

Notes

- 1. The Whole System Plans have been developed through the lens of a patient's optimum experience through their care pathway.
- 2. Each of the actions are referenced back to the Service Delivery Unit Plans, Workforce Plan and Financial Plan
- 3. A number of the milestones are repeated through the plans as they address several of the actions along the patient pathway
- 4. Each of the actions are aligned to a National Delivery Framework Measure

Prioritisation Methodology of Service Delivery Unit Plans

Units prioritised their own plans using the MoSCoW (Must do, Should do, Could do) method  
Plans were then prioritised using the strategic priorities agreed by the Executive Board being:

- Unscheduled Care
- Planned Care
- The Cancer Centre
- Healthcare Acquired Infections.

All schemes for implementation in Year 1 were then further categorised as:

- Tier 1 –Priority scheme with significant impact where funding is in place or already included as part of the financial plan – included in the Plan.
- Tier 1 Choice – Priority action where no funding is in place for Executive Board to decide whether to be included in the Plan.
- Tier 2 – Actions which are not a strategic priority or where no funding identified which are included in the Plan to proceed if can be supported through redesign of existing resources or a business case is developed and supported or where external funding becomes available.

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Domain	Reference	Measure
Staying Healthy	NDF 1	Of those women who had their initial assessment and gave birth within the same health board, the percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks of pregnancy)
	NDF 2	Percentage of children who received 3 doses of the hexavalent ‘6 in 1’ vaccine by age 1
	NDF 3	Percentage of children who received 2 doses of the MMR vaccine by age 5
	NDF 4	Percentage of children who are 10 days old within the reporting period who are eligible for a contact and received the 10-14 days health visitor component of the Healthy Child Wales programme
	NDF 5	Uptake of the influenza vaccination among: 65 year old and over; under 65s in risk groups; pregnant women and; health care workers
	NDF 6	The percentage of adult smokers who make a quit attempt via smoking cessations services
	NDF 7	The percentage of those smokers who are CO-validated as quit at 4 weeks
	NDF 8	European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales
	NDF 9	The percentage of people with learning disabilities who have an annual health check
Safe Care	NDF 10	Percentage of compliance for staff appointed to new roles where a child barred list check is required
	NDF 11	Percentage of compliance for staff appointed to new roles where an adult barred list check is required
	NDF 12	Rate of hospital admissions with any mention of intentional self-harm for children and young people (aged 10-24 years) per 1,000 population
	NDF 13	Amenable mortality per 100,000 of the European standardised population
	NDF 14	Percentage of in-patients with a positive sepsis screening who have received all elements of the ‘Sepsis Six’ first hour care bundle within one hour of positive screening
	NDF 15	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the ‘Sepsis Six’ first hour care bundle within one hour of positive screening
	NDF 16	The number of potentially preventable hospital acquired thromboses
	NDF 17	Opioid average daily quantities per 1,000 patients
	NDF 18	Number of patients aged 65 years or over prescribed an antipsychotic, as a percentage of all patients aged 65 years and over
	NDF 19	Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)
	NDF 20	Fluroquinolone, cephalosporin, clindamycin and co-amoxiclav items per 1,000 patients
	NDF 21	Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population
	NDF 22	Cumulative rate of laboratory confirmed S.aureus bacteraemia (MRSA and MSSA) cases per 100,000 population
	NDF 23	Cumulative rate of laboratory confirmed C.difficile bacteraemia cases per 100,000 population
	NDF 24	Number of Patient Safety Solution Wales Alerts and Notices that were not assured within the agreed timescales
	NDF 25	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales
	NDF 26	Number of new never events
	NDF 27	The number of grade 3, 4 and un-stageable healthcare acquired (both hospital and community) pressure ulcers
	NDF 28	Number of administration, dispensing and prescribing medication errors reported as serious incidents
Effective Care	NDF 29	Number of patient falls reported as serious incidents
	NDF 30	Number of health board mental health delayed transfer of care (rolling 12 months)
	NDF 31	Number of health board non mental health delayed transfer of care (rolling 12 months)
	NDF 32	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death
	NDF 33	Crude hospital mortality rate (74 years of age or less)
	NDF 34	Percentage compliance of the completed level 1 information governance (Wales) training element of the Core Skills and Training Framework
	NDF 35	Percentage of episodes clinically coded within one reporting month post episode discharge end date
	NDF 36	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme
	NDF 37	All new medicines recommended by AWMSG and NICE, including interim recommendations for cancer medicines, must be made available where clinically appropriate, no later than two months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation
	NDF 38	Number of Health and Care Research Wales clinical research portfolio studies
	NDF 39	Number of Health and Care Research Wales commercially sponsored studies
	NDF 40	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies
	NDF 41	Number of patients recruited in Health and Care Research Wales commercially sponsored studies
Dignified Care	NDF 42	The average rating given by the public (aged 16+) for the overall satisfaction with health services in Wales
	NDF 43	Number of procedures postponed either on the day or the day before for specialised non-clinical reasons
	NDF 44	Evidence of how NHS organisations are responding to service user experience to improve services
	NDF 45	Percentage of concerns that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to an including 30 working days from the date the concern was first received by the organisation
	NDF 46	Percentage of people in Wales registered at a GP practice (age 65 years or over) who are diagnosed with dementia
	NDF 47	Percentage of adults (aged 16+) who had an appointment in the last 12 months, who felt that they were treated with dignity and respect

Domain	Reference	Measure
	NDF 48	Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that is provided by their GP/family doctor
	NDF 49	Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital
	NDF 50	Percentage of employed NHS staff completing dementia training at an informed level
	NDF 51	Percentage of GP practice teams that have completed training in dementia care or other training as outlined under the Directed Enhanced Services (DES) for mental illness
Timely Care	NDF 52	Percentage of people (aged 16+) who found it difficult to make a convenient GP appointment
	NDF 53	Percentage of GP practices open during daily core hours or within 1 hour of daily core hours
	NDF 54	Percentage of GP practices offering daily appointments between 17:00 hours and 18:30 hours
	NDF 55	Percentage of OOH/111 patients prioritised as P1CH that started their definitive clinical assessment within 60 minutes of the initial call being answered
	NDF 56	Percentage of OOH/111 patients prioritised as P1F2F requiring a Primary Care Centre (PCC) base appointment seen within 60 minutes following completion of their definitive clinical assessment/face to face triage
	NDF 57	Percentage of health board population regularly accessing NHS primary dental care
	NDF 58	The percentage of patients waiting less than 26 weeks for treatment
	NDF 59	The number of patients waiting more than 36 weeks for treatment
	NDF 60	The number of patients waiting more than 8 weeks for a specified diagnostic
	NDF 61	The number of patients waiting more than 14 weeks for a specified therapy
	NDF 62	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care specialities
	NDF 63	95% of ophthalmology R1 patients to be seen by their target date or within 25% in excess of their target date for their care or treatments
	NDF 64	The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)
	NDF 65	The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days of receipt of referral
	NDF 66	Percentage of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours
	NDF 67	Percentage of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes
	NDF 68	Percentage of patients who are diagnosed with a stroke who received a CT scan within 12 hours
	NDF 69	Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours
	NDF 70	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment
	NDF 71	Percentage of patients waiting less than 26 weeks to start a psychological therapy
	NDF 72	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral
	NDF 73	The percentage of therapeutic interventions started within (up to and including) 28 days following and assessment by LMPHSS
	NDF 74	Percentage of qualifying patients (compulsory and informal/voluntary) who had their first contact within an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA
	NDF 75	The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes
	NDF 76	Number of ambulance handovers over one hour
	NDF 77	The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge
	NDF 78	The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge
	NDF 79	Percentage of survival within 30 days of emergency admission for a hip fracture
Individual Care	NDF 80	Qualitative report detailing evidence of advancing equality and good relations in the day to day activities of NHS organisations
	NDF 81	Qualitative report detailing progress against the 5 standards that enable to health and well-being of homeless and vulnerable groups to be identified and targeted
	NDF 82	Qualitative report detailing the achievements made towards the implementation of the all Wales standard for accessible communication and information for people with sensory loss
	NDF 83	Qualitative report providing evidence of implementation of the Welsh language actions as defined in More Than Just Words
	NDF 84	Number of calls to the mental health helpline CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population
	NDF 85	Number of calls to Wales Dementia Helpline by Welsh residents per 100,000 of the population (age 40+)
	NDF 86	Number of calls to the DAN 24/7 helpline (drugs and alcohol) by Welsh residents per 100,000 of the population
	NDF 87	The percentage of health board residents in receipt of secondary mental health services (all aged) who have a valid care and treatment plan (CTP)
	NDF 88	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place
Our Staff and Resource	NDF 89	The percentage of patients who did not attend a GP appointment
	NDF 90	Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product plus including biosimilar
	NDF 91	The number of hours lost to critical care delayed transfer of care per month
	NDF 92	Percentage of headcount by organisation who have had a Personal Appraisal Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)
	NDF 93	Percentage of staff who have had a performance appraisal who agree it helps them improve how they do their job
	NDF 94	Overall staff engagement score – scale score method
	NDF 95	Percentage compliance for all completed level 1 competencies within the Core Skills and Training Framework by organisation
	NDF 96	Percentage of sickness absence rate of staff
	NDF 97	Percentage of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment

PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
Prevention, Wellbeing and Self Care	I don't smoke I am given every opportunity to eat	Targeting Prevention Priorities	PCS_1_1	MECC is embedded across all tumour sites and Brief intervention embedded across all tumour sites	T1	<b>PCS_013 - Provision of MECC and measurement of impact on behaviour change</b> (Evaluate) Q1 - Measuring impact of MECC intervention on actual behaviour change by reviewing metrics; Q2 to Q4 Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required	NHSDF_05 NHSDF_06 NHSDF_07 NHSDF_08 NHSDF_09
			PCS_1_2	Peri-natal Mental Health	T1	<b>PCS_028 - Through Health Visiting, review lessons learnt from safeguarding concerns, developing actions around domestic abuse; peri-natal mental health and maternal suicide.</b> (Implement) Q1 - Ensure Ask and Act training compliance with workforce together with competition of FRAIT tool. Plus the competition of the routine enquiry form; Q2 to Q4 Continue with training and safeguarding compliance throughout the workforce to ensure that schemes are being implemented on and on-going basis	
			PCS_1_3	Encourage healthy lifestyle to prevent obesity	T1	<b>PCS_042 - Roll out of Exercise and Lifestyle programme if pilot results positive</b> (Implement) Q1 - Awaiting funding, but hopeful to implement programme; Q2 - Continue implementation of new programme; Q3 to Q4 Evaluate success of rolled-out model by data analysis	
			PCS_1_4	Prevent substance mis-use in order to reduce cases and deaths	T2	<b>PCS_043 - Development of substance misuse pathways to reduce high rates of substance misuse cases and deaths</b> (Plan) Q1 - Proposed service available for review by all stakeholders / parties; Q2 Exploring funding opportunities in order to deliver services within each sector; Q3 to Q4 Begin implementation of new service model	
			PCS_1_5	Help me quit campaign, Smoking cessation services widely available and No smoking culture on sites	T1	<b>PCS_078 - Alignment of the Help Me Quit hospital team with the Help Me Quit community team in order to streamline the Smoking cessation service</b> (Implement) Q1 Following OCP, scope potential premises to co-locate staff; Q2 - Q3 Begin the process of aligning the two teams; Q4 Roll-out of fully integrated working with both teams working under a single brand.	
	Develop Community resilience		PCS_1_6	Establish Wellness Centres	T1	<b>PCS_001 - Develop integrated Wellness Centres in Neath Port Talbot</b> (Plan) Q1 SOC submitted for Upper Afan Valleys and Neath Wellness Centres; Q2 Appoint supply chain partner; Q3 Establish project board and Develop OBC; Q4 Submit OBC to WG for approval	
					T1	<b>PCS_002 - Develop integrated Wellness Centres in Swansea</b>	
			PCS_1_7	Actively promote to all staff and patients at higher risk from influenza	T2	<b>PCS_014 - Improve Flu Vaccination uptake rates for children, people with chronic conditions, people over 65 and staff through Flu immunisation campaign and Flu Action Plan through Flu steering group</b> (Implement) Q1 Evaluation of 19/20 programme and action plan; Q2 Finalise flu plan; Q3 & Q4 Implement flu action plan	
			PCS_1_8	Peri-Natal Mental Health	T1	<b>PCS_028 - Through Health Visiting, review lessons learnt from safeguarding concerns, developing actions around domestic abuse; peri-natal mental health and maternal suicide.</b> (Implement) Q1 - Ensure Ask and Act training compliance with workforce together with competition of FRAIT tool. Plus the competition of the routine enquiry form; Q2 to Q4 Continue with training and safeguarding compliance throughout the workforce to ensure that schemes are being implemented on and on-going basis	
			PCS_1_9	Actively promote to all patients at higher risk from influenza	T2	<b>PCS_030 - Improve uptake of childhood immunisations, particularly for those in areas of high deprivation through the Childhood Immunisation Group</b>	
			PCS_1_10	Implement the Healthy Child Wales programme inc Phase 2 when required	T1	<b>PCS_035 - Foster partnership working across communities and clusters to successfully deliver against the Healthy Child Wales programme in line with the Parliamentary Review of Health and Social Care in Wales and ensure Health Visiting practice utilises the FRAIT tool in assessing the resilience and needs of the family</b> (Evaluate) Q1 to Q4 Review programme and ensure that standards are maintained in line with Welsh Government standards around the delivery of the Healthy Child Wales programme	
			PCS_1_11	Breastfeeding Coordinators delivering direct support -Infant Feeding Coordinators supporting Baby Friendly standards. Monitor compliance with All Wales Breastfeeding Strategy - 5 year	T2	<b>PCS_037 - In line with the Baby Friendly Initiative, improve and increase breast feeding rates</b> (Implement) Q1 Substantive full time Infant Feeding Co-Ordinator is in post to fully roll-out programme across Swansea Bay; Q2 & Q3 Establish links and grow role throughout the Health Board; Q4 Maintain accreditation of Baby Friendly Status and further develop role and programme	
			PCS_1_12	Early identification of speech, language & communication development and any other developmental delays	T1	<b>PCS_038 - SLT will continue to work with local education authority partners and maintained nurseries to deliver WellComm a programme at a universal and targeted level to support early speech and language development, enabling children to have the best start in life.</b> (Evaluate) Q1 to Q4 Evaluate impact and feedback QI measures to SBUHB and Local Authority partners	
			PCS_1_13	Encourage healthy lifestyle through relevant programmes	T1	<b>PCS_042 - Roll out of Exercise and Lifestyle programme if pilot results positive</b> (Implement) Q1 - Awaiting funding, but hopeful to implement programme; Q2 - Continue implementation of new programme; Q3 to Q4 Evaluate success of rolled-out model by data analysis	
			PCS_1_14	Development of Substance Misuse pathway	T2	<b>PCS_043 - Development of substance misuse pathways to reduce high rates of substance misuse cases and deaths</b> (Plan) Q1 Proposed service available for review by all stakeholders / parties; Q2 Exploring funding opportunities in order	
	Up to date, accessible and easy		PCS_1_15	Dental care for housebound patients	T1	<b>PCS_032 - Improve the oral health of vulnerable groups specifically children, the elderly and housebound</b> (Implement) Q1 to Q3 Implement new model for dental domiciliary and other groups; Q4 Review	

