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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Integrated Medium Term Plan

2018/19 – 2020/21

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EXECUTIVE SUMMARY

INTRODUCTION

Aneurin Bevan University Health Board (ABUHB) is responsible for promoting wellness, preventing disease and injury, and providing health care to a population of approximately six hundred and forty thousand people who live in the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys with a budget of circa £1.1billion.



The Board is chaired by Ann Lloyd, CBE and the Chief Executive is Judith Paget.

The Health Board is also responsible for planning, designing, developing and securing the delivery of safe and high quality preventative, primary, community, hospital care services and specialised and tertiary services for their resident population. The Integrated Medium Term Plan (IMTP) is a statutory requirement of Health Boards and provides the organisation with a process and vehicle to review and articulate the organisation's values, future strategy, key priorities and delivery actions over a three year timeframe.

The Integrated Medium Term Plan for 2017/18 – 2019/20 for the Health Board was approved by Welsh Government on 16th June 2016 and therefore this document provides an overview of the refreshed plan for 2018/19 to 2020/21, reflecting on the progress made in over the past 12 months, current challenges and the updated outlook for the next three years. There is a clear focus on the Health Boards work to prepare for the commissioning of The Grange University Hospital in 2021 and transformation of our service models in the lead up to and beyond the opening of this hospital.

This report is divided into four sections:

Section One sets out the national, local and organisational context for the Health Board, including its vision, values and ways of working supported by the Health Board's Clinical Futures Strategy.

Section Two sets out the achievements that have been delivered in 2017/18, summarises opportunities and challenges faced by the Health Board and describes the significant service change agenda that will be addressed over the life of this plan.

Section Three sets out the key components of the Three Year Plan, reflecting on the achievements of 2017/18 and the key service sustainability and service change priorities for the next three years supported by the key enablers including finance and workforce plans.

Section Four summarises the key outcomes anticipated over the three years and the governance framework that will support delivery of the plans.

This plan is supported by a detailed set of appendices which complies with the Welsh Government planning guidance and provides greater detail and depth to the key areas covered in this overarching narrative.

SECTION 1 - STRATEGIC OVERVIEW AND CONTEXT

1.1 Health Board Vision & Values

Aneurin Bevan Health Board was established in October 2009 and achieved 'University' status in December 2013. It serves an estimated population of over 639,000, representing approximately 20% of the total Welsh population. With a budget of £1.1 billion it commissions and delivers healthcare services for the people of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The Health Board also delivers many services to the population of South Powys.

The Health Board is responsible for promoting wellness, preventing illness and disease and for planning, designing, development and securing the delivery of safe, high quality service to meet the needs of our population.

Our vision for Aneurin Bevan University Health Board is to:



During 2017/18, the Health Board has continued to take forward its vision through delivering the next steps of its clinical services strategy and achieving the following key organisational objectives:

- Improving public health and reducing health inequalities by working with our partners to promote healthy lifestyles and ensure there is access to preventative services, particularly for those in areas of greatest need.
- Actively engaging patients, carers and communities and building strong partnerships to ensure services focus on need.
- Providing and commissioning services that focus on the needs of the patient, in their homes, communities and where necessary hospital settings.
- Ensuring safety, excellence and quality in all our services at all times.
- Improving the efficiency and effectiveness of our services.
- Focusing on prudent and value based healthcare to ensure clinical value and value for money is improved.
- Driving excellence through innovation and research which is embedded in practice.
- Trusting and supporting our staff to make the right decisions for patients and to improve care.

The Health Board has a longstanding, approved clinical service strategy in **Clinical Futures**, which sets out our vision for modernising clinical services for the population of Gwent and South Powys. At its heart, the strategy seeks to rebalance the provision of healthcare, enabling citizens to play a more active role in their health and well-being, providing more services within the community using Neighbourhood Care Networks to drive and deliver change at local level. In keeping with the outcomes of the South Wales Programme, it reshapes our hospital services in order to centralise

specialist and critical care services in a single purpose built hospital, whilst maintaining a network of local hospitals to meet routine care needs.

The Clinical Futures Strategy continues to form the platform for service planning from 2018 – 2022 and is consistent with the wider planning context for NHS Wales. The Health Board is wholly committed to working collaboratively and at pace with Health Boards and other key partners in the region to secure benefits for patients wherever this is appropriate. The Health Board continues to participate and lead work on behalf of the Region and Team Wales.

Our Values

Everyone who works within Aneurin Bevan University Health Board share four core values that guide the approach we take to work, how we do things, how we treat each other and how we expect to be treated. We demonstrate our values, each and every day, across our organisation and care system through these behaviours.

Figure 1.2 - We live our values by



1.2 National Context

At a national level, 2017/18 has seen significant development in terms of National Strategy and legislation. A new programme for government that has led to the publication of a new National Strategy "Prosperity for All", the final report on the Parliamentary Review of Health and Social Care, the increasing profile of the Well Being Future Generations Act and the adoption of the Nurse Staffing Levels (Wales) Act 2016. The Health Board is proactively working with its partners and staff to ensure our future plans align with the requirements and expectations of the national agenda.

1.2.1 Prosperity for all

This National Strategy for Cross-Government action sets out the priorities of Welsh Government, and addresses the issues that Wales faces that can only be tackled through working differently, in particular by joining-up programmes and working across boundaries. This strategy includes twelve whole of Government objectives under four areas as shown in Figure 1.3.

Figure 1.3 - Prosperity for all



These areas taken together give a strong sense of cross-government action on the wider determinants of health, and challenge the NHS to make a greater contribution to other government objectives such as economic growth and education.

In developing the strategy, five areas emerged as having the greatest potential contribution to long-term prosperity and well-being. These reflect the times in people's lives when they may be most in need of support, and where the right help can have a dramatic effect on their life course. These are:

- Early years;
- Housing;
- Social Care;
- Mental Health;
- Skills and employability.

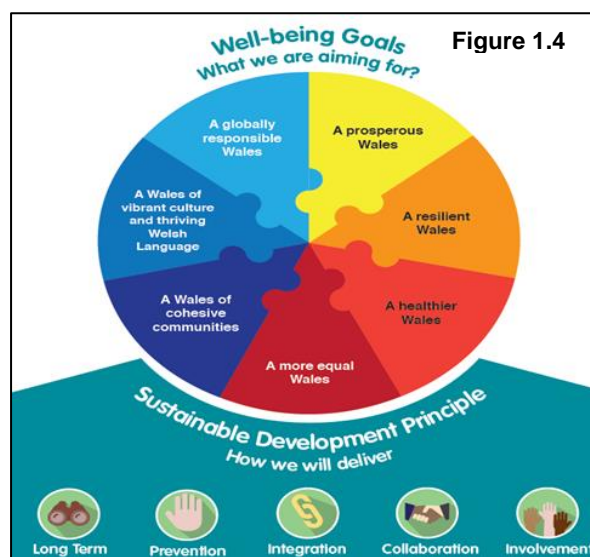
Focusing on the five priority areas is intended to help Welsh Government and its delivery partners integrate services and programmes better, and maximise benefits for citizens. This is particularly relevant in the context of cross-strategy working, collaboration and continued emphasis on well-being and sustainability. These priority areas are consistent with many of the Health Board plans and will continue to be areas of further development as the plans progress into future years.

1.2.2 Well-being and Futures Generation Wales Act (2014)

The Act, places a wellbeing duty on public bodies to do things in pursuit of the economic, social, environmental and well-being of Wales, in a way that accords with the principles of sustainable development.

This will direct thinking as to how services are designed, planned and delivered to enhance wellbeing within the population. Delivering responsibilities under the act requires closer partnership working across health and local government, and with the third sector and requires the development of new models of care.

The national framework encapsulates the required five ways of working (illustrated in Figure 1.4) as specified in the Wellbeing of Future Generations Act,



promotes collaboration with our partners, the involvement of our patients in designing a new system of care. It is predicated on preventative services and providing health services fit for future generations.

The Health Board has been proactively working with its partners through the Public Service Boards structures and has made real progress with the Local Well Being Plans that are key in informing our IMTP.

1.2.3 Parliamentary Review

The findings of the Parliamentary Review of Health and Social Care in Wales was published on 18th January 2018. The report recommends a fundamentally different approach to health and care in Wales, “**evolution is no longer enough, Wales needs revolution**”.

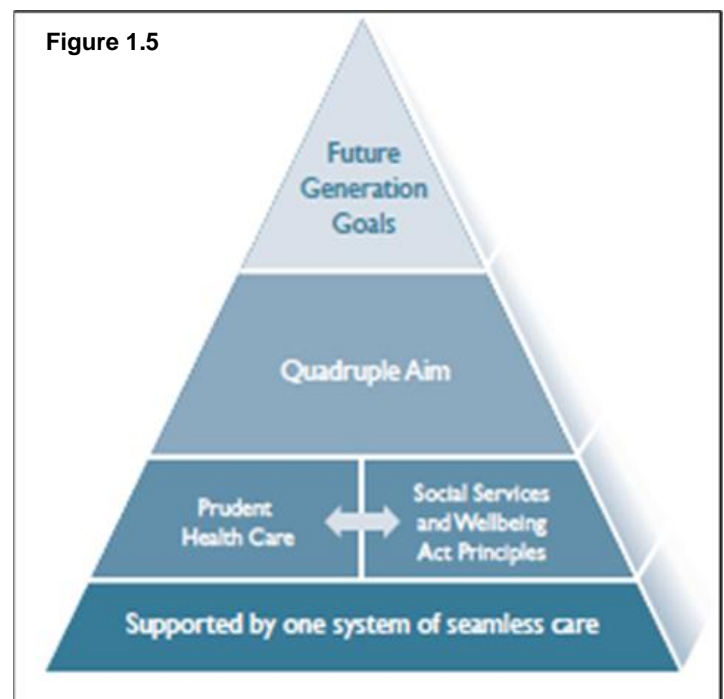
The report has recommended the vision to be adopted in Wales, a new model of seamless health and care that is focused on innovation and improvement, a learning, listening and empowering system that continually adapts to provide health and care services of the highest quality. Delivering this new approach is guided by the clear goals of the Quadruple Aim, which are consistent with the aims of the Well-being of Future Generations.

Quadruple Aim

1. improve population health and wellbeing through a focus on prevention
2. improve the experience and quality of care for individuals and their families
3. enrich the wellbeing capability and engagement of the health and social care workforce and
4. increase the value of health and care through improvement, use the best practice and eliminate waste

The report emphasises the need for health and care services in Wales to have a different relationship with the public; to support and nurture its health and care workforce; adopt and make full use of technological innovations; and be clear and bold in its leadership. Much of what is needed is not about structures but about culture and behaviour. Changing these aspects requires long term commitment to working in a different way.

Figure 1.5



Whilst this report has only recently been published, many of the Health Board plans are consistent with the ambitions of the review with a strong focus on culture, innovation, value and population health reflected in its emerging plans and enhanced Clinical Futures delivery programme.

1.2.4 The Social Service and Well-being Wales Act (2014)

This Act provides the framework for improving the well-being of people who need care and support, and their carers. It requires Local Authorities and their partners to consider the integration of care with health services where this would benefit the wellbeing of children, adults and carers, prevent or delay the need for care, and improve the quality of care and support.

The premise of the Act, was the need to provide a robust Welsh legal framework, to support the rebalancing of a social care and health system, making it sustainable for future generations. The Act provides new powers, and new statutory requirements to achieve this, which must underpin the development of integrated health and care service models within the Greater Gwent Health, Social Care and Well-being Partnership. Of particular relevance are:

- A new collaborative model of governance and delivery (Part 9).
- The provision of preventative services Part 2 (14, 15).
- The integration of partnership working of care and support with health services (Part 9).
- The requirement to establish and maintain pooled budgets Part 9 (167).

The Health Board has well established relationships with its Local Authority partners and continues to work closely together on identifying new opportunities to provide services that meet the requirements of this Act.

1.2.5 Nursing Staffing Levels (Wales) Act 2016

The Nurse Staffing Levels (Wales) Act sets out the Health Boards' overarching responsibility when considering how many nurses are necessary to meet all reasonable requirements, to have regard to providing sufficient nurses to care for patients sensitively. This duty applies also when the local Health Board/NHS Trust is securing the provision of nursing services. This duty includes a requirement to undertake workforce planning, including the recruitment, retention, education and training of nurses.

With effect from April 2018, the Health Board must take all reasonable steps to maintain the nurse staffing level and to make arrangements for the purpose of informing patients of the Registered Nurse staffing level. Initially this section duty applies to adult, acute medical and surgical in-patient settings.

In order to comply with this section of the Act, the Health Board has reviewed and strengthened a number of systems and processes that can demonstrate that the Board has regard to ensuring that the services it both provides and commissions result in the supply of sufficient numbers of nurses to care for patients. These are set out in **Appendix 1 Quality Assurance and Improvement**.

1.3 Regional Context

In response to the national context and local priorities at a regional level, there remains continued emphasis on delivering quality health and care services fit for the future and promoting good health and well-being for everyone. Driven by the ambitions in 'Prosperity for All' and the recent 'Parliamentary review of health and social care in Wales' considerable work is underway to translate national strategic ambitions into reality across the Health Board and with its partners.

Recognising the strong emphasis on integration of services at a locality level, through collaboration with partners, the Health Board has played a leading role in the development of the new statutory Wellbeing Plans, and Area Plan for Health and Social Care, required from April 2018. The plans set a clear vision for improving population health and wellbeing through the identification of wellbeing objectives. The Health Board has committed to the development of enhanced primary and community services, prevention and early intervention services, and a step change in the pace of integration with our partners in social care. The plans will achieve the shared national and Gwent wide ambitions of developing enhanced prevention and early intervention services, providing more care closer to home, and securing sustainable services across primary care.

The Health Board has committed to the development of an '*integrated system for health, care and wellbeing*' as a key element of our transformational Clinical Futures strategy which also is a key development in our IMTP this year. The Health Board has developed a new framework to direct activity, internally and in collaboration with its partners through the area board and Public Service Boards.

1.3.1 Well-being and Future Generations Act – Our Shared Ambition

The Health Board recognises the important shared leadership role of the Public Service Boards (PSBs) in promoting collaboration across the public sector, to develop new solutions and improve collaboration. With a strong emphasis on wellbeing, the Health Board has identified four wellbeing objectives that are derived from the activity described in the IMTP. These have been adopted by the five PSB's in Gwent and will drive activity around improving health and wellbeing.

Table 1.1 - Aneurin Bevan University Health Board/ Public Service Board Wellbeing Objectives

Our aspiration is to reduce health inequalities and improve the health of people in Gwent by working with our partners, focusing particularly on those in greatest need.	
1.	To provide children and young people with the best possible start in life.
2.	To achieve impact on preventable heart disease, stroke, diabetes, cancer, respiratory and liver disease.
3.	To improve Community & Personal Resilience, Mental Health and Wellbeing.
4.	To enable people to age well and for those that need care to receive it in their home or as close to their home as possible.

A strategic network of PSB managers and partners has been established to ensure good practice is shared when developing individual Well-being Plans and an opportunity for PSBs to undertake joint planning against regional priorities. The Gwent Strategic Well-being Assessment Group (GSWAG) promotes consistent approach to the plans where they can easily be read and referenced in tandem across the region and with other statutory plans to promote alignment.

1.3.2 The Social Service and Well-being Wales Act (2014) – Our Shared Priorities

The new legislative framework requires a step change in the pace of collaboration with partners to provide a wider range of integrated services across health and social care, and with partners in housing and the third sector. The Health Board have played a leading role in the development of the new partnership landscape and an internal partnership governance framework will be produced in 2018. The Health Board are a key partner at the Greater Gwent Partnership Board for Health and Social Care, which has established four priority areas to drive forward integration across services for:

- older adults with complex needs;
- carers;
- children;
- mental health and learning disability services.

The Board have overseen the development of the first statutory Gwent Area Plan, which describes an ambitious vision of service modernisation and integration, to support the delivery of an integrated system of primary, community care and wellbeing.

New Wellbeing plans, developed by the five Public Service Boards across Gwent, will also drive change, as they seek to improve population wellbeing outcomes through collaboration across the public sector, focusing particularly on those in greatest need. Each of the plans adopt a shared commitment to:



Greater Gwent Carers Strategic Partnership supporting Carers to continue with their caring activity continues to be a high priority for the health board. Working in collaboration with partners in social services and the third sector, the Health Board has established the Greater Gwent Carers Strategic Partnership. Through the first 'Carers Statement of Intent' a set of priorities have been

established, with aligned work programmes which seek to address the requirements of the Social Services and Well-being (Wales) Act, as they apply to carers. It is supported by the multi-agency Adult Services Operational Group and the Young Carers and Younger Adults Operational Group. The key priorities that these groups are progressing include:

- Information, Advice and Assistance;
- Advocacy;
- Young Adult Carers and transition;
- Mental Health service areas;
- Ongoing staff training.

These priorities are reflected in the work programme of the Carers Strategic Partnership and, during 2017/18, the work programmes have identified next steps priorities for sustained action to address the needs of carers.

Substance Misuse Area Planning Board - the substance misuse Gwent Area Planning Board works across the Gwent region to reduce substance misuse through a combination of education, prevention, treatment and rehabilitation. The current priorities the board are working to address are below and the RPB will work in partnership to avoid duplication and create a synergism across partners. Our priorities include:

- Improving emergency service substance misuse training and Naloxone roll out.
- Increasing alcohol provision both in terms of treatment and education.
- Improved primary prevention.
- Co-occurring mental health and substance misuse.
- Improved housing options.
- Securing capital estates funding.

1.3.3 An integrated system of Health, Care and Wellbeing

As part of our Clinical Futures Programme, the Health Board is developing its integrated system of health, care and wellbeing which encapsulates its commitment to the delivery of wellbeing objectives, as part of the Public Service Board agenda, and the delivery of new models of care, support and wellbeing as part of the work of the greater Gwent Area Partnership Board. At the heart of integrated service delivery is the continued development of the Neighbourhood Care Networks (NCN) Model, which is unique to Gwent. A consistent regional service model will be developed, which promotes equity of access, but maintains local flexibility to provide specific services defined by population need.

Developing and enhancing our collaborative approach with partners across NHS Wales (particularly within SE Wales Region), Local Authorities, in housing and in the third sector is a key priority. This includes establishing dialogue about the opportunity to build integrated and ambitious models of care that maintain independence, and wellbeing of vulnerable adults, and where enhanced support to manage long term and chronic conditions, will ensure that people are able to remain outside of hospital and receive more care closer to home. The work of the regional forum on Health and Housing will play a leading role, developing a shared strategic programme of work, and developing new models of care.

To do this will require radical transformation of services, and the development of new models of community based care. The Health Board's vision is to create a system of primary, community and wellbeing services, based around the NCN footprint, where there is a consistent regional service offer, and effective locality based multi-disciplinary teams.

The Health Board's ambition is to create a new system of primary, community care and wellbeing across Gwent, in partnership with local government and the third sector. The Health Board wants people to be able to access the care they need in their own community and homes, where appropriate and avoid the need for unnecessary hospital admission.

The system is predicated on the shared agreement by both Health and Local Government to provide more care closer to home, to use primary and community care services appropriately, to reduce a

reliance on secondary care services, and prevent unnecessary hospital admissions. It will build on the existing innovation across Gwent, and use the NCN footprint, as the basis from which services will be planned and delivered, around a model of community wellbeing.

A framework has been developed to set out our vision, with a 5 year programme plan developed from 2018/19 to deliver change. The four stages are:

1. Keeping people healthy and well (Integrated Wellbeing Networks).
2. Self-care.
3. Primary Care and NCN Team.
4. NCN Hub with specialist and enhanced services.

As the Health Board develops its “Integrated System of Health, Care and Wellbeing”, it will continue to learn from and share our experiences across our region and more widely across Wales. Further details of our approach, priorities and plans are set out in **SCP 1** and **SCP 2**.

1.3.4 Regional Planning with Health

The Health Board has played an active role in strengthening regional planning amongst Health Boards and Trusts, particularly in the development of collaborative plans for paediatric, obstetric and neonatal services with Cwm Taf and Powys Health Boards, and with Velindre NHS Trust in the development of a Radiotherapy Satellite Centre at Nevill Hall Hospital. It is leading regional planning for Vascular and Ophthalmology services and is playing an active and integral role in other work streams, including diagnostic, orthopaedic, major trauma, Sexual Assault Referral Centre (SARC) and mental health services.

The Health Board has welcomed the strengthening of Regional Planning with the creation of the South East Wales Regional Planning and Delivery Forum. Within the Health Board, the regional planning agenda is taken forward through the Service Sustainability Service Change Plan and Clinical Futures structures, with the latter considering the enabling role of the advent of The Grange University Hospital. Further details of the Regional Planning priorities are shown in **SCP 7**.

1.4 Local Context

The Gwent Health Social Care and Wellbeing Partnership published the first Population Needs Assessment in 2017. It recognises that the “Greater Gwent”¹ population covers diverse geographical areas including a mix of rural, urban and valley communities.

Blaenau Gwent is situated in the valleys of South East Wales and covers approximately 10,900 hectares with a population of 69,674. The area has accessible green space and close community working however it is an area with high levels of unemployment and a high percentage of people who are dependent on benefits.

Caerphilly County Borough has the largest population in Gwent of 179,941. People are widely dispersed amongst 50 small towns and villages with the main settlements largely reflecting the area’s rich mining heritage. The County Borough has an expanding economy and benefits from good transport links to Cardiff, however there are significant levels of unemployment and poor health.

Figure 1.7



¹ Greater Gwent is a term used to reflect the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen.

Monmouthshire is classed as a “semi-rural” area. There are four main towns with a total population of 92,336. Monmouthshire has the lowest level of unemployment, however there are pockets of deprivation as evidenced in North Abergavenny.

Newport City is the 3rd largest urban centre in Wales with a population of 146,841. The city has the second largest number of people from ethnic minority communities (after Cardiff) and has continued to increase since 2009 when the figure was estimated at 6.6% of the population.

Torfaen is the most easterly of the South Wales urbanised valleys with a population of 91,609. There are 3 urban centres, Pontypool, Blaenavon and Cwmbran. The largest number of traveller caravans was recorded in Torfaen during the January 2016 bi-annual Gypsy and Traveller Count with a total of 61 caravans equating to 41% of the Gwent total.

Figure 1.8

1.4.1 The changing structure of our Population

Overall our population has remained stable over the past decade increasing by just 0.5% since the Census of 1991. Small increases in Newport and Monmouthshire are balanced by similar decreases in Blaenau Gwent and Caerphilly.

It is predicted that although the total population of Gwent will remain stable over the next ten years, this will include an increasing population of elderly people and a generally higher dependency ratio leading to further increases in demand and pressures for change in the way services are delivered.



In 2014:

- 1 in 5 are over the age of 65 years.
- The population aged under 16 has decreased by 2,700 (1%).
- 6 in every 10 are working age.
- Almost 1 in 5 are under the age of 16.

By 2036:

- The population is projected to increase by 4.1% (circa 30,000 people).
- 1 in 4 will be over 65 years of age.
- 147% increase in the number of people aged 85 and over (circa 19,000 people).

1.4.2 Overall health of our citizens

Overall the health status of the population of Gwent is slightly worse than Wales as a whole in terms of general health status, but has some of the greatest inequalities at Local Authority level:

- 22% of people describing their health status as being fair or poor compared to 19% of peers.
- 17% identified their day to day activities are limited because of health problems or disability lasting 12 months or more, compared to 15% of peers (the range within Gwent is broad 12% in Monmouthshire versus 22% in Blaenau Gwent).
- 52% of our adults report currently being treated for an illness (Wales 50%) within this:
 - 21% are being treated for high blood pressure (20% Wales);
 - 15% are being treated for respiratory illness (14% Wales);
 - 14% are being treated for arthritis (12% Wales);
 - 14% are being treated for a mental illness (13% Wales);
 - 9% are being treated for diabetes (7% Wales).
- There has been a significant decrease in under 75 mortality rates of 17.1% (males) and 17.4% (females) demonstrating the positive impacts of programmes and services designed to reduce mortality rates.

1.4.3 Lifestyle of our citizens

- **Tobacco Use** - smoking remains a major risk factor for heart disease and remains a significant public health concern with 21% of the adult population being active smokers. Prevalence is lower in females than males. Females in Monmouthshire report the lowest levels of smoking (13%), the highest rates of 26% being in Blaenau Gwent.
- **Alcohol** - 1 in 20 of all deaths in Wales each year are attributable to alcohol. Within Gwent alcohol consumption has decreased with 40% of adults reporting drinking about the guidelines

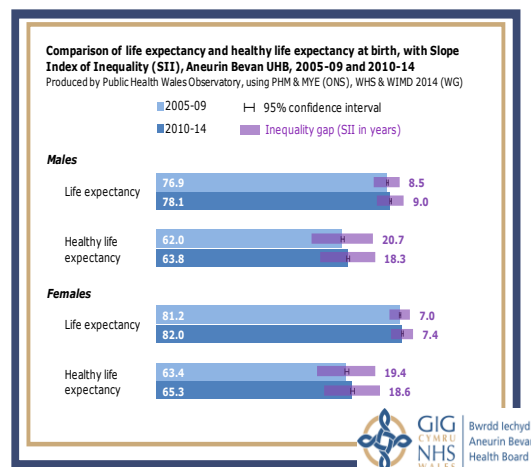
in the previous week. 20% reported binge drinking, these figures are comparable across Wales.

- **Healthy eating, physical activity and weight** - a healthy balanced diet is an essential component of healthy living. A balanced diet combined with physical activity helps to regulate body weight and contributes to good health. Across Gwent:
 - 29% of adults reported meeting the guidelines of five or more fruit and vegetables in the previous day (Wales 32%).
 - 61% of adults are classified as overweight or obese (Wales 59%).
 - 55% of adults report being physically active (Wales 58%).
 - 34% of adults report being inactive (Wales 30%).

1.4.4 Health Inequalities

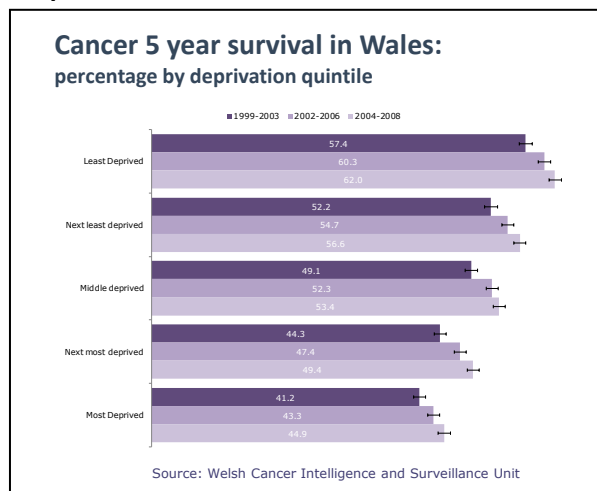
Within Gwent, there is an 18 year difference in healthy life expectancy at birth between people living in the least and most economically deprived areas within the Health Board area, and a 9 year difference in life expectancy between men and a 7 year difference between women [Graph 1.1]. For men, these figures highlight the difference between living in good health past retirement age to 72 years or developing health problems at age 56 years that may make it difficult to continue to work, particularly in manual jobs. People living in economically disadvantaged areas are therefore doubly affected. As well as the burden of ill health and economic costs for individuals, the costs of healthcare treatment, loss of productivity, lost taxes and higher welfare payments are an economic burden on society as a whole.

Graph 1.1 Life expectancy and healthy life



1.4.5 Cancer Survival rates for our citizens

Graph 1.2



Improving cancer survival rates in disadvantaged areas health inequalities are particularly evident in cancer survival rates (Graph 1.2) which have greatest impact in older age because age is the biggest risk factor for developing cancer with two thirds of all cases of cancer in the UK being diagnosed in people over 65 years. The main preventable risk factors for cancer are:

- Smoking;
- Being overweight or obese;
- Eating an unhealthy diet;
- Physical inactivity;
- Excess alcohol consumption;
- Exposure to too much sun.

Other factors contributing to lower cancer survival rates in the most deprived areas are:

- Lower uptake of screening programmes;
- Not recognising symptoms of cancer;
- Delay in acting on symptoms of cancer;
- Less ability to access and navigate available healthcare services.

As elsewhere, much of the inequality in health across the Health Board's area is due to heart disease, stroke, cancer, diabetes, respiratory conditions and liver disease. Health inequalities from these diseases are largely attributable to higher rates of lifestyle risk factors leading to disease, compounded by presentation and diagnosis at a later stage of the disease when there is less likelihood of optimal treatment. Reducing the current rate of these diseases for the most deprived fifth of the population to nearer the rate for the least deprived fifth would make a significant

contribution towards the Health Board's ability to achieve sustainability and meet forecast demand increases from demographic changes.

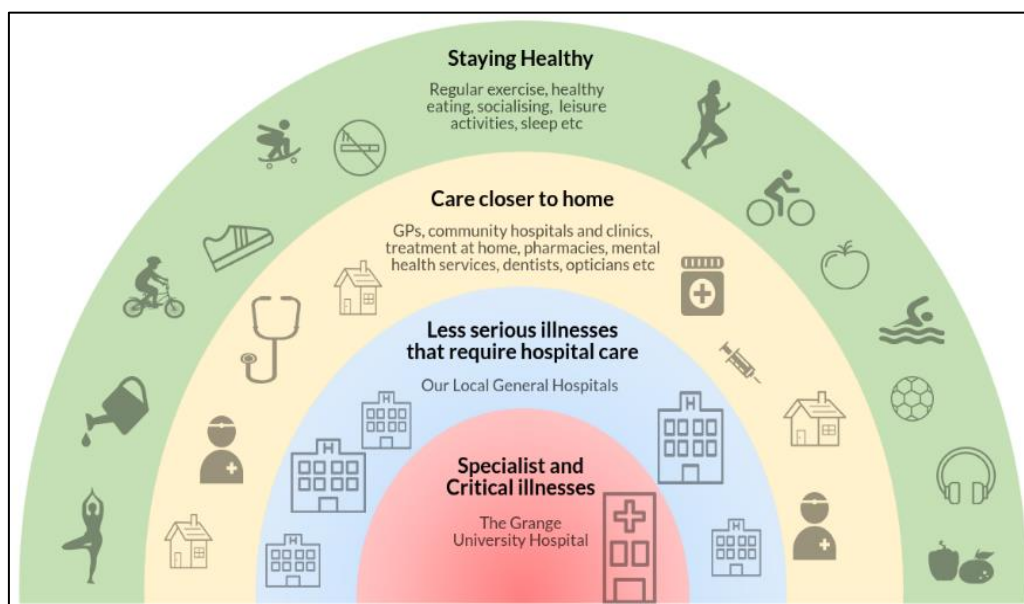
1.4.6 Clinical Futures Strategy

The strategy has been in place for several years with very committed clinical involvement and direction. It is continually checked and adapted to ensure it remains relevant and ambitious in its aims and effective in its delivery. The strategy is entering a different phase for 2018/19, its momentum and innovation focus have both been escalated.

With quality and safety at the heart of design, Clinical Futures delivers a refreshed clinical model that:

- Will improve population health by focussing on well-being and prevention services.
- Will increase the range of services provided at home and in communities through primary, community, self-care and mental health services, enabled by technology as well as a highly skilled workforce.
- When people need routine hospital services they are delivered through a new network of Local General Hospitals (LGH) providing enhanced services including emergency care; day case and short stay surgery; outpatients; diagnostic and integrated care.
- When people need specialist and critical care services they are provided at a single Specialist and Critical Care Centre, known as The Grange University Hospital. This will provide care that cannot be provided on multiple sites based on sustainability, clinical effectiveness, patient safety and affordability.

Figure 1.9 - Clinical Futures Strategy Levels of Care



The new system is a "network", bringing care as close to the patient as possible. Teams are evolving work practices, creating new relationships with patients, allowing them to become experts in their own health, harnessing the use of new technology and the development of new infrastructure (hospitals, primary care and integrated health and social care facilities).

This new network works effectively together to be able to make the best use of its resources, so that it can improve and sustain health services for decades to come.

Primary and community services are at the heart of the model and central to developing a new relationship with patients as partners/co-producers in preserving, maintaining and improving their own health and well-being. Investing in and strengthening primary, community and social care services to create the capacity to support and treat patients in their homes and communities is a core component of the strategy.

The Health Board has made good progress over many years in delivering against the strategy. Some of the key progress areas include the establishment and development of the NCN model, establishment of integrated health and social care community resource teams which enable patients to be assessed and supported in their own homes. Significant strides have been made to modernise primary and community services, including the opening of integrated health and social care facilities in Monmouth, Rhymney, Blaenavon and Brynmawr. These facilities have enabled and accelerated the delivery of truly integrated health and social care services centred around patients. Workforce changes and alternative roles such as the development of the pharmacists and the wider multi-disciplinary team including establishment of a 24 hour District Nursing Services. Stay Well Plans for older citizens, a truly 'home to home' Stroke service, and an enhanced focus on prevention and population health with the Living Well Living Longer Programme being recognised as an award winning approach to addressing inequalities and improving health. A range of services have also been established in communities and primary care away from the traditional hospital setting in services such as Eye Care, Oral Surgery, Dermatology and MSK services.

Estate and information technology have been embraced and leveraged to improve patient care. With the service models and clinicians setting direction, examples of successful pilots and roll outs of information technology include electronic patient flow, electronic referral, booking and patient information, tele-health, tele-dermatology and WCCIS.

Our hospital network has seen the opening of two new hospital facilities, Ysbyby Aneurin Bevan in Ebbw Vale and Ysbyby Ystrad Fawr in Ystrad Mynach that are integral to the future model. In parallel we continue to create an estates infrastructure that supports the delivery of our clinical service strategy.

1.5.1 The Grange University Hospital

The Grange University Hospital plays a critical role in the strategy, improving the provision of services and clinical outcomes; sustaining fragile services through consolidation in a single site that is geographically accessible to the population served; addressing workforce recruitment/retention challenges and improving flow and system performance. It will improve patient experience and provide modern facilities for the delivery of care.

By 2021, when The Grange University Hospital is commissioned we will:

- Care for the sickest people on one site.
- Concentrate Emergency Departments onto a one site, and have a single centre for cardiology, gastroenterology, trauma, emergency and high acuity surgery.
- Provide consistent services across seven days.
- Improve access to comprehensive diagnostics across seven days.
- Consolidate fragile specialties.
- Improve patient safety by providing consultant led service across seven days.
- Maximise ambulatory care models.
- Separate routine/planned care from emergency care.

For a number of services, and as a result of significant recruitment and retention difficulties, there will be challenges in maintaining the current configuration of services in the interim. These are described within the **Service Sustainability Service Change Plan** and set out where interim measures may be necessary as a transition to the Clinical Futures model for services such as inpatient paediatric and obstetric services. Service Sustainability is developed from a Regional Collaborative perspective



Figure 1.10

recognising that the challenges faced by our Health Board are shared across NHS Wales and solutions for robust service models span Health Board boundaries.

1.5.2 Establishing the Next Phase of the Clinical Futures Delivery Programme

As we move into year one for our three year transition plan leading up to the opening of The Grange University Hospital, the level of testing, scrutiny and robustness of new service models is being heightened. We are optimising the improvement methodology capacity that has been developed within the Health Board over the past few years and are reviewing service models through the value driven healthcare lens, demography and technology. Through this we aim to ensure that our service models and resource are used to provide the greatest possible benefit to the population.

Over the next three years we will develop these new networks and provide increased and better services closer to, and in patient's homes. By improving the way we plan and deliver services, we will reduce the need for patients to travel to hospital for their diagnosis and treatment.

As set out earlier the Health Board with its partners is developing an **integrated system of health, care and wellbeing** which encapsulates our commitment to the delivery of wellbeing objectives, as part of the Public Service Board agenda, and the delivery of new models of care, support and wellbeing as part of the work of the greater Gwent Area Partnership Board. At the heart of integrated service delivery is the continued development of the *Neighbourhood Care Networks* (NCN) Model, which is unique to Gwent. A consistent regional service model will be developed, which promotes equity of access, but maintains local flexibility to provide specific services defined by population need.

In 2017/18 the Health Board has developed and established an overarching programme structure to support the delivery of this next ambitious, yet critical phase of the Clinical Futures Strategy using MSP and PRINCE 2 methodologies. An enhanced focus on the workforce, Organisational development and culture has been a key component which has led to the development of a change ambition to support the articulation of the changes planned and its impact on services to our staff partners and the public. Our Board have described what our health and care system will feel like in 2021.

Realising our vision means that by 2021

In our area people are looking after their own health and well-being and that of their families, when the need help, this is readily available at home and in their community, supported through innovative technology.

We work in a modern system with our partners that delivers the best outcomes, utilising best practice in the most appropriate settings. Our service is the first in the NHS to provide truly holistic care from home to home and continuously evolves so it remains leading edge.

Compassionate care is delivered by talented, creative teams that we trust and respect to put the needs of our patients at the heart of everything we do. Our staff tell us they feel empowered, equipped and driven to make a difference to the lives and outcomes of people. Our teams feel valued, trusted and listened to.

We are a dynamic organisation that cares, learns and improves together.

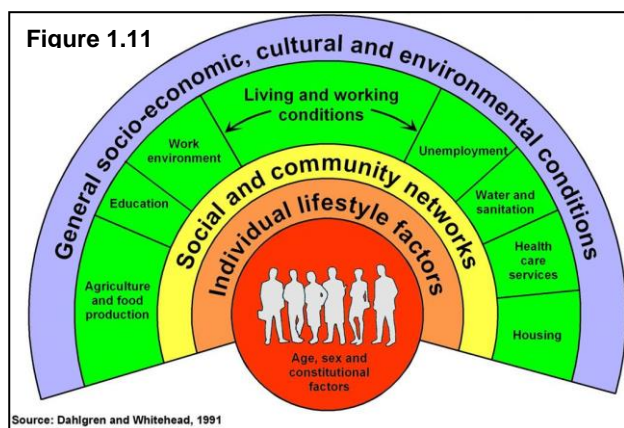
The Health Board is continuously looking at how it communicates, engages and involves its staff, the public in key partners in the delivery of this ambition. (Further detail on this delivery programme is covered in Section 2).

1.6 Our Guiding Principles and Ways of Working

The Health Board commissions and delivers services based on a number of golden threads that are the principles that underpin the way in which the Health Board plans, deliver and improve services for its population.

1.6.1 Reducing Health Inequalities

As set out in the earlier section, on population demographics reducing health inequalities is a strategic priority for the Health Board and is a fundamental component of our longer term plan to reduce demand for healthcare through systematic, population scale interventions that target the underlying causes of poor health, such as lifestyle choices and socio-economic deprivation, and the uptake of screening to improve early detection and optimum treatment of disease. This is reflected in the Health Board's Living Well Living Longer and Adverse Childhood Events programmes.



This inequality reflects the social determinants of health across the communities serviced, including the difference in social and community networks, local living and working conditions and general socio-economic, cultural and environmental conditions (Figure 1.11).

The World Health Organisation (WHO) Ottawa Charter (1986) provides a framework for the organisation of partnership actions to address the social determinants of health. This underpins our approach to reducing health inequalities and improving the health of our population and

provides a platform for delivering our responsibility under the Well Being of Future Generations Act.

The best start in life the burden of ill health accumulates over the life course starting in the womb with a child's physical and emotional development over the first 1000 days of life setting the foundation for their future adult health. The 'Welsh Adverse Childhood Experiences Study (Public Health Wales 2015) provides compelling evidence of the association between exposure to Adverse Childhood Experiences (**ACE**) in childhood and health-harming behaviours in adult life.

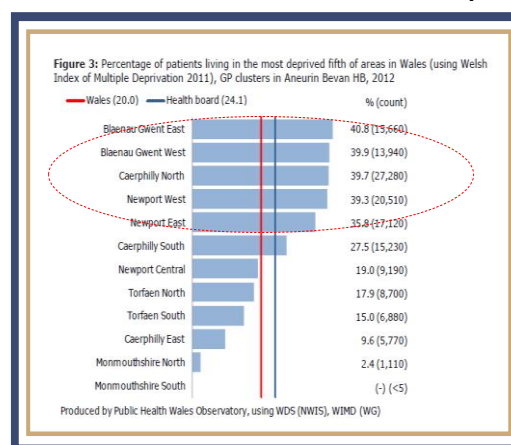
Adults who have experienced ACEs in their own childhood often end up raising their own children in households where ACEs are more common. Such a cycle of childhood adversity can lock successive generations of families into poor health and antisocial behaviour. Preventing ACEs in a single generation, or reducing their impacts, would benefit not only the current generation of children but future generations.

The Living Well Living Longer Programme is our award winning, innovative Living Well Living Longer programme is being rolled out in the areas of highest deprivation in the Health Board's area (Figure 1.7). The programme is a systematic, population scale approach to increasing the proportion of people at risk of heart disease, stroke and diabetes who are benefitting from proven, effective interventions to reduce their level of risk. The programme invites eligible adults age 40-60 to have a Health Check, and supports those that attend to set personal goals and access support to reduce their lifestyle risk factors as well as to access appropriate treatment for high blood pressure, high blood lipids or diabetes.

The programme is addressing the Inverse Care law by providing additional capacity in the primary care system where the need is highest. The programme is being planned and implemented through

the Neighbourhood Care Networks (NCNs) covering the most deprived areas within the Health Board area. The NCNs are the footprint for the development of a sustainable, social model of primary care to support people to reduce their risk of heart disease, stroke, diabetes, cancer, respiratory and liver disease. Our plans to reduce health inequalities are set out within the **Reducing Health Inequalities and Improving Population Health Service Change Plan (SCP 1)**.

Graph 1.4



1.6.2 Quality and Patient Safety

Quality and patient safety is at the centre of our work in seeking to achieve excellence. The Health Board always aim to put the person first, so that every individual that uses our services, whether at home, in their community, or in hospital, has a good experience. To do this, the quality and safety of our care and services is a core focus throughout all our plans, from small changes in one service to the driving force for Clinical Futures.

Our Approach to Quality Improvement is that all staff have two roles: to continuously improve in their job and see patients as equal partners in their care and the services provided. This will ensure that the highest quality services are provided for the people the Health Board served. To empower staff to be able to do this, Improving Quality Together training is available to everyone, encouraging teams to undertake training together so that they all have an understanding of improvement methodology and share the same “common language” to support innovation and delivery of change. The focus is to empower staff to deliver significant improvement of patient flow across the healthcare system.

Historically, the main focus for quality and safety in the health service has been on hospital services. The Health Board is actively seeking to cover the whole scope of its services from the patient’s home, through community services to hospital care for services it provides and those it commissions. Where improvements are needed, the Health Board looks right across the healthcare system to ensure that any changes ensure the best possible outcomes and experience for the greatest number of people (examples illustrated in Table 1.5). There is close collaboration with partners in social care, the independent sector and the third sector to deliver improvements in quality. For example, the Dementia Board spans Health, Social Care and the 3rd sector, jointly setting and delivering a strategy for ensuring that people and their carers can live well with dementia, working together to increase the numbers of dementia friendly communities and ensuring acute hospital wards have the skills and resources to provide effective and compassionate care for people with dementia.

Table 1.3 - Quality Improvements across the whole healthcare system

Area of work	Home	Primary Care/ NCN Team	Hospital
Deteriorating patient/Sepsis NEWS as a common language	District Nurses record baseline physiological observations, determine what is normal for patient OOH using NEWS	GPs report patient obs/ parameters when contacting hospital to admit Nursing Homes trained in NEWS	NEWS used across all acute and community hospitals ABC sepsis using trigger tool to recognise and respond to sepsis at front door
Reducing C Diff	Infection control links within Nursing Home Sector	Antibiotics prescribing practice information and data for GPs Significant event review of cases	Antibiotic prescribing practice, Cleaning/deep cleaning Handwashing Review of each C diff case
Reducing Pressure Damage	Reporting of pressure damage for patients on Community Nurse caseloads	Reporting pressure damage in Nursing Homes Training for prevention of pressure damage in place	Training on prevention of pressure damage Revised reporting Improved supply of mattresses
Reducing Falls	Falls Response Service (with WAST) ensuring patients are not taken to ED following a fall at home. Support required is provided in the patients home through the Community Falls service	Use of I-Stumble tool and training in Nursing Homes to keep people in their home environment and prevent hospital admissions. “Deck my Zimmer” introduced to Nursing Homes	Revised Falls Multifactorial Risk Assessment Tool Review of each inpatient falls that leads to a fracture

The 22 Health and Care Standards are the quality framework against which all our healthcare services are assessed. They have been designed to fit with the 7 quality themes identified in the NHS Outcomes and Delivery Framework and continue to prioritise areas that reduce avoidable harm to patients, specifically:

- Avoidance, early identification and management of sepsis, healthcare associated infections, hospital acquired thrombosis, falls and pressure damage.
- Compliance with fundamental aspects of Trusted to Care including dementia, nutrition, hydration, medicines and continence care.
- Adopting prudent healthcare principles, ensuring that patients are equal partners and fully engaged in our improvement events.
- Embed identification and treatment of dementia across all areas.
- Reducing mortality and sustain this reduction to decrease variation across our hospital sites.
- Improving the quality improvement skills of our staff.

The Board monitors quality across the Health Board through a number of mechanisms. Independent Members are involved directly through championing specific issues and areas of service, providing challenge and support. They also consider a performance report on quality at every Quality and Patient Safety Committee and Board meeting, which monitors quality outcome measures, many of which are reflected in the quality improvements in this plan. Increasingly the measures reflect quality across the whole patient pathway. The reporting arrangements enable them to monitor against milestones that have been set, to ensure progress towards each outcome.

Further assurance is provided through comprehensive surveillance and review, starting with the patient voice by triangulating concerns, patient experience information, mortality reviews, national clinical audits, incident reporting (including serious incidents), complaints and Ombudsmen reports.

Details of our overarching approach and specific plans for quality assurance and improvement for this planning cycle are set out in an extended report in Appendix 1.

1.6.3 Patient Experience

Understanding the experience of what it feels like to use the services of the Health Board is fundamental to being a learning organisation that is person centred in the design and delivery of services. Patient experience is at the heart of quality in healthcare and it needs to be embedded across the organisation with visible leadership (figure 1.12). In order to achieve this, there is a need to be able to see the experience of care through the patient, family and carers' eyes. This means that the patient voice needs to be heard at all levels of the organisation, and that the patient is involved and listened to as an equal partner in their care, and in the processes of designing and delivering care.

The organisation is driven with a person centred focus and this is fundamental to the values and culture. There is a need to continuously improve and embed this approach to care and the delivery and development of services. Working with communities to assess and design services driving improvement, whilst seeing individuals as equal partners in treatment decisions and self-care management improves outcomes. The challenge is to develop a new relationship with the public as co-producers in their own care, empowering the public to make informed decisions about the appropriate use of healthcare.

The Health Board's fundamental expectation is that care for every patient should be given in the same way as we would want our family, friends and loved ones to be cared for. The overarching ambition is to demonstrably improve the experience of care for patients and their families and

Figure 1.12



carers. To work collaboratively with patients, families and carers to bring about real change in their experience and in how the Health Board learns and improves the delivery of care and services provided, understanding what matters to the population served.

The key aims of the “What Matters to me” framework:

- Provide accessible ways to actively engage with patients their families and carers encouraging all feedback.
- To act on feedback, demonstrating genuine learning and improvement from listening.
- Identify our key ambitions and an annual programme of work that will be overseen by the Patient Experience Committee to improve patient, family and carer experience throughout the Health Board.
- To better understand from people who use our services “what matters to them” and ensure patients, families and carers are provided with the best possible experience of care whilst using our services.
- Develop the approach to and understanding of person centred care in the planning and delivery of services and care.
- Develop co-production within all service development and improvement work.

1.6.4 Patient Engagement and Partnership

The Health Board has a clear and ambitious agenda of modernisation and reform which is articulated through the Clinical Futures Strategy and the Integrated Medium Term Plan. Effective engagement with communities and citizens is essential to this agenda. A number of legislative frameworks and supportive guidance have reinforced this work including the Social Care and Well-Being Act, Future Generation and Well-Being Act and NHS Planning Guidance.

The Health Boards’ Engagement Team has increased community engagement and involvement in health and health services locally. The team work closely with colleagues in communications, patient experience, value based healthcare, ABCI and Public Health as well as with service divisions to both offer guidance and understand the volume of engagement and involvement activity that is underway across the Health Board footprint. The Engagement/Involvement framework is outlined below:

Figure 1.13



Through these approaches, the Health Board is gaining real insight into the community perspective and behaviours, hearing the voices of **15,338 Gwent residents** through 188 different engagement opportunities over the past two years. Throughout this IMTP period, the following will assist in realising the full implementation of the Clinical Futures Strategy by 2021.

- **Supporting the Growth of Asset Based Community Development** - Asset based community development (ABCD) is a methodology for the sustainable development of communities based on their strengths and potential. The Health Board is building on this approach to create considerable community capacity for well-being, this has the capacity to support the delivery of Integrated Wellbeing Networks (outlined in SCP 1, section 3.1.4) as part of the Clinical Futures Level 1 framework.
- **Sustained community presence** – a minimum of a full day each week in one of the counties of Gwent actively listening to citizens about their views, thoughts and experiences of health and health services in the area. This will be further enhanced by the strengthening of relationships with varying networks that exist within localities.
- **Establishment and growth of locality fora in the 5 Unitary Authority areas of Gwent** to support structured conversations with our citizens on the system of health and care in Gwent and influencing changes that will happen over coming years. Through these, people in communities will be able to request the Health Board to come and speak with them about 'What is important' in their area, and staff in the Health Board will also be able to utilise them to share developments in services as the transitional phase of Clinical Futures is underway.
- **Active community engagement in formulating and testing new models of care** –engaging communities in co-producing new models of care is of paramount importance to the Health Board. During the current planning cycle a significant focus will be on new models to delivery sustainable and accessible neighbourhood care network services (including primary care). Community involvement in the development of Health & Well-being hubs in Tredegar, Ringland and Chepstow are examples of our current work programme.
- **Active Community involvement as the system of health provision in Gwent changes** delivering our four year transition plan will require proactive, regular and sustained conversations with communities across Gwent about 'How their health services look now' 'How they will change into the future' 'How to access them during and after transition'. The last twelve months has already seen consultation/engagement on Out of Hours services, breast services and Older Adult Mental Health. It is anticipated that early 2018 will require activities related to Older Adult Mental Health, implementation of 111 and Paediatric services.
- **Active community engagement and consultation on regional service change** – An increase in regionalisation will also require collaborative activity across Health Board areas. This will be specifically relevant to Thoracic Surgery; Major Trauma Services; Paediatric and Obstetric Services; and Vascular Service during this period of the IMTP:

1.6.5 Prudence and Value Based Healthcare

The Health Board has made a commitment to make prudent and value based healthcare an active movement for change within and outside the organisation, including demand management. It is a vehicle to deliver new ways of working within a clinical value based framework and enables lower healthcare costs whilst also providing improved quality for patients and offering opportunities for outcomes to be collaboratively and co-produced with patients and the public. The Health Board have focussed on three key areas in taking forward prudent healthcare: innovation and improvement, communication and engagement, and measurement and delivery.

The Health Board now has a rapidly maturing value-based healthcare system. Considerable time and effort has been spent in achieving cultural change, involving multidisciplinary teams in looking at both the outcomes of their care as well as the cost of delivering those outcomes. In parallel there is good progress in achieving a robust infrastructure for large scale outcomes and cost measurement and are now developing the analytical capability to utilise the data to best effect for our patients. This is being achieved in partnership with DrDoctor, the software provider.

Achieving value can only be done across a whole system of care for a population of patients. High value interventions (i.e. those that cause a large improvement in outcomes at lower cost) tend to be concentrated in prevention and early optimisation of disease. Value incorporates the philosophy of Prudent Healthcare and Choosing Wisely; reducing low value tests and encouraging coproduction through shared decision making are an important pillar. Supporting patients with good outcome data to inform their decision making is crucial to this process to ensure success.

Value is also generated through the optimum use of skill mix in the workforce. Similarly, clinical teams are motivated to make savings in low value areas of care if they can influence a level of reinvestment into high value care for their population.

Finally the Health Board will be using digital health technology, not only to gather outcome data, but to fundamentally change the way patients are communicated with. This will support self-management, improve experience of care and reduce unnecessary healthcare utilisation such as arbitrary face to face outpatient attendances.

The following are examples of each of these facets of value-based healthcare which are being achieved, but represent a fraction of the work ongoing.

1. **Workforce configuration along VBHC principles:**

- a) Redesigning the vascular pathway – patients with poor circulation in their legs were previously experiencing long waits and having at least two outpatient visits to the vascular surgeon prior to a trial of exercise therapy. They then required a further referral back to the surgeon for consideration of surgery if the therapy was unsuccessful. Value-based reconfiguration has shifted initial assessment and treatment to a partnership between GP and National Exercise Referral Scheme who have a protocol to access vascular surgery directly within agreed parameters. This scheme begins February 2018.
 - b) Treating paediatric constipation- large numbers of children experience long waits to treat this condition in hospital outpatients and often have poorer outcomes as a result. An innovative scheme in Monmouthshire has vastly improved the care of these children and reduced costs through community nursery nurse management, linked into to specialist support. This model is an excellent example of cluster development work using VBHC methodology.
 - c) Teledermatology with GP minor surgeons with extended skills removing low grade cancers in the community. This has drastically reduced wait times for lesion removal and increased capacity in secondary care.
2. **Achieving allocative value** – one of the key challenges in our system is to direct resource to where it has greatest impact. The integrated health board status has been used to shift resource from reducing low value prescribing in respiratory care to investment in high value patient support such as pulmonary rehabilitation..
3. **Digital transformation for value** – clinical teams working in inflammatory bowel disease and heart failure are keen to use a combination of outcome data and new means of patient communication to reduce face to face healthcare utilisation. The rheumatology and urology departments are also interested in this approach to supporting patients with inflammatory arthritis and prostate cancer- but it has wide application in chronic disease management.
4. Other teams will be using their **outcome and costing data to reduce variation** in service provision and improve patient experience of care. At the moment this part of the work is centred in the management of Parkinson's disease and dementia but will be moving to orthopaedic subspecialties in 2018.

The value-based healthcare team also host and support the National Strategic Alliance with ICHOM (International Cons

ortium for Healthcare Outcomes Measurement) and are keen to share knowledge and successes across Wales in the coming year, focusing on lung cancer.

1.6.6 Innovation and Research

The Aneurin Bevan Continuous Improvement (ABCi) team is a corporate resource that focuses its efforts on supporting the Quality Improvement agenda within the Health Board. Its aim is to foster a culture of improvement and innovation by delivering high quality training, development & coaching within the organisation. The team has four key objectives:

- Building the necessary capability for improvement within the Health Board.
- Creating conditions that supports innovative thinking and system re-design.

- Supporting the delivery of strategic objectives through the use of the Institute for Improvement's Breakthrough Series collaborative methodology.
- Building networks both within the organisation, and outside of our Health Board.

These objectives are seen by the Health Board to be mutually self-reinforcing, encouraging the engagement which lies at the heart of our approach to improving quality and patient experience, which is coherent and supportive of the quality and patient safety agenda as a key component of their daily work.

ABCI take the approach that no "one" methodology is right for every improvement thus encouraging our frontline staff to find innovative, new and better ways of doing things.

Innovation is also about identifying what works elsewhere and maximising the opportunity to share and learn within the organisation, across our public sector partner organisations, across NHS Wales, the UK and the world. Over the last 12 months the focus of ABCi has been developing more improvement capability. Improvement and innovation are closely linked and in the coming 12-18 months ABCi will look to align both by building the necessary infrastructure to support the organisation.

Research generates new knowledge that benefits the public, patients and staff by addressing clearly defined questions with systematic and rigorous methods. It also demonstrates the key role that research has in fulfilling the Health Boards' responsibility to delivering the Wellbeing of Future Generations. Research in the Health Board works alongside improvement and innovation seeking out new and better ways of delivering Health and Care outcomes. Working in partnership and collaboration with universities and industry is a key part of our collaborative approach to bring more high quality research into our Health Board.

Establishing research as a core activity across clinical and non-clinical practice is an ambition that is being realised through a steady increase in the quantity and quality of funded research activity that feeds into practice. Building on our existing R&D Strategy, a new five year has been developed which will strengthen financial stability to ensure that research thrives and continues to grow, promoting the value of research by engaging staff across all areas (Further details shown in Appendix x)

1.7 Staff Empowerment and Organisational Development

Whilst the challenges facing the University Health Board are significant, the opportunities available to make positive changes to the way we work are even greater. Transformation to a more sustainable organisational model requires a systemic and holistic approach in order to remain connected to our community, delivering on our Corporate Social Responsibilities and realising the benefits of the Wellbeing of Future Generations Act. The Health Board will be promoting improved team working and developing broader working partnerships.

