priority for the Health Board.
Specifically the Health Board will:

- Continue to implement the ThinkGlucose programme
- Review evaluation of self management e-digital films and roll out across primary care
- Review evaluation of feasibility study of DSMP and provide access to more programmes for people with Type 2 Diabetes
- Seek to optimise treatment and outcomes for patients by ensuring the Diabetes Planning and Delivery Group has access to the range of data and information available e.g. prescribing patterns, admission rates etc.

v. Improving foot management for all patients

The Health Board will prioritise foot management with the longer term aim of reducing amputation rates.
Specifically the Health Board will:

- Promote ‘Putting Feet First’ Integrated Care Pathway across all disciplines.
- Standardise foot screening by promoting an alternative method of accessing training which is resource neutral, for example FRAME e-learning foot screening module.
- Podiatry and Expert Patient Programme to complete and implement the self management programme ‘Healthy Footsteps’

Links to Prudent Healthcare

There are a number of opportunities within Diabetes to take forward the principle of Prudent Healthcare. For example these include:

- Equity of access to structured education
- Increasing the menu of options to self management training therefore increasing numbers of people accessing educational opportunities
- Improve access to digital educational films in primary care to start the introduction to self management as early as possible in the patient pathway

Links to Workforce Plan

In order to ensure a sustainable workforce within diabetes across primary, community and secondary care, there is a need to review current roles, skills and capacity across these sectors. Hywel Dda will be undertaking a review of all specialist nursing roles.
Links to Finance Plan
The Diabetes Delivery Plan highlights where possible new ways of working will be introduced using current resources. However further work is ongoing to assess other resource implications that this will be reviewed as part of the IMTP planning for localities supported by the development of business cases.

Performance
The first Diabetes Annual Report was published in November 2014 and summarises the Health Board’s performance against the outcome and assurance measures within the Diabetes Delivery Plan.

The plan and its associated actions will form the work programme for the Diabetes Planning and Delivery Group, progress against which will be monitored on a quarterly basis and reported to the Executive Board annually.

B) Respiratory Disease

Key Strategic Drivers
Chronic Obstructive Pulmonary Disease (COPD), smoking cessation and pulmonary rehabilitation are a particular focus for the Health Board. There are approximately 7,090 patients registered in primary care as having COPD (1.4%). Hywel Dda has a 21% smoking prevalence rate which equates to 66,000 smokers and a COPD admission rate of 3,203 for 2013/14. Respiratory disease is a very common cause of death, severe acute illness, A&E attendances and a major cause of emergency hospital admissions. COPD is generally the most frequent cause of an emergency admission to hospital. In 2011-12 Hywel Dda spent 5.9% of its total expenditure on respiratory services which equated to £ 106.0 per head of population compared to the Welsh average of £117.7.

Priorities
In response to the national Respiratory Delivery Plan for Wales published in April 2014 Hywel Dda developed its local Respiratory Delivery Plan. The plan sets out how the Health Board will address the actions identified within the national plan thereby improving the care and support, experience and outcomes for people living with a Respiratory condition. Our work programme is focused on four key themes which are underpinned by a range of specific actions:

- Preventing poor respiratory health
- Early detection
- Prompt effective treatment
- Patient education and support services

The Health Board Planning and Delivery Group have identified three local priorities for the first year. These are:

- COPD- Improving discharge utilising the discharge care bundle
- Smoking Cessation- In particular improving access across all four hospital sites to a secondary care service
- Improving access to self management programmes from diagnosis onwards. This includes pulmonary rehabilitation, COPD SM4L and Community respiratory exercise and education programmes combined.
The Health Board is currently awaiting the publication of an addendum to the national plan which focuses specifically on services for children and young people (CYP) with respiratory conditions. Our local priorities for improving services for CYP include:

- Reduce the number of children exposed to passive smoking, and reduce the number of teenage smokers.
- More focus on health promotion/education sessions in schools.
- Establishing better working relationships between primary care and the paediatric team.

**Links to Prudent Healthcare**
The Respiratory Planning and Delivery Group are applying the principles of Prudent Healthcare across the work programme. Examples of specific actions include:

- Improving access to smoking cessation services at all levels including accessibility to smoking cessation services across all 4 hospital sites in Hywel Dda thus improving outcomes for those with respiratory conditions including reduction in hospital admissions.
- Updating the Hywel Dda Respiratory Formulary to improve correct prescribing of inhalers thus improving cost effectiveness.
- Improving access to self management programmes across the Health Board for people with a chronic respiratory condition including pulmonary rehabilitation.

**Links to Workforce Plan**
The Respiratory Planning and Delivery Group are currently reviewing the service and workforce model for respiratory services in light of the Plan and known capacity issues in relation to capacity of the workforce to deliver community Non Invasive Ventilation services and Interstitial Lung Disease services.

**Links to Finance Plan**
The Respiratory Delivery Plan highlights that where possible the majority of actions will be taken forward by making best use of current resource. However further work is ongoing to assess other resource implications that cannot be indentified and this will be reviewed as part of the IMTP planning for localities.

**Performance**
The plan and its associated actions will form the work programme for the Respiratory Planning and Delivery Group, progress against which will be monitored quarterly basis and reported to the Integrated Governance Committee on behalf of the Board annually.

**C) Neurological Services**

**Key strategic drivers**
In May 2014, Together for Health – A Neurological Conditions Delivery Plan was launched. The recommendations are underpinned by the Report of the Welsh Neuroscience External Expert Review Group (2008) and a series of subsequent reports. Each has highlighted the need to significantly improve neurological services in Wales, with the Delivery Plan acting to consolidate the key recommendations.
All Health Boards and their partners are required to develop and implement a local Neurological Conditions Delivery plan underpinned by a local base line assessment of need and demographic profile.

**Current Service**  
Neurological services for residents of the Hywel Dda footprint are hosted by Abertawe Bro Morgannwg with some tertiary services also being accessed from Cardiff and Vale. Outreach neurological clinics are provided at Glangwili and Prince Philip Hospital with a telemedicine clinic also being delivered at Bronglais.

Whilst neurological services are commissioned through a number of agreements that require review and ongoing monitoring, a significant number of patients with neurological services in Hywel Dda receive their clinical care from a physician, geriatrician or general surgeon. People with neurological conditions are admitted to medical beds in all 4 hospitals

**Hywel Dda local Delivery Plan focuses on the following priorities:**

- Raising awareness of neurological conditions – people with neurological conditions in Hywel Dda are accessing specialist services for the first time with already advanced disease. Staff in primary care and secondary care require greater awareness of current recommendations and pathways.
- Timely diagnosis – access to specialist diagnostics such as neuro-radiology need to be readily available rather than generic services, where this can make a difference to effective diagnosis.
- Fast and effective care – specific priorities will require reorganisation of current services if patients admitted with a neurological condition are to see a neurologist within 24hrs of admission as advocated.
- Living with a neurological condition – improving access to multidisciplinary condition specific support and neuro-rehabilitation services
- Improving information – management of information for performance management and commissioning purposes, as well as improved systems to enable appropriate access to clinical records for joint working between organisations.

**Performance**  
Outcome measures are being determined by the all Wales Implementation Group, and will be reported upon via Annual reports. Meanwhile, Hywel Dda is liaising with Abertawe Bro Morgannwg to clarify the detail of services accessed and opportunities for improvement.

**Link to workforce Plan**  
Development of the delivery plan has highlighted workforce shortfalls in neurological services, for example in consultant levels, specialist nursing, neuroradiology, neuropsychology, neuro-rehabilitation and brain injury services. Specific plans to address priority needs will be developed during 2015/16
D) End of Life Care

Key Strategic Drivers
“Together for Health – Delivering End of Life Care” was published in 2013 and provides a framework for action by Health Boards and NHS Trusts working together with their partners. It sets out the Welsh Government’s expectations of the NHS in Wales in delivering high quality end of life care, regardless of diagnosis, circumstance or place of residence in Wales. The Delivery Plan puts forward clear ways in which the voice of the individual, supported by those closest to them, is heard and respected at the centre of the services they need.

Hywel Dda produced its first End of Life Care Delivery Plan in September 2013.

Priorities
In the Delivery Plan we set the following priorities for 2014:
• Official opening of the new Tŷ Cymorth Hospice facility on the Glangwili Hospital site;
• Delivery of the Core Curriculum Training Programme from September 2014;
• Development of a new medical model to support Palliative and End of Life Care within Hywel Dda;
• Continued support for the Third Sector in the provision of Palliative and End of Life Care services;
• Strengthening of Hospice @ Home services across the three counties;
• Roll out of Macmillan Information and Support Service across the remaining three acute hospital sites;
• Closer working, training and education within Care Homes in the statutory and independent sector on Palliative and End of Life Care services;
• Utilisation of Practice Development Plans to inform service developments;
• Improved information sharing across all sectors;
• Improved transition information and services;
• Continuous improvement in all outcome indicators.

Links to Workforce Plan
• The inability to recruit to Palliative Care Consultant posts had resulted in a review of the medical model, which will be strengthened to support Palliative and End of Life Care across Hywel Dda;
• A Consultant Pharmacist post is under development;
• 7 day working of Clinical Nurse Specialists has been established.

Links to Financial Plan
Previously, funding for hospices was directly distributed and monitored by Welsh Government. The Minister has agreed, on advice from the End of Life Care Board, that with effect from the 2015/16 financial year, the funding for hospices will be distributed and managed by Health Boards and Trusts. Funding will be ring-fenced for three years and will continue to be allocated on the formula established by the End of Life Care Board.

Estates/Capital Requirements
• Two Palliative care single rooms have been refurbished at Amman Valley Hospital, funded by the Amman Valley Hospital League of Friends;
• Construction work commenced during 2013 in partnership with Tŷ Cymorth Hospice Trustees to provide new facilities on the Glangwili Hospital site, funded by Tŷ Cymorth Hospice and the unit opened in 2014;
• A commitment to develop a new Chemotherapy Day Unit at Withybush Hospital;
• Support continues for independent sector Hospices within the Health Board area in their plans to strengthen their day care services and respite care services.

Performance
An outcome framework to accompany Welsh Government’s ‘Together for Health – Delivering End of Life Care’ provides the main mechanism for annual performance reporting. It measures the following outcome indicators:
• Residence at time of death;
• The number of emergency admissions for palliative care patients amongst our population;
• The number of people recorded on a primary care palliative care register prior to death;
• The number of people receiving specialist palliative care.
The first Hywel Dda End of Life Care Annual Report was submitted to Welsh Government in June 2014.

E) Critical Care

Key Strategic Drivers
“Together for Health – a Delivery Plan for the Critically Ill” was published in 2013 and provides a framework for action by Local Health Boards and NHS Trusts working together with their partners. It sets out the Welsh Government’s expectations of the NHS in Wales in delivering high quality critical care ensuring the right patient has the right care at the right time. It focuses on maximising efficiency and effectiveness, tackling variation in access and reducing inequalities in service provision across five key priority themes.

Priorities 2013-16
Theme 1: Delivering appropriate, effective ward based care - The Right Patient
• Patients, for whom critical care is appropriate, are identified in a timely manner so they have the best chance of a good outcome;
• Patients for whom critical care is not appropriate are discussed and agreed pre-referral to critical care so they have the best chance of the correct outcome.

Theme 2: Timely Admissions to Critical Care – The Right Patient receiving the Right Care at the Right Time
• Patients, for whom care is appropriate, are admitted to an appropriately staffed critical care unit in a timely manner so they have the best chance of a good outcome;
• Each Local Health Board must assess what level of critical care it can safely provide in each hospital.

Theme 3: Effective critical care provision and utilisation – The Right Care
• Critical care patients will receive care from dedicated critical care medical staff in critical care units which are aligned to the hospital's acute services;
• Critical care patients will receive evidence based care in the form of compliance with care bundles, national guidance and care pathways, etc.;
• Patients will receive the right level of care in the right environment;
• Ensure that critical care patients are managed by dedicated critical care consultants and middle tier doctors.

**Theme 4: Timely Discharge from Critical Care - *The Right Patient receiving the Right Care at the Right Time***

• Patients are discharged from critical care in a timely manner so they have the best chance of early rehabilitation;
• Patients requiring critical care will have improved access due to improved flow through the units;
• 95% of patients will be discharged within 4 hours of being ready for discharge and the bed being requested.

**Theme 5: Improving information and Research**

• Information systems to support high quality care and performance, clinical audit and review to drive service improvement. Critical Care research in Wales should be supported to drive forward improvements in care and outcomes;
• Local Health Boards must use effective ways of finding out patient's views and using these to plan and deliver better critical care.

**Links to Workforce Plan**

The Health board recognises the need to review the level 3, 2 and 1 bed base required to facilitate critical and high dependency and enhanced care across the Health Board, which will inform the workforce requirements across all acute sites.

The recruitment of Consultant Anaesthetists with an ICU specialty in their job plan is a continuing issue.

In addition, there is a recognised shortage of Allied Health Professional (AHP) staff across the Health Board providing the level of support required to facilitate step down from critical care.

**Links to Financial Plan**

The clinical configuration of services across the Health Board’s acute sites will have financial implications associated with any changes in the staffing model which is still to be assessed.

**Estates/Capital requirements**

Decisions on the future clinical configuration of services will determine the estates and capital investment requirements for Critical Care services across the Health Board.

The Delivery Plan has also drawn attention to the lack of level 1 beds at all sites, which may have capital investment implications.

**Performance**

The Delivery Plan for the Critically Ill is based on the following vision:

• Patients and clinicians to discuss and agree appropriateness of critical care and level of escalation of care in time of need;
• Patients to have timely access to (where appropriate for their condition and needs) and discharge from critical care;
• Patients to be cared for in the correct facility with highly qualified specialists;
• Patients and carers to be as involved in their care as they feel appropriate;
• Patients to receive care that is clinically effective.

The Health Board is using three outcome indicators to measure and track how well critical care services are performing over time in terms of the vision outlined above. These are:
• Hospital Mortality - Risk Adjusted Mortality Index;
• Critical Care Mortality;
• % Delayed Transfer of Care from Critical Care.

Achievement against these outcome indicators is reported in the Health Board’s Annual Progress Report.

F) Cardiac

Key Strategic Drivers
Following the launch of the Welsh Government Together For Health Heart Disease Delivery Plan, Health Board have developed a local Heart Disease Delivery Plan 2013. This plan sets out how we will work towards prevention of avoidable heart disease, and demonstrates the plan of securing and delivering high quality person-centred care for our residents affected by heart disease, in conjunction with our partners.

The Heart Disease Delivery Plan requires each Local Health Board to carry out local population needs assessments to promote healthy hearts and treat heart disease, review their services in the light of that assessment, identify gaps between need and current provision and identify where service provision needs to change to meet demand.

A key element of the plan is based on a local population Needs Assessment undertaken by Public Health Wales. This needs assessment generally follows themes within the Heart Disease Delivery Plan utilising an epidemiological, comparative and corporate needs assessment approach.

The permanent resident population of Hywel Dda is currently in excess of 375,200. Life expectancy at birth is slightly higher than the Welsh average with life expectancy at birth being 77.1 years for males and 82.0 years for females.
• Current population projections suggest that the total population of Hywel Dda will rise to 425,400 by 2033.
• The number of deaths from cardiovascular diseases has been decreasing over recent years.
• The age standardised prevalence of heart disease is lower than the all Wales rate.
• 23% of adults in smoke.
• Smoking prevalence is socially determined with the prevalence of smoking doubling between least and most deprived quintiles.
• Changes in smoking prevalence have been minimal over recent years, and recent improvements have not affected the inequalities gap.
• 22% of the adult population of Hywel Dda is classified as being obese with a body mass index greater than or equal to 30. This is the same as the Welsh average and is increasing over time. Both adult and child obesity are more prevalent in the most deprived areas.

• The percentage of people who report meeting physical activity guidelines (30 minutes of at least moderate intensive physical activity on 5 or more days of the week) across Hywel Dda is only 32%. This was just above the Wales average of 30%.

• Adults who report eating 5 or more portions of fruit and vegetables a day is around 38% compared with a Welsh average of 34%.

• 40% of the population report drinking above guidelines on at least one day a week which is the lowest figure for a Health Board in Wales. This compares to a figure of 44% as the Welsh average.

• 24% of the Hywel Dda population reported binge drinking on at least one day in the week prior to being surveyed. The Welsh average was 27%.

• The age standardised percentage for patients with CHD on GP practice registers was 2.5% for Hywel Dda compared to a Wales average of 2.6%. This equated to 2.3% for Pembrokeshire, 2.7% for Carmarthenshire and 2.3% for Ceredigion compared to the Welsh average of 2.6%.

• The age standardised percentage for patients with hypertension on GP practice registers in 2012 was 10.4% for Hywel Dda compared to a Wales average of 11.1%. This equated to 10.5% for Ceredigion, 10.5% for Pembrokeshire and 10.4% for Carmarthenshire compared to the Wales average of 11.1%.

**Priorities**

The Delivery Plan 2013 sets out the following 6 priority theme areas with an action plan of how the Health Board will work towards a comprehensive prevention agenda, the challenges of addressing the service delivery agenda, meeting target waiting times and working in conjunction with WHSSC and ABMU in achieving timely access to Cardiac Surgery for the residents of Hywel Dda.

• Promotion of health hearts

• Timely detection of heart disease

• Fast and effective care

• Living with heart disease

• Improving information

• Targeting research
In order to further improve the pathway of care for patients, priorities for 2015 have been refined to include:
1. Developing a consistent model for the delivery of cardiovascular risk assessment.
2. Delivering the cardiac waiting time target through more effective pathways.
3. Developing component or differential waiting time targets.
4. Consider new workforce models of delivery that release capacity.
5. Improving participation and case ascertainment in National Clinical Audit.

In addition to these, local priorities include developing a service model for Cardiac services within the Health Board, improving Referral to Treatment time targets, improving participation in cardiac rehabilitation, development of a business case for a Cardiac Catheterisation Laboratory within the Health Board.

The Health Board have established a Cardiac Service Programme Board with 4 subgroups to take forward these priority areas. A key milestone is the workshop arranged with all key stakeholders on the 28th January in defining the service delivery model.

**Links to Workforce Plan**
The workforce requirements identified through the planning process to meet RTT, access to timely diagnosis include additional Consultant Cardiologists. The nursing workforce are reviewing current service provision and models of care within the community. The full extent of this will be scoped as an element of the Service delivery model for Cardiac Services in their entirety.

**Links to Financial Plan**
The increased demand for services in primary, community, acute and specialist care, reducing waiting times and improving timely access to diagnostics cannot be underestimated. The alignment of current and future demand of services based on the needs assessment, will require the financial budget and resources to be clarified.

The Cardiac Services business case developed following the workshop for submission to the Executive Board will include financial modelling.

**Performance**
The Cardiac Services Programme Group is responsible for overseeing delivery, reporting progress to the Strategy & Planning Committee to the Board and producing an Annual Report for the Health Board on progress against the Delivery Plan actions.

**Capital / Estates Requirements**
It is acknowledged that the Health Board require a Cardiac Catheterisation Laboratory. This will require the development of a Business Case.

Estate requirements will be considered as part of the Service Delivery Model.

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**G) Stroke**

**Key Strategic Drivers**
Stroke remains a high priority for Hywel Dda. Our Stroke Delivery Plan was launched in March 2013 and provides the focus for our stroke teams. The vision within our stroke delivery plan is that

- People of all ages have a minimised risk of having a stroke and, where it does occur, an excellent chance of surviving, returning to independence as quickly as possible.
- to have stroke incidence and mortality rates comparable with the best in Europe

We have seen great developments in our stroke care over the last three years. Indicators show that we perform well in many aspects of stroke care compared to our Welsh peers. However we know that there is more that we need to do to ensure that our stroke care is amongst the best in the UK.

Priorities

Our stroke delivery plan aligns with the all Wales Stroke Improvement Group on the 3 main priorities identified across Wales;

- The identification and management of patients with atrial fibrillation
- Development of hyper acute stroke units
- Community rehabilitation

We also however have to tackle the areas which we have identified as gaps in our services in particular access to psychology and consistent Transient Ischaemic Attack services across the Health Board. We have also prioritised action to ensure that patients admitted with a stroke have timely access to a stroke bed.
Links to Workforce Plan
Our staffing levels fall short of the RCP guidelines on our acute and rehabilitation stroke units. Access to psychology is a priority for the Health Board with the following workforce requirements identified; (ref SBAR Psychologist in Stroke Services)

- 0.8 Consultant psychologist band 8c
- 1wte Senior Psychologist (with doctoral training) band 8a.

Additionally the All Wales Stroke Improvement Group is developing a specification for a community rehabilitation service that we will need to ensure aligns with our community service teams.

Links to Finance Plan
The implications financially are largely associated with an increase in staffing to meet Royal college guidelines but further work, aligned to the all Wales work on the development of hyper acute stroke units will determine final staffing model. One of the identified priorities is the development of consistent TIA services which may have a financial impact once the work is completed on the service model.

Estate/Capital Requirements
At the present no estates requirements have been identified.

Performance
We monitor our performance through the SSNAP tool monthly and Royal College Audits annually/bi annually.

H) Mental Health and Learning Disability

Key Strategic Drivers
The National strategic direction is to move services to more community focused delivery wherever it is appropriate and safe to do so, and recent Welsh Government policy clearly indicates the changes needed in the way we deliver Community based care in Wales. The ‘Together for Mental Health Strategy and Delivery Plan’ in conjunction with the Health Board Mental Health and Wellbeing Strategy 2012 - 2017 have given a clear focus for the Hywel Dda community to work in partnership to improve the health and wellbeing gains for people who are, or have potential to experience mental health problems.

The overarching imperative and emphasis of the Strategy is the promotion of mental wellbeing, mental illness prevention, appropriate and easy access, early interventions and timely treatment. Effective and evidence based treatments and interventions need to be accessed and delivered at the most appropriate stage and cohesively across services.

SCAMHS services across Wales are currently under immense scrutiny nationally and following an Health Inspectorate Wales / Welsh Audit Office review in 2009 and 2013 there is a CAMHS Delivery Plan in place to address key issues identified within the reports.

The Substance Misuse Strategy for Wales 2008-2018 “Working Together to Reduce Harm” is the Welsh Assembly Government’s 10 year strategy for tackling the harms associated with the misuse of alcohol, drugs and other substances in Wales. We are continuing to take a joint approach to tackling drugs, alcohol and other substances with our partners through the established Area Planning Board and are committed to
delivering core Health Board services in line with the National strategic direction. Co-occurring substance and mental health issues is an area of significant growth in our communities and therefore any service development needs to address cross-service strategic drivers.

In 2007, the Welsh Government issued a new 'Statement on Policy and Practice for Adults with a Learning Disability'. This confirms a vision for the future based on the principle that all people with a learning disability are full citizens, equal in status and value to other citizens of the same age. The Mid and West Wales Learning Disability Partnership (MWWLDP) has developed as part of the Regional Collaborative structure and is key to the Health Board delivering modern Learning Disability services with our partners going forward. The MWWLDP in supporting a transformation programme that develops the commissioning of a progressive model of care, and promotes the integration of services and infrastructure where appropriate. The MWWLDP has produced a Statement of Intent which reflects a range of priorities across health and social care for the region which includes a strategic commitment to work collaboratively over the next three years to address areas of current need.

Service Priorities
MH&LD services in Hywel Dda have undergone a major programme of service redesign in recent years which has enabled the delivery of enhanced community mental health provision, with a resulting reduced reliance on in-patient services. The implementation of primary Mental Health legislation with The Mental Health (Wales) Measure 2010 has provided an opportunity for services to be delivered differently, enabling a more flexible and targeted use of resources across primary and secondary care ensuring that people receive the most appropriate support at the right time by the most appropriate service.