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						2020/21	
			PCS_1_16	Community Children's Services offered at home and on an equitable basis	T1	<b>PCS_040 - Flying Start programme to be reviewed in line with new Local Authority Funding Stream from 2020, by reviewing Geographical Core and Flying Start areas to align with Cluster working which will provide a more equitable service</b> (Implement) Q1 Review funding and provide details of programme delivery; Q2 Depending on outcome of funding, implementation of agreed programme; Q3 & Q4 Further implementation across the Health Board	
			PCS_1_17	Implement regional service for consistency across the Health Board footprint	T1	<b>PCS_048 - Merger of NPT and Swansea Single Point of Contact District Nursing service, Community Wound Clinic Admin and Continence Admin departments</b> (Implement) Q1 Commence OCP process in order to re-locate staff members; Q2 Review outcome of OCP; Q3 Re-locate service and teams to new site; Q4 Continue implementation of re-location	
					T1	<b>PCS_049 - NPT District Nursing OOH service to merge with Swansea model to operate out of Morriston Hospital/GP OOH</b> (Implement) Q1 Commence OCP process in order to re-locate staff members; Q2 Review outcome of OCP; Q3 Re-locate service and teams to new site; Q4 Continue implementation of re-location	
					T1	<b>PCS_050 - Swansea District Nursing Service to mirror the Neath Port Talbot District Nursing service with regards to their day/night operating hours.</b> (Implement) Q1 Commence OCP process in order to re-locate staff members; Q2 Review outcome of OCP; Q3 Re-locate service and teams to new site; Q4 Continue implementation of re-location	
			PCS_1_18	Digital consultations in the community	T1	<b>PCS_077 - Roll out of Skype/FaceTime digital consultations in Care Homes through the Acute Clinical Team</b> (Implement) Q1 Review and analyse advantages and impact that initial device has had on ACT service; Q2 to Q3 Depending on the outcome of analysis, extend roll-out	
			PCS_1_19	Implement new pathways for Diabetes through the New Cluster model	T2	<b>PCS_025 - Ensure that Diabetic pathways are extended to include the ongoing management of vulnerable housebound patients who require daily support and intervention for managing their Insulin administration</b> (Plan) Q1 Work alongside corporate colleagues in order to develop and review the current framework policy; Q2 Facilitate and support all existing Band 3 HCSW in the community to achieve QCF Level 3 or equivalent Standard in preparation to undertake delegated administration of insulin to housebound diabetics; Q3 Review HCSW workforce competencies against the QCF Level 3 or equivalent and facilitate outstanding workforce to complete qualification; Q4 Ensure all HCSW are at QCF Level 3 Standard or equivalent	
			PCS_1_20	Review of Acute Clinical Teams and opportunity for improved pathways from community and front door through Keep Me at Home Workstream of OP programme including right size capacity for rapid response.	T1	<b>PCS_011 - Merger of NPT and Swansea Acute Clinical Teams in order to form one service across Swansea Bay University Health Board</b> (Plan) Q1 Scope both services in order to align and provide consistency across the Health Board footprint; Q2 Commence plans to implement a one-way and consistent way of working across two teams - e.g. job roles to be aligned; Q3 Start the process of OCP; Q4 Begin the implementation process of alignment	
Timely, Equitable Access and	I receive the timely and appropriate assessment and	Ensuring that local primary care provision is accessible and provides a wide range of clinical expertise to make an initial assessment of the patient's condition and provides diagnosis and treatment where appropriate	PCS_2_1	Implement new pathways and Service Models for Primary Care	T2	<b>PCS_017 - Hearing loss Pathway has been implemented in Sept 2018. Expected to reduce ENT demand by 1000 cases/year. Additional benefits to ENT should accrue through increased management of complex cases by Audiology</b> (Evaluate) Q1 to Q4 Analysing data to ensure that there's a reduction on demand on ENT services in secondary care	NHSDF_18 NHSDF_51 NHSDF_52
					T2	<b>PCS_018 - Development of Podiatry led community vascular diagnostic service in line with Limb at Risk pathway</b> (Implement) Q1 to Q2 Implement new model; Q3 Begin evaluation process by analysing data to identify success of model outcomes; Q4 Continue evaluation process	
					T1	<b>PCS_019 - Identification of prudent foot casting pathway model</b> (Implement) Q1 to Q2 New model available for stakeholder engagement; Q3 to Q4 Implement new model	
					T1	<b>PCS_062 - Development of Podiatry walk-in service in Swansea locality</b> (Plan) Q1 to Q2 Identify capacity required and begin staff development plan; Q3 to Q4 Being process to start to implement staff development plan	
					T1	<b>PCS_067 - Integrated SLT services at GP services - SLT first point of contact for swallowing and communication difficulty triage</b> (Evaluate) Q1 to Q4 Evaluate success of talk-in clinics and a child's school readiness by the age of 5	
					T1	<b>PCS_065 - Development of service model in conjunction with model for Physiotherapy first point of contact practioners</b> (Implement) Q1 to Q4 Dependant on progress and agreement of FCP (First Contact Practitioners) model	

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						2020/21	
						PCS_071 - Completion and consideration of Physiotherapy Business Case for mainstream funding for cluster based physio	
						T1 PCS_020 - Review of the Pain Management Programme Model (Plan) Q1 to Q2 Model plan for stakeholder engagement available; Q3 Make required changes to model; Q4 Back out for further stakeholder engagement	
						PCS_2_2 PCS_021 - Deliver Sexual Health services within Swansea Bay University Health Board that reflect the five priority areas from Public Health Wales (Plan) Q1 Review Swansea Bay Health Services against the priority areas and commence plan; Q2 Implement findings from plan; Q3 Review performance against WG targets through data analysis; Q4 Evaluate first year performance and prepare for second year	
						PCS_2_3 PCS_029 - Service available for dementia population in assessment, inpatient and community environments for communication, swallowing and family support (Implement) Q1 Appoint to new service; Q2 to Q4 Scope out and commence data collection	
						PCS_2_4 PCS_032 - Improve the oral health of vulnerable groups specifically children, the elderly and housebound (Implement) Q1 to Q3 Implement new model for dental domiciliary and other groups; Q4 Review	
						PCS_2_5 PCS_034 - Designated SLT in neonatal services, NICE standard and develop SLT workforce for neonatal and children's services (Plan) Q1 to Q4 Identify funding for additional workforce to achieve targets	
						PCS_2_6 PCS_038 - SLT will continue to work with local education authority partners and maintained nurseries to deliver WellComm a programme at a universal and targeted level to support early speech and language development, enabling children to have the best start in life. (Evaluate) Q1 to Q4 Evaluate impact and feedback QI measures to SBUHB and Local Authority partners	
						T1 PCS_082 - In collaboration with Western Bay, continue to develop access to SLT assessment and intervention for Children and Young people in the Youth Justice system (Implement) Q1 Following successful appointment of new SLTs for Youth Offending service, implement new model; Q2 to Q3 Continue implementation of new model; Q4 Evaluate success of the new investment into Youth Offending model	
						T1 PCS_039 - SLT role in Neurodevelopmental Disorders pathway for assessment and diagnosis of ASD and/or ADHD in accordance with NICE guideline. (Evaluate) Q1 to Q4 Evaluate impact and feedback QI measures to SBUHB	
						PCS_2_7 PCS_063 - Identify role and model of Cluster based Chronic Pain services (Plan) Q1 to Q3 Identification of model for stakeholder engagement; Q4 Make required changes following stakeholder engagement	
						PCS_2_8 PCS_073 - Audiology is developing new roles such as Advanced Primary Care Practitioners (Band 7 and above). To ensure efficient skill mix a new Associate practitioner (Band 4) role is being developed. The band 4 role is designed to manage non-complex cases and enable the Advance practitioner to maximise the number of ear and hearing cases that can be removed from GP caseload. (Implement) Q1 2019/20 Associate Audiologists fully embedded in Cluster clinical work; Q2 Recruitment of HEIW funded Associate Practioner trainees; Q3 to Q4 Continuation of training for trainees	
						PCS_2_9 PCS_077 - Roll out of Skype/Facetime digital consultations in Care Homes through the Acute Clinical Team (Implement) Q1 Review and analyse advantages and impact that initial device has had on ACT service; Q2 to Q4 Depending on the outcome of analysis, extend roll-out	
						PCS_2_10 PCS_091 - Implementation of the Primary Care Mental Health Service within HMP Swansea (Implement) Q1 Undertake recruitment and training with new staff which will include Mental Health Practitioners, Psychology Therapists and HCSWs. Also need to develop practice and supervision framework; Q2 Implement the agreed service model; Q3 to Q4 Review service model and develop plans for further training and up-skilling as appropriate. Strengthen interface between Primary Care and Mental Health	
	Improving primary care service sustainability			Improved access to Primary Care services	T1	PCS_016 - Vulnerable groups: improve equity and access to special care dentistry required under a General Anaesthetic, working with Hospital Delivery Units to increase capacity to maintain and reduce RTA and RTT from current levels (Implement) Q1 Identify additional/available GA lists to treat rising number of SCD patients requiring GA treatment; Q2 Implement new capacity; Q3 to Q4 Monitor Progress	



PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
Improving Quality Value and	I receive my treatment in a timely manner without	Ensure Good Primary and Community Care	PCS_3_1	Development of Wellness Centres	T1	<b>PCS_045 - Increase access to general dental services through implementation of contract reform programme</b> (Implement) Q1 New intake of practices 50% Monitor those on phase 1 and phase 2; Q2 Monitor progress against objectives; Q3 New intake of practices Monitor those on phase 1 and phase 2; Q4 Monitor progress against objectives	NHSDF_51 NHSDF_52
					T1	<b>PCS_048 - Merger of NPT and Swansea Single Point of Contact District Nursing service, Community Wound Clinic Admin and Continence Admin departments</b> (Implement) Q1 Commence OCP process in order to re-locate staff members; Q2 Review outcome of OCP; Q3 Re-locate service and teams to new site; Q4 Continue implementation of re-location	
					T2 Query	<b>PCS_088 - Develop a framework and opportunities for Advance Practitioner rotation across primary care and community settings, reducing staff turnover and supporting a sustainable future workforce</b> (Implement) Q1 Begin recruitment process for newly qualified and existing secondary care ANPs to commence primary care and community rotational programme; Q2 Further consolidation of skills within Primary Care and Community settings; Q3 Continuation of rotational placements within general practice to ensure competence and confidence in this specialist area; Q4 Initial evaluation of ANP internship programme to establish set skill mix for future primary care / community collaboration	
					T1	<b>PCS_060 - Reduce variation in access and treatment and improve safety; reducing number and percentage of children treated under a GA. Priority is to transfer service to an acute hospital setting</b> (Plan) Q1 Service transferred to MH Site; Q2 to Q3 Begin planning of long term sustainable HB delivered model; Q4 Implement long term plan	
					T2	<b>PCS_090 - Remodel Primary Care services in HMP Swansea creating a salaried GP model</b> (Implement) Q1 Developing MDT structure aligning role descriptors to service delivery needs; Q2 Review efficacy of MDT structure with a view to expanding service; Q3 Maximising skill mix and scope of practice for each workforce role to ensure prudent healthcare approach; Q4 Review of MDT structure to further develop on-going workforce model	
			PCS_3_1	Development of Wellness Centres	T1	<b>PCS_001 - Develop integrated Wellness Centres in Neath Port Talbot</b> (Plan) Q1 SOC submitted for Upper Afan Valleys and Neath Wellness Centres; Q2 Appoint supply chain partner; Q3 Establish project board and Develop OBC; Q4 Submit OBC to WG for approval	
					T1	<b>PCS_002 - Develop integrated Wellness Centres in Swansea</b>	
			PCS_3_2	Ensure health and well-being are being promoted at every opportunity	T1	<b>PCS_013 - Provision of MECC and measurement of impact on behaviour change</b> (Evaluate) Q1 - Measuring impact of MECC intervention on actual behaviour change by reviewing metrics; Q2 to Q4 Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required	
			PCS_3_3	Develop strong links between Primary Care and Secondary Care services	T1	<b>PCS_027 - Development of stroke ESD SLT service bridge between secondary and primary care services would not only meet targets but would facilitate patient flow and reduced LOS</b> (Plan) Q1 to Q4 Identify funding for additional workforce to achieve targets	
			PCS_3_4	Re-Model Child Dental Services	T1	<b>PCS_033 - Complete transformation of re-modelled 'Design to Smile' programme focusing on younger children; inclusive of 'Lift the Lip' campaign Health Board wide</b>	
			PCS_3_5	Implement the Healthy Child Wales programme inc Phase 2 when required	T1	<b>PCS_036 - Development and implementation of the All Wales acuity tool for Health Visiting across SBUHB to accurately deliver the Healthy Child Wales programme</b> (Plan) Q1 Continuation of workshops in readiness for the implementation of the acuity tool; Q2 Evaluate outcomes from Q1 workshops and feedback into the All Wales Health Visiting forum; Q3 As a result of feedback from the All Wales Health Visiting Forum, continue with workshops as part of the PDSA cycle; Q4 Continuation of workshops in readiness for the implementation of the acuity tool	
			PCS_3_6	Ensure geographical services are offered on an equitable basis	T1	<b>PCS_040 - Flying Start programme to be reviewed in line with new Local Authority Funding Stream from 2020, by reviewing Geographical Core and Flying Start areas to align with Cluster working which will provide a more equitable service</b> (Implement) Q1 Review funding and provide details of programme delivery; Q2 Depending on outcome of funding, implementation of agreed programme; Q3 to Q4 Further implementation across the Health Board	
			PCS_3_7	Re-Model Ophthalmology services	T1	<b>PCS_046 - Reduce reliance on face to face ophthalmology outpatient appointments by further increasing number and percentage of patients receiving pre-operative assessment and post op follow up in primary care (Optometry) practice</b> (Implement) Q1 Commence implementation of a new pathway Q2 to Q4 Monitor progress against objectives	

## PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
			PCS_3_8	Develop regional service in order to develop consistency across Health Board footprint	T1	<b>PCS_048 - Merger of NPT and Swansea Single Point of Contact District Nursing service, Community Wound Clinic Admin and Continence Admin departments</b> (Implement) Q1 Commence OCP process in order to re-locate staff members; Q2 Review outcome of OCP; Q3 Re-locate service and teams to new site; Q4 Continue implementation of re-location	
			PCS_3_9	Continue with professional development		<b>PCS_056 - Ensure sufficient training places to develop and maintain Advanced Nurse Practitioners</b> (Implement) Q1 On-going review of service areas to identify AP recruitment and retention issues - Align to recruitment; Q2 Continuous liaison with education lead, HEIs and Heads of Service regarding AP workforce planning - Align to recruitment; Q3 Continuous review of current AP staff to ensure rolling upskilling of this role - Align to training and development; Q4 Continuous review of mentorship and supervision requirements within units for the role of AP development. Align to recruitment and training	
						<b>PCS_093 - Develop the role of the HCSW and commission training programmes to meet service needs</b> (Implement) Q1 Submission of HEIW funding application for Primary Care HCSW development; Q2 Scoping exercise amongst Primary Care and Community Services / Independent contractors to establish level 3 and 4 Skill Mix; Q3 Liaison with HEI to establish relevant QCF and Diploma courses; Q4 Commencement of on-going level 3 and 4 courses	
						<b>PCS_089 - Review practice to ensure staff are working to the top of their licence and that skill mix within services supports this</b> (Plan) Q1 Scoping exercise to determine current skill mix associated with extended roles within Primary Care and Community; Q2 Analysis of service needs and alignment to skill mix associated with each Healthcare role; Q3 Framework compilation to outline required output for Healthcare roles and service delivery; Q4 Decimation of information to service leads for discussion and implementation within individual teams	
			PCS_3_10		T1	<b>PCS_057 - Ensure sufficient workforce to meet population needs in line with CNO principles</b> (Implement) Q1 Continue to scope workforce needs across the unit. Align to recruitment; Q2 Continually scope skill mix to ensure demand/capacity needs are met. Align to recruitment; Q3 Review of workforce, vacancies in line with service needs. Align to recruitment; Q4 Continued evaluation of all service areas to ensure prudent workforce. Align to recruitment	
			PCS_3_11	Ensure that Workforce targets are consistently met	T1	<b>PCS_061 - Sickness absence, PADR and Mandatory Training are within target</b>	
			PCS_3_12	Efficient Cluster led services	T1	<b>PCS_068 - Roll out the Whole System Approach to Cluster-led, integrated Health and Social Care System across all 8 Clusters</b> (Implement) Q1 Evaluation of Phase 1; implementation of phase 3; Q2 Evaluation of phase 2; continued implementation of phase 3; Q3 Evaluation of phase 3	
			PCS_3_13	Promote services through the medium of Welsh in accordance to Welsh Government guidelines	T1	<b>PCS_075 - Ensure further development and implementation of Unit plan to secure delivery of more communication and more services through the medium of Welsh in both directly managed and contracted services.</b> (Plan) Q1 to Q4 Look at areas and services within the unit where the Welsh language needs to be implemented, working alongside the Welsh Language Development Group	
			PCS_3_14	Consistent Digital working across Health and Local Authority partners	T2	<b>PCS_076 - Implement WCCIS into core service working to assist with improved communication, reduced duplication of work and to enable Health and Social Care colleagues to access one system</b> (Implement) Q1 Roll-out to Flying Start in Swansea and to existing PARIS users; Q2 Roll-out to Flying Start across Swansea Bay Health Board; Q3 Roll-out to Health Visiting and Swansea District Nurses; Q4 Roll-out to District Nursing across Swansea Bay University Health Board	
			PCS_3_15	Ensure all patients are treated with dignity and respect		<b>PCS_080 - Ensure further development of supervisory body function within PCS to assist HB overall management of Deprivation of Liberty Safeguards</b> (Implement) Q1 Continue maximisation of Best Interest Assessor rota and continue to review access to DoLS database. Ensure that update of Standard Operating Procedures on DoLS breaches report has been completed; Q2 to Q4 Review workforce in-line with demand	
			PCS_3_16	Ensure that End of Life patients are treated with dignity and respect	T1	<b>PCS_081 - Promote the use of the Advance Care Plan to all suitable patients. Thus ensuring consistency of ACP process across the Health Board</b> (Implement) Q1 Care Home staff should already be fully trained and confident to use the ACP, although training on-going for Care Home staff yet to receive training; Q2 Training on-going. Monitor progress and evaluate processes; Q3 to Q4 Through further implementation, we should see a significant increase of Advance Care Plans with measureable outcomes e.g. admission avoidance and better patient care	

PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
Rebalancing Care Closer to Home	I can get an urgent GP appointment when needed	Embed Value based healthcare that responds to patient reported experience and outcomes.(draft)	PCS_3_17	Early identification of speech, language & communication development and any other developmental delays	T2	<b>PCS_034 - Designated SLT in neonatal services, NICE standard and develop SLT workforce for neonatal and children's services</b> (Plan) Q1 to Q4 Identify funding for additional workforce to achieve targets	NHSDF_51 NHSDF_52 NHSDF_20 NHSDF_33
		Strengthen urgent care in the community	PCS_4_1	Continue remodelling of multi disciplinary primary care out of hour services and Continue to maximise use of 111	T1	<b>PCS_003 - Remodel Urgent Primary Care service (GP-led Out of Hours service), creating multi-disciplinary model</b> (Implement) Q1 Establishing MDT structure and aligning role descriptors to service delivery needs; Q2 Introduction of further workforce roles to directly support GP workload; Q3 Maximising skill mix and scope of practice for each workforce role to ensure prudent healthcare approach during winter pressures; Q4 Review of MDT structure to further develop on-going workforce model	
					T2	<b>PCS_004 - SLT integrated into A+E, ambulatory care and AMU wards and ESD services across HB to support turn around and management of respiratory patients at front door</b> (Plan) Q1 Secure funding via IBG; Q2 Appoint Staff; Q3 Scope out project using quality improvement methodology; Q4 Review project using data collection	
					T1	<b>PCS_007 - Further advancement of the role of Urgent Primary Care Paramedics to incorporate advanced practice skills.</b> (Plan) Q1 Liaison with WAST regarding APP rotational service; Q2 SLA agreement and identification of workforce - commencement of role within urgent primary care; Q3 Further collaboration with WAST to ensure efficient replacement of B6 skills with advance practice level; Q4 Continuation of workload/scope of practice and supervision needs to ensure further service delivery	
					T1	<b>PCS_085 - Development of nursing workforce within Urgent Primary Care to include a professional development nurse and targeted nurse rotations</b> (Plan) Q1 Collaboration with 111/WAST for identification of nursing roles with extended skills. Recruitment of PDN; Q2 SLA agreement regarding rotational placements within Urgent Primary Care; Q3 Identification of supervision, scope of practice and workload capabilities; Q4 Implementation of multiple nursing roles to match extended skills with service needs	
					T1	<b>PCS_086 - Implementation of the HCSW role within Urgent Primary Care</b> (Implement) Q1 Identification of the HCSW workforce and skills analysis; Q2 Upskilling in accordance with in-house supervision and alignment with Level 3 QCF Diploma; Q3 Further development of core skills inline with Urgent Primary Care development; Q4 Expand number of HCSW within Urgent Primary Care to meet service needs	
					T1	<b>PCS_087 - Further advancement and utilisation of the pharmacist role within Urgent Primary Care to include face to face consultations</b> (Implement) Q1 Agreement of scope of practice and skills assessment between 111 and Urgent Primary Care; Q2 Implementation of workforce; Q3 Continued implementation and on-going review of role effectiveness; Q4 Continued up-skilling in line with identified service needs and individual scope of practice	
			PCS_4_2	Co-production working with Secondary Care	T1	<b>PCS_010 - Critical care service development with SLT as integrated team members for swallowing, communication and weaning management for intubation, tracheostomy and critical care caseload</b> (Implement) Q1 Substantive full time Speech and Language Therapist should be in post to fully roll-out scheme across Swansea Bay; Q2 Continuation of roll-out of scheme across Swansea Bay; Q3 to Q4 Review and ensure that standards are maintained in line with Welsh Government standards around the delivery of the Critical Care Standards	
			PCS_4_3	Re-model Acute Clinical Team service to ensure consistency across the Health Board footprint	T1	<b>PCS_011 - Merger of NPT and Swansea Acute Clinical Teams in order to form one service across Swansea Bay University Health Board</b> (Plan) Q1 Scope both services in order to align and provide consistency across the Health Board footprint; Q2 Commence plans to implement a one-way and consistent way of working across two teams - e.g. job roles to be aligned; Q3 Start the process of OCP; Q4 Begin the implementation process of alignment	
	Timely access to diagnostics maximising use of direct access from primary care		PCS_4_4	Implement new pathways and Service Models for Primary Care		<b>PCS_004 - SLT integrated into A+E, ambulatory care and AMU wards and ESD services across HB to support turn around and management of respiratory patients at front door</b> (Plan) Q1 Secure funding via IBG; Q2 Appoint Staff; Q3 Scope out project using quality improve	
					T1	<b>PCS_009 - Development of Podiatry in-patient service in order to reduce hospital admissions and decrease length of stay</b> (Implement) Q1 Implement new model in Morriston; Q2 Implement new model in Singleton; Q3 Implement new model in Neath Port Talbot Hospital	



PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
Implementing the Primary Care	I am offered services through the medium of Welsh				T1	<b>PCS_023 - Develop plan to reduce FUNB for Persistent Pain</b> (Plan) Q1 to Q2 Identify capacity and demand and potential for re-design of follow-up service; Q3 Plan in place to meet demand; Q4 Begin implementation of new follow-up service model	NHSDF_18 NHSDF_05 NHSDF_06 NHSDF_07 NHSDF_08 NHSDF_09
					T1	<b>PCS_024 - Develop plan for reduction of DNA, New to follow up ratios. Roll out Podiatry SOS (PIFU - Patient Initiated Follow Up) model</b> (Evaluate) Q1 to Q3 Having implemented during 2019/20, being process of evaluation to identify any further improvements required; Q4 Implement any necessary changes	
					T1	<b>PCS_062 - Development of Podiatry walk-in service in Swansea locality</b> (Plan) Q1 to Q2 Identify capacity required and begin staff development plan; Q3 to Q4 Being process to start to implement staff development plan	
					T1	<b>PCS_063 - Identify role and model of Cluster based Chronic Pain services</b> (Plan) Q1 to Q3 Identification of model for stakeholder engagement; Q4 Make required changes following stakeholder engagement	
					T1	<b>PCS_065 - Development of service model in conjunction with model for Physiotherapy first point of contact practioners</b> (Implement) Q1 to Q4 Dependant on progress and agreement of FCP (First Contact Practitioners) model	
					T2	<b>PCS_031 - Use Referral Management Centre and/or e-referral approach supported by joint orthodontic/paeds clinic to improve orthodontic pathway and reduce waiting times for appropriate patients.</b> (Implement) Q1 New system via FDS to manage ortho waiting lists; Q2 Joint ortho/paeds assessment clinics established; Q3 to Q4 Monitor success of new model	
			PCS_4_5	Improve Dental Services for Children	T1	<b>PCS_033 - Complete transformation of re-modelled 'Design to Smile' programme focusing on younger children; inclusive of 'Lift the Lip' campaign Health Board wide</b>	
			PCS_4_6	Equitable access for Speech and Language Therapy	T1	<b>PCS_041 - Develop sustainable response to ALN reform and statutory obligation for children and young people age 0-25 with identified needs to have timely and equitable access to SLT services</b> (Plan) Q1 to Q4 Work with DECLO and ALN transformational lead to establish full effect of ALNET act	
					T2	<b>PCS_052 - Develop sustainable response to Gender Identity reform and statutory obligation for patients with identified needs to have timely and equitable access to SLT services</b> (Plan) Q1 to Q4 Scope out number of referrals following the Welsh Gender Identity pathway and commence data collection and impact of SLT provision	
		Develop and implement enhanced community provision in line with CSP pathway developments	PCS_4_7	Reduce risk of in-patient falls and pressure ulcers	T1 Choice	<b>PCS_005 - Deliver Hospital to Home Service for frail older people</b>	
		Prevention and Wellbeing in the community	PCS_5_1	MECC is embedded across all tumour sites and Brief intervention embedded across all tumour sites	T1	<b>PCS_013 - Provision of MECC and measurement of impact on behaviour change</b> (Evaluate) Q1 - Measuring impact of MECC intervention on actual behaviour change by reviewing metrics; Q2 to Q4 Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required	
			PCS_5_2	Encourage healthy lifestyle to prevent obesity	T1	<b>PCS_042 - Roll out of Exercise and Lifestyle programme if pilot results positive</b> (Implement) Q1 - Awaiting funding, but hopeful to implement programme; Q2 - Continue implementation of new programme; Q3 to Q4 Evaluate success of rolled-out model by data analysis	
			PCS_5_3	Prevent substance mis-use in order to reduce cases and deaths	T2	<b>PCS_043 - Development of substance misuse pathways to reduce high rates of substance misuse cases and deaths</b> (Plan) Q1 - Proposed service available for review by all stakeholders / parties; Q2 Exploring funding opportunities in order to deliver services within each sector; Q3 to Q4 Begin implementation of new service model	
			PCS_5_4	Actively promote to all patients at higher risk from influenza	T2	<b>PCS_030 - Improve uptake of childhood immunisations, particularly for those in areas of high deprivation through the Childhood Immunisation Group</b>	
			PCS_5_5	Actively promote to all staff and patients at higher risk from influenza	T2	<b>PCS_014 - Improve Flu Vaccination uptake rates for children, people with chronic conditions, people over 65 and staff through Flu immunisation campaign and Flu Action Plan through Flu steering group</b> (Implement) Q1 Evaluation of 19/20 programme and action plan; Q2 Finalise flu plan; Q3 & Q4 Implement flu action plan	

PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
		24/7 Service in Primary Care Services	PCS_5_6	Continue remodelling of multi disciplinary primary care out of hour services and Continue to maximise use of 111	T1	<b>PCS_003 - Remodel Urgent Primary Care service (GP-led Out of Hours service), creating multi-disciplinary model</b> (Implement) Q1 Establishing MDT structure and aligning role descriptors to service delivery needs; Q2 Introduction of further workforce roles to directly support GP workload; Q3 Maximising skill mix and scope of practice for each workforce role to ensure prudent healthcare approach during winter pressures; Q4 Review of MDT structure to further develop on-going workforce model	
					T2	<b>PCS_004 - SLT integrated into A+E, ambulatory care and AMU wards and ESD services across HB to support turn around and management of respiratory patients at front door</b> (Plan) Q1 Secure funding via IBG; Q2 Appoint Staff; Q3 Scope out project using quality improvement methodology; Q4 Review project using data collection	
					T1	<b>PCS_007 - Further advancement of the role of Urgent Primary Care Paramedics to incorporate advanced practice skills.</b> (Plan) Q1 Liaison with WAST regarding APP rotational service; Q2 SLA agreement and identification of workforce - commencement of role within urgent primary care; Q3 Further collaboration with WAST to ensure efficient replacement of B6 skills with advance practice level; Q4 Continuation of workload/scope of practice and supervision needs to ensure further service delivery	
					T1	<b>PCS_085 - Development of nursing workforce within Urgent Primary Care to include a professional development nurse and targeted nurse rotations</b> (Plan) Q1 Collaboration with 111/WAST for identification of nursing roles with extended skills. Recruitment of PDN; Q2 SLA agreement regarding rotational placements within Urgent Primary Care; Q3 Identification of supervision, scope of practice and workload capabilities; Q4 Implementation of multiple nursing roles to match extended skills with service needs	
					T1	<b>PCS_086 - Implementation of the HCSW role within Urgent Primary Care</b> (Implement) Q1 Identification of the HCSW workforce and skills analysis; Q2 Upskilling in accordance with in-house supervision and alignment with Level 3 QCF Diploma; Q3 Further development of core skills inline with Urgent Primary Care development; Q4 Expand number of HCSW within Urgent Primary Care to meet service needs	
					T1	<b>PCS_087 - Further advancement and utilisation of the pharmacist role within Urgent Primary Care to include face to face consultations</b> (Implement) Q1 Agreement of scope of practice and skills assessment between 111 and Urgent Primary Care; Q2 Implementation of workforce; Q3 Continued implementation and on-going review of role effectiveness; Q4 Continued up-skilling in line with identified service needs and individual scope of practice	
	Data & Digital Technology		PCS_5_7	Reduce risk of in-patient falls and pressure ulcers	T1 Choice	<b>PCS_005 - Deliver Hospital to Home Service for frail older people</b>	
			PCS_5_8	Digital consultations in the community	T1	<b>PCS_077 - Roll out of Skype/FaceTime digital consultations in Care Homes through the Acute Clinical Team</b> (Implement) Q1 Review and analyse advantages and impact that initial device has had on ACT service; Q2 to Q3 Depending on the outcome of analysis, extend roll-out	
			PCS_5_9	Consistent Digital working across Health and Local Authority partners	T2	<b>PCS_076 - Implement WCCIS into core service working to assist with improved communication, reduced duplication of work and to enable Health and Social Care colleagues to access one system</b> (Implement) Q1 Roll-out to Flying Start in Swansea and to existing PARIS users; Q2 Roll-out to Flying Start across Swansea Bay Health Board; Q3 Roll-out to Health Visiting and Swansea District Nurses; Q4 Roll-out to District Nursing across Swansea Bay University Health Board	
	Workforce & Organisational Development		PCS_5_10	Ensure that Workforce targets are consistently met	T1	<b>PCS_061 - Sickness absence, PADR and Mandatory Training are within target</b>	
			PCS_5_11	Develop Primary Care services in order to relieve pressure from GP caseload	T1	<b>PCS_073 - Audiology is developing new roles such as Advanced Primary Care Practitioners (Band 7 and above). To ensure efficient skill mix a new Associate practitioner (Band 4) role is being developed. The band 4 role is designed to manage non-complex cases and enable the Advance practitioner to maximise the number of ear and hearing cases that can be removed from GP caseload.</b> (Implement) Q1 2019/20 Associate Audiologists fully embedded in Cluster clinical work; Q2 Recruitment of HEIW funded Associate Practitioner trainees; Q3 to Q4 Continuation of training for trainees	

PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
			PCS_5_12	Continue with professional development	T2 Query	<b>PCS_088 - Develop a framework and opportunities for Advance Practitioner rotation across primary care and community settings, reducing staff turnover and supporting a sustainable future workforce</b> (Implement) Q1 Begin recruitment process for newly qualified and existing secondary care ANPs to commence primary care and community rotational programme; Q2 Further consolidation of skills within Primary Care and Community settings; Q3 Continuation of rotational placements within general practice to ensure competence and confidence in this specialist area; Q4 Initial evaluation of ANP internship programme to establish set skill mix for future primary care / community collaboration	
						<b>PCS_056 - Ensure sufficient training places to develop and maintain Advanced Nurse Practitioners</b> (Implement) Q1 On-going review of service areas to identify AP recruitment and retention issues - Align to recruitment; Q2 Continuous liaison with education lead, HEIs and Heads of Service regarding AP workforce planning - Align to recruitment; Q3 Continuous review of current AP staff to ensure rolling upskilling of this role - Align to training and development; Q4 Continuous review of mentorship and supervision requirements within units for the role of AP development. Align to recruitment and training	
						<b>PCS_093 - Develop the role of the HCSW and commission training programmes to meet service needs</b> (Implement) Q1 Submission of HEIW funding application for Primary Care HCSW development; Q2 Scoping exercise amongst Primary Care and Community Services / Independent contractors to establish level 3 and 4 Skill Mix; Q3 Liaison with HEI to establish relevant QCF and Diploma courses; Q4 Commencement of on-going level 3 and 4 courses	
						<b>PCS_089 - Review practice to ensure staff are working to the top of their licence and that skill mix within services supports this</b> (Plan) Q1 Scoping exercise to determine current skill mix associated with extended roles within Primary Care and Community; Q2 Analysis of service needs and alignment to skill mix associated with each Healthcare role; Q3 Framework compilation to outline required output for Healthcare roles and service delivery; Q4 Dissemination of information to service leads for discussion and implementation within individual teams	
					T1	<b>PCS_007 - Further advancement of the role of Urgent Primary Care Paramedics to incorporate advanced practice skills.</b> (Plan) Q1 Liaison with WAST regarding APP rotational service; Q2 SLA agreement and identification of workforce - commencement of role within urgent primary care; Q3 Further collaboration with WAST to ensure efficient replacement of B6 skills with advance practice level; Q4 Continuation of workload/scope of practice and supervision needs to ensure further service delivery	
			PCS_5_13		T1	<b>PCS_057 - Ensure sufficient workforce to meet population needs in line with CNO principles</b> (Implement) Q1 Continue to scope workforce needs across the unit. Align to recruitment; Q2 Continually scope skill mix to ensure demand/capacity needs are met. Align to recruitment; Q3 Review of workforce, vacancies in line with service needs. Align to recruitment; Q4 Continued evaluation of all service areas to ensure prudent workforce. Align to recruitment	
			PCS_5_14	Ensure all patients are treated with dignity and respect by ensuring the right workforce are		<b>PCS_080 - Ensure further development of supervisory body function within PCS to assist HB overall management of Deprivation of Liberty Safeguards</b> (Implement) Q1 Continue maximisation of Best Interest Assessor rota and continue to review access to DoLS database.	
			PCS_5_15	Ensure that Workforce targets are consistently met	T1	<b>PCS_061 - Sickness absence, PADR and Mandatory Training are within target</b>	
			PCS_5_16	Help me quit campaign, Smoking cessation services widely available and No smoking culture on sites	T1	<b>PCS_078 - Alignment of the Help Me Quit hospital team with the Help Me Quit community team in order to streamline the Smoking cessation service</b> (Implement) Q1 Following OCP, scope potential premises to co-locate staff; Q2 - Q3 Begin the process of aligning the two teams; Q4 Roll-out of fully integrated working with both teams working under a single brand.	
		Communications & Engagement in Primary Care Services	PCS_5_17	Promote services through the medium of Welsh in accordance to Welsh Government guidelines	T1	<b>PCS_075 - Ensure further development and implementation of Unit plan to secure delivery of more communication and more services through the medium of Welsh in both directly managed and contracted services.</b> (Plan) Q1 to Q4 Look at areas and services within the unit where the Welsh language needs to be implemented, working alongside the Welsh Language Development Group	

PRIMARY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
		Transformation & Vision for Clusters	PCS_5_18	Implement the Healthy Child Wales programme inc Phase 2 when required	T1	<b>PCS_035 - Foster partnership working across communities and clusters to successfully deliver against the Healthy Child Wales programme in line with the Parliamentary Review of Health and Social Care in Wales and ensure Health Visiting practice utilises the FRAIT tool in assessing the resilience and needs of the family</b> (Evaluate) Q1 to Q4 Review programme and ensure that standards are maintained in line with Welsh Government standards around the delivery of the Healthy Child Wales programme	
			PCS_5_19	Implement new pathways and service models through the new Cluster model	T2	<b>PCS_017 - Hearing loss Pathway has been implemented in Sept 2018. Expected to reduce ENT demand by 1000 cases/year. Additional benefits to ENT should accrue through increased management of complex cases by Audiology</b> (Evaluate) Q1 to Q4 Analysing data to ensure that there's a reduction on demand on ENT services in secondary care	
					T1	<b>PCS_067 - Integrated SLT services at GP services - SLT first point of contact for swallowing and communication difficulty triage</b> (Evaluate) Q1 to Q4 Evaluate success of talk-in clinics and a child's school readiness by the age of 5	
						<b>PCS_071 - Completion and consideration of Physiotherapy Business Case for mainstream funding for cluster based physio</b>	
					T1	<b>PCS_063 - Identify role and model of Cluster based Chronic Pain services</b> (Plan) Q1 to Q3 Identification of model for stakeholder engagement; Q4 Make required changes following stakeholder engagement	
					T2	<b>PCS_018 - Development of Podiatry led community vascular diagnostic service in line with Limb at Risk pathway</b> (Implement) Q1 to Q2 Implement new model; Q3 Begin evaluation process by analysing data to identify success of model outcomes; Q4 Continue evaluation process	
			PCS_5_20	Introducing new roles within the Cluster environment	T2 Query	<b>PCS_088 - Develop a framework and opportunities for Advance Practitioner rotation across primary care and community settings, reducing staff turnover and supporting a sustainable future workforce</b> (Implement) Q1 Begin recruitment process for newly qualified and existing secondary care ANPs to commence primary care and community rotational programme; Q2 Further consolidation of skills within Primary Care and Community settings; Q3 Continuation of rotational placements within general practice to ensure competence and confidence in this specialist area; Q4 Initial evaluation of ANP internship programme to establish set skill mix for future primary care / community collaboration	
			PCS_5_21	Efficient Cluster led services	T1	<b>PCS_068 - Roll out the Whole System Approach to Cluster-led, integrated Health and Social Care System across all 8 Clusters</b> (Implement) Q1 Evaluation of Phase 1; implementation of phase 3; Q2 Evaluation of phase 2; continued implementation of phase 3; Q3 Evaluation of phase 3	

UNSCHEDULED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
1. Helping people choose	I don't smoke I'm given every opportunity to eat well	Target Prevention Priorities	USC_1_1	Actively promote to all staff and patients at higher risk from influenza	T2	All to promote to colleagues, patients and relatives at every opportunity: Use a team brief session to promote influenza vaccination uptake - annual exercise (Q2)	NHSDF_05 NHSDF_06 NHSDF_07 NHSDF_08 NHSDF_09
					T1	Provision of MECC and measurement of impact on behaviour change: Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required (Q2-Q4)	
					T2	Improve Flu Vaccination uptake rates for children, people with chronic conditions, people over 65 and staff through Flu immunisation campaign and Flu Action Plan through Flu steering group: Evaluation of 19/20 programme and action plan (Q2), Implement flu action plan (Q3-Q4).	
					T1	Implement a range of actions to promote uptake of flu vaccinations with staff and patients: Implement as part of winter plan (Q3-Q4)	
			USC_1_2	Adopt a tobacco control approach to smokefree health board premises	T1	MHDU Scoping group to be established with support from Public Health team to identify a list of priority pathways to tackle unhealthy behaviours and promote prevention messages. Set up task and finish implementation groups aligned to agreed prioritised pathways programme. Focus on one cancer related pathway. As part of the implementation plan develop evaluation metrics for each pathway: Identify 5 priority areas and develop approach for reviewing secondary care pathways and developing improvement/ implementation plans (Q1)	
					T2	Plan to be scoped and developed in conjunction with the Public Health team: Scope plan in conjunction with Public Health (q2)	
			USC_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach, Adopting approaches that develop health literacy and Taking action aimed at obesity	T2	Therapies Expanding the MECC to all OP services, including additional staff awareness sessions	
					T1	Provision of MECC and measurement of impact on behaviour change: Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required (Q2-Q4)	
					T2	Development of Podiatry led community vascular diagnostic service in line with Limb at Risk pathway: Implement new model (Q2), Begin evaluation process by analysing data to identify success of model outcomes(Q3)	
					T1	Deliver Sexual Health services within Swansea Bay University Health Board that reflect the five priority areas from Public Health Wales: Review Swansea Bay Health Services against the priority areas and commence plan (Q1), Implement findings from plan(Q2)	
					T1	Roll out of Exercise and Lifestyle programme if pilot results positive: Continue implementation of new programme(Q2), Evaluate success of rolled-out model by data analysis (Q4)	
					T2	MHDU Scoping group to be established with support from Public Health team to identify a list of priority pathways to tackle unhealthy behaviours and promote prevention messages. Set up task and finish implementation groups aligned to agreed prioritised pathways programme. Focus on one cancer related pathway. As part of the implementation plan develop evaluation metrics for each pathway: Identify 5 priority areas and develop approach for reviewing secondary care pathways and developing improvement/ implementation plans (Q1)	
		Develop Community resilience	USC_1_6	Implement the Neighbourhood Model	T1	Governance arrangements agreed (Q2)	



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						2020/21	
• Tier 2 – Actions which are not a strategic priority or where no funding identified which are included in the Plan to proceed if can be supported through redesign of existing resources or a business case is developed and supported or where external funding becomes available.	I am able to support myself at home and in my community I actively manage my conditions and am supported to do so by my health and care professionals I get the advice and support I need to live at home quickly and efficiently I am able to speak to/access professionals who understand my complex needs when needed I am supported by people who understand my needs as an older person I am supported effectively and given the right information as a carer of someone with complex needs I have the tools and knowledge at my disposal to help me when something unexpected happens I only have to tell my story once	Ensuring My Home First - implementing pathways which enhance care delivery in or close to the patients home where clinically safe.	USC_1_7	Establish Wellness Centres			
			USC_2_1	Implement risk stratification approaches to cohorts of			
			USC_2_2	Implement new pathways for Respiratory Health through the New Cluster Model	T1	Plan and implement RHIG actions : (1) COPD Integrated Team - development/introduction of an expanded COPD Early discharge service across Swansea to focus on the front door, GP admission avoidance and WAST working to reduce/avoid transportation to ED : implement new service(Q1), evaluate new service (Q2-Q4)	
					T1	Embed ESD for COPD into baseline capacity of the delivery Unit. Ensure there are robust evaluation arrangements in place to assess impact of the service on respiratory los and bed day consumption : evaluate ESD element(Q1-Q4)	
					T1	Continue to evaluate the impact and build on the established Respiratory hot clinics - Ongoing: evaluate and monitor impact(Q1-Q4)	
					T1	RHIG action - Plan review/reconfiguration of the SBU Respiratory service during 2020/21 and implement 2021/22: Plan (Q1-Q4)	
						Citizen held portal via PKB Offer all patients a platform which they can receive their laboratory results, appointments, documents and letters directly from the national architecture and the ability to communicate and share their information with their clinical teams and carers accordingly, empowering them to manage their health and well-being in a more effective way: Business Case completed and approved(Q2), Procured solution(Q3)	
						Virtual clinics/ telehealth The provision of virtual clinics and access to key information will provide patients and clinicians with greater opportunity to work together on the management of care pathways. Tools to monitor their condition remotely and provide virtual support as required. Support the changes in clinical pathways need to improve the quality and efficiency of our outpatient services.: Business case process started - driven by planning of CSP(Q1), Business case approved(Q4)	
						Welsh Community Care Information System (WCCIS) WCCIS - the implementation of WCCIS will facilitate the knowledge transfer required to improve the flow of patients from secondary to community care. As the Health Board’s mobilisation project has proved it will also facilitate the freeing up of capacity in community services: Subject to Business case approval and deployment order sign off and integration - start go live in Swansea community nursing proposal - 1st tranche(Q2)	
			USC_2_3	Implement new pathways for Heart Failure through the New Cluster Model	T2	Heart Failure Integrated Team - development/introduction of an integrated Community model to focus on a shift from secondary to primary and community care: Implement integrated community respiratory service (Q1)	
						Citizen held portal via PKB- Offer all patients a platform which they can receive their laboratory results, appointments, documents and letters directly from the national architecture and the ability to communicate and share their information with their clinical teams and carers accordingly, empowering them to manage their health and well-being in a more effective way: Business Case completed and approved(Q2), Procured solution(Q3), Roll out to other specialties aligned to CSP (Q4)	
			USC_2_4	Implement new pathways for Diabetes through the New Cluster Model	T2	Diabetes Work programme (1) discharge Type 2 diabetic patients on injectable, which is going to have an impact on annual reviews for T1 and complex T2s, FUP OP appointments and hopefully emergency admissions: Implement (Q1-Q2), Evaluate (Q3-Q4)	