Our Values and Behaviours Framework (Figure 1.1, page 7) continues to be embedded in every day practice and is an integral part of driving the cultural change required to deliver the 'change ambition' reflected in our Clinical Futures strategy.

Organisational Development is a golden thread throughout the IMTP and is a shared responsibility, focusing on:

- Developing leadership and management potential.
- Improving staff experience and engagement.
- Bringing our organisational values to life.
- Facilitating talent management and succession planning at all levels.
- Supporting the delivery of the Service Change Plans.
- Supporting Primary care transition and integration.
- Creating a sustainable workforce through growing our own talent.
- Developing the widening access agenda.

- Preparing our staff for and supporting them with service and workforce redesign leading up to the opening of the Grange University Hospital.
- Enhancing and protecting the well-being and health of staff.
- Building reciprocal relationships with the community.
- Increasing capacity for greater collaboration with other Public and Third sector colleagues to drive the delivery of the 'five Ways of Working' and Wellbeing Objectives.

The reduction of inequalities remains a cross cutting theme throughout the IMTP. Progress continues to be made in the implementation of our Strategic Equality Objectives. The Health Board will continue to embed equality impact assessments throughout its planning and decision making processes and, in particular, collaborative working with public sector and third sector partners to deliver the 'National Training Framework for Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015'. A new focus for 2018 will be the promotion of training and resources to improve the experience of those who are transgender and the development of training and support for staff participating in the 'Change Agents' programme for Clinical Futures.

Figure 1.14 - Staff Empowerment and Organisational Development Framework



There is a commitment to being a learning organisation that has improvement at its heart. That is both improving the skills of staff and equipping them to build improvement into delivering quality care to patients. The Health Board has worked hard to make the Improving Quality Together training available to everyone. More than 4,500 staff have completed this training, 240 have completed silver level IQT and there are over 120 alumni of the Enhanced Leadership and Management Programme.

The Health Board continues to build and consolidate trust through employee engagement, a clear focus on staff experience and working in partnership with the wider workforce, Trade Union colleagues, patients, their families and carers and external partners. Our ambition for our staff is that they are both confident and competent with the skills to work collaboratively with the community to develop a fundamentally different approach to health and care in Wales as set out in the findings of the recently published Parliamentary Review of Health and Social Care in Wales.

1.8 Welsh Language

It is recognised that Wales is a country with two official languages, Welsh and English, and that the community has the right to live their life through either or both languages. Welsh speakers can be found in all areas of the community (ABUHB Bilingual Skills Strategy 2014), those who have the greatest language need are likely to be among those recognised as coming from the most vulnerable groups. Provision of a bilingual service is a statutory requirement of the Welsh Language (Wales) Measure 2011 which is further strengthened by the Welsh Government Follow-on Strategic Framework for Welsh Language Services in Health, Social Services and Social Care - 'More Than Just Words.....'. This is the Welsh Government's response to the Welsh Language Commissioner's Primary Care Inquiry Report, impending Welsh Language Standards, and the requirement for community health needs assessment to identify issues of language and population assessment undertaken in line with the Social Services and Well-being (Wales) Act 2014.

The Health Board has faced challenges in improving service provision in relation to bilingual patient care. The availability of Welsh speaking applicants in many staff groups has been a key challenge where there are already shortages such as nursing and medicine. The Health Board has made some progress in respect of translation services (key documents, patient information, and social media)

through the recruitment of a Welsh Language Translator/Support Officer. A shortage of qualified translators has meant that the Health Board were unable to appoint additional officers.

All opportunities are taken to recruit more Welsh speakers through the Workforce Planning, Recruitment Strategy and Bilingual Skills Strategy, up-skilling the existing workforce through the Welsh Language Skills Training Plan. This is included as a longer term objective of encouraging young people with Welsh language skills to consider the NHS as a potential career option. A focus on community engagement and volunteering opportunities continues to help us make the best use of the Welsh language skills available within our community.

The Health Board's our performance is tracked through monitoring and reporting against the implementation of the Bilingual Skills Strategy, the Welsh Language Standards through our Welsh Language Strategic Group and annual reporting to the Welsh Language Commissioner. Further details are shown in Appendix X.

In summary, the Health Board faces the same National, Regional and Local challenges that have been well described within public sector bodies, an ageing population with declining health and ever increasing complex needs, increasing patient acuity and a disproportionate number of our adult population living with one or more chronic conditions.

We cannot address these challenges alone and welcome the opportunity that the Well-being and Futures Generation Act provide to strengthen joint ownership of priorities and shared responsibility for solutions across public sector organisations. This Act, together with the Social Service and Well-being Act, have emboldened Greater Gwent partners to develop an Integrated System of Health, Care and Well-being which encapsulates our commitment to the delivery of well-being objectives as part of the Public Service Board agenda and as a core strand of delivering our Clinical Futures Service Strategy of Care delivered Closer to Home.

We are at a critical phase in implementing our "Clinical Futures Programme" over the next three years from our existing configuration of services to a model that will set us up for the opening of The Grange University Hospital and beyond. We continue to embrace working with our broader NHS family across our Region, to seek the best solutions for a sustainable healthcare system. We will reshape hospital based services, ensuring that the hospital network provides our citizens and our primary and community care services with appropriate, accessible and timely care.

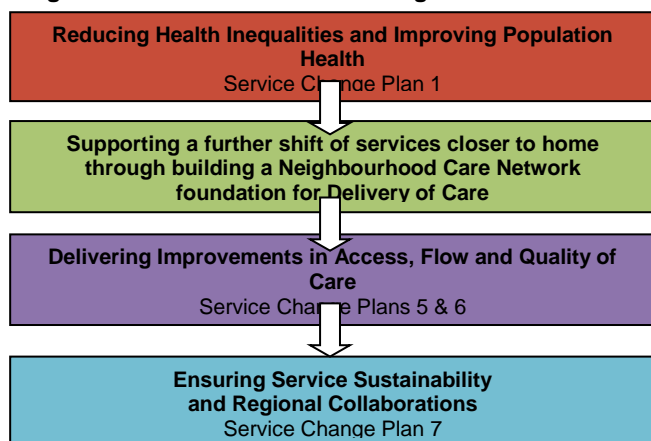
At all times, in every part of our health, care and well-being system, we strive to be the best, pushing boundaries to improve population health and well-being, reduce health inequalities and to provide efficient, effective and proportionate interventions that are prudent and add value.

SECTION 2 - ACHIEVEMENTS IN 2017/18, OPPORTUNITIES/ CHALLENGES AND SIGNIFICANT SERVICE CHANGE

2.1 Progress in Delivering the 2017/18 – 2020/21 IMTP

As we refresh our approved three year plan, it is important to reflect back on 2017/18 and capture the key achievements and lessons learned over the past 12 months. The 2017/20 IMTP was organised into seven Service Change Plans (SCPs) aligned to the Health Board's priority areas. These work programme areas were derived from our organisational clinical service strategies, our Divisional IMTPs and national programmes and priorities.

Figure 2.1 - 2017/18- Service Change Plan Overview



An executive led delivery framework has continued to oversee implementation of the SCPs and ensure that further opportunities to improve services and realise benefits are explored and developed. In addition, monthly assurance meetings monitored implementation of Divisional plans and delivery of performance take place.

Significant progress has been made on many issues within our SCPs during the past twelve months. Some of the key achievements are set out below with further detail at Appendix x.

Reducing Health Inequalities and Improving Population Health (SCP 1)

A continued and increasing focus on improving population health and prevention of avoidable disease including:

- Living Well Living Longer (LWLL) programme rolled out across 6 Neighbourhood Care Networks in Gwent with the highest deprivation levels providing health checks to 13,000 citizens to date. This has resulted in, 658 referrals to Stop Smoking Wales/Help me quit; 546 referrals to National Exercise Referral Scheme; 305 referrals to Adult weight management and 84 referrals to Gwent Drug and Alcohol Service.
- Further development of the Mental Wellbeing Foundation Tier with Psychologist led developed pathway for responding to disclosure of poor mental health well-being introduced to the LWLL Programme.
- Working towards improving cancer survival rates in disadvantaged areas and reduce inequalities by supporting people to reduce their preventable risk factors for cancer through the LWLL Programme.
- 432 staff to date have received training in Making Every Contact Count and are on track to train 10% (913) of our frontline staff this year.
- Gwent Child Obesity Strategy "Fit for Future Generations" has progressed with the mapping of the All Wales Obesity Pathway Level 1 provision for 3 Local Authority areas.
- To date, 1.7% of the estimated Health Board's adult smoking population were treated by NHS Smoking Cessation Services with 34% validated as successful.
- 'More People, More Active, More Often' programme re-commissioned to encourage young women to join and feel part of a community - online channels campaign has a following of 1,019 people and 8,758,902 opportunities for the campaign to be viewed online.
- Uptake of 96.1% achieved for children who received three doses of the 5-in-1 vaccine by the age of 1 surpassing the Welsh Government target of 95%.
- Launch of Ffrind i mi/Friend of Mine with local schools and nurseries visiting older people in care homes and wards participating in multigenerational exercise, becoming pen friends and holding 'bake off' competitions.

- Launch of the 'Pimp My Zimmer' project involving local school children in decorating Zimmer frames for care home residents with the aim of reducing falls in people with dementia. The project was featured on BBC World Radio which was listened by 1.1 million people across the globe.

Supporting a further shift of services closer to home through building a Neighbourhood Care Network foundation for Delivery of Care (SCP 2, 3 and 4)

Neighbourhood Care Networks continue to be the bedrock of strengthening the delivery of care closer to home outside of hospital settings. Our NCNs are continuing to mature and play a key role in the development of future models of integrated health, care and well-being services. Some highlights include:

- Practice Based pharmacists are now embedded in GP practices and are employed in 11 NCNs. Since April 2017, the team (14.9wte) are estimated to have replaced 3,941 hours of GP time through: 5,241 practice based medication reviews; 354 housebound medication reviews; 276 nursing/care medication reviews; 4,971 prescription based queries and 2,612 discharge summaries reviewed.
- The role of practice based social workers to support GPs has developed with the appointment of 11wte in Caerphilly. 1,200 referrals have been made to the service so far which has released GP time.
- Primary Care Operations Support Team (PCOST) is well established and supporting vulnerable practices with clinical and leadership resources. Implementing our 5 year plan to redesign Out of Hours primary care through the increase of skill mix and introduction of new roles including pharmacy and advanced paramedics. This has resulted in the team actively managing 2 practices, ensuring the continued provision of primary care services to a population of circa 16,000 people.
- The Older Persons Pathway work in Newport, working proactively with at risk individuals to prevent injury/illness and unnecessary admissions to hospitals has been evaluated. 9 practices are now using the risk stratification tool and 896 stay well plans (SWP) are currently in place. For every 100 people with a SWP, it is estimated that 22 A&E attendances and 15 emergency admissions are avoided each year.
- Implemented new Integrated Autism Service to improve access to diagnostic assessment and support for those with autism.
- Opened the new White Valley Centre for children and young people needing outpatient CAMHS.
- Peri-natal Mental Health services have been established for pregnant or post-natal women at risk of developing or being affected by mental illness.
- 30 practices are now engaged in delivering "Level A" Anti-Coagulation Services in Primary care leading to a 21% reduction in hospital lab tests for INR
- Referrals from General Dental Practitioners to locality based Minor Oral Surgery Services have more than doubled from 1,304 to 2,879 as the new service model has become embedded, this shift has improved access to maxillofacial services in out of hospital settings.
- Further development of the Care Closer to Home Strategy including an outline planning framework and programme plan of which the delivery of this strategy is a key enabler for the successful delivery of the Health Board's Clinical Futures Strategy.
- Additional community cardiology clinics have been established in GP practices in order to provide more accessible patient services closer to home. Further progress is being made to support practices with ECG Echocardiography and ambulatory monitoring.

Delivering Improvements in Access, Flow and Quality of Care (SCPs 5 & 6)

Quality and Patient Safety is a key priority, we continue to improve patient experience and clinical outcomes through a focus on improving access and patient flow, including:

- The Unscheduled Care Collaborative facilitated by ABCi has seen evidence of improvement in length of stay and discharges in RGH since the programme commenced 14 months ago.
- Significant improvements in looking after stroke patients at RGH which is now the best performing hospital in Wales for routine admissions since the opening of the hyper-acute stroke unit (HASU)

and significant investment in seven-day multi-disciplinary services

- Following the successful delivery of the patient flow SAFER bundle, both acute hospital sites have moved the work on to the required number of speciality specific discharges ensure patients are under the management of their condition specific medical team earlier in their pathway of care.
- Key successes for the Front Door Redesign project at NHH includes innovative view of emergency flow, allowing clinicians to design a fit for future model. Success at RGH has been improvement in flow through MAU and LOS and NHH remains one of the best performing hospitals in Wales against the 4 hour and 12 hour targets.
- Improved flow through Therapies staff working as part of a pilot at the front door in the RGH. Therapists are able to identify patients that can be discharged earlier in MAU with their input.
- Transformation of the vascular service has been achieved via changes which include implementation of a claudication pathway, where clinics are led by Vascular Advanced Nurse Practitioners.
- Streamlining of colorectal surgery pathways, through the introduction of a new model for anorectal physiology and the strengthening of research clinics.
- The extension of Ophthalmic Diagnostic Treatment Centres to six locations, with the scope now extending to new patients. The service aims to see 630 new patients per year (3,500 in total per year) and has achieved a 97% patient satisfaction rate.
- The introduction of 'Seen on Symptoms Clinics' for ENT, augmenting the adoption of the Health Board ENT follow up guidelines across Wales.
- The commencement of a One-Stop PSA service encompassing MRI, assessment and biopsy within urology.
- The implementation of a number of initiatives to transform radiology services, including the extension of One-Stop Clinics, increased home reporting (70,000 plan film reports), implementation of electronic request vetting and successful recruitment of 12 Radiographers.
- Continued progress has been made in implementing text and email reminder services, reducing DNA rates by 30%.
- The Musculoskeletal service focuses on ensuring patients see the right healthcare professional in the right setting at the right time. The complexity of the multi-disciplinary approach involves linking the medical input at the correct juncture between secondary and primary care. Good progress has been made on the osteo-arthritic knee pathway and spinal triaging, in line with Clinical Musculoskeletal Assessment Service (CMAT) philosophy.
- Sustained delivery of 80% compliance with the Adult Mental Health Primary Care Access target for assessment and intervention during this year.
- Ambulance response time within eight minutes to Category Red Calls continues to be well above the 65% target throughout the year.
- Significant improvements in waiting lists for psychological therapies and a number of new developments introduced including development plans to further improve waiting times and informatics processes and data captures improvements to ensure accurate reporting.
- Improved access to neurodevelopmental services with no waiting list as a result of the new Integrated Service for Children with Additional Needs (ISCAN).
- Significant improvement in diagnostic waiting times with a reduction in the number of patients waiting in excess of 8 weeks. 1,525 patients are currently waiting over 8 weeks compared to 6,075 in the same period last year which is a reduction of 76%.
- 38% reduction in the number of patients waiting more than 36 weeks for treatment (RTT). 1,529 patients are currently waiting over 36 weeks for treatment compared to 2,479 in the same period last year.
- The success of the Concerns Team in reducing the number of Legacy closures for Serious Incidents that were outstanding from 132 in December 2016 to 1 in November 2017.
- The success of the staff working to prevent falls at home and in hospital in winning 2 NHS Wales awards.
- The roll out of the sepsis trigger tool to all wards, supported by a Sepsis Awareness Day which was very well attended by the staff from the wards and very well received
- MAU at RGH has increased the number of cases of sepsis recognised and consistently has an 80% or more compliance with the sepsis 6 bundle
- The use of the I-Stumble tool for residents that have fallen in Nursing Homes with associated training has reduced the number of calls to WAST and attendances in the Emergency Department
- The "Deck my Zimmer" campaign has harnessed enthusiasm and motivation in Nursing and

Residential Homes to ensure that residents can recognise their own walking aid – as well as have fun!

Ensuring Service Sustainability (SCP 7)

- Plans have been developed to centralise breast services at Ysbyty Ystrad Fawr for Aneurin Bevan and Powys Community Health Council to improve critical mass.
- Detailed transition plans have been developed to reconfigure services within the Health Board prior to the opening of The Grange University Hospital for Paediatrics and Obstetrics with services sustained despite workforce challenges.
- Successful implementation of a new workforce model at the Royal Gwent Hospital for neonatal services and the Welsh Government funded Neonatal development at the Royal Gwent Hospital has enabled additional capacity that is essential in supporting the Health Board's contingency plans for its paediatric, obstetric and neonatal services.
- Surgical Specialties and Medical Specialities have achieved the revised Educational Contract through the implementation of detailed plans.
- Robust programme and governance structure established for Clinical Futures programmes with programme wide governance process in place. The programme has clear time bound objectives, a well-defined and documented scope and clinicians have developed and agreed clinical design principles for all aspects of programme delivery.

In addition to the achievements outlined above, the Health Board has also:

- Sustained its policy for no "off-contract" agency usage since April 2016 on all Hospital Sites.
- Won the Developing a Flexible and Sustainable Workforce award for the "Band 4 HCSW's in Complex Care: Developing the Role" project.
- Won first, second and third awards at The University of South Wales Annual Mentorship Awards in May 2017.
- The Health Board has improved its reputation as an inclusive employer. This is measured by the Workplace Equality Index.
- We continue to recruit external and internal registered nurses to our bank and have sustained last year's level of recruitment at 500 RN's. This has improved our bank fill rate success from 58% to 62%.
- We have hosted 84 placements through the LIFT programme and are on track to hit the target of 125 placements by March 2018.

2.2 Opportunities and Challenges

The environment in which the Health Board operates has become increasingly complex and dynamic. The challenges facing the Health Board include the ageing population, increasing demand for health and social care, significant workforce challenges and increased public expectation, at a time of sustained austerity in public sector finances.

The Clinical Futures Strategy sets out the strategic direction for modernising clinical services for the population of Gwent and South Powys. Clinical Futures is a clinically owned and led programme that seeks to rebalance the provision of healthcare in Gwent. This enables citizens to play a more active role in their health and wellbeing, providing more services within the community using Neighbourhood Care Networks to drive and deliver change at a local level and reshaping our hospital services in order to centralise them at The Grange University Hospital (SCCC), whilst maintaining a network of local hospitals.

Extending its scope wider than health, the Well Being of Future Generations Act provides the framework for the Health Board to work with its partners to improve the economic, social, environmental and cultural well-being of Gwent. The further integration of services across health and social care has been heralded by the interim Parliamentary Review of Health and Social Care and Health Board is committed to working with its partners through the Public Service Boards to develop a bold and unified vision for the whole of health and social care system, and further that

translates this vision to tangible actions.

The approval of The Grange University Hospital provides a clear focus for the Health Board to develop detailed transition plans for its clinical services in the run up to its opening in 2021. For a number of services, and as a result of significant recruitment and retention difficulties, there will be challenges in maintaining the current configuration of services prior to the advent of The Grange University Hospital and these are described within the Health Board's Service Sustainability Service Change Plan (SCP), where interim steps may be necessary as a transition to the Clinical Futures model for services such as inpatient paediatric, obstetric and neonatal services.

The Grange University Hospital is an enabler for wider regional change and the Health Board is committed to closer collaboration and partnership working with its neighbouring Health Boards. Whilst there has been effective joint planning of a number of services on a regional context, the scale, scope, and momentum of regional planning will increase and this is described in greater detail in the section on service sustainability and regional collaborations. The Health Board welcomes the opportunity to lead a number of initiatives across South East Wales, notably the Radiotherapy Satellite Unit at Nevill Hall Hospital as part of both the Health Board's and Velindre NHS Trust's Transforming Cancer Services Strategies.

The Health Board strives to continuously improve its efficiency and productivity and has responded by adopting Cross Cutting Themes to drive organisation wide change. This has led to targeted improvements in performance against a number of indicators, and aligned to enabling improvements in urgent and emergency and elective access. As part of its internal IMTP process, the Health Board has undertaken a significant piece of work which scopes the wide range of opportunities within each Division and has used the Divisional planning process to ensure that Divisional Plans address the key opportunities.

Whilst the Health Board continued to improve performance on a range of measures and plans in 2017/18, there are a number of key lessons and challenges that have been considered in developing this IMTP, including:

- The scale of ambition versus what is realistically achievable over a 12 month period, in particular urgent and emergency access.
- Further strengthening of partnership working with Local Authorities and the Third Sector, within the context of the Well Being and Future Generations Act and the Parliamentary Review of Health and Social Care.
- Continued workforce pressures due to the national recruitment issues and additional costs that has resulted in over reliance on agency staff for medical and nursing staff.
- The need to build on the progress made in year in strengthening the Health Board's Clinical Futures Programme Business Case to ensure that the Health Board realises the potential of The Grange University Hospital and the essential underpinning of enhanced primary and community services.
- The need to deliver regional change in priority areas and to implement transition plans for inpatient paediatric, obstetric and neonatal services.
- The need for greater efficiency and productivity to achieve financial sustainability.

General reflections also include the pace and scale of change required to support the strategic ambitions of the Board alongside the need for strengthening the performance management and delivery framework.

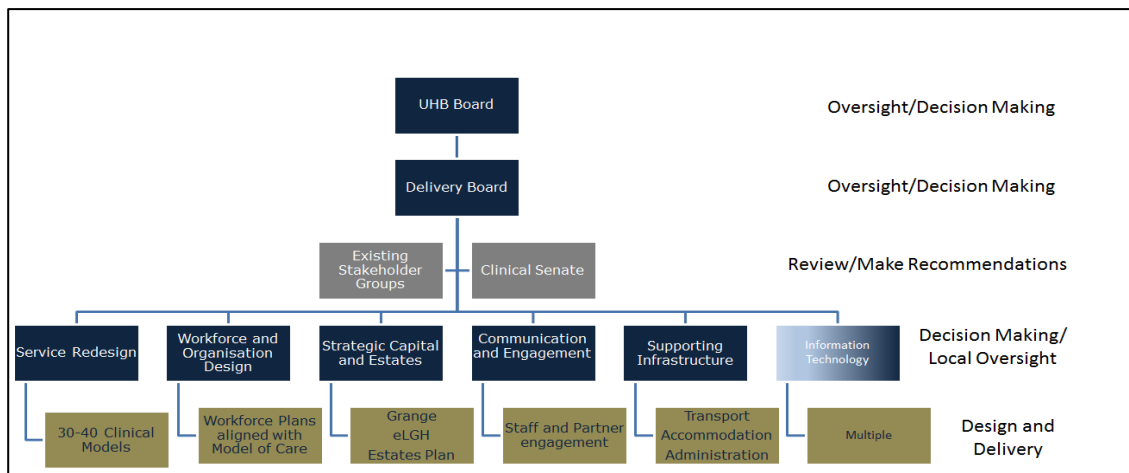
2.3 Delivering the Clinical Futures Strategy – Transformation Programme

Our clinically owned and led Clinical Futures Strategy, is delivered through strategic change plans and a longer term transformation programme. Some key delivery elements of the transformation programme delivery approach are:

- There is a clear and robust governance structure linking the innovative transformation work of Clinicians and Divisions up to the Health Board.

- Executive and Clinical Leadership roles have been clarified to ensure there is clear ownership, accountability and so that the organisation feels a true sense of leadership from Clinicians and Senior Leaders. The Chief Executive is the overall programme sponsor with an Executive leading each work stream. Senior Clinicians, usually Divisional Directors, are leading service design.
- Organisation development and service improvement methodologies are complementary to programme management and they are being deployed to address cultural and service change and to bring innovation and true transformation.
- Managing successful programmes (MSP) and Prince2 methodologies are used to manage the programme and form the basis of the overall planning, delivery and assurance framework.
- The overall ethos is that service changes are owned, designed and delivered by clinical teams, innovation is nurtured and encouraged with an overarching programme that also provides direction, assurance and support.

Figure 2.2



The programme has clear objectives which are:

1. Improve citizen well-being and patient outcomes for people of all ages, including satisfaction, by designing (January 2017-December 2018) and delivering (January 2019 –March 2021) new models of care for the population of Aneurin Bevan University Health Board across the whole health and well -being system. The models are designed with a focus of prevention, delivering care close to home where ever possible, routine care and specialist and emergency care in the most appropriate care setting.
2. Improve the efficiency and sustainability of service provision from 2018 – 2022 by ensuring that service development, model of care design and implementation is patient-centred, transformative, evidence based and economically viable.
3. Ensure that care quality and safety is of the highest importance during a period of transition to different delivery models, that any changes are well planned.
4. Improve staff satisfaction, recruitment and retention through the enhancement of patient and citizen focussed services.

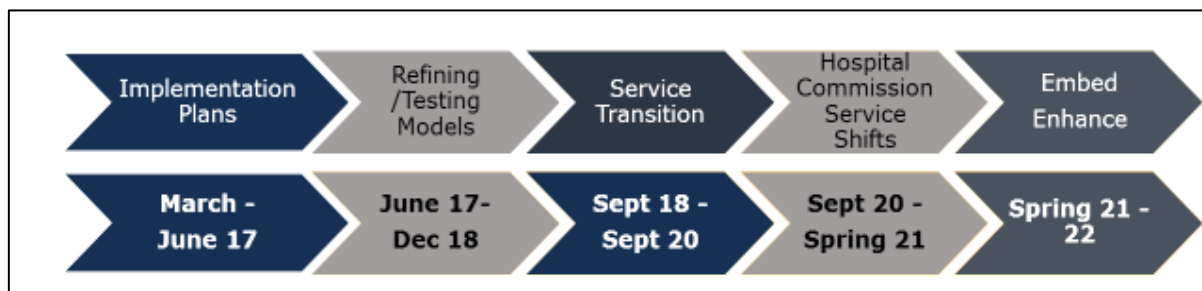
All transformation work is delivered through a set of clinically developed design principles to ensure that design is aligned:

1. **Patient centred**, concentrating on safety, quality and experience.
2. **Home to home**: integrated services in the community to prevent illness and improve wellbeing, and providing care closer to home where appropriate.
3. **Data and evidence driven**, patient **outcome** focussed.
4. **Innovative** and transformative, considering new ways of organising and delivering care around the patient and their carers.
5. **Standardised, best practice** processes and care pathways.
6. **Sustainable** with efficient use of resources.
7. **Prudent** by design, following NHS Wales' prudent healthcare principles.

Delivery Milestones

In summary delivery across the whole programme over the coming years is:

Figure 2.3



A four year transition plan has been developed, this includes all work streams, service re-design, workforce and organisation development, communication and engagement, strategic capital and estates and informatics. The opening of The Grange University Hospital in spring 2021 as a useful fixed point to develop service change plans. The scale of service transformation is much wider than the opening of the new hospital but this date provides a clear deadline and helps increase momentum. objectives, scope, accountabilities including leadership, products, high level timelines, resource requirements, risks, issues and benefit measures.

Interdependencies across the transformation agenda have been mapped at a high level with service re-design being the key driver.

By December 2018, all service models (40) will have been re-tested for maximum population benefit, true innovation with a further test for deliverability.

The programme is entering a new phase signalled by the building of the Grange University Hospital. Pace of delivery has noticeably accelerated in 2017/18. In addition to the integrated and primary care developments noted in previous sections clinically led service model redesign has already been undertaken for Emergency Department, Acute Medical Take, Cardiology, Gastroenterology, Women and Children's acute services, An innovative, best in class, capacity and demand system-wide modelling tool has been built in house by ABCi mathematicians which ensures redesign is based on robustly predicted demand. Clinical design and engagement events happen quarterly bringing together 120 clinicians from all disciplines and parts of the service, partnership design meetings also continue with other part is the health and social care system including WAST.

By the way the programme has gone about its work the organisation is already starting to see cultural change and an increase in organisational effectiveness. ABUHB and the diverse population it serves are uniquely positioned with productive partnerships, a health and social care system ethos, talented clinicians, strong innovation track record, thought leadership, investments in state of the art estate and focus on value.

Our ambition is to make the most of these unique opportunities to become a test and rapid roll out hub for patient and citizen improvements that can be shared across NHS Wales, aligned strongly with Welsh Government policy and direction. ABUHB will take the very best of what it does, transform and innovate much further and develop both published research, tool kits and advice for other Health Boards and Public Services to adapt and adopt.

SECTION 3 - DELIVERING OUR PLANS

The Health Board's three year IMTP demonstrates how the organisation aims to meet the needs of the population, deliver sustainability, service change and service improvement based on value driven healthcare. It also sets out how substantial progress in delivering **our vision for 2021** will be made through the Clinical Futures Transition Plans. The Clinical Futures Strategy is an essential underpinning of the IMTP, and the plan is the mechanism that seeks to provide the bridge to the opening of the Grange University Hospital in spring 2021, this hospital facility is an important enabler of the Clinical Futures Strategy. However our transition programme sets out the breadth of service transformation that will be delivered across the whole health and well-being system, and beyond through our regional partnerships within NHS Wales.

Our key objectives as a Health Board over the next three years are synonymous with those of our Clinical Futures Programme, which have been set out in section 2.3 and are summarised here as to:

- Improve citizen well-being and patient outcomes for people of all ages by delivering new models of care across the whole health and well-being system. These models focus on prevention, delivering care close to home where ever possible, routine care and specialist and emergency care in the most appropriate care setting.
- Improve the efficiency and sustainability of service provision by ensuring that service development, model of care design and implementation is patient-centred, transformative, evidence based and economically viable.
- Ensure that care quality and safety is of the highest importance during a period of transition to different delivery models, that any changes are well planned.
- Improve staff satisfaction, recruitment and retention through the enhancement of patient and citizen focussed services.

Figure 3.1



People are looking after their own health and well-being and that of their families, when they need help, this is readily available at home, in their community, supported through innovative technology

We work in a modern system with our partners that delivers the best outcomes, utilising best practice in the most appropriate settings. Our service is the first in the NHS to prove truly holistic care from home to home and continuously evolves so it remains leading edge

Compassionate care is delivered by talented, creative teams that we trust and respect to put the needs of our patients at the heart of everything we do. Our staff tell us they feel empowered, equipped and driven to make a difference to the lives and outcomes of people. Our teams feel valued, trusted and listened to

We are a dynamic organisation that cares, learns and improves together

Figure 3.2

Approach to Planning in 2018/19

As part of the IMTP refresh process, the updated plan continues to be developed using the three levels of planning (Operational, Tactical and Strategic) to support the development and understanding of the components of the plan which will support the delivery of the key objectives and ambitions of the organisation. These levels of planning help identify the programme of work across the different levels and those that lend themselves to short term operational planning and those that are longer term system wide change programmes. These are described below and the following sections provide an overview of the work programme under each level.



Operational Planning – Improving Operational Efficiency

The Health Board has a clear ambition to maximise the use of its resources through achievement of delivering “best in class” performance in its efficiency and effectiveness. During 2017/18, the Health

Board had adopted Cross Cutting Themes to drive organisation wide improvement in productivity and efficiency. This has led to targeted improvements in performance against a number of indicators, and aligned to enabling improvements in urgent and emergency and elective access. During 2018/19, the Health Board will strengthen the programme and processes to drive a greater delivery of efficiency and productivity across the organisation to support the service, workforce and financial challenges over the next three years and beyond. Key areas that feature under this Cross Cutting Themes work programme include:

- Workforce Efficiencies – improving rostering, reducing current levels of sickness absence and high levels of agency usage, using workforce benchmarking to target interventions and enabled by improving recruitment and retention and staff deployment. Our programme has dedicated streams to focus on medical workforce, nursing workforce, therapies workforce and others.
- Procurement – working with shared services to optimise non-pay expenditure across the Health Board to support our financial plan.
- Medicines Management – using benchmarking and local variation data, the Medicines Management Strategic Group and deep-dive methodology will continue to be used to maximise opportunities to mitigate growth in medicine expenditure.
- Optimising Capacity Utilisation - ABCi are supporting the delivery of a capacity and patient flow re-alignment programme, focusing on improving performance and demand/capacity planning for beds across the system. Work-streams are also in place for maximising theatre utilisation, outpatient transformation and Continuing Health Care.

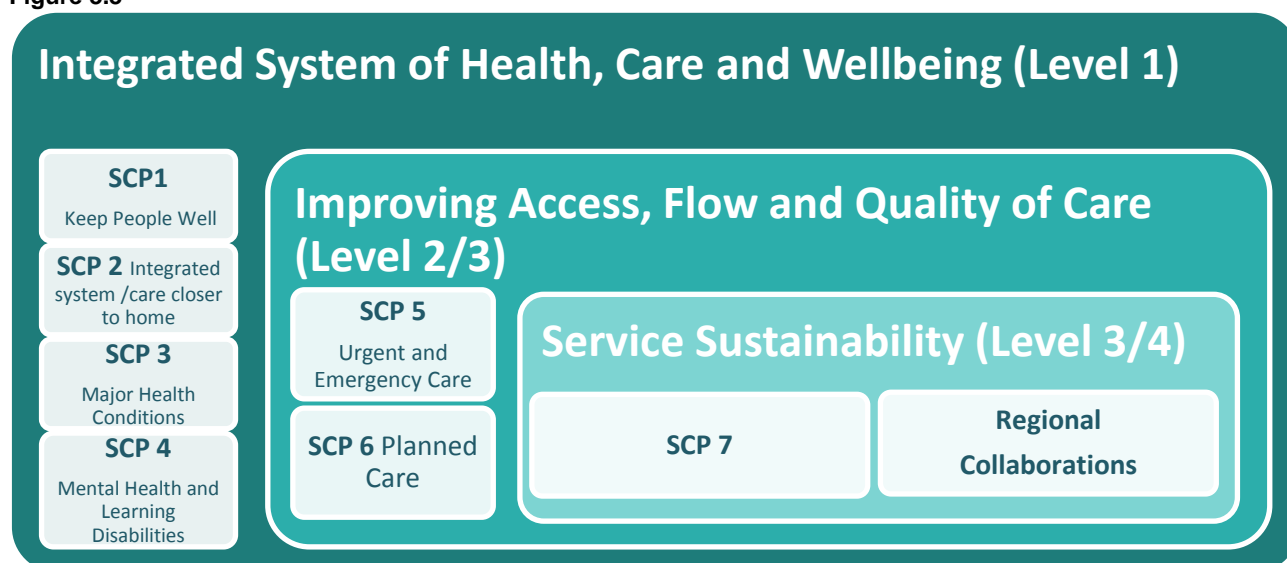
These cross cutting work programmes will be embedded at a Divisional and Directorate level and will support the delivery of operational plans and performance managed through the overarching delivery and assurance programme and is fundamental to the delivery of financial and service sustainability.

Tactical and Strategic Planning – Service Change Plans

The Health Board has continued to develop its Service Change Plans as the mechanism by which it progresses changes that spans the tactical and strategic levels of planning. These primarily relate to corporate priorities that support delivery of key objectives.

With a vision of integration and improvement, the Health Board will continue to concentrate its change efforts into the creating an Integrated System of Health, Care and Well-being, with Neighbourhood Care Networks as the primary mechanism for delivering care. There will be a focus on enabling patients to access to the right service, and flow through the system unimpeded and ensuring service sustainability both in the transition to the Grange University Hospital and beyond. The alignment of priority plans against the Health Boards' vision are illustrated in Figure 3.3.

Figure 3.3



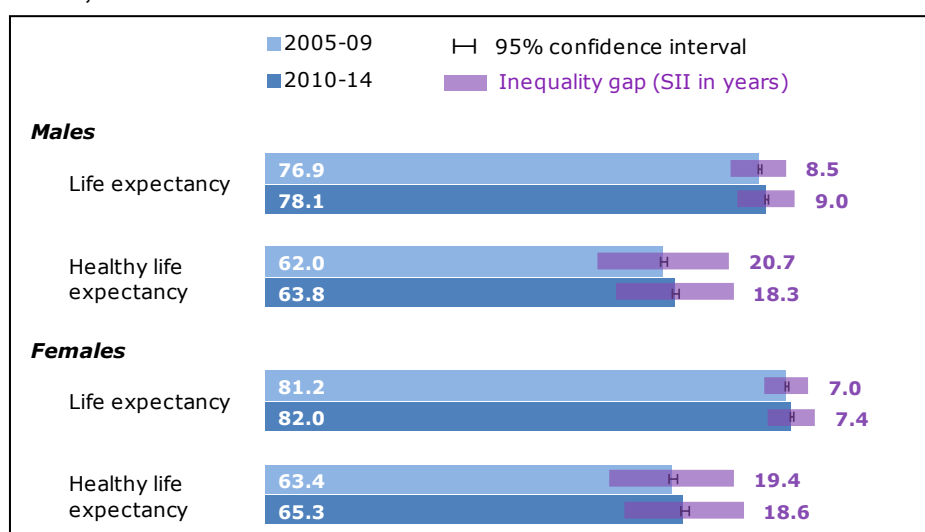
SCP 1 – Improving Population Health and Well Being

This SCP seeks to improve the health and wellbeing of the Health Board's population, reduce health inequalities and benefit individuals and ensure the sustainability of our healthcare system.

Increasing the proportion of the population who do not smoke, who are a healthy weight, who eat a healthy diet, are physically active and do not exceed guidelines on alcohol consumption would have population impact on rates of heart disease, stroke, diabetes, cancer and liver disease. Smoking in particular is the biggest risk factor for productive life lost due to disability and premature mortality. As well as impacting on quality of life for individuals and their families, the burden of preventable diseases due to lifestyle factors are putting current NHS treatment services under considerable strain. There is a high risk that the projected increase in lifestyle related disease will continue to create an unsustainable strain on NHS services and finances.

There is also a persistent issue of health inequities in our Health Board area. Men living in our most economically disadvantaged areas die 9 years younger and women 7 years younger (on average) than men and women living in our least economically disadvantaged areas. This gap has widened over the last decade, although life expectancy has been increasing for the population as a whole. Furthermore, the difference in average years spent in good health is over 18 years for both men and women (see Graph 3.1.1). Much of this inequity in health is due to heart disease, stroke, cancer, diabetes, respiratory conditions and liver disease. In practice, this gap means that a man living in one of our most economically deprived areas is more likely to develop health problems in his 50s and to subsequently retire early, particularly from a manual or heavy labouring job. In comparison, a man living in one of our least economically deprived areas is more likely to live in good health past normal retirement age, into his 70s. People living in economically deprived areas are therefore doubly affected by living longer in ill health and by loss of employment income at an earlier age.

Graph 3.1.1. Comparison of life expectancy and healthy life expectancy at birth, with Slope Index of Inequality (SII), Aneurin Bevan UHB, 2005-09 and 2010-14



Produced by Public Health Wales Observatory, using PHM & MYE (ONS), WHS & WIMD 2014 (WG)

The Health Board published its Well-being Statement with 10 Well-being Objectives in the Integrated Medium Term Plan, 2017/18- 2019/20. The Health Board is able to influence overall population health, health inequalities and the associated impact on treatment services of preventable conditions. This is possible through both direct action and through system leadership at Public Service Board (PSB) level. Four of the Health Board's Well-being Objectives have been selected as proposed priorities for PSB Well-being Plans on the basis that they can only be addressed successfully by working with PSB partners, these are:

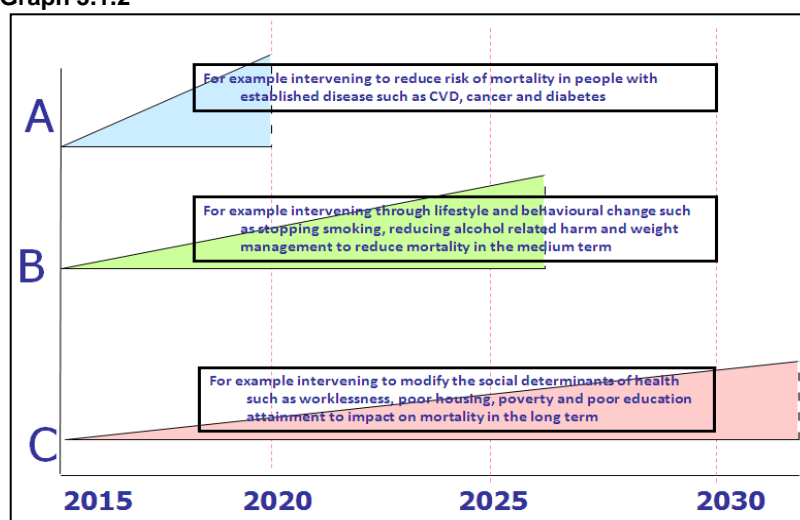
Our Aspiration	Reduce health inequalities and improve the health of people in Gwent by working with our partners, focusing particularly on those in greatest need.
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to:		
Our proposed priorities for PSB Well-being Plans	1. To provide children and young people with the best possible start in life.	2. To achieve impact on preventable heart disease, stroke, diabetes, cancer, respiratory and liver disease.
	3. To improve Community & Personal Resilience, Mental Health and Wellbeing.	4. To enable people to age well and for those that need care to receive it in their home or as close to their home as possible.

Success in achieving these objectives will depend on action across the public sector system, using the Well-being of Future Generations and Social Services and Well-being Acts to drive system-wide collaboration.

The Health Board will continue to provide system leadership for improving population health and reducing inequalities by agreeing a strategic framework for action to reduce health inequalities and improve population health (including tobacco control and physical activity) by November 2018. Achieving these aspirations will require a range of actions some of which will have impact on population health over a relatively short time period of three to five years, some over a ten year period and others over a twenty year period or longer (Graph 3.1.2) [Bentley].

Graph 3.1.2



Whilst considering ‘improving population health’ it should be recognised that one person’s health behaviours can be harmful to other people (e.g. passive smoking) and also that some interventions may restrict people’s personal freedoms (e.g. smoking ban in public buildings). Because of this, ethically, public health interventions beyond those which prevent the harm of children and vulnerable people, should be proportionate. That is, the benefits of an intervention should be enough to justify the interference in people’s lives and be the least intrusive, whilst still achieving their aims.

The ‘**intervention ladder**’ (Table 3.1.1), is a useful tool when thinking about the different ways that public health policies and interventions can affect people’s choices. The overall aim should be to achieve the desired health outcomes while minimising restrictions on people’s freedom. Interventions that are higher up the ladder are more intrusive and therefore require a stronger justification.

Different strategies may be pursued to improve population health including implementing universal public health interventions (which apply to all) or taking a targeted approach (e.g. for disadvantaged groups). However, different people may respond differently to universal measures. For example, better food labelling may benefit some more than others, as not everyone will read the labels or be able to use the information provided to inform their food choices. In general, those most able to benefit from information-based strategies are better educated and from higher socio-economic status groups. Universal measures can therefore have the effect of increasing health inequalities.

Table 3.1.1 - The Intervention Ladder
Eliminate choice. For example compulsory isolation of people with infectious diseases.
Restrict choice. For example, introduce laws that restrict the options available to people, for example, removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.
Guide choice through disincentives. Introduce financial or other disincentives to influence people's behaviour, for example, increasing taxes on cigarettes, or bringing in charging schemes to discourage car use in inner cities.
Guide choices through incentives. Introduce financial or other incentives to influence people's behaviours, for example, offering tax-breaks on buying bicycles for travelling to work.
Guide choices through changing the default policy. For example, changing the standard restaurant side dish from chips to a healthier alternative, with chips remaining as an option available.
Enable choice. Help individuals to change their behaviours, for example, providing free 'stop smoking' programmes, building cycle lanes or providing flexibility in working hours to enable physical activity options at the work place.
Provide information. Inform and educate the public, for example through a campaign.
Do nothing or simply monitor the current situation
Nuffield Council on Bioethics (2007), Public Health: Ethical issues

To enable the remaining groups to achieve the same benefit to health outcomes, additional targeted interventions may be required. This is referred to as proportionate universalism, which is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need (Marmot, 2010). Services therefore need to be universally available, with additional resource and delivery able to respond to the level of presenting need. For example, uptake of cancer screening programmes is highest in the most affluent areas, adding further to the health inequality gap. The Health Board will reach out to those people who do not access these services to understand who and where they are and how to gain their trust and acceptance. This approach is required to simultaneously improve population health whilst also reducing health inequalities.

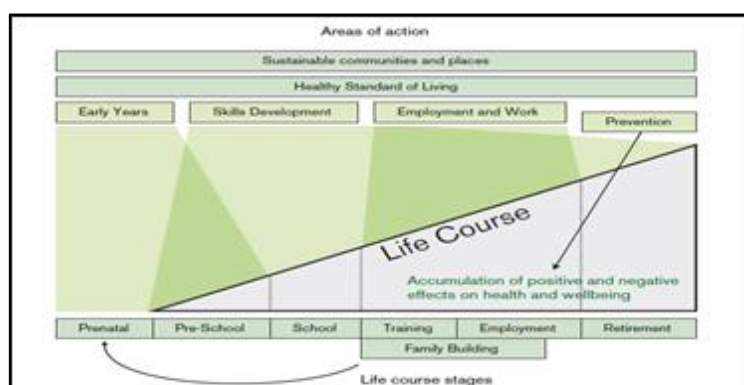
There are 7 key programmes of work in SCP 1, to support the objectives of improving population health across the life course, reducing health inequalities, and ensuring the sustainability of our healthcare system. These programmes will ensure the concepts described above are at the heart of planning, delivery and monitoring of our impact.

3.1.1 Provide children and young people with the best possible start in life

Disadvantage starts before birth and accumulates throughout life, as shown in the Figure below. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken (Marmot, 2010). For this reason, giving every child the best start in life is a priority.

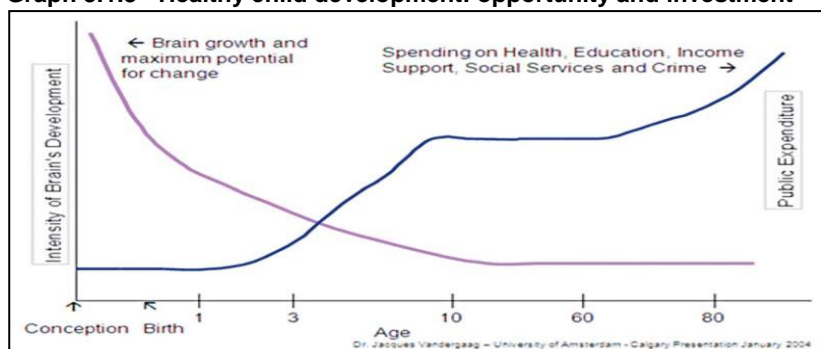
The bulk of public spending, including health services, occurs later in the life course. However evidence points to greatest impact on outcomes being made in the early years. Realigning investment into the early years will not only improve outcomes for the younger generation, but will prevent problems in the future. There is also a strong economic

Figure 3.1.1 - Accumulation of effects and action areas across the life course (Marmot, Fair Society, Healthy Lives, 2010)



case for investing in the early years as programmes are often less expensive than the services needed to address the physical, mental, behavioural and socio-economic consequences of poor early child health and development (Graph 3.1.3).

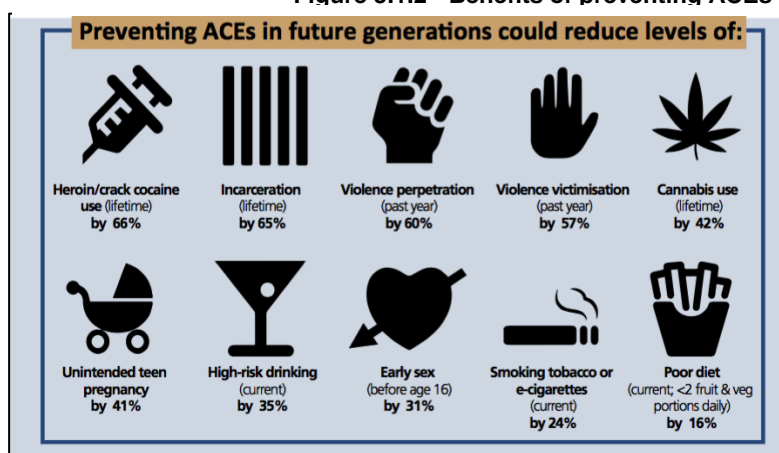
Graph 3.1.3 - Healthy child development: opportunity and investment



Related to this are Adverse Childhood Experiences (ACEs) which are known to have direct and immediate effects on a child's health. The first Welsh ACE survey identified that substantial proportions of the Welsh population have suffered abuse, neglect and other ACEs during their childhood.

Such stressors arise from the abuse and neglect of children but also from growing up in households where children are routinely exposed to issues such as domestic violence or individuals with alcohol and other substance use problems. The effects can impact on the long-term physical and mental wellbeing of an individual, which in turn can be inter-generational. Therefore, preventing and mitigating the effects of ACEs can improve health across the whole life course, enhancing individuals' well-being and productivity while reducing pressures and costs on the health service (Figure 3.1.2).

Figure 3.1.2 - Benefits of preventing ACEs



Those experiencing four or more ACEs have increased risk of health harming and criminal behaviours. Thus, health, social, criminal justice and educational systems are all likely to see better results for the Welsh population if ACEs are prevented and mitigated. The impact of ACEs is everybody's business, preventing and mitigating ACEs is our common purpose across the public sector in Gwent.

Young people are an important group, particularly as they are the parents of future generations. Evidence is also emerging that brain structure is still developing and is not mature until the early 20s, and that after infancy, the brain's most dramatic growth spurt occurs in adolescence. The teenage years are thus a key stage for action to strengthen health behaviours, build resilience and ensure individuals reach their potential.

Oral health of children in the Health Board area is improving, but tooth decay rate (and dental general anaesthetic rate) is highest in the most deprived parts of the Health Board area and lowest in the least deprived areas. The Designed to Smile Programme will expand its focus to include children from birth to age 5 years.

The Gwent Childhood Obesity Strategy 'Fit for Future Generations' has been adopted by all five Public Service Boards in the Health Board's area. The strategy provides analysis of the increasing problem of childhood obesity including local data analysis and a compelling case for coordinated, multiagency and evidence-based action. Schools and pre-school settings provide universal platforms to enable children and young people to be a healthy weight.

As elsewhere, the proportion of both the child and adult population who are overweight or obese is highest in the most deprived parts of the Health Board's area and lowest in the least deprived areas.

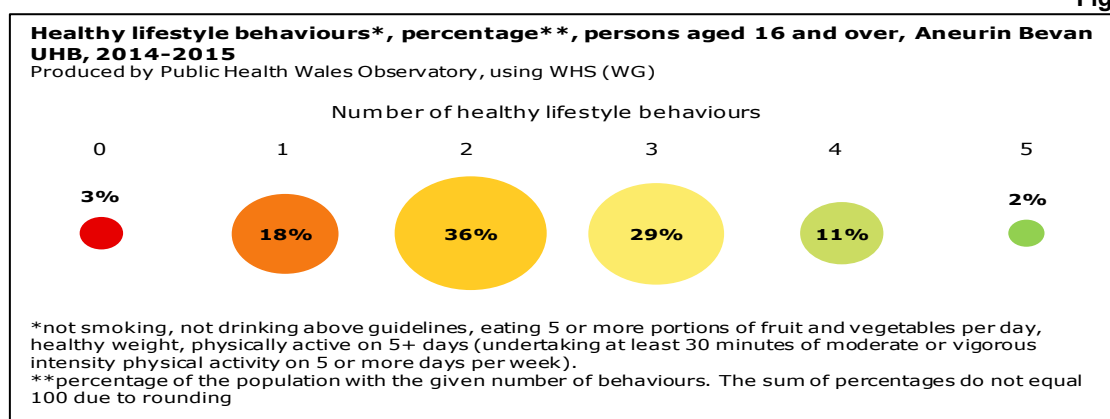
To provide children and young people with the best possible start in life the Health Board will:

- Further develop support for pregnant women to stop smoking (2018/19)
- Fully implement the Healthy Child Wales programme, ensuring a universal health visiting service for all, with an enhanced service proportionate to the differing needs of families by March 2019 (subject to business case approval)
- Implement refreshed Designed to Smile programme fully by April 2019
- Become an ACE (Adverse Childhood Experiences) aware organisation, through developing a programme of staff awareness-raising by March 2019 and ensuring implementation by March 2020.
- Scope an Early Years Collaborative, led by ABCi (April 2019)
- Implement a Level 3 weight management service for children and families with severe obesity by December 2018 (subject to business case approval).
- Develop a model for Level 2 weight management service for children and families and implement across NCNs March 2021 (subject to funding), supported by community asset mapping of healthy eating and physical activity services (see section 3.1.4)

3.1.2 Making Every Contact Count

Currently (Figure 3.1.3) only 2% of the people living in the Health Board's area are achieving all five healthy lifestyle behaviours with 3% achieving none, 36% only two and 29% three.

Figure 3.1.3



Historically, policy and services have tended to focus on individual lifestyle risk factors but increasingly the importance of multiple lifestyle risk factors is being recognised. A study of adults age 45-79 in Norfolk found that over a ten year period, 95% of those with no unhealthy lifestyle risk factors were still alive in contrast to only 75% who smoked, had a low consumption of fruit and vegetables, were physically inactive and consumed alcohol above guidelines. Importantly, this association was graded with 92% of those with one unhealthy lifestyle risk factor still alive, 88% of those with two and 85% with three [Khaw et al 2008].

The Health Board's Making Every Contact Count (MECC) strategy addresses multiple rather than individual lifestyle behaviours. The Health Board is committed to provide MECC training to 10% of its frontline staff each year to ensure that all opportunities to help our population to address their lifestyle risk factors are optimised.

To Make Every Contact Count, the Health Board will:

- by March 2019 provide MECC training for an additional 10% of frontline staff;
- by March 2020 provide MECC training for an additional 10% of frontline staff;
- by March 2021 provide MECC training for an additional 10% of frontline staff;
- systematically embed MECC approach into hospital smoking cessation support by March 2019;
- systematically embed MECC approach into Integrated Well-being Network well-being workforce development by 2020.

3.1.3 Developing the Health Board as an exemplar health and well-being employer

The health and well-being of employees can have a big impact on how well a workplace functions, including the quality of care that can be provided to patients in healthcare settings. Organisations that recognise this, and that actively support staff health and well-being have been shown to perform better, and provide better, safer services with less staff turnover and absenteeism.

As one of the largest employers in the area, Aneurin Bevan University Health Board has an opportunity to impact on population health by improving the health of the workforce with a large proportion of staff living and working in the Gwent area.

To improve the health and well-being of Health Board staff, through:

- Develop and implement an improvement plan to achieve revalidation for both Gold and Platinum Corporate Health Standard by December 2018.
- Develop a business case to support active travel across the organisation by 2019.
- Develop a holistic workplace health improvement plan to support the development of The Grange Hospital and the implementation of Clinical Futures Strategy by March 2020.
- Prepare for implementation of the Public Health Bill in relation to tobacco and smoke-free environments, by March 2020.

3.1.4 Disease prevention through population scale services to improve health and well-being

To achieve impact on preventable heart disease, stroke, diabetes, cancer, respiratory and liver disease at a population scale will necessitate reaching thousands of adults living in the Health Board area to encourage and support them to make lifestyle modifications to reduce their risk of preventable disease. The scale of the challenge can be determined from the results of the new National Survey for Wales (2016/17) which tells us that in the Health Board's adult population, approximately:

- 18% of adults are smoking²;
- 20% of adults are drinking 'above guidelines'³;
- 34% of adults are a healthy weight⁴;
- 53% of adults meet physical activity guidelines⁵;
- at least 1 in 6 adults in Gwent experiencing poor mental health.

Produced by Public Health Wales Observatory, using the National Survey for Wales 2016/17

In line with the 'People staying healthy and well' element of the Clinical Futures Level 1 framework, Integrated Well-being Networks will be developed on NCN footprints in order to ensure a consistent offer of universal prevention programmes, delivered at a population scale across Gwent. There will be an emphasis on the outcomes the patient wishes to achieve through the development of a 'Wellbeing Workforce', focused on improving and maintaining a person's wellbeing, having meaningful conversations which enable co-production to achieve the desired personal outcomes. Links will be made to work developing on Asset Based Community Development, in order to ensure we support and develop existing community strengths and assets for health.

Development of Integrated Well-being Networks will include a range of healthy lifestyle and mental well-being support services as outlined in Figure 3.8, as well as ensuring integration with wider well-being services such as housing, employment and debt advice. As outlined in the introduction to SCP

²Rates aren't comparable between the National Survey for Wales and the previous Welsh Health Survey, primarily due to a change in the survey methodology.