Our service model is underpinned by evidence based psychological interventions, delivered in a timely fashion by appropriately trained, competent practitioners. In order to impact on the mental health of future generations, the Hywel Dda community is committed to focussing its health and well-being services on young adults, through transition and into adult services, the promotion of personal strengths, resilience and recovery being key to our service model. Our Mental Health & Learning Disability services are focussed on a progression model aimed at improving community resilience and enablement through choice, self direction and control over our own lives, with an opportunity to move away from traditional services such as hospital and residential care. The MH&LD Directorate Integrated Medium Term Plan sets out the detailed plan over the next 3 years to achieve:

- 24hr Mental Health Centres with Hospitality / Crisis Beds
- Centralisation of acute admission, Psychiatric Intensive Care Unit, Low Secure Unit and ECT Therapy.
- Integrated Unscheduled Care and Liaison Psychiatry
- Enhanced Primary Care Mental Health Provision
- Management of complex dementia via repatriation to core Challenging Behaviour Unit
- Develop services to meet the growing demand in Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) in adults.
- Alternative commissioning of core Learning Disability Assessment & Treatment, ASD and Residential provision
• Commission local personality disorder Supported Living project to enhance repatriation potential
• Deliver Specialist Child and Adolescent Mental Health (SCAMHS) Crisis Intervention Service
• Integrate Psychological Services to compliment core service delivery
• Review and re-commissioning of third sector / Local Authority services to support delivery of revised service models
• Joint commissioning of Supported Living provision to facilitate repatriation from high cost residential provision
• Decommission commissioned Learning Disability respite and core residential provision

Adult Mental Health
Current traditional acute in-patient units in our outlying areas are unsustainable going forward both clinically and financially due to workforce challenges, without significant re-modelling. The intention is to commence a period of engagement with stakeholders on the choices and views associated with the delivery of acute Mental Health care. This could be transformed as part of our whole systems plan in order to provide enhanced integrated community mental health centres in partnership with our Local Authority and Third Sector partners. Centres could provide access to a range of psychological interventions and day opportunities in additional to crisis / hospitality beds. Reconfiguration of the In-Patient and Crisis Home Treatment Teams to create an integrated acute care service would streamline the patient pathways and enable the transition to new models of care. The implementation of unscheduled care and liaison psychiatry are key components of the future service model.

The comprehensive review of existing community mental services will further align primary and secondary care provision and integrate the forensic mental health services to better meet the needs of our population.

Old Age Mental Health
A multi agency workshop in 2015 will commence development of a regional Dementia Strategy to facilitate the service change set out in the IMTP.

An Invest to Save proposal is being developed to provide an Intensive Care / Challenging Behaviour Unit for OAMH in order to facilitate the repatriation of individuals from high cost, out of area placement with the independent sector. The provision of this core service will provide a comprehensive care pathway for individuals requiring specialist in-patient care.

Additionally the redesign of our existing community services in order to realign with general health and social care community provision will ensure that a range of care needs can be met in a timely way. The development of an information “one stop shop” in partnership with social care and the third sector provides a local facility for individuals to drop in to obtain information on dementia and community support for carers. The current pilot will inform the progression of a Primary Care based Dementia Diagnosis Service and support the comprehensive review of the existing memory assessment services in each locality. The Health Board is linked in with a national project led by Public Health Wales, to undertake an All Wales audit on Memory Assessment Services.
The role out of the Dementia Friendly Communities has commenced across the Health Board in line with the Dementia Vision for Wales, with Pontyberem in Carmarthenshire being the first to formally launch. The concept of Dementia Friendly Communities aims to raise awareness within the general public, and has the potential of increasing the rate of early dementia diagnosis.

Specialist Child & Adolescent Mental Health
The Choice and Partnership Approach (CAPA) was initially implemented in SCAMHS in 2013/14 in order to ensure delivery of a standardised evidence based model of care. The service is undertaking an audit to review the compliance with the model and to ensure the current service provision is in balance in relation to demand and capacity. The integration of SCAMHS within the MH&LD Directorate in 2014 has provided significant opportunity to realign services in order to improve services during transition from children’s to adult services. There is a commitment to further invest in Early Intervention Psychosis and At Risk Mental State initiatives to improve outcomes for children and young people.

The development of a Community Crisis Assessment and Treatment Team (CITT), closely aligned to the adult Crisis Resolution Home Treatment Team will provide intensive opportunity at the point of crisis so that access to local or Tier 4 in-patient services is minimised and young people are supported within their local communities.

Learning Disabilities
A comprehensive review of our existing Learning Disability Residential services will be completed taking into account the recommendations from the Winterbourne View review with view to re-commissioning the services with the independent sector. Current community learning disability services vary across the Health Board and therefore the review of existing residential and in-patient services will facilitate reinvestment in enhanced community service provision. Greater integration with mental health, general health and substance services will be progressed via the development of formal shared care protocols, and realignment of core services where appropriate.

The Health Board’s limited ASD diagnostic service will need to expand to address the increasing incidence of Autistic Spectrum Disorder / Attention Deficit Hyperactivity Disorder within our population. There is an urgent need for appropriate intervention services to promote early detection, intervention and self-management.

Substance Misuse
The focus for our core Health Board substance misuse service is to consolidate the integrated care pathways for substance misusers based on a stepped model of care, ensuring that service users have their needs met at the least intensive level of service and intervention. The Health Board interventions provided are focused on those service users with the most complex and high level need, are evidence based. The focus for service development is on structured psycho social interventions, strengthening of the range of harm reduction services i.e. BBV testing and vaccination, naloxone provision, and robust pathways into Tier 4 service.

Substance services will be progressing through a comprehensive commissioning review in partnership via the Area Planning Board which will define the level and range of services required for commissioning over the next 3 years.
Psychological Therapy
In line with Welsh Government “Delivery of psychological therapies: Policy implementation guidance”, the Psychological Services Management Committee (PSMC) is undertaking the following programme of work;

- Increasing access to psychological therapies
- Training / skilling up the multi-disciplinary workforce so that it is fit to deliver a range of psychological interventions.
- Setting and Monitoring Quality Standards of the delivery of psychological therapy in terms of accessibility, appropriateness (i.e. evidence base), acceptability i.e. Service user perspective) and Outcome.
- In addition to training staff in psychological interventions, it is also tasked with increasing the psychological mindedness of staff in all aspects of care i.e. enabling staff to engage with patients attuned to their emotional / social needs as well as physical / medical.

The Therapeutic Day provides a robust alternative to hospital admission and / or placement external to the health board for a number of client groups and also allows for greater provision of psychological therapy at a primary care level and will be further enhanced over the next 3 years to provide improved access at a primary care level.

Prudent Healthcare
The MH&LD Directorate is applying the principles of Prudent Healthcare across its work programme. Examples of specific initiatives include:

- Delivery of Therapeutic Day Service, providing timely access to the appropriate evidence based intervention at Primary or Secondary Care level to minimise the need for intensive secondary care intervention and / or admission to hospital.
- Delivery of a Street Triage service in partnership with Dyfed Powys Police, via a successful bid to the Police & Crime Commissioners Fund, to provide access to information across agencies and an appropriate alternative to Section 136 disposal and admission to hospital where safe to do so.
- Development of At Risk Mental State (ARMS) service alongside existing Early Intervention in psychosis (EIP) service to promote early detection of young people at risk of developing a psychosis so that the appropriate preventative psychological intervention can be available.
- Implementation of a stepped care approach in our substance misuse service to ensure that the least intervention appropriate is provided to meet the individual needs.

Partnerships
The Hywel Dda Local Mental Health Partnership Board (LMHPB) is well established with a range of stakeholders engaged. The LMHPB has good service user and carer representation and has in 2014 produced its first truly co-produced Annual Report which sets out its delivery against the “Together for mental Health” Delivery Plan, with our service users receiving payment for their contribution to its publication.

Hywel Dda were one of the first organisation’s that stepped up and engaged with Time to Change Wales (TTCW) when the Organisational pledge was formally signed in October 2013. The Health Board campaign is led by the MH&LD Directorate.
TTCW is the first national campaign to end the stigma and discrimination surrounding mental health in Wales. A local partnership team has developed and involves individuals from across all areas of the Health Board but also engages with other organisations across the region including the Fire Services, Police, West Wales Action for Mental Health, local TTCW staff as well elements of the local community. A launch week was undertaken in 2014 and the impact of this high profile activity engaged Health Board staff, patients, local community and other relevant statutory and third sector organisations and raised awareness within our communities. The Health Board has been selected as the only one in Wales to contribute to a national evaluation of the project and is being heralded as setting a footprint for all other HBs to follow.

The Hywel Dda Mental Health service has been a member of the International Mental Health Collaborating Network (IMHCN) since 2013 and have presented at 2 international conferences. A positive connection has been established with Mental Health services in Italy which will assist us in transforming our service models in Wales. Trieste mental health services are a world leader in ‘Recovery’ in mental health. The Trieste Model focuses on service users’ recovery by enabling them to become active citizens. The focus is on helping and empowering rather than treating and fixing. A formal Twinning Agreement is being progressed and the Health Board recently shared its international partnership experience at the launch of the Welsh International Partnerships Charter.

Workforce Development Plan
Our directorate workforce strategy will increasingly focus on developing our staff to deliver the best possible healthcare closer to patients’ homes through integrated working across health, social care and the voluntary and independent sectors. Building on our current progress we will seek to modernise and support alternative methods of service delivery through the extension, development and enhancement of roles, looking at new ways of working and utilising IT/technology where. This will require a workforce that is adaptable, appropriate in terms of skill mix and competency levels, affordable within our budgetary constraints and that meets our patients’ needs both in hospital settings and community environments 24/7.

Psychological Therapies is high on the agenda of Mental Health, Learning Disabilities & Specialist Child and Adolescent Mental Health Services in Hywel Dda. This is promoted through the local Psychological Therapies Management Committee (PTMC) that is widely represented and includes membership from general health and chronic conditions and there is a strong commitment to the development of a psychologically minded workforce.

The MH&LD Directorate has a number of significant workforce challenges over the coming years that the IMTP Workforce plan will need to address, namely:

- Learning Disability nursing workforce age profile
- Recruitment and retention of Nursing and Medical workforce in Pembrokeshire and Ceredigion
- Sustainability of Medical on-call provision across 4 sites

The Directorate is working with other services within the HB to consider innovative solutions to its workforce challenges.
Financial Plan
The key issues shaping the Mental Health & Learning Disability Service Financial Plan and which the service must manage carefully in the next 3 years are:-

- The maintenance of existing income and expenditure to ensure that the delivery of services remain within the resource envelope
- The delivery of our agreed efficiency target
- The required recurrent Cost Improvements Programmes (CIPs) in Operational and Commissioned Mental Health & Learning Disability services
- The balance of prioritising essential expenditure over developmental priorities
- The management of risks to the financial plan through cost pressures and mitigations

In line with the principles of prudent healthcare the focus of the MH&LD Directorate going forward will be to ensure that:

- Service user, family and societal engagement, and increased responsibility, in planning and evaluating services
- Services and interventions are targeted at those most in need and provided at the earliest opportunity
- Services that are delivered focus on best outcomes and best evidence
- Best value is considered in the use of resources

Estates / Capital Requirements
The majority of Mental Health and Learning Disability Services are delivered within Community settings with minimal reliance on in-patient services. The service development plan clearly sets out the Directorate’s intention for further disinvestment in in-patient provision and growth in Community provision in partnership, for all ages and specialities within Mental Health and Learning Disabilities. It is therefore essential that our Community estate and facilities are fit for purpose to deliver these service models. The geographical spread of our Community service provides further challenge which dictates a flexible approach to the utilisation of Health Board and Local Community facilities and venues.

Therapeutic Day Services have developed and expanded across the Health Board area as an alternative to hospital admission and have demonstrated a significant impact on in-patient service demand. These services will develop further as part of this plan and therefore will require appropriately accessible facilities within local communities within which to deliver psychological and functional services.

The proposed adult and older adult mental health in-patient service configuration requires capital investment to extend our current facilities and capacity in Carmarthenshire to enable the centralisation of acute and specialist in-patient provision. This will facilitate the transformation of existing county based in-patient provision into integrated Community Mental Health Centres within the provision of crisis beds. Opportunities will also be sought for the progression of share care arrangements within existing Acute Hospital provision to ensure that specialist mental health nursing is available locally to support the frailty agenda.

The proposed commissioning of a Complex Care Unit on the PPH site alongside existing mental health facilities, for challenging presentations within old age mental health, will require capital investment to allow for the necessary environmental
adaptations. This will facilitate the repatriation of individuals currently placed within private facilities at an additional cost to the Health Board.

A comprehensive optional appraisal has been undertaken to identify and secure multi-agency premises for the delivery of substance misuse services in Ceredigion, which will need to be progressed in order to achieve sustainability of the current level of service delivery locally.

The principles of prudent healthcare support the provision of intervention at the earliest opportunity to ensure the greatest impact and therefore the requirement for the delivery of Mental Health services in Primary Care settings will continue to increase.

**Integrated Performance**
An integrated Directorate Performance Dashboard has been developed as part of the implementation of the revised Directorate structure, which scrutinises performance across finance, quality & safety and workforce indictors in order to inform the operational management and strategic development of our services.

The Directorate reports its performance against the Welsh Government Tier 1 targets for Parts 1,2,3 & 4 of the Mental Health (Wales) Measure 2010, KPI for Substance Misuse and AQF targets for CAMHS and Crisis Resolution Home treatment provision internally and externally on a monthly basis. The Directorate has a robust plan to monitor and address any fluctuation in performance against key indicators which is monitored via the Health Board Integrated Governance Committee (IGC) on a quarterly basis.

| I) Cancer |

**Key Strategic Drivers**
Our aim is to deliver safe, sustainable, high quality care for our population that is patient centred. The rural nature of the health board however presents a particular challenge in relation to recruitment and delivering safe sustainable care close to home.

The executive recognise that to meet these aims and deliver prudent health care we will need to develop innovative ways of working and strengthen our existing working relationship with neighbouring health boards.

**Priorities:**
The Health Board is working to 2 sets of closely aligned priorities. Those identified by the Cancer Network and internal priorities.

Network priorities
- National focus on lung cancer
- Patient Experience
- Single urgent cancer pathway
- Primary Care Oncology
- Organisation of Cancer Support Services

Health Board Priorities
To complete a review of current non-surgical Oncology services and develop recommendations for a networked regional service model linked with ABMU HB

As part of the above overarching review to develop a model of acute oncology care and access to out of hours advice

To strengthen all MDTs and develop an overarching governance group to inform the future Health Board strategy

To complete a review of all cancer pathways to ensure that performance targets can be sustainably met and that patients receive timely investigation and treatment. This will include the primary care element of the pathway

To address the patient experience survey results focusing on both the primary and secondary care pathway

As you can see these sets of priorities closely overlap and in addressing the Health Board’s priorities we will encompass those issues identified by the network. This work is being carried out alongside the work identified within the delivery plan.

To-date the following progress has been made:

- **An oncology review programme board has been established with the following subgroups:**
  - **Acute Oncology Group.**
    - Funding for 5 acute oncology nurses with Macmillan has been identified and an Oncologist from ABMU has been seconded to develop the implementation plan.
    - We are working with ABMU developing a shared Chemotherapy Advice Line service
  - **Chemotherapy Services Group.**
    - A multidisciplinary group is looking at chemotherapy clinic models including new methods of pre-chemotherapy assessment such as telephone reviews suited to our more rural environment
    - Chemotherapy nurses are investigating nurse led clinic models
  - **Out patient access Group.**
    - An oncologist from ABMU has been seconded to develop an option appraisal for a networked model
  - **Data subgroup:**
    - This group has completed a needs analysis and activity analysis
    - The Health Board has become a pilot site and has already submitted data for key indicator analysis of Systemic Anti Cancer Therapy

- **A new Cancer Services Clinical Lead has been appointed**
  - MDT lead job descriptions have been reviewed with a view to Health Board roll out in 2015
  - Terms of reference of a new governance group have been agreed and this group will be established in 2015. The group will include primary care membership
    - This group will be responsible for revision of clinical cancer pathways
    - Acting upon patient experience feedback
    - Building prudent health care into all aspects of cancer patient care
Aligning to Prudent Health Care:
They key elements of prudent health care as described by the CMO are being built into our service development:

- Constantly apply evidenced based practice
- Equity based care- treating the greatest need first
- Equal partnership with patient and professional
- Do the minimum necessary
- Do no harm
- Co-create health with public, patients and partners and prevent the preventable

Co-creation of health is already built into our delivery plan and we have well established examples of working with our population including our innovative Smoking Cessation Service. In addition we are working closely with the CHC and using their cancer experience information to inform service developments as well as jointly taking forward initiatives such as the patient held cancer record to allow greater patient ownership of their cancer journey.

The development of an acute oncology service is also a key element to our service improvement strategy which we know shortens length of stay, can improve outcome and the patient experience.

In revising our pathways and reflecting on patient experience we will ensure we build in prudent health care into the heart of what we do. In particular we know from evidence from the Kings Fund that in cancer care medical teams expectations are not always aligned to those of the patient in terms of treatments offered and can worsen the end of life experience.

Aligning to workforce Plans:
As part of our non-surgical oncology review we have carried out a full staffing and skills baseline assessment as well as an activity analysis. In addition we have seconded an ABMU consultant oncologist to carry out a staffing review and option appraisal. This will form the basis of our service development and will be taken forward alongside new staffing developments. These include:

1. The staffing review will look at a range of networked models providing a S W Wales regional service
2. We are working closely with MacMillan Cancer to establish five 3 year funded acute oncology nurses into Acute Oncology Teams within each hospital site. We recognise that single handed models are not sustainable and by developing local teams we feel we can produce a strengthened model and provide professional development opportunities for existing staff
3. Funding has been identified to establish Haematology Specialist Nurse provision in Carmarthenshire
4. Information Officers have been appointed

Aligning to Financial Plans
- Consultant staff: Funding currently exists within the HB for 4 consultant staff however 3 of the posts are vacant and currently occupied by agency locums. There is a significant financial cost associated with existing non-viable clinical as well as issues with quality of care. Detailed financial modelling is not yet available but will form part of the option appraisal and has been identified within the IMTP
- MacMillan funded posts will also be addressed.
- Haematology Specialist Nurse: Funding has been identified for 4 years from charitable funds and the role includes professional development of chemotherapy staff to develop team expertise within chemotherapy staff.

**Aligning to estates planning:**
There are 2 major estates developments related to chemotherapy services within the Health Board which are at the planning stage:
- Development of a new Haematology-Oncology Day Unit within Withybush Hospital. This is partnership development with charitable organisations set up to raise funds to support cancer services in Pembrokeshire. There is a project board leading this development chaired by our Chief Operating Officer and the membership includes clinicians and local fund raisers.
- The potential to development a new Haematology-Oncology Day Unit within Bronlais Hospital. This is part of a bigger estates review within the hospital and has not yet reached a project board stage. It is being led by the Director of Acute Services.

**Aligning to Performance:**
The Health Board is committed to meeting the tier 1 targets for both urgent and non urgent cancer pathways and continues to work closely with tertiary partners to ensure appropriate access and high quality outcomes for our residents.

![Graph showing pathway performance](image)

Work has already been completed to try to overcome backlogs in the system and process improvements such as systems for requesting of radiology and histology for USCs cases have been put in place. It is however our clinical pathway reviews through strengthened MDT working that will be key to developing sustainable improvements in cancer performance.

It is important to note that some of the bottle necks in our systems are due to capacity and are related to recruitment issues in radiology and pathology.
necessary we are outsourcing non cancer work in an attempt to allow our own staff to focus on this key area.

We have also commissioned in collaboration with the 1000 Lives Team an external review of radiology which will report in January 2015 on the opportunities for pathway improvements.

However recruitment in Histology and Radiology are a major and ongoing challenge in meeting performance targets.

J) Substance Misuse

Strategic Drivers
Tackling drug and in particular alcohol misuse is an increasing focus for the Health Board. Those at risk of harm from alcohol misuse come from across the spectrum of society. They include chronic heavy drinkers, adults at home drinking at hazardous or harmful levels, and children and young adults who suffer from, and who cause, much of the alcohol related violence and disorder on our streets – often as a result of binge drinking. The impact on health of alcohol misuse is significant and more people die from alcohol related causes than from breast cancer, cervical cancer and MRSA infection combined. Excessive alcohol consumption is a major cause of serious liver disease, which is often fatal and alcohol is a major contributing factor to the risk of cancer to the breast, mouth, gullet, stomach, liver, pancreas, colon and rectum. Furthermore, foetal alcohol syndrome is a risk to the babies of mothers who abuse alcohol.

In Wales, 15% of all hospital admissions and 30,000 hospital bed days are related to alcohol every year. Liver disease is responsible for around 1,600 admissions with the health service costs in Wales as a result of alcohol related chronic disease and alcohol related incidents estimated at between £70 million and £85 million each year.

Much of the harm from drug misuse is caused by a small number of drug users. These people are thought to account for 99 per cent of the total costs associated with drug misuse, are responsible for the vast majority of drug related crime and are the group most likely to harm their health. However, health services costs can still be significant with the health service cost in Wales estimated at £17.6 million per year.

Between April 2013 and March 2014, 2053 referrals were received in Hywel Dda area for alcohol treatment and 535 referrals for drug treatment. The scale of actual demand for alcohol treatment is likely to be much higher, with Pembrokeshire in particular experiencing higher than the Welsh average number of alcohol – specific and alcohol attributed hospital admissions.

Tackling drug and alcohol misuse is complex and difficult for any one organisation to tackle in isolation. In recognition of this, in April 2013 Welsh Government created Drug and Alcohol Misuse Area Planning Boards (APB), co-terminus with Health Board areas. These are multi agency partnerships made up of the key statutory responsible authorities for substance misuse including Probation, Police, Health and Local Authorities. The Hywel Dda Area Planning Board Executive and Strategy Delivery Group is chaired by a Hywel Dda Assistant Director and supported by a Health Board drug and alcohol misuse strategy and commissioning team.
Hywel Dda has in place a Drug & Alcohol Misuse Commissioning Strategy for 2012/15 which is in accordance with the Welsh Government’s strategy “Working Together to Reduce Harm - The Substance Misuse Strategy for Wales 2008-18”. The strategy is focused around four key themes as follows:

- **Preventing harm** - helping children, young people and adults resist or reduce drug or alcohol misuse by providing information about the damage that substance misuse can cause to their health, their families and the wider community.
- **Supporting drug and alcohol misusers** - to improve their health and aid and maintain recovery thereby reducing the harm they cause themselves, their families and their communities.
- **Supporting families** - reducing the risk of harm to children and adults as a consequence of the substance misusing behaviour of a family member.
- **Tackling availability** and protecting individuals and communities - reducing the harms caused by substance misuse related crime and anti-social behaviour, by tackling the availability of illegal drugs and the inappropriate availability of alcohol and other substances.

The local Hywel Dda Strategy has five key objectives, linked to population health outcomes, supported by five detailed action plans for delivery. The plans are founded on the principles that intervening early works and saves money, investing in alcohol interventions improves health and saves money and investing in drug treatment cuts crime and saves money.

In addition, the third commissioning strategy for drug and alcohol misuse is currently in development with work underway on the needs assessment, gap analysis and development of commissioning intentions.