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
					T2	Work relaunched with Medicine Management to develop a programme of diabetic drug switches, which can generate skilled workforce and resource opportunities for succession planning and future developments: Plan (Q1), Implement (Q2-Q3)	
					T2	Diabetes Work programme (2) implement an integrated Community model to /support both Primary and Secondary care, and discharge slightly more complex T2 patients from secondary care: Implement (Q1-Q4)	
					T2	Diabetes Work programme - (3) plan review/reconfiguration of the SBU Diabetes service during 2020/21 and implement recommendations/findings during 2021/22: plan review/reconfiguration of the SBU diabetes service(Q1-Q4)	
			USC_2_5	Evaluate and agree recommendations regarding Care and Repair Scheme	T1	Develop robust framework for evaluation of the extended care and repair scheme to assess impact: Evaluate (Q1-Q4)	
			USC_2_6	Review of Acute Clinical Teams and opportunity for improved pathways from community and front door through Keep Me at Home Workstream of OP programme including right size capacity for rapid response.	T1	Review of Acute Care Teams and opportunities for improvements pathways from community and front door through keep me at home work streams - Complete scoping exercise to quantify the scale and impact on inpatient beds in Morriston Hospital, of alternative service commissioned for delivering appropriate IV treatment in the community. Assess impact versus cost of increasing capacity: evaluate winter period(Q1-Q2), implement sustainable service(Q3-Q4).	
			USC_2_7	Work closely with WAST to ensure appropriate triage preventing hospital admission	T1	Further advancement of the role of Urgent Primary Care Paramedics to incorporate advanced practice skills: Liaison with WAST regarding APP rotational service(Q1), SLA agreement and identification of workforce - commencement of role within urgent primary care(Q2)	
					T1	Merger of NPT and Swansea Acute Clinical Teams in order to form one service across Swansea Bay University Health Board: Scope both services in order to align and provide consistency across the Health Board footprint. (Q1), Commence plans to implement a one-way and consistent way of working across two teams - e.g. job roles to be aligned.(Q2), Start the process of OCP (Q3)	
					T2	Develop pilot for GP triage model of green calls on the stack to evaluate impact over winter and to inform implementation decision. Link to USC_3_2 (Funding required - source to be confirmed) Link to NPT IMTP plan: implement and evaluate impact(Q1-Q4)	
			USC_2_8	Ensure best practice in caring for patients with dementia across all settings by implementing the actions of the All Wales Dementia Plan	T2	Implementation programme for Dementia Strategy Action plan: Develop plan (Q1-4)	
					T1	MHDU to work with Corporate Dementia team to scope out priorities for a Delivery Unit focused dementia improvement plan: scope priorities for improvement plan(Q1-Q2), Start implementation phase(Q3-Q4)	
			USC_2_9	Scope opportunities through existing resources for maintaining My Home First approach for care homes including in reach and participate in NCCU NEWS project	T1	Merger of NPT and Swansea Acute Clinical Teams in order to form one service across Swansea Bay University Health Board: Scope both services in order to align and provide consistency across the Health Board footprint. (Q1), Commence plans to implement a one-way and consistent way of working across two teams - e.g. job roles to be aligned.(Q2), Start the process of OCP (Q3)	
		Reducing Unnecessary hospital attendance	USC_2_10	Evaluate and agree recommendations regarding Care and Repair Schemes	T1	Develop robust framework for evaluation of the extended care and repair scheme to assess impact: Evaluate (Q1-Q4)	

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
			USC_2_11	Develop a Single Point of Access for urgent care needs	T2	Develop a single point of access for urgent care needs - Develop proposal for a single point of access for urgent and emergency paediatric pathways in conjunction with Singleton Hospital Delivery Unit and confirm phased implementation timeline: Develop full business case for single point of access for unscheduled paediatric pathway(Q1-Q2)	
			USC_2_12	Improve diagnostic access within the community to prevent admission within existing resources	T1	Evaluate the introduction of hot clinics across a range of surgical and medical specialties to provide quicker access to diagnostics through hot clinic pathway -Evaluate impact to ensure that model is delivering maximum impact and benefit: evaluate and monitor impact(Q1-Q4)	
						WRRS – Welsh Results Reports Service The Welsh Results Reports Service provides users of the Welsh Clinical Portal with the ability to view diagnostic reports and test requests for their patients regardless of where in Wales they were produced: Go live of additional diagnostic information in WCP(Q1-Q4)	
						WCP - Electronic Test Requesting and Phlebotomy Module The implementation of ETR means that clinicians are able to request and review progress of test electronically. This is more efficient and also reduces the number of duplicate test requests being made: Morriston inpatients go live with Phlebotomy module(Q1), Singleton inpatients phlebotomy module implementation(Q2): Radiology test requesting - commence roll out 1st site(Q4)	
			USC_2_13	Implement fall response vehicle with WAST (funded through EASC A Healthier Wales monies )	T2	Level 2 Falls Response Service paper submitted between Physio, OT and WAST to implement this evidenced based approach: Plan (Q1-Q4)	
					T2	Evaluate impact of the fall response vehicle on admission avoidance into hospital: evaluate impact of the fall response vehicle on admission avoidance(Q1-Q4)	
			USC_2_14	Continue multi-agency approach to manage frequent attenders	T2	Dependant on funding approval, reduce frequent attender frequency by implementing a sustainable service model working with multi agency stakeholders to develop a whole system approach: Implement and evaluate impact(Q-Q4)	
3. Providing the right type of care	I can get an urgent GP appointment when needed	Strengthen urgent care in the community	USC_3_1	Continue remodelling of multi disciplinary primary care out of hour services and Continue to maximise use of 111	T1	Remodel Urgent Primary Care service (GP-led Out of Hours service), creating multi-disciplinary model: Establishing MDT structure and aligning role descriptors to service delivery needs(Q1), Introduction of further workforce roles to directly support GP workload(Q2), Review of MDT structure to further develop on-going workforce model(Q4).	
					T1	Further advancement of the role of Urgent Primary Care Paramedics to incorporate advanced practice skills: Liaison with WAST regarding APP rotational service(Q1), SLA agreement and identification of workforce - commencement of role within urgent primary care(Q2)	
					T1	NPT District Nursing OOH service to merge with Swansea model to operate out of Morriston Hospital/GP OOH: Commence OCP process in order to re-locate staff members(Q1), Re-locate service and teams to new site(Q3)	
					T1	Development of nursing workforce within Urgent Primary Care to include a professional development nurse and targeted nurse rotations : Collaboration with 111/WAST for identification of nursing roles with extended skills. Recruitment of PDN(Q1), SLA agreement regarding rotational placements within Urgent Primary Care(Q2), Implementation of multiple nursing roles to match extended skills with service needs(Q4).	
					T1	Implementation of the HCSW role within Urgent Primary Care: Identification of the HCSW workforce and skills analysis (Q1), Expand number of HCSW within Urgent Primary Care to meet service needs(Q4)	
					T1	Further advancement and utilisation of the pharmacist role within Urgent Primary Care to include face to face consultations: Agreement of scope of practice and skills assessment between 111 and Urgent Primary Care(Q1), Implementation of workforce(Q2)	
			USC_3_2	Implement Acute GP unit triaging from live ambulance stack (if funded)	T2	Develop pilot for GP triage model of green calls on the stack to evaluate impact over winter and to inform implementation decision. Link to USC_2_7 (Funding required - source to be confirmed): Implement and evaluate impact(Q1-Q4)	
	Improving ambulance handovers at hospital front door		USC_3_4	Test feasibility of decontamination unit holding to release ambulance subject to agreement on protocols	T2	MHDU to undertake a risk assessment of feasibility of using decontamination unit to release ambulance: undertaken risk assessment and confirm next step(Q1)	
			USC_3_5	Implement the Ambulance Liaison role if funded	T2	Consider introduction of HALO role as part of 19/20 winter and develop evaluation framework to assess impact. ? Implement 20/21 funding dependant: evaluate impact(Q1)	

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
	Improving patient care and managing demand at the hospital front door		USC_3_6	Implement recommendations of the process mapping ambulance handover exercise	T1	Build on the process mapping workshop session to develop improvement plan for ambulance handover - Programme of work being led by Deputy COO: develop improvement plan(Q1), implement and evaluate improvement actions(Q2-Q3)	
			USC_3_7	New pathways from Emergency Department to be explored for a Mental Health Distress Sanctuary	T1	Development and implementation of a Mental Health Sanctuary service across Swansea and NPT for people in mental distress: Commencement of sanctuary service. Contract for evaluation awarded (Q1), 6 month multiagency steering group review (Q3).	
			USC_3_8	Improve rapid access to assessment for CAMHS patient through commissioning approaches	T1	CAMHS - Integration of Primary & Secondary CAMHS including a single point of access. Implementation of an Emotional Health & Wellbeing Service hosted by CAMHS, along with a website for CYP and professionals: MHDU ED clinicians fully engaged in the Mental Health Distress Sanctuary group to support development of new pathways from ED	
			USC_3_9	In line with the CSP, standardise the front door Frailty Model, standards of care and ways of working on all sites	T2	SLT integrated into A+E, ambulatory care and AMU wards and ESD services across HB to support turn around and management of respiratory patients at front door: Secure funding via IBG (Q1), Appoint staff(Q2)	
					T1_C	MHDU Clinical teams actively involved in the older persons clinical redesign group. Explore funding options to extend the scope and working hours of the current OPAS service and to cover weekends the extend the admission avoidance impact of having front door geriatric assessment Link to action to expand the scope of OPAS to deliver increased admission avoidance impact.USC_3_10: Implement agreed business case for HB frailty at the front door service(Q1-Q4)	
					T2	Create an integrated Health Board Workforce plan for deployment of COTE consultant workforce in line with service priorities: Implement integrated HB COTE workforce plan(Q1-Q4)	
					T2	Embedding good practice in patient flow, SAFER EDD and Board Rounds - MHDU to progress with implementation of a range of improvement actions to fully embed good working practices	
			USC_3_10	Comprehensive Geriatric Assessment embedded across hospital pathways	T1_C	MHDU Clinical teams actively involved in the older persons clinical redesign group. Explore funding options to extend the scope and working hours of the current OPAS service and to cover weekends the extend the admission avoidance impact of having front door geriatric assessment Link to action to expand the scope of OPAS to deliver increased admission avoidance impact.USC_3_10: Implement agreed business case for HB frailty at the front door service(Q1-Q4)	
					T1_C	Explore funding options to extend the scope and working hours of the current OPAS service and to cover weekends the extend the admission avoidance impact of having front door geriatric assessment : Implement agreed business case for HB frailty at the front door service(Q1-Q4)	
			USC_3_11	Respond as appropriate to the NCCU ED Quality and Delivery	T1	Response as appropriate to NCCU ED quality and delivery framework - see USC_3_2 :Implement (Q1-Q4)	
			USC_3_12	Progress Kendal Bluck work on ED rotas	T2	MIU Consultant Nurse to contribute and lead on MIU implications: Develop a plan for MIU staffing to align to the Kendall Bluck analysis(Q1)	
					T1_C	Progress with phased implementation of ED medical and nursing workforce plan with supporting evaluation framework to assess impact at agreed points during the process: Implement and evaluate impact/progress(Q1-Q4)	