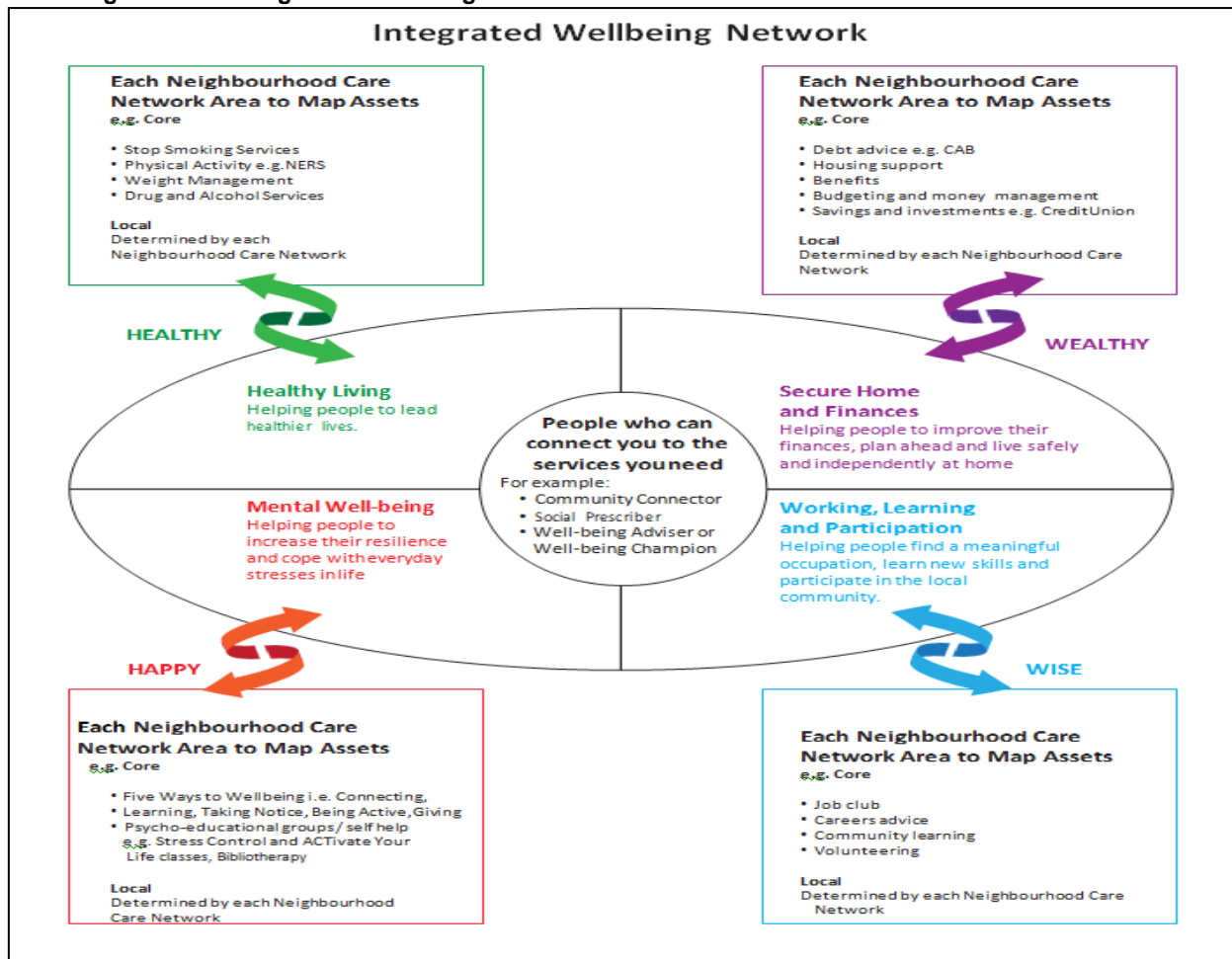
³ Based on the current 'drinking above guidelines' definition (average weekly consumption above 14 units), therefore the results are not comparable with Welsh Health Survey data using the former definition

⁴ Rates aren't comparable between the National Survey for Wales and the previous Welsh Health Survey, primarily due to a change in the survey methodology

⁵ Based on the current physical activity guidelines (150 minutes or more of physical activity in the previous week), therefore the results are not comparable with Welsh Health Survey data using the former definition

1, the Health Board will also work at PSB level to influence action on aspects of peoples' lives that the evidence suggests are critical for tackling health inequalities (e.g. employment, living standards and sustainable communities).

Figure 3.1.4 - Integrated Well-being Networks



In order to enable citizens to make informed and empowered choices that help them stay healthy and well, the Health Board will:

- Work with community partners through NCNs to develop and test Integrated Wellbeing Networks (IWNs) on NCN footprints, linked to development of integrated community teams and health and well-being centres (Blaenau Gwent West, South Monmouthshire, Newport East). Implemented on a phased basis by March 2020.
- Develop and test systems (including methods for social prescribing) for linking patients to support that addresses the social causes of poor wellbeing, linked to development of IWNs and integrated community teams and health and well-being centres (Blaenau Gwent West, South Monmouthshire, Newport East), by March 2020.
- Share the learning and implement Integrated Well-being Networks, including systems for linking patients to support that addresses the social causes of poor wellbeing, in remaining NCNs by March 2021.
- Work with partners to develop a well-being workforce aligned to IWNs, including competencies in well-being & care navigation, health improvement, behaviour change (MECC) and mental well-being, by March 2020.
- Scope the additional components required for an Integrated Well-being Network suitable for children and families (linked to Early Years Collaborative and Healthy Child Wales Programme) and older people by March 2019.
- Undertake a study on behalf of the Gwent Health Social Care and Housing Partnership, of how appropriate Housing Options could contribute to the health, well-being and independence of older people in Gwent in the future (by December 2018).

Smoking remains the largest single preventable cause of ill health and death in Wales with high costs to the NHS, society and the economy. Smoking rates are 2.5 times higher in the most deprived populations and 4 times higher in the long term unemployed. In order to meet the Welsh Government target of reducing smoking prevalence to 16% by 2020, the Health Board aims to establish a clear focus on wider tobacco control measures by taking action on preventing young people from starting smoking, increasing access and uptake to NHS smoking cessation services, targeted action on reducing smoking in pregnancy, advocating for smoke free environments and policies, targeted action on addressing illicit and illegal tobacco use.

Physical activity is essential for good physical and mental health and contributes significantly to the prevention of ill health. It can reduce the risk of many chronic conditions, like cardiovascular disease by 35%, type 2 diabetes by 40%, cancers (colon and breast) by 20%, joint and back pain and by 25%. Regular physical activity also helps maintain healthy weight, promotes mental health and prevents vascular dementia. Creating opportunities for active travel also contributes to environmental sustainability. The Health Board has been a partner in the 'More People, More Active, More Often' programme, piloting Large Scale Change (LSC) methodology to tackle physical inactivity in the Gwent Heads of the Valleys area. As part of the sustainability plan for this programme, the Health Board will implement evidence-based actions including supporting active travel for staff/patients and Making Every Contact Count, detailed throughout this SCP.

The 'Fit for Future Generations' childhood obesity strategy complements the chapter on Diabetes in the 2015 Aneurin Bevan University Health Board Director of Public Health report which sets out the case for action to halt the rise in obesity to prevent the increase in Type 2 diabetes, because 85% of Type 2 diabetes is attributable to obesity. In line with the predicted rise in diabetes in adults across Wales, diabetes in adults in Gwent is predicted to rise to 10.7% in 2020 and 11.9% in 2023 (ABUHB DPH Report 2015).

Poor mental wellbeing is strongly associated with unhealthy behaviours. Improving mental wellbeing is a necessary first step towards making lifestyle changes for many people, particularly in the most disadvantaged communities and amongst vulnerable groups. In 2016, the Mental Wellbeing Foundation Tier across the Health Board's area has been enhanced by the roll out of the Road to Wellbeing group psycho-education classes. Supporting our citizens to improve their mental well-being will enable individuals to take more responsibility for their physical health and well-being, ultimately our aim is to support them to be more self-reliant, aware and informed about the choices they make.

In order to address the impact of preventable diseases, the Health Board has plans for scaling up healthy lifestyle and mental well-being support services as part of Integrated Well-being Networks, to ensure a consistent provision across NCN areas.

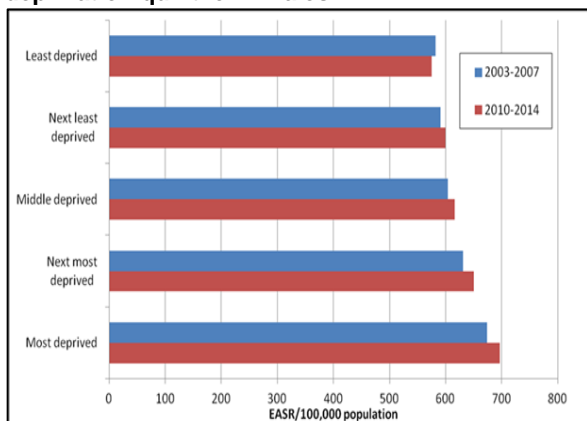
To scale up healthy lifestyle support services, the Health Board will:

- Continue to implement local action plans to increase the number of referrals to NHS smoking cessation services, to reach the IMTP Tier 1 smoking cessation target to treat 3.8% of the adult smoking population (2018/19), 4.3% (2019/2020) and 5.0% in 2020/2021 and achieve a 40% CO validated quit rate.
- Implement plans to extend the Alcohol Care Team to seven days a week and introduce an outreach service, informed by evaluation and subject to business case.
- Evaluate and review adult weight management services by March 2019, including service provision for specific risk groups such as pregnant women and pre-diabetics.
- Work with community partners to map community assets that promote physical activity, healthy eating and healthy weight across NCN areas and align with Integrated Well-being Networks, by March 2020.
- Further develop the mental well-being Foundation Tier as part of the IWN by integrating and making visible services which build resilience in the face of stress (including Road to Well-being), and community assets that enable people to be active, take notice, give, keep learning (Five Ways to Well-being), by March 2020.

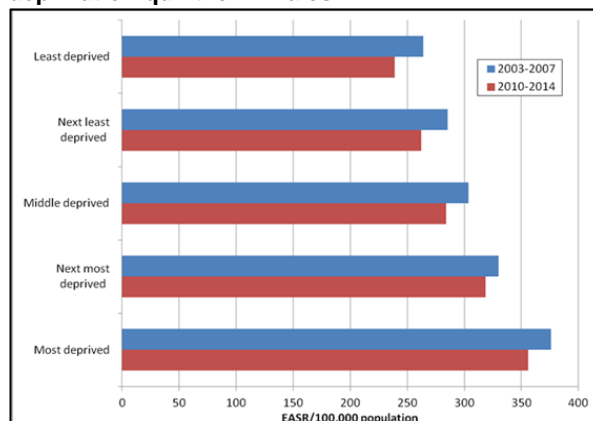
3.1.5 Reducing inequalities in the incidence and rates of survival from cancer

Health inequalities are particularly evident in cancer incidence and survival. The charts below show that incidence and mortality are associated with deprivation, with rates highest in the most deprived populations in Wales. Also, trend data is showing a widening inequalities gap; incidence in the most deprived quintiles have increased whilst the least deprived have decreased. In addition, the decrease in the mortality rate is greater in the least deprived than the most deprived quintiles.

Graph 3.1.4 - Cancer incidence rate per 100,000 by deprivation quintile in Wales



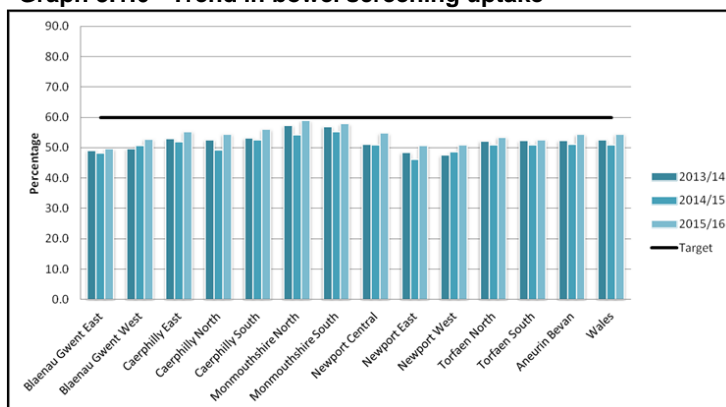
Graph 3.1.5 - Cancer mortality rate per 100,000 by deprivation quintile in Wales



Source: Welsh Cancer Intelligence and Surveillance Unit

Improving cancer survival rates in disadvantaged areas is one of the key planks of our strategy to reduce health inequalities. Cancer screening can be cost-effective and early identification could lead to patients living longer and to fewer hospital emergency admissions and diagnostic tests (PHW 'Making a Difference'). However, inequities in screening participation have been shown across Wales, with participation for all of the adult screening programmes decreasing with an increase in deprivation. In particular, bowel screening uptake in the Health Board, although similar to Wales as a whole, is below target.

Graph 3.1.6 - Trend in bowel screening uptake



To improve Cancer Survival Rates the Health Board will:

- Support people to reduce their preventable risk factors for cancer through the Living Well Living Longer Programme (see SCP 2).
- Work to encourage prompt presentation and uptake of national cancer screening programmes in the population to enable diagnosis as early as possible, by March 2019.

3.1.6 Population Immunisation Programmes

In 2016 the Health Board successfully implemented a new service model for providing the routine childhood immunisation programme in response to provide greater service capacity to deliver the

extensions to the programme in recent years. Childhood immunisation is a highly effective population health measure.

Influenza vaccination is a highly effective population health measure to prevent older people, those with a chronic condition, pregnant women and children becoming ill with flu and developing serious complications. The Health Board has some of the highest community flu vaccination uptake rates in Wales and in 2017/18 implemented a focussed programme to improve uptake by Health Board staff.

To maintain and improve uptake of population immunisation programmes the Health Board will:

- Work with partners in NCNs to improve uptake of MMR vaccinations across the Health Board to meet the 95% uptake required to achieve population herd immunity.
- Extend the roll-out of the school based flu vaccination programme, in primary school aged children, in line with national guidance (subject to funding).
- Improve uptake of flu vaccine in 2 to 3 year old children, delivered by General Practices.
- Build on the 2017/18 programme to achieve the 60% target and increase influenza uptake by Health Board front line staff.
- Maintain position as leading Welsh Health Board performance on influenza immunisation for over 65 year olds and those in at risk groups and reduce the variation in uptake through peer-led improvement at NCN level.

3.1.7 Population Health Protection

The Public Health Wales local Health Protection Team is responsible for protecting the population from infectious diseases and environmental threats to health, through the surveillance, prevention and control of communicable diseases, vaccine-preventable diseases and non-communicable public health incidents. It provides a local presence as part of a national health protection service that offers a source of expert reactive and proactive services that contribute to reductions in morbidity and mortality (including inequalities) linked to infections and environmental hazards. The Health Protection Team works closely with and reports regularly to the Health Board's Director of Public Health who has accountability for the Health Protection agenda.

Over the past few years, the TB Service in the Health Board along with Public Health Wales' Health Protection Team have noticed an increase in numbers and complexity of TB cases being notified within the Health Board area. This complexity includes cases at risk of becoming multi-drug resistant and some infectious cases refusing to be compliant with their treatment regime.

Air quality remains a persistent public health concern locally and the Health Board are committed to supporting wider NHS and Welsh Government air quality management policy. New guidance from Welsh Government requires the NHS in Wales to support others to assess and appropriately prioritise air pollution in local areas, engage senior local decision-makers to take action on air pollution, communicate with the public (including patients) about local air pollution, and champion air quality improvement both outside and inside their organisations. There is an opportunity to maximise environmental sustainability of the Grange University Hospital development while at the same time protecting and improving public health e.g. minimising air quality impacts from NHS facilities and services through the introduction of sustainable travel systems that discourage vehicle use and promote active travel.

To protect the population from infectious diseases and environmental threats to health, the Health Board will:

- Support Public Health Wales to review and revise the Communicable Disease Outbreak Plan for Wales to clarify the statutory responsibilities of both organisations during an outbreak investigation.
- Identify and mitigate potential environmental public health problems associated with the development of the Grange University Hospital (Specialist Critical Care Centre), supported by Public Health Wales' Health Protection Team who will provide advice to inform local planning

decisions to maximise environmental sustainability while at the same time protecting and improving public health.

- Work with Public Health Wales' Health Protection Team to undertake a needs assessment for Tuberculosis. The needs assessment can subsequently be used to assist Health Board colleagues with the planning of future TB service delivery.

The following table sets out the links to key enablers including finance, workforce and capital at a high level.

Table 3.1.2

Key Theme	Reducing health Inequalities and improving population health
Finance	Funding implications have either been secured through national funding sources or included in the service investments within the financial plan. Funding for Childhood Obesity been included within the financial plan for 2016/17
Workforce	Additional workforce to support Childhood Obesity programme have been recruited to.
Capital	No capital implications

3.2.1 Introduction

The Parliamentary Review into Health and Social Care in Wales states that the

“Growing demand for care in the face of modest economic growth means that health and care services must change and adapt to best meet need and help people achieve the outcomes they desire. As we will show, the health and care system is not sustainable into the future in its current form; change which delivers major improvement to services is urgently required much faster than in the past.”

This Service Change Plan focuses on developing an integrated, sustainable primary, community and social care system on a Neighbourhood Care Network (NCN) footprint over the next 5 to 10 years that will achieve the ambitions of the Wellbeing of Future Generations Act, the Social Services and Wellbeing Act. The content of this SCP is aligned to the Greater Gwent Regional Partnership Area Plan (the Gwent Area Plan) and the five Public Service Board (PSB) Well-being Plans across the Gwent area. This SCP responds to the findings of the Parliamentary Review and provides the mechanism for system change at greater pace.

3.2.2 Our ambition: an integrated, locality based system

Our ambition is to create a truly integrated, locality-based system of health, social care and well-being services. These locality based systems will be capable of sustaining consistent and high quality care, but with an ability to change and adapt to meet local needs and circumstance.

The Gwent Clinical Futures system transformation programme will provide the mechanism for moving services and resources from a hospital setting to a community setting and implementing new models of locality based care underpinned by the principles of Prudent Healthcare. The emphasis will be on providing services in partnership with patients using co-production as the means to maximise self-management and decision making and appropriate support from a skilled, multi-professional workforce.

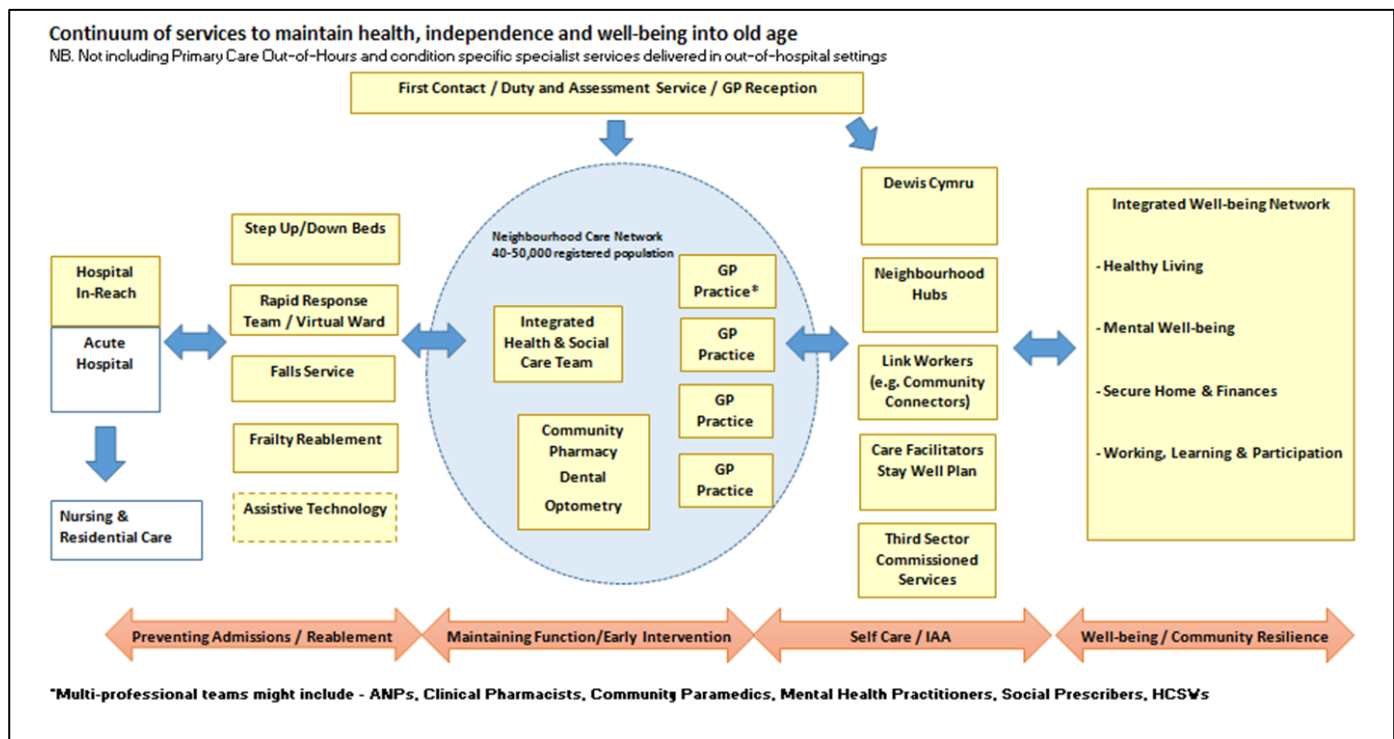
The Clinical Futures framework for an integrated, locality based system is structured into four tiers:

1. People staying healthy and well;
2. Self-Care;
3. Primary Care and NCN Team;
4. NCN Hub with specialist and enhanced services.

The emphasis is on delivering more care closer to home, through integrated health and social care teams, built around NCNs and adopting the design principles agreed in the Gwent Care Closer to Home strategy. The framework will enable coordination of activity across the Health Board's divisions in collaboration with partners in local government and the third sector to provide universal services as well as additional support for vulnerable groups including the homeless, gypsy and travellers, asylum seekers and prisoners.

Unpaid carers are the single largest provider of care to people with support needs in our communities. Carers hold families together, enable loved ones to get the most out of life and make an enormous contribution to society. They save the NHS and Social Services millions of pounds a year. The implementation of integrated, locality systems of health, social care and wellbeing services will better meet the needs of carers including prevention and early intervention, advocacy, flexible respite and transition.

Figure 3.2.1



3.2.3 Leadership and organisation development: Neighbourhood Care Networks

Neighbourhood Care Networks (NCNs) bring together a range of professionals as a complete care community – drawn from GP surgeries, community services, mental health, social care providers and the voluntary sector – to focus on local population needs and provide care closer to patients' homes. The purpose of NCNs is to plan and deliver:

- Provision of integrated, locality based services for a defined, registered population of 40,000 to 50,000 people.
- Whole population approach to care and well-being.
- An integrated, multi-disciplinary workforce.
- Home to home pathways of care.

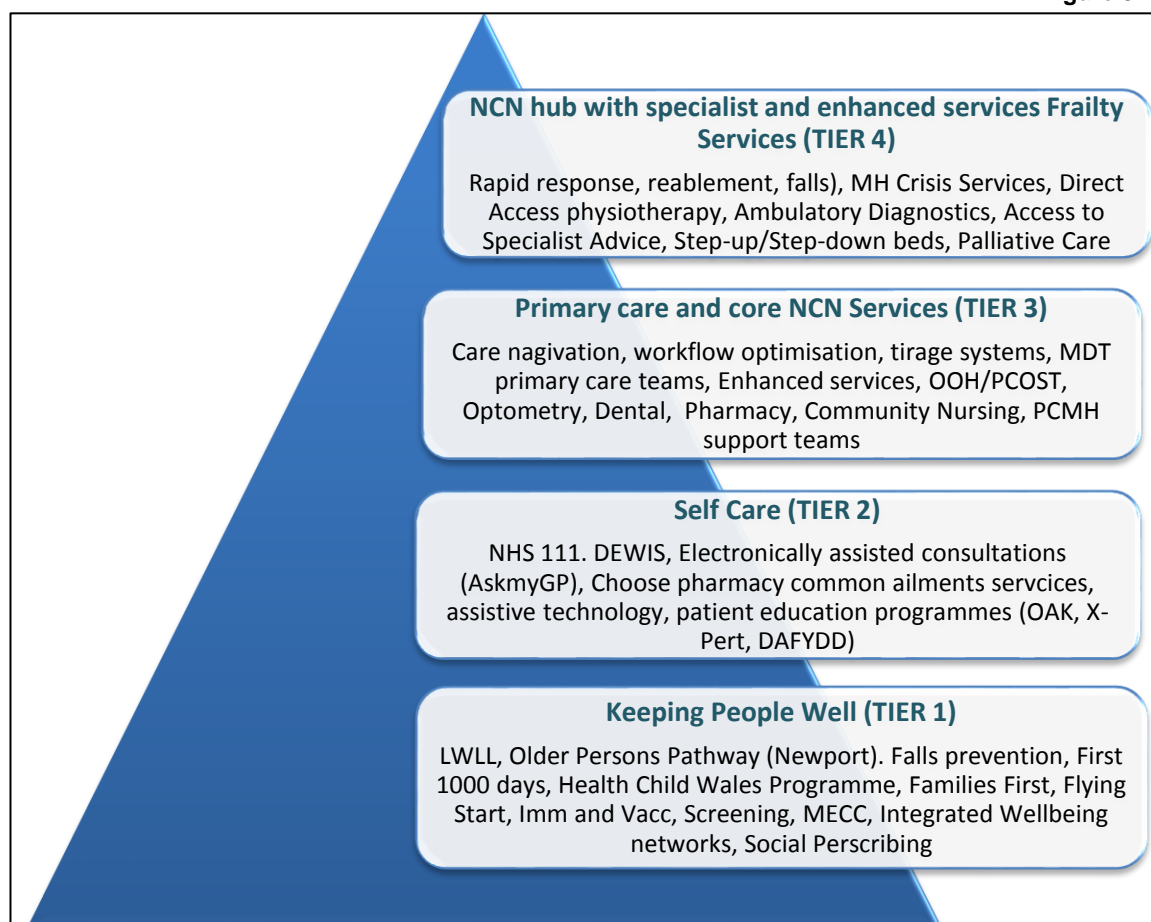
Through NCNs there is an opportunity to establish place-based, integrated systems of care in which organisations collaborate to address the challenges they collectively face and improve the health and well-being of their local populations. This will require organisations to adopt the five ways of working specified in the Wellbeing of Future Generations Act. Achieving this culture change will need joint organisational development programmes to build the trust, skills and relationships needed to successfully work across organisational boundaries and reconfigure services to achieve improved population outcomes.

The creation of an integrated community based system, that cross cuts organisational boundaries and drives partnership working across budgets, workforce and practice is challenging, and requires an alignment across all SCP's to describe a whole systems approach to transformational change. Our approach to this alignment is set out in the following figure.

Figure 3.2.2



Figure 3.2.3



Tier 1 – People staying healthy and well

SCP 1 aims to improve the health and well-being of the population with ABUHB, to reduce health inequalities. This outcome of greater health equity will also ensure the sustainability of our healthcare system. A key element of SCP 1 is the development of Integrated Well-being Networks, which draw together the health-enhancing community assets within NCNs. This SCP highlights the need for mechanisms for linking patients to these well-being services, including the infrastructure required for social prescribing.

Tier 2- Self Care

Empowerment and patient activation are concepts, which describes the knowledge, skills and confidence a person has in managing their own health and care. This concept links to all the principles of person-centred care, and enables the delivery of personalised care that supports people to recognise and develop their own strengths and abilities. It underpins an approach that supports people to develop their capability to manage their own health and care by giving them information they can understand and act on, and providing them with support that is tailored to their needs.

Choosing Wisely Wales, now known as Making Choices Together is a movement which encourages open conversations between patients and their clinicians, to rebalance decision making to be shared and personalised to that individual. It provides patients with the tools to enable them to make informed choices about their health based on sound evidence relating to their condition. The approach is supported by tools which encourage patients to take control of their own health and where possible, to take ownership of the management of their condition. The tools are centred on

prompting shared decision making by asking 4 key questions which are supported by easy read factual resources about their condition.

Figure 3.2.3 - Making Choices Together – 4 key questions



This provides patients with clear information about their condition in an understandable format including an easy read version and details on how to manage their condition including where appropriate, making lifestyle choices for themselves, which may modify the course and progression of the disease. Often this will lead to patients choosing less invasive or self-care options tailored to their own personal needs, which may avoid tests and treatments which may be of marginal benefit to them, or might even be harmful. Making Choices Together requires a significant shift in professional practice prompted by the 4 key questions and supported by a range of patient education resources that support this new approach.

Ensuring people have the information, technology and skills to treat minor illnesses and manage long term conditions at home or in the local community is enables people to choose well and self-care to avoid unnecessary or inappropriate treatment. In light of this there is a need to drive forward the services, information and assistance to support people to self-care effectively.

To ensure people have the information, technology and skills to act as empowered and education patients, and treat minor illnesses and manage long term conditions at home or in the primary care facility, the Health Board will:

- Implement NHS 111, the new number for urgent but non-emergency calls, which allows patients to speak with a trained adviser about whether they can self-care or need an appointment with a health professional.
- Support regional implementation of Dewis Cymru the national platform and online directory of well-being services in local communities.
- Use emerging ICT platforms (e.g. apps, podcasts, online videos, e-learning) to provide information and advice about self-care or therapeutic options within clinical care pathways for MSK conditions and diabetes.
- Review the evidence base for assistive technology and tele-health as means of supporting people to maintain their independence at home and receive self-care advice using telecommunications.
- Invest in a pathfinder programme and online portal which allows patients to check their symptoms, self-care and share information with the GP surgery to assist with triage.
- Continue to implement the Choose Pharmacy common ailments service.
- Implement Choosing Wisely / Making Choices Together to ensure that initial conversations are informed by the evidence base and provide the outcomes patients want and, where appropriate, consider self-care options.
- Agree a strategic approach for the provision of patient education groups that provided extended support for patients with a wide range of conditions (e.g. low back pain, glaucoma) including the monitoring outcomes.

Tier 3 – Primary Care and NCN Team

The challenges to the sustainability of primary care in the past five years have been greater than those in the preceding 65 years. This challenge remains the main focus for this SCP as stability and sustainability of primary care is a prerequisite for standardisations and transformation of the wider system. The response set out in this SCP reflects:

- Clinical demands, demography and a changing profile of morbidity.
- Public and political expectations.
- Complexity within the system and interfaces with secondary care and other agencies.
- Workforce and working patterns.
- Health inequalities and the inverse care law.

Welsh Government pacesetter funding has informed an Emerging Model of Primary Care which is recognises the need for a more differentiated workforce, collaborative working (often at greater scale), more anticipatory approaches and patients taking greater responsibility for their own care. There is an opportunity to pilot the components of the emerging model with 3 GP practices that are directly managed within the Primary Care and Community Service Division.

To provide stable, sustainable and accessible primary care services, supported by more efficient systems, the Health Board will:

- Implement the agreed plan for securing the medical workforce in primary care through a senior retainer scheme, modernise GP pay scales, a practitioner settlement scheme and GP fellowships.
- Pilot the Emerging Model of Primary Care through the 3 GP practice that are directly managed by the Health Board and share learning through the NCNs.
- Implement receptionist care navigation training to ensure patients are directed to the most appropriate service or professional to meet their needs.
- Implement workflow optimisation as a new method for dealing with clinical correspondence, to ease the administrative burden for GPs and other clinical staff.
- Introduce a more differentiated workforce within primary care through the development of advanced practice roles, including clinical pharmacists and advance nurse practitioners, and maximising the use of their independent prescribing status to complete episodes of care.
- Complete the reconfiguration of the Urgent Primary Care Out-of-Hours Service including the potential for Paediatric ANP and Advanced Paramedic roles.

The Health Board will continue to create locality-based integrated teams to proactively manage patients that require extended support or have complex needs and provide a rapid response when a patient's condition deteriorates.

To build an integrated NCN team around primary care, the Health Board will:

- Build capacity and capability in practice to address the inverse care law areas through a Primary Care Well-being Service to complete CVD risk assessment of 40-65 year olds and undertake clinical and lifestyle management of high risk patients, supported by a CVD dashboard and standardised searches to improve recall of 'off target' patients (2019/20).
- Explore the potential for NCN financial incentives, to replace the 'Living Well, Living Longer' local enhanced service, where the combined network attainment exceeds the targets set for CVD risk assessment and management (2020/21).
- Conduct a pharmaceutical needs assessment and scope the potential for scaling up Health Living Pharmacies as part of the universal platform for CVD prevention across Gwent (2020/21).
- Review the current community nursing provision (including Urgent Primary Care Out-of-Hours, District Nursing, Rapid Response Nursing) and develop a more integrated and efficient model.
- Further develop the stepped model of Primary Care Mental Health Support Service to include early intervention CAMHS, low intensity interventions for adults and universally accessible self-help psychoeducational interventions (Road to Well-being Programme).

- Implement the Frailty Service Action Plan, following the recent review, to include strengthening of the interface with Primary Care OOH and admission avoidance following episodes of care provided by the Community Resource Team.
- Continue to develop integrated community teams in partnership with local authorities.
- Pilot learning from the Buurtzorg model, which has shown how self-managed community nursing teams, who work in small neighbourhoods, can build nursing capability, promote self-management and boost morale within the profession.
- Evaluate Social Workers based in GP surgeries in Caerphilly which aim to increase dialogue and joint working between general practice and social services and improve preventive work with vulnerable patients to help them continue to live independently.
- Develop a consistent method of social prescribing (e.g. through Dewis Cymru, community connectors, social prescribers) to support patients with social, financial and housing support needs.
- Engage with WAST to provide a community paramedic service to undertake GP home visits, support care home staff to manage non-injurious falls and consolidate the Falls Response Service.
- Use the capital developments in Blaenau Gwent West (Tredegar), Blaenau Gwent East (Brynmaur) and Newport East as the catalyst for further integration.

Tier 4- NCN Hub with specialist and enhanced services

NCN clinical lead, through their work with secondary care specialties, will assist in the development of home-to-home clinical pathways within the Clinical Futures model. These new pathways will improve access to timely specialist advice for both planned and urgent care, via local clinics and home visits, as well as cost-effective diagnostics close to home. A recent review of shifting the balance of care suggests where schemes have been most successful, they have:

- targeted particular patient populations (such as those in nursing homes or the end of life);
- improved access to specialist expertise in the community;
- provided active support to patients including continuity of care;
- appropriately supported and trained staff in the community; and
- addressed gaps rather than duplicating or destabilising existing services

The Health Board is investing in the analytical capacity and capability to demonstrate the impact of shifting resources from secondary to primary care with standardised metrics on cost and outcomes.

To provide more specialist planned care, the Health Board will:

- Consolidate existing services transferred out-of-hospital settings including the ophthalmic diagnostic and treatment centres, extended skin surgery, diabetic nurse specialist teams and respiratory nursing teams.
- Engage NCNs in service redesign to identify alternatives to secondary care referrals to reduce waiting times and improve patient experience and quality of care (e.g. speciality advice lines, community cardiology, primary care gynaecology services and MSK interface service).
- Support further system shifts in community audiology, enhanced general dental care and eye care services.
- Commission a comprehensive review of palliative care provision across Gwent.

To prevent unnecessary admissions to acute hospitals and facilitate early discharge where appropriate, the Health Board will:

- Provide a direct access physiotherapy service in primary care for patients with MSK conditions to reduce unnecessary GP appointments and waiting times and improve patient outcomes.
- Engage NCNs in pathway redesign to identify where rapid access to diagnostics in primary care and alternative methods of management (e.g. paediatric “hot” clinics) can provide a safe alternative to hospital admission.
- Engage NCNs to identify possible conditions which are suitable for ambulatory care being managed in a setting which avoids the need for referral to The Grange Hospital.

- Implement the organisation bed plan for community hospitals in line with the Clinical Futures Strategy and use NCNs to assess opportunities for optimising the use of community hospitals (e.g. urgent care and day services).
- Assess the demand for step-down beds and increase step-up capacity for use by GPs and Rapid Medical Teams.
- Agree a consistent model of hospital in-reach to appropriately identify patients that require social work assessment and low level interventions to allow safe discharge and prevent delayed transfers of care.
- Extend learning from 'My Care, My Home' to establish a standardised discharge to assess model across Gwent.
- Review the future of community hospitals taking account of demand for step-down beds (e.g. consultant-led, nurse-led & therapy-led wards) and the potential for greater step-up capacity for use by the NCNs (e.g. GPs and Rapid Medical Teams).

3.2.4 Development of a new financial model

Ensuring an effective and sustainable financial system that underpins the delivery of SCP 2, is critical and is a key action as part of the Clinical Futures programme for 2018-19. During 2018 dedicated work will be undertaken to identify where those shifts in resource allocation from secondary to primary care are required to facilitate the development of a sustainable financial system at Level 1 of Clinical Futures.

It is critical that resourcing decisions (new investment or shifts) support effective, efficient and sustainable services that improve outcomes for patients and improve the value of the service both allocative and technically whilst ensuring patient relevant outcomes are the driver. Limiting factors will be a key consideration of the sustainability of a future service. Measures and metrics will be critical to ongoing evaluation and the opportunity provided by the digital agenda should be used to support service improvement.

A three pronged resourcing strategy will be developed to drive the delivery of a new integrated financial system as part of SCP 2 and will consider the need to:

- Prioritise investment in business cases where effectiveness, efficiency and sustainability is demonstrated and fit with strategic Level 1 deliverables.
- Shift services and associated resources from acute to community/primary care setting where evidence proves this is the optimal approach.
- Evaluate and determine the future position on existing community and primary care services where they are substantive or pilot schemes, i.e. stop or do more or do differently.
- The resources of all partners should be considered where these services promote integration to ensure the 'citizen' offering and public service value is improved. Where appropriate, pooled budgets may offer an opportunity to catalyse joint working and integration.

A sustainable financial approach requires a health economy to define and measure population outcomes, puts in place budgets covering the whole of a population's care and align contracts or service agreements to those outcomes. The Canterbury Clinical Network in New Zealand is one example where organisations involved in delivering health and care services have come together to lead clinical service improvements collectively across their local system. The network is led by an alliance leadership team and supported by a dedicated alliance support team. Different work streams and service level agreements fit within a single governance structure, which is underpinned by a 'one-system, one-budget' approach.

Integrated service boards allow the resources of all partners to be taken into account when considering the outcomes that arise from the whole systems of care. Local people care about the quality, responsiveness and relevance of the services they receive and are less concerned about who supplies them. Pooled and aligned budgets can often deliver more efficient and effective services that better meet local needs. The development of a sustainable financial model should promote sensible and collaborative behaviour, leading to better outcomes and value for money.

3.2.5 Maximising our workforce potential

The vast majority of NHS contacts are in primary care and community service. These services are experiencing unprecedented and changing patterns of demand at a time of increasing financial pressures. The workforce is our greatest asset and more needs to be done to recognise where high quality care is provided, whilst also reducing inappropriate variation.

There needs to be an ongoing shift in workforce planning to create integrated, person-centred teams. Future models of care will require a change in the typical skill mix, with greater emphasis placed on generalist rather than the traditional specialist roles. This approach should allow greater continuity of care and reduce the frequency of hand-offs between professionals.

Investment in leadership development will also be critical. Effective teams require three different types of expertise - system leadership, technical expertise and day-to-day operational leadership. NCNs should ensure that there is sufficient expertise in these areas to support their improvement efforts.

Jönköping County Council is best known for its work on quality improvement and developing integrated health and care services. Staff and clinical teams have been encouraged to work together to think about how they can deliver the best outcomes for a fictional elderly resident, Esther, enabling them to map services that people receive across different settings and explore how they can be improved across systems. The benefits of this approach have included significant reductions in hospital admissions, days spent in hospital and waiting times for specialist appointments.

SCP 3 – Management of Major Health Conditions

This SCP aims to deliver more systematic and proactive management of major health conditions to improve health outcomes, reduce inappropriate use of hospital services and have a significant impact on reducing health inequalities.

3.3.1 Introduction

This Service Change Plan addresses the nine major health conditions which are subject of a Welsh Government Delivery Plan and the SCP aligns to the national priorities set out by each of the National Implementation Groups. Detailed progress reports for the conditions detailing progress and achievements in 2017-18 can be found here: [<Hyperlink to Major Health Conditions Progress Reports \(Web\)>](#).

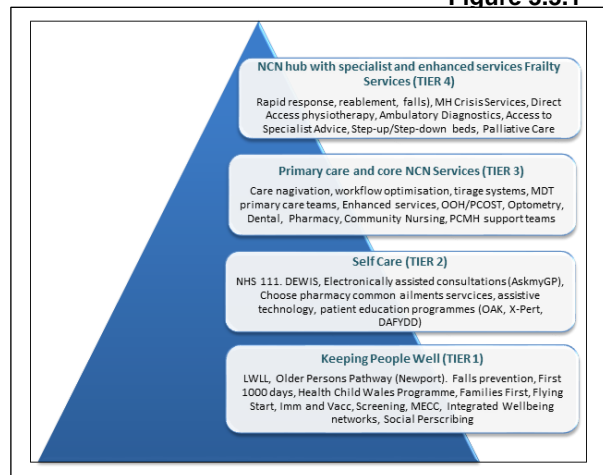
The emphasis of SCP3 is on a strategic approach to delivering change across the Major Health Conditions where there is value in managing change across divisions, directorates, corporate structures and partnerships. As the new model of care is developed by the Health Board in collaboration with its partners towards realising Clinical Futures, the Major Health Conditions Planning and Delivery Groups are extremely well placed to co-produce some of the design work due to their multidisciplinary clinical engagement with patients, patient groups, directorates and divisions, local authorities and third sector partners and focus on the vision of a fully integrated model delivered through the 10 high impact actions leading to seamless pathways of care. Improving

community capacity to support improved health behaviours such as reducing or stopping smoking, preventing and managing obesity, increasing exercise and reducing alcohol consumptions will be a priority as will identifying early in the pathways if people need care or support to prevent ill health or decline in wellbeing. Reducing unnecessary hospital admissions through responsive and accessible integrated community capacity and locally integrated health, social services and third sector provision will help to achieve the vision of care closer to home or provided at home for people with Major Health Conditions.

Figure 3.3.2



Figure 3.3.1



In a change of approach to that specified in the previous iteration of the IMTP, existing governance structures are being used instead of setting up a new Major Health Conditions Board. The advantage of this approach is in the maintenance of a clear, effective governance and delivery framework with an overarching prevention strategy and recognition of the interdependence of prevention activities across multiple conditions. Appendix <> indicates the known interdependencies between the conditions, other service change programmes, directorate and divisional plans.

3.3.2 Stroke

A key example of the approach mentioned above is the changes in the stroke pathway implemented in January 2016, including the establishment of a Hyper-acute Stroke Unit and Community Neuro-rehabilitation Service.

Our performance against Sentinel Stroke National Audit Programme standards and Welsh Government Quality Improvement Measures has improved significantly since re-design and the improvement was sustained throughout 2016-17. Stroke care is now carried out in four specialist stroke units which are now more able to meet the standards set by the Royal College of Physicians and assessed through the Sentinel Stroke National Audit Project. However; more needs to be done

to ensure that our stroke services consistently meet the required standards across the whole pathway and to achieve the Stroke Quality Improvement Measures targets consistently.

Our focus is to fully realise the stated benefits of the Stroke Services Re-design Programme and make progress with further areas for improvement identified in a recent evaluation of the programme. A business case will be developed to move the service towards full alignment with the Clinical Futures Programme by 2021.

Increasingly, outcomes will be measured through the collection of PROMs and PREMs. ABUHB is leading an all-Wales research project to validate a tool to determine patient outcomes through use of Patient Recorded Outcomes Measures (PROMS) in Stroke.

Preventing stroke through appropriate identification and treatment of Atrial Fibrillation (AF) remains a priority and the Stroke Planning and Delivery Group will determine the actions needed to improve the management of childhood stroke and to develop the pathway for thrombectomy with tertiary partners and commissioners.

In a collaborative research project with ABCi improvement team, research has commenced into the location, age, gender and deprivation patients who arrive outside of the time window for thrombolysis treatment.

Table 3.3.2 - Stroke Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Reduced health inequalities and improved population health	<ul style="list-style-type: none"> ▪ Achieve the priorities for reducing health inequalities and improving population health set out in SCP1
Prevent stroke through identification and appropriate management of Individuals with Atrial Fibrillation (AF)	<ul style="list-style-type: none"> ▪ Review the evaluation of outcomes from Living Well Living Longer Programme in identifying and ensuring impact on identification and management of atrial fibrillation ▪ Agree an action plan based on outcomes from the evaluation
Improved quality of care for people suspected of having a stroke	<ul style="list-style-type: none"> ▪ Evaluate alignment of the agreed stroke pathway with the Clinical Futures strategy ▪ Develop a business case to ensure full alignment with the Clinical Futures ▪ Agree a protocol for protection of HASU beds during periods of winter pressure
Improved access to thrombectomy following a stroke	<ul style="list-style-type: none"> ▪ Define the pathway and referral criteria for thrombectomy ▪ Agreed pathway and referral criteria for thrombectomy with commissioners and providers ▪ Agree an action plan for future access to thrombectomy
Improved management of childhood stroke	<ul style="list-style-type: none"> ▪ Agree a plan to improve the management of childhood stroke
Improved continence care following stroke	<ul style="list-style-type: none"> ▪ Agree an action plan for educating staff on high-quality continence care following a stroke
Improved information and services based research and patient outcomes	<ul style="list-style-type: none"> ▪ Evaluation report on Stroke PROMs R&D Project ▪ Validated stroke PROMs tool available for use in Wales ▪ Maximise the benefits of stroke research

3.3.3 Heart Disease

The Health Board is making good progress with delivering prudent pathways for people with heart disease and is developing a plan to upscale population-based risk assessment and prevention whilst improving waiting times, access and diagnostics. Improved services for cardiac patients will increasingly be based on measurable patient outcomes aided by progress with the Heart Failure ICHOM project and use of PROMs to drive service improvement

Funding allocated by the All Wales Heart Disease Delivery Group is supporting developments in community cardiology with community cardiology clinics at three sites across Gwent and recruitment of three GPs with a special interest in cardiology who are being trained at Bradford University's established Postgraduate Diploma in Cardiology course with support from local cardiologist mentors.

The community cardiology initiative supports open access to selected cardiac diagnostics closer to home; development of pathways for common heart conditions; cardiologists working alongside GPs in the community; improved communication, appropriateness of referrals, dissemination of knowledge and confidence managing cardiac problems in the community; collaborative working with existing community teams including heart failure service; reduction in waiting times and referral demand thereby improving access to secondary care for patients with more serious conditions.

Replacement of equipment is providing additional interventional and diagnostic capacity along with on-line access to cardiac investigation reports and images to support timely access to diagnosis and treatment. The All-Wales Accelerated Cardiac Informatics (AWACI) Project to improve the availability of appropriate patient information at all stages of a heart patient's journey with accelerated developments and implementation of the Welsh Clinical Portal e.g. electronic diagnostic testing.

Table 3.3.3 - Heart Disease Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Reduced health inequalities and improved population health	<ul style="list-style-type: none"> ▪ Achieve the priorities for reducing health inequalities and improving population health set out in SCP1
Timely access to cardiac diagnostics and treatment	<ul style="list-style-type: none"> ▪ Improved access to interventional cardiology diagnostics and treatment ▪ Phased increase in catheter lab sessions facilitated through a second catheter lab at RGH ▪ Complete roll out of community cardiology clinics
Improved approach to RTT based on clinical need	<ul style="list-style-type: none"> ▪ Agreed implementation plan for new approach to RTT based on clinical need ▪ Contribution to a national proposal for the introduction of a new approach to a managing RTT
Improved survival following Out of Hospital Cardiac Arrest	<ul style="list-style-type: none"> ▪ Implement recommendations of the Out of Hospital Cardiac Arrest Plan for Wales ▪ Appropriate pathways and protocols in place for referral to rehabilitation services including cardiac rehabilitation. ▪ All OHCA survivors are assessed by a heart rhythm specialist prior to hospital discharge ▪ High quality individually tailored information relating to the potential psychological, physiological and social impact of OHCA.
Reduced inequity in the provision of heart failure rehabilitation for Newport and Caerphilly through service expansion	<ul style="list-style-type: none"> ▪ Action plan to address inequity in provision of heart failure rehabilitation and ensure that cardiac rehabilitation services meet national standards

3.3.4 Cancer

The Health Board wants people of all ages in the population to have a minimum risk of developing cancer through healthier lifestyles including reduction and stopping tobacco use, reduced alcohol consumption, healthy weight and increased physical activity and where cancer does occur, an excellent chance of survival. The National Patient Experience Survey 2016 identified many positive aspects within the Health Board that were considered good in comparison to other parts of Wales and reinforces that Health Board staff provided patients with dignity, privacy, care and compassion. The number of people living with the impact of cancer in Wales is increasing and a recent learning event for practice nurses gave an introduction to cancer supporting foundation knowledge in primary care. A new '*Cancer Thriving and Surviving Course*' co-ordinated through Public Health Wales is to be run by accredited volunteer tutors across Wales.

Nevill Hall Hospital is the preferred location for a new Radiotherapy Satellite Centre. Our focus is now to develop and agree outline and full business cases for the programme in partnership with Velindre Cancer Centre. A Systemic Anti-Cancer Therapy (SACT) workstream is established to map how the optimal SACT provision in partnership with Transforming Cancer Services (TCS).

Electronic prescribing is being implemented to unify chemotherapy prescribing throughout the Health Board along with other technological developments to further improve tracking information to facilitate improvements in diagnostic and treatment pathways and information for audit and capturing

outcomes in the future. Further investment in Primary Care is helping to further establish robust links between primary and secondary care. Macmillan Cancer Support has provided funding for an additional Upper Gastrointestinal Clinical Nurse Specialist Post and for benefit advisors to provide benefit advice for our Cancer Patients.

The One Stop Neck Lump Clinic is shortening the diagnostic pathway for head and neck cancer patients, enabling earlier treatment. Single Cancer Pathway monitoring was also successfully commenced.

Robust links for teenagers and young adults with cancer are helping to establish a recognised pathway and increasing access to appropriate treatment and care for people aged 16-24.

Table 3.3.4 - Cancer Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Reduced health inequalities and improved population health	<ul style="list-style-type: none"> ▪ Achieve the priorities for reducing health inequalities and improving population health set out in SCP1
Improved cancer services planning	<ul style="list-style-type: none"> ▪ Develop an updated 5 year plan for Cancer Services across the ABUHB.
Improved access and efficiency of cancer diagnostic pathways and treatment services	<ul style="list-style-type: none"> ▪ Develop single urgent cancer pathway ▪ Reduction in cancer waits in radiology and endoscopy in line with specific tumour site pathway Q1 ▪ Improved cancer pathway ▪ Improve performance for 62 and 31 day pathways
Improved access to acute oncology support	<ul style="list-style-type: none"> ▪ Extend and further develop the Acute Oncology Service with dedicated Oncology support Q3/4
Improved patient care for haematology inpatients	<ul style="list-style-type: none"> ▪ Develop a robust business case Q3 ▪ Develop a single Haematology in-patient facility ▪ Plan to ensure compliance with Nice Guidelines and Cancer Standards
Improved access to radiotherapy and strategic anti-cancer services	<ul style="list-style-type: none"> ▪ Develop outline and full business cases for the Transforming Cancer Services Programme (radiotherapy satellite centre and local cancer centre) in partnership with Velindre Cancer Centre
Improved services for breast cancer patients	<ul style="list-style-type: none"> ▪ Unify breast cancer services and the proposed new build on Ysbyty Ystrad Fawr site
Improved awareness of the symptoms of cancer amongst the general public	<ul style="list-style-type: none"> ▪ Increased awareness of the symptoms of cancer amongst the general public
Improved population uptake of Cancer Screening targeting our more deprived communities	<ul style="list-style-type: none"> ▪ Increased population uptake of Cancer Screening targeting our more deprived communities
Improved interface between primary and secondary care to support earlier diagnosis of cancer and survivorship	<ul style="list-style-type: none"> ▪ Develop an action plan to improve the interface between primary and secondary care to support earlier diagnosis of cancer and survivorship Q2
Improve Cancer Waiting Times and performance against both current and proposed Cancer Time to Treat Targets.	<ul style="list-style-type: none"> ▪ Improved Cancer Waiting Times and performance

3.3.5 Diabetes

The Diabetes Planning and Delivery Group has carefully considered its priorities and will focus on continuing its development of a robust business case for diabetes services. An interim locum consultant post has been established to provide antenatal cover for mothers with diabetes whilst a sustainable solution is agreed. Psychological and emotional support for children and young people with diabetes remains a priority and is being considered in the context of the wider need for a prudent approach to psychological support across a range of patient groups with diabetes.

A small number of insulin pumps were purchased, working with procurement services on a prudent approach until an all-Wales contract is agreed and a sustainable plan is in place for insulin pump technology.

'Think Glucose' was implemented at The Royal Gwent Hospital and Ysbyty Ystrad Fawr and there is now a renewed focus on identifying and training link nurses in diabetes management to ensure safe, high quality care.

Agreement was reached to initiate virtual clinics ensuring timely follow-up for diabetes patients approaching and past target follow-up date.

Table 3.3.5 - Diabetes Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Reduced health inequalities and improved population health	<ul style="list-style-type: none"> ▪ Achieve the priorities for reducing health inequalities and improving population health set out in SCP1
Ensure adequate staffing levels to ensure safe, high quality care for people with diabetes	<ul style="list-style-type: none"> ▪ Establish a robust business case for diabetes services ▪ Agree an action plan to implement options agreed from the Diabetes Services business case and local findings of the National Peer Review Report for Paediatric Diabetes Services
Improved psychological support for children and young people with diabetes	<ul style="list-style-type: none"> ▪ Increased psychological well-being ▪ Reduced risk of psychological or physical harm ▪ Increased diabetes team access to psychological ▪ Increased partner agency access to psychological consultation to support patients e.g. education
Improved transition care for children with diabetes moving to adult services	<ul style="list-style-type: none"> ▪ Develop an action plan for compliance with the new standards for transition of diabetes care to ensure safe, high quality transition for children with diabetes moving to adult services including establishment of a joint Paediatric/Adult Diabetes Transition Team
Improve availability of high quality information and educational resources to encourage self-management for people with diabetes	<ul style="list-style-type: none"> ▪ Agree an action plan to make high quality information and educational resources available ensuring:
Ensure adequate funding for insulin pump technology	<ul style="list-style-type: none"> ▪ Agree an action plan to ensure adequate funding for the diabetes service to support insulin pump technology for appropriate patients with type 1 diabetes ensuring that sufficient staff have expertise in safe Insulin Pump Therapy
Improve foot care for patients with diabetes	<ul style="list-style-type: none"> ▪ Implement an agreed foot screening tool for all in-patients with diabetes

3.3.6 Respiratory Conditions

The Health Board is aiming for people of all ages to value good lung health, to be aware of the dangers of smoking and take responsibility for their lifestyle choices, reducing the risk of acquiring a respiratory condition. When problems with lung health occur, individuals can expect early and accurate diagnosis and effective treatment so the quality of life can be optimised.

Our focus over this planning cycle is to reduce waiting times for lung cancer, improve access to pulmonary rehabilitation and develop a Non-invasive Ventilation (NIV) retrieval service. In the longer term the Health Board will re-design the respiratory nursing service across primary, secondary and community services working towards a 7 day consultant rota across RGH and NHH aligning to the Clinical Futures model.

A pilot of Pulmonary Rehabilitation service has begun, the evaluation of which will inform further development of the service. The 98% compliance with referral to treatment targets has been sustained whilst reducing the number of patients past target date. A second Advanced Nurse Practitioner was recruited and will enable the pilot of non-invasive ventilation to commence.

A business case was approved to appoint an additional consultant to clear the significant backlog of new outpatients and associated follow-ups in the sleep service and addressing resultant clinical risks. This case enables an efficient and uniform patient pathway with streamlined use of diagnostic and treatment pathways. Appointment of a consultant will also enable the longer term sustainability of the local service by training a specialist sleep practitioner as part of a succession plan and a longer term vision to develop a Sleep Medicine Centre (SMC) for Wales.