**Local Achievements & Priorities**

As part of the implementation of the local Commissioning Strategy the following has been achieved:

- Following a successful tender exercise a new regional drug and alcohol service for young people commenced in October 2013 delivered by Drugaid Choices. In addition, additional investment was provided to CAMHS to provide a specialist CAMHS worker for substance misuse and access to a young persons drug and alcohol misuse consultant.
- Funding was secured for the creation of Alcohol Liaison Nurses in Prince Phillip Hospital and Bronglais. This will include the introduction of assessment for alcohol misuse via A & E and general admission and ensure onward referral to community alcohol services.
- Implementation of a Hywel Dda wide Naloxone Scheme providing training in the administration of Naloxone, which temporarily reverses an overdose whilst waiting for an ambulance, to service users. To date this has been used 34 times, potentially saving 34 lives.
- Implementation of a blood borne virus action plan
- Increase in capacity of family support for those concerned about the drug or alcohol use of a family member or friend
- Development and implementation of a process for the review of fatal and non fatal overdoses within the Hywel Dda area.
- Capital funding obtained for purchase of a fibro scan for utilisation in Gastroenterology in Prince Phillip Hospital
Work currently underway includes:

- Large re-tendering exercise in partnership with criminal justice partners for all third sector adult drug and alcohol treatment provision across Hywel Dda area. The tender exercise will be completed during January 2015, with implementation from April 2015.
- Capital funding obtained for the purchase of new multi agency drug and alcohol premises in Aberystwyth
- Roll out of Alcohol Liaison Services across all four hospital sites

**Links to Prudent Healthcare**
The drug and alcohol field has been practising prudent principles for a long time, largely as a result of until recently, relatively low public sector funding levels and the critical importance of service user motivation and commitment in terms of achieving positive outcomes from services. Examples of specific actions include:

- **Single point of contact and single assessment services** which promote the prudent healthcare principles of only carrying out interventions with proven clinical benefit, as well as carrying out the minimum appropriate intervention.
- **Co-production** of services is particularly visible within drug and alcohol services and focus will continue on ensuring service users are linked in to a range of Mutual Aid services such as AA, NA, SMART Recovery and their locally developed equivalents. In addition services will be delivering a range of user led, user provided services and peer led interventions focused on recovery of individuals and reintegration into the community.
- Continuing to monitor the impact of the Communities Together Programme which has been working since January 2014 in Fishguard and Goodwick Pembrokeshire, encouraging people to collectively explore their alcohol use and its impact.

**Links to Workforce Plan**
A particular focus will be the roll out of Alcohol Brief Interventions (ABI) training and training in use of AUDIT – C initial assessment for hospital staff across all four sites as part of the implementation of the Alcohol Liaison Service.

**Links to Finance Plan**
The drug and alcohol misuse strategy is being delivered utilising the £1.72 million NHS ring-fenced substance misuse monies, the £2.2 million Welsh Government Substance Misuse Action Fund (managed by the Health Board) and contributions made by partner organisation such as the Police and Crime Commissioners Office, NOMS, Dyfed Powys Police and the local authorities.

**Performance**
Delivery of the Hywel Dda Drug and Alcohol Strategy is closely monitored by Welsh Government and bi-annual monitoring visits are undertaken by Welsh Government Substance Misuse branch. All commissioned services submit quarterly performance reports to the Drug and Alcohol strategy team within the Health Board which are also then submitted to Welsh Government with the quarterly financial claim for the Substance Misuse Action Fund (SMAF).

Monthly reports are submitted to the national substance misuse database on progress of commissioned treatment services against the six Welsh Key Performance Indicators (KPIs). KPIs include achieving a waiting time of no more than 20 days between referral and treatment and the percentage of positive
treatment completions. Between April and November 2014 Hywel Dda had green status against all of the KPIs.

**K) Maternity services**

Please refer to section 5.10 – Women’s & Children’s Services

**L) Organ donation**

In January 2014 the Welsh Government published “Taking Organ Transplantation to 2020 – Wales Action Plan” with the overall objective that Wales will become one of the best performing countries in the world for donation and transplantation. The plan sets out the actions and outcomes up to 2020 to enable this to be achieved. Hywel Dda UHB also has a local strategy and action plan.

The responsibility of the Hywel Dda Organ Donation Committee is to ensure that organ donation within the Health Board achieves its potential, to examine aspects of the processes which may be hindering that aim and implement changes to improve organ donation rates. The Wales Transplantation Advisory Group provides national leadership and will monitor progress made within the Health Board with compliance in implementing UK and Welsh strategies, and deliverance on actions required from the Wales Action Plan.

**M) Oral Health**

As detailed in Chapter 4.4 it is the intention of the Health Board to have a networked dental service offering an accessible and safe service to our population with routine care delivered as close of home as possible. We also have an employed Community Dental Service, offering care to those patients who may find it difficult engaging with a traditional high street dentist. Annex 12.2 details the Health Boards plans to help support delivery.

**N) Eye Health**

Hywel Dda is currently developing its eye health services especially through the enhanced use of the 52 optometry practices within its boundaries. Annex 12.3 details the Health Boards draft plans to help support delivery.
5.15 Research & Innovation

Research & Development (R&D) is undertaken across a wide range of disciplines within the Health Board. Currently there are 194 active research studies, led locally by a variety of staff including Doctors (143), Nurses (9) and Allied Health Professionals (AHPs) (18).

These research studies can be broken down into the following categories:
- 44 Clinical Trials of Investigational Medicinal Products (CTIMPs), of which 7 are commercial studies and 3 have been developed and led by the Health Board.
- 111 Research studies (non-CTIMPs), of which 22 are led by the Health Board.
- 39 Educational Research projects, of which 12 are led by Health Board staff.

The National Institute of Social Care and Health Research (NISCHR) Clinical Research Portfolio (CRP) studies are high quality patient-facing studies which have been externally peer reviewed and are externally funded. Hywel Dda currently has 89 active Portfolio studies, of which 8 are Health Board led.

R&D activities cover many areas, however Health Board researchers are building a national reputation within Respiratory (22 studies), Diabetes (18), Dermatology (5) and Breast Cancer (8).

Vision for the next few years

The Health Board’s R&D Department will maintain its close working relationship with NISCHR, Welsh Government following the restructuring of the NISCHR Academic Health Science Collaboration (AHSC) and NISCHR Clinical Research Centre (CRC) in April 2015. This will include contributing to the development of, and supporting the implementation of, a the NISCHR Support & Delivery Partnership Statement between NHS Wales, NISCHR Support Centre and NISCHR Workforce in order to meet both the Health Board’s and NISCHR’s R&D Strategies.

The aim is to continue to increase R&D activity overall, particularly the number of NISCHR CRP studies, the number of commercial studies, the number of Health Board Chief Investigators, and the numbers of subjects recruited to both CRP and commercial studies. This is essential to maintain or increase Hywel Dda’s NHS R&D Activity Based Funding from NISCHR, Welsh Government which is determined annually in competition with the other Health Boards and Trusts across Wales.

Hywel Dda researchers’ achievements have been recognised by winning a number of national awards, for example:
- MediWales Innovations within the NHS Award (2010) awarded to Dr Keir Lewis, Respiratory Unit and CDM Team, HD for development of innovative technology within the NHS which will have an impact on patient care.
- ASH Wales, Tobacco Excellence Award (2013), category 5: Academic and Research Organisation awarded to Dr Keir Lewis and Rachel Roberts for outstanding achievement in the area of tobacco prevention and cessation across Wales.
- MediWales Partnership with UK/International Industry Award (2014) awarded to Hywel Dda for collaboration with industry that has resulted in major impact on patient care/cost saving.
The R&D Department will continue to encourage research excellence to hopefully increase the number of research awards won by Hywel Dda researchers, thus continuing to raise the Health Board’s research profile.

There will also be a drive to increase the Health Board’s amount/proportion of research grant capture by promoting and facilitating applications from Hywel Dda’s research community and also by increasing the number of joint applications submitted with collaborative research partners.

By working closely with the Finance Department (R&D Finance Manager and R&D Finance Officer), the R&D Department will continue to ensure that all R&D activities are costed and accounted for in line with the organisation’s Standing Financial Instructions. The R&D Costing Process has been drafted and is under discussion at the NISCHR Costings Working Group which is tasked with producing an all Wales non-commercial R&D costing template. The R&D Costing Process includes a Cost Recovery Plan and Income Distribution Model which meet NISCHR’s Key Performance Indicators (KPIs) and targets, thus ensuring that transparent and efficient mechanisms are in place to allocate resources and recover costs from relevant sources including industry and research grants.

Enhanced collaborative research opportunities will continue to be explored and expanded upon with Higher Education Institutions (HEIs), commercial companies, Small and Medium Enterprises (SMEs) and the third sector (e.g. charities). This will be driven by working with the South West Wales AHSC Hub Coordinator, a post which has been jointly developed and funded by Hywel Dda and Abertawe Bro Morgannwg since January 2014, and with the South West Wales Industry Manager through Health Research Wales, NISCHR.

The R&D Department will continue to liaise with the Pathology Department, Clinical and Research Nurse Communities to progress a Human Tissue Authority (HTA) Licence for Research. This will be essential to support a future bid to develop a Biobanking Centre to enable tissue banking activities covering a wide range of disease areas across the Health Board. The aim is to work with the Wales Cancer Bank (WCB) to reinstate the Health Board’s WCB Licence, previously held at the Withybush General Hospital (WGH) site. This will require a commitment from the Pathology Department to support tissue sampling activities on site, which would be undertaken by the Advanced Biomedical Scientist (Research).

The Health Board is working with local Universities to increase the number of clinical academic appointments made, which would lead to increased opportunities for R&D and would in turn increase our share of the NHS R&D Activity Based Funding allocation from NISCHR.

The R&D Department will need to liaise with relevant Divisional/Directorate Leads to implement the research-related recommendations of the Mid Wales Healthcare Study Report (2014), and will continue to promote the Health Board as a centre of excellence for Rural Health Research, with Bronglais General Hospital as the Rural Health Research Hub.

The Senior R&D Manager and R&D Manager will continue to facilitate the development of a Research and Development Strategy for Nurses, Midwives and Allied Health Professionals, which is led by the Assistant Director of Nursing &
Midwifery and the Assistant Director of Therapies & Health Care Sciences. Through its implementation, greater opportunities will be made available for these staff groups to undertake their own research.

In order to promote equity of access to opportunities for patients and service users across all sites to participate in and potentially benefit from research, the R&D Director and Senior R&D Manager continue to lobby the Health Board for improved facilities to undertake and support research, as outlined in the Research and Development Strategy (2014 – 2017 Annex 13). Ideally, dedicated space for R&D activities will be made available for clinicians and Research Nurses, and capacity issues addressed within the clinical support services such as Pathology, Pharmacy and Radiology, in order to build capacity to undertake and support high quality research.

Through further development of the R&D intranet and internet sites as part of the Clinical Effectiveness website, and by creating links to the South West Wales AHSC Hub, Health Research Wales and forthcoming new NISCHR websites, enhanced dissemination of R&D undertaken within the Health Board will be made possible. In addition, translational research activities will be supported and the research community encouraged to summarise how their research findings have made a difference to clinical practice. Staff groups will also be encouraged to apply evidence-based decision making in their everyday practice, and the R&D Department will continue to liaise with relevant departments to ensure that R&D is a key component of this, thus demonstrating an organisational mechanism for increasing the translation of research into practice.

The R&D Department currently lacks the necessary resources and expertise to identify, protect and exploit Intellectual Property Rights (IPR) including training, know-how and copyrighted material (training aids etc). This issue is likely to be addressed through NISCHR’s restructuring (from April 2015) and the increased opportunities to establish closer working relationships.

Enhanced joint working between the Health Board and ABMUHB R&D Departments and the NISCHR Clinical Trials Units (CTUs) in Wales will be explored and further developed. The R&D Department also works closely with members of the Forum of NHS Wales for R&D Management in Health and Social Care (FORWARD), through which it promotes the spread of innovation and good practice across the NHS both within Wales and Nationally (through some members’ involvement in the UK Wide Compatibility Group).

Hywel Dda will continue to strengthen its links with Primary Care by promoting research activity through the Primary Care Research Incentive Scheme (PiCRIS). This is a Welsh Government funded scheme whereby research-active GP practices can gain research accreditation and receive funding in return for a commitment to support research projects. The aim is to increase PiCRIS registered Health Board GP Practices. Currently we have 1 Affiliated Practice and 1 Level 1 Practice; in 2014/15, 2 more Practices have applied for Level 1 and 1 Practice has applied for Level 2. If successful, we will have a total of 1 Affiliated, 3 Level 1 and 1 Level 2 Practices.

The R&D Department will continue to work towards maintaining compliance with current NISCHR KPIs and targets, and to achieving compliance with the forthcoming KPIs and targets. Compliance status reports are made to the Board twice a year.
Current resources to achieve this in practical terms

The R&D Department comprises the following staff: R&D Director, Deputy R&D Director, Head of Clinical Effectiveness, Senior R&D Manager, R&D Manager, R&D Coordinator, R&D Administrator, Research Portfolio Coordinator, Research Nurse (Commercial and Internal studies), Research Nurse, R&D Finance Manager, R&D Finance Officer, Advanced Biomedical Scientist (Research), Clinical Trials and Research Pharmacist, Research Assistant.

The R&D Office is based on two main sites as follows: the R&D Manager and R&D Coordinator, who together maintain a register of R&D projects and coordinate research applications for R&D permission, are based at WGH. The R&D Manager also spends 1 day per month at BGH to provide R&D advice to the local research community. The Senior R&D Manager (strategic role), R&D Administrator, Research Portfolio Coordinator, Research Nurse (Commercial and Internal studies) and Advanced Biomedical Scientist (Research), who facilitate the operational delivery of R&D, are based at the Clinical Research Centre, Prince Philip Hospital (PPH). All these posts are Health Board-wide.

Research Nurse Teams are based at all four main hospital sites as follows: there are 3 Research Nurses and a Research Assistant, led by the Research Nurse Team Lead, at WGH. There are 2 Research Nurses and a Research Assistant based at BGH. A Research Nurse is based at Glangwili General Hospital (GGH), and one of the WGH Research Nurses provides cover 2 days per week as required. The Clinical Trials and Research Pharmacist is a Health Board-wide post based at GGH, and oversees the other Clinical Trials Pharmacists; both WGH and BGH have a dedicated Clinical Trials Pharmacist (0.5WTE). A new Clinical Trials Pharmacist post at PPH (0.5 WTE) will be advertised in early 2015.

The Assistant Director of Workforce and Organisational Development (Leadership, Education & Development) was the nominated representative on NISCHR AHSC’s Knowledge Transfer Task and Finish Group. The Head of Clinical Effectiveness attended a NISCHR Workshop to discuss implementation of these recommendations (September 2014) and concluded that additional resources would need to be made available in order for the recommendations to be implemented.

The R&D Department is represented on the Board by the Medical Director. Through ongoing regular meetings between the Medical Director, R&D Director, Assistant Director of Safety, Assurance & Improvement and Head of Clinical Effectiveness, mechanisms to ensure that leadership and R&D are actively integrated into local planning, financial and decision making structures will continue to be discussed and implemented.

The Health Board continues to develop a quality research culture that values and promotes research through leading and/or hosting research studies, with high quality NISCHR CRP studies being prioritised for support. The R&D Department is involved in the promotion of research so that staff recognise and understand the role that research plays in increasing and delivering good quality care. A R&D presentation was delivered at the Organisational Development session of the Board in October 2014 outlining the benefits to patients involved in research studies and clinical trials, and cost savings to the organisation.
By supporting high quality research, maximising collaborative research opportunities with both industry and academia, facilitating subject recruitment into research studies and clinical trials and ensuring dissemination of research findings, Hywel Dda will continue to improve patient outcomes through participation in research and maximise impact from research results.

5.16 Sensory loss

In response to the publication of the All Wales Sensory Loss Standard by Welsh Government in 2013, Health Board convened a multi-agency group (SLSIG) to help deliver their implementation. This group has met regularly since September 2013 and it has been recognised that this is a work in progress, underpinned by efforts by the Health Board to build dialogue that is open and trusting with colleagues.

Primary care generally seems to be an area for development although some good experience has been reported in Ceredigion. This may be helpful in terms of helping to drive forward a wider improvement agenda. Generally, there are positives reported on emergency care and this may be related, in part, to the booklet prepared by the Welsh Ambulance Services Trust. Plans remain active to localise and disseminate this booklet widely as part of raising awareness amongst staff in particular.

The work undertaken on estates, for example the Walk and Talk, seems to be valued. Opportunities should be taken for further involvement in estates projects and suggestions have also been made for improvement. The most positive themed score was on ‘raising concerns’. Consolidating this would seem useful and as is encouraging a culture where patients or their carers and families are empowered to speak up.

The NHS does seem responsive is people ask but not everyone will express needs. Furthermore, we know that more needs to be done - not least the recording of medical records and issuing of outpatient correspondence which currently is inconsistent. There are also issues of basic communication and lack of awareness in some settings. There are opportunities to address this via staff training, probably through the third sector.

In moving forward the priorities for 2015/16 have been identified as:

- Development of a pre hospital communication guide for staff to be able to communicate with those with sensory loss.
- Further enhancement of identifying SI patients through Medical Records utilising the symbols agreed by the Sensory Loss Group.
- Roll out of Out Patient Department letters in font size 14 following discussions at the group.
- Provision of specific SI training for NHS staff provided by the Third Sector.
- Standardisation of all Interpreter and translation services across the Health Board.
- Enhancement of internal and external signage at PPH (through Front of House) and GGH bringing them up to the standards attained in WGH & BGH.
- Further work with Community Health Council to include SI issues in their HPE visits e.g. Hearing Loop Systems.
Chapter 6: Ensuring a flexible, skilled and motivated workforce

6.1 What we know about our workforce and its challenges

The aim of this section of the plan is to specify how the Health Board intends to ensure that we have a flexible, skilled and motivated workforce ready to support the effective delivery of quality services to our healthcare community. However, first, we need to explain where we currently are.

The Workforce and Organisational Development Directorate work closely with Operational Services as well as corporate service colleagues in Planning & Finance to enable proactive and integrated working and, where relevant for specific services, with regional service provision and planning. This enables the team to engage with the planning of new services and modernisation of workforce models from the outset and ensure that workforce planning is fully integrated and embedded at all levels within Health Board planning.

The principles of Prudent Healthcare underpin all plans as does the investment in the development of our staff to maximise their full potential to deliver the prioritised service outcomes. The Health Board will achieve this via number of workforce initiatives and techniques which are detailed within this chapter.

Hywel Dda has 9,967 directly employed staff; which equates to 43% of our budget and does not include our Primary Care contractor workforce or the significant number of social care staff across our three Local Authorities. Historically, we have spent up to £10million per year on temporary medical locum and agency workers to fill posts where we have gaps due to the recruitment challenges we face in some sub specialties. This is neither economically sustainable nor does it provide the highest quality of care.

We also face the challenge of providing care in a largely rural area. The consequence of running 4 district general hospitals means that we have an expensive workforce model, in particular medical rosters and overheads which are disproportionately expensive to provide. A summary of key core information on our current workforce is represented below:

Our workforce is predominantly female with the majority of staff working full time.
The Health Board takes its responsibility to provide bilingual services to our patients very seriously and to support this has developed and begun to implement its bilingual skills strategy. The first part of the strategy for all service areas is to identify our welsh speakers and below is our progress to date. Details of the strategy are included below for further clarity.

Age Profile

The age profile of our workforce indicates that 34% of our total staff are between the ages of 46 & 55. There are very few employees below the age of 20. However when looking at the different staff groups the ranges change considerably. Below are a few examples:-
Workforce Challenges

The challenge of maintaining safe and appropriate staffing and services across four main hospital sites is that it limits our ability to maximise cost effectiveness and efficiency and also means we are unable to recover our excessive costs.

The national legislative, qualitative, professional, and clinically led drivers influence workforce skill mix and professional practice across all Health Boards. However, within the timeframe of the plan there are the following specific challenges:

Age Profile/Retirement

As noted, the potential retirement rates present opportunities for some services to modernise roles and workforce models in line with planned changes. There are real concerns in relation to GP, practice nurse and community nurse workforce retirement projections. There are some risks which will need to be mitigated throughout the changes to our workforce model:

- Consideration of the dilution of our more knowledgeable and experienced staff
- The management of succession planning
- The ability to successfully support the mentorship of educational placements of students
- Potential impact on career pathways (acknowledging that there may be additional pathways defined by new roles)
- Where there are specific professional standards defining establishment/skill mix the Health Board will need to continue to monitor compliance with the standards

The projected potential GP retirements over the next 5 years indicate that 29.2% (around 63 GP posts) of the total workforce could retire, and of this 39.8% are currently within South Ceredigion & Teifi, 38.8% the 3 T’s, 30.8% Llanelli and 27.9% South Pembrokeshire. There is a national shortfall across the UK in terms of the GP’s in training and the service needs which is already impacting upon our success in recruitment locally.

The projected potential Practice Nurse retirements over the next 5 years indicate that 29.9% (around 30 posts) could retire and of them 68.4% are based in North Ceredigion, 35.3% in the 3 T’s and 34.1% in Amman Gwendraeth which have to date proved to be challenging from a recruitment perspective. The Practice Nurse posts are often filled by locally based district nurses, but the same age profile risks apply within community nursing. Either way, regardless of education commissioning this is a risk to service provision. The risk is further compounded by the likely growth in advanced practice roles which may attract applications from the more experienced staff further diluting the skill mix within the core service teams.

The Health Board has undertaken an analysis by staff group, locality and sub-specialty in order to identify where the greatest risks sit in order to strategically mitigate the risk through planned recruitment. In addition the primary care workforce development plan sites a range of initiatives to mitigate these risks including:

- Increase independent prescriber training for a wide range of professionals in order to facilitate a change in the Primary Care skill mix
- Salaried structure for new GPs to the area to attract new GPs to the area to work in a defined cohort of GP Practices
• Retainer scheme for experienced GPs to support vulnerable practices or provide leadership to support change.

• Employed practice nurse bank to develop new nurses skills in primary healthcare and to support backfill for training or leadership and professional support to existing practices.

• Recruitment and publicity campaign to have a sustained and co-ordinated presence for Primary Care recruitment to Hywel Dda. This will be multi-faceted, utilising social media, traditional printed press and open days / supported visits.

• Development of Prescribing Pharmacist Model for GMS creating a pathway into GMS work will support the diversification of the workforce.

• Development of Physician associates to support doctors in the diagnosis and management of patients. The training takes 2 years and it is proposed that bursaries are made available to support the development of a cohort of physicians associates who can then work within Primary Care.

• Growing Primary Care skills, leadership and knowledge to manage a programme of structured education and learning, including backfill costs where appropriate on a systematic basis utilising needs assessment information.

• Development of Champions: Building on the funding received in 2014/15 from WG to continue to build champions in Primary Care who can support the preventative and engagement agenda.

Recruitment & Retention

The Health Board is experiencing difficulty in recruiting to some counties/staff groups (these are detailed in the workforce spreadsheets within the supplementary spreadsheets). The greatest challenges lie in clinical staff/rota maintenance to deliver secondary care services within some sub-specialties in some localities and Primary Care. The Deanery requirements for doctors in training also impact on the ability to deliver services in specific areas raised earlier in this plan.

Nursing Acuity Modelling

The Health Board will need to implement the outcomes from the national nursing acuity modelling work streams and any resultant national standards set through the CNO for Wales for district nursing, community hospitals nursing, and mental health once trends and information are strong and validated.

The Safe Nurse Staffing Levels (Wales) Bill

The above Bill will impose a duty on health service bodies in Wales to take all reasonable steps to maintain recommended safe nurse to patient ratios in adult inpatient wards in acute hospitals. There will be a provision for Welsh Ministers to extend this duty to other healthcare settings as evidence on safe staffing levels within other sectors are developed. To ensure that resources are not diverted from areas where recommended safe staffing ratios do not apply there is a duty for health service bodies to have regard to the importance of ensuring nurses are deployed in sufficient numbers to ensure safe nursing care to patients at all times.