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						2020/21	
		Implement urgent ambulatory care models	USC_3_13	Implement actions to achieve CSP Scenario C efficiency assumption that admissions for NURHA and ACS conditions will be reduced by 35%	T1_C	Development and implementation of a revised service model for acute care medicine in Morriston Hospital - phase 1 ambulatory emergency care (start with 5 day service and phase up to 7 days): finalise business case(Q1), phased implementation of case(Q2-Q3)	
					T2	To develop a dedicated junior medical staffing team for AMAU: Evaluate impact of enhanced junior medical doctor arrangements(Q1-2)	
			USC_3_14	60% of admissions to assessment and short stay areas (30% for geriatric assessment) will be discharged before being transferred to the speciality bed base, with associated reductions in length of stay for patients currently staying 1,2,3 days beyond the maximum assessment stay and Continue to develop Hot clinics at both admitting sites including AMAU, Vascular & #NOF Pathways	T1	AHPs and Meds Management to contribute to the staffing requirements within assessment units. AHP teams need to expand , and to include nutrition and dietetics, to support timely, appropriate care and rehab and early discharge. Pharmacy to be involved in the redesign of the Singleton front door service (incorporating more ambulatory services) to consider pharmacy workforce implications and any new opportunities for pharmacy staff to ensure maximal impact in management of medicines. Expand Front door pharmacy service in Morriston to undertake medicines reconciliation, medication review and admission prescribing to resolve MM issues at earliest opportunity and identify 'high risk MM patients' with problems which may delay discharge. Increase ward based dispensing and role of ward technician to improve prescription turnaround time. Increase pharmacy input into discharge planning, early reablement of target groups (e.g. elderly care and stroke): Implement:Q1-Q4)	
					T2	SLT integrated into A+E, ambulatory care and AMU wards and ESD services across HB to support turn around and management of respiratory patients at front door: Secure funding via IBG (Q1), Appoint staff(Q2)	
					T1	Development of Podiatry in-patient service in order to reduce hospital admissions and decrease length of stay : Implement new model in Morriston(Q1), Implement new model in Singleton(Q2), Implement new model in Neath Port Talbot Hospital(Q3)	
					T1_C	Development and implementation of #NOF service investment and improvements following KPMG, Mortality review and Gold Command steering group”: finalise business case(Q1), phased implementation of case(Q2-Q3)	
					T2	Develop and implement a plan to create a hybrid theatre in Morriston Hospital to support delivery of clinically effective and efficient treatment to the patient population of south west wales: finalise business case(Q1), phased implementation of case(Q2-Q3)	
					T1_C	Finalise the capital plan and business case for SDMU/SSS Wrap to deliver an integrated unscheduled surgery service model: :finalise business case(Q1-Q2)	
			USC_3_16	Improve choice for patient and care at end of life at front door	T1	Scope options with relevant stakeholders to develop improved pathways for patients at end of life presenting at front door. Establish local working group which has links to the EOL steering group to provide a MHDU focus on EOL across all aspects of hospital care: plan EOL improvement plan(Q1-Q4)	
					T2	Scoping out how Specialist Palliative care will support/fit into acute services with a front Door (EOL): Arrange to meet with ED and SAU colleagues and to benchmark the need(Q1), scope out how SPC can deliver the identified need in USC at the front door(Q2), formulate a model of delivery after discussion with key leads including AOS team(Q3)	
					T2	As part of resizing our bed complement for Oncology and Haematology, we are reviewing our ambulatory model delivery.: Confirm workforce requirements to deliver agreed model(Q1), Finalise impact and submit Business Case(Q3)	
			USC_3_17	Improve Psychiatric Liaison Service to meet national standards	T2	Introduce evaluation framework to measure the impact of the extended service until 10pm and access to dedicated assessment facility which has enabled accreditation of the service: evaluate impact(Q1-Q4)	
4. Providing the best bed	I am treated holistically with an understanding of	Ensure good hospital care	USC_4_1	Reduce numbers of patients staying 1-2 nights to 0 nights, in line with CSP Scenario C efficiency assumptions			
			USC_4_2	Embedding good practice in patient flow, SAFER EDD and Board Rounds	T1	Senior Matrons to ensure SAFER is embedded: Audit SAFER compliance on medical wards at NPTH (Q1), Audit SAFER compliance on medical wards at NPTH (Q3)	
					T2	Development of Podiatry led community vascular diagnostic service in line with Limb at Risk pathway: Implement new model (Q2), Begin evaluation process by analysing data to identify success of model outcomes(Q3)	
					T1	Critical care service development with SLT as integrated team members for swallowing, communication and weaning management for intubation, tracheostomy and critical care caseload: Substantive full time Speech and Language Therapist should be in post to fully roll-out scheme across Swansea Bay(Q1): Review and ensure that standards are maintained in line with Welsh Government standards around the delivery of the Critical Care Standards(Q3-Q4)	



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						2020/21	
					T2	Embedding good practice in patient flow, SAFER EDD and Board Rounds - MHDU to progress with implementation of a range of improvement actions to fully embed good working practices	
					T1	Plan and implement the establishment of a team of patient pathway coordinators through the redesign and consolidation of existing resources(impact equivalent to 6/7 beds): Implement (Q1-Q4)	
			USC_4_3	Reduce LoS with sustainable improvement over the period of the IMTP in line with the CSP Scenario C efficiency assumptions	T1	Implement H2H, Good Hospital Care and Keep me at home projects	
					T1	Evaluate the impact of flexible beds model in Neurology - reduction in los for patients with a Neurological condition (2 beds equivalent): evaluate impact(Q1-Q4)	
			USC_4_4	Analysis of the required capacity for Ortho geriatrics and surgical liaison to reduce length of stay and improve surgical and longer term outcomes for older people	T1_C	Development and implementation of #NOF service investment and improvements following KPMG, Mortality review and Gold Command steering group”: finalise business case(Q1), phased implementation of case(Q2-Q3)	
					T2	Analysis of the required capacity for Ortho geriatrics and surgical liaison to reduce length of stay and improve surgical and longer term outcomes for older people - Good Hospital care programme will be picking up the scoping of this work in phase 2 from January 2020: Plan (Q1-Q4)	
			USC_4_5	Changing skill mix and ward configurations to manage patient cohort and improve patient flow, reviewing rehab and recovery models in hospital to include (No Suggestions), NPT and Singleton	T1	Ongoing review of recent ward reconfiguration and opportunities for further service improvements: Current ward reconfigurations concluded. Consider any opportunities to reconfigure as Hospital to Home embeds(Q1)	
					T1	Assess feasibility of optimal ward configuration in MHDU, taking into account patient mix and acuity, balanced with availability of staffing and skill mix (nurse staffing act link):evaluate options(Q1),develop plan on way forward(Q2)	
			USC_4_6	Explore digital mobilisation in hospitals to develop documentation that is transferable across all parts of the patient pathway	T2	Explore digital mobilisation in hospitals to develop documentation that is transferable across all parts of the patient pathway - links to action USC_4_2:plan approach(Q3-Q4)	
						Health records modernisation - Digital tagging of Health Records Roll out RFID tagging of health records and new tracking system. Will facilitate the better management of the paper acute record meaning higher availability and turnaround of the record to clinicians at the point of care. Supports new ways of working and reduces cost of record provision: Release of savings and project close(Q1)	
						Electronic outpatients documentation The initial outpatient appointment has always been critical to the patient and their journey through care as it allows for diagnosis, reassurance and definitive decisions on treatment, sometimes including treatment itself. To support the modernising outpatient agenda we want to challenge our approach to the provision of the medical record by providing as much, if not all of the record digitally. We will deliver an electronic continuation sheet, linking it to the clinic outcome form, support electronic internal referrals, MDT’s will be documented electronically and will be accessible to all clinicians involved in the patients’ care regardless of where they are based: Establish road map and resources to deliver paper light outpatient clinics(Q1): Commence paper light implementation in outpatients(Q3), Complete roll out electronic continuation sheet in 1st specialty(Q4)	
						Document management system Document management system (DMS) is a key platform for creating and storage of clinic letters and noting for ABM. This system provides essential information for clinicians in patient care. The searchable documents are accessible in the ABM Clinical Portal and feed the All Wales Welsh Clinical Care Record Service (WCCRS) for viewing in other settings, e.g. Health Boards and GPs via Welsh Clinical Portal (WCP). The DMS is developed in ABMU and is regularly updated for functionality. The increased importance of DMS in completing the digital patient record and the potential implications of Office 365 mean that a planned review and potential redevelopment of DMS will be undertaken through the course of this IMTP: Start Assessment of requirement(Q2): Start redevelopment of product/procurement(Q4)	
						HEPMA The project will see the elimination of the paper drug chart across inpatient wards at the sites when implemented; staff will be provided with a device such as a laptop or tablet to prescribe medications and to record their administration to patients and will use our Wi-Fi to allow doctors and nurses to continue their current processes at the patients’ bedside. The system will automatically alert staff to drug allergies when recorded on the electronic drug chart, and can notify users when medications are due. This will lead to efficiencies in prescribing and medicines management, including improvements in quality through reductions in transcription errors and missed doses: Implement Singleton(Q1): Subject to evaluation commence business case for roll out to Morriston. (Q4)	

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						2020/21	
						Digitisation of nursing documentation This will be a phased transition from paper to electronic with an initial focus on the adult inpatient assessment document, to include six nationally agreed risk assessments, followed by the ability to electronically capture e-observation. It is anticipated that the adoption of a set of standardised documents across all secondary care settings in Wales will deliver the following outputs: 1. • Timely response to deterioration in patients’ conditions 2. • Effective multi-disciplinary team working 3. • Standardised, coded and structured data to support storage, retrieval and analysis on patient outcomes 4. • Simultaneous access to e-nursing documents 5. • Supporting point of care and real time data enter on mobile devices at the patient’s bedside 6. • NIIAS monitoring to report on access to electronic nursing documents. 7. • Auto-population of the Health and Care Standards Monitoring data tool 8. • Visibility of vital signs scores across organisation boundaries. Implement(Q1-Q4)	
						Patient Flow The implementation of a electronic flow system in our hospitals will be essential to manage work flow, escalate patients, and identify and address blockers to discharge: Implement (Q1-Q4)	
						Patient Flow/Transfer of Care (TROCAR) The implementation of a electronic flow system in our hospitals will be essential to manage work flow, escalate patients, and identify and address blockers to discharge: Implement (Q1-Q4)	
						Digital dictation the implementation of a digital dictation system in Morriston has improved effectiveness and efficiency of clinical letters. The expansion of this across all sites and the exploration of the utilisation of voice to text will further enhance the quality and efficiency of the process: Business Case Approved(Q1), Rollout Site 1(Q3-Q4)	
			USC_4_7	Implement actions to delivery CSP scenario C Length of Stay efficiencies			
			USC_4_8	Reduce harm from inpatient falls	T2	Nursing and Meds Management interventions Ward reconfiguration AHP involvement at ward level, and on the strategy group. Older People Pharmacy group leading inpatient pharmacy falls assessment tool (medication review) development and education package. Pharmacy input into falls investigations by identifying possible drug contribution to the fall: Roll out of training on the new falls policy and new investigation tools(Q1), Draft DU SQuIPs(Q3)	
					T1	Maintain established process for reviewing and learning from cases of harm linked to inpatient falls. Develop and test targeted evidence based improvement actions to deliver harm reducing impact. Improvement actions informed by outcome of regular review of cases. Unit falls dashboard in place to support monitoring of performance: ongoing evaluation and learning (Q1-Q4)	
					T1	Maintain established process for reviewing and learning from cases of harm linked to inpatient falls. Develop and test targeted evidence based improvement actions to deliver harm reducing impact. Improvement actions informed by outcome of regular review of cases. Unit falls dashboard in place to support monitoring of performance ongoing evaluation and learning(Q1-Q4)	
			USC_4_9	Reduce Pressure Ulcers	T2	Continuation of PUPSG work: Support Dus to assurance rate their QI workstreams (Q1)	
					T1	Undertake a detailed review of moisture lesion cases to provide delivery unit assurance on the improvement position for hospital acquired pressure ulcers. That review will provide and test assurance framework and outcomes will then inform the next steps: ongoing evaluation and learning (Q1-4)	
			USC_4_10	Reduce incidence of HealthCare Acquired Infections	T2	Continue Nursing scrutiny and root cause analysis approach. Consultant antimicrobial pharmacist to review capacity and resources required to meet 25% reduction target for primary care prescribing by 2024 and ongoing 1% reduction target in acute care. Support primary care with roll out of Community Pharmacy enhanced services (relating to infections and antibiotic treatment protocols): Evaluate (Q1-4)	
					T1	Healthcare acquired infection -Maintain robust multi disciplinary scrutiny, review and lessons learnt process to inform improvement actions and change: Evaluate (Q1-4)	
			USC_4_11	Improve choice for patient and care at end of life	T2	Ensure training in EoL care for all front line staff. Medicines Management to review and promote Just in Case box scheme and use in paed.	
					T2	Scope options with relevant stakeholders to develop improved pathways for patients at end of life presenting at front door. Establish local working group which has links to the EOL steering group to provide a MHDU focus on EOL across all aspects of hospital care: plan EOL improvement plan (Q4)	
					T2	Continue robust DNA CPR discussions with patients and families: Audit in patient areas re level of patient and family conversations (Q1)	
					T2	Ensure EoL documentation is in use: Audit ward areas to understand compliance (Q1)	
					T2	Continue to revise our model for emergency patients, linking our AOS model into our central triage line for Cancer Patients across HD and Swansea Bay in a more robust manner, improving communication and appropriate access: Finalise agreed communication model between Triage to AOS and ED/SAU(Q1), Communicate and engage fully with ED/SAU teams(Q2)	