Table 3.3.6 - Respiratory Conditions Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Reduced health inequalities and improved population health	<ul style="list-style-type: none"> ▪ Achieve the priorities for reducing health inequalities and improving population health set out in SCP1
Improved access to pulmonary rehabilitation across ABUHB population	<ul style="list-style-type: none"> ▪ Increased access to pulmonary rehabilitation programmes ▪ Improved quality of life ▪ Reduced length of stay
Improved care for patients requiring non-invasive ventilation	<ul style="list-style-type: none"> ▪ Development of Non-invasive Ventilation (NIV) retrieval Service ▪ Improved NIV retrieval ▪ Improved quality of life ▪ Increased patient flow through resuscitation beds ▪ Reduced bed-blocking
Improved access to respiratory nursing support	<ul style="list-style-type: none"> ▪ Business case for a redesigned respiratory nursing service across primary, community and secondary care
7 day consultant cover across all sites	<ul style="list-style-type: none"> ▪ Business case to move towards 7 day consultant rota across all sites flexible to suit needs of service ▪ Increased flexibility to suit needs of respiratory patients

3.3.7 Care of the Critically Ill

Patients should have timely access to, and discharge from, clinically effective critical care where appropriate for their condition and needs and clinically effective care in the correct facility with highly qualified specialists. Patients and carers should be as involved in their care as they feel appropriate.

The key priority following the Health Minister's confirmation of the SCCC is to move towards a unified critical care service on one site, allied to good recognition of deteriorating and critically ill patients and safe transfer to a critical care unit which meets recognised service requirements. In addition the successful post-anaesthetic care unit (PACU) model will be sustained, which is improving patient safety in the post-operative period, with consideration given to 7 day working. The Health Board will also continue to improve sustainability of the critical care workforce, improving staff to patient ratios where possible.

Success with the business case for outreach services will help to ensure appropriate management of deteriorating patients. It is also aimed to reduce the number of hours lost to Delayed Transfers of Care (DTOCs) by 10% every quarter until a position of no more than 5% of bed occupancy lost to DTOC is achieved.

Table 3.3.7 - Care of the Critically Ill Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Improved patient safety in the post-operative period	<ul style="list-style-type: none"> ▪ Further develop the PACU to improve patient safety in the post-operative period. ▪ Confirm Clinical Futures service model for PACU ▪ Determine the need for ACCP to cover gaps in the junior medical rota and facilitate Deanery rota compliance (1:11) ▪ Consider 7 day working ▪ Reduced elective cancellations ▪ Reduction in referral to treatment time for elective cases ▪ Reduce delayed transfers of care (DTOC) to no more than 5% of bed occupancy lost to DTOC ▪ DTOC Reduced by 10% per quarter
Improved staff to patient ratios	<ul style="list-style-type: none"> ▪ More critical care follow-up clinics ▪ Increased HDU consultant cover at weekends ▪ Meet medical staffing to patient ratios at the Royal Gwent site through consultant recruitment ▪ Medical workforce plan including exploration of middle grade posts
Improved sustainability of the critical care workforce	<ul style="list-style-type: none"> ▪ Continue the Advanced Critical Care Practitioner (ACCP) programme.
Improved Critical Care Outreach Service	<ul style="list-style-type: none"> ▪ Seek executive approval for the business case and implement, and expanded Critical Care Outreach Service

3.3.8 Neurological Conditions

ABUHB continues to work with a broad range of partners to raise public awareness across the neurological conditions including timely and appropriate education and training for patients and their families for multiple sclerosis (MS), epilepsy, Parkinson's disease (PD) and Motor Neurone Disease (MND). Recent changes have improved access to MS infusions and recruitment of a second epilepsy nurse is helping to increased numbers of eligible patients are able to access treatment on a timely basis, reduce the number of patient relapses and reduced re-admissions. Patient Reported Outcomes Measures (PROMS) are now in use across all Parkinson's clinics.

People should have access to services which promote healthy living and prevent the complications associated with neurological conditions and the Health Board will be prioritising patient-centred multi-disciplinary team services and patient-centred approaches to co-ordination and co-production of care whilst continuing to progress expansion of access to neurological services and reduction in waiting times for neurological patients. In common with a number of the major health conditions, improving access generally along with diagnosis and psychological care for neurological patients are also priorities.

Table 3.3.8 - Neurological Conditions Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Improved coordination and co-production of neurological care	<ul style="list-style-type: none">▪ Patient centred MDT services▪ Patient centred meetings including accessible and appropriate venues
Improved access for neurological outpatients	<ul style="list-style-type: none">▪ Reduction in waiting time for neurological outpatients
Improved access to neurological services including diagnostics	<ul style="list-style-type: none">▪ Action plan for expansion of Neurological Services including diagnostics▪ Business case for expansion of neurological services▪ Action plan to establish an ABUHB Dystonia Clinic▪ Action plan to expand neurological management clinics (non-medical injectors, BTX-An injections, Botox service etc.)
Improved access to clinical psychology for neurological patients	<ul style="list-style-type: none">▪ Action plan to provide clinical psychology for neurological patients

3.3.9 Liver Disease

The Health Board is a national pathfinder in timely detection of liver disease. A pilot project looking at the earlier detection for advanced liver disease in people having liver blood tests in primary care and electronic alerts for abnormal liver function tests is being evaluated to determine how stronger links with primary care can be built, supported by guidelines and rapid access to specialist advice ensuring high quality liver care across the whole pathway.

Facilitated by the new All Gwent Alcohol Pathway Group an alcohol care team including alcohol liaison nurses was introduced with funding from the Liver Disease Implementation Group. Due to the success of this collaborative model of working that the Area Planning Board has funded a full time in reach worker at the Royal Gwent site to further strengthen the links and develop the service with a particular focus on repeat attenders.

The advice delivered to people assessed via the Living Well Living Longer Programme was modified to incorporate a discussion around risk of liver disease when the appropriate measured risk factors are present, improving public knowledge of the risk factors for liver disease and how that risk can be minimised. A handbook for nurses on the management of liver disease is now available and supported by an annual training event.

In collaboration with the Gwent LMC the Health Board piloted a novel project aimed at improving the early detection of liver disease and involves automatic calculation of a ratio (AST:ALT) to identify patients at high risk of significant fibrotic liver disease. Gwent LMC are now adopting the whole LFT pathway as a quality improvement programme and this has also been shared with GPC Wales with

a view to Wales-wide adoption

A weekly complex liver disease MDT was set up on the Royal Gwent site to discuss those admitted with chronic liver failure aimed at improving recognition of the slowly deteriorating liver patient and enhancing decision making about levels of escalation and involvement of palliative care where appropriate.

The Gwent Liver Unit continues to be research active having had multiple abstracts published at national or international liver conferences and a manuscript has been submitted to a major, high impact journal for consideration of publication and another 2 are in development.

Table 3.3.9 - Liver Disease Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Reduced health inequalities and improved population health	<ul style="list-style-type: none"> ▪ Achieve the priorities for reducing health inequalities and improving population health set out in SCP1
Improved liver disease care	<ul style="list-style-type: none"> ▪ Finalise the business case for dietetic support ▪ Finalise the job description for a band 6 hepatology specialist nurse to allow for diversification of the service in line with the aims of the plan ▪ Complete the recruitment of the additional 2 consultants with an interest in hepatology ▪ Work with the values based team and the director of planning to secure the long term future of the alcohol care team ▪ Introduce the BASL care bundle to the medical assessment unit and
Improved information for liver disease	<ul style="list-style-type: none"> ▪ Embed the alcohol screening tool in the A&E electronic health record ▪ Complete development of a junior doctors handbook ▪ Complete development of short, focussed clinical guidelines on liver disease
Improved palliative care for liver disease	<ul style="list-style-type: none"> ▪ Strengthen the palliative care pathway for liver disease through learning from the complex disease MDT

3.3.10 End of Life Care

For our population, the Health Board want people in Gwent to have an appropriate, healthy and realistic approach to dying and for people dying in Gwent to have access to high quality care wherever they live and die, whatever their underlying disease or disability and devoid of any prejudice in relation to their personal situation.

The main focus has been to promote and embed the principles of Advance Care Planning (ACP) into practice. A collaborative approach between ABUHB and the third sector led to several developments supporting the ACP agenda including a collaborative launch focused on the 3 main areas of engagement, education and empowerment (*Triple E*). A Public Engagement and Communications Strategy for Advance Care Planning was developed and is being implemented alongside an e-learning programme to provide access to education across Wales.

A research proposal is agreed and retrospective data collected as a baseline for a pilot project supporting respiratory teams in outpatients department to evaluate whether education and facilitation improve ACP discussion and documentation.

The Health Board is an Ambassador for Bwy Nawr (Live Now) and the agenda is integrated within all our public events. The Health Board have contributed to several national Byw Nawr events.

Table 3.3.10 - End of Life Care Planning and Delivery Group Priorities

Priority/Benefit	Outputs/Outcomes
Sustainable and equitable end of life care in all settings	<ul style="list-style-type: none"> ▪ Modernise models of care to provide sustainable and equitable provision of End of Life Care in all settings.

Priority/Benefit	Outputs/Outcomes
	<ul style="list-style-type: none"> Explore and share opportunities for research and audit to effect change and enable Palliative Care in ABUHB and across Wales.
Integration of advance care planning into practice	<ul style="list-style-type: none"> Continue to embed Advance Care Planning across all settings in Gwent using the triple E model
Improved communication skills in end of life care	<ul style="list-style-type: none"> Continue to drive foundation and advanced communication skills training
Improved identification and prevention of avoidable admissions	<ul style="list-style-type: none"> Explore increases in the number of palliative care ANPS that can be integrated into the emergency departments
Improved outcome measures	<ul style="list-style-type: none"> Develop a dashboard for outcome measures Success measured through better engagement with patients Outcome measures that more accurately reflect patient experience
Improve access to bereavement care	<ul style="list-style-type: none"> Evaluate pilot and explore options to provide a service across all acute areas in Gwent Appropriate facilities in the acute setting

3.3.11 Rare Diseases

The Health Board adheres to national standards and best practice guidance to ensure that patients are provided with a bespoke service to support and manage their condition. A significant amount of work being undertaken to ensure that patients with rare diseases receive a timely diagnosis where possible, and have access to highly quality accessible information at all stages of their disease to help them make informed decisions. MDT work is undertaken to support families, mutually developing and refining care plans, often with quite significant input across disciplines and agencies and moving away from departmental condition-specific information in favour of directing families to online, national resources which tend to be of a higher standard and are kept up to date.

A webpage for patients and families is being developed which will provide endorsed information links, information on local support groups and signposting for further support and information along with easy read, accessible information for individuals with a learning disability.

Table 3.3.11 - Rare Diseases Priorities

Priority/Benefit	Outputs/Outcomes
Improved pathways and collaborative working between primary and secondary care	<ul style="list-style-type: none"> Use of patient feedback and best practice. Explore opportunities to introduce specific 'rare disease coding'.
Improved use of outcome and experience measures	<ul style="list-style-type: none"> Identify ways of including rare disease treatment in POMS and PREMS in specific clinical areas.

SCP 4 - Mental Health and Learning Disabilities (MH/LD)

This SCP seeks to provide an integrated whole system model of care that improves the mental health and wellbeing of our population.

3.4.1 Strategic Context

The Health Board's vision for mental health is underpinned by the national 'Together for Mental Health' Strategy, the MH Measure (Wales) 2010 and the 2012-17 local integrated strategies developed in partnership with Local Authorities. These aim to provide an integrated whole system service model which:

- Improves the mental health and wellbeing of the whole population.
- Better recognises and reduces the impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities and the economy more widely.
- Reduces inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness.
- Ensures individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions.
- Improves access to, and the quality of preventative measures, and early intervention and treatment services, to ensure more people recover as a result.
- Improves the values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness.
- Is co-produced and delivered in partnership with our stakeholders, in line with service user needs and supporting community resilience.

The vision for Learning Disabilities remains aligned with the local Learning Disabilities strategy 2012-17 which seeks:

"To enable adults with a learning disability living within Gwent to lead fulfilling lives and have the same opportunities as other people in society. Adults with a learning disability and their carers should have access to the full range of public services and receive support from specialist services when required".

Both strategies are currently being reviewed and refreshed in a co-produced partnership approach with service users, carers, staff and members of the public. The new LD strategy will be launched early 2018 and the MH strategy will be launched in spring 2018. Implementation plans for both strategies will also be co-produced with key actions included in the finalised version of the 2018-21 IMTP. Delivery of the plans will be overseen by the Gwent Mental Health & Learning Disability Strategic Partnership, which reports to the Regional Partnership Board.

The Well-being of Future Generations (Wales) Act 2015 places a well-being duty on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales, in a way that accords with the principle of sustainable development.

Implementation of the Social Services and Well-being (Wales) Act also requires very significant changes in the way services are planned, commissioned and delivered, characterised by a stronger emphasis on:

- increased citizen engagement and ensuring **voice and control** for people who need care and support, and carers who need support;
- **prevention** and **early intervention**;
- the promotion of **well-being**;
- **co-production** – citizens and professionals sharing power and working together as equal partners;
- **multi-agency working** and co-operation.

All of the key plans outlined in SCP4 involve using the 'Integrated Wellbeing Network' model as a planning framework, in order to make more prudent use of scarce staff resources, utilising professionals with the most appropriate skills / expertise based on patients' needs. This approach includes the use of other healthcare and wellbeing professionals including Social Prescribers, Community Connectors, Paramedics, Pharmacists and Mental Health Practitioners to enable a more flexible approach to workforce model development and implementation across all service tiers. For example many teams in both mental health and learning disabilities are integrated with health and social care with strong working relationships with partners in the Third Sector and other public sector services such as Police, Education and Housing.

Service user and carer voices are integral to the Health Board's work. For example the Foundation Tier/Tier 1 services are being co-produced to ensure they focus not only on individuals, but the longer term wellbeing and resilience of communities. There is a greater focus on early intervention and prevention at whatever stage of an individual's journey, for example the Support Plus team to support improved access to Foundation Tier/Tier 1 Mental Health services for people with a learning disability.

The Health Board is anticipating continued growth in mental health and substance misuse services in future years to cope with forecast increases in demand and its plans will play an important role in supporting strategies for prevention and early signposting of mental health issues working in partnership with others.

3.4.2 Service Model

Mental health and learning disability services in Gwent work in the context of an overall service model, spanning foundation level, primary, secondary and specialist tertiary services, as described in Figure 1.

Services for the target client groups are organised within a number of directorates and divisions:

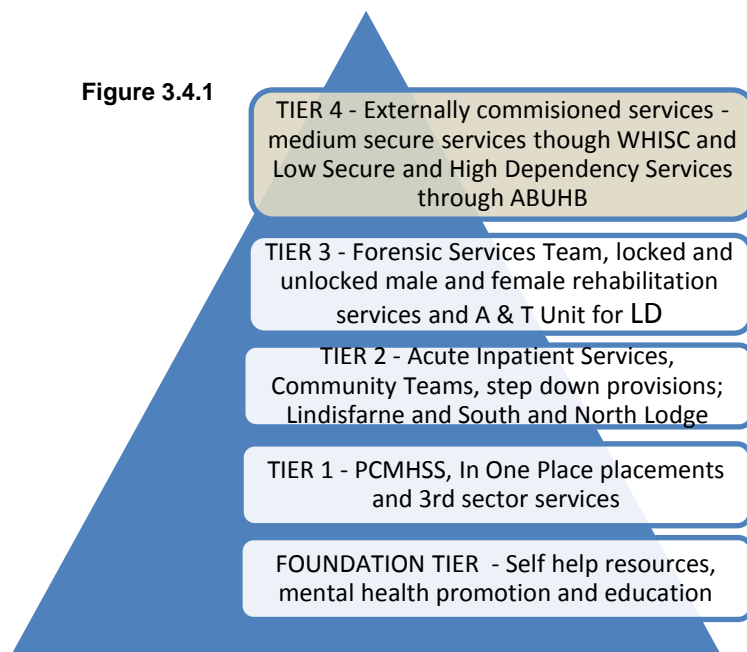
- Primary Care mental health services (children, young people and adults with MH or LD).
- Adult mental health and specialist services (18 years to 65 years).
- Older adult mental health services (65 years and over).
- Learning disability residential, specialist and community services (18 years and over).
- S-CAMHS – (under 18 years) - Families and Therapies Division.

The majority of MH services are provided or commissioned at Foundation level, Tier 1 and Tier 2, with limited provision at Tier 3. Tier 4 providing low to medium secure services are commissioned from external providers (Figure 1).

Specialist CAMHS provide specialist assessment and treatment of serious mental health disturbances and associated risks in young people under the age of 18 years. It includes:

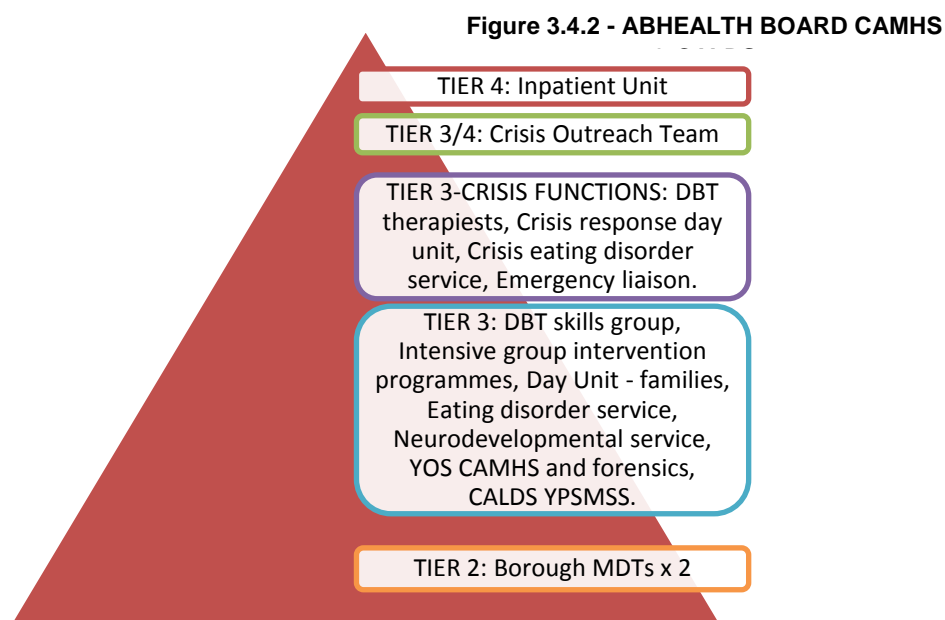
- Crisis care and out of hours provision;

Figure 3.4.1



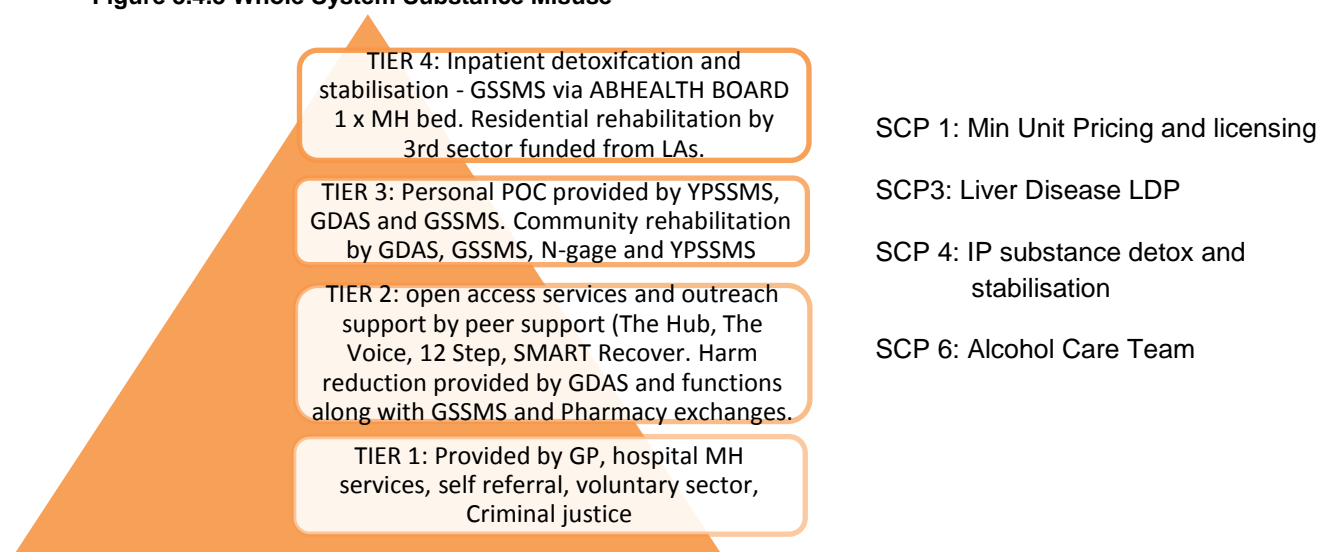
- Early intervention for young people with psychoses;
- Evidence based psychological therapies;
- Assessment and diagnosis for Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

In addition S-CAMHS works in collaboration with the Integrated Service for Children with Additional Needs (ISCAN) to deliver integrated specialist care for children with neurodevelopmental mental health, paediatric, therapy and Learning Disability needs.



The clinical leadership for specialist substance misuse services is also provided by the Health Board. Substance misuse is a whole system pathway coordinated with multiple partners across Gwent and commissioned by the Area Planning Board. The diagram below illustrates the services provided at each level by which provider. Health services within the pathway are further provided by different Divisions and are reflected in different SCPs across the IMTP.

Figure 3.4.3 Whole System Substance Misuse



3.4.1 Key achievements

The Health Board's 2017-20 IMTP organised its MH/LD priorities around the three themes of Access, Quality/Patient Safety and Sustainability. A summary of the key achievements to date are:

Access

This aimed to reduce waiting times in key areas across all service model tiers and age categories, and to reduce variation in service provision across different localities. Key achievements have been:

- **Local Primary Care Mental Health Support Services (PCMHSS)** – sustained performance against Part 1 of the Measure for assessment and significantly improved performance against the intervention target. The targets are now expected to be met on a sustainable basis from Q4 2017/18.
- Compliance against Parts 2 and 3 of the Measure have remained above the national target and

are expected to be sustained.

- **Older Adult Mental Health** – recruited to a new Flexible Hospital Resource Team in the DGHs to improve the quality of care and access to hospital liaison for older adults with MH in acute settings, as part the existing Rapid Assessment, Interface and Discharge (RAID) service.
- Completed ICHOM and Patient Level Costing analysis on the dementia pathway for assessment and diagnosis. This work underpins new standards being rolled out to harmonise and improve Memory Assessment Services across Gwent.
- **Specialist Child and Adolescent Mental Health Services** – Specialist CAMHS is performing well against a range of national benchmarks.
 - The integrated neuro-developmental service and the extension of the Crisis Outreach Team (COT) and Emergency Liaison service into out of hours working has evaluated well, delivering timely and effective patient care. All self-harm and overdoses are being seen same day and bed day usage has significantly decreased.
 - Improved access to neurodevelopmental services as a result of the new **Integrated Service for Children with Additional Needs (ISCAN)** set up in each of the children's centres across Gwent in collaboration with the heads of children's services for the local authorities. ISCAN has no waiting list, however there remains a small backlog of patients within S-CAMHS awaiting assessments over the 26 week target. The longest waiting time for this has been significantly reduced from 2016/17 to 31 weeks.
 - Opened the new White Valley Centre for children and young people needing outpatient CAMHS following investment from discretionary capital. The centre was designed with children and adolescent service users.
 - Additional Welsh Government funding for CAMHS has been invested in enhancing Tier 3 services, e.g. more specialised psychological therapy, intensive group therapy programmes, enhanced specialist eating disorder interventions, Day Unit, Dialectical behaviour therapy, Crisis Outreach Team and embedding of CAMHS nurses in Youth Offending and Substance Misuse Teams.
- **Learning Disabilities** - continued the ICF Support Plus project to improve access to local PC MHSS for people with Learning Disability. The process of integrating the team into local PCMHSS teams, will be starting with Newport East NCN in early 2018/19.
- Implemented the new **Integrated Autism Service** as one of the main objectives of the national Autism Strategic Action Plan. The service provides improved access to diagnostic assessment and support for adults, children and young people with autism with or without a learning disability or mental health difficulties. Although still in the early stages of operation the service has already reduced waiting time for adult diagnosis from 14 months to 9 months and received positive patient experience feedback.
- **Substance Misuse Pathway** – there is currently very limited access to inpatient beds for detoxification and stabilisation programmes within the Health Board or neighbouring Health Boards. A programme of multi-disciplinary and multi-agency workshops commissioned by a sub-group of the Gwent Area Planning Board and facilitated by the Health Board, have undertaken a systematic review of desired outcomes and benefits of developing an improved pathway and centre of excellence which would enable more clients to receive more timely and effective care closer to home and a much improved patient experience. Discussions are also commencing with Welsh Government on regional options.

Quality, Patient Safety and Patient Experience

As well as reviewing and strengthening the Health Board's MH/LD quality, patient safety and patient experience governance structures, key achievements include:

- Ligature risk reduction programme on inpatient units utilising £2.5 million WG funding is due to be completed end Q4 2017/18.
- Quality metrics aligned to the performance dashboard have been developed in order to provide assurance and target improvement intervention. The Health Board's MH/LD programme of audit, peer review, spot checks and quality improvement initiatives have also been improved to support a culture of continuous improvement in all clinical areas.
- Person-centred approaches such as LEAP and Vanguard have been embedded as underpinning principles for service redesign within our LD community and specialist services reviews.

Sustainability

The sustainability priorities span the service model for adult, older adult MH and adult LD and form the main part of the Health Board's medium and longer term strategic plans. Key achievements are set out under our Service Transformation Programmes section. The key programmes are:

- Prevention and Early Intervention – building resilience in schools
- Older Adult MH Service Redesign
- Adult Inpatient and Crisis Support
- Complex Health Care
- Learning Disabilities Services Redesign

3.4.2 Key Challenges

As summarised above, good progress was made in 2017/18 especially around improved access, QPS and sustainability. As the Health Board moves into the next IMTP many challenges remain to be addressed. In summary these are:

Population demand

Forecasts show that demand is rising associated with an ageing population and higher incidence of mental health disorders linked to social deprivation factors. Public Health Wales has recently shown that mental health and substance misuse is one of the top five 'burdens of disease' which have the greatest impact on lost disability-adjusted life years and the second highest factor associated with years lived with disability.

An ageing population is more likely to have at least one major chronic condition including the onset of dementia, which is predicted to rise by 39% by 2030. The Health Board has a comprehensive Dementia Action Plan, overseen by an executive led Dementia Board, to ensure that our responses to "Wales: a Dementia-Friendly Nation" improves the outcomes and experiences for patients and their families living with dementia. A key element of the plan involves educating and supporting general physical health care services in the management of patients with dementia. This is covered in more detail in Section 3.8 on Older People.

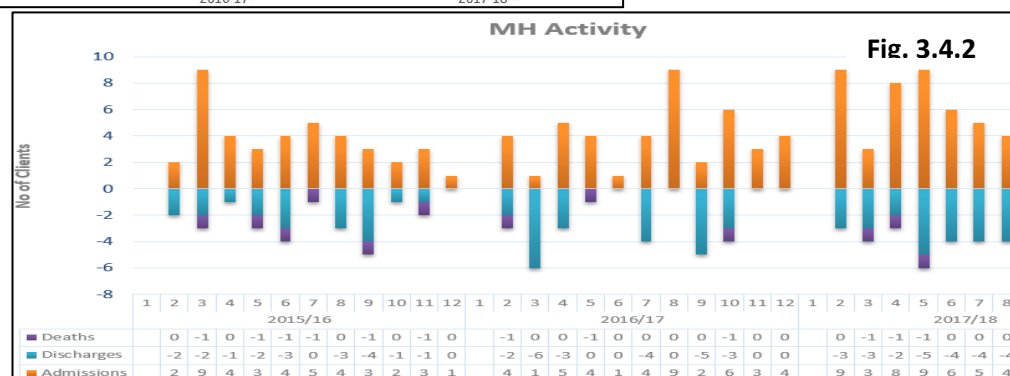
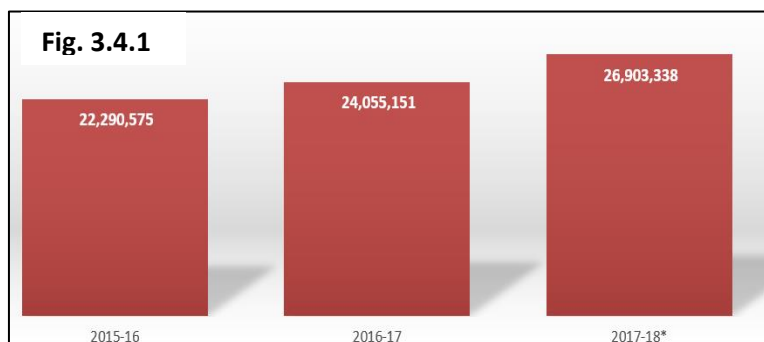
Forecasts also indicate year on year increases in the incidence of people with learning disabilities. In Gwent 2012-20, this is expected to be around 2.3%. This is likely to impact not just on LD services and Continuing Healthcare (CHC), but across the whole system of health and social care.

In Primary Care Mental Health Support Services (PCMhSS) there has been a continuing rise in demand since inception of the service. In 2013/14 the number of referrals for adults and children was 13,165 compared to 19,734 in 2016/17. The rate of referral for the Health Board is 50% higher than the national average. Between January and June 2017, the Health Board accounted for 25.5% of referrals in Wales and 34.5% of referrals for under 18s.

Increasing Acuity and Complexity

The impact of rising demand and acuity on our adult MH services is increasing pressure on beds in inpatient services with occupancy levels above recommended Royal College of Psychiatry levels. In addition, implementation of the Policing and Crime Act which is designed to eliminate the detention of mental health patients in police cells may increase pressure on acute beds. This is being closely monitored by the multi-agency Crisis Care Concordat and contingency capital funding is being identified for 2018/19 to extend the 136 suite at St Cadoc's Hospital to meet this potential demand.

Complex Health Care / Continuing Healthcare (CHC) growth is predicted to rise at a significant rate in adult MH over the next 3 years and will continue to be a major cost pressure for the service. This is in part due to new pathways into low secure services, including community, prison transfers and step down from medium secure units. For example, prison referrals have steadily increased and are predicted to be 13 in 17/18. Cost and demand growth is shown in the graphs below.



Our scope to manage future demand in CHC is limited because we do not have a Low Secure Unit which would enable clients to be stepped up/down as appropriate and would reduce the number of externally commissioned placements. Meanwhile inpatient occupancy levels on the 7-bedded Assessment and Treatment Unit for LD averages 60%. The configuration and model for this service is being reassessed as part of the longer term review of tier 3 and tier 4 service provisions and the potential for more integrated working with MH services. The creation of an integrated LSU, HDU and PICU would re-provide the existing A&T unit and improve operational efficiency.

Workforce Availability and Costs

The Health Board continues to experience severe issues with recruitment, especially junior and middle grade doctors across the MH/LD division and registered MH and LD nurses in some key areas, such as Older Adult inpatients. Detailed workforce plans have been developed for each service which includes a range of ongoing interventions such as a monthly recruitment wheel, student recruitment events as well as role review and redesign.

Medical staffing in adult services is a particular challenge due to the reduced allocation of junior doctors since August 2016. We have been carrying vacant slots at Core Training (CT) levels for several years, the cumulative vacancies therefore have resulted in significantly low junior doctor coverage by day and during out of hours since August 2016. This is a nationwide issue with a reduced training pipeline across the UK but is particularly prevalent in Wales. There are 2 consultant, 5 specialty doctors and 8 junior doctor vacancies as at September 2017. An initial recruitment intake has produced a fill rate of only 25%. We have had some success in recruiting Fixed Term Appointments to fill some of these junior doctor gaps and revert back to a 1:12 rota over the last year. In addition an additional MTI training post has been recruited into in 2018. There is also a national challenge around the provision of funding for training grade doctors and core training for psychiatrists in CAMHS.

Nurse staffing difficulties are compounded by the preceptorship requirement for newly qualified nurses which prevents them from taking charge of shifts for the first 6 months. We also have an ageing workforce which means many nurses are at or nearing retirement age. As at September 2017 there were 26.6 wte vacancies, most of which were in Older Adult MH services and which has led to temporary ward closures since January 2016 in order to maintain safe patient care. The Older Adult MH service is currently out for formal consultation on service reconfiguration proposals to provide a more sustainable model for the future.

Increases in acuity on wards has required higher observation levels and need for specialising which continues to impact on variable pay and use of bank and agency staff. While in-house productivity

and efficiency measures are ongoing, the expansion of PICU beds will reduce some 2-1 and 3-1 staffing levels on acute wards.

Infrastructure

There are also infrastructure challenges in the provision of a number of key enablers.

- **IT Infrastructure** - network capacity at some sites and IT equipment across the boroughs is inadequate and requires investment and upgrading.
- **Welsh Community Care Information System (WCCIS)** – this new national information system aims to provide an integrated health and social care record enabling information about an individual to be available to practitioners across NHS and Social Services. The critical timeline for transition to the new system is December 2018 at which point the Health Board's EPEX provider will cease to support the current system. Its interim replacement, Careworks, needs to go live in October 2018 but delays in signing the deployment order are likely to delay implementation.
- **Accommodation** – the Health Board's old facilities are often not suited for the client group and have required adaptations to address ligature risks. There is also a lack of suitable accommodation to support the delivery of clinical sessions in various boroughs.
- **Capital funding** – the pace of transformation is constrained by the limited availability of capital to extend, refurbish or re-provide appropriate environments of care for our vulnerable client groups.
- **Management capacity** – the ambition for MH/LD service transformation means that proposals and plans are being developed in major parts of the service model at the same time as delivering operational services experiencing severe pressures. These programmes require full time dedicated planning support in order to maintain pace. Increased support from corporate teams and a review of the divisional management structure for MH/LD is underway to increase management capacity.

3.4.5 Opportunities - Bench marking

A high level summary of the key bed performance indicators for Adult Mental Health services from the draft national benchmarking report for 2017 shows:

Table: 3.4.1

Measure	ABUHB	Wales Mean	Comments
Beds per 100,000 population	20.4	20.6	ABUHB has fewer beds than the mean.
Mean length of stay (excl. leave)	14 days	25	This is one of the lowest LOS of all participants.
Delayed transfer of Care	1%	3%	This is the lowest value compared to the other Welsh LHBs.
Emergency Readmissions within 30 days	16.2%	8.7%	We are the highest with a slight increase from 16% last year.
Bed Occupancy (including leave beds)	95.2%	103.6%.	Excluding leave beds presents a distorted figure because between April and June 2017 the average bed occupancy for each ward was actually between 95-130%.

Evidence from bench-marking and other data analyses indicates a need to redesign our Crisis Resolution Home Treatment Team and inpatient model, including Out of Hours. There is poor flow management between crisis and inpatients and few alternatives to admissions. This is compounded by the high number of assessments undertaken by the CRHTT, leaving insufficient capacity to provide Home Treatment. Bed pressures have given rise to unacceptable levels of internal transfers

which have a negative impact on patient care and are an inefficient use of staff. Our lack of specialist beds also contributes to problems with flow and underline the need to develop a Low Secure Unit with supporting HDU and PICU.

Key observations for Older Adult Mental Health services from the benchmarking report for 2017 indicate:

Table: 3.4.2

Measure	ABUHB	Wales Mean	Comments
Beds per 100,000 population	62	57	ABUHB is just below the upper quartile.
Admissions per 100,000 population	294	187	This is a significant reduction to last year's level of 394.
Mean length of stay (excl. leave)	61 days	78 days	Just above the Upper Quartile
Delayed transfer of Care	6%	13%	This is the lowest value compared to the other Welsh LHBs.
Emergency Readmissions within 30 days	6.4%	4.4%	In the upper quartile of all participants and second highest of all of the Welsh LHBs.
Bed Occupancy	82%	86%	We are just below the lower quartile at 82%, which is an increase from the 2014 level of 78%.

The redesign of Older Adult MH services is predicated on strengthening care closer to home and community based services such as memory assessment clinics to reduce unnecessary hospital admissions and provide more person-centred planning. Reconfiguration plans for inpatient beds, if approved, would bring older adult services closer to the mean number of beds per head of population and provide a more sustainable service model moving forward. Further detail on the service transformation programme for Older Adult Mental Health is set out in the next section.

At the time of writing no benchmarking information for Learning Disabilities was available. The LD Assessment and Treatment Unit currently has an average bed occupancy level of 60.4% and average length of stay of 72.8 days. There is an opportunity within our plan for a local LSU/HDU/PICU to re-provide this facility in a more integrated service model with a better environment of care, clinical outcomes and more efficient workforce model.

3.4.6 Service Transformation Programmes and Priorities

In this 2018-21 refreshed plan the key strategic priorities are organised around our tiered service model and particular service user needs. Table 3.4.3 provides a high level summary of our overall service plans aligned to each tier/sector. All our programmes are underpinned by Prudent Healthcare and Value principles and have measureable impacts based on the National Outcomes Framework. The detailed milestones and outcome measures for these plans are available at [>link to Divisional IMTP to be added<.](#)

Table 3.4.3

Service Tier	Programme	Priority Plans
Foundation & Primary Care (all ages)	SCP 1- Prevention and Promotion	Building resilience – MH awareness and education in schools
	Prevention and Early Intervention	Improving access to Local PCMHSS
Adult Mental Health (18-65)	Whole Person, Whole System Acute & Crisis Support	Redesign Acute inpatients & Crisis Resolution Home Treatment Teams Host Families Crisis House and Sanctuary Single Point of Contact Review conveyancing pilot (ICF) WAST Crisis Pathway Police Control Room MH Practitioners
	Substance Misuse Pathway	Inpatient detoxification and stabilisation development
	Complex Care	In One Place supported living Male/Female complex pathways LSU/PICU/HDU Integrated service model and capital scheme Interim PICU extension
	Psychological Therapies in Secondary MH Care	Access to Psychological Therapies
Older Adult MH (65+)	Service redesign	Enhancement of community service model Reconfiguration of inpatient services ECT service transfer Dementia - Memory Assessment Services (MAS) - Roll out of PLICs and ICHOM development Flexible hospital resource Team (ICF) Dementia - Behavioural support services pilot (ICF)
CAMHS (0-18)	S-CAMHS	Neuro-developmental pathway Improving transitional care for 18-25 yrs Improving access for hard to reach groups
Learning Disabilities (18+)		Support Plus integration with PCMHSS (ICF) Residential Services Review Community Services Review Alternative services for people with complex LD needs National Autism Strategy implementation

Top Priorities

Five of our existing major transformation programmes are identified as our top priorities for this refreshed IMTP. All have significant financial, workforce and patient quality implications. Each of the programmes fits within an agreed programme/ project and governance framework. These are outlined below:

Building Resilience in Schools (previously highlighted in SCP 1)

This is a partnership project started in 2017/18 between Health (adult and CAMHS), Social Services and Education aimed at increasing awareness and understanding among schoolchildren and teachers of mental illness, psychoses and eating disorders. The project is planned to run in two phases; phase 1 for children in Year 8 (age 12-13) and phase 2 for year 12 pupils. It will deliver teaching and support for teachers and support staff and empowerment tools and a range of formal and informal supports to protect emotional well-being and mental health for school children.

A part time Educational Psychologist and CAMHS O/T have been seconded in to lead a formal pilot which has recently started in Newport High School. The pilot will also involve a small cluster of other schools in line with the Royal College of Psychiatrists and the National Association of Head teacher's recommendations. Eight pupils have signed up to become Mental health Champions and actively participate in the planning, delivery and evaluation of the projects and the production of a Service Level Agreement (SLA) been agreed and signed. (*The project scope has since been expanded to include*

a further interventional element to be piloted in BG/Powys and Mon which is subject to a bid using the ring-fenced Welsh Government monies).

Key Milestones 2018/19

- Newport Pilot evaluation
- Proposals for future development and delivery
- A project timetable for the Blaenau Gwent, Powys and Monmouthshire scheme is to be developed.

Table 3.4.5

Outcomes	Measures	Benefits
<ul style="list-style-type: none"> ▪ Earlier diagnosis and intervention to reduce acuity and demand for CAMHS. ▪ Better access to informal sources of help ▪ Improved compliance with treatment programmes and better clinical outcomes ▪ Reduced stigma and negative impacts on quality of life for children and families. 	<ul style="list-style-type: none"> ▪ Service user surveys ▪ Level of uptake for support services and information e.g. visits to web-based tools and info pages. ▪ Number self-harm episodes ▪ Referral rates to PCMHSS and S-CAMHS 	<ul style="list-style-type: none"> ▪ Children have greater awareness of risks and early signs ▪ Teachers and support staff able to identify children at risk or showing early signs of distress. ▪ Reduced self-harm episodes ▪ Reduced referrals to S-CAMHS due to earlier intervention and support preventing progression

Enabling Support: Currently being scoped but early indications are the need for trainers and training materials for teachers and support staff, ICT investment for web-based materials, and clinical sessions for interventions.

Older Adult MH Service Redesign

The whole system redesign of Older Adult MH Services includes the following elements:

- Enhancement of community service model.
- Reconfiguration of inpatient services.
- ECT service transfer.
- Dementia - Memory Assessment Services (MAS) - Roll out of PLICs and ICHOM development.
- Flexible hospital resource Team (ICF).
- Dementia - Behavioural support services pilot (ICF).

Key achievements in 2017/18 have been the completion of a robust stakeholder engagement programme and public consultation on the reconfiguration of inpatient services which if approved will reduce the number of inpatient wards to three dementia assessment units and one centralised functional unit. This will result in a net reduction of 5 beds which will bring older adult services closer to the mean number of beds per head of population and will provide a more sustainable service model moving forward.

Key Milestones 2018/19

- Management of Change process subject to outcome of public consultation. Q1
- Implementation of inpatient reconfiguration Q2
- Roll out of PLICs/ICHOM.
- Standardise MAS clinics.
- Service model development proposals for enhanced community services.

Key Milestones 2019/20

- ECT service transfer.
- Complete implementation enhanced community services plan.

Table 3.4.6

Outcomes	Measures	Benefits
<ul style="list-style-type: none"> Sustainable workforce to support in-patient services. Functional and dementia wards provided separately. Patients cared for in appropriate environments. Equitable access to service. Improved use of resources. 	<ul style="list-style-type: none"> Referral to diagnosis waiting time. Reduced admissions from residential homes. Brings bed numbers closer to national benchmarking average and frees up resources. Cost per bed. Staff: patient ratios. Reduced length of stay (as result of enhanced community support). Reduced agency factor to approx. 3 wte. 	<ul style="list-style-type: none"> Improved quality of inpatient care. Better environment to promote wellbeing and better patient experience. Patients receive appropriate care sooner. Consistent standard of care. Patients supported in their homes. Reduction in MAS waiting times. Better support for residential nursing homes.

Enabling Support: To be fully assessed at the conclusion of the consultation process.

Whole Person, Whole System Acute and Crisis Transformation Programme

This is a major transformational programme managed under the auspices of the Gwent Strategic Partnership and covering the redesign of the acute patient pathway from acute crisis support and response with partners, through admission, discharge and follow up. The programme is anticipated to span 3-5 years to deliver a range of alternatives to admission including 24 hr crisis support, Crisis House short term accommodation and Sanctuary day care, Host Families, robust home treatment services and a broader range of discharge options. The work programme will also realign flow and acuity across inpatient services.

Key achievements in 2017/18 have been translating the vision of the multi-disciplinary/multi-agency Action Learning Set, which included service users and carers, into a formal transformation programme responsible for developing the service model and implementation plan. ICF monies have been secured to undertake a feasibility study for the Crisis House model. Other innovations implemented in 2017/18 include a new pathway with WAST and a conveyancing pilot project. Our partnership scheme involving the deployment of a MH practitioner into the Police control room to support the police to manage people in crisis has evaluated well and is being extended to cover all police shifts.

Key Milestones

2018/19	<ul style="list-style-type: none"> Complete workforce and detailed model review of CRHTT and inpatient services and produce a list of options Q1 Host Families clinical audit and identification of potential service users Q1 Crisis House/Sanctuary service model co-production with stakeholder groups and design consultant. Business case approval for Crisis House (3rd sector lead) Q1 Stakeholder engagement and options appraisal for IP and CRHTT redesign Q2 Host Families operational model development. Commence a pilot scheme in one borough. Q2 Identify potential facilities for Crisis House and Sanctuary site/s. Q2 Commence Sanctuary pilots (ICF 3rd sector project) Q3 Host Families evaluation and funding plan for roll out. Q4
2019/20	<ul style="list-style-type: none"> Develop Single Point of Contact BC for Host Families model roll out subject to evaluation. Implementation Host Families. Commence build for Crisis House
2020/21	<ul style="list-style-type: none"> Complete Crisis House build. Evaluate benefits of Host Families post implementation

Table 3.4.7

Outcomes	Measures	Benefits
<ul style="list-style-type: none"> Provide access to 24 hr crisis assessment Provide robust home treatment services as an alternative to admission Improved patient experience Improved patient safety In-patient model that is designed to respond effectively to acuity and to improve patient flow Deployment of workforce to point of highest acuity/demand 	<ul style="list-style-type: none"> Assessment to treatment time Number of patients supported at home not requiring admission Patient surveys, complaints, Reduction in SUIs Reduced conveyancing. PDSA cycles Reduced admissions out of hours 	<ul style="list-style-type: none"> Improved patient outcomes Safer care More patients supported within the community Improved workforce recruitment and retention Better staff well-being

Enabling Support: ICF funding secured for Design consultant for Crisis House. Support from Psychology student for Host Families audit to be confirmed. Value Programme Team also supporting outcome measurement for Host Families. Project Manager secondment in place for Acute IP/CRHTT project.

Complex Needs Transformation

The aim of this programme is to address a particular gap in the provision of suitable environments of care for this client group, where currently many have to take up external placements to meet their needs. In order to better manage forecast rises in demand and costs, our work programme has developed options that provide further supported living facilities using the 'In One Place' special purpose vehicle and refurbishment of South Lodge for a third service user placement. The longer term service transformation is focused on the development of an integrated MH/LD low secure facility supported by an extended PICU and an HDU. This is expected to be a 3-5 year programme dependent on the availability of Welsh Government capital.

Key achievements in 2017/18 have been the development of a Scoping Case for WG for the LSU/HDU and PICU which secured support for the development of a Strategic Outline Case. The SOC includes options for a regional solution and is to be submitted to Welsh Government in January 2018. In the meantime, an interim extension of PICU has been approved and is about to begin building.

Key Milestones

2018/19	<ul style="list-style-type: none"> Interim PICU completion. Q1 Decision on SOC. Q1 OBC development Q2 OBC approval Q3 Commence FBC development Q3 Interim refurbishment of LD A&T Unit Q4 Development of 2 new accommodation proposals for patients with complex needs via PMLD project. Q4
2019/20	<ul style="list-style-type: none"> FBC approval Construction start
2020/21	<ul style="list-style-type: none"> Construction completed New unit operational from July 2021

Table 3.4.8

Outcomes	Measures	Benefits
Development of integrated service model for complex care Fit for purpose Mental Health Unit (LDU/HDU/PICU) facility Extension of current PICU to 9 beds	Reduction in number of patients sent outside HB Reduction in CHC expenditure Reduction in LOS Increased number of interim PICU beds	Improved patient flow Improved patient experience Better integrated care and discharge Better value for money More sustainable service Interim PICU savings approx. £655k - £875k per annum (net revenue savings of £280k to £500k p.a.)

Enabling Support: Capital funding c. £35m for MH Unit.

Learning Disability Service Reviews

The Health Board's LD residential service currently has 24 residents across its five homes. The residential services review involves undertaking detailed multi-disciplinary assessments with service users and their families to determine whether there is a primary health need and then to discuss tenancy options for residential care or the appropriate package of care for those with continuing health care needs. This will ensure service users have a more appropriate environment of care and services appropriate to their needs in line with Prudent Health care principles and could deliver significant cost savings. However it has attendant risks as it may require a complex transition process involving double running of staff and facilities.

To date all clients in Blaenau Gwent, Caerphilly and Torfaen have been assessed. The process is continuing in Newport and Monmouthshire.

A review of specialist and community services is also continuing. Key Milestones 2018/19:

- Complete individual needs assessments for Newport and Mon.
- Complete workforce and financial modelling and strategy.

Table 3.4.9

Outcomes	Measures	Benefits
<ul style="list-style-type: none">▪ Individual needs assessed and packages of care developed and agreed with partners and families▪ Individuals living in most appropriate accommodation to meet their needs	<ul style="list-style-type: none">▪ Service user surveys▪ Clinical outcome measures▪ Cost measures	<ul style="list-style-type: none">▪ Improved quality of life▪ Increased independence and choice▪ More cost effective service delivery. Some savings.

Enabling Support: TBA Pay protection likely to apply and redeployment for 70.6 wte HCSWs with MHO status.

3.4.7 Governance Framework

The Executive Lead for this SCP is the Director of Planning and Performance. The implementation leads, accountabilities and delivery milestones are identified against specific work streams within the Divisions and are overseen by Divisional management level monitoring structures. The executive oversight of the SCP is to be provided by the new MH & LD Committee.

A number of joint working and partnership developments are overseen by the Gwent MH and LD Strategic Partnership, the Children and Young People's Partnership Board and specific regional strategic boards e.g. for implementation of the Autism strategy.

Additional corporate support will be provided for ongoing demand and capacity analysis and review of flow opportunities, BC development and engagement and consultation activities.

Alignment of Plans

Our key plans are underpinned by the requirements of our clinical services strategy Clinical Futures and WG policies and strategies such as Well-being of Future Generations and Together for Health. Table 3.4.4 illustrates how these are aligned.

Table 3.4.10

Plan Name	Clinical Futures	Well-being Future Gens	Prosperity for All	Together for Children & Young People	Together for MH	Dementia Strategy (not pub)
Local Primary MH Support Services Access	✓	✓	✓	✓	✓	
Access to Psychological Therapies		✓	✓	✓	✓	
PC MH support in LD		✓	✓	✓	✓	
S-CAMHS /ISCAN Access		✓	✓	✓	✓	
Hospital liaison for Older Adult MH (OAMH)		✓	✓		✓	✓
Service redesign for OAMH	✓	✓	✓		✓	✓
Care closer to home for people with complex LD needs (In One Place)		✓	✓		✓	✓
LD Residential Services Review	✓	✓	✓		✓	
LD Community and Specialist Services Review		✓	✓		✓	
Review of Substance Misuse Pathway	✓	✓	✓		✓	
MH Complex Care service transformation	✓	✓	✓		✓	
Whole Person, Whole System MH Crisis Support Transformation	✓	✓	✓		✓	

Conclusion

In conclusion, the complex and challenging agenda for improving MH/LD remains a key priority for the Health Board. While there have been significant achievements in the last year, many challenges remain. The refreshed IMTP provides an overview of the Health Board's ambitious programme of transformation ahead.

SCP 5 - Urgent and Emergency Care

This SCP seeks to develop coherent, co-ordinated, high quality urgent and emergency care system that works seven days a week, and where possible 24 hours a day, in accordance with patient expectations, delivering the best clinical outcomes.

3.5.1 Introduction

There continues to be significant pressures on the urgent and emergency care services across the Health Board that require an improved whole system approach that maximises the contribution of every service, with the aim of caring for patients in the right place, at the right time and by the right care team.

Delivering sustainable, system-wide urgent and emergency care services remains a priority for the Health Board and partners are driving change through the Urgent Care Board which includes multi-disciplinary and partner organisation representatives. The Urgent Care Board is dynamic, it agrees and sets shared clinical and management action across the care system and seeks innovative solutions that deliver:

- A preventative approach which identifies those at risk of being admitted to hospital and seeks to intervene to avoid this where appropriate.
- A proactive approach which balances and minimises competing clinical risks, including the identification and management of those at risk of becoming delayed when in hospital.
- Effective systems and processes to identify and manage those who experience a delay in their discharge or transfer to a more appropriate setting seeking to reduce those delays through sustainable interventions.
- Optimises patient flow through the urgent and emergency care system.

The Urgent Care Service Change Plan is then delivered through divisional structures to ensure:

- Clinical and operational leadership at all levels.
- Modernised services prioritised on the basis of evidence.
- Improved quality of patient care.
- An empowered and sustainable workforce.
- A system which can respond to surges in demand, including seasonal pressure as a core function.

This Service Change Plan sets out the key priorities that will be the focus over the next three years to continue the journey in redesigning the urgent and emergency care system to better meet the needs of the population, drive further integration across its component parts and meet national quality and access expectations.

The ultimate aim is to consistently deliver safe, high quality, effective and timely care for all patients wherever they present in the system. In addition to clinical quality and safety benefits, the most immediate benefits for patients are to eradicate 12 hour waits in ED, avoid delays in ambulance handover and maintain the progress that has been made to eradicate the need for any patients to be managed on trolleys in corridors.

3.5.2 Baseline position

Table 3.5.1 - Summary of urgent and emergency flow data 2017

Emergency Departments in 2017	Emergency Admissions in 2017
<ul style="list-style-type: none">▪ 22% of patients conveyed by ambulance▪ 78% self-present▪ 122 average daily attendances at Nevill Hall Hospital in 2017▪ 224 average daily attendances at Royal Gwent Hospital in 2017	<ul style="list-style-type: none">▪ 56% of patients admitted are referred by their GP or another healthcare professional▪ 44% of patients are admitted from ED▪ 41 average daily emergency admissions at Nevill Hall Hospital (range 15 – 73)▪ 83 average daily admissions at Royal Gwent

Emergency Departments in 2017	Emergency Admissions in 2017
<ul style="list-style-type: none"> Large degree of variability in number of ambulance conveyances: <ul style="list-style-type: none"> average for NHH is 33, ranging from 17 to 52 average for RGH is 58, ranging from 32 - 81 34% of attendees are categorised as majors/resus 47% of attendees are categorised as minors 17% of attendees are categorised as paediatric attendances 29% of adult patients are admitted, 20% of children are admitted 71% of adult patients are discharged from ED, 80% of children are discharged Corridor trolleys at Nevill Hall Hospital and Royal Gwent have been eliminated as care locations 	<ul style="list-style-type: none"> Hospital (range 44 – 115) <ul style="list-style-type: none"> Ambulatory care consistently sees 20% of the acute assessments at Nevill Hall Hospital – 62% go home Ambulatory care consistently sees 12% of the acute assessments at Royal Gwent Hospital – 56% go home 41 average daily emergency discharges at Nevill Hall Hospital (range 9 – 81) 83 average daily emergency discharges at Royal Gwent Hospital (range 31 – 131) Where additional discharge resource has been deployed there is a significant improvement in the ability to discharge and discharge early.

There continues to be a pattern of variability in attendances and arrival methods at our hospitals but because of the actions that have taken in 2017/18 to improve site operational management and clinical leadership to better predict demand at the front door. The number of attendances is largely consistent with previous years (0.3% change between December 2015 and November 2017).

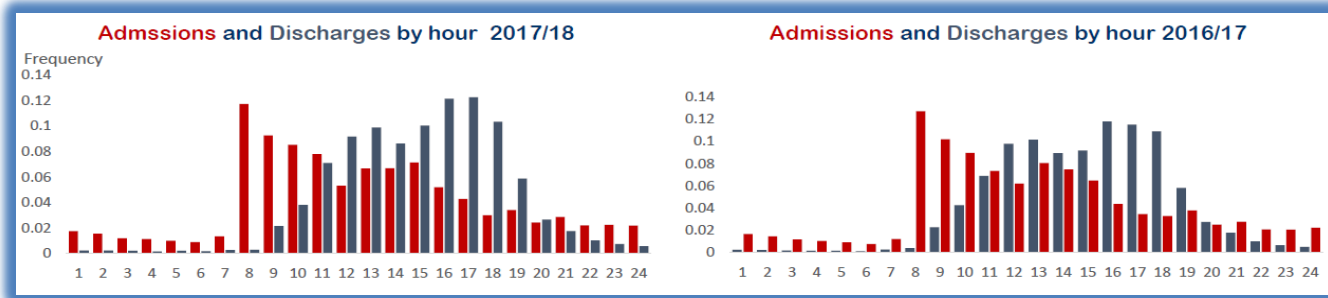
A high level view of the demand at the front door shows that whilst ambulance arrivals have reduced over the last two years there has been a significant increase in the percentage of patients who are being triaged to majors. In the same period there has been a reduction in the number of patients attending minor injuries.