This Bill poses significant challenges to the Health Board, there is a financial consequence linked with supernumerary status of ward sisters as well as ensuring...
the regular collection of patient acuity and use of electronic staff deployment tools plus the ability to release and train staff.

Nurse Revalidation

Between January 2016 and December 2018 all staff in the Health Board who are registered with the Nursing and Midwifery Council will be required to commence a new system of professional revalidation in order to maintain their registration. This will involve around 3,300 staff. In the proposed revalidation model, the nurse or midwife will need to continue to declare that they remain fit to practice as they do currently but this will require confirmation from another registrant who is familiar with their practice. The Health Board implementation plan is currently being refined and will assume that the professional confirmation process (ie the Professional Appraisal) will be integrated within a single organisational Performance Appraisal and Development Review (PADR) process which will take place in a consistent manner on an annual basis. This will require 100% compliance in achieving an annual PADR for all nurses and midwives.

Every nurse and midwife employed in the Health Board needs to be aware of the new process and the personal requirements this places on them and also the timing of when it will affect them in order to avoid any risk to their registration being maintained. Also, as the process is significantly different from the current organisational PADR system, the new system will require every nurse/midwife line manager (approximately 600 staff) to undertake a one day preparation programme for this new function during 2015. In addition, consideration also needs to be given and support provided for registrants working in primary care and the independent care home sector as they will also need to have robust systems in place to enable them to sustain a workforce which is fit to practice and where every registrant maintains their registration in full compliance with the additional NMC standards and criteria. The Health Board will need to invest in work with these two vital parts of our health care services over the coming year (2015/16) in order to ensure that the potential risks of revalidation to the nursing and midwifery workforce, such as lapsed registrations or rise in decisions to retire in order to avoid new requirements, do not impact on the whole systems ability to meet care needs from January 2016.

IT Infrastructure

The IT infrastructure needs to be strengthened and focused to enable modernised practice across services to make best use of our workforce on an all Wales basis as well as locally. This is particularly important given the geography of the Health Board.

Education and Training

Staff release to attend training is an ongoing challenge. This includes both the ability to ensure mandatory and essential training is delivered, as well as ongoing continuing professional and personal development (CPD). The NHS Wales Staff Survey for Hywel Dda indicated that 32% agreed that there was strong support for training in their area of work, compared to an All-Wales 36%. Where new and modernised roles are being developed, the required education timescales will need to be included in the plan. This is particularly of note for Assistant Practice, Advanced Practice and Physician Associate roles.
There will also be a requirement for backfill to support development of staff for these posts. We are currently reviewing all roles with ‘Advanced’ in the title, to ascertain whether some of these can be converted to Advanced Practice roles in line with NHS Wales Advanced Practice Framework, to support service developments and new initiatives with minimal development interventions. Also there are implications of education commissioning in terms of the student placements and mentorship required.

Finally, in re-configuring our staffing profile, we will need to ensure consideration is given to the loss of knowledge and skills of longer serving more experienced staff. Combined with recruitment weaknesses by county; and then by profession, it makes our challenges in terms of creating a truly flexible skilled workforce across the three counties as the geography limits cross county working.

6.2 Key Workforce Assumptions, Strategies & Policies

The key workforce assumptions for the Health Board over the next 3 years are as per the National Finance Agreement work, which at a high level, comprises

- A 1% pay award in each year
- Agenda for Change incremental drift of £908k per annum over the next 3 years

We estimate the staff turnover will remain at 7.99% in 2015/16 (the trend is 7.99% based upon last 3 years although current turnover excluding junior medical staff is 11%) This is a key factor for the Health Board in delivering planned reductions in pay spend.

The Health Board will apply a series of national and local strategies which act as enablers to support workforce sustainability and development actions which will work within our workforce assumptions, which includes:

Workforce and OD Strategies & Policies

There are a range of key strategies and policies to support the delivery of the plan. The All Wales ‘Working Differently, Working Together’ Workforce and OD Strategy informs our local strategy which is currently under review with the objective of focusing and aligning strategic actions to support operational service priorities.

Organisational Change Policy (OCP) is applied to the operational delivery of all service changes impacting upon the workforce. In addition to this a number of policies and strategies exist to support modernisation and these include:

- Voluntary Early Release Scheme (VER) - designed to assist staff in taking a personal decision regarding their future employment and enable staff who may wish to leave their employment with NHS Wales to do so with an appropriate compensatory payment. It is a scheme under which an individual employee, in agreement with their employer, chooses to leave employment in return for a severance payment. VER is not a contractual entitlement and is not redundancy.
- Deployment Policy - This policy sets out the principles and processes to support the flexible movement of staff between services and teams to support service delivery.
• Recruitment and Retention Strategy - The Health Board is currently reviewing its strategy and has begun to modernise its approach to recruitment and advertising practices to maximise not only the volume of applicants but also the quality, we are working closely with Shared Services to refine systems and processes and enable swift and timely employment and finally and most importantly, improved retention of staff through a range of staff benefits, staff engagement and a more personalised induction process and opportunities for both starters and leavers to give the Health Board feedback.

• Welsh Language Bi-lingual Skills Strategy - The Health Board's strategy focuses on the following:
  - Identifying local service need through analysis of census data relating to the Welsh language within the population of Hywel Dda
  - An audit of staff's current Welsh Language Skills to find out where our current Welsh speakers are based
  - Identifying current skills gaps and addressing these on a prioritised basis through action plan development with managers, teams and departments across the Health Board.
  - Bridging the gap – ensuring our staff are able to deliver the service bi-lingually where appropriate. This includes staff confidence and language development opportunities, and assessing vacant posts to establish whether the ability to speak Welsh is essential or desirable.

6.3 Motivating our Workforce by Becoming an Employer of Choice

The Health Board is working towards being the Employer of Choice within not only the local community but also in terms of attracting a highly skilled workforce to join the organisation from across the UK. To achieve this there are a range of initiatives currently in place as well as new work underway to strengthen our position as an employer:

Recruitment and Retention

Hywel Dda is currently reviewing its current Recruitment and Retention Strategy in an effort to:
  - Attract and retain talent from a wider range of sources
  - Refine and speed up the current systems and processes and, as a result be more
  - Cost effective in terms of effort/ outcomes.

The Health Board has developed recruitment campaigns for difficult to fill posts and will continue with its approach by not only using NHS Jobs but to also use Facebook, Doctors.net, Twitter and LinkedIn. We will be engaging with our communities and Universities to raise the profile of the Health Board and its highly successful workforce champions (e.g. first Physiotherapist prescriber in Wales, clinicians who are published and internationally renowned for their research and medical caseloads). We all also look to engage with passive candidates and not only those actively looking for a new role. We have begun to review our corporate web-pages and recruitment documents and have begun to engage personally with candidates throughout the recruitment process. To further strengthen our approach the Health Board is developing its employer 'brand' and working with our partners to help raise
the profile of the Health Board to candidates who may search for information about
the Health Board.

A range of new documentation/activities to support the process include:

- updated management guidance
- monthly recruitment statistics
- recruitment flow process chart
- exit interview questionnaire
- revised/enhanced Induction process
- behavioural selection methods
- open days and job fairs
- improved detailed job descriptions
- Core 'bank' of interview questions and finally
- We will develop a strategic recruitment plan aligned to our prospective
  workforce models which will encompass the turnover/age profile risk
  through targeted structured proactive recruitment by staff group and
  thereby mitigate risks.

In addition to this there will be opportunities for staff to develop their knowledge and
applied experience through structured rotation and development programmes
aligned with their individual performance review.

The Workforce and OD team have a range of partners with which they work. Key
successes in partnership include working with Careers Wales, for work experience
placements, and the Prince’s Trust Cymru to offer work experience and training
opportunities to young people aged 18-25 who are not currently in employment,
education or training. Further partnership working will begin with schools, colleges
and universities to support the development of our workforce for the future.

Health & Wellbeing

Good staff health, well-being and sustainable engagement is vital for ensuring that
the Health Board can meet the challenges of delivering comprehensive and
consistent high-quality patient care, continuing to improve services within resource
and financial restraints, reinforcing and supporting public health promotion and
prevention initiatives, attracting and retaining staff and being recognised as an
employer of choice.

The Health Board has undergone a period of significant change with more to come
and this inevitably has an impact on employee well-being and the services and
functions in place which are designed to support staff. The challenge lies in
managing change in ways which promote and support employee well-being, line
managers having the skills and support to effectively manage the human element of
change processes and the various support teams having the capacity to provide
timely and appropriate advice and support to staff where that is needed.

Increasing work demands and ongoing change processes are known to increase the
risk of work related stress, which in turn can lead to increased absenteeism or
presenteeism with decreased productivity, increased interpersonal conflict and an
impact on the quality of patient care. The challenge is around the ongoing promotion
of employee well-being, taking effective systemic measures to prevent and reduce
work related stress and having cost effective and evidence based support services in place to address staff well-being issues in a timely way when they do arise.

The Health Board recognises that we need to think more broadly about health and well-being. Instead of focusing solely at the level of the individual employee, we need to pay attention to the range of complex, inter-related factors that influence individual well-being (such as organisational culture, leadership, environment and engagement)

The Health at Work Group and the Staff Engagement Sub-Group are currently under review and a more effective, integrated forum for addressing the interplay of employee well-being, staff engagement and organisational culture will be established.

**Reward & Recognition**
Staff engagement is further supported by a commitment to Reward and Recognition through a range initiatives acknowledging that our staff are not only our most important asset, they are our population and our patients and we must develop our commitment to them as much as possible. The Health Board has developed a Staff Benefits Scheme which covers a wide range of benefits including

- NHS Discounts encompassing entertainment, finance, health, shopping, travel, communication and IT,
- access to local fitness clubs,
- cycle to work schemes
- Technology schemes
- Leave Purchase Scheme which allows staff to have a greater work life balance.

Our Best of Health Staff Awards is an award scheme to recognise and reward the abundance of innovative and good practice in delivery of health services across the Health Board. It aims to encourage and highlight best practice and support quality initiatives at all levels of the organisation and awards can be won by anyone who has achieved or demonstrated measurable or clearly visible improvements in patient care or service delivery. Nominations are received from individual staff members, teams, directorates, departments and members of the public, patients, carers and service users. All nominations are judged against set criteria by a panel including representation from the Executive Team, Independent Board Members, the Health Board’s Partnership Forum, Hywel Dda Community Health Council and sponsors of the awards.

**Work Experience**
The Health Board has established links with local schools and colleges and is committed to working with them to provide students and any individual interested in working within the NHS, not only with work placement but also with an understanding of the wide range of professions required to support the NHS. The team ensure that they are aware of access to apprenticeships, in house development programmes as we want all our staff to achieve their full potential. In the past year, the Health Board have provided 335 placements across all services.

**NHS Pension Scheme**
The NHS Pensions Scheme is still a tremendous advantage to working within the NHS. The scheme will change from 2015 and introduce new pension arrangements
to members. These are:

- A Career Average Re-valued Earnings (CARE) scheme, with benefits based on a proportion of pensionable earnings during a career.
- An accrual rate of 1/54th of each year’s pensionable earnings with no limit on pensionable service.
- A normal pension age at which benefits can be claimed without reduction for early payment, linked to the same age as you are entitled to claim your state pension.
- Pensions in payment to increase in line with inflation (currently CPI)

**Volunteers**

The use of volunteers within the Health care setting can be often overlooked and misunderstood. Volunteers pose tremendous benefits to patients from having someone to sit with them for a chat when they are alone, to helping with nutrition needs. The Health Board currently has over 200 volunteers and will look to widen the scope of use of volunteers acknowledging the value of them to the organization.

Volunteers come from a range of age groups and backgrounds and volunteer for a variety of reasons. The service has and is enabling volunteers to develop social networks, confidence, self esteem and a variety of new skills through the range of interesting and stimulating opportunities. Last year 22 volunteers went onto paid employment, 6 with Hywel Dda and 24 volunteers have gone onto university. ‘Volunteering for Health’ recruits volunteers for a variety of roles in the Health Board including ward befriending, and, peer support roles, both of which are very popular with the local community. The Meet & Greet Volunteer Services in Glangwili Hospital, Withybush Hospital and Prince Philip Hospital are now established and have supported over 3,605 visitors to these hospitals. Interest in the volunteering service and demand for volunteering opportunities from the general public has remained constant and there has been an increase in the demand from wards and departments for volunteers.

**Organisational Development**

**Culture**

To achieve our organisational vision, we have been developing a culture of engagement, openness and honesty and in which all elements of the workforce are encouraged to be innovative. Central to this is the need for clear and supportive leadership, including robust and empowering clinical leadership and staff engagement.

Our desired culture is one where high quality care is delivered through:

- **Effective Leadership** to create the environment where staff treat patients and each other with dignity and respect, and there are high levels of trust, and empowerment throughout the organisation, underpinned by effective communication, collaboration and partnership working.
- **Continuous Improvement and Innovation**, underpinned by a culture of learning, where staff maximise their potential and feel they are part of Hywel Dda’s success
• **Accountability and Productivity** where individuals and teams have clarity about their roles and responsibilities, and are held to account for delivery of agreed objectives, team working and effective governance, ensuring the organisation provides the best possible health and well-being outcomes for the people the Hywel Dda serves.

**Values & Behaviours**
The Health Board has commenced a major staff engagement exercise to create value statements which staff can recognise and own. Being clear about our values, in a language the organisation can relate to and will underpin other work (eg values based recruitment and dignity in care), The Health Board will also be very clear about what behaviours will not be tolerated. A ‘Hywel Dda Manager’s Standard’ was developed in 2012, which set out the behaviours expected of all Hywel Dda Managers. A supporting manager’s passport development programme supports managers to achieve the competencies and behaviours required of the manager’s standard. Hywel Dda has adopted the Aston ‘Team Based Working’ approach. This has an evidence base which demonstrates the clear link between Workforce & OD practice (including team working, engagement) and improved patient outcomes.

**Continuous Innovation And Improvement**
The Health Board has taken an organisational development approach to improvement, through the delivery of the Improving Quality Together programme. This All-Wales development brings a coherent approach to service and process improvement, utilising a methodology which is designed to empower staff to make changes within their own environment. It starts from the principle that all NHS staff have a duty not only to perform to their job description, but to continuously suggest and make improvements in their working practices and that of their teams.

**Staff Engagement**
The Health Board recognises that the plan can only be delivered through strong and honest partnerships with staff and their representatives as well as through our engagement with individuals and openness through a variety of communication methods responding to ‘queries and myths’.

Partnership working is imperative if we wish to ensure a locality perspective to healthcare delivery. The Health Board works in partnership with Trade Union representatives through the Local Partnership Forum, which is supported by three County-based Partnership Forum Groups and an Organisational Change Sub-Group. There are also three Local Medical Staff Committees and also a Local Negotiating Committee (LNC) which is a specific forum established to discuss and agree policies, and terms and conditions etc relating to medical staff.

The diagram below outlines the key drivers for staff engagement:
The Health Board recognises the importance of having a workforce with high levels of engagement. Therefore these plans will be assessed for the anticipated risks on the level of staff engagement, and where appropriate, mitigation will form part of the implementation plan. This will fall into 5 categories for assessment.

- **Leadership and Management** – what focus will leaders and managers need to have to implement the plans, and how will they work with their staff to allow them to contribute, inform, engage and deliver. It will also include support for management and leadership competency and confidence development.
- **Enabling involvement in decision making** – How staff are/will be involved in contributing to the service development and improvement.
- **Valuing Roles** - ensuring every role counts – how does skill-mix, opportunity role design support an engaged workforce.
- **Staff Development** – providing access to skills development to meet current and future needs of both the Health Board and the individual.
- **Healthy and safe work environment** – Ensuring the environment and working practices support the physical and psychological well-being of staff.
Workforce Development

Performance management and accountability

A key action for the Health Board is to strengthen and increase compliance with the application of the Performance and Development Review (PADR) and Medical appraisal system and job planning across all services. This is key to each staff member understanding what is expected of them, how they contribute to the delivery of the Health Board service priorities and strategic objectives, and how, as individuals, the Health Board will support their development to fulfil their role.

The PADR/Appraisal meetings enable staff, with their reviewers, to critique current performance and set work objectives, identify and where identified, plan any education and training requirements. It also aids managers in considering succession and career planning for individuals, teams and services. This information feeds into the Health Board training needs analysis and into the workforce planning and education commissioning process.

Effective Leadership - Developing Leaders and Managers

The Health Board recognises that high quality leadership is crucial to the achievement of organisational objectives and to ensure sustainability and future development. The Health Board has a strong Leadership Development agenda to increase capability of current leaders and develop future leaders. This is achieved through a number of internal programmes, and access to a range of external programmes including those delivered through Academi Wales, the Kings Fund and Universities.

In addition to creating bespoke solutions for individuals, a range of internal offerings support leadership development at all levels. Many of these programme offer formal accreditation.

- Board Development Programme
- Quarterly Leadership Forum
- Consultant Leadership Programme
- ‘PULSE’ Medical Leadership Programme (for 2015 launch)
- Empowering Healthcare Leaders Programme
- Manager’s Passport
- Coaching from corridor coaching to Executive Coaching

To support our succession planning, a talent management process is being piloted in a number of areas including the Population Health Group Chairs and Co-chairs, Consultants and Senior Managers.

As an integrated provider, we work with other public services and third sector partners to provide appropriate education and development opportunities. The opportunities to build new roles – some of which cross sectors, utilising a skills based approach will become increasingly important, and the Health Board has developed a ‘skills wheel’ for the identification of required skills in a service area. While this is still in development, it is similar in to the Centre for Workforce development model below:
This will allow us to design roles through understanding of the skills sets required, and then using this to build roles. The Health Board has a robust governance framework (Eagle) to allow us to do this in the absence of statutory regulation and issues around employer led registration and regulation is resolved within the Health Board.

We will continue to develop our extended and advanced roles to support service development and to meet the needs of the population where traditional roles are hard to recruit or require modernisation.

As the detailed individual service and workforce plans are refined, analysed and cross referenced a more detailed picture will emerge to inform a strategic workforce education and development plan aligned to service priorities/timelines which will inform not only the education commissioning priorities but also in house education and training priorities as it will be key to ensure that there is a clear tangible return on investment. The Continuous Professional Development (CPD) Strategy for Nursing and AHP’s is currently being implemented/applied within the workforce planning and will support the increased flexibility and responsiveness the IMTP covers with a key focus being work-based learning.
6.4 Re-aligning our Workforce - Delivering the Change

There is too much reliance on overtime, bank and agency staffing and therefore once the Health Board has reviewed and clarified service plans, arrangements will be made to realign the workforce in order to ensure the right staff, are in the right place with the right skills to deliver the appropriate services.

In our chapters on Care Closer to Home and Quality we describe the service being delivered in each locality and the workforce required to deliver these services, this also includes impact both positive and negative and these are summarised in our future workforce section below.

The financial outlook over the next three years is very challenging as the Health Board continues to face cost pressures from an ever increasing demand on health services across all areas, new drugs and inflationary increases over and above National Finance Agreement levels etc. In order to meet our financial challenge every service area has been given a 3.5% CIP. The realignment of the workforce to meet this challenge will be tailored as appropriate.

Corporate Functions

All service leads within the corporate functions have an agreed savings target and following discussion rightsizing methodology has been applied. Managers have been provided with a toolkit which will help them realign their workforce. The toolkit includes:

- Analysis of current workforce by service, band, professional group,
- Average turnover
- Potential retirements based on the service average retirement age.
- Template to identify potential savings based on natural turnover plus ability to articulate proposed service changes including impact on service, workforce and clarifying any risks to Health Board performance/reputation.

Managers over a period of 8 weeks will

- Gather local intelligence from individuals in terms of their plans to further support anticipated turnover.
- Map out current functions across all teams to identify potential for:
  - Modernising practices by changing how activities are delivered
  - Assess activities in context of impact to front line services
  - Evaluate potential to cease some activities which are not essential
  - Areas where non pay savings are achievable on a recurring basis.
  - Triangulate information to maximise organisational benefit
  - This methodology will be worked through by services throughout January and February with rightsizing plans being presented to Executive Directors in March.

Any service changes would then be managed via the deployment policy, redeployment policy and OCP where appropriate and necessary.

Areas and expected savings covered by this area of work are:-
<table>
<thead>
<tr>
<th>Service Area</th>
<th>Yr 1 Saving</th>
<th>Yr 2 Saving</th>
<th>Yr 3 Saving</th>
<th>Total Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target £k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Corporate</td>
<td>126.28</td>
<td>147.32</td>
<td>180.39</td>
<td>453.99</td>
</tr>
<tr>
<td>Clinical Services</td>
<td>4.93</td>
<td>5.75</td>
<td>7.04</td>
<td>17.72</td>
</tr>
<tr>
<td>Finance &amp; Planning</td>
<td>142.94</td>
<td>166.77</td>
<td>204.21</td>
<td>513.92</td>
</tr>
<tr>
<td>Corporate Nursing</td>
<td>99.55</td>
<td>116.14</td>
<td>142.21</td>
<td>357.9</td>
</tr>
<tr>
<td>Strategic Partnerships</td>
<td>112.66</td>
<td>131.44</td>
<td>160.95</td>
<td>405.05</td>
</tr>
<tr>
<td>Therapies &amp; Health Science</td>
<td>126.04</td>
<td>147.05</td>
<td>180.06</td>
<td>453.15</td>
</tr>
<tr>
<td>Workforce &amp; OD</td>
<td>158.88</td>
<td>185.36</td>
<td>226.97</td>
<td>571.21</td>
</tr>
<tr>
<td>Medical Education</td>
<td>43.01</td>
<td>50.18</td>
<td>61.44</td>
<td>154.63</td>
</tr>
<tr>
<td>Medical &amp; Quality</td>
<td>28.93</td>
<td>33.76</td>
<td>41.33</td>
<td>104.02</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>1195.51</td>
<td>1394.76</td>
<td>1707.87</td>
<td>4298.14</td>
</tr>
<tr>
<td>Informatics</td>
<td>261.13</td>
<td>304.65</td>
<td>373.04</td>
<td>938.82</td>
</tr>
<tr>
<td><strong>Target Saving</strong></td>
<td><strong>2299.86</strong></td>
<td><strong>2683.18</strong></td>
<td><strong>3285.51</strong></td>
<td><strong>8268.55</strong></td>
</tr>
</tbody>
</table>

Workforce reductions arising out of this process will be evaluated centrally and RAG rated in terms of deliverability. This will give the Board assurance around deliverability of the plan.

A similar methodology to achieve workforce expenditure reductions is required for service delivery directorates across the Health Board. This will focus on the following key work-streams.

**Administrative Support**

- Review admin support provided to clinical areas, teams and individuals to ensure best use of technology is made and appropriate activities are undertaken by the most suitable workforce.
- Benchmark current support arrangements across Wales to ensure consistency

**Nursing Workforce**

- E-rostering – aligning budget, workforce and rostering systems to ensure services are efficiently provided. With the alignment and increase in budget to cater for safe staffing levels and acuity, these areas will be able to cover sickness, annual leave and study leave without the need to deploy additional workforce via bank, overtime and more expensive Agency.
- Permanent recruitment to all substantive nursing posts in line with above establishments to avoid the need for high cost agency workforce.
- Review ward configuration to ensure maximization of nursing workforce in line with safe staffing levels
- The workforce management panel will continue to meet and review and monitor variable pay and vacancy control until such time as the above is complete once these areas are complete this group will cease to meet.
- Extend the nurse bank and develop a nursing pool to increase capacity to support service pressures thus eradicating as much as possible the need for overtime and agency.
Medical Workforce

- Make effective use of job planning process ensuring value for money from SPA sessions plus clinical outcomes are linked to DCC sessions across the sub specialty
- Appoint to substantive medical positions to eradicate the use of high cost locum and agency workers.
- Review rosters across the Health Board to streamline the intensity wherever possible.