Table 3.5.2 - Comparison on Front Door Demand (Dec 2015 - November 2017)

	Number of ED Attendances						Emergency Admissions		
	Ambulance	Walk In	Total	Resus	Major	Minor	GP	ED	Total
Dec 2015 - Nov 2016	35264	120484	155748	3891	50938	73318	20063	23310	43373
Dec 2016 - Nov 2017	33611	122634	156245	3955	55596	68789	21322	25681	47003
Total +/-	-1653	2150	497	64	4658	-4529	1259	2371	3630
% change	-4.7	1.8	0.3	1.6	9.1	-6.2	6.3	10.2	8.4

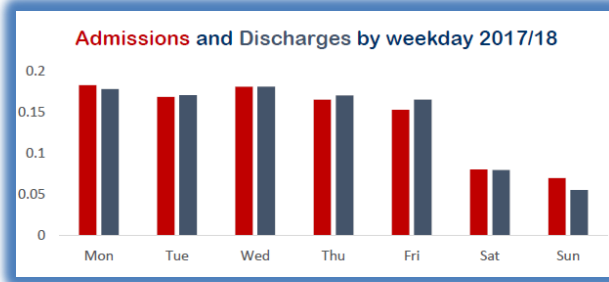
11% of patients that attend the emergency department are aged over 75 years. Of those patients, 38% will wait over 4 hours to be discharged or admitted from ED (accounting for 24% of all 4 hour breaches across the Health Board) and 50% of those older patients will be admitted to a hospital ward. Around 61% of patients aged 75 and over are conveyed to hospital by ambulance.

Graph 3.5.1 - Comparison of admissions and discharges by hour (2016/17 and 2017/18) for entire ABUHB



Graph 3.5.2 - Admissions and Discharges by weekday in 2017/18 for entire ABUHB

The ability to release bed resources to maximise flow through the system is made difficult because of the time that patients present to the system and variability in the volume of patients accessing services on a day to day basis. This pattern has not changed significantly in 2017/18. The number of daily discharges remain broadly in line with admissions across each week.



The challenge is to sustain and build on the improvements seen in 2017 and continue to manage variability by embedding the outputs of the six essential actions as part of core business.

3.5.3 Changes in patterns of demand

The overall number of people presenting to emergency departments has remained relatively stable over recent years. However the pattern of presentation at the Royal Gwent Hospitals' Emergency Department has changed:

- fewer patients arrive by ambulance (6.6% reduction)
- walk in presentations have increased by 4%
- the numbers of patients accessing the majors pathways has increased by 11%
- an 8% decrease in the numbers of patients presenting to the minors pathway has been noted

A similar pattern is evident at Nevill Hall hospital, with ambulance conveyances down by 1.2%, ED walk-ins up slightly (0.3%) and a 6% in patients accessing the majors pathway. Like RGH the minors pathway has seen an 8% reduction.

Less people attending the hospital front doors by ambulance, especially in the South, but of those attending there has been an increase in those being streamed to majors.

Whilst there is variation in GP demand by time of year, all acute sites have seen an increase in the number GP referred emergency admissions over the last two years. This year a further 7% increase in GP generated activity for Emergency Medical Assessments.

As well as variation at times of the year there is also variation by GP referrals time of arrival, which presents a challenge to the acute medical services at all three sites. Work has taken place within Unscheduled Care Division to understand this variation and has led to operational discussions with WAST to seek to change the arrival method and times for GP referred patients to improve flow through assessment units using scheduling, alternative transport methods and a dedicated crew for GP calls.

The introduction of Ambulatory Care Services at Nevill Hall and the Royal Gwent Hospitals has increased capacity for Acute Care Physicians (ACPs) to manage patients referred by their GP and following assessment and/or intervention enable the patient to return home the same day with on-going clinical follow-up as required. The Health Board will now explore how it maximises the contribution of ambulatory emergency care, whilst developing whole system approaches to people who do not require hospital care.

Understanding the nature of GP referrals and consideration of options to reduce demand on secondary care through provision of appropriate alternatives (urgent diagnostics, advice and support from specialist physicians) remains a key priority for this planning cycle but also as part of the Clinical Futures Programme to prepare for transition to the Grange University Hospital in 2021. This requires a system wide response and is not reliant on the acute hospitals' medical services alone.

Out of hours (OOH) referrals for assessment do not indicate a significant pressure point with around 2-3 patients per day being referred for assessment out of hours (between 7pm and 7am). However, increasing numbers of patients are assessing urgent primary care out of hours service at a time when resourcing these services has been difficult (17% medical hours unfilled as at August 2017).

The sustainability of primary care OOH services remains a key concern for this Health Board, the reconfiguration of which is a Tier 3 priority within SCP2 and within the Primary and Community Care Divisional plan.

3.5.4 Delayed Transfers of Care

The Health Board manages inpatients who experience delays through the Complex List. This list continues to show a high number of bed days lost in 2017 in the acute hospital system, despite efforts to move patients with rehabilitation needs to community hospitals at the earliest opportunity. Whilst a third of patients are reportable DToCs awaiting transfer for social care reasons, a significant proportion of delays are within the Health Boards' sphere of control, with innovative "discharge to assess" approach in place at Nevill Hall Hospital and a further innovation planned to support patients to access care home placements where this is their assessed need.

The top three reasons for Welsh Government defined DToCs are:

1. Patient/Carer choice – waiting for home of choice to become available
2. Packages of care on discharge
3. Determination of next steps in the health and social care pathway

Graph 3.5.3 Complex Care List Bed Days Lost in 2017



By addressing the delays in the pathway from hospital to home or care home setting with appropriate support presents opportunities to further improve the flow of patients through the acute and community hospital system, thereby freeing up beds for those in greater need of specialist support provided in a hospital setting. This is pivotal to the success of our Clinical Futures Programme.

The challenge is to optimise the urgent care system to ensure that demand for services is managed effectively in primary and community care at the beginning and end of patients' care journeys, so that only those that need the highest levels of medical care are referred to emergency departments and assessment units and are able to return to their home of choice as soon as possible.

3.5.5 Bed Capacity Requirements

The immediate priority is to continue to use current bed capacity as efficiently as possible, reducing the need for additional capacity and reducing the variable costs associated with staffing additional capacity. Therefore the cross cutting organisational capacity priorities addressed in last year's IMTP remain a focus within this SCP, below, and for divisional plans in 2018/19.

Following Welsh Government approval of the funding for the Grange University Hospital (GUH), the Clinical Futures programme is working with divisions to refresh the clinical models of care and with ABCi to model the demand for beds in the GUH and enhanced Local General Hospitals (eLGH) in the urgent care system.

The challenge is to ensure an adequate bed base on each site to support transformed care models which ensure the GUH operates effectively as a specialist and critical care centre from 2021, with no delays to timely transfer from those specialist care services to a network of hospitals. The Full Business Case for the GUH set out the bed reduction requirements across the system as follows:

ABCI is currently re-testing the business case assumptions to ensure the system is prepared over the next 3 years to establish this new bed base without adversely impacting on the rest of the system. This modelling will **enable the Health Board to refresh its 3 year organisational capacity plan during 2018** and, where possible, capacity that does not add value to patient care will be reduced or re-configured across the system.

Table 3.5.3 summary of SCCC Full Business Case Bed Changes requirement by division

Division	Bed change
Family & therapies	-33
Scheduled Care	-38
Unscheduled Care	-60
Community Services	-57
Cross organisational	-70
Subtotal	-259 (-230)
Primary Care Services	+67 (+67)
Net change	-192 (-163)

3.5.6 Ensuring patients receive the right care, in the right place and at the right time

The Health Board and **Welsh Ambulance Services Trust** have established a joint forum that meets on a quarterly basis, with a view to focussing on the strategic and transformational changes that will reshape the way services are delivered locally with a view to optimising flow across the 5 steps, improve clinical outcomes, patient experience and reduce the proportion of Gwent residents conveyed to Emergency Department by ambulance. The figure below illustrates the priority actions that will be progressed during this planning cycle.

The key priority for working with WAST this year is the handling and management of HCP calls ensuring that requests for transport for patients within agreed 1-4 hr timeframe are met, ensuring dedicated Urgent Care Service resource to exclusively manage this demand.

3.5.7 The Health Board's approach to system wide change

In 2017/18 the key components of NHS Scotland's "6 Essential Actions" for transforming urgent care (figure 3.5.1) was adopted. This has provided a more focussed approach to patient rather than bed management, medical and surgical processes to pull patients from ED and strengthening hospital capacity and patient flow alignment through more robust hospital site management.

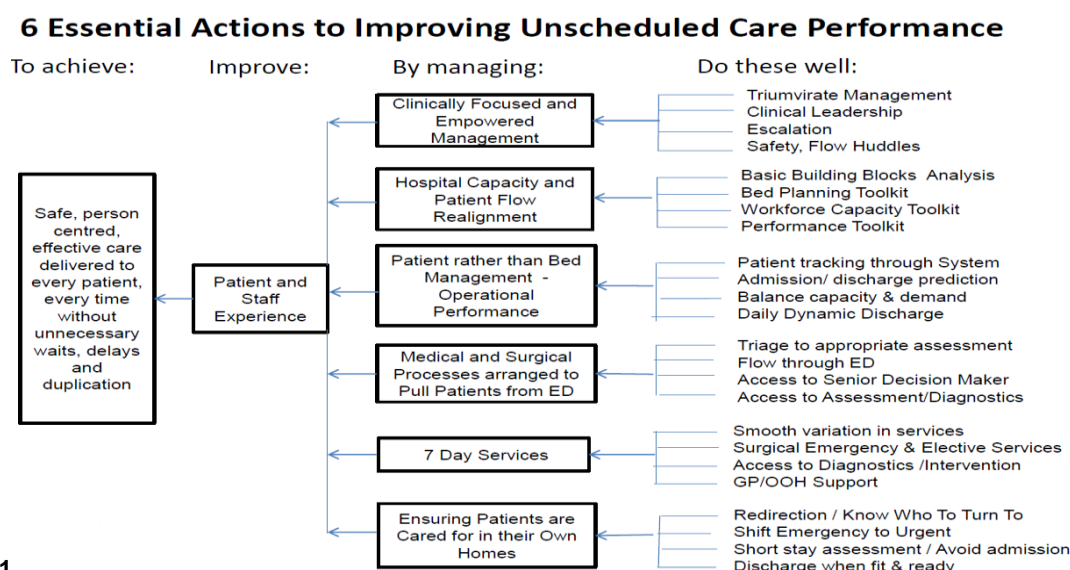
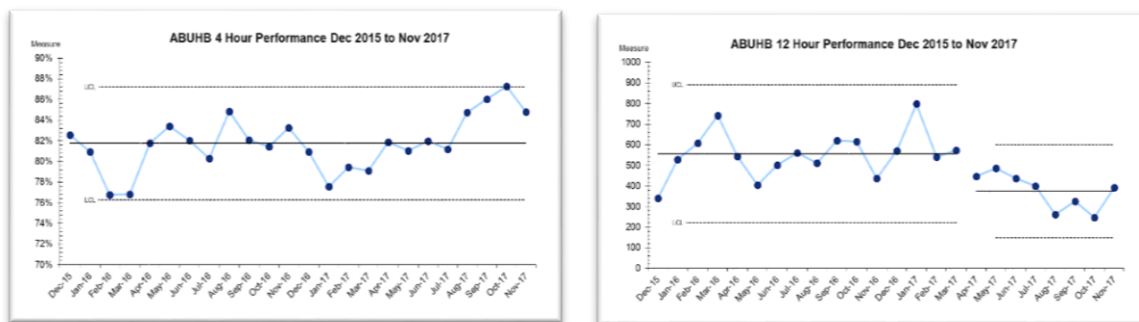


Figure 3.5.1

This approach in 2017/18 saw improved tier 1 performance going into the end of quarter 3 and the second half of 2017 saw a 28% reduction in 12 hour waits.

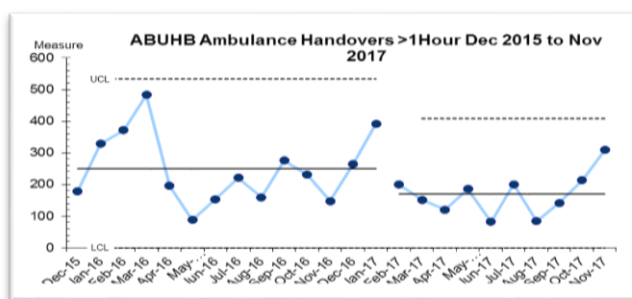
Graph 3.5.4 & 3.5.5 ABUHB 4hr and 12hr performance



However, the improvement against the 4hour target has not yet seen a significant shift and the Health Board continues to implement measures in the acute part of our system to manage demand effectively. The Health Board shall continue to embed and scale up projects that have delivered improvements in 2017/18 with the aim of further improving 4 hour performance to achieve 92.5% by March 2019.

There has also been an improvement in the 60minute ambulance handover performance in 2017. However, recognising that there should be zero 12hour waits and zero 60minute handovers, this plan shall continue to seek to eliminate these delays across the system.

Graph 3.5.6 ABUHB Ambulance Handover performance

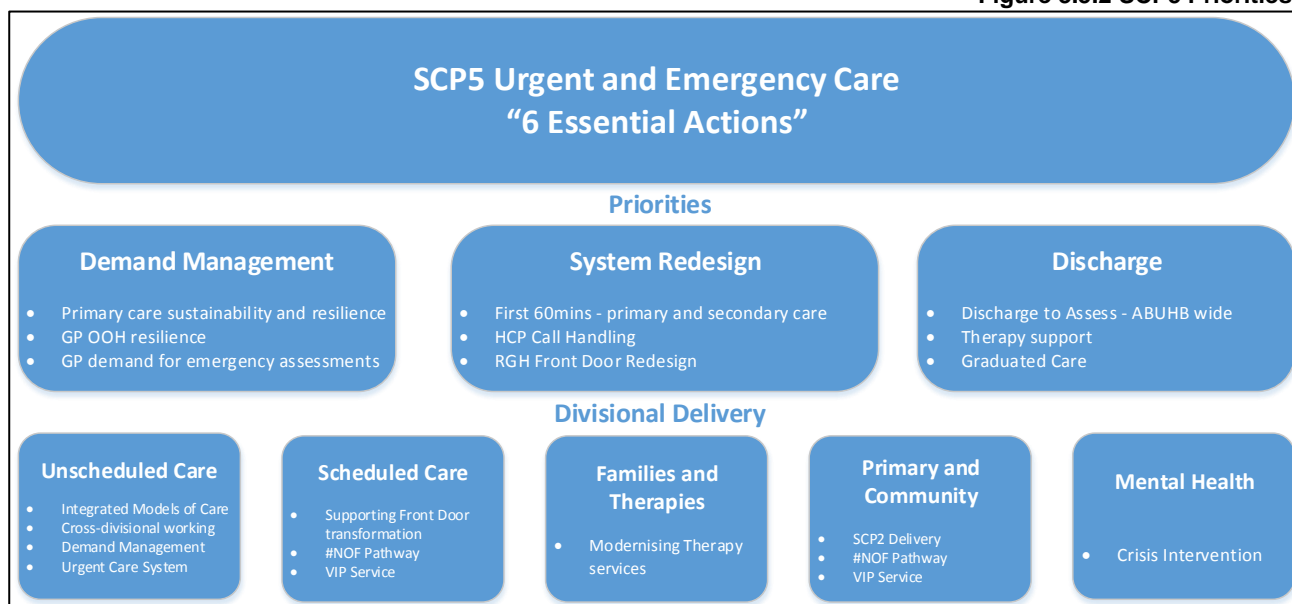


3.5.8 Service change priorities

The Health Board continues to frame transformational change of the Urgent Care system over the next three years according to the “6 Essential Actions” but Urgent Care Board shall focus on three key priority areas in 2018/19:

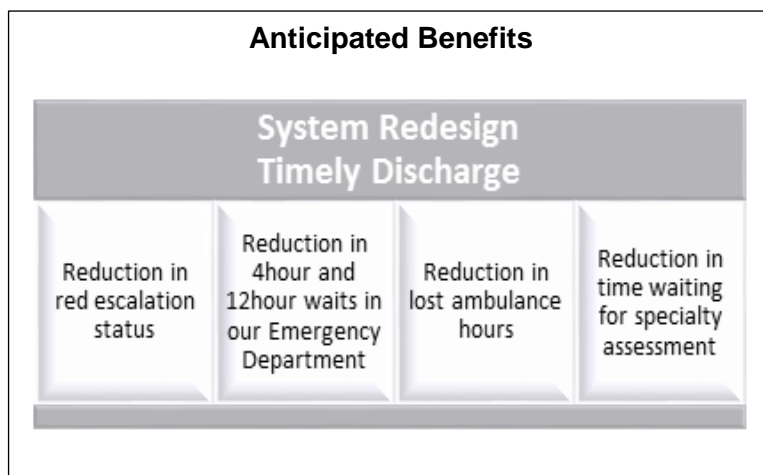
1. **Managing Demand** for Urgent and Emergency Care
2. **System Redesign** particularly at Royal Gwent Hospital in readiness for the transition to the Grange University Hospital in 2021
3. Timely **Discharge** of patients to their home of choice

Figure 3.5.2 SCP5 Priorities



Essential Action 1 Clinically Focused and Empowered Management

During 2017/18 site operational and medical leadership was established, with two new Heads of Operations for Nevill Hall and Royal Gwent Hospitals in post in January 2018. Nevill Hall has also completed its triumvirate management structures with clearly defined nursing leadership. LEAP, escalation and full capacity protocols were refreshed to ensure clarity of responsibility and focuses attention on the operational management of patient flow as opposed to bed management. As a result Nevill Hall has seen some of best performance against 4 hour and 12 hour targets in Wales. Medical specialties have trialled new operating procedures as part of the RGH Front Door Redesign project. This has contributed to an improvement in 12 hour performance and began to impact on 4hour performance during quarter 3: 2017/18.



Work to finalise the triumvirate management structures at Royal Gwent Hospital and inter-specialty SLAs with medical and surgical specialties to ensure timely pull from the front door will continue into the first quarter of 2018/19..

Therefore the objectives for essential action in this plan will be as follows:

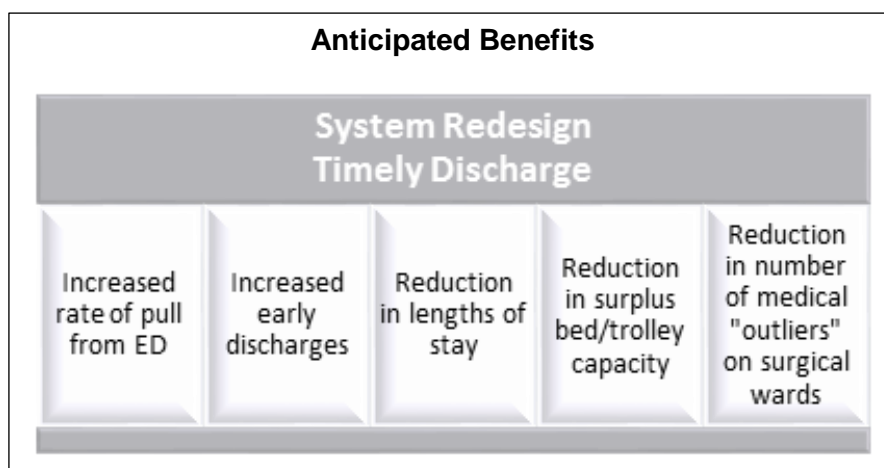
- Site management processes will be embedded as core business and site management leads will be in post to support medical and nursing leads. Medical leaders are already in place in the north and south of the area, **but there is further work required to ensure nursing leadership is clearly defined and in place.**
- Escalation plans will be agreed and accepted by all clinical and managerial leads, embedded in core business and monitoring processes will be in place to ensure they are followed as routine.
- Robust **Standard Operating Procedures** will be developed and implemented with inter-specialty service level agreements for time standards and practice standards, agreed across divisions and owned at all levels of the organisation.

Essential Action 2 Capacity and Patient Flow Re-Alignment

Essential Action 3 Patient not Bed Management – Operational Performance

The key component elements within Essential Steps 2 and 3 are:

- Better use of data to inform tactical and operational planning
- ABCi quality improvement through its collaborative networks
- Improving flow – **SAFER** bundle roll out and **Dynamic Daily Discharge**
- Bed demand and capacity



Data

Whilst there has been significant progress on the use of data and understanding the system better the Health Board can still improve further and aims to use Business Intelligence tools more effectively to manage the system both operationally and tactically.

ABCi

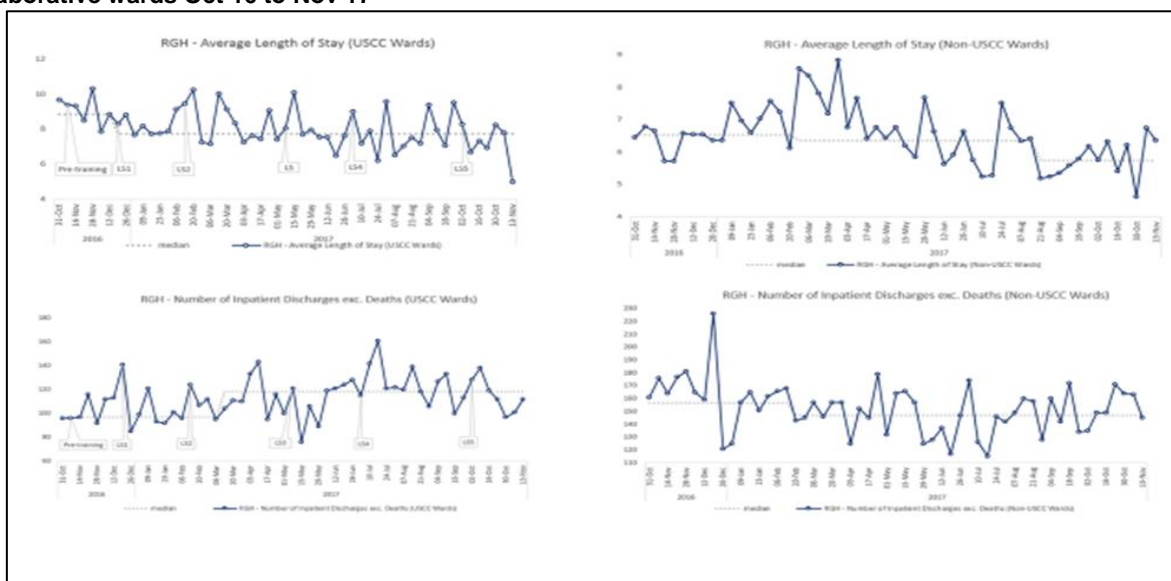
Aneurin Bevan Continuous Improvement (ABCi) directorate have supported the delivery of a capacity and patient flow (planned and urgent/emergency) re-alignment programme through the Unscheduled Care Collaborative, incorporating much of the work described in improving flow below.

Early morning medical discharges and <12pm medical discharges have improved by 33% on ABCi collaborative wards at RGH (shift in median from 10 to 15 per day), and 10% across other RGH wards. However, the improvement has not been as significant across the rest of the Health Board.

The aim in 2017/18 was to discharge 33% consistently before midday and this remains a commitment in 2018/19, to support efforts to improve flow and reduce lengths of stay (LOS).

However, the collaborative initially focussed on a small number of wards in Royal Gwent Hospital. Quarter 3 2017/18 saw the collaborative expand to a number of community wards.

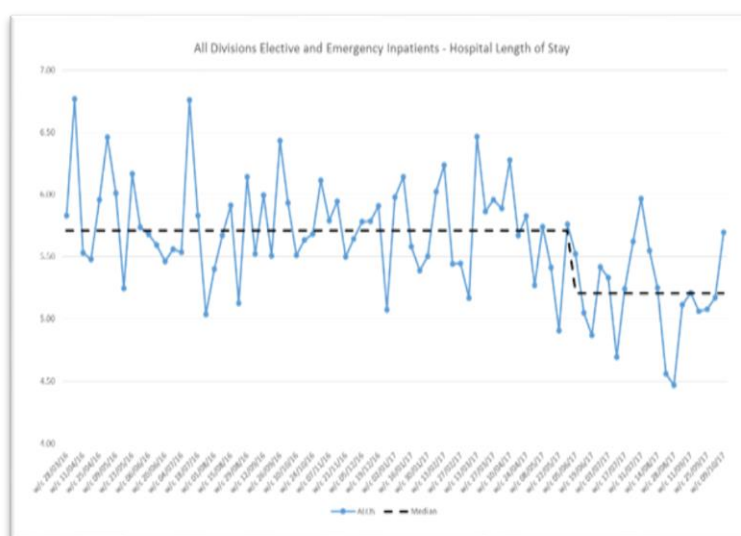
Graph 3.5.7 High Level LOS and Discharge Performance Unscheduled Care Collaborative wards versus non-collaborative wards Oct 16 to Nov 17



Improving flow

The focus for 2017/18 was the adoption of the “SAFER” patient flow bundle across all medical wards to embed daily dynamic discharge into the system, supported by ABCi. This was supported by a small cohort of discharge co-ordinators who provide a specialist role allowing clinical staff to focus on clinical activity with patients, whilst maintaining a clear focus on timely discharge. Where this has been achieved significant improvements in discharges and lengths of stay have been delivered, but Health Board wide there is further to go on daily discharges. However, whilst improvements in Hospital Lengths of Stay have been achieved, the main impact was seen in Quarter 3’s 12 and 4 hour performance rather than reduction in core bed capacity.

Graph 3.5.8 Improved Hospital LOS in 2017



Further embedding the SAFER bundle and increasing the availability of DiSCo’s across all wards as

a core part of their daily processes will increase the numbers of discharges by site each day, increase green days (where patients receive interventions or actions that move their care forward), a decrease in red days and most significantly, improve the numbers of people that are discharged earlier in the day.

Bed demand and capacity

Actions taken as part of the approach to bed planning within the Health Board's Organisational Capacity cross-cutting theme have supported the improvement in performance, and allowed a reduce in the use of corridors and capacity in areas that were not designed for medical bed-based care. However, there is further work to be undertaken to understand demand on beds going forward and the required capacity at specialty level, for which there will need to be a revised plan for bed capacity and configuration across the Health Board.

As part of the Clinical Futures Programme, the demand and capacity modelling for the bed base across the organisation is being refreshed by ABCi in preparation for transition to the Grange University Hospital in the third year of this plan. During year 1 of this plan detailed analysis will be undertaken at specialty level in acute, primary and community settings to determine the capacity required to meet future demand, taking account of the new service models required for Clinical Futures.

The challenge for 2018/19 and beyond will be to “embed and spread” change that has had a positive impact across all sites and specialties, and work with partners to bring patients that need acute care into hospital in a planned way that aligns to the capacity to meet their needs at the right time, thus delivering system wide improvements in discharges and lengths of stay to enable optimum flow.

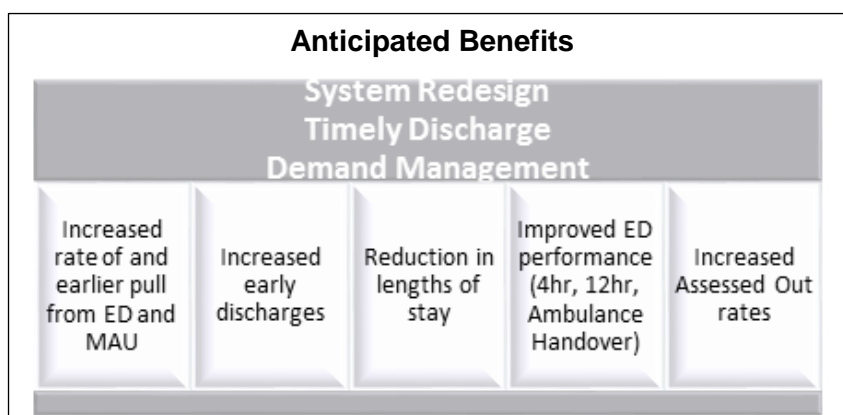
Therefore the objectives for essential action in this plan will be as follows:

- Scale up the impact of the Unscheduled Care Collaborative across the whole urgent care system, training coaches and measurement leads to add capacity to support wards undertaking flow quality improvement initiatives
- ABCi to complete the bed demand and capacity modelling to enable a revised bed plan to be delivered with alignment to Clinical Futures programme
- Embed the SAFER bundle as core business on all wards.
- Ensure sufficient DisCo capacity across areas of the Health Board where this will have most impact.

Essential Action 4 Medical and Surgical Processes

The key component elements of this essential step are:

- Nevill Hall Hospital Front Door Redesign – Single Urgent Care Access
- RGH Front Door Redesign
- Surgical Specialties



Nevill Hall

Welsh Government supports in principle the redesign of the physical infrastructure and pre- and post-GUH models of service delivery in Nevill Hall hospital as an enhanced Local General Hospital. The work was clinically led, and the design is fit for the future. The next step for this project is to develop an internal case for the works required with detailed options appraisal for rebuild or refurbishment, pending capital being available to support the changes.

Royal Gwent Hospital

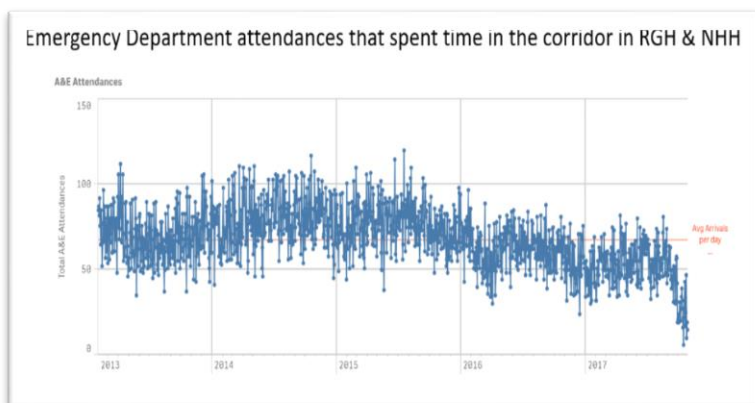
The Royal Gwent Hospital has begun a programme of redesign focussed on the model of care at the front door, joint working with the medical assessment unit and supporting flow through the urgent and emergency floor by implementing:

- Two hourly huddles involving key staff across the whole ED and assessment floor
- Introduction of Emergency Physician in Charge (EPIC) role
- Consistent availability of ACP cover 5 days per week for Ambulatory care
- Transfer team pilots that seek to reduce time between bed availability and transfer
- “Golden Hour” discharges pulling up to 5 patients before 9am to ensure flow through MAU

This resulted in:

- Elimination of the ED corridor as “normal” capacity
- Elimination of corridor trolleys in MAU
- Improvement 4 hour and 12 hour performance in quarter 3 2017/18

Graph 3.5. 9 Reduction in corridor usage at RGH and NHH in 2017



The number of patients waiting in corridors as a location of care has also significantly reduced and corridors are no longer deemed to be a place of normal care, so there are no longer corridor trolleys in Royal Gwent ED and MAU or in Nevill Hall ED, as normal “care locations”.

However, increased pressure over the winter in 2017/18, especially at the Royal Gwent Hospital where high volumes of patients, with high acuity,

has demonstrated the fragility of improvements and further work is required to establish a model of care at the Royal Gwent which utilises resources effectively. This is not the responsibility of the Royal Gwent or Unscheduled Care division in isolation and demand from GP referrals needs to be managed by improved HCP call handling and through a flatter pattern of referral and arrival through the day. The Health Board is working closely with the Welsh Ambulance Services Trust to align these key priorities within each organisations IMTP.

Decisions taken during the first hour of the patient’s journey through the urgent and emergency care system will determine both their clinical outcomes and how efficiently the system meets their needs. This is an area where the opportunity for further improvement is significant.

In both primary and secondary care, the Health Board needs to manage demand effectively by ensuring patients are directed and re-directed to the streams and services most appropriate to their needs. This requires a system-wide approach based on a clear understanding of the patterns of demand highlighted above, with capacity to deliver and a team based approach which meets that demand from the first few minutes in which the patient has contact with the system.

Graph 3.5 10 % of patients triaged within 15minutes and seen by a doctor within 60 minutes at RGH E D

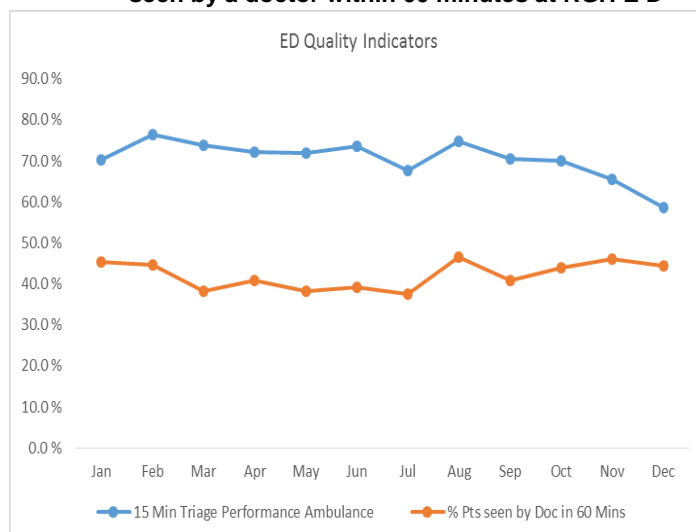
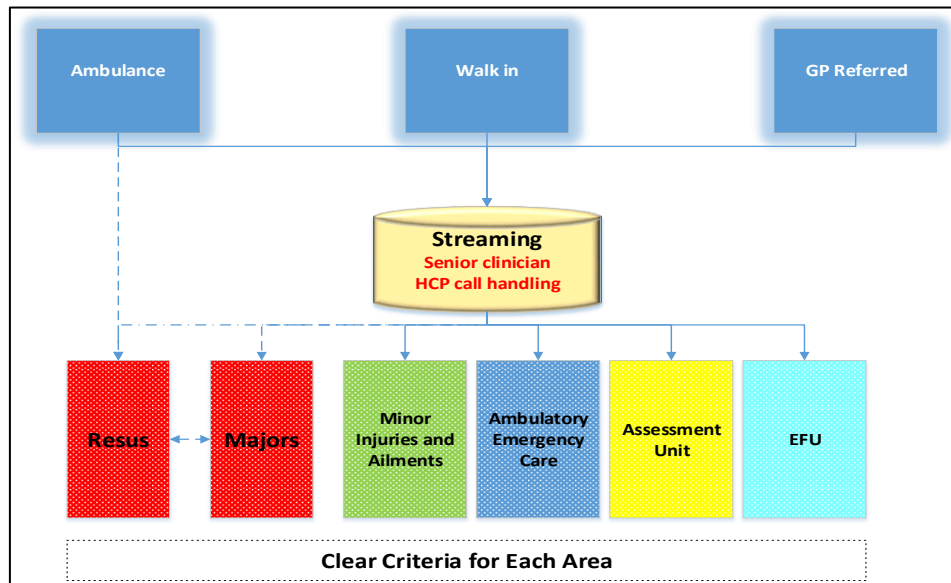


Figure 3.5.3 Proposed Front Door Design RGH



Better use of existing resources, encouraging patients to appropriately use Local Emergency Centre at YYF and Minor Injuries at YAB, and working with primary care NCN leads to scope the potential for an Urgent Care Centre at the Royal Gwent Hospital.

The challenge will be to stream patients effectively during the first 60 minutes of their urgent care journey ensuring that they are directed or re-directed to the services that best meet their needs.

The plan is to continue to redesign the front door at the Royal Gwent Hospital, enabled by improved flow, to ensure that zero corridor trolleys are maintained and begin to sustain improved tier 1 performance.

Surgical specialties

The redesign of the front door at Royal Gwent Hospital also needs to be supported by developments in Scheduled Care division such as the revised Fractured Neck of Femur (#NOF) pathway and VIP service for patients who deemed to be medically stable enough to go home following assessment but require urgent investigations. These services are in their infancy and will be monitored and evaluated through Urgent Care Board. The division is also developing protocols to support inter-specialty SLAs (Essential Action 1) to ensure surgical patients are either reviewed within 30 minutes of arrival at ED or transferred to the Surgical Assessment Unit at the Royal Gwent Hospital.

The objectives for essential action in this plan will be as follows:

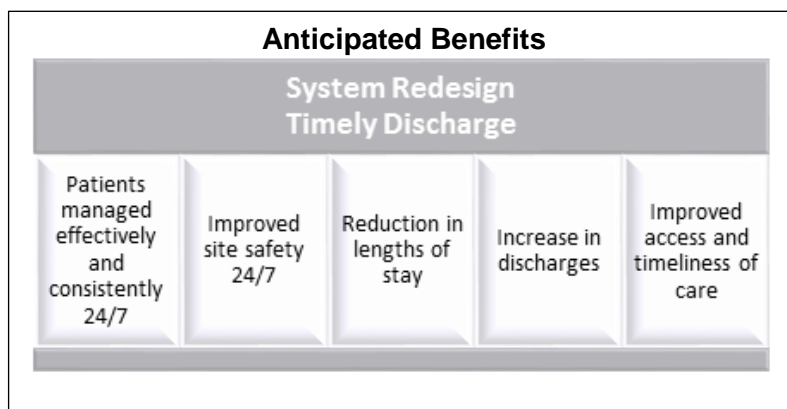
- Work with WAST to trial taxi transport for suitable GP referred patients, securing a UCS crew to prioritise GP transport and scheduling patients effectively to manage demand across the day when capacity is available to respond.
- Embed current changes at Royal Gwent front door and complete a full redesign (which is fit for purpose for transition to the Grange University hospital), establishing senior decision making early in the patient's journey and sustaining 5 day ACP cover on both sites for ambulatory emergency care.
- Consider the system wide support required to further improve ambulatory care services, and spreading the philosophy and ethos of ambulatory care beyond acute medicine to other medical and surgical specialties.
- Ensuring that urgent care services (including HCP call handlers) respond appropriately within the first 60 minutes, directing patients to pathways that meet their needs in a timely manner.
- Implement VIP service at Royal Gwent hospital and monitor impact through Urgent Care Board.
- Establish routine reporting for #NOF pathway through Urgent Care Board

- Further develop the case for Nevill Hall Front Door redesign to create a single front door for urgent and emergency care.
- Develop programme structure to support development of an outline business case for an of Urgent Care Centre in Newport

These actions should ensure that there is prompt access to appropriate assessment and clinical intervention from specialists in the appropriate environment to enhance patient experience and establish care management plans promptly, minimising unnecessary waits and delays wherever possible.

Essential Action 5 Seven Day Working

The Urgent Care plan has sought to reduce variation in service and care provision across 7 days in and “out of hours” to improve the patient journey and prevent unnecessary waits and delays. Not every service needs to be available 24/7 but understanding the need and impact of the current provision is key to determining improvements and innovations required locally.



Families and Therapies division undertook a programme of work in 2017/18 aimed at modernising and improving access to therapy services across the Urgent Care system and NCN networks, identifying patients early in their journey, but also at the end of their journey to support discharge from both the front door and from community hospitals at Ysbyty Aneurin Bevan as part of the wider Graduated Care approach within the community.

The three key projects within this plan were:

Therapies at the front door – pilot commenced 14th November 2016 with 1x physiotherapist and 1x occupational therapist at the front door in Royal Gwent and Nevill Hall hospitals. Ongoing monitoring, data capture and reporting up to week 46 of the pilot (up to end of September 2017) shows that 1079 therapy assessments were undertaken at Nevill Hall and 1308 at Royal Gwent assessment units. Of these 1325 patients were admitted with therapy plans enabling earlier discharge planning and 875 patients were discharged home (308 with a follow up plan in the community).

Enhanced Therapy support at Ysbyty Aneurin Bevan – pilot commenced 21st November 2016 to provide enhanced therapy support to enable complex discharge, contributing to a 21% reduction in LOS on Tyleri Ward in 2017 when compared with 2016.

Therapy led reablement ward – service models are being scoped for this service as part of the Graduated Care development. This remains a key component of integrated planning within this IMTP.

Whilst the pilots are providing evidence of positive impact, it has not yet been possible to secure or allocate recurrent funding for these services. Therefore, the continuation of these services depends on alternative funding or workforce solutions, which are being scoped early in this planning cycle.

During 2017/18 a task and finish group was established to improve site safety across secondary care hospital sites by establishing a Hospital at Night model. This work will conclude in quarter 1 2018/19 and be implemented in quarter 2.

Another key enabler of the Health Board's plans is the availability of advanced practitioner roles across the urgent care system, a full review of advanced practitioner roles will be undertaken to

ensure consistency and cost effectiveness across services.

Implementing 111 across Gwent

The 111 service is an amalgamation of NHS Direct Wales and the GP out-of-hours service and is currently being piloted in Swansea, Neath Port Talbot and Bridgend. It is anticipated that 111 will be implemented within the Health Board in 2018. The service will provide health information, advice and access to urgent care. Its purpose to ensure that patients are signposted to the right services and its functions, subject to evaluation of the pilots, will include:

- Identify and manage patients with complex needs by undertaking a holistic, multidisciplinary telephone assessment to determine the appropriate outcome in line with the patients' needs and wishes.
- Provide clinical support for health professionals working in the wider urgent and emergency care system who may require advice or support in developing appropriate treatment or management plans.
- Provide clinical support to other colleagues working within the 111 service either on site or virtually by providing telephone advice to remote centres, with a potential for 3 way call management with patients.
- Support an effective interface between the 111 service and GP Out of Hours service by acting as 'flight controller' overseeing 111 call queues, assisting in routing calls to the right queue/health care professional, and making decisions as part of the wider 111 escalation process.

Implementation of 111 is overseen by a multi-agency programme board and progress is monitored through Urgent Care and Level 1 boards.

GP Out of Hours services feature as part of Primary Care sustainability in SCP2, however the success of GP Out of Hours services remains a key component of urgent and emergency care transformation and improvement. Embryonic discussions are ongoing to establish whether there can be a regional solution to GP Out of Hours call handling to support ongoing sustainability.

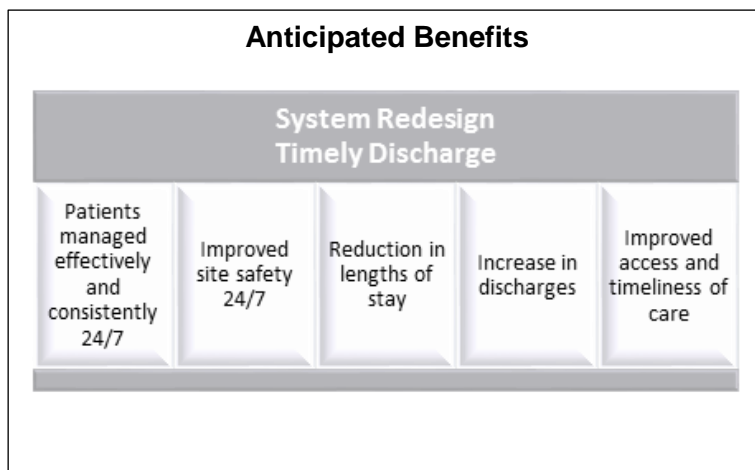
Therefore the objectives for essential action in this plan will be as follows:

- Scope alternative staffing and funding solutions from within the current financial envelope to continue therapy services at the front door and YAB and to develop a therapy led rehabilitation ward as part of Graduated Care developments.
- Develop and implement a Hospital at Night model in Royal Gwent and Nevill Hall hospitals.
- Establish a cross divisional working group to review plans for advanced practitioner roles.
- Implement the 111 service in Gwent.

Essential Action 6 Ensuring the Patient is cared for in their own home

The Health Board has developed a portfolio of services over the past few years to ensure the more patients with an unscheduled care episode can be optimally cared for, or discharged to their own home as soon as possible.

Given the large and increasing numbers of patients that are referred by their GP to acute assessment units the Health Board will prioritise the development of plans for optimising access in General Practice for urgent care – e.g. same day consultation (face-to-face; telephone or home visit) with particular focus on the development of Urgent Care Hubs aligned with the Royal Gwent and Nevill Hall Hospitals Emergency Departments as described above. As demand placed on our system by primary care referred patients is further understood, plans can be finalised to shift the balance of care from secondary to primary care where appropriate.



Supporting the ambition for a shift of care closer to home, NCNs have developed and implemented “Stay Well plans” (risk stratification in primary care) with 9 practices now using the risk stratification tool and 896 stay well plans (SWP) in place, as at September 2017. The early results of an evaluation carried out by the Health Board’s ABCi team estimates that 22 ED attendances and 15 emergency admissions are potentially avoided each year for every 100 people with a Stay Well Plan.

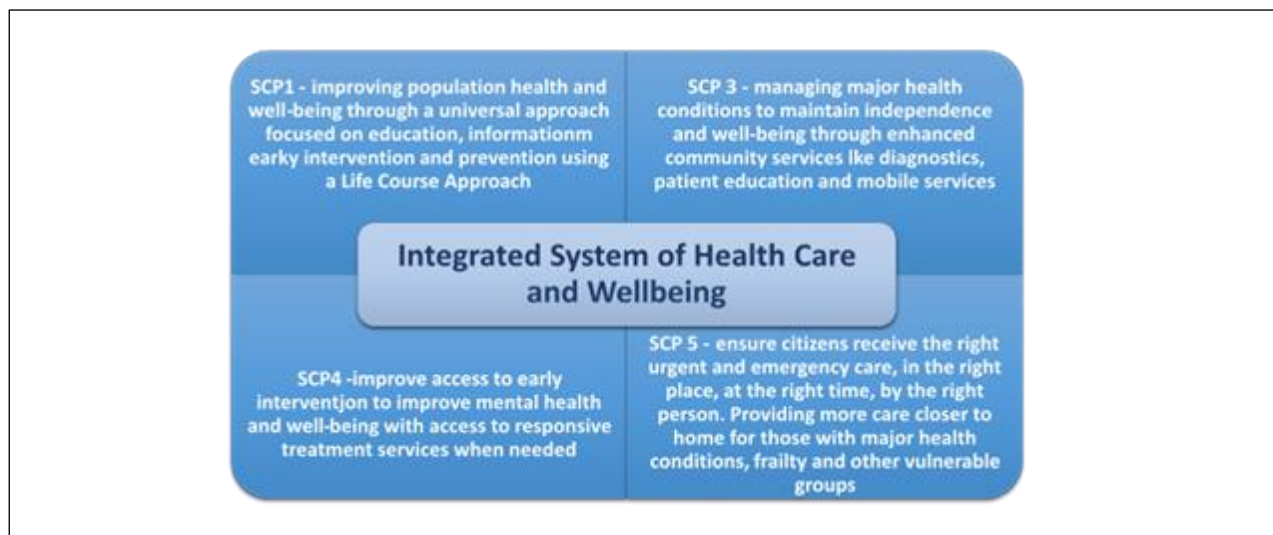
Alongside this, community teams have been working to ensure patients who live in

nursing or residential care homes have Advanced Care Plans in place, to prevent unnecessary conveyance to hospital. 61% of residents in nursing homes have an Advance Care Plan in place as at September 2017.

In April 2017, the Health Board commissioned a “Discharge to Assess” pilot at Nevill Hall hospital. The pilot has seen 64% of patients assessed discharged within one day or less and an increase in the number of complex discharges resulting in around 10% reduction in length of stay. Costs avoided by discharging patients earlier in their journey, as a result of this pilot, were calculated to be in excess of £0.5 million. The Health Board will work with partners to secure this type of service longer term to cover all acute hospital sites.

The Complex Care team also plans to pilot a service which helps reduce delays to patient discharge due to choice of care home.

Figure 3.5.4 Aligning plans with SCP2



Service Change Plan 2, developing an Integrated System of Health Care and Wellbeing for those with a care and support need, aims to provide more care closer to home, integrated services, a seamless pathway of care for individuals across organisational boundaries, and an enhanced focus on providing consistent locality based care and support.

An integrated system, is the underpinning foundation of the Clinical Futures Strategy, and a five year programme plan has been developed to direct coordinated activity in collaboration with partners in local government and the third sector. The plan is structured into four key elements:

1. People staying healthy and well

2. Self-Care
3. Primary Care and NCN Team
4. NCN Hub with specialist and enhanced services

Therefore the objectives for essential action in this plan will be as follows:

- Accessible/sustainable primary care – ensuring capacity, skill mix and demand management within primary care through a wide reaching programme of work, including OOH sustainability.
- Advanced Care Planning – this project is well advanced and will focus on upskilling care staff working in the independent and third sector to manage deteriorating conditions and advanced care plans.
- Stay Well plans – improving uptake and evaluating the impact of Stay Well plans.
- Graduated Care – developing nurse and therapy led wards in the community to reduce length of stay and improve longer terms outcomes for patients at home.
- Discharge to Assess – secure ongoing funding to procure appropriate services across all acute sites to support people home following the successful pilot at NHH in 2017.
- Patient Flow Co-ordinators – embedding the role in community hospitals to bolster discharge teams in the community, supporting the principles of SAFER bundle highlighted above.
- Implementing key actions for Urgent Care within the Care Closer to Home strategy.

3.6 SCP 6 – Planned Care

This SCP seeks to secure improvements in efficiency and productivity that in combination with prudent healthcare will improve access and deliver high quality, affordable and sustainable services.

3.6.1 Planned Care Programme Board

The Health Board's Planned Care Board has revised its purpose and governance to ensure it operates in a more structured 'programme' format, to improve grip and pace on delivery. The Programme structure enables a wider and more managed focus whilst maintaining engagement, activity and monitoring on improvement across the whole planned care service. Whilst the Programme acknowledges many opportunities and challenges it also recognises the value in collaborative opportunities to support this. Membership has been broadened to include NHS Wales Delivery Unit in the core membership and members contribute to the Regional Planning workstreams, in addition to the Health Board leading the Regional Planning for Ophthalmology.

The Health Board's Planned Care Programme Board is the means by which the Health Board delivers improvements in elective access, productivity and efficiency. The work programme is aligned with:

- Clinical Futures Strategy and emerging models of care;
- National Planned Care Programme Board (NPCB);
- Regional elective collaborations (Ophthalmology, Orthopaedics and Diagnostics).

It monitors improvements and status of specialities and the 5 identified priorities in NPCB within:

- Urology;
- Ophthalmology;
- ENT;
- T&O;
- Dermatology.

It will deliver active improvements in local productivity and efficiency through its 4 key activity work programmes for:

- Care Closer to Home;
- Theatres;
- Demand Management;
- Outpatient Improvement.

The Programme oversees and assures:

- The development of annual plans to improve elective, diagnostic access and therapies, delivering sustainable services that meet recurrent demand and aligned with the National Planned Care Programme Board.
- Clear framework for elective demand and capacity that underpins local delivery plans, including those to eliminate backlogs.
- A focus for the implementation of prudent healthcare and value based initiatives in Planned Care as a means of optimising demand and delivering services.

3.6.2 Work Programmes – Priorities

The Planned Care priorities for 2018/19 bring together local, regional and national initiatives within the context of the Health Board's value based healthcare work stream and the health Board's Clinical Futures Programme. The detailed mapping of these at specialty level is included at Appendix x, with the following overarching priorities:

- Delivery improvement in theatre performance.

- Improving elective access (RTT, diagnostics and therapies).
- Service transformation (MSK and outpatients).
- Transforming cancer performance.

I. Delivery Improvement in Theatre Performance

A Theatre Programme Board has been established to transform theatre productivity across the Health Board. Chaired by the Divisional Director and managed by the Directorate, the Theatre Programme Board seeks to deliver sustainable improvements in theatre performance in support of improving elective access.

Benchmarking and internal data shows that there are opportunities to improve theatre utilisation, with cancelled operations identified as a priority for improvement.

The aim is to deliver improvements in quality, efficiency and effectiveness of Theatre services, monitored and managed through a series of specific projects and sub groups. The key priorities are:

- To optimise theatre utilisation (i.e. reduction of avoidable/short notice theatre cancellations).
- Local improvements and implementation of key elements to enhance safe care with the implementation of additional **NatSSiPs**. (**National Safety Standards for invasive Procedures**).
- Establishment of an electronic stock control system.

II. Access to Services

Referral to Treatment Time

Baseline Position- the Health Board is on track to reduce the number of 36 week breaches from the 975 in March 2017 to 145 by the end of March 2018, with the 26 week compliance anticipated to be 90%.

Desired Future State - the Health Board seeks to deliver Best in Class Planned Care by improving elective access to deliver RTT targets through the following:

- Managing demand through prudent healthcare.
- Optimising capacity, improving productivity and efficiency.
- Rebalancing activity between secondary and primary care.
- Eliminated backlogs and providing sustainable services.
- Working collaboratively across Health Boards.

Plan for future delivery and profile for delivery for all specialities- the Health Board has delivery plans for the Division in each specialty, including contributions from efficiency, increased capacity and prudent healthcare in eliminating recurrent and non-recurrent gaps.

The Health Board plans to:

- Deliver 'zero' wait >36 weeks by the end of March 2019;
- Increase 26 week compliance to 92.5% at the end of March 2019 and to deliver 95% compliance by the end of 2019/20.

To support this there are comprehensive and regular reviews 'in year' of specialty demand/capacity assessments that include a continued emphasis on efficiency and productivity, together with a focus on prudent healthcare. Specialty specific plans fully reflect the operational, workforce and financial implications of delivery.

The profile for delivery for the next 3 years is:

Table 3.6.1

	March 2019	March 2020	March 2021
36 weeks	0	0	0
26 weeks	92.5%	95%	95%

The Health Board has detailed profiles for improvement (Appendix C1) with accountability for the

delivery of RTT targets lying with the Chief Operating Officer, and the Directorates and Divisions with regular reporting through the Finance and Performance Committee and the Planned Care Programme Board. Operational delivery is supported by Access Groups within Divisions.

Workforce and Financial Impact - the Health Board is seeking to deliver recurrent demand through core budgets by improved efficiency, alternative pathways and application of prudent healthcare principles wherever possible with a focus on reducing reliance on additional activity. The workforce and financial impacts of the RTT delivery plan are included within the Health Board's overall workforce and financial plans and will be subject to further scrutiny.

Diagnostic Waiting Times

Baseline Assessment - significant progress was made in 2017/18 in improving diagnostic access, in particular CT, ultrasound and endoscopy waiting times. The Health Board is on track to eliminate 8 week breaches, from an opening position of 2,491 at the end of March 2017. In addition, the volume of 6 week breaches will reduce to 1,700 at year end.

Desired Future State - the Health Board seeks to deliver Best in Class diagnostic services through the following:

- Managing demand through prudent healthcare.
- Optimising capacity, improving productivity and efficiency.
- Eliminating backlogs and providing sustainable services.
- Working collaboratively across Health Boards.

Plan for delivery - having made significant progress in 2017/18, where use of external capacity was required, the Health Board is seeking to consolidate its position and sustain a maximum 8 week waiting time in 2018/19. Further work will be undertaken in appraising the feasibility of delivering further reduction in waiting times and the impact of the adaption of a single cancer pathway on diagnostic demand.

Radiology

The delivery plan for the radiology services includes review of further demand management opportunities, improved turnaround from referral to report with increasing utilisation of technology and a number of internal schemes. To maximise flexible working opportunities and to enable 7 day working on all sites for CT and MRI, this includes the potential introduction of new workforce models building on regional collaborations.

As part of its Gastroenterology Sustainability plan, the Health Board continues to review plans for its endoscopy services. This includes a review of the current configuration of services and capital plans to meet the forecast demand and the requirements for JAG accreditation. In addition an ongoing review is required to identify and meet anticipated but as yet undetermined rise in demand as an impact of the single cancer pathway. A detailed delivery plan with associated workforce and recruitment content is in development to ensure sustained services at ELGHs and The Grange University Hospital.

Profile for delivery - the table below summarises the profile for improvement in eight week diagnostic performance over the next two years.

Table 3.6.2

	March 2019	March 2020	March 2021
% 8 week compliance	100%	100%	100%
% 6 weeks	1700	TBC	TBC

Workforce and Financial Impact - as demonstrated above, the Health Board is seeking to deliver recurrent demand through core budgets by improved efficiency, alternative pathways and application of prudent healthcare principles wherever possible with a focus on reducing reliance on additional activity. The workforce and financial impacts of the diagnostic delivery plan have been included within the Health Board's overall workforce and financial plans, for which the Health Board

recognises the need to manage the financial risks.

III. Service Transformation

Musculoskeletal Service Transformation (MSK)

MSK transformation is a key priority within National Planned Care and locally, and a significant element of the Health Board's Value Base Healthcare Programme.

The Health Board has an MSK Collaboration Group, which is a multi-divisional group with a view to having overarching responsibility for coordinating the collective effort in transforming MSK across the whole health community. Pathway work will be delegated to pathway experts spanning the health community to determine the best value, evidence based pathways. The MSK Group is being clinically led through the Clinical Futures Service Redesign Programme, with stakeholders across the whole healthcare system.

Orthopaedics

The Health Board has made significant progress in improving access to orthopaedic care, with the Directorate on track to reduce the number of breaches of 36 weeks to 145 at year end, the lowest position for many years. The Directorate continues to focus on improving access within the context of meeting recurrent demand via sustainable and prudent initiatives. The Health Board's plans align with the National Planned Care Programme and take forward these together with local initiatives (Appendix x).

In response to the NHS Wales report commissioned to look at Orthopaedic surgery ("Getting it Right First Time" (GIRFT)) ABUHB plans and monitoring are implemented in awareness of the report's recommendations and findings, shown in the table below:

Table 3.6.3

GIRFT Recommendation/finding(NHS Wales)	ABUHB developments
Capacity: balancing capacity and demand across Wales is a real challenge and effects patient care, outcomes and RTT delivery	Increasing sustainable capacity year on year. However, current infrastructure limits further expansion and the directorate is actively pursuing additional capacity (in outpatient clinic facilities/ and a laminar flow theatre to support larger medical teams in clinic and increased operating potential.
Minimum critical volumes: there is evidence of surgeons undertaking low annual volumes of certain surgical procedures. This is a concern because low volumes of arthroplasty may result in less favourable outcomes as well as increased costs.	New demand is distributed by subspecialty leads and only to dedicated subspecialists. Further work streams to be initiated to review 'second sides'.
Failure to follow the evidence: the review found that in some cases there was a failure to follow the evidence of the national joint register (NJR) and other registers in decision making around implant choice, especially in those aged over 68 years.	Continuing to monitor implant usage and pathways inline most recent guidance to ensure evidence and value based approach is adopted.
Ring fenced facilities and experienced staff: ring fencing elective orthopaedic beds, dedicated orthopaedic theatres and dedicated theatre staff are not universal in Wales and this is felt not to be ideal. Evidence supports that loss or absence of ring fenced orthopaedic elective beds increases the risk of infection.	maintaining three dedicated ring fenced wards and has implemented fast track swabbing process to protect these wards whilst also contributing to hospital flow.
Ortho-geriatric expertise: is considered a critical factor in delivering a safe efficient fractured neck of femur service. The UK shortage is noted. It has been suggested that specialist training be formally credited as a career progression point.	Two Orthogeriatric consultants have been appointed, these roles are embedding and the Directorate continues to review existing team structures and pathways to optimise patient care particularly for fractured neck of femur patients.
Procurement: the review found significant evidence of variation in selection and cost of implants across Wales. However it is noted that some excellent work has already been undertaken to address this.	The Directorate has implemented a rolling programme to regularly review implant usage and volumes to ensure best value is achieved from the optimal number of providers.

Outpatient Transformation

The Health Board's Transformation Programme seeks to ensure that patients receive appropriate and timely access to care, which is designed through the use of prudent healthcare principles. This is consistent with the National Programme and is underpinned by a three stage approach.

Stage 1: Evidence of best practice from within the Health Board and beyond

This stage has been undertaken in line with the national outpatient agenda, seek to discover best practise within all of the Health Boards within Wales. As a consequence, a Good Practice guide is available from the National Group and is supported by all 7 Health Boards and 1000 Lives. Examples of good practice within the Health Board include:

Table 3.6.4

Stage	Example
Pre – referral	<ul style="list-style-type: none">Community Osteoarthritis GroupMinor Oral Surgery ServiceDiabetes Email Advice Line for GPsImplementation of Primary Care Paediatric Constipation Pathway
Referral	<ul style="list-style-type: none">GP Email Advice Lines (Cardiology, Rheumatology, Urology)High level coding of referral on receiptTele dermatologyAdvice Letters (Haematology)Gynaecology Referral AuditCollaborative Referral Validation; Reducing Risk in Tertiary Paediatric Cardiology Service
Triage	<ul style="list-style-type: none">Community Based Lower Back Pain TriageNurse Practitioners – multiple specialtiesDirect listing Audiology ReferralsDirect listing hernia pathway
Booking	<ul style="list-style-type: none">DrDoctor Reminder ServiceCentralised Colposcopy Booking Service
Utilisation	<ul style="list-style-type: none">Performance Management – clinic utilisation prospective and retrospectiveCWS information for ad hoc analysis of clinic utilisation
New attendance	<ul style="list-style-type: none">Diagnostic coding in place e.g. OphthalmologyOphthalmic Diagnostic Treatment Centre for Wet AMD patientsNurse injectors for AMD patientsOne-stop Varicose Veins ServiceNurse Led Annual Review Clinic for Individuals with Serious Mental IllnessRespiratory Group Appointments for CPAP Set-up
Follow up attendance	<ul style="list-style-type: none">Virtual clinics; PSA urology, ENT, Rheumatology, OphthalmologyPost-operative cataracts by OptometristsOphthalmic Diagnostic Treatment Centre for Cataract & Glaucoma PatientsOne stop head and neck lump clinic (Unscheduled Care)See on Symptom Approach for MS PatientsRespiratory Drop-In Service for Patients with CPAP
Discharge	<ul style="list-style-type: none">See on Symptoms (Rheumatology)Knee Service Active Monitoring

Stage 2: Innovation and demonstration of impact

The evidence of best practice within the Health Board and from the other Health Boards provided scope:

- Combined the principles derived from the Best Practice examples and focus those principles on one directorate in order to demonstrate impact and potential to spread and scale up.
- Developed the evidence based change package to support an improvement collaborative.
- Trained identified speciality frontline staff in the necessary skills to enable on-going continuous improvement within outpatient services.

ENT has been the focus for stage 2, with the Health Boards agreed ENT pathways being recommended as Best Practice and distributed by Welsh Government to Welsh Health Boards.

Stage 3: Outpatient Improvement Collaborative

The evidence and demonstrated impact from Stage 2 is being utilised to develop a change package to support an improvement collaborative. By utilising the IHI Breakthrough Series methodology, there is an opportunity to more effectively build capability, share learning, spread improvement and scale up rapidly into other areas of the organisation. The programme, facilitated by ABCI, has trained Quality Improvement Coaches and identified 8 directorates to build the necessary capability, test and implement improvements. Subsequently, more directorates will be brought into the Improvement Collaborative, and will identified depending upon their readiness for change.

The programme is overseen and facilitated by ABCi. It is governed the Health Board's Planned Care Programme Board within the Outpatient Improvement Programme.

IV. Collaborative Regional Planning

The Health Board is an active stakeholder in the 3 regional collaborative initiatives, for diagnostic, orthopaedic and ophthalmology services, with the Health Board's Director of Planning leading the Regional Ophthalmology Group. The regional planning work will strengthen in the coming year, developing and building planning processes and clinical relationships which are described at Section 3.7.

V. Cancer Services

Baseline Assessment - Over the last 12 months, the Health Board has shown continued commitment for cancer care. Despite a series of difficult and challenging operational pressures in delivering cancer services, there has been good progress and a number of improvements in the delivery and sustainability of the Health Board's Cancer Delivery Plan, as described in the Health Board's Annual Cancer Services Report ([hyperlink](#)).

Desired Future State - the Health Board seeks to deliver exemplary cancer services through the delivery of its cancer plan and the sustained delivery of access waiting times. It will embrace the advent of the single cancer pathway and seek to place an increased role in the regional provision of services.

Profile for Improvement - the profile for improvement for the 31 day and 62 day targets is summarised below.

Table 3.6.5

Parameter	2017/18	2018/19	2019/20	2020/21
Non USC	97.5%	98%	98%	98%
Urgent Suspect Cancer	90%	92.5%	95%	95%

Demand and Capacity -there is evidence that the Health Board referral numbers for some cancer tumour sites remains higher than expected, but this level of outpatient demand is not reflected in higher treatment rates than compared to the rest of Wales. This suggests that there may be scope to streamline the pathway and reduce demand in areas such as breast. Aligned to the ongoing demands, demand and capacity work will continue to be undertaken in a number of areas including head and neck, breast, respiratory and cancer services so that capacity is responsive to increasing demand and will include consideration of the impact of the adoption of a single cancer pathway on diagnostic testing and reporting.

Service Delivery Plans and Milestones - the Health Board has a Cancer Delivery Plan for each tumour site that covers both compliance with Cancer standards and delivery of cancer treatment times. Through its Cancer Implementation Group, the Health Board continues to focus on five key priorities:

- Services, delivery, planning and performance.
- Primary care oncology.
- Develop single urgent cancer pathway.
- Patient experience.

- Lung cancer.

A large part of work in delivering these key priorities is in progress within the Health Board. The Cancer Delivery Plan remains very much a key priority for the Health Board in order to optimise and improve the quality of service we provide to Gwent and South Powys residents in cancer care. This is also important in order for the Health Board to retain its excellent reputation for cancer service delivery with our patients, Welsh Government and key stakeholders.

Aligning our SCPs that seek to deliver improvements in access, flow and quality of care with key enablers including finance, workforce and capital at a high level. The table below summarise the impacts that these service change plan is intended to deliver.

Table 3.6.6

Key Theme	Delivering Improvements in Access, Flow and Quality of Care
Finance	The indicative financial implications of the Planned Care and Urgent and Emergency Care plans are included in baseline budgets or have been identified as priority areas. These primarily relate to the solutions to deliver RTT, cancer, diagnostics, Out of Hours, the front door model and community beds and will need to be finalised in the context of the overall plan and efficiency opportunities.
Workforce	Additional workforce required to support Urgent & Emergency Care Plan including nurse consultants, pharmacists, ENPs/PAs/ANPs and radiographers. New workforce models are considered as part of the overall workforce plan and to support service sustainability. Better use of our resources is a key component of planned care with a focus on improving productivity.
Capital	Capital plans include potential schemes to support redesign of 'The Front Door' plans at Nevill Hall, potential improvement in breast services, and additional diagnostic equipment.
Digital Health	Extensions of the DrDoctor interventions to all elective specialties, including therapies, to reduce DNAs and improve the patient booking experience. Procurement and Electronic Patient Record (EPR) implementation for Ophthalmology

Service Sustainability and Regional Collaboration

3.7 SCP 7 – Service Sustainability and Regional Collaboration

3.7.1 Introduction

In accordance with the Health Board's Clinical Futures Strategy, the sustainability of a number of acute specialties will ultimately be achieved through their centralisation at The Grange University Hospital in 2021. This includes inpatient care for high acuity elective and emergency surgery, paediatrics, obstetrics, neonatology, acute stroke, cardiology and gastroenterology. The Grange University Hospital provides the enabling infrastructure and critical mass for such services, with the objective of delivering both improved outcomes and Deanery expectations to improve medical training. It is however recognised that there will be a challenge in sustaining services prior to the advent of The Grange University Hospital and this section describes the transition plans the Health Board will develop to sustain a number of services together with its increasingly important Regional Collaborations with other Health Boards.

Recognising the scale of the challenge for the Health Board in delivering organisation wide change required to support the Clinical Futures model and the opening of The Grange University Hospital, the Health Board has strengthened its planning infrastructure, including strong clinical leadership across the system to ensure that its service and capital planning resources are fit for purpose, and that there is a supporting organisation development programme. This work programme is complimentary to the Service Redesign element of the Clinical Futures Transformation Programme described in Section 1.5.

3.7.2 Service Sustainability

The Health Board has a track record of transforming its services to deliver both improved outcomes and sustainability. The Health Board has successfully centralised its hyper acute stroke services at the Royal Gwent Hospital, established early supported discharge and rationalised stroke rehabilitation, with a marked improvement in outcomes and quality of care. This has built upon the centralised models in place for a number of specialties, including urology, ENT, ophthalmology and maxillofacial surgery. The Health Board has also implemented and maintained an innovative workforce model for its neonatal services following the redistribution of Tier 1 & 2 trainees to Singleton Hospital and the University Hospital of Wales, sustaining neonatal services at the Royal Gwent Hospital in a recently refurbished unit.

The feasibility of reconfiguring medical and surgical specialties prior to the advent of The Grange University Hospital has been appraised in 2017/18 with clinical interdependencies such that there is limited potential to significantly change the physical configuration of services. As a consequence, the Health Board will seek, as far as is practical, to retain the existing configuration of acute services until the opening of the SCCC in 2021, though it will seek to standardise practice and introduce new models of care in advance wherever possible. The key work areas for 2018/19 priority programmes will include:

- Transition plans for inpatient paediatric, obstetric and neonatal services.
- Hospital at Night.
- Breast services.

Whilst this Service Change Plan describes the development of transition plans for a number of acute services, it is recognised that the scope of the Health Board's transition plans extends to its Primary and Community services and these are described in Section X.X.

3.7.3 Paediatrics, Obstetrics and Neonatal Services

Aim

This SCP seeks to provide a transition plan for paediatric, obstetric and neonatal services within the Health Board prior to the anticipated opening of The Grange University Hospital in 2021

Baseline Position

In 2015/16, the Health Board implemented new workforce models to sustain paediatric, obstetric and neonatal services at the Nevill Hall and Royal Gwent Hospitals to achieve Deanery requirements to centralise medical training at the Royal Gwent Hospital and enable improved quality of medical training. This has required the appointment of hybrid consultants, Clinical Fellows and specialist nursing posts at Nevill Hall Hospital. While the new workforce model has been implemented, it has not proven possible to recruit to substantive roles for all posts, notably Clinical Fellows and it is therefore over reliant upon medical agency staff to cover posts and remains fragile.

The Health Board has continued to manage risks within year and it has been necessary to introduce contingency measures on weekends, with limited changes in patient flows. Significant workforce pressures have persisted despite a detailed action plan that sought to strengthen recruitment and retention. This is compounded by national recruitment difficulties and the calibre of some agency doctors which has resulted in their early release, exacerbated by maternity leave and sickness. The Health Board has therefore been working with neighbouring Health Boards, notably Cwm Taf UHB and Powys THB, on the development of a transition plan for its paediatric, obstetric and neonatal services. In advance of The Grange University Hospital centralisation.

The Health Board has developed a transition model for its inpatient paediatric, obstetric and neonatal services and has identified the retention of a Children's Assessment Unit to maintain local access as a key element of its transition plan. There has been pro-active division with Cwm Taf UHB and the proposed clinical model broadly equates to that proposed for the Royal Glamorgan Hospital.

There has been a detailed assessment of the likely change in patient flows and the timetable for change has been appraised across South East Wales. The current capital developments at Prince Charles Hospital, Merthyr and the University Hospital of Wales are key enablers to potential flows outside the Health Board, with February 2019 being the planned date for the completion of these enabling works.

In the light of the vulnerability of the current workforce model, and the anticipated opening of The Grange University Hospital in 2021, the Health Board will determine the optimal transition plan for inpatient paediatric, obstetric and neonatal services, and its enablers and associated timetable.

Desired Future State

The objective is to develop and implement a sustainable transition plan for inpatient paediatric, obstetric and neonatal services for the population of Gwent and South Powys, working closely with Cwm Taf UHB and Powys THB. Subject to the outcome of engagement, it is considered that this will require the centralisation of inpatient paediatric and obstetrics services as a transition to the model described within the Health Board's Clinical Futures Strategy.

The detailed planning includes the sustainable workforce model, enabling infrastructure changes and resultant financial impact across Health Boards in South East Wales.

Work Programme Overview

To support the above the following milestones have been identified:

Table 3.7.1

1.	Current contingency measures to be appraised in terms of impact and resilience.	Q4 2017/18
2.	Potential revisions to clinical model and flows to be appraised.	Q4 2017/18
3.	Feasibility assessment of capacity and enabling actions.	Q4 2017/18
4.	Timetable for potential internal capital enablers to be determined and considered as part of Health Board Capital Programme.	Q4 2017/18

5.	Board consideration of available options prior to engagement.	Q4 2017/18
6.	Engagement phase.	Q1 2018/19
7.	Modification of plans in response to engagement.	Q2 2018/19
8.	Development of detailed implementation plan.	TBD
9.	Potential change in service provision.	TBD

Interdependencies

There are interdependencies with the plans of Cwm Taf and Cardiff and Vale UHBs in implementing the outcome of the South Wales programme and the completion of relevant capital developments, including potential changes in the allocation of Paediatric trainees. It is anticipated that the completion of the capital development at the University Hospital of Wales in February 2019 will enable the delivery of the outcome of the South Wales Programme with regard to Cwm Taf and Cardiff and Vale UHBs, and is a key enabler in potentially identify capacity to support service changes within the Health Board.

Workforce and financial issues

The financial costs of the current service are fully reflected in the Health Board's underlying position and the workforce and financial consequences of potential changes, including flows outside the Health Board, will be established as part of detailed planning. In the light of the complexity of the potential change, and the completion of capital enabling works, it is considered unlikely that changes in the service model will be material in 2018/19.

Risks

The Health Board is heavily reliant upon agency and locum staff, together with consultants providing resident Tier 2 cover at nights. It has sustained services on this basis albeit through the adoption of contingency plans on weekends since October 2017. Whilst potential changes in service reconfiguration are being considered, the Health Board has continued to prioritise recruitment and retention.

3.7.4 Hospital at Night

Baseline Position

In response to the restructuring of Deanery trainees in medicine, the Health Board has successfully implemented a Hospital at Night model of care at Ysbyty Ystrad Fawr. Whilst there are long established rotas covering medical and surgical specialties at Nevill Hall and Royal Gwent Hospitals these have yet to be formalised as Hospital at Night Teams. The model of care is a key underpinning of the Health Board's Clinical Futures Strategy with the advent of The Grange University Hospital and this has been identified as a priority as part of transitional planning.

Desired Future State

The objective is to develop and implement a Hospital at Night model at Nevill Hall and Royal Gwent Hospitals to strengthen the care of patients out of hours and to inform out of hours models of care with the advent of The Grange University Hospital.

Work Programme Overview

Table 3.7.2

1.	Establish overarching governance structure.	Q4 2017/18
2.	Undertake baseline assessments of available work.	Q1 2018/19
3.	Agree key underpinning principles.	Q1 2018/19
4.	Develop and appraise options to strengthen out of hours care for the two sites.	Q2 2018/19
5.	Engage widely with relevant specialties on emerging models.	Q3 2018/19
6.	Implement preferred model.	Q4 2018/19

Interdependencies

By its very nature, the introduction of a Hospital at Night model spans all acute specialties and there will be a need to ensure there is comprehensive engagement as part of the process, encompassing medical and nursing staffing.

Workforce and Finance Issues

The emphasis will initially be on using existing workforce resources more effectively, with a need to consider the Health Board's outreach service provision as part of the work programme.

Risks

There is a risk that if unaddressed the Health Board will face a significant change process associated with the opening of The Grange University Hospital.

3.7.5 Breast Service Sustainability

Aim

This SCP seeks to deliver sustainable breast services for the Health Board in the context of regional plans for South Wales

Baseline position

The Health Board currently provides ambulatory and inpatient breast services at both Nevill Hall and Royal Gwent Hospitals. The current configuration of services lacks critical mass and is inflexible, resulting in longer waiting times than desired and suboptimal patient experience. There is a clinical consensus that the centralisation of services would give critical mass and improve increase flexibility, with the opportunity through improved infrastructure to revise the clinical model to improve patient experience, efficiency and productivity.

Desired Future State

The objective is to provide a centre of excellence for Breast Services within Gwent that improves patient experience and access, and which is consistent with both the plans for neighbouring Health Boards and the All Wales Imaging Strategy.

Work Programme Overview

The Health Board undertook an extensive engagement strategy in 2016/17 and has secured agreement of both Aneurin Bevan and Powys Community Health Councils to proceed with the development of plans to create Breast Unit at Ysbyty Ystrad Fawr. Detailed operational and capital planning has been undertaken which will lead to the completion of a capital case by xxxx 2018.

Within the context of pressures on capital funding. It had been anticipated that the development would be considered for funding as part of the All Wales Capital Programme but constraints on this funding are such that the Health Board will consider the case as part of its Discretionary Capital Programme (Section 3.12). The business case will however be developed in sufficient detail to be considered for All Wales Capital Funding should the funding become available.

Interdependencies

There are a number of interdependencies, which have been fully taken into consideration, with a limited number of patients with co-morbidities requiring surgery at the Royal Gwent Hospital.

Workforce and financial issues

There is no change in workforce and the centralisation will result in revenue savings which will be described in the detailed capital case.

Risks

The key risks relate to the availability of capital to support the creation of a Breast Unit at Ysbyty Ystrad Fawr.

3.7.6 Regional Planning

The Health Board is committed to working collaboratively and at pace with Health Boards in the region to secure benefits for patients wherever this is appropriate. The Health Board has previously been an active partner in a number of collaborative mechanisms including the NHS Wales Health Collaborative, South Central Acute Care Alliance, WHSCC, EASC and the Clinical Networks and more recently the Regional Planning and Delivery Forum has therefore been established, which

includes the Chief Executive NHS Wales and Chair and Chief Executive representation from Cwm Taf, Cardiff & Vale, Aneurin Bevan, Abertawe Bro Morgannwg, Powys, Velindre and WAST. The key work areas for 2018/19 include:

- Vascular service redesign.
- Ophthalmology (Aneurin Bevan lead).
- Orthopaedics (Cardiff & Vale UHB lead).
- Diagnostics (Cwm Taf UHB lead).
- Transforming Cancer Services (with Velindre NHS Trust).
- MH Services with Powys THB.

The Forum will also consider and review the development of services at the Grange University Hospital in Cwmbran and any related implications for the South Central and East Region, and, in due course, consideration of the role and future of the University Hospital of Wales in Cardiff. More widely it is playing an integral role in considering the optimal future configuration of a number of services, including major trauma, SARC and pathology services.

Whilst the detail of how Regional Planning and Centres of Excellence will be taken forward is being considered by Chief Executives via the NHS Collaborative, there is agreement that a number of initiatives will be undertaken to strengthen regional planning in South East Wales, which includes work with the following key areas:

3.7.7 Vascular Services Redesign

There is a well-established Emergency Vascular Network in South East Wales, with the Out of Hours Service focussed on the University Hospital of Wales (UHW) with the rota comprising Vascular Surgeons from each of the component Health Boards. There is a strong evidence base for the further centralisation of arterial surgery, with an option appraisal undertaken in October 2014 identifying UHW as the preferred hub location, with spoke services retained within Aneurin Bevan and Cwm Taf University Health Boards.

The strengthening of network working is a requirement of Wales Abdominal Aortic Aneurysm Screening Programme and the commencement of the programme in South East Wales was predicated on the further development of the Network. Whilst good progress has been made in agreeing the final model, this is dependent on an enabling plan to deliver the new service model, and in particular theatre and bed capacity at the UHW hub, including a hybrid theatre, which has an indicative date of 2020 for completion subject to Welsh Government funding approval.

To maintain momentum, and address clinical priorities, an interim plan is being developed with initial outputs considered by Chief Executives in December 2017. This has identified that the creation of a South East Wales 24/7 Interventional Radiologist out of hours rota comprising consultants from Aneurin Bevan, Cardiff and Vale and Cwm Taf UHBs is a priority for 2018/19, and detailed planning work to enable this has commenced. The scope and timetable for the centralisation of arterial surgery and enabling actions will be considered with clinicians in January 2018 and a resultant implementation plan agreed. To support the process, the governance arrangements to manage the change process are being strengthened and is overseen by the Regional Planning and Implementation Group.

3.7.8 Regional Ophthalmology

The Regional Ophthalmology Planning Group has now met twice, with a further monthly meetings planned. The group is working to develop plans in parallel with work that is on-going at a national level, including the National Eye Care Plan and the National Ophthalmic Planned Care Board.

A baseline assessment of demand and capacity plans from each organisation has been completed and reviewed. This confirms the reliance on capacity outside core capacity both for outpatients and treatments in all organisations. Key areas of work to be taken forward by the group in 2017/18 and forward into 2018/19 include:

- Updated demand/capacity assessments.
- Identifying opportunities for maximising existing capacity in terms of theatres and workforce.
- Identifying and rolling out areas of best practice, specifically in terms of new workforce roles, booking processes, pre-assessment processes and ODTG models.
- Consideration of opportunities for better managing demand, including a focus on outcomes.
- Review of impact of electronic patient record as an enabler for change.
- Delivery of a robust regional plan for Ophthalmology for inclusion in final 2018/19 IMTPs.

3.7.9 Regional Orthopaedics

In 2017/18, The Regional Orthopaedics Planning group have reviewed each Health Board's plans particularly around the achievement of RTT targets and have confirmed that there were limited opportunities for improvement on a regional footprint. However, moving forward into 2018/19, the group plans to:

- Ensure that links are established with the National Planned Care Board:
 - Criteria and threshold work on all-Wales basis to inform regional model;
 - Consistent demand and capacity planning approach and tools.
- Look at opportunities to manage demand: sharing of good practice of community based service models that manage demand more appropriately (in line with National Planned Care Board).
- Finalise demand and capacity plans at sub-specialty level for the next 3 years to identify key gaps and opportunities to address on a regional basis.
- Review opportunities to maximise capacity: detailed benchmarking to identify further opportunities for better utilisation of existing capacity over next three years.
- Develop a regional service model to address theatre and trauma capacity issues.

3.7.10 Regional Diagnostics

The Regional Diagnostics Planning Group has met twice, with bi-monthly meetings now planned going forward. A number of areas of work are being planned for achievement in 2017/18 including:

- Diagnostic Hub open at RGH in November 2017, with additional, offered MRI capacity available from January 2018.
- Health Boards sharing information on areas of spare capacity which could help 2017/18 year end diagnostics position.
- Agreement reached with Region and Cancer Network to develop a proposal for commissioning of a regional EUS service (paper to be completed with options February 2018).
- Health Boards sharing best practice in implementation of MRI workforce redesign (e.g. increased use of Band 3s) and early cancer pathway redesign (December 2017).
- Feasibility study completed on potential for regional collaboration on management of mobile MRIs (October 2017).
- CEO agreement reached that mobile MRIs currently in use in Cardiff will be managed regionally via Diagnostic Hub in 2019/20.

Looking forward to 2018 / 19 and beyond, the group will be looking to:

- Develop standardised, robust demand and capacity modelling across the region with the support of the Delivery Unit, with the aim of maximising opportunities for collaboration in balancing demand and capacity plans.
- Complete a scoping study with recommendations to look at regional opportunities to support the timely provision of endoscopy services.
- Design and implement transformed early cancer diagnostic pathways across the region building on lessons learnt.
- Review opportunities to design, test and implement transformations of other patient pathways, with the aim of dramatically shortening the diagnostic phase.
- Agree the plan and implementation programme for Phase 2 of the Diagnostic Hub at the Royal Glamorgan.

3.7.11 Transforming Cancer Services

Under the auspices of its Transforming Cancer Services Programme, Velindre NHS Trust are seeking to develop a Radiotherapy Satellite Centre (RSC) as the first phase of increasing radiotherapy capacity in South East Wales to meet forecast increase in demand. The development seeks to provide two linear accelerators at the Radiotherapy Satellite Centre together with shell accommodation for a further two.

Aneurin Bevan University Health Board expressed an interest in locating the RSC at Nevill Hall Hospital and have worked with the Velindre Transforming Cancer Services Programme Team on the potential development. Following an externally supported option appraisal, Velindre NHS Trust have identified Nevill Hall Hospital as the preferred location and work has since commenced in the collaborative development of an Outline Business Case, with the RSC case led by the Health Board.

This will require active engagement with Velindre NHS Trust, other Health Boards, patients and other stakeholders to develop the case and the governance structures to support this are being established. The RSC is a significant development for the Health Board, providing a regional service that will meet 20% of radiotherapy demand in South East Wales. It will become a key element of the new Nevill Hall Hospital, post the advent of The Grange University Hospital and provide a fixed point in the development and implementation of the Health Board's emerging Cancer Services Strategy. The Health Board is developing plans for Nevill Hall Hospital to act as a hub for cancer services within the Health Board, with spoke activity undertaken at other hospital sites across the Health Board. It is provisionally anticipated that the OBC will be completed in the second half of 2018/19.

3.7.12 Mental Health and Learning Disabilities Services

The Health Board is seeking to transform its complex care service provision through the development of an integrated MH/LD low secure facility supported by an extended PICU and an HDU (Further detail included at Section 3.4). A Strategic Outline Case has been produced which includes options for a regional solution with Cwm Taf and Powys Health Boards and it is planned to be submitted to Welsh Government in January 2018.

3.8 Older People

Providing high quality care and support for older people is a fundamental principle of social justice and is an important hallmark of a caring and compassionate society. Demographic changes coupled with a decade of difficult public finances means this is one of the biggest challenges facing NHS Wales.

Supporting and caring for older people is not just a health or social work responsibility – we all have a role to play; families, neighbours and communities; providers of services like housing, transport, leisure, community safety, education and arts; and also shops, banks and other commercial enterprises. It is also important to recognize that older people themselves have a critical role to play in keeping other older people out of the formal care system and living independently at home; they actually, as a whole, provide far more care than they receive.

An important concern for older people is the increasing likelihood of unplanned or emergency hospital admission. It may be the right course of action for someone who has a potentially serious or life threatening health problem that needs urgent specialist investigation or treatment in hospital. However, for many older people an admission to hospital can be followed by complications such as a serious loss of confidence and confusion that prolong their stay, compromising their independence and ability to return home quickly.

For Older People success is:

Being able to **stay in their own homes** for as long as possible.

Having a greater degree of **personalised care**, being much more involved in planning their own care and **better informed** about their **options** and choices. Anticipatory Care Plans cannot work unless older people are far more involved in decisions about their own care.

Joined up working between health and social care in terms of service planning, service delivery and use of resources.

Support for carers and proper funding and support for older people to create networks of community groups.

Regular health and wellbeing checks for over 75s.

Hospital admissions providing solutions not creating more problems – prolonged hospital stays are not a good thing for a person's general well-being, especially their sense of control and independence.

Accessible services for people with dementia.

Appropriate housing options, currently there is little choice for people who want to plan ahead to downsize or move into more appropriately designed accommodation, capacity for sheltered and very sheltered housing is limited and family homes with granny flat annex are limited.

Response times for adaptations to people's homes are expedient and allow people to get home from hospital.

Information about range of common issues (for example personal care entitlements, side effects of different medications, how to navigate through health and social care systems).



Determining how we effectively care for a population that is not only larger in volume, but is also living with a greater prevalence of frailty and disease is a critical challenge, that the Clinical Futures strategy is seeking to address, in collaboration with our partners in social care. Our aim is to improve the care pathway and experience for older people in Gwent, to support improved wellbeing. We recognise that to do this will require the creation of alternative pathways for patients who might otherwise be admitted to hospital; and, where admissions are unavoidable, facilitating earlier supported discharges from hospital wherever possible. New models of delivering care are being actively developed through our Clinical Futures strategy, to define the longer term models and its requirements.

Delivering more Care Closer to Home remains our priority, considering what services must be developed, integrated and shifted from secondary care settings into the community, In order to help people remain at home to live healthy lives for as long as possible. The aim of building capacity

within community settings to reduce demand on health and social care resources, particularly acute and institutional care, remains the priority. Considerable activity is underway to deliver health and social care support for Older People with complex needs on a whole system basis for example Anticipatory Care Planning continues to develop, in partnership, so that people's needs and wishes can be supported, even in times of crisis.

Through the Adults strategic partnership, establishes as part of the Gwent regional partnership board for health and social services, an ambitious programme of work has been developed, to target resources effectively at improving the health and social care pathway for older people, and this will include:

- The development of case co-ordinators will be taken forward, so that older people with complex needs have a single point of contact, who is able to cross professional and organisational barriers to find solutions to meet a wide range of individual needs.
- Extended and 24/7 working, with some key services re-designed to meet this requirement.
- We will consider the national changes proposed for '111' as well as our experience of GP Out of Hours and Social Care Emergency Duty Teams to inform future decisions.
- We will take forward joint commissioning processes, where appropriate, to ensure that commissioning skills are shared and used effectively across the partnership.
- We will develop our staff with the range of skills – such as needs assessment, engagement, negotiation, political awareness and creativity, alongside business acumen and financial and analytical skills – that are needed for the future.
- We will support care homes to care for older people with increasingly complex needs; to reduce unplanned admissions to hospitals and improve the quality of life for those who are not able to remain in their own homes, through offering specialist training and access to clinical expertise – making use of the 'Better Life' programme developed by Joseph Roundtree Foundation.

Our approach to meeting the needs of older people

The Health Board adopts a whole system approach to the development and delivery of plans to improve services for older people. The overall scope of the Older People's integrated pathway is shown in the figure below.

Figure 3.8.3

Preventative and Anticipatory Care	Proactive Care and Support at home	Effective Care at times of transition	Hospital and Care Home(s)
<ul style="list-style-type: none"> • Build social networks and opportunities for participation (social prescribing, community connectors, scripts for loneliness) • Early diagnosis of dementia • Prevention of falls and fractures • Information and support for self management and self directed support (living well, living longer, smoking cessation/obesity, alcohol) • Prediction of Risk (of recurrent admissions), stay healthy plans Newport OPP • Anticipatory Care Planning • Suitable and varied housing and housing support • Support for Carers 	<ul style="list-style-type: none"> • Responsible flexible self-directed home care (respiratory and diabetes community pathways) • Integrated Case/care Management (CRTs) • 24/7 district Nursing Services • Carer Support • Rapid access to equipment • Timely adaptations including housing adaptations • Telehealthcare • Access to timely primary care (demand/capacity, triage, federations/mergers, skill mix) 	<ul style="list-style-type: none"> • Reablement and rehabilitation (CRTs) • Specialist clinical advice for community teams (rapid access assessment teams) • 111, Out of hours access to Advanced Care Plans • Range of intermediate care alternatives to emergency admission • Responsive and flexible palliative care • Medicines management • Access to range of housing options • Support for Carers 	<ul style="list-style-type: none"> • Urgent triage to identify frail older people (ACPs, EFU), Ambulatory Care • Early assessment and rehabilitation in the appropriate specialist unit • Prevention and treatment of delirium • Effective and timely discharge home or transfer to immediate care (Safer bundle in community and secondary care hospitals - LOS/DToC, in-reach teams) • Medicine reconciliation and review • Specialist clinical support for care homes • Carers as equal partners

The Health Board continues to work in partnership with patients, carers, public sector partners and the third sector to roll out service models that work well for our communities. Our aim, over time, is to ensure consistency and equity of access for our older citizens to every component of the older person's pathway.

3.9 Maternal and Child Health

Current Service Provision

The UHB delivers a range of maternity and children's services in both the community and acute setting. Detailed plans for maternal and child health have been developed by our Families and Therapies Division and dovetail with relevant plans and strategies in Public Health, Primary Care and Community and Mental Health and Learning Disabilities divisions as well as relevant multi-agency and multi-disciplinary partnerships and regional planning fora. As such these are captured via a number of the Health Board's Service Change Plans.

They are underpinned by relevant strategies and guidance including:

- National Service Frameworks.
- Strategic vision for maternity services in Welsh strategy.
- Welsh Government screening and immunisation policy.
- Healthy Child Wales programme.
- Special educational needs guidance.

Our operational plans continue to deliver and maintain National Service Framework standards for children, young people and maternity services and important mechanisms such as complying with child safe-guarding requirements.

Breast feeding rates are monitored through our key performance indicators and reported to WG on an annual basis. All three units have baby friendly accreditation and peer support breast feeding support has been rolled out across all sites.

Caesarian section rates are also monitored through our key performance indicators and have continued to reduce to below the recommended standard of 25%. This continues to improve with the introduction of STAN fetal monitoring and additional training and education for STAN and CTG.

Key Priorities

Our priorities are incorporated into our corporate Service Change Plans which are overseen through our executive led boards. An overview of these is encapsulated in the table below.

Table 3.9.1

Service Priority	Delivery Plan
Improve uptake of childhood immunisations especially disadvantaged groups.	SCP 1 - Population Immunisation and vaccination programmes
Disease prevention through population scale services to support lifestyle changes, e.g. increasing maternal smoking cessation rates, reducing childhood obesity and prevalence of Type 2 Diabetes.	SCP 1 – Implementation of a new Tier 3 weight management service for children and families. Smoking cessation action plans. Implementation of MECC within Midwifery (making every contact count).
Deliver the outcomes of the Healthy Child Wales Programme.	SCP 1: Implement Healthy Child Wales programme
Adverse Childhood Experiences	SCP 1: Adverse Childhood Experience Aware Health Board
Improve timely access to Specialist Child and Adolescent Mental Health services.	SCP 4 – Access work programme
Consolidate and evaluate the newly established multi-disciplinary service for Integrated Specialist Children with Additional Needs (ISCAN)	SCP 4- Access work programme
Provide access to appropriate health care support for victims of domestic violence, looked after children and vulnerable young people.	SCP 4 – Access work programme: integrated care pathway for vulnerable young people.
Sustainable services for inpatient paediatrics, obstetrics and neonatal	SCP 7 – Sustainability plan for paediatrics, obstetrics and neonatology

Service Priority	Delivery Plan
services for Gwent and South Powys.	
Regional sustainability plan for Paediatric Sexual Assault Referral Centre services	SCP 7 – Regional Collaborations

Enablers

3.10 Workforce

At a time of national and international health workforce shortages and austerity, the pressure to control workforce costs, at the same time as deliver good quality, safe and clinically effective services, requires detailed integrated service, workforce and financial planning. This will inevitably place higher levels of expectation about extracting maximum efficiency, productivity and flexibility from existing employees. It will also rightly create a focus on leadership, management and setting the right cultural expectations on accountability and performance management.

We have an ambitious programme of improvement that ensures our activities are fully aligned to the needs of the organisation both now and into the future.

Our work programme reflects these key drivers:

- Reducing health inequalities and improving population health.
- Supporting the further shift of services closer to home through building a strong Neighbourhood Care Network foundation for delivery of care through removing barriers between hospital and community, health and social care and with ambulance services. This will mean that staff may work in different settings and across sectors.
- Enabling our workforce to work across care pathways through improving access, flow and quality of care for patients.
- Supporting service sustainability through the development of new roles and new ways of working as well as maximising the talents and skills of our existing workforce.
- Fulfilling our ambition of achieving 'best in class' across the organisation through an efficient and productive workforce.
- Using opportunities arising from new technologies and new facilities to streamline and modernise working practices.
- Further develop effective clinical teams and provide services, facilities and development opportunities that attract and retain enthusiastic, motivated and competent staff.
- Promote strategic alliances between schools, colleges, universities and employer partners in both the public and private sector to better anticipate and develop the skill needs over the coming years.
- Focus on enabling workforce productivity and efficiency driven through technology advancements, and ensuring our staff have opportunities to develop new skills
- Focus on well-being and promoting healthy lifestyles and strengthening support arrangements to keep people in work Nurture a positive culture where staff are fully engaged, listened to and valued.
- A focus on growing our own workforce through to deliver sustainable services.
- Improve health and employment outcomes through employers, health services and employment services working together more effectively (Prosperity for All, 2017).
- Focusing on our Wellbeing objectives to meet the requirements of the Wellbeing of Future Generations Act. We are working closely with our Local Authority, Public and Third Sector colleagues in the Public Service Boards to ensure that the wellbeing goals prioritise the needs of our local community.
- Responding positively to the results of the Staff Survey and using regular short surveys to test the temperature of our staff.
- Review our strategy to support staff who are carers and increase the involvement of volunteers.

We have worked with stakeholders, managers and employees to clearly define our workforce priorities over the next 3 years. In our 2017/2018 IMTP we described a programme of work based around a three key themes. We wanted to simplify a complex range of activities and describe these in a way that can be readily understood and supported by colleagues across the Health Board. Our first People Plan was drafted during 2017 and having been widely tested, it will be published early in 2018.

Figure 3.10.1



The three themes are underpinned by a number of objectives, with a more detailed work plan found in [Appendix X](#):

Table 3.10.2

Productive and Efficient Workforce 	Engaging Workforce And Developed 	Sustaining Services Now And For The Future 
<ul style="list-style-type: none"> Reducing and maintaining sickness absence at below 5% Reducing variable pay Health and wellbeing of staff Maximising the capability of e-systems and paperless solutions Driving improvement and efficiency through exploiting technology platforms Better signposting and support tools for managers and staff. Ensuring all our medics have up to date job plans Ensuring we continue to develop new roles to support service sustainability with less reliance on scarce resources Development of a carers strategy to support flexible working for staff 	<ul style="list-style-type: none"> Fundamentally overhaul our OD programme of work to better align with Clinical Futures. Improve our PADR compliance to exceed the 85% target within the next year and evidence quality improvement. Further activate and embed our Values and Behaviours Framework Critically assess our manager/leader development programmes to ensure we are delivering appropriate skills with pace and scale. Via pulse surveys, listen more regularly to our staff and act on the staff survey results Further implement the HCSW Framework to ensure we have a competent and skilled workforce Implement our Strategic Equality Objectives Maximising opportunities to share and learn Maximising opportunities for staff to engage in change agenda Positively responding to the staff survey Focus on succession Planning Maximise opportunities to transfer knowledge and learning 	<ul style="list-style-type: none"> Improve our staff recruitment, retention and reduce our recruitment timelines and developing a strong employer brand based on learning and development Improve collaborative planning and working with other Health Boards and partners to share experience, expertise and opportunities Future plan our workforce to support our Clinical Futures Strategy and the Grange University Hospital through new roles and ways of working Enhancing our offer of work experience and apprenticeships, with a particular focus on disadvantaged groups Strengthen our connection with schools and higher education to ensure that health service careers are promoted at the earliest opportunity Improve the participation and involvement of volunteers Widen the range of work experience on offer, extend our approach on apprenticeships and our widening access activities Review our approach to flexible working in partnership with Staff Side

During the last 12 months we have achieved a number of our objectives set out in our 3 year plan:

Table 3.10.3

<i>Our achievements</i>		
Enabling our staff to work productively and efficiently	Engaging and developing our staff	Sustaining our services now and for the future
<ul style="list-style-type: none"> ✓ More of our staff have joined the Staff Resource Bank which has contributed to a reduction in high cost agency usage. ✓ All bank staff can now access employee online making the booking of shifts easier. ✓ We have started to reduce the reliance on paper based timesheets with 2,500 staff already moved to paperless payslips. ✓ 96% of staff have access to online ESR and 7,000 staff are accessing ESR through the user friendly portal app, giving access to e-learning, annual leave, payslips etc. ✓ We are planning technology improvements to give more time to care e.g., ESR functionality, digitised health records ✓ We have strengthened our wellbeing provision with the inclusion of a employee assistance scheme 	<ul style="list-style-type: none"> ✓ We have a number of our staff who have received national and local recognition for their contribution to working practices. ✓ The University Health Board has improved its reputation as an inclusive employer. This is measured by the Workplace Equality Index. ✓ We have developed a staff communication and engagement plan to support Clinical Futures. ✓ We continue to run new leadership and management programmes available for staff at all levels of the organisation. ✓ The results of the 2016 NHS staff survey in ABUHB showed many scores above the overall NHS Wales scores with 63% of our staff saying they would recommend this organisation as a place to work compared to 50% in 2013. ✓ We are supporting apprenticeship qualifications across all areas of the workforce. ✓ We are placing staff engagement as a core activity for the health board and have developed a programme of culture change 	<ul style="list-style-type: none"> ✓ A variety of new roles in advanced practice, extended roles for a number of clinical and non-clinical staff have been implemented. ✓ We are implementing the recruitment plan using videos, roadshows and technology promoting us as the preferred employer. ✓ We have supported national recruitment initiatives in line with the Welsh Government "Train, Work, Live" initiative. ✓ We have launched local recruitment initiatives for nurses living in the community who require support to gain their registration to operate as qualified nurses. ✓ We have continued to train our healthcare support workers to obtain extended skills. A number of these staff have proceeded to undertake undergraduate studies. ✓ We have increased the number of nursing students training within our University Health Board. ✓ We are collaborating with partners to develop pathways for learning, shared arrangements and resources
<i>The results of the 2016 staff survey in ABUHB show positive improvements since the 2013 survey, with many scores above the overall NHS Wales scores</i>		

The significant workforce challenges facing the Health Board have been highlighted throughout the IMTP and are summarised below:

- Junior Doctor recruitment challenges in multiple specialities resulting in increased agency and locum expenditure.
- Continued recruitment challenges in nursing, specialist roles in therapies and Allied Health Professionals such as sonographers and cardiology physiologists and electrical and mechanical trades.
- Provision of 7 day and extended services for a number of professional groups.
- Specialist skills spread too thinly as a result of existing site configuration.
- A competitive climate, both internally and externally, for salaries particularly in certain specialist areas and the impact this has on both recruitment and retention.
- Educational commissioning numbers across Wales will not meet demand despite increases in a number of professional groups.
- Unlikely to recruit staff with Welsh Language skills to deliver requirements of the Welsh Language Standard.

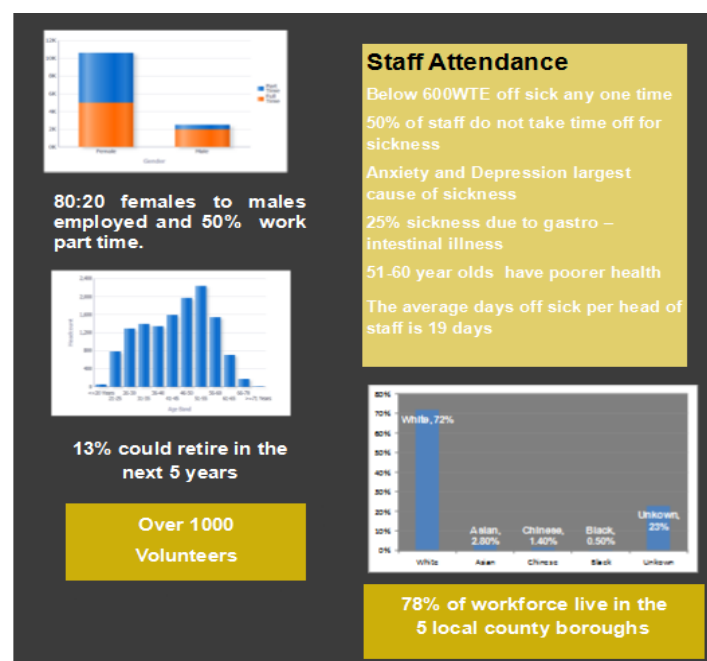
As at December 2017 the Health Board employs 14,019 staff (11,178 WTE) and is the largest employer in Gwent. The staff group profile has remained relatively unchanged in the last year. The largest staff group is Nursing and Midwifery at 32% of the total workforce followed by Additional Clinical Services at 20%.

Table 3.10.3

Staff Group	Heads	WTE	% of WTE
Add Prof Scientific and Technic	410	329	3
Additional Clinical Services	2731	2251	20
Administrative and Clerical	2578	2067	18
Allied Health Professionals	857	715	6
Estates and Ancillary	1510	1089	10
Healthcare Scientists	246	216	2
Medical and Dental	1586	979	9
Nursing and Midwifery Registered	4101	3533	32
Grand Total	14019	11178	100

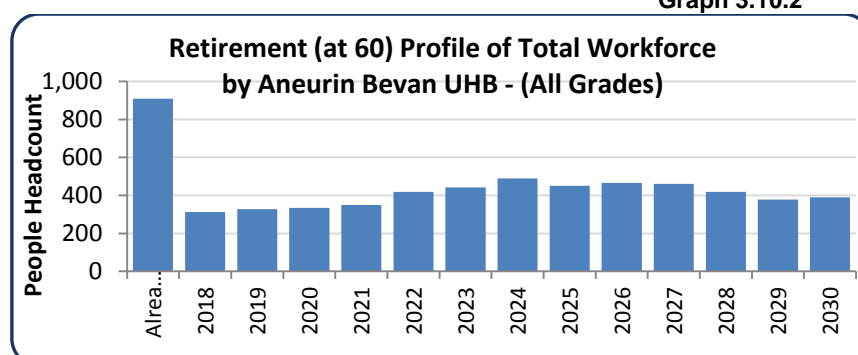
Workforce demographics

Graph 3.10.1



Based on our age profile and average age of retirement as 60 we could expect the following numbers of staff to retire each year:

Graph 3.10.2



There is an ageing workforce profile in a number of staff groups particularly in non-clinical staff groups, estates and ancillary workforce which has 48% of its workforce over the age of 51 years and administration and clerical with 40%.

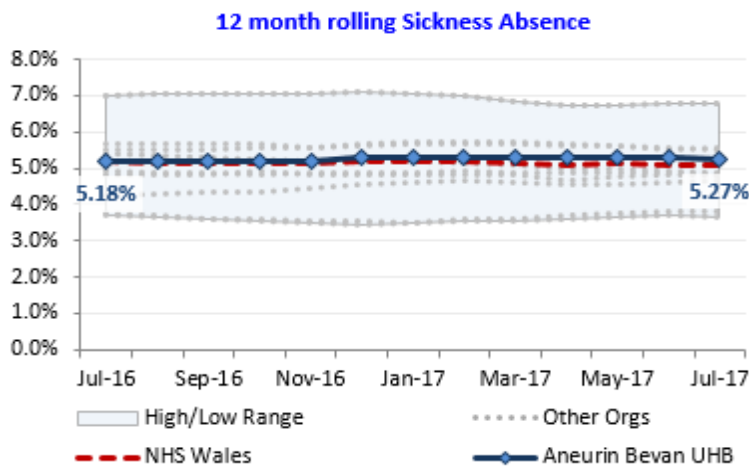
A large number of staff are already at retirement age and a number of these are accounted for as are retire and return employees. Whilst it is difficult to predict actual retirements due to changes in pension legislation and NHS pension changes, we anticipate that the biggest impacts will materialise from 2022 onwards. For this purpose educational commissioning figures will be need to reflect these retirement figures in addition to reviewing skill mix in areas of workforce skills shortages. Areas

where predicted retirements are outside of normal distribution include associate specialists, district nursing, community hospital nursing, additional clinical services, management roles and also estates and ancillary.

Sickness

Managing sickness absence continues to be challenge and the current rate is 5.44%. However, 50% of our staff have not had any sickness leave. A detailed action plan has been developed to support a targeted reduction in high sickness areas.

Graph 3.10.3



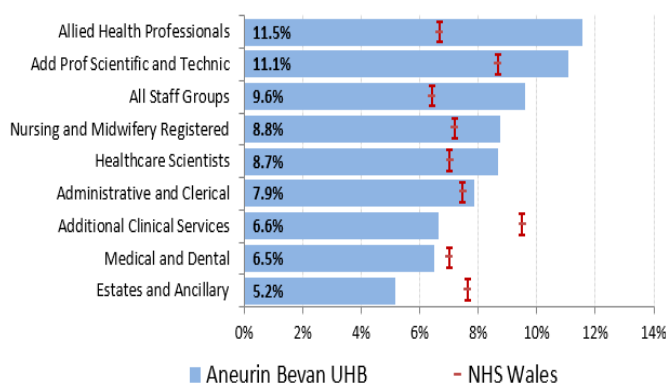
We will continue to focus on registered nursing and HCSW's who have one of the highest sickness rates where reductions in sickness will also have positive impacts on variable pay.

Turnover

Turnover is 7.69% with higher rates in specific staff groups compared to NHS Wales benchmarking.

Graph 3.10.4

12 month Turnover Rate rate for Aneurin Bevan UHB (Jul-17) and NHS Wales (Jun-17)



A 14 point action plan has been developed to support staff retention, as detailed in the programme plan (appendix x)

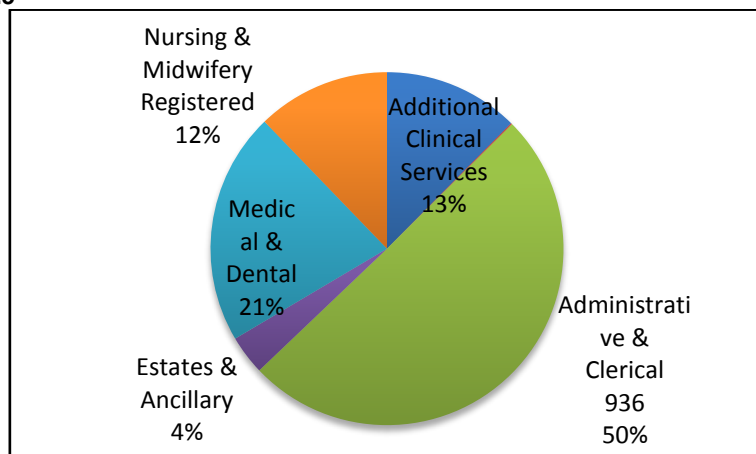
PADR – To include

Primary Care workforce

- The Primary Care General Practitioners workforce is made up of 398 GP's, 6 registrars and 95 salaried GPs of these 13 are directly employed by the Health Board. There has been an overall reduction in 18 GP's since this time last year.
- There are 78 GP Practices compared with 81 last year, of these 3 are managed by Health Board increase by 2 from last year.
- 8 GP vacancies are covered by locums within the Health Board
- 34% of the 398 GP workforce is over 50 years, with the potential that 91 GPs could leave the service within the next 5 years.
- There are 204 nurses working in General Practices of which 19 are Nurse Practitioners. 114 practice nurses are over 50 years and could leave the service within the next 5 years.
- The workforce plan for the next 5 years includes active recruitment of multi-disciplinary roles to support GPs in practices including Paramedic, nurse practitioners, Pharmacists, Therapists and social prescribers.
- There are approximately 1884 staff working in Primary Care including practice nurses, pharmacists, advanced specialist nurses, healthcare support workers and administration. The

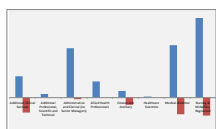
distribution of these is show below:

Graph 3.10.5



Nursing Homes- to be verified middle of January 2018

A large number of nursing homes provide information on their workforce profile to inform training and educational needs and to share challenges facing their workforce. They employ more than 284 nurses, approximately 1216 Health Care Support Workers and over 172 other staff including catering, laundry, and maintenance and administration staff. Comments received from nursing homes demonstrate they are experiencing similar recruitment difficulties and are becoming reliant on agency workers. The larger nursing home companies use their own bank workforce. An ageing workforce profile is also a potential problem, with on average 40 nurses expected to retire each year. These numbers will be reflected in the nurse educational commissioning figures.



Future workforce profiles

There is a demanding workforce change programme required for the foreseeable future. To meet the in-year challenges of minimising workforce costs, delivering the Clinical Futures Strategy and sustainable services, the Health Board will continue to ensure the existing workforce is deployed as efficiently as possible.

The Nuffield report (2016) emphasises the urgent need to reshape the NHS workforce in order to find a sustainable balance between available funding, patient and staff needs and explores how organisations can do this and the benefits that would result. It focuses on the opportunities and challenges, and calls for workforce development to be a central part of local sustainability and transformational plans whilst recognising the vital importance of a training pipeline that secures sustainable numbers for the future. The Health Board has assessed their position against the evidence and case studies within the Nuffield report, many of which are already being implemented and captured within our Compendium of new roles. Existing frameworks and improved provision of skills and training at a local and national level enable the the development of the HCSW workforce and extending the scope of practice of existing staff. Further workforce modernisations opportunities which the Health Board will be exploring in 2018/2019 are listed below:

Table 3.10.4

Area	Workforce Impact
Primary Care	<ul style="list-style-type: none"> Development of new roles increase practiced based pharmacists, social workers, therapy staff, HCSW as well as Advanced Nurse Practitioners and Physician Associates to support GP sustainability due to an ageing GP workforce. Review of pilot workforce models in Urgent Out of Hours Services including use of Pharmacists and Paramedic Practitioners Development of integrated teams supporting continuing health care. Alignment of Care Closer to Home Workforce plans between Secondary Care and Primary Care ensuring appropriate use of resources and the development of OD support to enhance delivery of Social services and Well Being act. Increasing the need of direct Physiotherapy services to patients across NCNs.