Specialists, Enhanced Roles, extended scope practitioners and Advanced practitioners

The Health Board has a number of staff across nursing, therapies and other specialist clinical teams who are specialists in their field, either through workload based on patient contact or via qualification. A programme is underway to identify the roles/job titles of these individuals and then undertake a detailed scoping project of all current post holders to gain clarity in terms of the roles to enable consistency in how they practice within services.

It is recognised that these posts along with Physicians Associates and new support worker roles will play a key role in supporting new service models within the overarching service model.

In addition to the above initiatives the following are also being developed.
- Changes to working practices including shifts and rosters and shift towards 7 day working;
- Potential changes of location/work base;
- Modernisation and enhanced roles;
- Development of housekeeper roles in the wards
- Developing generic worker roles across health and social care;
- Looking at multi partner teams to deliver care in the community;
- Developing the workforce to provide Psychologically minded services
- Succession planning for key clinical roles

Future Workforce and Education Commissioning Rationale

Future Workforce

There are a number of themes emerging from the initial service plans:

- New working practices with a move to focused 7 day working for some services/staff groups
- The use of expanded/advanced practice roles
- Need to ensure clinical staff (not solely medical, but all clinical staff groups) are utilising their knowledge and skills to the maximum in daily applied practice and undertaking appropriate activities and maximise benefits
- Focused assessment of specialist roles across all professions
- Working more closely with IT specialists to prioritise where IT infrastructure will be essential to modernising working practice and better use of workforce time
Education Commissioning Rationale

The education commissioning figures have been defined on the basis of the workforce risks within the Health Board associated with the age profile and rurality.

The Health Board will be working to blur the current boundaries between the medical roles within Primary and Secondary care using portfolio GP, Consultants, Physicians Associates and Advanced practice roles, (nursing and therapy) and independent prescribers to develop more imaginative workforce models.

In secondary care the Health Board is moving towards a more consultant delivered model in the future with less reliance upon training grades and would be seeking to commission around 25% increase each year within prioritised clinical sub-specialties to support the aim to have a more consultant led service and also the RTT activity. This is a high level assessment as we are currently undertaking the detailed modelling of service provision. The Health Board has analysed the age profile by staff group, county and individual services to identify where the greatest risks sit in order to focus our 3 year plan. That being said, on the assumption that the activity targets across all subspecialties will be 26 weeks the Health Board will assume to have to increase the consultant workforce across all sub specialties by yr 3. Within surgery and orthopaedics this may require the consultant levels to be doubled to achieve outputs.

The Medical Director has and will continue to actively campaign for a shift in the medical education from sub specialisation to more generalist and ruralist programmes in medical education which far better support the service needs in general hospitals.

Until this detailed modelling is complete the number of places commissioned for advanced practice will necessarily need to be fluid, so the figures presented in January 2015 IMTP within the Appendices are a high level assessment and subject to change. The same applies to the detailed commissioning for medical subspecialties. This has been discussed with the commissioning team in WEDS who will be working with us to define the final numbers.

6.5 Skilling the Workforce by effective Information and Communication Technologies & Mobilizing our Workforce to help with Flexibility

Already discussed in Care Closer to Home as part of Chapter 4, the right person having the right information at the right time can make all the difference to the experience of a patient, service user or carer. Good information also enables care professionals to make the process of care safer and more efficient. We recognise that we will need to invest, at pace, in the training of our community staff in order to achieve wide-spread adoption of these technologies, and their associated benefits. Daily care in patients’ homes, at clinics, schools, nursing homes and other such disparate locations will change, and improve, with their use and we see this as an essential enabler in terms of workforce modernisation.

Improved ICT, especially mobile ICT allows our clinicians to better manage their time and workload. They can communicate more freely with colleagues and patients, and have the flexibility to work in the office, in the community or at home. The potential benefits in addressing the rurality issues of our Health Board to adoption of mobile devices are compelling, including facilitation of patient involvement.
in the care process, as well as increased efficiencies and cost savings for the organization.

**University Status**

As previously noted within the plan, University status provides the Health Board with research networks/research and development activity, and access to work closely with the academic community to support the delivery of the plan through a range of opportunities to up-skill staff as well as access to an ever growing range of development programmes. Annex 14 details our plans for the establishment of a University Partnership Board (UPB). The UPB will replace the Innovations Board and become the focal point for joint partnership working. It will act as a creative hub to drive joint developments and monitor activity to ensure that maximum benefits are delivered for the organisations and for the health and well being of our population.

We have very positive relationships with our university providers who deliver much of the education to support our assistant practice and advanced and specialist practice roles. Further links will be made to review training provision by enhancing relationships with universities to make better use of resources available and enabling innovation and modernisation of both individual staff as well as researching and developing new workforce models focused on patient outcomes/care pathways.

The current excellent partnership with Swansea University will be key in terms of the need to be creative in relation to sourcing our initial workforce locally as well as developing our own staff within local environments across the three counties. This will be essential for development of specialist skills and there will be a need for flexibility to support the likely service needs. Where possible the Health Board would aim to develop bespoke programmes with the University to meet the specific local challenges, such as movement of staff who are accustomed to acute based working to a community driven service. The Health Board has for the first time given a guarantee of employment to its students entering nurse training subject to successful completion and work placement assessments and the Health Board would aim to apply the same principles across all clinical professions.
Chapter 7: Eliminating Waste, Duplication & Ensuring Value-for-Money

7.1 Our Financial Planning Approach

In terms of resourcing the ambitions of our 3 Year Integrated Medium Term Plan, Hywel Dda will receive initial income of £683.588m from 2015/16 Welsh Government Allocation Letter to commission and provide services for our residents.

We are also expecting to receive an additional £23.513m income issued during the year, giving a total planned ‘rollover’ income including pay award funding of £707.1m for 2015/16. In terms of the optimal deployment of this resource across all of the Health Board’s services and activities, it is important to realise that our overall strategy, of involving clinicians in the review of ‘flow’ and ‘variation’, can be greatly supported by several financial information developments already in place.

Using Patient & Service Level Costing, as well as Locality Based Resourcing, and aligning these to the National Patient Flow Collaborative work and the new Community Information System, we can begin the process of identifying not only the costs of each part our service delivery to match the income / funding provided, but also the opportunities where we could use our resources much better, eliminating waste, duplication and ensuring value-for-money. This allows us to target our resources to where they are most needed.

7.2 Our service & financial planning assumptions

This is a 3 year service, workforce and financial planning journey, and, our starting position is the need to address the 2014/15 out-turn deficit of £9.297m so in addition to our anticipated rollover income of £707.1m, our plan assumes the following:

- As we are not changing our 4 site hospital model, the 2014/15 funding of £38.7m for our structural deficit by Welsh Government, will continue. Income of £14.445m above our resource mapped share of £24.255m (12.12%) is required to address our configuration issues. This is required recurrently in our baseline funding, and cannot be abated by the removal of Transitional Funding of £10m, otherwise the net income above resource mapped share is £4.445m.

- In addition, provider (and commissioned services) pay award and pensions costs are funded by Welsh Government over the 3 years, as assumed in £707.1m;

- In order to deliver the shift of resource to Care Closer to Home, the plan assumes funding from our shares of the £10m All-Wales Primary Care Fund and the £70m All-Wales NHS Monies announced December 2014, £1.212m and £8.540m respectively or £9.752m in total, will be available. Subject to further testing against improvements in ‘access’ and ‘flow’ over the next 2 months, we intend to use this to invest in Health Promotion and Prevention up to £1.5m, stabilise and develop Primary Care General Medical Services up to £2.8m, Dental Services up to £0.600m and Community Pharmacy up to £0.750m and growing our Locality Community Resource Teams with the balance of £4.102m;

- Over the course of the next 3 years, cost pressures arising from inflation and demand of £63.5m, which are recognised nationally from the National Finance
Agreement (NFA) work, will be met fully by internal cost improvement / savings plans;

- It is assumed that all recurrent Welsh Government Allocation Letter rollover income is maintained at current levels unless otherwise stated, and that if removed, then the impact would be resource and cost-neutral;

- Assumed that Non Cash limited expenditure will continue to be funded in full by Welsh Government;

- Savings delivery therefore is 10.9% or £77m over the next 3 years, targets of 3.2% up to £22.5m in year 1, 3.5% or £24.5m in Year 2 and 4.2% or £30m in Year 3. These will need to be cash releasing having a full effect on the monthly run rate. Within this, through turnover, workforce savings of £10m are required in Year 1, and rising to £15m in year 2 and £22m in Year 3, a cumulative workforce savings requirement of £47m over 3 years. This will result in workforce costs which are upper quartile but achieved through turnover and the elimination of expensive agency costs;

- We are assuming our withdrawal of £3.8m from the WHSSC Risk Share, as we have managed this cost out by pro-active referral management.

- Invest-to-Save repayments of £3.116m are due in 2015/16 Voluntary Early Release (VER) & Virtual Ward in the main. This is an increase of £2.042m over and above the repayable sum in 2014/15. The Pay budgets set do not include posts saved by VER, and net savings from the Virtual Ward initiative are being realised in terms of ward reduction;

- The balance of our savings delivery are required to fund £6.272m costs arising from 2014/15 service developments, mainly the Women’s & Children’s Transfer of Services costing £5.6m, and, Smoking Cessation of £0.242m. It also needs to cover £3.5m of unavoidable local cost pressures mainly being driven by WHSSC commissioning decisions and ward nursing bed ratio standards. In terms of the latter, these are being classified as local but in fact a national professional assessment of 24/7 staffing levels required on our wards, and our local assessment of acuity. It is assumed that these represent the maximum exposure and no further costs will be incurred;

- Our £6.3m investment in Waiting Times will increase to £12.446m over the next 3 years in order to deliver 36 week referral to treatment times again this investment is underpinned by the 10.9% savings requirement;

- The plan is still subject to clarification of the impact of plans received from All-Wales commissioned services (WHSCC, WAST). The National Finance Agreement includes an assessment from WHSSC around the cost pressures for specialist services over the next 3 years which equate to £1.967m, however if all of their development plans were approved, which is unlikely, the total additional cost for Hywel Dda would be closer to £2.9m. At this point, no additional investment is assumed, above the NFA instead we envisage discussions on improving flow should help avoid further increases in cost;
• We are assuming no increased costs for WAST;

• This version of the Plan assumes the full year cost of all developments in the first instance. Further iterations undertaken in February and March will include the phasing and lead-in time for any developments;

• Revenue Consequences of Capital Schemes (RCCS) are assumed to be containable in the NFA cost allowance in future years. At present there are no appreciable RCCS anticipated in the planning period. It is also assumed that funding of Depreciation and Impairments are cost neutral. Any changes to the costs in 2014/15 will be added / withdrawn from the allocation without creating a cost pressure;

• Continuing Health Care (CHC) – there is as yet an unknown risk in respect of fee increases due to the knock on effect of Local Authority settlements. At present it is assumed that this risk is containable within the National Finance Agreement cost pressures for CHC already included. With regard to Funded Nursing Care, the same assumption has been made;

• There is also a major risk in relation to 31st July 2014 deadline claims through the Powys process as referred to above. There is no provision for the potential new Powys handled claims numbering circa 300 in the plan. At the present stage they represent only a contingent liability in the 2014/15 position. Should all claims provide the required legal and financial proof (which we acknowledge is unlikely), in line with the HDUHB provision methodology the Health Board may need to provide at circa £5m additional cost, which could fall in the 2015/16 year;

• Finally, a recurrent contingency of £3m has been established to help mitigate the risks of any adverse financial impact of unplanned events.

Subject to further discussion and agreement with Welsh Government on our assumed income above rollover income, and on the basis of all of these financial planning assumptions, including the agreement by the Board of a comprehensive set of savings plans underpinning the £77m savings target, and the phasing of their delivery, the Health Board financial plan is breakeven

The following table provides the high-level detail on the rolling effect of our 3 year plan from 2015 to 2018, stating the assumed income and expenditure changes, and savings assumptions, over 2 scenarios. It is important to note that both scenarios show ambitious savings positions of 3.2% or £22.5m in Year 1, 3.5% £24.5m in Year 2 and 4.2% £30m in Year 3 which given the current configuration will be challenging. In addition both scenarios show the impact of the £10m transitional relief, which either leads to £11.129m deficit the end of Year 3, or with no deduction shows that the plan could breakeven.
7.3 Base Income & Expenditure Plan

The following table summarises the SoCNE income and expenditure plans for the 3 years. (To be completed once the IMTP savings plans allow for completion of the tables)
7.4 Board Approved Developments in 2014/15

In 2014/15, as a part of our Consultation, we transferred Neonatal, Obstetrics & Maternity, and Paediatric services from Withybush to GlanGwili Hospital; this redesign involved a comprehensive review of our services and how we would meet
Royal College and Deanery standards. This led to an increased investment into these services with a full year effect cost of £5.572m.

In addition, there are full year effect cost pressures of several developments (including some of which are All Wales developments) amounting to £1.3m, shown as follows:

<table>
<thead>
<tr>
<th>Board Approved Developments</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, Maternity &amp; Paediatric Service Change</td>
<td>5.572</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>0.242</td>
</tr>
<tr>
<td>Infection Control Phase 1</td>
<td>0.055</td>
</tr>
<tr>
<td>Deprivation of Liberty Standards (DOLS)</td>
<td>0.087</td>
</tr>
<tr>
<td>Microsoft</td>
<td>0.236</td>
</tr>
<tr>
<td>Crymych full year impact of development</td>
<td>0.080</td>
</tr>
<tr>
<td><strong>Total Approved Development</strong></td>
<td><strong>6.272</strong></td>
</tr>
</tbody>
</table>

### 7.5 Inflationary & Service Demand Cost Pressures

The National Finance Agreement (NFA) provides the basis for the annual recognition of basic cost uplifts in pay and prices across NHS Wales. The NFA is an indication of the likely level of cost increases within the organisation and enables proper recognition of certain costs within the financial planning cycle. The items recognised as part of the NFA for the 3 year plan are categorised into two elements, inflationary pressures and demand & service pressures. There is very little the HB can do to avoid the **inflationary cost pressures**, which for Hywel Dda for the next 3 years are as follows:

<table>
<thead>
<tr>
<th>NFA - Inflationary Pressure</th>
<th>2015/16 £m</th>
<th>2016/17 £m</th>
<th>2017/18 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Inflation</td>
<td>3.571</td>
<td>2.899</td>
<td>2.795</td>
</tr>
<tr>
<td>Pensions Costs</td>
<td>0.725</td>
<td>5.176</td>
<td>1.398</td>
</tr>
<tr>
<td>Non pay Inflation</td>
<td>1.605</td>
<td>2.329</td>
<td>2.329</td>
</tr>
<tr>
<td>Statutory Compliance and National Policy</td>
<td>0.932</td>
<td>0.932</td>
<td>0.932</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>0.725</td>
<td>0.976</td>
<td>0.828</td>
</tr>
<tr>
<td>Funded Nursing Care</td>
<td>0.104</td>
<td>0.104</td>
<td>0.104</td>
</tr>
<tr>
<td>Welsh Risk Pool</td>
<td>0.932</td>
<td>0.932</td>
<td>0.621</td>
</tr>
<tr>
<td><strong>Total NFA - Inflationary Pressure</strong></td>
<td><strong>8.592</strong></td>
<td><strong>13.147</strong></td>
<td><strong>9.006</strong></td>
</tr>
</tbody>
</table>

The **demand and service growth pressures** for the Health Board are scheduled as follows
In the third year, the current financial plan assumes that the Continuing Health Care cost pressure within the demand and service growth section may be avoidable after benefitting from the investment in Care Closer to Home. This will need further evaluation.

The Demographic/Demand on Acute Services growth is assumed fully used to deal with Waiting Times / RTT.

7.6 Unavoidable Local Cost Pressures

The following are local cost pressures which have been identified by the organisation during the latter quarter of 2014/15 as matters which are likely to present financial exposure in future years. Whilst they have not been formally approved by the Board in detail, as issues, these have been flagged as part of the Board discussion on the IMTP, and are as follows:

<table>
<thead>
<tr>
<th>Unavoidable Local Cost Pressures</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Wales Continuing Health Care</td>
<td>0.260</td>
</tr>
<tr>
<td>Ultrasoundographers Down's Screening</td>
<td>0.065</td>
</tr>
<tr>
<td>Ward Nurse Staffing - Chief Nursing Officer &amp; Acuity</td>
<td>2.668</td>
</tr>
<tr>
<td>RTT</td>
<td>0.506</td>
</tr>
<tr>
<td>Realignment Head/Neck Cancer Tariff ABMU</td>
<td>0.463</td>
</tr>
<tr>
<td>Add Spinal Services Consultant ABMU</td>
<td>0.125</td>
</tr>
<tr>
<td>Vascular Stents</td>
<td>0.072</td>
</tr>
<tr>
<td>RTT ABMU</td>
<td>0.365</td>
</tr>
<tr>
<td>Children's Hospital C&amp;V</td>
<td>0.120</td>
</tr>
<tr>
<td>Robotic Surgery C&amp;V</td>
<td>0.135</td>
</tr>
<tr>
<td><strong>Total Unavoidable Local Cost Pressures</strong></td>
<td><strong>4.799</strong></td>
</tr>
</tbody>
</table>

The ward nurse staffing are being driven by current guidance from the Chief Nursing Officer on safe ward staffing.

The other unavoidable pressure faced by the Health Board is the cost of delivering the 36 week RTT target. The current level of funding shown in the table below allows the Health Board to deliver this target over the 3 years of this plan and details how this is to be funded over the 3 year plan:
7.7 Planned Discretionary Developments aligned to deliver against the aims of our Mission Statement and aligned to the priorities of our 3 Year Integrated Medium Term Plan

As part of the planning cycle, service leads have been asked for details of all the service developments that would improve patient flow and achieve the step-change in primary and community care over the next 3 years, and these developments have been quantified.

With the exception of Workforce which is reflected within every planning area, as per the Health Board’s Mission Statement, service plans have been categorised into the following sections - Care Closer to Home, Quality & Safety, Promoting Health & Wellbeing and Eliminating Waste.

The following table quantifies the current identified resource requirement and for planning purposes provides the indicative position on the scale of ambition by Service Leads on what the 3 Year Plan needs to address. However, these cannot all be funded and over the next 2 months, the Health Board intends to further explore integration and interface opportunities, and to test these plans, re-prioritising them for the final submission by end of March. Annex 16 illustrates the full list of initiatives identified, the majority of which are reflected below. Also included as part of Annex 16, is the SBAR format utilised to evidence the essential details of the bids.

In summary, subject to WG confirmation of our resource planning assumptions pertaining to the £9.752m, therefore, we are indicatively advancing the following plans:

<table>
<thead>
<tr>
<th>Service Development/Change</th>
<th>Gross Cost of Service Developments/Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015/2016 - Year 1 - £m</td>
</tr>
<tr>
<td>CARE CLOSER TO HOME</td>
<td>12.552</td>
</tr>
<tr>
<td>CARE CLOSER TO HOME - MENTAL HEALTH</td>
<td>1.384</td>
</tr>
<tr>
<td>QUALITY &amp; SAFETY</td>
<td>7.661</td>
</tr>
<tr>
<td>PROMOTING HEALTH &amp; WELLBEING</td>
<td>1.602</td>
</tr>
<tr>
<td>ELIMINATING WASTE</td>
<td>0.424</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>23.623</strong></td>
</tr>
</tbody>
</table>
Care Closer to Home

As previously stated, subject to confirmation from WG, our share of the Primary Care Fund and the All-Wales NHS Monies announced December 2014 is £1.212m and £8.540m respectively or £9.752m in total.

Subject to approval, we intend to use this to invest in Health Promotion and Prevention up to £1.5m, stabilise and develop Primary Care General Medical Services up to £2.8m, Dental Services up to £0.600m and Community Pharmacy up to £0.750m and growing our Locality Community Resource Teams with the balance of £4.102m.

It is evident that whilst conceptually we want to deliver on the resource and capacity shift into the provision of Care Closer to Home, this can only be delivered by a real terms decrease in bed capacity in hospital services, as not to do so, leads to the kind of excess cost pressures shown in the table below.

We are scoping the sequencing of how and when we could release current secondary care bed capacity / workforce and community hospital bed capacity / workforce in order to deliver the shift, so making a significant proportion of the £13m costs effectively resource neutral. The Care Closer to Home developments can be summarised as follows:

<table>
<thead>
<tr>
<th>CARE CLOSER TO HOME</th>
<th>WTE BY STAFF GROUP</th>
<th>WTE</th>
<th>Revenue Implications - Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Service Development/Change</td>
<td>Nursing WTE</td>
<td>Therapies WTE</td>
<td>Other WTE</td>
</tr>
<tr>
<td>Community Resource Team/Discharge Liaison</td>
<td>48.15</td>
<td>78.72</td>
<td>12.90</td>
</tr>
<tr>
<td>Palliative</td>
<td>1.20</td>
<td>1.80</td>
<td>1.00</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>74.80</td>
<td>1.00</td>
<td>-</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>31.89</td>
<td>22.16</td>
<td>1.43</td>
</tr>
<tr>
<td>Frailty</td>
<td>-</td>
<td>12.60</td>
<td>-</td>
</tr>
<tr>
<td>District Nursing</td>
<td>13.20</td>
<td>-</td>
<td>0.80</td>
</tr>
<tr>
<td>Psychology</td>
<td>-</td>
<td>-</td>
<td>5.00</td>
</tr>
<tr>
<td>GMS Commissioning Plan</td>
<td>-</td>
<td>9.40</td>
<td>9.40</td>
</tr>
<tr>
<td>Community Pharmacy Commissioning Plan</td>
<td>-</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>Dental Services Commissioning Plan</td>
<td>-</td>
<td>0.40</td>
<td>0.40</td>
</tr>
<tr>
<td>TOTAL</td>
<td>174.04</td>
<td>116.28</td>
<td>31.43</td>
</tr>
</tbody>
</table>

The split of costs by staff group behind these figures are shown below:

<table>
<thead>
<tr>
<th>CARE CLOSER TO HOME</th>
<th>£m</th>
<th>Revenue Implications - Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Service Development/Change</td>
<td>Nursing</td>
<td>Therapies</td>
</tr>
<tr>
<td>Community Resource Team/Discharge Liaison</td>
<td>3.342</td>
<td>2.992</td>
</tr>
<tr>
<td>Palliative</td>
<td>0.137</td>
<td>0.064</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>1.650</td>
<td>0.036</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>0.883</td>
<td>0.728</td>
</tr>
<tr>
<td>Frailty</td>
<td>-</td>
<td>0.395</td>
</tr>
<tr>
<td>District Nursing</td>
<td>0.383</td>
<td>-</td>
</tr>
<tr>
<td>Psychology</td>
<td>-</td>
<td>0.257</td>
</tr>
<tr>
<td>GMS Commissioning Plan</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community Pharmacy Commissioning Plan</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dental Services Commissioning Plan</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4.395</td>
<td>4.472</td>
</tr>
</tbody>
</table>
In terms of indicative ranking, the overarching priority in this plan is stabilising unscheduled care, so we know that we will need to invest all of the Primary Care Fund plus part of the All-Wales monies to stabilise and develop Primary Care General Medical Services, and propose that this will be combined additional funding up to £2.8m.

Similarly, Dental Services needs to be prioritised to begin to address our poor performance in meeting the population health need for robust dental services and we are indicatively working to £0.600m additional investment. Finally, Community Pharmacy has been indicatively prioritised for additional up to £0.750m.

After prioritising £1.5m for Health Promotion from these new monies, this leaves £4.102m additional new monies to grow our Locality Community Resource Teams as part of the step-change to Care Closer to Home.

It is assumed that the investment in Palliative Care and Continuing Healthcare plans as identified by Service Leads should be able to be financed from the existing resources being spent in these areas, albeit we recognise that we would need to invest in Community Resource Teams as the ‘alternative’ provision to help this endeavour. We will be testing this over the next 2 months.

Any additional requirements for administrative and clerical roles to support the Care Closed to Home developments should be considered by redeployment of staff from within the Health Board.

The therapies investment on plans needs to be more fully worked through – in particular, the interface of community and Secondary Care Therapies, as well as what therapeutic inputs can be provided from generic Health & Social Care workers. It is appreciated that Allied Health Professionals, particularly therapists, unlock flow blockages and help prevent admission and faster discharge, and are key to 24/7 working, so this contribution needs to be further examined before the March 2015 submission. Once evaluated, this would have to be funded from re-prioritising the balance of £4.102m.

In terms of service planning for Mental Health & Learning Disabilities, with the exception of the ASD/ADHD and Learning Disability service re-design, developments are self financing either from Mental Health resources or from General Continuing Healthcare resources, as follows:

<table>
<thead>
<tr>
<th>MENTAL HEALTH Name of Service Development/Change</th>
<th>Locality</th>
<th>WTE</th>
<th>Revenue Implications - Costs</th>
<th>Revenue Implications - Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Redesign</td>
<td>HB Wide</td>
<td></td>
<td>0.232</td>
<td>(0.242)</td>
</tr>
<tr>
<td>Mental Health Centres Pembis &amp; Ceradigion</td>
<td>Pembis &amp; Ceredigion</td>
<td>7.11</td>
<td>0.244</td>
<td></td>
</tr>
<tr>
<td>ASD/ADHD Service Development</td>
<td>HB Wide</td>
<td>8.10</td>
<td>0.459</td>
<td></td>
</tr>
<tr>
<td>Old Age Mental Health Service</td>
<td>HB Wide</td>
<td>13.00</td>
<td>(0.589)</td>
<td>(0.589)</td>
</tr>
<tr>
<td>Learning Disability Service Redesign</td>
<td>HB Wide</td>
<td>4.00</td>
<td>0.188</td>
<td></td>
</tr>
<tr>
<td>Ceredigion Model</td>
<td>Ceredigion</td>
<td>8.149</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL MENTAL HEALTH</strong></td>
<td></td>
<td>32.31</td>
<td>1.384</td>
<td>(0.830)</td>
</tr>
</tbody>
</table>
Quality & Safety

In terms of how we intend to progress these, we need to understand and test our service prioritisation, workforce skill-mix and financial planning assumptions further on the basis of the following:

- Sexual health action plan - could it be funded from Health Prevention & Promotion set-aside (part of the £1.5m)
- Prince Philip Unscheduled Care – may need pump-priming but otherwise, needs to be self-funding from current capacity
- Rheumatology – needs further evaluation as part of clinical review of variation
- Radiology – should be containable as part of RTT, and looking at opportunities to repatriate external reporting
- Medicine – we already spend up to £100m on drug interventions (in Primary Care, Hospital Care and with our External Providers, the latter mainly High Cost drugs particularly Cancers & Rheumatology). In Year 1, we intend to undertake a full Business Justification Case to establish how any further investment will help deliver:
  - More effective use of Pharmacy Teams to help support appropriate treatment interventions can help reduce waste, harm and variation and ensure cost effective use of new and existing medicines;
  - Monitoring of prescribing in line with All Wales Medicines Strategy Group (AWMSG) indicators and limiting the use of drugs of limited clinical value will help ensure best clinical effectiveness within medicines.
  - More appropriate monitoring of medicines that have not been approved by NICE or AWMSG can be strengthened;
  - Formulary compliance both primary and secondary care continues to be monitored.
  - Further development of a Prescribing Management Scheme that supports clinically effective prescribing across primary care is well established but needs to be developed to fully engage clinicians in all sectors.

- A large investment has been signalled for Therapies and this needs to be evaluated in light of a similar position in Care Closer to Home. A comprehensive Business Case will need to be undertaken in Year 1, and if proven, this Business Case would need to identify how and where investment in existing acute services could be reduced.

These schemes include local initiatives to deal with existing pressures along with new initiatives and are as follows:
<table>
<thead>
<tr>
<th>Name of Service Development/Change</th>
<th>What is the investment achieving</th>
<th>Year 1 - WTE</th>
<th>Year 2 - WTE</th>
<th>Year 3 - WTE</th>
<th>Revenue Implications - Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health</td>
<td>Local Development</td>
<td>11.55</td>
<td>19.06</td>
<td>17.00</td>
<td>0.136</td>
</tr>
<tr>
<td>PPH - unscheduled care model (front of house)</td>
<td>Tier 1 Target</td>
<td>1.00</td>
<td>4.40</td>
<td>0.173</td>
<td>0.156</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Improved Patient Flow</td>
<td>14.00</td>
<td>20.00</td>
<td>17.00</td>
<td>0.752</td>
</tr>
<tr>
<td>Radiology</td>
<td>Improved Patient Flow</td>
<td>1.00</td>
<td>0.75</td>
<td>0.029</td>
<td>0.020</td>
</tr>
<tr>
<td>Pharmacy &amp; medicines management - Intermediate Care</td>
<td>Improved Patient Flow</td>
<td>4.50</td>
<td>9.00</td>
<td>10.00</td>
<td>0.222</td>
</tr>
<tr>
<td>Pharmacy &amp; medicines management - Primary Care</td>
<td>Improved Patient Flow</td>
<td>8.00</td>
<td>4.00</td>
<td>0.160</td>
<td>0.320</td>
</tr>
<tr>
<td>Pharmacy &amp; medicines management - Automation</td>
<td>Improved Patient Flow</td>
<td>4.00</td>
<td>8.00</td>
<td>16.00</td>
<td>0.217</td>
</tr>
<tr>
<td>Pharmacy &amp; medicines management - Development of pharmacists as non-medical prescribers to meet needs of HB</td>
<td>Improved Patient Flow</td>
<td>1.00</td>
<td>1.00</td>
<td>0.052</td>
<td>0.028</td>
</tr>
<tr>
<td>Pharmacy - PPH Front of House</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right sizing orthotics budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychology Stroke - NEW FOR INCLUSION</td>
<td>Variation</td>
<td></td>
<td></td>
<td></td>
<td>0.028</td>
</tr>
<tr>
<td>Ward 10 Refurbishment, WGH</td>
<td>Local Development</td>
<td>15.25</td>
<td>5.00</td>
<td>0.239</td>
<td>0.009</td>
</tr>
<tr>
<td>Chemotherapy Day Unit, WGH</td>
<td>Local Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Services Development</td>
<td>Local Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Nurses</td>
<td>Local Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology Services, Tenby</td>
<td>Local Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWP - Lymphoedema</td>
<td>Local Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWP - Pathology - Andrology</td>
<td>Local Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry - HB Wide &amp; Acute</td>
<td>Local Development</td>
<td>11.70</td>
<td>3.40</td>
<td>0.404</td>
<td>0.011</td>
</tr>
<tr>
<td>SALT - HB Wide &amp; Acute</td>
<td>Local Development</td>
<td></td>
<td></td>
<td></td>
<td>0.025</td>
</tr>
<tr>
<td>Diabetology - HB Wide &amp; Acute</td>
<td>Local Development</td>
<td>11.50</td>
<td>3.15</td>
<td>0.690</td>
<td>0.060</td>
</tr>
<tr>
<td>Physio Acute Service Growth</td>
<td>Local Development</td>
<td>12.00</td>
<td>12.00</td>
<td>0.370</td>
<td>0.054</td>
</tr>
<tr>
<td>OT Acute Service Development</td>
<td>Local Development</td>
<td>15.50</td>
<td>15.50</td>
<td>0.541</td>
<td>0.022</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>12.55</td>
<td>38.60</td>
<td>59.35</td>
<td>43.70</td>
</tr>
</tbody>
</table>
Promoting Health & Wellbeing

An allocation of £1.5m has been earmarked for investment in Promoting Health & Wellbeing schemes, particularly, for Tier 1 initiatives like Smoking Cessation, Immunisations & Vaccinations and Early Year Obesity, as follows:

<table>
<thead>
<tr>
<th>Name of Service Development/Change</th>
<th>What is the investment achieving</th>
<th>2015/2016 - Year 1 - £m</th>
<th>2016/2017 - Year 2 - £m</th>
<th>2017/2018 - Year 3 - £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Cessation Pharmacy already Board Approved</td>
<td>Tier 1 Target</td>
<td>0.062</td>
<td>-0.003</td>
<td>0.000</td>
</tr>
<tr>
<td>Smoking Cessation - In Hospital</td>
<td>Tier 1 Target</td>
<td>0.020</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Smoking Cessation - Smoke free sites</td>
<td>Tier 1 Target</td>
<td>0.030</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Early Years Smoking Cessation</td>
<td>Tier 1 Target</td>
<td>0.070</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Dementia</td>
<td>Local Development</td>
<td>0.002</td>
<td>-0.002</td>
<td></td>
</tr>
<tr>
<td>Prevention (County Level)</td>
<td>Local Development</td>
<td>0.750</td>
<td>0.249</td>
<td>0.501</td>
</tr>
<tr>
<td>Integration PH &amp; UHB</td>
<td>Local Development</td>
<td>1.000</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Immms and Vaccs</td>
<td>Tier 1 Target</td>
<td>0.100</td>
<td>0.350</td>
<td>0.050</td>
</tr>
<tr>
<td>Early Years Obesity</td>
<td>Tier 1 Target</td>
<td>0.500</td>
<td>0.000</td>
<td>0.250</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>1.602</strong></td>
<td><strong>0.378</strong></td>
<td><strong>0.800</strong></td>
</tr>
</tbody>
</table>

Eliminating Waste

Would expect these to be more about pump-priming of self-funding initiatives rather than additional funding, and service leads will be requested to submit Business cases on this basis for delivery of the following schemes:

<table>
<thead>
<tr>
<th>Name of Service Development/Change</th>
<th>What is the investment achieving</th>
<th>2015/2016 - Year 1 - £m</th>
<th>2016/2017 - Year 2 - £m</th>
<th>2017/2018 - Year 3 - £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM&amp;T</td>
<td>Service Sustainability</td>
<td>3.243</td>
<td>-0.054</td>
<td>0.240</td>
</tr>
<tr>
<td>Transport - Central Transport Unit</td>
<td>Local Development</td>
<td>3.600</td>
<td>0.095</td>
<td>0.071</td>
</tr>
<tr>
<td>Transport - NEPT</td>
<td>Local Development</td>
<td>1.600</td>
<td>0.065</td>
<td>0.100</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>5.200</strong></td>
<td><strong>0.424</strong></td>
<td><strong>0.207</strong></td>
</tr>
</tbody>
</table>

7.8 Welsh Health Specialist Services Plan

The first draft plan from WHSSC signals the key national issues are

- Development of quality assurance framework
- Development of specialist service strategy
- Cardiac Surgery
- Thoracic Surgery
- ALAS
- Prioritisation – impact assessments for disinvestment

In addition, Hywel Dda would want to ensure full implementation of the new risk based shares, as we are a major beneficiary, up to £3.8m, a benefit that has been earned by our robust clinical referral management. Repatriation proposals are also being scoped. Our anticipated joint work programme is as follows:
- Cardiology – link with Hywel Dda’s own plans
- Plastics
- CAMHS
- Eating disorders
- Referral management – refine and redesign Vascular and Cardiac Services to Imperial, Cambridge and Heart of England.

With regard to our financial planning assumptions, figures produced by WHSSC for the NFA gave an indicative cost pressure of 0.38% which equates to £1.967m – this is included in our financial planning assumptions.

The full WHSSC Plan includes provider issues and speculative business cases which totalling £18m. If these were all approved the total additional cost to Hywel Dda would be £2.9m, which we have not assumed.

7.9 Savings Delivery

Progress against traditional savings themes

Like most Health Boards in Wales, we have had to make savings in these times of austerity. These savings, however, have probably been more about cost containment than the full cash-releasing savings that we actually need to deliver our services within the funding provided, and are shown as follows:

<table>
<thead>
<tr>
<th>Savings Schemes</th>
<th>Annual Achievement</th>
<th>Current Year: 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010/11 £’000</td>
<td>2011/12 £’000</td>
</tr>
<tr>
<td>Accounting</td>
<td>14,242</td>
<td>6,000</td>
</tr>
<tr>
<td>CHC &amp; DTOC</td>
<td>342</td>
<td></td>
</tr>
<tr>
<td>CHC (excl DTOC)</td>
<td>15,028</td>
<td>1,361</td>
</tr>
<tr>
<td>Chronic Conditions Management</td>
<td>1,425</td>
<td></td>
</tr>
<tr>
<td>Commissioned Services</td>
<td>5,225</td>
<td></td>
</tr>
<tr>
<td>Demand Management</td>
<td>341</td>
<td>140</td>
</tr>
<tr>
<td>Estates/Energy</td>
<td>1,537</td>
<td></td>
</tr>
<tr>
<td>Externally Commissioned Services</td>
<td>4,003</td>
<td>312</td>
</tr>
<tr>
<td>Improved Commissioning</td>
<td>929</td>
<td>9,069</td>
</tr>
<tr>
<td>Management Costs Reductions</td>
<td>303</td>
<td></td>
</tr>
<tr>
<td>Medicines Management (Primary &amp; Secondary Care)</td>
<td>929</td>
<td>9,069</td>
</tr>
<tr>
<td>Mental Health</td>
<td>303</td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>3,695</td>
<td>6,498</td>
</tr>
<tr>
<td>Procurement &amp; Other Non Pay (excl Energy)</td>
<td>1,806</td>
<td>1,425</td>
</tr>
<tr>
<td>Procurement &amp; Shared Services</td>
<td>1,200</td>
<td>339</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>10,635</td>
<td>2,460</td>
</tr>
<tr>
<td>Workforce Modernisation</td>
<td>10,635</td>
<td>2,460</td>
</tr>
<tr>
<td>Total Cost Improvement Programme</td>
<td>27,758</td>
<td>48,909</td>
</tr>
<tr>
<td>Cumulative Savings to Date</td>
<td>27,758</td>
<td>76,659</td>
</tr>
</tbody>
</table>

We are on a journey which requires a more innovative approach to savings delivery as public sector austerity continues. Our focus has to be on efficiency and productivity savings which allow us shift resource from secondary care into community and primary care in order to deliver the kind of Care Closer to Home which our frail elderly demographic requires, in order to remain healthy and independent for longer.
How our work on Efficiency & Productivity at scale will help manage Unscheduled care, and, Improve Flow

This Plan is attempting to be very much more ambitious in the delivery of efficiency and productivity savings which are achieved by the following approach:

- **Main objective** is to get the acute / hospital operational systems into ‘balance’ in workload and workforce terms;
- **Strengthen Care Closer to Home**, in order to stabilise unscheduled care or acute emergency medical admissions – from this, deliver a significant, phased reduction in premium medical variable pay;
- **This should also allow us to deliver the required bed capacity reductions** so that, in addition to the WG monies, we can also co-fund the increased workforce costs involved in Care Closer to Home to top up WG monies;
- **We will invest in a new Unscheduled Care model for acute Medicine & A&E** but this will be self-financed by a reduction in variable pay - premium agency medical,
- **We will stabilise acute nurse staffing in line with CNO guidelines & optimise our direct patient care nursing workforce into new and innovative roles**;
- **By developing centres of excellence**, this should allow us to effectively ring-fence elective capacity and deliver Tier 1 Waiting Times, delivering this within core capacity and within improved waiting times, so avoiding expensive backfill and out-sourcing;
- **We will of course pursue the usual productivity and efficiency savings measures** – optimisation of day case basket, theatre productivity & elimination of Interventions Not Normally Undertaken;
- **And using turnover, we will be right-sizing the workforce**;
- **Our renewed focus on the provision of services and not beds and buildings** means that we will be rationalizing our estate, whilst creating community hubs, which have a greater critical mass of services and staffing, which will be cost effective and represent greater value for money;
- **We will use IT as a key enabler in the delivery of flexible workforce practices**.

As part of the testing of the cases received from Service Leads, and in particular as part of identifying the interface opportunities between Secondary and Community Care, we are currently working through the sequencing of the aforementioned approach with Operations / Directorates / Services.

In particular, we can only proceed with plans once the inter-dependent funding relationships are agreed, namely how and where we will invest, how and when this will achieve a shift in capacity or resource from Secondary to Community Care, and how and when service disinvestment and resulting savings can be made. We have already received the workforce requirements as part of the submissions by service leads, from this we have scoped the cost exposure, and we have also scoped the financial planning impact of delivering shift. We are now working through this in operational delivery terms, with key steps broadly given as follows:
<table>
<thead>
<tr>
<th>Service Change: key steps – to be agreed by March 2015</th>
<th>Invest &amp; Achieve Shift</th>
<th>Or Save</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE</td>
<td>Resource £</td>
</tr>
<tr>
<td>Care Closer to Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Bed Reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Hospitals become Integrated Resource Centres with Bed Reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Unscheduled Care Model for Acute Medicine and A&amp;E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Medical Premium Pay:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabilise ward nurse staffing in line with CNO guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ring-fence planned care by Centres of Excellence for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Orthopaedics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ophthalmology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gynaecology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pursue usual efficiencies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Day Surgery Basket</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Eradication of INNUs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Theatre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Productivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Critical care usage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce Rightsizing:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Admin &amp; Clerical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Corporate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ancillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estate Reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7.10 Base Capital Plan

Our overall approach is that the IMTP must prioritise both capital developments and backlog maintenance in line with our Mission Statement, and is informed by the current risks we hold as an organisation.

Context

Previous years’ reduction in the discretionary capital allocation has made it difficult for the Health Board to resolve risks around:

- infrastructure and statutory backlog
- replacement of medical equipment
- standardisation of medical equipment across sites to enable cross site working
- rolling ward refurbishment programme to deal with statutory and infrastructure backlog
- replacement of major radiology equipment – general rooms along with CT & MRI replacements
- significant upgrades of IT infrastructure

With the recent increase in the discretionary capital available and the indication that a separate diagnostic imaging pot will be created on an All Wales basis to deal with the replacement of CT & MRI scanners, the Health Board has reviewed its capital planning priorities accordingly.

This does not, however, remove the pressure on the overall capital pot in Wales going forward, but whilst over recent years the Health Board has had fairly large capital schemes on site, from 2015/16 onwards the only currently approved scheme on site will be the final stages of the Front of House Scheme in Bronglais.

Consequently, there are some real opportunities to start to address our backlog maintenance and equipment replacement programmes, which is significant.

**Estates & Infrastructure:** Services are currently provided from 4 acute sites, 7 Community Hospitals and over 30 other sites. The building and infrastructure backlog maintenance cost associated with these properties currently stands at £54m.

The Health Board already has a programme of estates rationalisation which will reduce the floor area of the estate by 11% 21,000m². As part of the IMTP process and the development of locality plans, further estates rationalisation is being explored.

Whilst this further estate reduction will have an impact on the backlog issues, our current backlog position is as follows:
There are some new build schemes within our IMTP which are enablers to the delivery of Care Closer to Home, such as Cylch Caron, the re-provision of services in Cardigan the redevelopment of some Health Centres and Primary Care facilities. In these instances the new builds will reduce backlog on the sites that will be disposed and enable 21st century healthcare in 21st century buildings.

**Information Management & Information Technology:** The Health Board currently has to prioritise its many Information and IT risks, from an annual allocation of between £0.3m and £0.8m from the Discretionary Capital Programme. The Capital Development Plan & Risk Register holds a complete schedule of the Information and IT investment required to deal with our current risks and developments over the next 5 years.

We have drawn up an e-Health Investment Plan which considers the current IM&T risks and issues which the Health Board needs to manage, along with new IT developments that will enable service change. Investment in the appropriate IM&T infrastructure will improve quality, safety and improve outcomes and also eliminate duplication of effort by ensuring that the right person has access to the right information at the right time.

We have prioritised these investments in our capital planning as we believe a shift-change in the IM&T infrastructure of the Health Board could bring benefits to:

- Patients, service users, by investing in Tele-health
- Clinicians and other care professionals, by enabling them to provide Care Closer to Home by investing in the ability of staff to access information whilst mobile; and
- Health service commissioners and providers, giving them the information they need to improve health outcomes and obtain the best value for the public money spent. One example of this will be the procurement of the Community Care ICT solution.

To deal with all the current backlog issues and progress with this development work will require around £12m over the next 5 years, the following table suggests how much investment is required over the next 3 year period.

<table>
<thead>
<tr>
<th>Quality of Buildings as at 31st March 2014</th>
<th>TOTAL ACUTE HOSPITAL SITES</th>
<th>TOTAL OTHER HOSPITAL SITES</th>
<th>ALL OTHER SITES</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Cost to eradicate High Risk Backlog</td>
<td>3.0</td>
<td>0.1</td>
<td>0.00</td>
<td>3.1</td>
</tr>
<tr>
<td>Cost to eradicate Significant Risk Backlog</td>
<td>15.1</td>
<td>5.7</td>
<td>0.82</td>
<td>21.6</td>
</tr>
<tr>
<td>Cost to eradicate Moderate Risk Backlog</td>
<td>14.0</td>
<td>2.6</td>
<td>1.52</td>
<td>18.1</td>
</tr>
<tr>
<td>Cost to eradicate Low Risk Backlog</td>
<td>8.4</td>
<td>1.6</td>
<td>0.79</td>
<td>10.8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>40.5</strong></td>
<td><strong>10.0</strong></td>
<td><strong>3.14</strong></td>
<td><strong>53.6</strong></td>
</tr>
</tbody>
</table>

**ESTATES & INFRASTRUCTURE BACKLOG**
IM&T BACKLOG & DEVELOPMENTS

<table>
<thead>
<tr>
<th>Investment</th>
<th>2015/2016 - Year 1</th>
<th>2016/2017 - Year 2</th>
<th>2017/2018 - Year 3</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>1.3</td>
<td>0.5</td>
<td>1.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>0.6</td>
<td>0.3</td>
<td>0.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Data Centres</td>
<td>0.1</td>
<td>0.4</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td>PC / Printer Replacement</td>
<td>0.5</td>
<td>0.5</td>
<td>0.1</td>
<td>1.1</td>
</tr>
<tr>
<td>VC</td>
<td>-</td>
<td>0.2</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Telecommunications</td>
<td>0.4</td>
<td>0.5</td>
<td>0.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Modernisation</td>
<td>0.3</td>
<td>1.0</td>
<td>0.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Health Records</td>
<td>0.2</td>
<td>0.4</td>
<td>0.1</td>
<td>0.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3.3</td>
<td>3.6</td>
<td>3.6</td>
<td>10.5</td>
</tr>
</tbody>
</table>

Replacement Equipment: In addition to the backlog issues around IT and Estates the Health Board currently has approximately an additional £32m of equipment which is fully depreciated. Of this around £4m of equipment is “out of support” and at risk of being un-repairable in the event of breakdown.