Area	Workforce Impact
	<ul style="list-style-type: none"> Support training and education within Primary Care and Nursing homes through ongoing implementation of HB education programmes. Implement District Nursing Principles to ensure greater sustainability / safer staffing levels and more prudent use of resources including through consolidating services, improving skill mix, and education.
Secondary Care	<ul style="list-style-type: none"> Collaborative working with other health boards to sustain services, for example integrated workforce planning with Velindre to support for to support radiotherapy satellite centre. Implementation and development of new roles –such as PA, ANP's, HCSW and extended scope practitioners in therapies and Pharmacy to support service sustainability and Clinical Futures. Development of non-registered workforce to improved sustained service delivery e.g. midwifery theatres to assist in maintaining Birth Rate plus midwifery staffing levels. Development of non-medical prescriber as an alternative to the traditional medical model to improve service sustainability and workforce modernisation. Appointment of MSK Consultant Physiotherapy with Independent prescribing rights. Therapy services are looking at opportunities following the introduction of the advanced practice career framework and its application of Therapy Advanced Practitioner roles and includes integrated roles working across health and local authority partners. It is anticipated that the framework which is currently evaluating favourably will be rolled out across all therapy areas following formal evaluation of the OT pilot. Development of blended therapy roles and therapy assistant practitioner support roles to ameliorate growing challenges around recruitment and retention. Development of extended nurse role to deliver enhanced services such as hysteroscopy and nurse led outpatients. Piloting of Physicians Assistant in paediatrics scheduled to progress over the next 12 months Introduction of skill mix model to support delivery of Health Child Wales Programme and to address recruitment and retention challenges Within Radiology implement 7 day working on all sites (CT and MRI). This includes a review of the workforce implications including skill mix, competency framework for all modalities, development requirements and implementation of e-rostering Reconfiguration of Microbiology and Histology workforce
Workforce and technology	<ul style="list-style-type: none"> Virtual reviews in gynaecology, paediatrics, sexual health and maternity. SLT Dysphagia assessment directly into nursing. Use of skype to deliver services in SALT, CAMHS on an individual and group level. Creation of Service specific Apps to help support patients in their home. Maximise the use of technology such as DHR, digital dictation. Embracing technology and accessing data/information whilst mobile (Mobile Working -MoWIC) is a prerequisite for roll out of WCCIS project within community nursing. Maximise the use of benchmarking through training and improve availability of benchmarking tools such as skill mix analyser, I view and the BI tools Implement recommendations from the Lord Carter report to maximise workforce productivity and efficiencies. Examples of technology utilisation being progressed over the next three years include an expansion of tele-medicine, theatre stock control system, e-prescribing, point of care, expansion of the Doctor Service and the development of vacuum assisted biopsies. The workforce impacts will need to be evaluated as these projects are expanded and rolled out. Develop agile ways of working to improve productivity and efficiency.



Training and development and educational commissioning

The future workforce requirements are supported through the annual educational commissioning process and are documented in the attached template (C18). The figures for graduate commissioning numbers for all non-medical clinical staff groups are calculated through an assessment of future demand and current supply of workforce based on age profiles and turnover of staff. The organisation also engages with the primary care sector, nursing homes and community providers to ensure that commissioning figures meet the needs of the Health Board and the local economy. In summary some the key requirements for education are:

Nursing

- Emergency Nurse Practitioners in emergency departments providing 24/7 cover
- Advanced Nurse Practitioner roles in neonates, gynaecology and paediatrics and a number of other specialties to support medical sustainability and Clinical Futures.
- Independent prescribing skills to support service sustainability and succession planning.
- The Nurse Staffing (Wales) Act 2016 (covered in chapter 1)
- Ensuring robust preceptorship and educational development is an essential element of the workforce plan for nursing. The Health Board has a preceptorship programme in place known as the Journey of Excellence (JoE), supported by practice educators and clinical skills trainers, providing formal support and guidance to registrants.

Allied Health Professionals/Healthcare Scientists/Additional Professional Technical

- Development and employment of Physician Associates in acute medicine and primary care
- Sustainable numbers of radiographers and those with extended scope of practice as a result of 7 day services and increases in demand for diagnostics.
- Increase in therapists to support Primary Care, 7 day services and an increase in the number of therapists with independent prescribing skills to support increased MDT working. In addition to this there will need to support and to extend the scope of practice for therapists through post graduate education provision Surgical Care practitioners providing assistance with theatre medical cover and an increase in ACCP's in Anaesthetics
- Increase training numbers in Pharmacy and increase in independent prescribing skills to ensure that the service can meet the anticipated increase in workforce required for Clinical Futures including Primary Care sustainability.

Additional Clinical Services

Health Care Support Worker development and programmes required to develop assistant practitioner workforce (Band 4).

Primary Care

Through implementation of the actions within the Primary Care Workforce Plan for Wales the Health Board will continue to support Primary Care:

- A rolling programme of training is in place for independent sector nurses. There will be a specific focus in developing the unregistered workforce in residential homes.
- The programme has been developed with Coleg Gwent to ensure that HCSWs in general practice are educationally and clinically safe and effective. This also forms the foundation for potential further HCSW qualifications for those wishing to develop as they are ideally placed to replace retiring Practice Nurses in the future.
- Scope the required numbers of Nurse Practitioners and Advanced Nurse Practitioners in GP practice has been undertaken. This scoping will inform a local training strategy to support GP sustainability.

The educational graduate commissioning figures and those to support extended practice and master's level of training requirements have been reviewed by the Nurse and Therapy Directors and have been aligned to service changes predicted for the medium and longer term for submission in March 2018.

Investments and Cost Pressures

There are a number of schemes seeking to increase core workforce and these include:

- Delivery of 1:11 rotas in scheduled care
- Replacement of locum and agency with substantive medical staff
- Increase in workforce linked with cancer pathways
- Development of ENP and ANPs to support service sustainability in ED and mental health
- Facilities management restructure to support 7 day cover
- RTT plans – increase in core sessions and reductions in WLI and locum and agency costs

Staff Group	Total WTE	Schemes
Additional Clinical services	3	Support graduated care model - Therapies and RTT delivery
Additional Professional Technical	1	ICF funding for pulmonary rehab
Administration	6	FM management resctructure to support 7 day cover, plus administration support for cancer pathway. could be -26 WTE depending on DHR plan achieved
Allied Health Professionals	8	SALT to support dimentia and 7 WTE ODP's to support RTT delivery
Estates and Ancillary	0	
Healthcare Scientists	3.4	Pathology BMS to support medical histopathology medical vacancies and blood transfusion
Medical & Dental	16	7 WTE to support 1:11 deanery, additional deanery posts in medicine, increase in core consultant hours/WTE in Urology,
Nursing and Midwifery	11	ENP, ANP, single cancer pathway
Grand Total	37.4	

Current pay savings associated with a number of the above investments are £2.5M.

The number of staff may reduce by 30 WTE in administration staffing depending on DHR roll out plans being achieved.

3.11 Finance

The Health Board has a statutory duty to ensure that expenditure does not exceed the aggregate of funding allotted to it, over a period of 3 financial years. This applies to revenue and capital expenditure.

Performance against 3-year rolling duty

Surplus / (Deficit) - £'000

Revenue:	Actual 2014/15	Actual 2015/16	Actual 2016/17	Forecast 2017/18
Annual	409	214	49	0 (*)
Rolling			672	263

(*) assumes breakeven delivered in 2017/18

The Health Board's key objective is to improve the health of the population, prevent ill health and provide safe and clinically effective integrated healthcare within available resources.

3.11.2 Long-term outlook

The Health Foundation report "The Path to Sustainability" describes a financially sustainable health system, where:

- Spending rises by an average of 3.2% in real terms to meet demographic demand and other costs,
- Funding is assumed to increase, in line with GDP growth, by 2.2% (real terms), and
- Minimum cash releasing efficiency savings, are delivered, of 1%.

This assumes the Health Board has a recurrently balanced starting financial position. Funding settlements for the NHS in Wales have been announced for 2018/19 and 2019/20 as £230m and £220m respectively. Taking into account these funding announcements and the headline

assumptions in the Health Foundation report, the Health Board has assumed a level of additional revenue funding which is broadly consistent and based on its relative population share using the needs based formula for 2019/20 and 2020/21.

3.11.3 Medium-term assumptions

This three year plan requires service and workforce changes to implement the next key phase of the Clinical Futures Strategy, including readiness for the opening of the Grange University Hospital. In terms of financial plans, these should be integral to the service and workforce plans which:

- Centralise the provision of some services, particularly in relation to medical rotas and associated staffing,
- Deliver improved lengths of stay and bed reductions consistent with previously approved plans,
- Improve and increase the provision of out-of-hospital services to support an effective and efficient health care system, designed to manage appropriate future population demands, and
- Make provision for essential transitional arrangements and associated costs.

The implementation of the Clinical Futures Strategy will need to incorporate other elements of the estate, services and workforce, including future service provision on the Royal Gwent and Nevill Hall hospital sites.

Based on a financial assessment of service and workforce plans developed, a medium term financial plan is summarised below. Further work is required on these plans in order to present a robust set of plans for the Board to consider in March 2018.

3.11.4 Medium-term financial plan (18/19 to 20/21)

	2018/19 £m	2019/20 £m	2020/21 £m	
<u>WG Allocations:</u>				
Core Inflation Uplift	17.60	17.60	17.60	
17/18 IMTP - Performance and Transformation	9.50			
Ring-fenced Mental Health	2.49	2.49		
Treatment Fund	3.06			
Allocation top-slice	(4.03)			
<u>Assumed funding allocations:</u>				
17/18 – IMTP sustained	5.50			
Performance improvement and service transformation	0	24.87	24.87	
Anticipated Allocation Adjustments	0.97	0.47	(0.87)	
Additional Funding Assumptions	35.08	45.43	41.60	
Underlying Position	33.69	15.99	10.87	
Inflation and cost growth	25.35	30.15	30.15	
Local spend assumptions	13.91	10.69	10.69	
Savings requirement	(20.18)	(11.40)	(10.11)	
Additional Net Cost Assumptions	52.77	45.43	41.60	
(Surplus) / Deficit	17.69	0.00	0.00	

3.11.5 2018/19 Health Board Revenue funding assumptions

The Health Board welcomes the approach taken by Welsh Government to notify funding allocations at the earliest possible stage and to allocate resources recurrently recognising the health needs of

the population.

In terms of material funding changes to the Health Board's allocation, for 2018/19, the following should be noted:

1. The Health Board IMTP, covering the 2017/18 financial year, identified a requirement for £15m funding to deliver the service and workforce plans. Welsh Government made this funding available in 2017/18. In 2018/19, £9.5m of this funding has been confirmed recurrently. ***In order to sustain delivery of these service and workforce plans, the Health Board is assuming that the £5.5m funding (received in 17/18) will be made recurrent*** as part of maintaining a financially balanced and approved plan.
2. Additional commitments discussed at the August 2017 NHS Executive Board, involving Chief Executives, comprise:

Top-sliced allocations/directed spend (£m)

	ABUHB	NHS Wales
Paramedic re-bandings	0.6	3.6
Clinical desk enhancements	0.1	0.6
111 rollout programme	1.2	6.6
Postgraduate medical education (*)	0.1	0.5
National Imaging Academy (*)	0.3	1.5
Genomics Strategy (*)	0.5	2.9
Non-medical education (*)	3.2	16.9
Total	6.1	32.5

(*) top-sliced allocations (£4.03m)

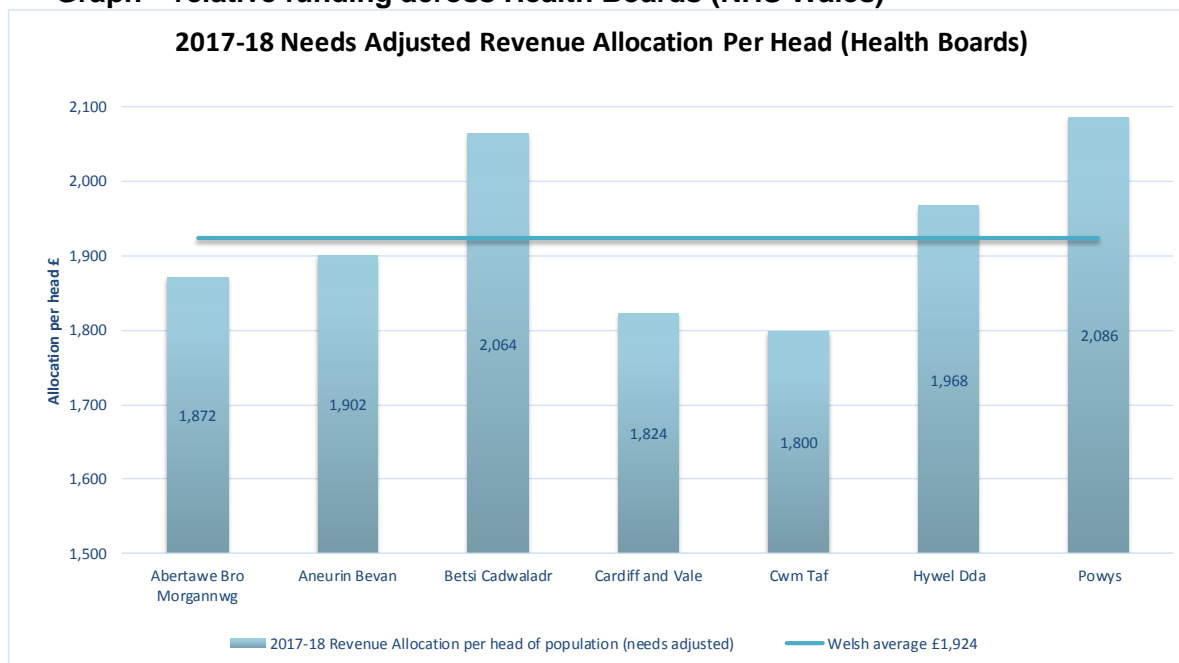
These have subsequently been top-sliced from allocations or represent additional spend commitments, as part of setting Health Board allocations in 2018/19.

3. Mental Health ring-fenced funding – in line with the budget agreement with Plaid Cymru, the Welsh Government have allocated an additional £20m funding for mental health services. £13m has been added to Health Board allocations which is circa £2.5m for this Health Board to cover inflationary and other cost growth in mental health services. £7m is being held centrally by Welsh Government, subject to plans being developed which demonstrate service transformation and innovation in mental health services.
4. The 2018/19 draft Welsh Government Budget provided an additional £230m for NHS Wales (subject to confirmation in the Final Budget on 16th January 2018). Health Board allocations currently include £92m for general inflationary uplifts along with the ring-fenced mental health funding. Decisions about the use of the balance of the funding will be made by Welsh Government based on plans which deliver improvements in performance and transforming services. This is consistent with the Health Board's priorities regarding improved access to high quality, safe services and delivering more sustainable services over the longer term. The Health Board's financial plan assumes that final service and workforce plans will demonstrate performance improvement and service transformation that are critical to the implementation of the next stages of the Clinical Futures Strategy and in particular in readiness for the opening of the Grange University Hospital. Based on the financial assessment of the plans developed, the Health Board has not assumed any further funding to support the delivery of these plans. At this stage therefore, the plans are presenting a financial risk of £17.69m in 2018/19, the management of which the Health Board will discuss with Welsh Government colleagues.

4.11.6 Relative funding position

The Health Board's population represents about 19% of the population of Wales. With a diverse population, which is not only ageing but has poor health associated with multiple co-morbidities and deprivation, this places significant demands on healthcare resources. A needs based formula is used to allocate new, additional revenue funding. If the formula was applied in full when setting the whole revenue funding allocation, the Health Board would receive about £13m additional funding.

Graph – relative funding across Health Boards (NHS Wales)



3.11.7 Cost growth assumptions

Based on the service and workforce plans developed, an assessment has been made of the likely growth in costs and these are set out in the following table.

Inflation and cost growth	2018/19 £m	2019/20 £m	2020/21 £m
Pay (pay awards, pension costs)	5.8	10.6	10.6
Non - Pay	1.8	1.8	1.8
Prescribing	2.8	2.8	2.8
Primary Care	1.9	1.9	1.9
NICE	5.4	5.4	5.4
CHC	4.1	4.1	4.1
WHSSC/EASC	2.5	2.5	2.5
Externally Commissioned Services	1.1	1.1	1.1
Total Net Costs	25.4	30.2	30.2

Pay costs assume a 1% pay award in each of the three years, along with other changes in the Living Wage, full year impact of pension auto-enrolment and other potential changes to employers' pension contributions (2019/20).

An assessment of non-pay inflation has been made, using the latest HSCI information available and its likely impact across different service areas.

Prescribing cost growth has been assessed based on previous spend and likely changes in prescribing patterns. Compliance with NICE/AWMSG guidance and continued receipt of the Treatment Fund is also assumed.

The Health Board's plans assume that additional funding will be made available to cover the GMS and GDS contract uplifts, with any inflationary increases covered by increased funding.

Commissioning external services, with NHS providers, to include applying the core funding uplift provided by Welsh Government. The contract to outsource services to Care UK, as part of reducing access times, ends in 2017/18 financial year. There is currently no financial provision to commission any further services at this stage.

The Health Board is currently reviewing specialist service plans, which will require discussion and agreement through the WHSSC Joint Committee (sub-committee of the Health Board).

The Health Board's plan assumes that implementation of a revised Cross Border Protocol will remain resource neutral.

Local spend assumptions include the following costs/financial impacts:

- Impact of changes to WHSSC financial risk share arrangements and some developments in specialist services,
- Supporting service transformation and implementing the Clinical Futures Strategy, and
- Further performance improvements.

These will continue to be reviewed and prioritised, as plans are further developed, along with identifying appropriate funding as part of discussions with Welsh Government.

3.11.9 Savings and efficiency

The Health Board identified a requirement to generate cash releasing savings of c2% to address the underlying financial position and support further cost growth, with a further 1% savings required to enable a shift of resources, in line with the Health Board's service/clinical strategy.

The following table summarises the savings required to deliver a balanced financial plan in each of the three years.

Savings analysis	2018/19 £m	2019/20 £m	2020/21 £m
CHC Savings	3.1	3.3	3.4
Commissioned Services	0.4	0.7	0.6
Medicines Management	6.0	2.0	1.4
Workforce Savings	4.1	2.5	2.2
Non-Pay	4.1	2.7	2.5
Accountancy gains (N/R)	2.4	0.3	0.0
Total	20.2	11.4	10.1

The Health Board has produced a comprehensive tool which sets out the efficiency opportunities available. This is based on national benchmarking information, which compares the Health Board to upper quartile performance, and other business intelligence. This identifies significant opportunities to improve efficiency and productivity which should be reflected in services and workforce plans, including:

- Reductions in lengths of inpatient stays – associated bed/workforce reductions,
- Improved use of outpatient services – outpatient efficiency,
- Rationalising and more cost effective estate utilisation, and
- Improved use of theatre capacity – increased throughput and/or workforce reductions.

In addition, the national capping of medical agency/locum rates further supports the Health Board to

reduce its use of medical workforce at premium rates of spend, with a savings target of c£1m.

The savings required also assume further savings in areas such as medicines (primary and secondary care services, non-pay/procurement) and continuing healthcare (CHC).

Whilst the focus of delivering savings through transactional efficiencies needs to be maintained, along with effective cost control and cost avoidance measures, the future financial sustainability of the Health Board will require significant further savings through reducing unwarranted variation in operational and clinical practice and service and workforce transformation. This will also be critical to delivering the changes required in service and workforce models for the next three years of the Clinical Futures Strategy. The impact of the Health Board's value based approach to delivering improved health and healthcare services will be expected to result in the improved allocation and use of resources during the period of this IMTP.

3.11.10 Financial Risks

An assessment of the key financial risks has been undertaken and are summarised in the following table. As plans are reviewed and developed further these will be revised as part of the ongoing financial assessment. There will also be an expectation that financial risks will be managed effectively as part of the wider IMTP delivery arrangements.

Description of Risk	£m
CHC - additional growth	2.0
Prescribing -additional growth	2.0
Velindre - NICE-HCD new approvals up to forecast	2.0
External commissioning -further activity risk	0.2
WRP - additional claims / financial risk	1.5
NICE-HCD - further growth	1.6
Non-recurrent vacancies	0.5
Other potential unavoidable cost pressures	2.7
Non-delivery of savings required	5.0
Total Risk Estimate	17.5

3.11.11 Years 2 & 3 (2018/19 – 2019/20)

In developing its 3 year plan the Health Board has made a number of assumptions in relation to years 2 and 3 as follows:

- Inflation funding is assumed to be approximately £17.6m per annum in line with previous IMTP assumptions, and reflects a requirement for necessary inflationary funding.
- 2.2% funding growth in real terms as outlined by the Health Foundation report "The Path to Sustainability" has been assumed for 2019/20 and 2020/21.
- Improvements in the Health Board underlying financial position, to improve financial sustainability and provide greater financial flexibility to support resource shifts between hospital and out-of-hospital services.
- Inflationary and demand growth are reflected based on the best known information at this point in time. This requires re-assessment on an ongoing basis as the Health Board continues to develop its service and workforce plans, including transition to the Grange University Hospital.

The financial assessment of service and workforce plans developed has been set out in the medium term financial plan (3.11.4). Further strengthening of savings and other plans is required and the Health Board will discuss with Welsh Government the potential for additional funding and agree any other actions to deliver its plan within available resources.

3.12 Capital and Estate

This section sets out the Capital Funding outlook for the Health Board over the next 3 years leading up to the opening of the Grange University Hospital and sets out the emerging issues and risks. It also describes the work of the Strategic Capital and Estates Work stream and the management of the Health Board's Capital Programme.

In terms of the successful delivery of the Clinical Futures Strategy 'Capital' is a key enabler and consideration of capital options and investment decisions must be articulated in the context of the service and workforce models and detailed planning is dependent on the development of a robust longer term organisational capacity plan with supporting workforce and financial plans.

The Health Board currently has an estates portfolio of 70 properties, some of which are over 100 years old and present challenges in sustaining as approximately 46% of the total estate is over 40 years old. The 6 facet "pilot" survey is now complete and will provide comprehensive information about the existing estate to inform future plans.

All Wales Capital programme

Due to current commitments against the All Wales Capital Programme, notably The Grange University Hospital, there are limited funds available to support other schemes. At this time, it is not known how much impact there will be on our share of capital for either strategic projects or national programmes such as Imaging and ICT.

The Health Board's 2017-2018 Capital Programme is funding at risk or making provision for fees for projects that now appear to have less prospect of AWCP funding in the short to medium term despite positive scoping with Welsh Government Capital and Estates division. It is therefore clear that the availability of Capital Investment to support wholesale strategic re-configuration is currently limited and will need to be a key consideration for our planning and prioritisation of investment. In terms of AWCP approved schemes progress is set out below:

1. The Grange University Hospital

Excellent progress was made in 2017/18 in progressing the The Grange University Hospital development following its approval in October 2016, with an enabling works contract and Stage 4 contract signed within the approved sum of £356.747m (including inflation). It has since been confirmed that Welsh Government and NHS-SES support the Health Board's intention to progress with the redesign of the external cladding to meet any likely changes in fire safety regulations. Discussion also continues about the provision of HSDU services on site and an OBC is under development.

2. Primary Care

The capital investment priorities are driven by the "Care Closer to Home" strategy which provides the strategic direction that shapes all future borough and NCN plans. Approval has been received from Welsh Government for two Primary Care Pipeline schemes which will provide capital funding for new developments at Tredegar and East Newport to support the Integrated Health and Well Being Hubs that form part of the Health Board's Integrated System of Health Care and Well Being.

Capital Requirements

The Health Board has identified capital requirements in the following areas some of which may now duplicate or overlap with bids previously ascribed for All-Wales funding that will need to be considered as part of the Health Board's Discretionary capital Programme:

(A) National Programmes

- Imaging – major equipment replacements including Gamma, MRI, CT and Ultrasounds;
- Imaging – developments.
- Informatics – this is a significant area of funding risk to the Health Board;
- Pharmacy;

(B) Statutory Compliance, Replacement and Maintenance

- Clinical Equipment;
- Main Theatres, Royal Gwent Hospital – condition;
- MH and Learning Disabilities premises condition and configuration;
- Divisional Risk Register requirements for equipment etc.;
- Community premises;
- Statutory Estate;
- Compliance;
- Environment – including ward upgrades;
- Endoscope decontamination.

(C) Service sustainability

- Paediatric, obstetrics and gynaecology sustainability;

(D) Strategic Developments

- Breast Centralisation YYF;
- Orthopaedics – reconfiguration and sustainability;
- Strategic Developments including eLGHS and Mental Health;
- Emergency Department NHH;
- Gastroenterology service reconfiguration and compliance;
- Strategic Laundry Investment;

Based on the All Wales Capital Outlook, the current planning assumptions are based on limited capital availability for 2018/19, and the Health Board need to prioritise its £10.8m annual Discretionary Capital Programme.

The basic annual requirements in areas such as Estate, high risk clinical equipment replacements, other equipment, small projects, non-programme imaging etc. are about £6.3m leaving £4.5m for all other expenditure.

The uncertainty around funding for National Programmes is also a significant risk to planning as the Imaging and ICT Programmes are critical to sustaining services and Discretionary Capital will need to be prioritised for these areas if necessary. This may include Gamma camera replacement, Pharmacy Aseptic Suite (reduced scheme) and key ICT projects.

It is estimated that Informatics alone could require up to £11m per annum simply to deliver the Health Board's Five Year Strategic Outline Plan for Informatics and Imaging which has a requirement of between £2 and £6m each year for the foreseeable future even if investment is directed where possible to upgrades etc. rather than replacements particularly of major items such as CTs, MRIs and Gamma Cameras.

This means that the flexibility within the programme to undertake strategic, sustainability and transition projects such as Breast Centralisation and the Emergency Department, Nevill Hall Hospital or any re-configuration plans that assist with the transition to eLGH functionality is very limited.

Strategic Implications

This constraints around availability of capital also has to be set in the context on any further requirements for capital that will emerge as the Health Board's ongoing work of the Strategic Capital and Estates.

This work stream has recently been established as part of the Clinical Futures Programme. The Workstream has been set up support the delivery of the capital and estate infrastructure that will deliver the whole system clinical model that characterises the Clinical Futures Strategy. This will include:

- An Estate Strategy and associated site development plans (including community hospitals such as County) reflecting the changing service models in the Clinical Futures Strategy.
- Service configuration by location and site for LGH and community services when The Grange Hospital opens.
- Service and facilities configuration by location and site for LGH services in the medium and long terms – and any resulting capital Business Cases.

The Strategic Estate requirements can be summarised as follows:

- A 'fit for purpose' hospital network of Local General Hospitals and the new Grange Hospital at Llanfrechfa. The transition phase of these developments is also a key focus of the programme to ensure the ongoing delivery of services from existing estate is assured.
- A Primary Care estate that is fit for purpose and supports the integrated models of care closer to home and is coherent with the service strategy.
- A MHestate that is consistent with the care closer to home strategy and meets the need of acute MHpatients in modern fit for purpose estate.

Developing and Managing the Capital Programme

The 2015 Programme Business Case (PBC) work did provide very high level overviews of the future configuration of the Royal Gwent Hospital and Nevill Hall Hospital sites, including a number of costed options for achieving the required facilities and this will be subject to review.

The following actions are planned:

- The Strategic Capital and Estates Work stream will carry out a high level review of 2015 PBC site plans and agree or not if these represent the "most likely" scenario post-2021.
- This will inform the scrutiny of any short term capital investment requests within the Discretionary Programme. This will ensure that any investment has a long life and maximum benefit is derived from any use of the limited resources available.
- Any equipment replacements or developments (other than minor/portable items) should be reviewed by the Capital Team in the context of the impending changes.
- Seek and consider any potential innovative sources for capital finding, including learning from other organisations which have had success in this area.
- A look forward to consider how the Health Board's £10.8m Discretionary Capital is best utilised recognising the significant risk underlying capital prioritisation and the need to work with Welsh Government on plans and funding for future years.
- Identify core discretionary requirements including statutory compliance and equipment replacement and other capital drivers such as efficiency, strategic change, transition, sustainability etc.
- Consider whether we require a formal capital prioritisation process which draws all of these factors together.
- Decide how the Discretionary Capital programme can be best used to not only address current high risk but support strategic change.
- The immediate implications of this are that the Health Board therefore has to decide how to prioritise within the Discretionary Capital Programme (particularly for 2018-2019) and if it wants to proceed at risk with fees etc. based on a deferred main programme for developments and address 'core' sustainability risks.

Medium to Long Term Actions

In terms of the medium to long term Capital Programme:

- The Health Board will prepare a Programme Business Case that sets out our implementation and benefits delivery plans for the Clinical Futures strategy and provide a strategic context for future major capital submissions to Welsh Government.
- This will reflect the immediate requirement for the Health Board to identify how it can deliver the requirements of the service changes in the Clinical Futures Strategy in the potential absence of significant All Wales capital investment other than the sum already approved for The Grange University Hospital until at least 2021-2022.
- The current assumption is that Welsh Government will have very little capital available to support developments even beyond 2019-2020 and the Health Board will need to consider carefully the resources used on capital business case preparation for strategic projects such as the eLGHs where the likelihood of early capital funding approval is currently remote.
- Our focus will therefore be on capacity, performance and configuration of services using existing facilities before condition etc. can be addressed.
- The initial focus for Clinical Futures 'estate' planning will be on 'Day 1' transition plans building on the Service Reconfiguration and Workforce work streams.
- The outcome of the Estates 6-Facet Survey will inform this work and will need to be factored into any prioritisation exercise for capital expenditure by better informing a risk based assessment of requirements.
- The Health Board will take forward the development of the Business Case process for the proposed Radiotherapy Satellite Unit at Nevill Hall as part of Velindre NHS Trust's Transforming Cancer Services Strategy and the Health Board's own Cancer Strategy.

The Health Board will seek to maintain an open and honest dialogue with Welsh Government so that shared understandings can be reached on how all outstanding requirements and risks are prioritised and reasonable progress made over a defined timescale.

3.13 Innovation, Development and Research

Innovation

The Aneurin Bevan Continuous Improvement (ABCi) team is a corporate division that focuses its efforts on supporting the Quality Improvement agenda within the Health Board. Its aim is to foster a culture of improvement and innovation by delivering high quality training, development & coaching within the organisation. The team has four key objectives:

- Building the necessary capability for improvement within the Health Board.
- Creating conditions that supports innovative thinking and system re-design.
- Supporting the delivery of strategic objectives through the use of the Institute for Improvement's Breakthrough Series collaborative methodology.
- Building networks both within the organisation, and outside of our Health Board.

These objectives are seen by the Health Board to be mutually self-reinforcing, encouraging the engagement which lies at the heart of our approach to improving quality and patient experience – point is that it is coherent with and supportive of the quality and patient safety agenda as a key component of their daily work.

The Health Board take the approach that no "one" methodology is right for every improvement thus encouraging its frontline staff to find innovative, new and better ways of doing things.

Innovation is also about identifying what works elsewhere and maximising the opportunity to share and learn within the organisation, across our public sector partner organisations, across NHS Wales, the United Kingdom and the world. Over the last 12 months the focus of ABCi has been developing more improvement capability. Improvement and innovation are closely linked and in the coming 12-18 months ABCi will look to begin to aligning both by building the necessary infrastructure across both to support the organisation.

3.13.1 Building Capability for Improvement and Innovation

Achieving improvements in patient experience, optimising clinical outcomes and ensuring the Health Board maximises the use of its resources (its workforce, facilities and finance) requires rigorous methodology that is deeply rooted in the Science of Improvement. By embedding this methodology at the frontline the capability to test, measure, implement and sustain improvement increases drastically. Furthermore, it reinforces a culture of innovative thinking. Whilst training members of the Health Board in improvement techniques has been the mainstay of ABCi's work for the past 3 years, it has begun to develop a deeper understanding of the needs of the organisation. Its training programmes, which are aligned to the national Improving Quality Together strategy, have built a unique set of skills at all levels of the organisation. In the last 12 months the team have evolved its delivery of the standard IQT Silver training, further developing the programme into two specific areas, coaching for improvement and measurement for improvement. These programmes will form the basis of the training in Quality improvement in the next 2 years.

ABCi is unique within the UK in that it has Mathematical modelling capabilities embedded within the team. Whilst this skillset is impressive, it will not realise its full potential without building modelling skills within the wider Health Board. ABCi has developed an innovative approach to achieving this by creating the Silver Mathematical Modelling fellowship. This year long course, supported classroom sessions, coursework, mentoring and final project completed its first cohort in Sept 2017, with 5 middle managers graduating. Cohort 2 is planned to start in January 2018 with a further 8 staff being enrolled in the New Year. The intention of this course is to seek closer links to Cardiff University to understand how positive outcomes can be spread to other areas of Wales.

ABCi has also continued to evolve the Enhanced Leadership and Management Programme. To date the team have over 120 alumni, providing a considerable resource to support improvement and innovation. The team are currently reviewing the course programme so that it fully supports the capacity and capability needed to implement the Clinical Futures models in the face of the new Grange University Hospital & focused on building skills in improvement and leadership amongst senior members of the Health Board.

Having trained over 4250 members of the workforce in both classroom & online bronze sessions this training is now delivered via our internet pages for all staff to access electronically. ABCi continues to focus on developing technical expertise within the organisation and the focus is now on delivering an improvement coach programme, and a measurement lead programme. These programmes are designed to significantly enhance organisational capability for improvement and specifically to support the larger improvement programmes that ABCi are supporting. Early indications via our course evaluation process have indicated that both of the training programmes are well received and deliver a much more collaborative approach to using the methodology that has been developed by ABCi.

What ABCi have done this year to date: November 2017

- Reviewed the needs of the Health Board regarding improvement capability. Consequently an Improving Quality Together (IQT) programme has evolved, with two new ABCi programmes developed to deliver specific skills to our staff in the Health Board:
 - Coaching for improvement, focussing on the skills of coaching and creativity needed to foster a culture of improvement.
 - Measurement lead, focussing on the necessary skills required to effectively analyse and demonstrate improvement and learning.
- Began the development IQT Gold modules in more advanced improvement techniques such as Statistical process control, planned experimentation and Human factors.
- Become the Bevan Commission Innovation Hub for mathematical modelling.
- Continued the delivery of our bronze mathematical modelling courses, including the core skill of interpretation and analysis to inform decision making, ensuring basic analytical and reporting skills are embedded within the organisation.
- Developed and delivered cohort one of the Mathematical modelling fellowship, with cohort 2 commencing in January 2018.
- Began the development of advanced modelling courses, such as Simul8 and Vensim.

- Continued to develop its IQT Gold network, which remains the only such Improvement network in Wales.
- Continue to build our capability encouraging publication and presentation of the work delivered. The team have presented at a number of national and international work.
- Delivering the next cohort of leading people through our on-going development programme over the next 6 months with a focus on building skills in improvement and leadership amongst the senior leaders within our health board and aligned to our 3 year plans.
- ABCi is increasingly recognised for its work, having been awarded the All Wales Continuous Improvement Community award for leadership for the second year running in 2017.

3.13.2 Creating the Conditions for Innovative Thinking

ABCi is very well placed to support and develop innovations within the organisation. Whilst much of this innovation takes place as individuals and teams take part in training programmes and improvement collaboratives, the team has also developed a 90-day innovation cycle to build rigor and pace to projects. Whilst this methodology is still evolving the innovation cycles are beginning to demonstrate impact within the organisation. Examples include:

Modelling – Completed Projects (2017/18)

- An Ophthalmology simulation model that more effectively enables the team to understand demand/ capacity issues, enabling them to make better planning decisions. This is a new simulation model, and provides a different way of understanding the demand/capacity challenge. It will be tested within the division over the next few months.
- Newport integrated Pathway, developed an innovative data dashboard which shows key metrics on the performance of the Newport pathway for keeping over 75 years old patients out of ED.
- Modelling future Dementia demand, development of a simulation model to assess future bed capacity given projected rise in population in Gwent.
- A system-wide model of unscheduled care utilising System Dynamics. This innovative approach to understanding ‘flow’ of patients and information provides a deeper understanding of the impact of strategic decisions across Gwent for both health and social care, and their consequences both intended and unintended.

Modelling – Ongoing / New Projects (2017/18/19)

- A number of projects are currently being supported across the health board, 3 are planned to be delivered at the end of this financial year - March 2018.
 - A Scheduling tool for Trauma and Orthopaedics to reduce cancellations.
 - Demand and capacity tool for Trauma and Orthopaedics elective care.
 - Demand and capacity for the Adult Weight Management service.
 - Geographical modelling of community C.difficile infection.
 - Modelling flow within the ED and MAU.
 - Predicting risk from pressure ulcer on arrival to hospital.
 - Falls prediction tool for 1000 Lives.
- As part of the Clinical Futures work to support the opening of the new Grange University Hospital ABCi has been asked to develop a suite of models to support thinking around clinical pathways in line with proposed methodologies from the Cumberland Initiative and NHS Improvement. This will provide a detailed understanding of demand and its impact on the Health Board between 2017 and 2035. It will also allow an understanding of the impact of intended transformations.

A number of the projects have undertaken could be spread to other areas. Additionally the team is seeking to incorporate the learning into larger improvement projects such as the Unscheduled Care, Out-patients & Pressure Ulcer Collaboratives over the next 6 months. Increasingly, ABCi is looking to apply these skills across a whole systems approach which will include Primary & Community services. Over the next 12-18 months ABCi will continue to apply for a number of grants / third sector funding that enables it to scale up some of its modelling capability work, and support innovation within the organisation. Rather than merely delivering small scale improvement the team is looking to more innovative ways of spreading scaling up work.

Quality Improvement

- With the collaboration between the facilities division & the ABCi department, 4-6 key projects will be delivered aligned to the facilities IMTP which have already started to yield some good results. This support will continue over the next 12-18 months as the teams spread the work across the various hospital sites in the Health Board. The benefits associated with the support that ABCi are providing is reported through the Facilities Divisional team.
- The improving quality together programme has delivered 53 small scale improvement projects across the health board which has also included “care home” Collaboration. The IQT method of delivering training has been further developed by ABCi and will form part of the development of the staff who are delivering the 3 main collaboratives that support the IMTP.
- ABCi has supported 100+ projects in the last several years, many of these have been through training programmes, such as IQT Silver, LQI & traditional lean methodologies. These cohorts provide a considerable resource to support some of the larger strategic objectives within the IMTP such as SCP 2 – Developing a skilled local workforce, SCP 5 – Urgent and Emergency Care, SCP 6 – Planned Care & SCP 7 – Paediatric, Obstetrics & Neonates.

Examples of some of the results from the Quality Improvement Projects

- A District Nursing team wanted to reduce the time they took to discuss their patients each day using the District Nursing Scheduling Tool developed by the ABCi Modelling Team. Through testing different ways to use the tool they reduced the time the team took by 25%. The use of this tool has been spread to around 25 district nursing teams across Gwent.
- A Care of the Elderly (COTE) pharmacist wanted to reduce the risk to patients due to extended use of Dalteparin by ensuring that patient have reliable risk assessment for venous thrombo-embolism. Through working with COTE clinicians, the median use of Dalteparin has been reduced by over 25%.
- Health and Social Care, Community Rehabilitation and District Nursing teams wanted to improve the way they communicate regarding patients in order to reduce duplication. They tested numerous ways to communicate effectively during the course of each day – they achieved a tenfold increase in patient centred conversations each week
- A pharmacist wanted to reduce the number of unnecessary calls in order to spend more time with patients. He identified that unnecessary calls were mainly due to queries around discharge or ward stock. Whilst working with ward teams focussing on these areas, there was a 30% reduction in unnecessary calls for pharmacy review.

3.13.3 Supporting the Delivery of Strategic Objectives through Collaborative Methodologies

ABCI is now 12 months into using the IHI's Breakthrough Series collaborative methodology to build, support and deliver on large scale improvement programmes. This methodology is used globally, and has delivered improvements across many complex healthcare issues within primary, secondary & third sector organisations, improving safety and operational efficiency. The improvement collaborative methodology has a number of intended impacts for the Health Board:

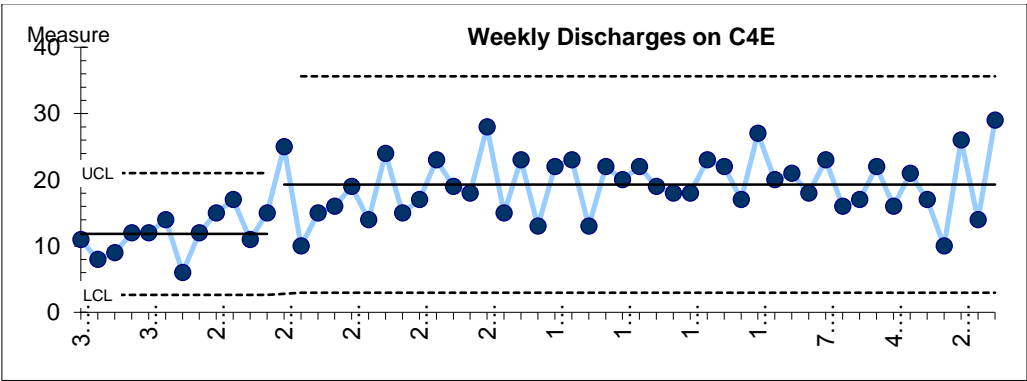
- To support the transformation agenda within the IMTP and beyond.
- To continue to develop a network of improvement experts within the Health Board.
- To foster a culture of innovation and improvement, and help spread and scale up innovative practice.
- Continue to develop the learning from the Unscheduled Care Collaborative focused at the Royal Gwent Hospital & further develop the methodology across community & NHH through 2018.
- The Pressure Ulcer Collaborative is underway with learning set 2 (LS2) delivered in November 2017.
- The Out-patient Transformation Collaborative will build on the learning from the ENT OPD improvement programme with the pre-learning session planned in December 2017.

Examples of some of the results that are being delivered at ward level

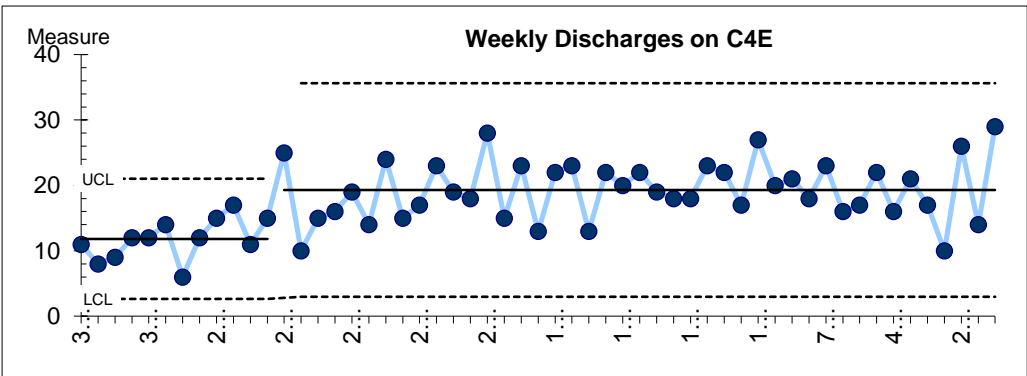
The collaborative approach has progressed from training teams in QI skills to developing coaching and measurement skills with the teams. Twelve months on from the start of the Unscheduled Care collaborative programme, there are local teams producing their own data that proves that they are

making an improvement. The data below is from C4E a Care of the Elderly ward that has reduced their length of stay by 4 days, increased their daily discharges and brought them forward to earlier in the day.

Graph 3.13.1



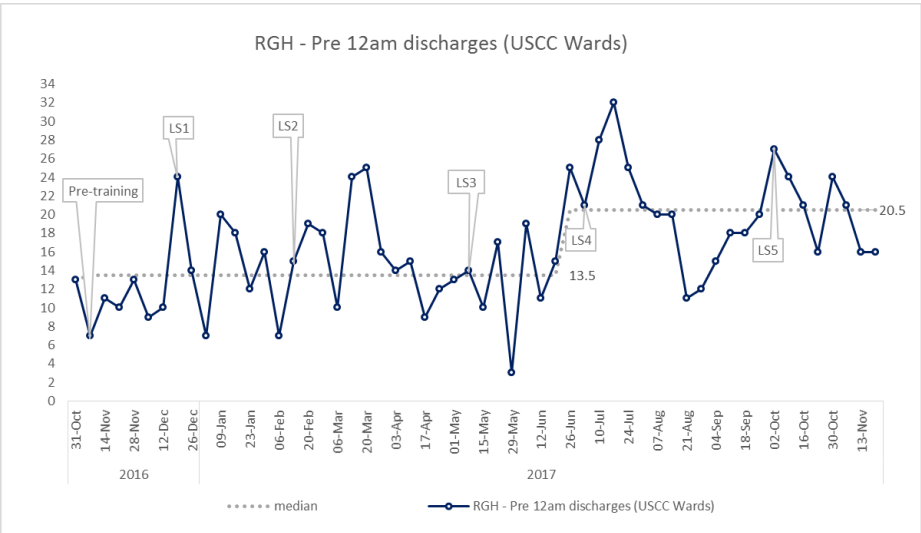
Graph 3.13.2



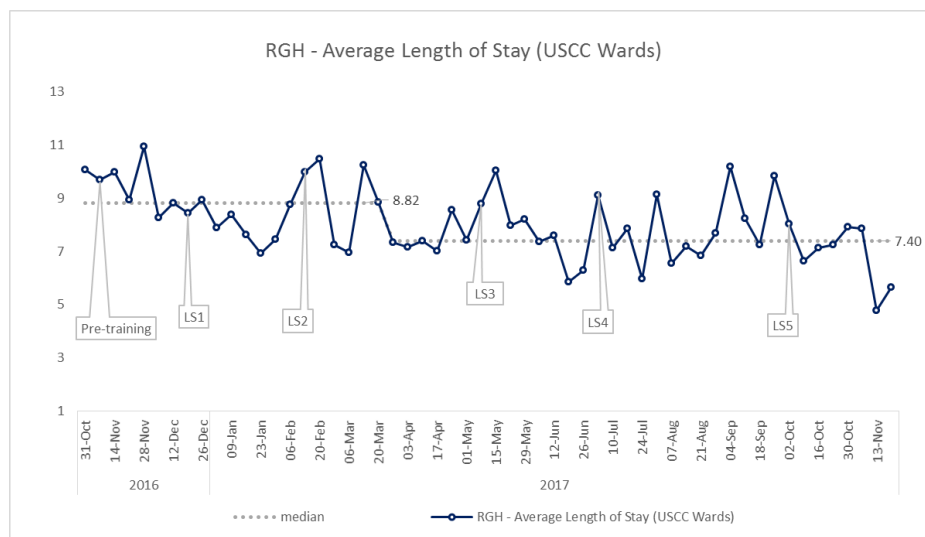
Data provided by: Diane Murray

An example of the improvements being seen across the 10 Un-scheduled care wards in RGH.

Graph 3.13.3



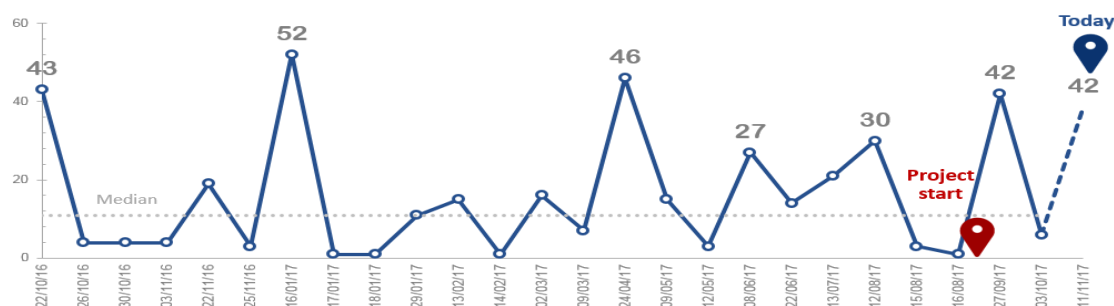
Graph 3.13.4



The Pressure Ulcers Collaborative supported by ABCi is very much in its infancy with learning set 2 recently attended by 43 staff from across the health board. The dashboard is being developed and will form part of the measurement and outcome from each of the wards in the Health Board. Below are some examples of the improvements in the Pressure Ulcer Collaborative.

Graph 3.13.5

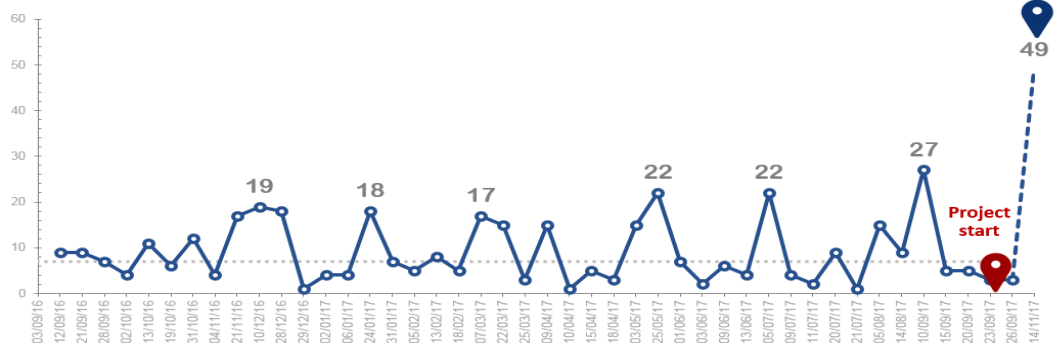
Number of days between two pressure ulcer incidences, C5 West (run chart)



On average 16 days between two incidences!

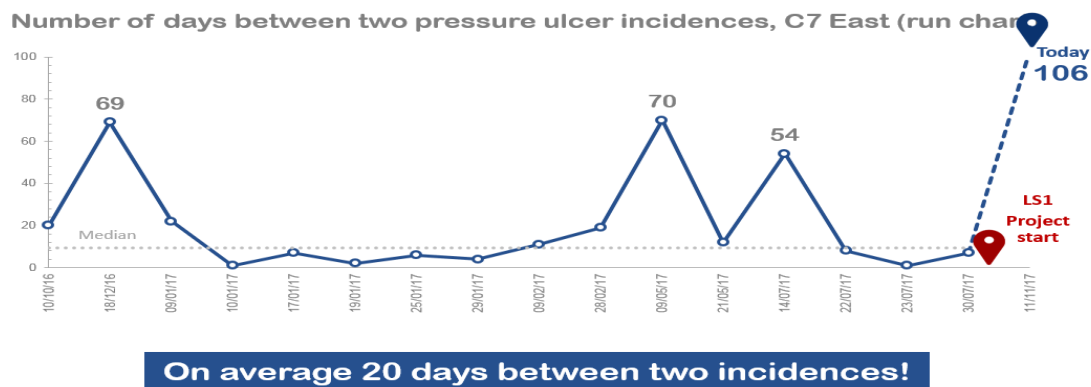
Graph 3.13.6

Number of days between two pressure ulcer incidences, ED (run chart)



On average 9 days between two incidences!

Graph 3.13.7



Data provided by: Dr Doris Behrens

3.13.4 Building Networks Inside and Outside of the Health Board

A key aspect of innovation and improvement is in harvesting learning, evidence of best practice and developments in technology. Achieving this requires us as a Health Board to build internal networks, and look beyond our organisation and learn from others. ABCi is key to supporting this, and it actively seeks to develop learning networks and partnerships with other organisations within Wales and beyond:

- ABCi works closely with the R&D department in order to ensure that generation of new evidence is translated into practice.
- ABCi and the Value Based Healthcare Team are beginning to develop aligned thinking as to how the Health Board designs effectively for value, specifically focussing on outpatients.
- ABCi has active external relationships with:
 - Cardiff University School of Mathematics, supporting the mathematical modellers within the ABCi team;
 - Roche Pharmaceuticals;
 - Simul8.com.
- The Bevan Commission, supporting:
 - the Bevan advocate scheme;
 - the Bevan innovators scheme;
 - the Bevan exemplar scheme, currently supporting three exemplars within the Health Board;
 - ABCi is currently one of the Bevan Innovation Hubs for Wales.
- 1000 Lives, supporting the development of the Quality Improvement agenda within Wales.
- Improvement teams within other Health Boards.
- NHS Improvement.
- Institute for Healthcare Improvement:
 - one member of the team is European lead faculty for their Improvement Coach Programme;
 - one member is delivering a measurement course on behalf of IHI;
 - 2 members of staff currently being trained to deliver Improvement Advisor level for the Health Board.
- Royal College of Physicians of London.
- AWCIC all Wales continuous improvement community.

- Working closely with OEE Consultancy on lean methodology within facilities.
- Collaboration with Roche – Pharmaceutical industry.

Indicators of success: the ABCi team is committed to rigorously measuring its impact in supporting improvement and innovation within the Health Board. Whilst not exhaustive, a number of measures are outlined below.

Key performance Indicators

Table 3.13.1

Deliverable	2017/18	Total to date	Plan 2018/19	Updated Information
Number of staff trained in IQT bronze by ABCi	125	4,250>	On line course	This is now delivered electronically
Number of staff trained in IQT Silver	78	269	0 (Course transferring to ML and QI Coach below)	This will be realigned to the needs of the org
Number of staff who have completed training on ABCi Measurement lead	41	16	50 (2 Cohorts Planned 2018)	New course – 2 cohorts x 4 days
Number of staff who have completed training on ABCi Coaching	43	18	100 (4 Cohorts Planned 2018)	New course – 2 cohorts x 4 days
Excel Courses	20	280	70	½ day courses
Graphical representation	21	166	70	½ day course
Statistics	0	20	15	1 day course
Silver Modelling Fellows Programme	6	6	8	12 months course
Number of staff on ELMP	37	137	46	12 months course
Leading People	21	70	20	12 months course
Unscheduled care collaborative	185	267	200	Attendances
Pressure Ulcer Collaborative	78	78	120	Attendances
Out-patients Collaborative	80 by April 18	0	160	Planned attendee's
Total Staff Trained:	735	5577	859	

Key objectives for 2018/19

- Support innovation:
 - To continue to develop a clear innovation strategy for the organisation that more clearly defines the link between innovation and improvement, and the necessary infrastructure required to develop both. This will ensure that the Health Board, ABCi, R+D, industry and beyond can maximise the ability to support innovation.
 - To continue to evolve the 90-day innovation cycles within ABCi and the Health Board
 - To continue to develop links and support networks within the Health board and beyond to more effectively connect with innovators.
 - To continue to foster links with WG, other NHS providers, third sector providers.
 - To enhance the partnership with Cardiff University and other academic institutions.
 - To apply for external funding to support innovation within the Health Board.
- Build capability:
 - To continue to develop learning materials that enhance our ability to deliver specific measurement and coaching skills to the 3 collaborative programmes being supported by ABCi.

- To develop IQT Gold modules, beginning to build higher levels of improvement expertise.
 - To continue the development of the Enhanced Leadership and Management Program
 - To further develop and deliver further cohorts within the mathematical modelling course which will include a second cohort of mathematical fellows over the next 15 months.
 - To develop a modular based Lean Health Care programme to support the primary care NCN networks.
- To support strategic transformation objectives:
 - To embed the Unscheduled Care Collaborative, and spread to other hospitals within the Health Board.
 - To develop an Outpatient improvement collaborative.
 - To develop similar methodologies to support the safety agenda, e.g., pressure ulcers.
 - To build a new demand and capacity model to support the clinical futures agenda in relation to the service re-design once the GUH is built.

3.14 Digital Health

Informatics Context

In 2016/17 the Health Board drafted a 5 year Informatics Strategic Outline Plan (SOP) which sets out how it aims to facilitate the provision of high quality health improvement and health and social care across through supporting and enabling the strategic developments in analytics, information management and communication technologies. At the heart of the plan are the principles from the “Informed Health and Care: A Digital Health and Social Care Strategy for Wales” (2015). The SOP details the technical infrastructure and information required to deliver and enable the Health Board’s strategy, the annual delivery plan for 2017/18 and future Integrated Medium Term Plans (IMTP). Welsh Government have now commented on and endorsed the Strategic Outline Plan which as a consequence will be updated and refreshed by the Health Board and will include the contribution the Health Board is making towards the patient platform.

The programme identifies that the resource needed to deliver the NHS Wales’ and Health Boards strategic objectives, to mitigate risk and sustain its infrastructure, systems and services are not adequate. As noted in the recent Wales Audit Office report, there are challenges in prioritising both revenue and capital funding to address the significant gap in investment required to deliver the Strategic Outline Case and transform the Health Board’s digital infrastructure. The Health Board will work with Welsh Government to optimise the benefits of investment within the context of available funding.

Transforming our services to a digitally enabled ones, and in doing so, ensuring that our services are fit for purpose and can cope with new and different expectations from our citizens, professionals and institutions, is complex and continuous. The Health Board has considered the significant opportunities of achieving a shift to a primary care led NHS, reducing demand on hospital services and providing efficient, sustainable services. It has set out how this will be realised in particular the opportunities which arise from the accelerating pace of change in digital technology and the increasing power of social innovation, however, its success is in part dependent on wider policy, economic, social, technological and potentially legislative enablers.

However, it is clear that qualitative and quantifiable gains must be achieved across all strategic objectives, in addition to improving health outcomes; changing the culture of the organisation and improving our population’s experience and satisfaction with our care and services. These are essential to ensure sustainable services, which are able to keep pace with the needs of a rapidly increasing, progressively ageing and more clinically complex diverse population.