The equipment backlog figure includes the following equipment

- Medical equipment, including scopes and theatre camera stacks
- radiology equipment,
- non-medical equipment such as decontamination equipment
- catering equipment like dishwashers and industrial freezer units

The following table shows the equipment backlog by area and how it will increase going forward over the next 4 years:

**EQUIPMENT BACKLOG**

<table>
<thead>
<tr>
<th>Department</th>
<th>Value of Equipment out of standard life as at Mar 15</th>
<th>as at Mar 16</th>
<th>as at Mar 17</th>
<th>as at Mar 18</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatre</td>
<td>5.9</td>
<td>0.8</td>
<td>0.8</td>
<td>1.3</td>
<td>8.8</td>
</tr>
<tr>
<td>Radiology</td>
<td>4.0</td>
<td>1.0</td>
<td>0.5</td>
<td>0.3</td>
<td>5.8</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>2.6</td>
<td>0.7</td>
<td>0.3</td>
<td>0.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1.9</td>
<td>0.3</td>
<td>0.2</td>
<td>0.5</td>
<td>2.8</td>
</tr>
<tr>
<td>Critical Care</td>
<td>1.0</td>
<td>0.4</td>
<td>1.4</td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1.5</td>
<td>0.4</td>
<td>0.2</td>
<td>0.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Pathology</td>
<td>1.4</td>
<td>0.2</td>
<td>0.3</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>0.6</td>
<td>0.3</td>
<td>0.1</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.7</td>
<td>0.2</td>
<td></td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Maternity Services</td>
<td>0.7</td>
<td></td>
<td>0.2</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>CSSD</td>
<td>0.6</td>
<td></td>
<td></td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>0.1</td>
<td>0.2</td>
<td></td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Estates</td>
<td>0.2</td>
<td></td>
<td></td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0.2</td>
<td></td>
<td></td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Hotel Services</td>
<td>0.2</td>
<td></td>
<td></td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Breast Care</td>
<td>0.2</td>
<td></td>
<td></td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>20.1</td>
<td>4.6</td>
<td>3.1</td>
<td>5.0</td>
<td>32.9</td>
</tr>
</tbody>
</table>
The Health Board is therefore carrying a significant backlog risk and the current level of the discretionary capital allocation makes it impossible, to replace all items as they come to the end of their expected asset lives. Discretionary capital is prioritised on a consistent risk score methodology. Current funding only allows a proportion of those items with a risk score of 20 or above to be purchased annually. This is the context in which the capital planning scenarios for Hywel Dda need to be considered for the IMTP from 2015/16.

Our 3 Year IMTP Capital Planning assumptions

The Health Board has created its capital programme around the assumption that there will be between £17.1m and £30m of capital available from 2015/16 onwards.

This is considered a reasonable planning figure given the capital allocations over the last four years have ranged between £22m and £27m. At this time, however, this assumption remains unconfirmed by WG.

The Health Board also acknowledges that the All Wales Capital available is likely to reduce over the next few years by approximately £65m across Wales, and the Health Board share of this is likely to be a reduction of around £7.9m. Against this planning assumption, therefore, the Health Board is carrying the following risks & backlog as previously detailed:

<table>
<thead>
<tr>
<th>Area</th>
<th>£m</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Infrastructure Backlog</td>
<td>53.0</td>
<td>Total as at 31/03/2014</td>
</tr>
<tr>
<td>IM&amp;T Backlog &amp; Developments</td>
<td>10.5</td>
<td>Required over next 3 years to maintain and develop services</td>
</tr>
<tr>
<td>Replacement medical equipment including Radiology</td>
<td>20.1</td>
<td>To replace equipment out of standard life as at 31/03/2015</td>
</tr>
<tr>
<td>TOTAL</td>
<td><strong>84.2</strong></td>
<td></td>
</tr>
</tbody>
</table>

There is a currently an expectation in WG that new requests for capital will be considered against the following five prioritisation criteria:

- Health gain
- Affordability
- Clinical and skills sustainability
- Equity
- Value for money

WG has also expressed a view that the use of capital funding should be based on one or more of the following principles, which we can demonstrate, align with our Mission Statement as follows:

- help tackle statutory and physical backlogs within the existing Health Board estate— which will assist us in focusing on quality, safety and improving outcomes
• that generate savings, invest to save– and help us ensure we eliminate waste, duplication and ensure value for money

• enable faster disposal of older non functionally suitable sites – which will assist us in the focus on quality and safety and enable us to deliver Care Closer to Home

• enabler to the deliverability of a change in the clinical service model – for us, this is Care Closer to Home and focus on quality, safety and improving outcomes

With these principles in mind, work has been undertaken to assess what our capital programme would look like if we continue to progress developmental schemes and try and deal with our current risks.

The table overleaf shows that the Health Board, using 3 different funding scenarios, £17.1m, £25m and £30m, over a three year planning cycle would be able to undertake a different mix of capital developments depending on the capital available.

Within these assumptions, the Health Board has also assumed that the Diagnostic Imaging funding and the funding for Cylch Caron will be over and above these planning figures. This will evidently need to be confirmed.

Funding below the £34m-38m, which is the most likely scenario given the reduction in capital availability at an All-Wales level, will mean that the Health Board will be unable to deliver on all of its capital planning priorities over the next three years.

In summary, depending on the funding scenario, between £2m-£22m of the Health Board’s capital plans will be undeliverable annually within the resource envelope available as follows:

<table>
<thead>
<tr>
<th>Over Commitment Scenario</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 £17.1m capital</td>
<td>Min</td>
<td>Max</td>
<td>Min</td>
</tr>
<tr>
<td>2 £25m capital</td>
<td>15.2</td>
<td>22.3</td>
<td>16.7</td>
</tr>
<tr>
<td>3 £30m capital</td>
<td>7.3</td>
<td>14.4</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td>2.3</td>
<td>9.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>

The Health Board recognises therefore that it will need to further prioritise our capital investment as part of this planning process.

The table overleaf shows the schemes and programmes which comprise these planning scenarios, which will need to be re-prioritised in the next 2 months.
### DEVELOPMENTS

<table>
<thead>
<tr>
<th>Sector</th>
<th>Scheme</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Min</td>
<td>Max</td>
<td>Min</td>
</tr>
<tr>
<td>Care Closer to Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary &amp; Community</td>
<td>Cardigan (including FBC &amp; Advanced Work)</td>
<td>3.0</td>
<td>3.0</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Cylich Caron</td>
<td>0.9</td>
<td>1.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Quality, Safety &amp; Improving Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>BGH Front of House Redevelopment</td>
<td>4.4</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Acute</td>
<td>Neonatal Phase 2</td>
<td>2.0</td>
<td>4.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Acute</td>
<td>PPH Unscheduled Care</td>
<td>1.3</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Ensuring a Flexible, Skilled &amp; Motivated Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventing in prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eliminating Waste, Duplication &amp; Ensuring Value for Money</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>HCBH Energy Project</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Acute</td>
<td>HCBH Pathology Phase 1</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>12.2</td>
<td>15.2</td>
<td>14.8</td>
</tr>
</tbody>
</table>

### RISK BASED PRIORITIES

<table>
<thead>
<tr>
<th>Sector</th>
<th>Scheme</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Min</td>
<td>Max</td>
<td>Min</td>
</tr>
<tr>
<td>Care Closer to Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary &amp; Community</td>
<td>HCBH Community &amp; Primary Care Modernisation e.g. - Crosshands HC - Llangennech Surgery</td>
<td>3.5</td>
<td>4.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Primary &amp; Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality, Safety &amp; Improving Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>Medical &amp; Non Medical Equipment Replacement</td>
<td>3.0</td>
<td>5.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Acute</td>
<td>Diagnostic Imaging</td>
<td>3.0</td>
<td>3.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Acute</td>
<td>Estates Statutory Backlog</td>
<td>3.0</td>
<td>3.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Acute</td>
<td>Estates Infrastructure Backlog</td>
<td>7.0</td>
<td>7.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Acute</td>
<td>TDA</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acute</td>
<td>Centre of Excellence</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Acute</td>
<td>Prudential Healthcare Contingency</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acute</td>
<td>GGH Angiography/Cath Lab</td>
<td>-</td>
<td>-</td>
<td>0.5</td>
</tr>
<tr>
<td>Acute</td>
<td>PPH Endoscopy &amp; Surgery</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ensuring a Flexible, Skilled &amp; Motivated Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventing in prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eliminating Waste, Duplication &amp; Ensuring Value for Money</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>HCBH IM&amp;T BACKLOG &amp; DEVELOPMENTS</td>
<td>3.3</td>
<td>3.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Acute</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>24.0</td>
<td>29.0</td>
<td>23.3</td>
</tr>
<tr>
<td>TOTAL CAPITAL</td>
<td></td>
<td>30.2</td>
<td>44.2</td>
<td>38.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>36.2</td>
<td>44.2</td>
<td>38.1</td>
</tr>
<tr>
<td>TOTAL SCENARIO 1 £17.1m capital plus diagnostic and Cylich Caron funding</td>
<td></td>
<td>21.0</td>
<td>21.9</td>
<td>21.4</td>
</tr>
<tr>
<td>TOTAL SCENARIO 2 £25m capital plus diagnostic and Cylich Caron funding</td>
<td></td>
<td>28.9</td>
<td>29.8</td>
<td>29.3</td>
</tr>
<tr>
<td>TOTAL SCENARIO 3 £30m capital plus diagnostic and Cylich Caron funding</td>
<td></td>
<td>33.9</td>
<td>34.8</td>
<td>34.3</td>
</tr>
<tr>
<td>OVER COMMITMENT SCENARIO 1</td>
<td></td>
<td>15.2</td>
<td>22.3</td>
<td>16.7</td>
</tr>
<tr>
<td>OVER COMMITMENT SCENARIO 2</td>
<td></td>
<td>7.3</td>
<td>14.4</td>
<td>8.8</td>
</tr>
<tr>
<td>OVER COMMITMENT SCENARIO 3</td>
<td></td>
<td>2.3</td>
<td>9.4</td>
<td>3.8</td>
</tr>
</tbody>
</table>
7.11 Best/Worst Case scenario planning – revenue and capital

The table below details potential best/worst case scenario variables;

Revenue - to be undertaken once plans are prioritised and savings plans are confirmed.

7.12 Our focus on involving our workforce and our clinicians in more innovative savings solutions because of multiple benefits

Environmentally friendly ‘Green’ Projects
We are supplementing the efficiency and productivity savings by more innovative savings solutions like that of the Energy Efficiency Project. The only issue with these is that they often require a more protracted lead-in time to deliver the savings. Nonetheless, when implemented, the savings are respectable.

Our energy efficiency scheme has taken an investment of £10m capital to yield revenue savings of between £0.600m-£0.800m per annum over the next 10 years. We will also save 4000 tonnes of carbon emissions.

In addition to saving money, these types of innovative solutions are also about doing the right thing on environmental sustainability grounds – adding great value in more than one way. It is our intention to do more of these types of schemes, especially those where energy efficiency / carbon reduction is optimised. A current example of this is the development of our Integrated Transport Unit where we are really trying to reduce unnecessary journeys.

Internal-trading to manage diagnostic services demand
In Pathology, we have begun an off-ledger internal-trading for the top 30 tests, as defined by activity, which is sent out to clinicians to show their use and uptake. We are able to establish monthly costs at a number of different levels including:

- The number of tests performed
- The cost per test
- The cost by ‘patient type’ e.g. accident & emergency; in-patient
- The cost by clinician

This will help us to establish test requesting profiles and to ensure a prudent healthcare approach of such requests.

Engaging our clinicians in population health and in service commissioning decisions
Over the past 5 years, we have tried to do all that we could to harvest the benefits of 4 former health organisations becoming Hywel Dda. Much of this has involved stream-lining within current service configuration, the stabilising and very partial optimising of resources.
From now on in, we need a step change in the way we approach service delivery – a more transformational approach is required. To this end, we are setting up a Commissioning Sub-Committee, which will clearly set out the expectations for how our Health Board will spend its resources, and how this will be monitored and evaluated through key performance indicators, whilst ensuring we align our work with the ethos of **Prudent Healthcare**.

Our seven Locality Networks, led by GPs, will be at the heart of driving decisions on where, and how, to most appropriately, and prudently, deliver services in the future, helping define the Health Services that are provided for their population, ensuring resources are spent effectively and measured against quality outcomes.

During 2013 the Health Board set up a three year Population Health Group (PHG) Programme. Over the same timeline, we have been able to identify the resources consumed by each of our Localities. As part of creating infrastructure to support demand management, our next steps are combining the Locality resourcing information, including Programme Budgeting to the work plans of our Population Health Programme which in turn will report to the Commissioning Sub-Committee, and should allow us to operate an effective clinical assessment and support unit to help manage demand.

It is our intention to set out a comprehensive commissioning work-plan delivering prudent healthcare through a robust understanding of:

- Population need – basing decisions on the needs of our population particularly around prevention and screening programmes
- Integrated Care – promoting integration within all sectors of health but also across social care and third sector organisations, with delivery focusing on care close to home
- Systematic approach – focusing on having the right systems in place to be able to deliver our healthcare to our population and making sure that our workforce are up-skilled in order to deliver the best care to our population
- Patient, Public and Partnership involvement – guaranteeing that we continue to engage with our population to understand what they want in terms of service delivery
- Employee engagement – making sure that our workforce are proud of the service that they deliver
- Value for money – ensuring that resources are channelled into high value activities so that our resources are put to best use
- Information-based decisions – ensuring the right information about the right patient is available at the right time
- Publish our innovation – ensuring an evidence base to what we do, and learn from what we do well and what we don’t do so well
- Knowledge management & Glossary – making sure all staff understand the need to use common healthcare language and to ensure that it is captured appropriately in our systems
- Assurance – ensuring that we capture the lessons from what PHG Programme has delivered through a comprehensive evaluation strategy.
From this, we intend to gain support to set up a **Clinical Assessment & Support Unit** to manage internal and external referrals / demand as follows:

### Pathways & Protocols
Short & clear pathways & protocols for common referrals – ideally specialty or sub-specialty based, preferably not individual condition

### Referral Made
Clinician to advise patient that they will be seeking specialist review, this may result in advice to enable the patient to continue to be treated by the referring clinician or they will be investigated or seen by another specialist. **Dear Doctor referrals**

### Clinical Assessment & Support Unit
Receives ALL referrals whether paper or electronic – potential for different rules for USC or red flag referrals. Log all referrals, Administrative check for key info – patient demographics, referrer info, medication, history, BMI, smoking status etc

### Low Demand Service
Those specialities without unusually high demand, high benchmark or INNUs

### High Demand Service
Those specialties with unusually high demand, high benchmark

### INNU / IFR
INNU or IFR referrals

### Booking “Opt in” Letter
Invite patient to call into booking centre in order to make a convenient appointment, time and location

### Phone Call
Admin to go through choices and book into clinical system appointment, time . . .

### NO Phone Call
Reminder letters to be sent – decision 2 or 3

### Outpatient Appointment
To go through booking process

### Investigation
To be booked for appropriate tests

### Clinician Review & Assessment
Appropriate clinician to review and stream referral

### Advice & Guidance
Feedback to referrer on future care and treatment

### Key Features:
- All administrative processes must be quick, not add delays and be able to be tracked electronically
- Clinical assessment must be turned around within 5 workings days to allow feedback to referrers for action
- Clinical assessment must be undertaken by appropriate skills and trained clinicians – normally can be done 3-5 minutes per referral
- Patient communication must be clear with appropriate information and capacity to enable booking
- Literature should be made available for patients to easily understand the process and details of who to phone if they need further information
- Clinical assessment does cost so should be targeted at those areas where demand is above expected need for the population or there are high levels deviation from protocol.
The following mechanisms will be used to assist in identifying variation in resource utilisation and ensuring performance delivery which supports this programme:

- Service Line Reporting (SLR) and Patient Level Costing (PLC)
- Locality Based Resourcing
- Clinical Assessment & Support Unit
- Programme Management Office

**Service Line Reporting (SLR) and Patient Level Costing (PLC)**

Hywel Dda has developed a Patient Level Costing (PLC) and reporting system focussed on better understanding and representing the costs of activities undertaken by the Board. The system, through its Service Line Reporting (SLR) package, also generates integrated reports, combining finance and activity data to give a broader view of delivery performance.

In 2013/14, approximately 50% of all health board expenditure was costed at individual patient activity level - this is 80% of our hospital and community provided services and covers all admitted patient care (costed per Finished Consultant Episode), outpatients, day care and A&E services (all costed per Attendance). The remaining elements of expenditure by the Board are not as detailed at this stage. Restricted in the main by a lack of detailed activity information, they remain areas for development both locally and nationally. The system also sub-divides the individual patient activity cost into cost types, providing a detailed view of our cost base and clinical activity. These cost types identify individual components of care that contribute to an activity (e.g. Wards, Theatres, Drugs etc.) and assign a cost to each. In addition, each individually costed patient activity, replete with cost type analysis, is aligned to all the clinical and administrative data one would expect to be associated with a hospital activity such as specialty, patient type, ward stay data, clinical coding and consultant identifiers among many more.

We aim to produce in-year, in-house PLC data on a quarterly basis. Due to timescales for data recording and consolidation, and the complexity of the process, our current experience is that it is a challenge to complete the costing project for a given quarter, much before the end of the following quarter (i.e. Q1: April to June data before the end of Q2: September). The standard suite of reports available through the web-based Qlikview platform provide multiple standardised views of the data and are fully drillable and dynamic.

The combination of these systems therefore, offers the opportunity to review, analyse and investigate costs and activities associated with virtually any aspect of the Board’s service delivery, particularly in respect of its hospital provided services. The ‘drillability’ and flexibility of the system should allow users to review large areas of service delivery and locate specific segments where there are areas of inconsistency and variation, and thus a need for further review and analysis. Identifying the drivers for these discrepancies may offer genuine opportunities to discover and adopt best practice to the benefit of the wider service and patients.

Often key to this initial ‘targeting’ process is the use of the SLR system’s integrated benchmark. At present, SLR uses All Wales Average Costs to give an immediate comparative measure of the Board’s financial performance in any given area, relative to the average position across Wales. Calculated at a very granular level and linked
to clinical coding, these average costs allow service managers to compare cohorts of activity against a standard with confidence that the ‘case-mix’ of patients has been taken into account.

An example of a key area of review made available by the system would be the ability to compare service delivery indicators such as Lengths of Stay and average spends across sites, patient types, specialties or clinicians. Service managers can review comparative indicators between clinicians within sites, across sites, across specialties or even with specific patient cohorts, to identify areas for further review. A further example area might be to examine the ratios between new and follow up outpatient activities and expenditure, perhaps across sites for given specialties, or clinicians for given sites & specialties for example.

The detail of costing data and patient information, also opens the opportunity to examine whether there are specific clinical or demographic drivers to longer stays and greater costs at the patient level within defined areas of service. For instance looking at the impact of age or co-morbidity scores on activities such as hip replacement or chest pain presentations.

The flexibility of the SLR system to adopt reporting structures independently of other established management hierarchies, increases the potential responsiveness of the system to organisational development and possibly even to multiple concurrent reporting structures or strategic emphases.

PLC data is also submitted to the Albatross Patient Cost Benchmarking system, a project collating data from across the UK and beyond. This data is available with virtually the same depth of detail as local systems and greatly extends the opportunities to review performance and identify areas of disparity.

Performance can be examined at macro levels (such as by site or specialty) across multiple organisations, or more targeted areas can be reviewed such as average drugs expenditure within specific clinical activities. This resource can be an invaluable tool in the identification of service areas which might benefit from sharing learning with peer organisations.

**Locality Based Resource Planning**

Locality Based Resource Planning (LBRP) is a Tier 1 Priority and is a tool which focuses on Locality rather than Practice based resource maps with the ability to drill down to practice level. It draws together actual Costs and activity for each Locality (& GP Practice) for each point of delivery and compares the results to key demographic data, including population, disease prevalence, CCM patients, socio-economic factors & Public Health data.

The tool seeks to encompass the whole Healthcare system, not simply APC (Admitted Patient Care) activity as provided by Service Level reporting and other performance models. It is able to map spend to GP practice, Ward, Locality, LSOA’s and other clusters. Financial results can be modelled based on integrating health needs and socio economic factors. Prevalence rates and other measures can be added to provide a full picture for strategic planning. Principles of performance measurement appropriate to this need to be agreed by the Board and key stakeholders in line with Foundations 4 Change, the emerging WG compliance
framework, and the Quality Delivery plan.
LBRP includes the following points of delivery:
- Inpatients & Daycases
- Outpatients / Outpatient Procedures & Regular Day Attendees
- Endoscopies
- Clinical Decision Units (Adult & Paediatric) & A&E & MIU
- Primary Care
- Community Activity
- Out of area / WHSCC

Benefits of this approach
- Allows greater understanding of current and future health needs of the population and cost impact
- Provides for more informed decision making on future configuration/management of services
- Ability to identify regional/local/ practice patterns of activity and expenditure
- Enables better targeting of resources to need
- Use as a performance management tool

Scope of Reporting and frequency
The scope of reporting depends highly on the level of supporting information and the respective reporting period. The table below highlights the Service Delivery Area and associated sources of information and timescales:

<table>
<thead>
<tr>
<th>Sector / Point of Delivery</th>
<th>Data Source / Supporting Information</th>
<th>Frequency / Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>GP Dashboards</td>
<td>Monthly</td>
</tr>
<tr>
<td>Acute Care: Admitted Patient Care (IP, DC, RDA, Endoscopies)</td>
<td>SLR / PLC</td>
<td>Monthly</td>
</tr>
<tr>
<td>Acute Care: Non-admitted Patient Care (OP, OPP, Direct Access)</td>
<td>Corporate Information reports / IRIS</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Community</td>
<td>Community Systems / Local Data Sources</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Out of Area / WHSCC</td>
<td>Local Systems / WHSCC</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

The table overleaf illustrates the 2013/14 results derived from Locality Based Resource Planning within Hywel Dda. These provide each locality (and each constituent GP Practice) with a detailed breakdown of the costs incurred by the health board as a result of the respective population on Hywel Dda Services.

The total incurred expenditure from each GP Practice has been split between Primary and Secondary Care and broken down to Point of Delivery (e.g. GMS, Inpatients, Daycases etc). The amounts shown within Secondary Care are driven at a patient level and the actual resources consumed at a procedure level are then matched to the registered GP Practice.
## Hywel Dda University Health Board
### Locality Based Resource Planning
#### 2013/14 Activity & Costs

### GP Locality

<table>
<thead>
<tr>
<th>Point of Delivery</th>
<th>Amman/Gwendraeth £</th>
<th>Llanelli £</th>
<th>Taf/Teil/Twyi £</th>
<th>Carmarthenshire County £</th>
<th>North Ceredigion £</th>
<th>South Ceredigion £</th>
<th>Ceredigion County £</th>
<th>North Pembrokeshire £</th>
<th>South Pembrokeshire £</th>
<th>Pembrokeshire County £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted Patient Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients - Elective</td>
<td>4,244,463</td>
<td>4,555,098</td>
<td>4,404,034</td>
<td>13,203,595</td>
<td>2,809,345</td>
<td>4,049,013</td>
<td>6,658,358</td>
<td>5,182,885</td>
<td>4,628,226</td>
<td>10,011,111</td>
</tr>
<tr>
<td>Inpatients - Emergency</td>
<td>17,175,706</td>
<td>21,358,488</td>
<td>16,733,527</td>
<td>55,267,721</td>
<td>14,180,005</td>
<td>14,760,666</td>
<td>28,940,671</td>
<td>21,456,705</td>
<td>18,227,404</td>
<td>39,684,109</td>
</tr>
<tr>
<td>Daycases</td>
<td>3,696,617</td>
<td>3,874,182</td>
<td>4,552,392</td>
<td>12,123,191</td>
<td>1,745,243</td>
<td>3,255,663</td>
<td>5,000,906</td>
<td>4,549,658</td>
<td>4,313,781</td>
<td>8,863,439</td>
</tr>
<tr>
<td>Regular Day Attenders</td>
<td>431,912</td>
<td>317,044</td>
<td>1,021,473</td>
<td>1,770,429</td>
<td>1,357,867</td>
<td>996,452</td>
<td>2,354,319</td>
<td>2,003,125</td>
<td>1,807,359</td>
<td>3,810,484</td>
</tr>
</tbody>
</table>

|  | 25,548,698          | 30,104,812 | 26,711,426     | 82,364,936              | 20,092,460       | 23,061,794        | 43,154,254        | 33,192,373           | 29,176,770           | 62,369,143             |

| APC Spend per Registered Population | 443 | 494 | 467 | 468 | 415 | 481 | 448 | 521 | 532 | 526 |

### Other Secondary Care

| Assessment Units | 580,396 | 709,795 | 594,306 | 1,884,497 | 228,687 | 443,313 | 672,000 | 600,527 | 561,883 | 1,162,410 |
| Daycare | 174,324 | 328,715 | 429,267 | 932,306 | 20,272 | 147,536 | 167,808 | 320,044 | 429,401 | 749,445 |
| Outpatient Attendances - 1st App | 1,178,770 | 1,482,659 | 1,191,532 | 3,852,961 | 851,777 | 1,070,939 | 1,922,716 | 1,696,009 | 1,451,374 | 3,147,383 |
| Outpatient Attendances - F'Up | 1,481,039 | 1,840,541 | 1,567,589 | 4,889,169 | 1,148,588 | 1,324,795 | 2,473,383 | 1,868,763 | 1,352,931 | 3,221,694 |
| Outpatient Procedure | 755,483 | 844,007 | 809,868 | 2,409,358 | 488,537 | 673,694 | 1,162,231 | 446,240 | 372,929 | 819,169 |
| Pre-Assessment Attendances | 121,266 | 134,846 | 124,786 | 380,698 | 85,496 | 115,338 | 203,834 | 140,441 | 114,146 | 254,597 |

|  | 6,872,914 | 8,971,720 | 7,270,778 | 23,115,422 | 6,489,827 | 5,679,366 | 12,169,193 | 8,916,369 | 7,855,574 | 16,771,943 |

| Other Spend per Registered Population | 119 | 147 | 127 | 131 | 134 | 119 | 126 | 140 | 143 | 141 |

### Primary Care

| GMS Enhanced | 945,407 | 947,568 | 892,329 | 2,785,304 | 690,200 | 746,921 | 1,437,121 | 1,006,945 | 863,012 | 1,869,957 |
| GMS General | 5,493,844 | 5,540,834 | 6,496,693 | 17,333,371 | 5,274,323 | 4,568,681 | 9,843,003 | 6,669,712 | 6,257,613 | 12,927,325 |
| GMS GOF | 546,836 | 553,457 | 549,949 | 1,650,242 | 420,891 | 467,308 | 888,199 | 678,057 | 707,267 | 1,385,324 |
| Prescribed Drugs | 10,333,066 | 10,987,799 | 8,471,596 | 29,792,461 | 6,166,315 | 8,152,879 | 14,319,195 | 9,755,660 | 9,165,880 | 18,941,540 |

|  | 17,319,153 | 18,029,658 | 16,412,567 | 51,761,378 | 12,551,729 | 13,935,789 | 26,487,518 | 18,110,374 | 17,013,772 | 35,124,146 |

| PCare Spend per Registered Population | 300 | 296 | 287 | 294 | 259 | 291 | 275 | 264 | 310 | 296 |

### Total Resources Consumed


| GP Locality Population (registered) | 57,706 | 60,880 | 57,255 | 175,841 | 48,464 | 47,914 | 96,378 | 63,744 | 54,871 | 116,615 |

| Spend per Registered Population | 862 | 938 | 880 | 894 | 807 | 891 | 849 | 945 | 985 | 963 |
7.13 Programme Management Office

We know we need to move at pace on these initiatives to deliver the 2015/16 priorities which are stepped improvement in the delivery of achievement of Tier 1 targets, improved patient flow and systems to support the reduction of variation. To do this, we need to set up a Programme Management Office (PMO) with the responsibility for improving patient flow and reducing variation in our practice. A PMO is a central support structure designed to provide assistance to change and delivery initiatives within an organisation. Without this functionality an organisation is forced to replicate support arrangements over and over again for different projects. It is essential therefore that the PMO has a dedicated team with the appropriate skills and resources at its disposal to perform the task at hand.

Within an organisation as diverse as Hywel Dda a number of different skill sets will be required within the PMO to ensure it works as effectively as possible. It will need to encompass expertise from Finance, Information & IT, Workforce, Planning, Procurement, Public Health, Co-opted expertise dependent on area being reviewed eg Pharmacy, Primary Care, Lead Secondary Care Clinicians.

Existing structures such as the Population Health Groups should make it easier to facilitate this. Business Change Managers (from within the service) will also need to be identified to create the new structures and working practices to ensure benefits identified by the programme are realised operationally.

Key to the success of the PMO is reliable data from which to establish a baseline to measure success against. Rightly or wrongly 'what gets measured, gets managed'. We need to focus our efforts on areas where data is readily available and evidence suggests we can improve from the average to upper quartile to best in class performance.

We have a vast array of data available to us but we often find it difficult to translate this into meaningful information that can be reproduced on a consistent and timely basis. This will need to be considered as part of the constraints and development requirements of the PMO. However, in the meantime both internal and external benchmarking data is available that we need to start using to drive improvement at pace. These include:

- WAO Reports
- Other external reviews eg Delivery Unit
- Reports commissioned by Hywel Dda
- Locality Based Resourcing
- Patient Level Costing & Other Costing Benchmarking data
- Daily/Weekly/Monthly/Annual activity data reports
- Prescribing data (PARS/CASPA/Medusa)
If we look at the principles of prudent healthcare:

- **Do no harm** – interventions which do harm or provide no clinical benefit are eliminated
- **Carry out the minimum appropriate intervention** – treatment should begin with basic proven tests and interventions with the intensity of testing consistent with the seriousness of illness and patient’s goals
- **Organise the workforce around the ‘only do, what only you can do’ principle** – all people should work at the top of their competence with no one for example routinely seeing a consultant for something that could be dealt with by an advanced nurse practitioner
- **Promote equity** – it is the individual’s clinical need which matters when it comes to deciding treatment
- **Remodel the relationship between user and provider on the basis of co-production**.

We can clearly see the link between the first three of these in particular and the reduction in variation and improvement in flow. For example

- **Do no harm** – we are still (2013/14 data) performing the same level of Interventions Not Normally Undertaken (INNUs) as in 2011/12. What validation checks are we undertaking to ensure all of these were clinically necessary?

- **Carry out the minimum appropriate intervention** – examples from other areas suggest that tests are routinely requested in primary care and then repeated in secondary care wasting both patients’ time and scarce resources. ‘Only do, what only you can do’ - a consultant’s hourly rate is 4 times that of a medical secretary but are there admin tasks being inappropriately undertaken by consultants? A detailed review of the patient pathway should identify opportunities for reducing/eliminating both of these scenarios.
Chapter 8: Governance

8.1 Planning Approach

The approach adopted for the development of the Health Board Plan has been to
- demonstrate the continuity in service planning from the ‘Your Health: Your Future’ consultation
- strengthen the planning process to create a stronger platform from which to both monitor planned activity and develop future plans
- Establish a clear set of priorities for the 3 years of the Plan and articulate these in term of stabilising, optimising or transforming characteristics.

Taking the key strategic aim, dictated by our changing demographics, to strengthen Care Closer to Home, a bottom up approach to locality planning was adopted. This required an integrated approach from our Single Integrated Plans, the emerging Primary Care cluster plans and locality plans for community services.

This has led to the drafting of detailed locality plans for each of the 7 Localities of the Health Board led by the respective County Directors, in liaison with Local Authority colleagues, and taking into account where possible the impact of their recent austerity measures. Their vision for the development of Locality service improvement has been articulated in detailed SBARs with financial and workforce implications.

There has been a clear read across to secondary care planning with an emphasis on areas of service challenge and the need to address tier 1 RTT targets. The planning process has been the subject of:

- Local engagement workshops to detail bottom up plans
- Testing of planning assumptions with
  - The Local Partnership Forum
  - The Local Medical Council
  - The Community Health Council Planning Committee
  - Meetings with each Local Authority
  - Meetings and development sessions of the Health Board

Plans have been prioritised to evidence clear progress against
- Tier 1 targets
- The stabilisation of core GMS services
- Strengthening capacity and capability to manage patient flow
- To address issues of variation

The Health Board recognises areas of planning which require further strengthening and which will be part of the on-going planning cycle. The Strategy & Planning Committee provides Board assurance on the management of the planning cycle and the
prioritisation and recommendation to the Board on strategic investment decisions.

Key to this will be a governance process to ensure Together for Health Delivery Plans are central to the development of improvement plans and the implications on service, workforce and cost of full compliance can be articulated in future plans. This will form part of the workplan of the Strategy and Planning Committee. In year monitoring of targets established for year 1 of the plan will be the responsibility of the Integrated Governance Committee of the Board.

The Health Board is embarking on an ambitious long term commitment to strengthen engagement at a locality level and this will be key to working with our partners to strengthen future plans and shared priorities.

8.2 Governance for Delivery
The Health Board has several important forums that will ensure the activities outlined above are appropriately managed, these being:

Integrated Governance Committee – The formal forum where Independent Members scrutinise and challenge progress on in-year delivery of the IMTP on a bi-monthly basis;

Quality and Safety Committee – Has the responsibility for scrutinising plans;

Performance Assurance Sub-Committee – The formal forum where individual Directorates are held to account by members of the Executive Team against a range of metrics including quality, safety, financial, performance and delivery;

Corporate Director Group Meeting – where the Executive team meet on a weekly basis to give oversight and coordinate all of the performance and improvement activities in the organisation and provide oversight on the direction of travel;

Operational Management Team – where the Chief Operating Officer meets weekly with his Senior Management Team to monitor the performance across the organisation to achieve medium to long term improvement trajectories;

Our performance management arrangements outlined in the table below provide further synergy to this delivery model:-
8.3 Corporate Governance

One of the underpinning principles recognised by the Board is that governance is about vision, strategy, leadership, probity and ethics as well as assurance and transparency, and should provide confidence to all stakeholders, not only to the regulators, in the delivery of its objectives.

The Health Board has in place governance and assurance arrangements which are continually being developed and strengthened. During the year, Welsh Audit Office undertook the Structured Assessment Year 5 review of the Health Board which examined the arrangements to support good governance, effective quality assurance and the efficient, effective and economical use of resources. In governing the business, the assessment concluded that the organisation has continued to strengthen governance arrangements and is building a more open and engaging culture, although it is recognised that some fundamental issues are yet to be addressed.

The Health Board is strengthening its change management arrangements and can evidence some positive examples of successful change. Improved communication mechanisms, a gateway process to delivering agreed plans and the establishment of a programme management office are all contributing towards these arrangements. The Health Board has systems in place to control, manage, mitigate and provide assurance
through our continually maturing governance structures in an open and transparent way. We recognise that the financial position remains a significant challenge and our governance systems are designed to monitor the implementation of our plans to ensure that the organisation continues to balance delivery against quality standards, cost impact and patient need.

The Health Board is committed to communicating, engaging and consulting with its staff, patients, citizens, and stakeholders. In developing the IMTP it is recognised that there is a need to communicate clearly about how services currently operate and identifies the service developments required to improve services. It is necessary to develop and continue conversations with communities in a meaningful and consistent manner and therefore it is proposed that existing mechanisms are strengthened furthered.

In addition to these existing mechanisms for engagement it is intended to establish a locality based programme of meetings to provide a mechanism for continuous dialogue on healthcare provision in the Hywel Dda area from January 2015. These meetings will be located across the seven localities with an open invitation to all Hywel Dda residents to attend. Enacting locality engagement groups will ensure local stakeholders are engaged, are informing locality planning and improving trust over the longer term.

The primary route for feedback to the Board for locality engagement groups will be will be through the Stakeholder Reference Group, where feedback will be considered and shared with the Board. Information gathered and collated will inform service planning and through the Strategy and Planning Committee the Board will be able to demonstrate feedback has been considered and has informed the decision making process.

The Health Board’s system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks and as such can therefore only provide reasonable and not absolute assurances of effectiveness. The Board draws on assurances from a number of different sources in order to demonstrate that the system of internal control has been in place, and combined, these provide the body of evidence required to support the continuous assessment of the effectiveness of the management of risk and internal control.

The governance structure is supported and informed by the work of Internal (including Clinical Audit) and External Audit, which provides the scrutiny and assurance underpinning the effectiveness of the system of internal control. The scope of the work of Internal Audit is focussed on the Health Board’s risk profile, in particular significant risk areas and local improvement priorities. The Health Board continues to develop the mechanisms regarding a similar level of assurance from clinical activities being reported through its Clinical Audit programme. As the Health Board’s appointed external auditor, WAO is responsible for scrutinising the Health Board’s financial systems and processes, performance management, key risk areas and the Internal Audit function.
The governance structure is further supported by the work of other independent / external bodies such as the Welsh Risk Pool and Healthcare Inspectorate Wales, with the outcomes of any such reviews and any emanating action plans discussed in the most appropriate forum with any lessons learnt shared throughout the Health Board. The Health Board also have an active Community Health Council who undertake a comprehensive visiting programme and their feedback and engagement with the Health Board is a key assurance tool utilised by the organisation.

In the continuous development of the organisation’s governance and assurance framework and in recognising that the legal obligations of the Health Board are wide ranging and complex, a legislative assurance framework has been implemented. It provides the Board with assurance of compliance on those matters that present the highest risk in terms of likelihood and impact of non compliance and is a central record that captures the following three categories:

- Details of all licensed and accredited functions, responsible individuals and inspection / review activity.
- Activities subject to regulation and inspection scrutiny.
- Other key pieces of legislation subject to scrutiny and sub-ordinate legislation.

During 2013/14, the Health Board undertook an evidence based self assessment of its governance arrangements, with a triangulation being made with the recommendations arising out of the joint HIW/WAO review of governance arrangements at BCUHB, other sources of assurance and recognised best practice guidance on governance arrangements. All of these placed emphasis on the collective role of the Board, the strong relationship between leadership capacity and performance and the impact of Board governance arrangements on the achievement of strategic objectives. The Health Board noted its current position and supporting evidence, together with identifying any actions required which would enhance existing arrangements. The composite action plan emanating from the assessments and other work undertaken was developed in line with the overarching themes identified from the best practice guidance referred to above and is aligned to the following areas:

<table>
<thead>
<tr>
<th>Improvement Area</th>
<th>Primary Rationale</th>
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<tbody>
<tr>
<td>Production of accurate and timely information / data for Board.</td>
<td>Receiving timely relevant and accurate information is paramount to aiding decision making.</td>
</tr>
<tr>
<td>Board Cohesion and Consensus.</td>
<td>Effectiveness of the Board and sub committees - aligning Board agendas with strategic objectives and collective role of the Board</td>
</tr>
<tr>
<td>Focus on Quality and Safety.</td>
<td>Dedicated board time to clinical and quality issues - clearly aligned clinical and quality issues to strategic objectives.</td>
</tr>
<tr>
<td>Probity.</td>
<td>Boards should be seen to demonstrate probity and transparency in their decision making, ensuring resources are used effectively and efficiently.</td>
</tr>
<tr>
<td>Strategy.</td>
<td>Boards are integral to setting strategic goals and should focus on strategic achievements.</td>
</tr>
<tr>
<td>Financial Stewardship.</td>
<td>Board assures itself that the Health Board is operating effectively, efficiently and economically and with probity in its use of resources.</td>
</tr>
</tbody>
</table>
The delivery of the governance action plan has been monitored by the Audit Committee and steady progress against all elements contained within the composite plan can be and will continue to be demonstrated.

In addition to the internal self assessment a review of the corporate and clinical governance structures and processes across Hywel Dda was undertaken by the Good Governance Institute. The review found the Health Board to be an organisation where there has been a palpable drives to transform services and significant focus on improving the effectiveness of clinical quality and safety assurance. This happens at a time of considerable change as well as political, financial and other challenges. Many of the issues identified within report were known to the Board and were the subject of current or planned action. It should also be noted that there were no serious issues of concern were noted during the review. An action plan was developed which has been monitored by the Quality and Safety Committee noting that steady progress has been made in most areas.

The Board draws on assurances from a number of different sources in order to demonstrate that the system of internal control has been in place and that a robust governance process is enacted. Combined, these provide the body of evidence required to support the continuous assessment of the effectiveness of the management of risk and internal control and ultimately the governance framework. The structured mapping of assurances is one of the fundamental steps in building a governance framework and the Health Board’s assurance framework, mapped to “Safe Care, Compassionate Care”, demonstrates how governance and internal control is enacted.
Safe Care, Compassionate Care

8 Quality Trigger Questions
Are we providing safe care?
Are we meeting required standards of effective care?
Are we improving user experience?
Are we providing efficient services within resources?
Are we engaging the workforce?
Are we providing accessible and equitable services?
Are we improving population health?
Are we working effectively with partners and
CEAC Audit Board

Board IGC Audit Committee
IGC Finance Sub Committee

Board IGC Audit Committee
IGC Finance Sub Committee

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The Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is supported in this role by the work of the following main committees, to ensure appropriate assurance and governance arrangements are in place. The 2014/15 WAO Structured Assessment found that changes to the structure and operation of Board committees have helped strengthen overall governance and assurance although it is recognised opportunities remain for further improvement.

These key Committees of the Board provide scrutiny on the Executive’s delivery of the Board’s strategic priorities and, in particular the IGC will closely monitor and scrutinise the in-year delivery of the IMTP. In addition to the above, a Board level Strategy & Planning Committee has been established with responsibility for the delivery of the three year planning cycle and major issues relating to strategic aims, whilst the Finance Sub Committee provides scrutiny to financial matters. Apart from the Audit Committee, all of the main committees of the Board are supported by an underpinning structure of sub-committees. The underpinning structures all support the Board who continue to be actively engaged in the ongoing development of the IMTP for which the Strategy & Planning Committee will be responsible, on behalf of the Board.

The NHS Wales Planning Framework document outlines specific requirements for delivery, monitoring and escalation of delivery of the IMTP. These include monthly
monitoring and as a minimum an Executive Group to oversee plan delivery with a Board sub-committee to be scrutinising and challenging progress on a routine basis.

The schematic below demonstrates the Health Board’s internal governance arrangements to ensure such requirements are enacted.

The above diagram provides an outline of the Health Board’s internal hierarchical governance arrangements for delivery, monitoring and escalation of non delivery of the plan. This will be supported by enacting robust governance arrangements for all underpinning structures, such as Population Health Groups, ensuring there are clear Terms of Reference and clear lines of accountability and reporting, directing the work of each component. The Health Board can evidence significant engagement in the development of the draft plan, a summary of which is attached as Annex 15. As part of the detailed Programme Management arrangements being established to take this plan forward a detailed engagement strategy will also be developed.

The Health Board also recognises that working in partnership/collaboration to develop/deliver services, requires governance arrangements to be clarified at the outset and will ensure that these are clearly articulated in any formal agreements.
8.4 Principal Risks to Delivery and Mitigating Actions

The Health Board views soundly based risk management as an integral element of effective governance and it is seen as central to its management processes in that risks are considered in terms of effect of uncertainty of objectives. Effective risk management is essential for the achievement of delivering against objectives in the delivery of high quality services.

The Health Board has an approved strategy for risk management which provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation. This is supported by a Risk Management Procedure providing detailed guidance on the risk assessment process to be undertaken across the whole organisation in order to populate the Health Board’s risk register in a consistent manner. It is recognised that risk management requires participation, commitment and collaboration from all staff and the process starts with the systematic identification of risks throughout the organisation, documented on risk registers. 

Creating clear ownership and well focused leadership to drive through delivery of any activity is a key requirement. Implementation of policies and new activities can fail or be delayed because the delivery teams do not have the right skills or techniques to identify and manage the associated risks. The Health Board will ensure that where possible an individual with a proven track record of delivery is given clear responsibility for development and implementation of any such activity.

The diversity of different cultures in partnerships requires an understanding of the diverse perceptive on risk and the arrangements for managing them. Separate statutory responsibilities and separate lines of accountability (e.g. as with Local Authorities) have to be managed. The terms of any agreements between such partners may be less explicit than in a typical contract with very little explicit agreement of risk management responsibilities. The Health Board will therefore endeavour to ensure that any such contracts/agreements, some of which may be with long term partners, should at an early stage in negotiation, agree on ownership of action to address risks and have clarity on what risks have been transferred. Taking these steps will reduce the possibility of unhelpful behaviour should a risk materialise.

The Health Board outlines its key risks in a Corporate Risk Register developed from common risk themes identified from reviewing all directorate and operational risk registers collated to an organisation level. The IMTP is aligned to address the Health Board’s key risks and to the improvement areas highlighted from internal and external regulators.

The Health Board currently works to a generic risk appetite statement which recognises effective risk management is a key component of corporate and clinical governance and is integral to the delivery of its objectives in service provision to the
citizens of the health community. It is acknowledged that whilst a certain degree of risk is inherent in all the Health Board’s activities, the Health Board will not accept risks that materially impair on the ability to deliver services to a high standard of safety and quality. As such the Health Board will not accept risks that materially impair its reputation or cause any disrepute with its stakeholders.

**Risk Appetite**

Hywel Dda University Health Board recognises effective risk management is a key component of corporate and clinical governance and is integral to the delivery of its objectives in service provision to the citizens of the health community.

It is acknowledged that whilst a certain degree of risk is inherent in all the Health Board’s activities, the Health Board will not accept risks that materially impair on the ability to deliver services to a high standard of safety and quality. As such the Health Board will not accept risks that materially impair its reputation or cause any disrepute with its stakeholders.

Although the concept of risk appetite is broad and evolving, it can help an organisation implement its strategic initiatives within established limits. It also helps with balancing risks and rewards and optimising the allocation of capital and resources. Whichever approach is used, a properly articulated risk appetite should provide the foundations of an organisation’s risk management framework. It is important therefore that the Health Board understands risk appetite in the context of its strategic and operational decision making. It is critical to have a risk appetite which aligns with the Health Board’s strategy, performance expectations and risk management capability and balances stakeholder interests. When the Board considers a strategy, it should determine whether that strategy aligns with the organisation’s risk appetite. When properly communicated, risk appetite guides management in setting goals and making decisions in such a way the organisation is more likely to achieve its goals and sustain its operations.

The Health Board is in the process of revising and developing an enhanced risk appetite statement which will be used in conjunction with, and applied to, the IMTP. The revised risk appetite will not be a single, fixed concept, but there will be a range of appetites for different risks which need to align and may vary over time. Work continues to ensure the Board’s governance and risk management arrangements are robust and aligned to the Board Assurance Framework which is being developed.

**8.5 Equality and Diversity**

The Equality Act 2010, covers discrimination because of Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex and Sexual Orientation. Public bodies are required to consider needs, by reference to these characteristics, when designing and delivering public services.
As a public sector body, in our policies and practices, we must also have due regard to the need to:-

- Eliminate discrimination, harassment, victimisation and other conduct that is prohibited by or under the Act
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not
- Foster good relations between persons who share relevant protected characteristics and persons who do not.

The Health Board is committed to ensuring that equality, diversity and human rights are integrated into our planning processes and produce a Strategic Equality Plan and Objectives Annual Report to evidence progress and next steps. The key issue is that we embed the consideration of these issues at the earliest stages of service planning. This can be evidenced in Board and Committee report templates which require consideration of any potential impact. In addition the Health Board has adopted a ‘gateway review’ process for issues of significant service change which again requires evidence that potential impact on those with protected characteristics under the Act has been considered and mitigating plans put in place. Service changes referenced in this draft 3 year plan will be subject to the same rigour. As saving and investment priorities are agreed, issues of equality, diversity and human rights will form a core component of the evidence in advance of decisions being taken.