Our vision and Strategic Outline Plan (SOP) are centred on the delivery of key strategic enablers from the “Informed Health and Care: A Digital Health and Social Care Strategy for Wales” (2015):

Information for you:

Empowering people to look after their own well-being and connect with health and social care more efficiently and effectively, with online access to information and their own records; undertaking a variety of health transactions directly, using technology, and using digital tools and apps to support self-care, health monitoring and maintain independent living.

Supporting professionals

Enabling health and social care professionals to do their jobs more effectively with improvements in quality, safety and efficiency by the provision of improved access to digital tools and information. These will be based on common standards and interoperability between systems, providing access to structured, electronic records in all care settings to join up and co-ordinate care for service users, patients and carers.

Improvement and innovation

Ensuring the health and social care system in Wales makes best use of data and information to improve decision making, plan service change and drive improvement in quality and performance. This will be delivered through collaboration across the whole system, and with partners in industry and academia, ensuring digital advances and innovation are harnessed and greater flexibility and agility in the development of new services and applications is facilitated.

Planned future:

Delivery of transformed health and social care services, through: Joint planning, partnership working and stakeholder engagement at local, regional and national level, and ensuring that the infrastructure, resources, competencies and connectivity is in place to grasp opportunities as they present.

The approval of the Grange University Hospital represented a fundamental commitment to the Health Board's Clinical Futures Strategy.

Plans for 2018/19

Our programme for the next few years will be structured around the delivery of the key strategic enablers of:

- Information for you;
- Supporting professionals;
- Improvement and innovation;
- Planned future.

The programme for the year (and subsequent years) is dependent upon national and local definitions and requirements and therefore will remain flexible in delivery schedules and resources. The Health Board will continue to work closely with NWIS and our partners to deliver solutions and improvements and to ensure appropriate sharing of information across organisational boundaries.

The Health Board will continue to take advantage of systems and processes that places patients at the centre of care following them through all phases of their pathway at hospital, in primary and community care settings and with care partners with seamless transfers of care (clinical flow). Our significant investment priorities for the 2018/19 are:

Technical services, devices and cyber-security- Keeping the lights on

There are significant investments to be made in our technical infrastructure in order to ensure that there is the capacity and technical capability to improve the delivery of services and to sustain the current requirements. Therefore, the Health Board will continue to upgrade and replace devices. This will include mobile devices that support all of our staff (medical, clinical, administrative and others) support the new ways of working requirements and also server and network devices that ensure the information remains available and secure.

2017 saw the largest cyber-attack on the NHS and although NHS Wales saw less of an impact there is no cause for complacency. The Health Board has eradicated unsupported Microsoft XP machines

with only 6 remaining and plans in place to migrate. These machines operate bespoke departmental software and funding has been secured to replace and upgrade.

The Health Board has contributed to a National Cyber Security Review and will act on its recommendations in 2018/19 to ensure systems and information remain secure. Significant integration improvements to our Wi-Fi network will continue, enabling staff patients and visitors to access both free and secured Wi-Fi connectivity throughout Secondary, Community and Primary care settings. Network access controls will continue to be enhanced to improve security to reduce the threat and restrict any impact of “cyber-attacks”. The Health Board will continue to invest in security arrangements to keep pace with the continually evolving technological threats.

The Health Board has moved to a different model of licence agreements with application providers, where a revenue based solution will ensure latest product availability. This is a significant change to previous capital based models and will require year on year investment of approximately £1million for Microsoft products alone, with a business case being developed to validate this approach.

Work is already underway to comply with the General Data Protection Regulation (GDPR) and the Health Board is investing in key posts to prepare and implement. Building on the excellent infrastructure of Information Governance Stewards Programme has provided good foundations.

Patient Empowerment

In 2017, the Health Board engaged a commercial partner to support the delivery of the Value Programme. The programme is using a “digital by default” approach to engage with Health Board patients to:

- Capture expectations
- Capture patient Outcomes
- Capture Experience
- Share targeted information about health and wellbeing.

The Health Board continues to support the “Digital Patient Group” in the Health Board through the use of a third party supplier to deliver text remind services, patient experience surveys and collaborate with the National PROMS programme to share learning and spread good practice for the benefit of all.

Technology Enabled Care Services (TECS)

The importance of new ways of working is recognised linked to the ‘Well Being of Future Generations’ requirements and our ‘Clinical Futures’ strategy that promotes and enables better co-ordinated care through a targeted and pro-active approach through improved service provision using telehealth/telecare technology such as, bedside health transaction and using video (Skype) consultations at the patient’s home and in the community.

The Health Board was successful in an Efficiency through Technology bid to support care homes through the adoption of Technology Enabled Care Services for admission avoidance, in and out of hours GP support and Speech and Language therapy assessment and support. In addition the Health Board will work with HMP Usk to improve health services access for prisoners using Technology enabled care services. 2018/19 will deliver the clinical and operational models, technology support and the first deployments.

The Health Board will also host a National Programme Office for Technology enabled care services which will provide for all Health Organisations a focal point for evidenced based evaluations of TECS on a Once for Wales basis. This Programme Office will act as a knowledge management service and assurance to ensure a “Fast Fail” approach to small scale projects and also ensure the adoption and spread of well evaluated projects to all parts of Wales.

Value Programme

The Health Board's Value programme is leading in terms of financial and clinical appraisal of effectiveness being driven from patient outcomes and experience. It will continue to invest in this critical area and share best practice with colleagues in Wales and beyond. Informatics is critical in delivering this agenda from how the information is collected from the patient through to how the information is presented to help make better decisions with the patient and commission services that add the most value.

Building the capability to capture integrated data sets for both clinical conditions and patient populations is a prerequisite to radical redesign of the way healthcare is delivered to meeting changing patient needs.

Business Intelligence

The Health Board recognises that it is information that enables continuous improvement and empowers better decisions about well-being, health and care to be taken. It aims to be leading in providing access interpretation and presentation of care data into meaningful and useful intelligence whilst improving information quality and data standards and ensuring the right quality information is provided, using clear governance and standards in data and data collections. It will ensure fair and equal access to information to providers, regulators, commissioners and the population.

With an ever increasing demand for information, the current static reporting processes do not allow the information department to meet the needs of the organisation. To adequately support the organisation in its requirements for more detailed up to date information, the Information Department has been developing a Business Intelligence strategy. This will provide a series of dynamic reporting methods which allow for easy interpretation of data by end users, with minimal input from the Information team. This would allow users to see (and change) their view of information, without being as dependant on additional work by the Information Department. This would enable the role of the Information Department to evolve into a more focused role in assisting operational and clinical managers to review and understand their service.

The vision of the Health Board is to provide a dynamic self-service Business Intelligence solution for service managers and clinicians reinforced by information department expertise for more detailed analysis.

To enable the vision there is a requirement for a new Business Intelligence solution (BIS). Business Intelligence (BI) is a set of techniques and tools for the transformation of raw data into meaningful reports and useful information for analytical needs. BI technologies are capable of handling large amounts of data to help identify, develop and create new service opportunities whilst allowing easy interpretation of the data.

The basis of any BI solution is a data warehouse which would draw in data from all clinical and non-clinical systems and store it within a single database on a scheduled basis. Its function is to provide clinical and corporate information to clinical and operational service managers. This ensures that the most current data is available when required and avoids any impact on live systems/services. The benefits of this approach is that by joining the data together it is possible to provide a more complete view of a patient journey as well as being able to see the impact of one area of the Health Board on others. With the responsibility for information reporting in the hands of a single team, expertise is concentrated and a single, integrated repository for ALL reporting for the benefit of the whole Health Board is provided.

The primary purpose of a Business Intelligence Solution is to provide a practical and cost effective Value for Money environment to reduce extensive manual analysis and provide strategic information for organisational decision makers to make informed decisions.

The need for a BI solution to meet organisational information requirements is not unique to the Health Board. A number of Health Boards in Wales have already introduced BI into their organisations and the remainder are currently undertaking an analysis of their requirements with a view to implementing a solution.

The major benefits from the integration of data systems and the BI solution will be:

- Release of local (non-information team) department resources currently producing local information, or their incorporation within the Information Department. The reporting needs can more easily be dealt with by the Information department and its numbers reinforced with appropriately skilled staff.
- Single location for all Health Board Reporting to be accessible from - “One version of the truth”
- Dynamic Reports – users can select their own parameters which will mean less repeat requests for information
- Organisation is able to make informed decisions based on real evidence.
- Automation of the information content of key documents such as the Integrated Performance Dashboard.
- Current information department resources will be able to be refocused into working directly with information users to help them understand their information in greater detail and to provide expert support in the use of the new BI solution to make informed business decisions.
- Ability to link data from a number of different systems e.g., activity and other information from clinical information systems, ESR, costing information from SLR, financial and non-pay information from Oracle
- As organisational needs change the BI solution will be able to adapt to the changing demands as required.
- A structured retrospective measures of outcomes and processes: How did we do?
- A real time clinical and management tools: How are we doing?
- A prediction and modelling services: How will we do tomorrow?

Electronic Patient Flow

The Electronic Patient Flow Management (EPfM) programme is a national programme being led by the Health Board on behalf of NHS Wales. The Health Board is key in managing the risk in investment and taking the benefits led approach engaging with operational and clinical teams, national organisations and commercial partners. An Outline Business Case has been developed and signed off by the National Programme Board and work in Q4 will conclude the financial model and best approach in terms of managing benefits realisation.

In addition the Health Board has undertaken an evaluation of electronic patient flow management in Ysbyty Ystrad Fawr (YYF) and will continue to deploy and evaluate on a larger scale in Neville Hall Hospital. Welsh Government have now endorsed this approach in de-risking a national investment through evidenced based practice.

Welsh Emergency Department system (WEDS)

Contractual difficulties have incurred serious delays in delivering the National WEDS solution. The Health Board has contributed to the negotiations and aspires to implement the WEDS solution in 2018/19.

Convergence with National Programme

The Health Board remains committed to convergence with the national portfolio and is leading on a number of fronts in terms of implementation. Last year, the Health Board signed a concordat with NWIS committing to a collaborative approach to converging the complex architecture to the National portfolio of products. Planning is underway with full engagement from the Health Board and NWIS with clinical leadership and benefits being adopted as the key determinants of the process. 2018 will see the publication of the programme plan, risk register and cost/benefit analysis which will be approved by both the Health Board and NWIS.

Welsh Community Care Information System (WCCIS)

The delivery of the Health Boards Clinical Futures strategy is inextricably linked to the delivery of WCCIS with a profound effect upon the delivery of a number of services across health and social care. Delivering the system aims to provide an integrated health and social care record enabling information about an individual to be available to practitioners from the NHS and Social Services.

This is a large project with implementation over several years. This year will focus on preparing the Health Board for its implementation. A programme is being developed with Local Authority colleagues to enable the Health Board to decide its investment strategy; understanding the technical requirements, preparing staff, reviewing processes and procedures and developing the relevant business cases.

2018 will see the first large scale deployment (subject to successful management of risks) in MHServices, replacing the end of life IT system currently in place. The initiation of a Regional Programme Office co-funded by Local Authorities and the Health Board will be initiated in April 2018 bringing much needed capacity to regional planning, risk management and benefits realisation.

The Health Board has approved a business case to implement WCCIS and is currently working on the deployment order, residual risks and issues including the information model required, integration of existing systems and regional approaches.

Laboratory Information Management System 2 (LIMS2)

The Health Board is currently still utilising a national LIMS system and two local systems due to delays in delivering the complete portfolio. It is hoped that the implementation of LIMS one will be achieved by the end of Q1. In parallel, the Health Board's Pathology Department is already contributing to the National LIMS2 programme. The Health Board is seeking to heavily contribute in order to ensure lessons are learned from the previous procurement and a truly benefits led approach is realised. In order to achieve this the Pathology and Informatics Directorate are engaging with the programme to design the roles and capacity required to inform and support the programme.

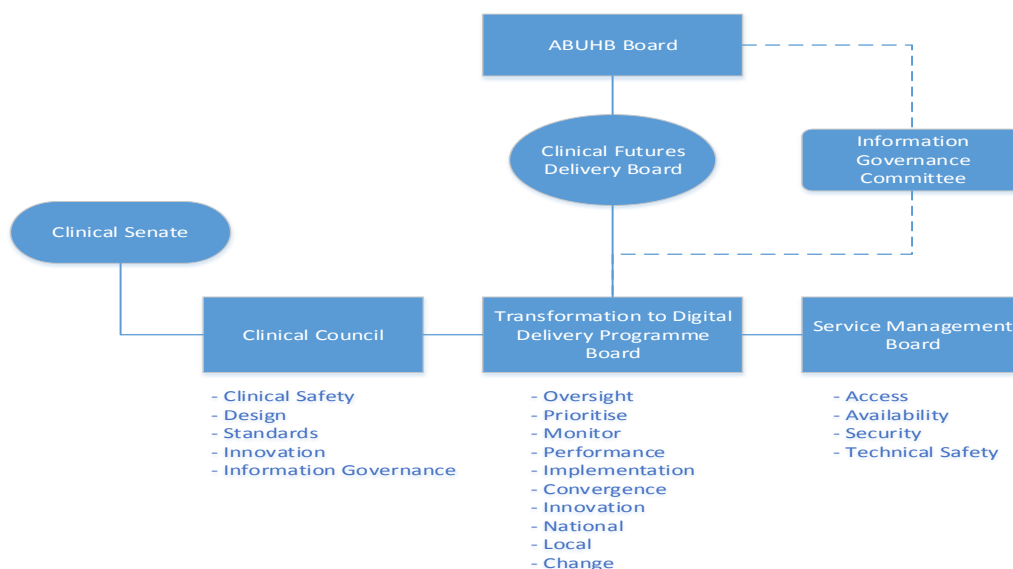
The Grange University Hospital and Clinical Futures

The Directorate is fully engaged in both the Clinical Futures Programme and in the Capital Project of the Grange University Hospital. It is clear that Digital is seen as the key enabler for the successful outcome of the Clinical Futures programme and additional resources have been agreed to ensure every opportunity is identified and prioritised.

In addition to implementing the ICT into the new build of The Grange University Hospital by 2021, Informatics will be fully engaged with the service redesign work that aims to bring care closer to home, mobilising the workforce by enabling professionals to access real time information at the point of care, where ever that may be according to the aims of the Clinical Futures strategy.

Governance for this work and the wider prioritisation of informatics work will be via the newly formed Transformation to Digital Delivery Programme board as demonstrated in the following diagram.

Figure 3.14.1



Digitisation of the current paper Health Record

The digitisation of the current paper record will continue with further progress of the Health Boards Digitisation of Health Records (DHR) project into eForm creation and use.

The Health Board has over 53% of its 400,000 acute patient records (up from 25%) digitised with all new acute patient record digitally created. This ensures that clinicians are able to instantly view the record wherever they see the patient. By Q2 of 2018 the Health Board expects this to rise to the critical mass point of over 60% with the majority of active patients being digitised.

Focus is currently on electronic data capture of information to negate the need to scan new records with a focus on “end of bed” records using Electronic Patient Flow and e forms development. This will allow the release of scanning staff due to decreased demand.

Innovation

Partnerships are already established with Research and Development. The Health Board is represented on the Board of the new Technology Adoption Hub, hosted by Velindre NHS Trust to bring an evidence base discipline to new technology.

The Health Board is collaborating with the Farr Institute and Swansea University to improve data linkage and adopt Natural Language processing and is also in a collaborative project with Intel and a Welsh SME to undertake research into machine learning with wound imaging software.

Governance & Assurance

The Health Board recognise that the governance of information and the systems providing and using information is one of the essential components that facilitate the effective and efficient delivery of services. Good governance provides patients, families, partners, service users and staff with the confidence that the Health Board is creating, collecting, storing and using information correctly and within the law.

Our Assurance Framework will recognise the other vital facets in delivering benefits through informatics, Safety, Security and Benefits.

This year the Health Board will be reviewing its approach to evaluate the success of new technologies and implementation will be based on a benefits-led approach and develop a benefits realisation programme to provide an evidence based mechanism to assist with future projects and sustain these over the life of the service.

The approach for a number of years has been one of individual and collective responsibility, where the governance of information is integral in the day-to-day working practices. The success of the IG Stewards programme shows the positive impact of this approach and therefore this will be progressed through the development of the Information Governance Delivery Groups (IGDG's) – one in each Division. In tandem the delivery and monitoring programmes for policy and training, using improved e:learning application and identifying different ways of providing training will be reviewed.

Working once for Wales will ensure pragmatic policies, procedures and guidance and work will continue with our partners to produce policies that are consistent across NHS Wales. In line with these policies, regular check and reviews of staff use of Health Board information systems will be tested and develop further our programmes to test, check and audit the quality and integrity of the information recorded and stored on the various media within the Health Board. Alongside these application audit tools, the new National Integrated Intelligent Auditing Solution (NIAS) assists to monitor access to information and will be used to inform the development of the Health Board's monitoring approach.

Financial Investment

Given the scale of ambition and opportunities presented through technology, additional investment in the informatics agenda will be required to deliver the priority programmes over the next three years. Whilst the financial outlook for NHS Wales and the Health Board is challenging, the potential benefits to be delivered through technology development is potentially significant.

The Wales Audit Office Report (Diagnostic Review of ICT Capacity & Resources) demonstrated that the Health Board past investment of 0.73% of budget has not met the recommended 2% level and

is lower than peers within Wales despite high levels of clinical engagement and satisfaction with systems.

The draft strategic outline plans across Wales identify significant levels of investment required to deliver the ambitions set out in the National Digital Health Strategy. The priority work programme for the next three years will be dependent on revenue and capital investment availability through both the National and local (Aneurin Bevan University Health Board) infrastructure, capacity and capability, as many of the solutions are interdependent and considered to be more clinically and cost effective if approached on a “Once for Wales” basis. The Health Board will work closely with Welsh Government and NWIS to ensure that both optimal benefit and value for money are obtained from available funding.

The Health Board following Best Practice of Nuffield “Delivering Benefits of Digital Health” (2016) has created a Programme Board reporting into the Clinical Futures Delivery Board to ensure a “Transformation First” approach to prioritising activity. This Board will oversee the tough decisions in terms of what can be achieved in the current financial climate whilst ensuring key enablers are delivered to support the Clinical Futures model.

A sustainability business case has been developed and scrutinised and in 2018 is expected to progress to a decision.

Conclusion

The plan provides a stable foundation by which the Health Board can move forward and build on the previous work by continuing to provide a robust delivery and management framework. It ensures that staff and partners are included in decision making and delivery processes and are responsible for the information they hold, record and use and ensure that the risk to service users care is minimised. At the heart of all of this is the care provided to the patient and the delivery of this year’s plans for Digital Health services and mechanisms allow our longer term strategic plans to be fulfilled.

3.15 External Commissioning

Commissioning is the process of specifying, securing and monitoring services to meet individual needs at a strategic level. It involves the commitment of finite resources to evidence based interventions, particularly but not limited to health and social care sectors with the aim of improving health, reducing inequalities and enhancing patient experience.

Essentially commissioning encapsulates the following key functions in order to deliver high quality and effective healthcare to patients:

- **Assessment and Planning** that demonstrates the evidence base for commissioning services captured in clear strategic and operational plans with agreed commissioning outcomes.
- **Contracting and Procurement.** This relates to agreeing, auditing and validation of contracts and ongoing monitoring of financial, clinical efficiency and patient outcomes performance of contract providers.
- **Performance management, settlement and review** by ensuring providers produce timely and accurate information, benchmarking activity and costs, regular financial and performance reporting, risk sharing arrangements and establishing clear rules of engagement with service providers.
- **Ensuring a value based approach to service provision** that is focused on outcome measures, comparison to “best in class” and evidence based guidelines.
- **Patient and public engagement** through the establishment of mechanisms for ensuring the public and patients have an input into decision making and establishing internal and external engagement and communication strategies.

The University Health Board will be commissioning to promote the objectives of the wellbeing and prosperity agenda for Wales, specifically through improvements in:

- Health gain outcomes: focussing on population well-being and health gains for specific or general

communities through service improvement or redesign (this includes promoting people's independence, reducing inequalities and promoting social inclusion).

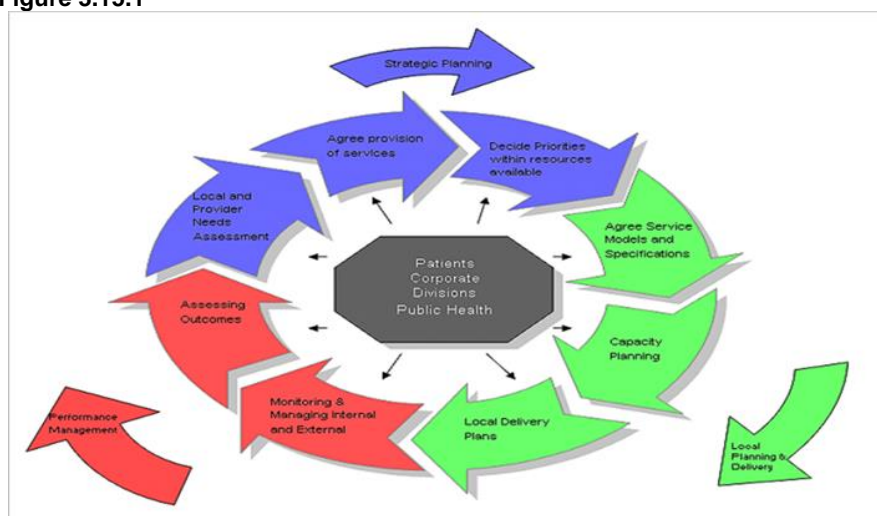
- Prudent healthcare principles and their application.
- Allocative value and efficiency: ensure resources are aligned to areas of greater health need and identifying what should be commissioned, where.
- Technical Value – identifying the best way to deliver a service, including shifting services into the community and primary care from hospital settings.
- Health community outcomes: that could result in another part of the system improving, for instance through a regeneration programme, in ways that enable health gains.
- Clinical and care outcomes: the results of health and social care interventions that matter to patients, for example clinically effective care pathways.
- Joint Commissioning; with Local authorities and partners is a growing area of commissioning work to improve efficiency and effectiveness of service delivery and provide citizens with an improved seamless service delivery experience and improved outcomes.

Contributing to and leading on elements of the national approach to commissioning will be a key part of the Health Board's agenda with existing 'Collaborative Commissioning' proposals being further developed. This will provide opportunities for shared learning, reduced duplication and development of a shared 'intelligent commissioner' portfolio.

Contracting as an element of the commissioning cycle will be developed to help act as a key catalyst to drive change with provider organisations, significant early benefits have been achieved through analysis of service delivery at a macro and micro level.

Moving into the clinical challenge arena of contracting and focusing on quality and outcomes will be the next stage of development, to ensure best value is being delivered. This approach should be developed for adoption as best practice and encompass all contracts and SLA's that the University Health Board commissions.

Figure 3.15.1



- **Commissioning as an enabler** - To ensure it is reflective of the Welsh Government's National Planning Framework requirements for commissioning and incorporates a clear, robust approach to using commissioning to integrate and enable programmes of work within and outside the organisation.
- **Value Based Commissioning** - It builds on the concept of value based clinical services articulated within the University Health Board's Three Year Framework through the introduction of 'value based commissioning'.
- **Driving and influencing national and regional commissioning initiatives across Wales** - By developing the necessary technical expertise and business intelligence to support the wider organisation and act as a significant contributor to the supra regional and national commissioning agenda.

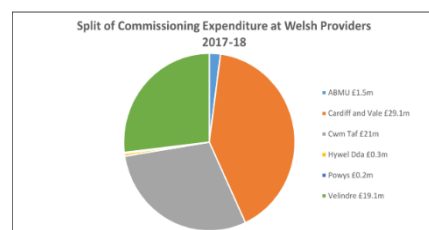
Overview of Commissioning Portfolio

The Health Board commissions a range of external activity for Health Board resident and registered patients through the Commissioning Business Portfolio. The Health Board also provides services for other Health Boards predominantly for residents of Powys tHB. The Portfolio includes LTA arrangements with Welsh Health Boards, English NHS and Foundation Trusts and Specialist Services through the WHSSC commissioning consortia. In addition externally outsourced commissioned services have been established with an NHS Treatment Centre in Bristol. The delegated resource in respect of the Commissioning Business Portfolio for 2017/18 is c£190m (c£207m expenditure offset by c£17m income).

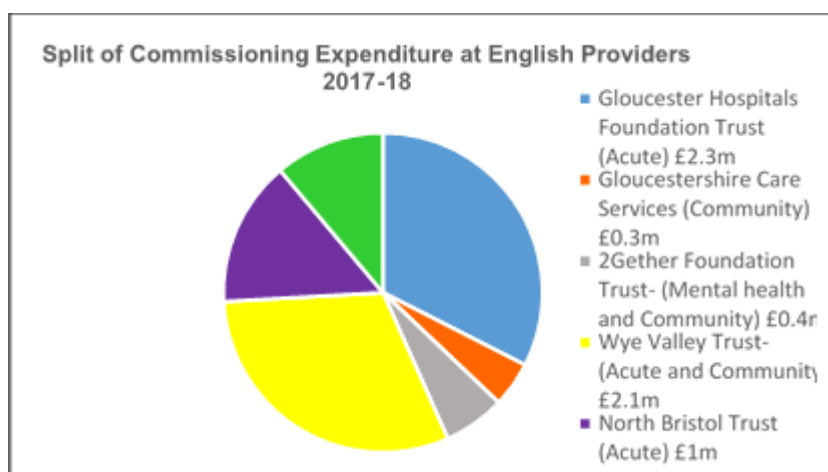
Graph 3.15.1

Split of Commissioning Expenditure in England and Wales

The charts opposite identify the expenditure values by key provider contracts for the c£71m of services commissioned by the Health Board. The three most significant providers of services in Wales are Cardiff and Vale UHB, Cwm Taf UHB and Velindre Cancer Centre.



Graph 3.15.2



Of the c£7m services commissioned by the Health Board from English providers in 2017/18 the greatest volume of activity is delivered by Gloucester Hospitals NHS Foundation Trust, who deliver both emergency and elective acute services for the Health Board. The split of providers and type of activity predominantly delivered is shown opposite.

Work streams of the Commissioning Team

The work of the team is currently focussed in the following areas:

- Value Contracting – Secondary Care. This includes all aspects of the management of contractual agreements and outsourced activity.
- Value Contracting – Specialised Services. This includes the development of IMTP prioritisation processes and the application of business intelligence to drive best practice.
- Applying Business Intelligence including identification of high performance benchmarks to challenge existing commissioned services.
- Maximising Allocative Value including service mapping and the identification and development of repatriation/development opportunities.
- Pathway Development including service redesign and managing change for external commissioned services.
- Prioritisation including needs assessment to inform future commissioning decisions.
- Commissioning Policies. This involves the development, updating and review of key policies including out of area treatment, cross border and non-contracted activity.
- Service Level Agreement Development supporting divisions through the development of standard documentation and providing support and expertise.
- National and Regional Agenda including cross border, collaborative commissioning and the 111 programme.
- Allocative Efficiency, developing supporting mechanisms to facilitate the shift of resources into the optimal value setting e.g. secondary to primary care.

Wales / England Cross Border Arrangements

The Commissioning team are leading the work with Powys TLHB, Betsi Cadwaladr UHB and Welsh Government to influence revised Cross Border arrangements between NHS England and Welsh Government at a strategic and policy level. Five Aneurin Bevan University Health Board GP practices took part in the test phase of the Referral Assessment Service (RAS) that enables English resident patients to exercise their right to choose a secondary care provider. This process is now being rolled out to all GP practices who have registered patients who are resident in England. The Health Board is working closely with the GP practices affected to ensure that there are no gaps in patient pathways.

A re-drafted Out of Area Policy is being progressed and shared with Clinicians and GP practices to ensure that it is understandable and fit for purpose. An Equality Impact Assessment has been undertaken and the Executive Team will be asked approve the revised policy.

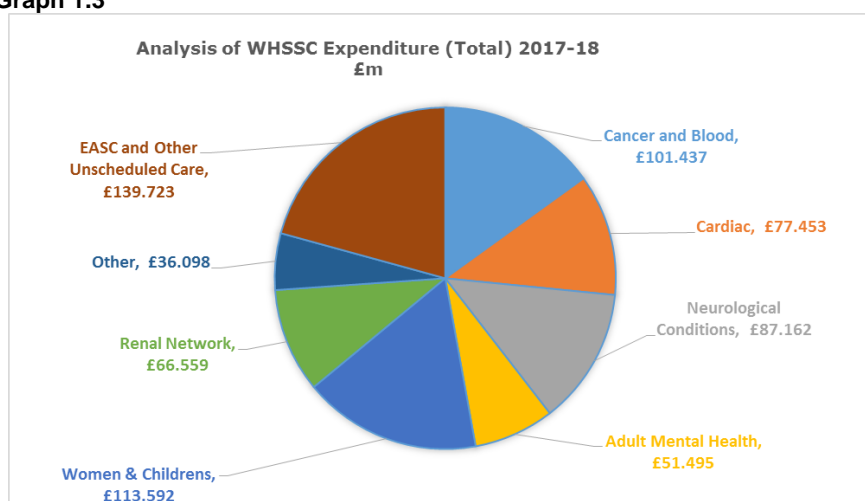
Specialised Services

Through the IMTP process and in line with previous years, the Health Board has continued to make significant investment in specialised services. WHSSC commission specialised services on behalf of the Health Boards in Wales with the key decision making bodies being the Joint Committee of Chief Executives and the WHSSC Management Team consisting of WHSSC/Health Board representatives. Costs are risked shared between commissioners with the Health Board accounting for approximately 19% where costs are shared on a population basis.

The WHSSC ICP is currently being developed jointly with Health Boards in accordance with the Framework of National Planning Requirements with particular focus on the requirements of prudent healthcare, quality and safety and addressing health inequalities.

The current commissioned portfolio is presented below:

Graph 1.3



The key elements being considered in the development of the plan include:

- **Strategic Specialised Services Commissioning Intentions** agreed by all Health Boards at Joint Committee.
- **Horizon Scanning** – This is focused on compiling and assessing a list of new drugs, interventions and technologies expected in 2018-21.
- **Prioritisation** – a process has been developed which outlines a clear, rational approach and a fair, transparent process to ensure that evidence-based health gain for the local population and value for money are maximised in health service planning and delivery.
- **Baseline Review** – A financial review is ongoing of each contract and service baseline within the WHSSC portfolio to identify recurrent service pressures and underspends.
- **Impact of Developments** in 2017-18 – As part of the IMTP process in 2017-18, a significant number of pressures/developments have been funded:

- thoracic surgery;
- implementation of NICE – including extending the use of Ivacaftor (Cystic Fibrosis);
- increasing the range of Genetic Testing and further roll out of Stratified Medicine;
- increasing the commissioning of PET-CT Scans.

A number of these developments have had a 'lead' time resulting in some financial slippage being recognised in the 2017-18 WHSSC financial position. However the FYE of these developments will represent a challenge in the overall WHSSC financial position in 2018-19.

- **Provider Performance** – a number of key services have been identified which require enhanced performance management due to failure to deliver RTT/commissioned activity levels. These services include:
 - interventional neuroradiology;
 - neurosciences, including neurosurgery;
 - plastic surgery;
 - thoracic surgery;
 - paediatric surgery;
 - bariatric surgery.
- **Action plans and an escalation process** are in place with any impact of plans to be considered as part of the 2018-19 IMTP process.
- **Developments in 2018-19** – a prioritisation process is currently underway to consider potential developments in 2018-19. This process is still ongoing but potential areas for investment include:
 - Sustainability of Interventional Neuroradiology Services including the commissioning of mechanical thrombectomies;
 - Wheelchair Replacement Programme;
 - Implementing BAHAS & Cochlears 26 week RTT;
 - Cardiac ablation;
 - Renal dialysis growth.

A number of schemes which strongly comply with Prudent Healthcare/Value principles around avoiding un-necessary treatment have been identified in 2017-18 with a significant FYE effect impact in 2018-19. These include developments around Genetic Testing and the PET-CT policy.

Partnership Commissioning Arrangements

Section 33 Pooled Budget Agreements – The Health Board has 5 local authority partners within its geographic partnership, the dynamic of a 6 partner region means that effective partnership governance arrangements need to be in place. From a pooled budget (section 33) perspective, the Health Board has established 4 major schemes which are described below, with a combined pooled budget value of £23m, with the Health board contributing £12m.

Monnow Vale Health & Social Care Unit - An agreement between the Health Board and Monmouthshire County Council. Provides health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. 2017/18 Forecast Pool spend £3.4m, the Health Board's contribution £2.3m.

Gwent Wide Integrated Community Equipment Service - The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of a seamless integrated community equipment service, to all service users who are resident in the partners' localities. 2017/18 Forecast Pool spend £3.2m, the Health Board's contribution £0.85m.

Mardy Park Rehabilitation Centre - A pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are used to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council. 2017/18 Forecast Pool spend £0.38m, the Health Board's contribution £0.16m.

Gwent Frailty Programme - A pooled budget established between the Health Board with the 5 Local Authorities in the Gwent area, for the provision of a Gwent wide integrated health and social care Frailty service (virtual ward model), for service users who are resident in the partners' localities. Under the arrangement funds are pooled for the purpose of establishing a consistent service for the Gwent area. 2017/18 Forecast Pool spend £15.7m, the Health Board's contribution £8.5m

Care Homes Section 33 development - The Gwent Region, as a partnership, is developing the pooled budget for care homes for the over 65 age category in line with ministerial and statutory expectations. Whilst there remain some local political concerns, the programme to implement the pool by the 31st March 2018 is progressing well, with all partners engaged and involved. The intended approach is start at a high level and develop a more joined up and consistent approach to commissioning over time, if and when agreed by all the partners.

There are expectations of synergies and improved efficiency and effectiveness to be achieved from joint working as part of establishing this section 33 agreement, regardless of financial issues. These objectives include:

- A Regional Market Position Statement & Commissioning Strategy for the provision of Care Home beds to Older People.
- Agreed contracts format for the region used by each partner.
- A single agreed fee setting methodology.
- Reciprocal Quality and Monitoring arrangements.
- Improved communication between partners commissioning teams.
- Develop an agreed pathway which minimises delays for people who need a care home placement.

The initial resource mapping work has identified, across Gwent partners:

Table 3.15.1

Spend Forecast indicates a potential Pooled Fund of £89million:
<ul style="list-style-type: none"> ▪ funded £20m from service user contributions; ▪ £69m from Public funding (£32m ABUHB and £37m Local Authorities).
Using Full Year Estimates this Funds in excess of 900,000 bed days:
<ul style="list-style-type: none"> ▪ 109000 long term bed days in LA owned Homes; ▪ 11,000 short term bed days in LA owned Homes; ▪ 600,000 Long term and short term Independent sector bed days (including FNC); ▪ 200,000 Continuing Health Care bed days.

This will be further clarified and consistency checked ready for the March 2018 deadline.

Section 28a Agreements - The Health Board has several agreements to fund Social Services within the Gwent area under the section 28a arrangements. The total agreement value is £8.8m, three significant schemes are Learning Disabilities across Gwent £3.8m, Torfaen Young People Support Services £1m and Resettlement of LD patients £1m.

Integrated Care Fund – building out of hospital capacity - The Gwent Region received £9.1m for 2017/18, an investment plan has been developed by all partners which focusses on developing integrated community services to support out of hospital care including building community services, admission avoidance and early discharge schemes. The investments have been applied in the following priority areas:

Table 3.15.2

Greater Gwent Regional Partnership Board	Priority Areas for Investment 2017/18						
2017/18 Gwent ICF Allocation	Older People	Autism	Children	Carers	LD	WCCIS	2017/18 Total
£000	£000	£000	£000	£000	£000	£000	£000
9,072	7,003	458	538	189	590	292	9,070

The future partnership ICF investment plan will reconsider both the approach to priority areas and will be influenced by the evaluation of current schemes. 2018/19 will be a pivotal year in the use of ICF resources.

ICF Capital Schemes will be considered through the Gwent Partnership arrangements in liaison with Housing, RSL and third sector partners.

Future Commissioning Priorities

Internal:

- Transforming Cancer Services Agenda.
- Developing commissioning intelligence and increasing the focus on performance and quality in commissioned services.
- Assessment of NICE growth in Velindre including capacity issues.
- Commissioning & Contracting IMTP Process.
- Ophthalmology Task and Finish Group.
- Ratification of the re-drafted Out of Area Policy by the Board.
- Progressing the divisional work outlines above.
- Aim to have all 2018/19 LTAs agreed and signed by end of March 2018.

External/Regional

There are a number of regional projects that the Commissioning Team have a role in and that will impact on how activity will be commissioned and provided and from whom in the future:

- Paediatrics, Obstetrics Neonatal and Gynaecology, the reconfiguration of services within Cwm Taf University Health Board under the South Wales Plan and impact on Prince Charles Hospital accessed by Aneurin Bevan University Health Board and Powys patients. Understanding the proposed reconfiguration of Health Board services, ensuring that plans have been communicated with commissioners and providers and the impact on LTA spend and income is considered as part of the planning process.
- Vascular Transfer, the creation of a vascular hub in Cardiff with spoke units in Cwm Taf and Aneurin Bevan necessitating combined vascular surgery and interventional radiology rotas as part of a vascular network.
- Major Trauma, the implications of the creation of a Major Trauma Network, commissioning of a Major Trauma Centre and Trauma Units needs to be understood.
- Transforming Cancer Services Agenda with Velindre.
- The creation of a Diagnostic Hub in the Royal Glamorgan Hospital may create capacity that the Health Board will be able to access to reduce diagnostic waiting times.
- Engaging in delivering the WHSSC IMTP refresh.

Conclusion

The commissioning approach and cycle to planning and delivering services is gaining ground within the Health Board both internally and externally with our partners. It provides a systematic mechanism to ensure best value is delivered in terms of allocative efficiency, technical efficiency and patient valued outcomes.

3.16 Governance

The Health Board has a strong organisational commitment to good governance, which includes having a clear vision and focus on public service values in everything the organisation does and with its partners. The Health Board is committed to continuing to be a learning and developing organisation to ensure that the health services we provide and commission are of the highest standard for our population. A key focus for the Health Board is the health and wellbeing of the population, how this can be optimised and how any health inequities are addressed, especially access to services across the Gwent area.

The Health Board will also aim to maximise the opportunities provided to work in new and innovative ways through our partnership approaches, particularly those offered by the Social Services and Well Being Act and the Well Being of Future Generations Act. These approaches will foster the integration of health, social and community based services and ensure that these are appropriate now and sustainable for future generations as the Health Board continues to deliver its Clinical Futures Strategy and transforms health and health care services in our area.

Therefore, the Health Board is focused on ensuring that our organisation is structured, has decision making arrangements and assurance processes in place that ensure that there is alignment with citizen and patient centred goals and objectives and those of the Health Board's IMTP and Clinical Futures Strategy. This enables the organisation to deliver services of the highest standard and quality and seeks to ensure that the Health Board responds promptly to any circumstances where its services do not meet our expected standards and expectations. This requires the organisation to have at its centre the needs and interests of patients and the public and requires the Health Board to ensure that the public interest is at the centre of all that is done.

These values and approaches are already well embedded in the organisation and have been borne out in our own and independent assessments over recent years. However, the Health Board as an organisation is not complacent and is aware that there is continuing work that has to be undertaken to further develop, especially to continue to realise the opportunities and requirements as a University Health Board and as the Clinical Futures Strategy is delivered. These are key features of the Health Board's current governance and assurance arrangements, but further work is now being undertaken to ensure all our arrangements are fit for purpose and a new NHS Wales Board Assurance Framework will be agreed in 2018 to guide the organisation's approach and support our taking and giving of assurance and our public reporting.

The Health Board has to ensure that its governance and assurance arrangements are clear and the Board Assurance Framework clearly maps the current profile of risks and required sources of assurance. It has to be clear about the threats to the delivery of its stated objectives as outlined in the IMTP and that there are mechanisms to assess and track risks to the achievement of those objectives and assurance that these are being managed in accordance with legal and other requirements. There has to be assurance that the Health Board is on track to achieve its objectives and if not that there are early warning systems to ensure that remedial action can be taken. The Health Board's approach to risk management is under review and a new system is being introduced during 2018.

The Board is clear that it is accountable for these governance requirements and internal control within the organisation, with the Chief Executive (as Accountable Officer) responsible for maintaining appropriate governance structures and procedures and assurance arrangements. This responsibility includes a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst also safeguarding the public funds and the organisation's assets (in accordance with the responsibilities assigned by the Accounting Officer of NHS Wales).

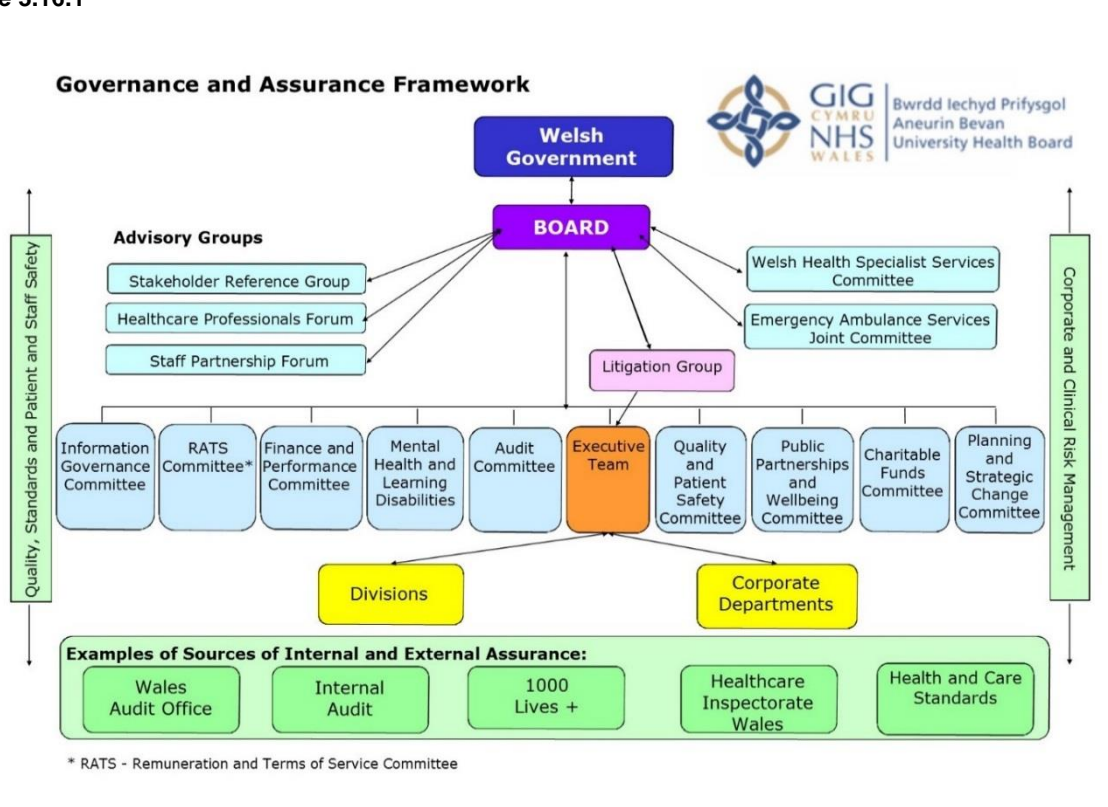
The Health Board has continued to develop its framework and systems of governance and assurance. The Board sits at the top of the organisation's governance and assurance framework and systems and sets strategic objectives via the IMTP, monitors progress, agrees actions to achieve these objectives and ensures appropriate controls are in place and are working properly throughout the organisation. To do this the Board also takes assurance from its Committees and

also its assessments against the Health and Care Standards in Wales and other professional standards and regulatory frameworks. The Health Board and its committees will also use the key themes of the IMTP and progress against key actions to inform the development of Board and committee agenda and also through this actively track progress against actions and outcomes to ensure that the intended benefits and improvements have been realised. Any ongoing risks to non-delivery of the IMTP will clearly feature on the Health Board's business and reporting.

The Health Board's governance and assurance arrangements have been established in accordance with our Standing Orders and Standing Financial Instructions. The Health Board's agreed objectives also seek to ensure we meet national and locally determined priorities and professional standards throughout the conduct of our business. As outlined reporting and monitoring against these objectives, and the risks associated with their delivery and achievement, are received by the Health Board and its Committees.

Further information on the Governance framework and arrangements is included in the Health Board's Annual Accountability and Governance Report, Annual Report and the Annual Quality Statement, which are available via the Health Board's web pages. The Health Board's current governance and assurance arrangements are outlined in the following diagram.

Figure 3.16.1



The Health Board also uses the Welsh Government's Citizen Centred Governance principles to guide our work of obtaining assurance from within the organisation and also giving assurance externally to others in order to demonstrate that the Health Board is achieving its objectives and meeting our responsibilities. The extent to which the Health Board with our partners is able to demonstrate its alignment with these principles and also how we plan for and deliver our responsibilities for citizens are important aspects of the ways in which we are organised, manage our business and perform.

The Wales Audit Office Structured Assessment Report for 2017 highlighted that the organisation's governance arrangements have continued to progress to meet our stated goals. Through this external assessment the Health Board recognises that there is further improvement work required to respond to our stated ambitions as an organisation to provide the best services for local people.

The Health Board has committed to a range of actions in response to the Structured Assessment to

be delivered during 2017/2018 and these include: (This section will need to be updated and clarified following agreement of the Structured Assessment):

Progress against these key actions is being taken forward via the Executive Team and is being monitored by the Audit Committee through tracking reports with a focus on assessing outcomes and realising intended benefits.

The Health Board has also be going through a period of significant change with a new Chair now in place during 2017 and a number of new Independent Members, who are bringing new ideas, approaches and scrutiny to the approach of the Health Board. The Health Board is actively developing and delivering a programme to support the new Board members and ensure that the governance and assurance arrangements of the Board harness these new perspectives and expertise to continue to build on the Health Board's positive reputation for good governance.

SECTION 4 - OUTCOMES AND DELIVERY FRAMEWORK

This section focuses on the outcomes and delivery framework for 2018/19 and beyond to ensure the service plans deliver the desired outcomes and benefits to the patients and populations of Gwent and South Powys.

4.1 Delivery Approach

Our approach is based on effective delivery and assurance principles by promoting effective leadership, positive culture, mutual support, strong governance and accountability and robust performance management. This is achieved by:

- Empowering leaders to deliver change at all levels within the Health Board.
- Providing support to enable leaders to understand, model and address complex, systemic challenges to delivery of our objectives.
- Being explicit about how staff are expected to contribute to change from their role in optimising their department's performance to wider organisational challenges.
- Having meaningful (not multiple) matrices that allow progress to be measured.
- Ensuring that there are clear structures and accountabilities for deliver change and integrated structures to monitor their delivery.

This framework enables the monitoring of progress against achievement of key priorities and ascertaining they are having the appropriate impact and outcomes. This monitoring measures progress of key deliverables both in terms of actions and against agreed profiles. There are reporting arrangements to ensure escalation where appropriate and support to effect remedial actions. This approach is underpinned by having strong focus on the delivery of Service Change Plans which gives clarity on delivery arrangements including:

- Executive leadership;
- Clinical and managerial leads;
- Status of detailed plans;
- Key milestones and timescales;
- Integrated outputs (quality, operational, efficiency, workforce and finance), that form the basis of tracking of plan delivery;
- Risks and mitigation plans.

To ensure that the Health Board's strategic priorities are being delivered, an integrated planning tracker is used for each Service Change Plan and incorporated into the performance management framework, providing the means by which progress is measured quarterly and includes the following:

- Progress against key project milestones within the quarter;
- Delivery against performance milestones;
- Delivery of planned workforce changes;
- Delivery of financial benefits;
- Realisation of quality, patient experience and performance outcomes;
- Key risks and mitigating actions;
- Enabling support required.

There is clarity on priorities, action and key deliverables for 2018/19 but less granularity for the subsequent two years. The delivery framework and governance structure continues to be reviewed and will be strengthened as required as we progress through the planning and delivery process.

Cross Cutting Opportunities

In support of both improving operational performance and delivering the Health Board's Financial Plan, a cross cutting work programme is being taken forward under the leadership of specific Executives.

Table 4.1

Key Area	Executive Lead & Support
Organisational Bed Capacity & LOS	Chief Operating Officer/ Director of ABCi
Workforce (Medical staff, Nursing, Therapies)	Director of Workforce & OD and relevant Executives
CHC	Chief Operating Officer
Medicines Management	Chief Operating Officer
Procurement	Director of Finance

This will align opportunities identified through benchmarking to a prioritised service of interventions, with a clearly defined work programme enabled by corporate support (Planning, Workforce and Finance) and with defined outcome measures (financial and non-financial). This will be delivered through a programme management approach.

4.2 Outcomes & Performance Framework

The refreshed plan has a greater focus on outcomes and performance with a new performance management framework that were implemented across the organisation during 2017/18. This has been aligned with the NHS Outcomes and Delivery Framework as part of a new approach to performance management which has a greater focus on the improvement of population outcomes rather than just simply process.

Figure 4.1



The framework is based on seven domains, identified through extensive public and stakeholder engagement.

The new Performance Management Framework will also encompass local delivery plans and programmes of work and will consider and include:

- Progress and Outcomes of Service Change Plans & Strategic Work Programmes.
- Productivity & Efficiency Indicators.
- Primary Care & NCN Performance Indicators.
- Progress around patient outcomes e.g., PROMS, PREMS, ICHOM.

This will be an iterative process as the information available across these areas is improved. A stronger

focus on quarterly monitoring is also being introduced to support the delivery process.

The following table sets out the key metrics that are included as part of the National Outcomes & Delivery Framework and the planned performance over the next three years, with their alignment to the Health Board's Service Change Plans.

Table 4.2 - Health Board Profile for Improvement in 2018/19 and SCP alignment

Domain	num	measure	national target	Mar-18	Mar-19	Mar-20	Mar-21	SCP/Section
STAYING HEALTHY	2	% children who received 3 doses of the '5 in 1' vaccine by age 1	95%	96%	95.0%	95.0%	96.0%	SCP 1
	3	% children who received 2 doses of the mmr vaccine by age 5	95%	90%	95.0%	95.0%	95.0%	SCP 1
	5	uptake of influenza vaccination - 65+	75%	69%	70.0%	70.0%	75.0%	SCP 1
	5	uptake of influenza vaccination - <65 in at risk groups	75%	52%	55.0%	55.0%	60.0%	SCP 1
	5	uptake of influenza vaccination - pregnant women - gp reported	75%	55%	60.0%	70.0%	75.0%	SCP 1
	5	uptake of influenza vaccination - healthcare workers	50%	50%	50.0%	50.0%	50.0%	SCP 1
	6	chronic conditions admissions per 100k population (rolling 12m)	12m reduction	1200	1100	1083	1000	SCP 3
	7	chronic conditions multi-admissions per 100k pop (rolling 12m)	12m reduction	250	225	217	200	SCP 3
	8	smokers making a quit attempt - extrapolated for full year	5% annually	4.0%	4.0%	5.0%	5.0%	SCP 1
	9	smokers who are CO-validated as quit at 4 weeks	40%	40%	55.0%	60.0%	60.0%	SCP 1
SAFE CARE	22	laboratory confirmed cases of e coli per 100k population (rolling 12m)	≤ 61 per 100k	79	70	60	60	Quality & Patient Safety
	23	laboratory confirmed cases of staph aureus per 100k pop (rolling 12m)	≤ 19 per 100k	26	16	15	15	Quality & Patient Safety
	24	laboratory confirmed c difficile cases per 100k pop (rolling 12m)	≤ 25 per 100k	35	22	20	20	Quality & Patient Safety
	26	patient safety solutions wales alerts not assured on time	0	0	0	0	0	Quality & Patient Safety
	27	patient safety solutions wales notices not assured on time	0	0	0	0	0	Quality & Patient Safety
	29	never events	0	0	0	0	0	Quality & Patient Safety
EFFECTIVE CARE	37	dtocs per 10,000 for people all ages - mh	reduce	0.17	1.40	1.30	0.16	SCP 5
	38	dtocs per 10,000 for people >75years non-mh	reduce	14.00	12.00	11.00	11.00	SCP 5
	40	crude hospital mortality rate (<75 years of age)	n/a	0.56%	0.59%	0.58%	0.57%	Quality & Patient Safety
	43	% valid principle diagnosis code ≤ 1 month after episode end date	95%	75%	91.0%	92.0%	92.0%	Quality & Patient Safety
DIGNIFIED CARE	51	manifesto commitment for procedures cancelled > once	improve	40.0%	50.0%	60.0%	60.0%	SCP 6
	55	% of population (≥65) registered with dementia with GP practice	annually improve	55%	62.5%	65.0%	67.5%	SCP 4

Domain	num	measure	national target	Mar-18	Mar-19	Mar-20	Mar-21	SCP/Section
TIMELY CARE	60	gps open during daily core hours or within 1 hour of core	annually improve	99%	100.0%	100.0%	99.0%	SCP 2
	61	gps practices offering appointments 17:00-18:30 hours (5 days a week)	annually improve	99%	98.0%	99.0%	99.0%	SCP 2
	64	% population regularly accessing nhs primary dental care	improve	57.5%	58.0%	60.0%	60.0%	SCP 2
	65	patients waiting less than 26 weeks for treatment	95%	90%	92.5%	95.0%	95.0%	SCP 6
	66	patients waiting more than 36 weeks for treatment	0	1500	0	0	0	SCP 6
	67	patients waiting more than 8 weeks for a specified diagnostic intervention	0	1500	0	0	0	SCP 6
	68	patients waiting for a follow-up delayed past their target date	reduce	32500	10000	6000	5000	SCP 6
	69	% stroke patients directly admitted to an acute stroke unit ≤4 hours	54.8%	60.0%	95.0%	95.0%	95.0%	SCP 5
	70	% stroke patients thrombolysed ≤45 minutes	12m improved	29.0%	30.0%	31.0%	32.0%	SCP 5
	71	% stroke patients who receive a CT scan ≤12 hours	94.0%	98.0%	99.0%	100.0%	100.0%	SCP 5
	72	% of stroke patients assessed by a stroke consultant ≤24 hours	81.1%	99.0%	99.0%	100.0%	100.0%	SCP 5
	73	category A ambulance response times within 8 minutes.	65.0%	75.0%	75.0%	75.0%	75.0%	SCP 5
	74	number of ambulance handovers over one hour	0	180	50	0	0	SCP 5
	75	% patients waiting < 4 hrs in A&E figures inc. YAB & YYF	95.0%	82.0%	90.0%	95.0%	95.0%	SCP 5
	76	number patients waiting > 12 hrs in ABUHB A&E departments	0	457	300	100	0	SCP 5
	77	delivery of the 31 day cancer standards for non-usc route	98.0%	97.5%	98.0%	98.0%	98.0%	SCP 6
	78	delivery of the 62 day cancer standards for usc route	95.0%	90.0%	92.5%	95.0%	95.0%	SCP 6
	80	assessment by LPMHSS within 28 days of referral.	80.0%	85.0%	90.0%	90.0%	90.0%	SCP 4
	81	therapeutic interventions ≤ 28 days following assessment by LPMHSS.	80.0%	82.0%	80.0%	80.0%	80.0%	SCP 4
INDIVIDUAL CARE	87	Rate of calls per 100,000 population to the mental health CALL helpline	improve	212.0	193.0	193.0	250.0	SCP 4
	88	Rate of calls per 100,000 population to the Welsh dementia helpline	improve	8.0	3.2	3.2	10.0	SCP 4
	89	Rate of calls per 100,000 population to the 'DAN 24/7' helpline	improve	35.0	41.5	41.5	42.0	SCP 4
	90	secondary mental health service user who have a valid ctp	90%	91%	92.0%	92.0%	92.0%	SCP 4
	91	people assessed under part 3 sent their assessment report ≤ 10 days	100%	100%	100%	100%	100%	SCP 4
	92	hospitals with advocacy arrangements in place	100%	100%	100%	100%	100%	SCP 4
STAFF AND RESOURCES	94	patients who dna - new opa - specific specialties	reduce	6.0%	6.4%	6.3%	6.0%	SCP 6
	95	patients who dna - follow-up opa - specific specialties	reduce	6.6%	6.9%	6.8%	6.5%	SCP
	100	% padr/medical appraisal in the previous 12 months	85%	74%	75.0%	80.0%	85.0%	Workforce & OD
	104	monthly % hours lost due to sickness absence	annual improve	4.9%	4.9%	4.8%	4.7%	Workforce & OD