UNSCHEDULED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
					T2	Scoping out how Specialist Palliative care will support/fit into acute services with a front Door: scope out how SPC can deliver the identified need in USC at the front door(Q2) , To present the revised model for the front door to ED and SAU teams(Q4)	
		Timely Access to Emergency or Urgent Care & Rebalancing Bed Capacity across the system	USC_4_12	Develop a Swansea Bay Acute Care Model through the Clinical Services Plan	T1	Critical care service development with SLT as integrated team members for swallowing, communication and weaning management for intubation, tracheostomy and critical care caseload: Substantive full time Speech and Language Therapist should be in post to fully roll-out scheme across Swansea Bay(Q1): Review and ensure that standards are maintained in line with Welsh Government standards around the delivery of the Critical Care Standards(Q3-Q4)	
					T1_C	Development and implementation of ambulatory emergency care (AEC) pathways and workforce model for medicine to support unscheduled care/ED crowding: Implement (Q1-Q4)	
					T2	Continue to revise our model for emergency patients, linking our AOS model into our central triage line for Cancer Patients across HD and Swansea Bay in a more robust manner, improving communication and appropriate access: Finalise agreed communication model between Triage to AOS and ED/SAU(Q1), Communicate and engage fully with ED/SAU teams(Q2)	
		Improving timeliness of discharge	USC_4_13	Implement the Trusted Assessor model across Swansea Bay	T1	Implement the Trusted Assessor model across Swansea Bay - Phase 1 in place in December 2019 - 2 wards on each hospital site - ward by ward roll out to be completed by end of Feb 2020 - dependant on level of funding secured for the implementation.: implement and evaluate impact (Q1-Q4)	
					T1	Implement the Trusted Assessor model across Swansea Bay - Pathway 1 implement an ESD model for the whole of Swansea bay, recruiting 2 additional teams to manage circa 40 to 60 people. Impact of the proposal to be fully quantified and mapped through the HB system.: implement and evaluate impact (Q1-Q4)	
					T1	Implement the Trusted Assessor model across Swansea Bay - Pathway 2 will be a traditional CRT model discharge within 72 hours. Assess whether this pathway will also have bed implications.: implement and evaluate impact (Q1-Q4)	
			USC_4_14	Implement the John Bolton Hospital 2 Home Model including a reablement recovery service	T1	Deliver Hospital to Home Service for frail older people	
			USC_4_15	Explore opportunities for implementing Early supported discharge for specific conditions where opportunities from economies of scale exist	T1	Implement the Trusted Assessor model across Swansea Bay - pathway 3 transfer to assess for patients who need long term care packages (bed base across gorseinon NPT/Bonymaen to be used effectively to deliver this pathway). Evaluate the system impact of introduction of this pathway and ensure benefit is assessed across HB system: implement and evaluate impact(Q1-Q4)	
					T1	Implement the Trusted Assessor model across Swansea Bay - Pathway 1 implement an ESD model for the whole of Swansea bay, recruiting 2 additional teams to manage circa 40 to 60 people. Impact of the proposal to be fully quantified and mapped through the HB system: implement and evaluate impact(Q1-Q4)	
			USC_4_16	Standardising data capture on ready for home patients through roll out of the Singleton live system	T1	Implement and evaluate the Singleton whiteboard model in all ward areas of Morriston Hospital: Implement (Q1-Q4)	
5. Helping people to recover	I am supported to get out and about and feel part of the community	Ensuring ongoing care and support	USC_5_1	Ensure Hospital to Home reablement and recovery service is right sized	T1	Ensure Hospital to Home Reablement and recovery service is right sized - H2H - scoping January 2020 - detailed implementation and evaluation plan 2020 onwards - ensure that the impact of the scheme is fully understood and mapped through the HB system: implement and evaluate impact(Q1-Q2)	
			USC_5_2	Ensure use of reablement in residential step down beds is maximised	T1	Ensure use of Reablement in residential step down beds is maximised - H2H -Develop plan to utilise NPT Hospital beds in a better way to support system requirements. Quantify the impact that this proposal could have on the system and map this through to MHDU: implement and evaluate impact(Q1-Q2)	
			USC_5_3	Continue to work through partnership arrangements to rightsize capacity for domiciliary care and longer term residential care	T1	H2H - recommissioning programme commencing in October 2019. Programme of work is looking to change the demand for the private doom care market and ensure that baseline resources for non private provision are being used to target gaps on service: implement and evaluate impact(Q1-Q2)	
		Develop Community resilience	USC_5_4	Implement the Neighbourhood approach	T1	Governance arrangements agreed (Q2)	
			USC_5_5	Establish Wellness Centres			

STROKE CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
Preventing Stroke	I don't smoke I'm given every opportunity to eat well	Target Prevention Priorities	STK_1_1	Support and deliver Public Health campaigns including actively promoting to all staff and patients at higher risk from influenza, tobacco control approach to smokefree health board premises, Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach, Adopting approaches that develop health literacy, Taking action aimed at obesity	T1	Provision of MECC and measurement of impact on behaviour change: Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required (Q4)	NHSDF_05 NHSDF_09 NHSDF_07 NHSDF_08 NHSDF_09
			STK_1_2		T1	Implement a range of actions to promote uptake of flu vaccinations with staff and patients: Implement as part of winter plan (Q3-Q4)	
			STK_1_3		T2	Participate in the further roll out of PKB. CVD pharmacy group to lead identification of at-risk patients and subsequent interventions in primary care and promote medicines concordance & optimisation to prevent strokes. Investment in Pharmacy to support this is required: If PKB is further rolled out across the HB, NPTH to start planning for roll out (Q1)	
			STK_1_4		T2	Development of Podiatry led community vascular diagnostic service in line with Limb at Risk pathway: Implement new model (Q2), Begin evaluation process by analysing data to identify success of model outcomes (Q3)	
			STK_1_5		T2	MHDU Scoping group to be established with support from Public Health team to identify a list of priority pathways to tackle unhealthy behaviours and promote prevention messages. Set up task and finish implementation groups aligned to agreed prioritised pathways programme. As part of the implementation plan develop evaluation metrics for each pathway: Identify 5 priority areas and develop approach for reviewing secondary care pathways and developing improvement/implementation plans (Q1)	
		Develop Community resilience	STK_1_6	Implement the Neighbourhood Model	T1	Governance arrangements agreed (Q2)	
			STK_1_7	Establish Wellness Centres			
• Unscheduled Care	I recognise the symptoms of stroke and I know what to do	Proactive and accessible information	STK_2_4	Deliver Local promotion of health issues and awareness of Stroke e.g. through involvement of stroke prevention society, FAST campaign.	T1	BP testing in Atrium - BP awareness week; Link with Nursing colleagues to arrange for staff to provide testing and advise (Q1)	NHSDF_21 NHSDF_26 NHSDF_27 NHSDF_28 NHSDF_29
		Call handlers and responders	STK_2_5	Defined, clear and up to date pathways are in place	T1	Escalation / redirection from MIU : Escalation pathways in place(Q1)	
			STK_2_6	Shared education and training on stroke pathways for Paramedics, hospital staff, GPs and call handlers so that staff (call handlers)			
		At risk and vulnerable people	STK_2_7	Work with Community Organisations to explore a model of Urgent Community Support Plans collaboratively developed			
		Paramedics/HCP provide the	STK_2_8	Dispatched staff trained and			
			STK_2_9	Effective triage protocols and training in place	T2	Need to increase SLT staffing to meet RCP guidelines in stroke units and post discharge in order to meet SSNAP tier 1 targets: Identify funding for additional workforce to achieve targets (Q4)	
					T1	Development of stroke ESD SLT service bridge between secondary and primary care services would not only meet targets but would facilitate patient flow and reduced LOS: Identify funding for additional workforce to achieve targets(q1-4)	
		STK_2_10	Explore implementation of TWIST scheme - wake up strokes				
		Ambulance Capacity available	STK_2_11	See USC Plan	T2	Ambulance Capacity available to respond to strokes quickly - see unscheduled care plan: Plan (Q1-4)	

## STROKE CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
		HASU model in place in SBUH	STK_2_12	HASU model developed and implemented including direct admission protocols, straight to CT pathways, ring-fenced capacity for stroke including specialist beds, Developing of nurses on Ward F to cover Ed strokes, specialist stroke nurse 24/7	T1_C	Action will be delivered through the phased implementation plan being developed for HASU: Develop HASU business case for submission to WG (Q4)	
		Effective communication and	STK_2_13	Consistent and streamlined systems and processes in place in place	T1_C	Action will be delivered through the phased implementation plan being developed for HASU - phase 1 explore local options for creation of a 24/7 stroke rota Swansea/NPT stroke patients which includes increasing number of people who can participate in a stroke rota 3 to 7/8.: Develop HASU business case for submission to WG (Q4)	
					T1_C	Action will be delivered through the phased implementation plan being developed for HASU -First phase to create an acute stroke retrieval service at the front door and assessments. This would involve the appointment of an 4th stroke consultant : Plan (Q1), Implement (Q2-4)	
			STK_2_14	Pre alert system from WAST/GP in place	T1_C	Pre alert system from WAST/GP in place - Action will be delivered through the phased implementation plan being developed for HASU: Develop HASU business case for submission to WG (Q4)	
			STK_2_15	Explore implement live transfer of information from ambulance to HASU/ED including patient data	T1	MIU Consultant Nurse to be aware of the system: Implement (Q1-4)	
					T1_C	Explore implement live transfer of information from ambulance to HASU/ED including patient data - Action will be delivered through the phased implementation plan being developed for HASU: : Develop HASU business case for submission to WG (Q4)	
						WCP - WCRS- Patient care is recorded in a number of ways in the healthcare system. Many different documents are generated which together build up a patient's records. These records are collected in an electronic document repository called the Welsh Care Records Service (WCRS). The WCRS standardises these documents and allows them to be accessed and viewed by clinicians across health sector boundaries as well as being audited more easily: Go live of additional documents in WCP (Q1-4)	
		Information and support is consistently made available to family/carers on arrival	STK_2_16	Explore introducing Stroke			
			STK_2_17	Explore PALS team utilised to			
			STK_2_18	Within Resources explore potential for Stroke coordinators CNS in place with communication role at front door	T1	Within Resources explore potential for Stroke coordinators CNS in place with communication role at front door: evaluate option (Q1)	
First 72 Hours	I want to be kept informed and for my family /car	Provide information and support to individual and family throughout pathway	STK_3_1	Ensure Visual map of pathways available	T1	Therapies to input, develop rehab pathway/ models of care	NHSDF_21 NHSDF_26 NHSDF_27 NHSDF_28 NHSDF_29 NHSDF_50 NHSDF_48
					T1_C	Action will be delivered through the phased implementation plan being developed for HASU: Develop HASU business case for submission to WG (Q4)	
			STK_3_2	Implement proactive planning for discharge and transfer	T1_C	MHDU to contribute as appropriate to the regional rehabilitation programme which will include stroke rehabilitation and ESD requirements: Implement and undertake ongoing evaluation of the impact of stroke ESD (Q1-4)	
			STK_3_3	Ensure Co-production conversations taking place e.g. ACP/DNACPR	T1	Therapies input and goal planning and Ensure Co-production conversations taking place e.g. ACP/DNACPR Link to EOL actions: Plan (Q1-4)	
			STK_3_4	Within resources explore the facilitation of nutrition and hydration (swallow test) in ED	T2	Need to increase SLT staffing to meet RCP guidelines in stroke units and post discharge in order to meet SSNAP tier 1 targets: Identify funding for additional workforce to achieve targets (Q4)	
					T1	Development of stroke ESD SLT service bridge between secondary and primary care services would not only meet targets but would facilitate patient flow and reduced LOS: Identify funding for additional workforce to achieve targets(q1-4)	
		HASU model in place in SBUHB	STK_3_5	HASU model developed and implemented including direct admission protocols, straight to CT pathways, ring-fenced capacity for stroke including specialist beds, Developing of nurses on Ward F to cover Ed strokes, specialist stroke nurse 24/7	T1_C	Action will be delivered through the phased implementation plan being developed for HASU: Develop HASU business case for submission to WG (Q4)	



STROKE CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
		Skilled decision makers immediately available with capacity to deliver care and treatment	STK_3_6	Develop HASU Business Case including workforce requirements	T1_C	Action will be delivered through the phased implementation plan being developed for HASU. To also includeTherapies and Meds management input/HASU. Include investment in Pharmacy team in HASU BC improve prescribing, medicines management and patient outcomes and assist with medical workforce pressures and reduce OP waiting lists (: Develop HASU business case for submission to WG (Q4)	
		Seamless care pathways and services	STK_3_7	Ensure early access to diagnostics	T2	Ensure early access to diagnostics - development of a business case to increase MR/CT capacity on the Morriston Hospital site: Finalise plan for Cardiac CT/MR sustainability (Q1-Q4)	
						WRRS – Welsh Results Reports Service The Welsh Results Reports Service provides users of the Welsh Clinical Portal with the ability to view diagnostic reports and test requests for their patients regardless of where in Wales they were produced: Implement Go live of additional diagnostic information in WCP (Q1-Q4)	
						WCP - Electronic Test Requesting and Phlebotomy Module The implementation of ETR means that clinicians are able to request and review progress of test electronically. This is more efficient and also reduces the number of duplicate test requests being made: Morriston inpatients go live with Phlebotomy module (Q1), Complete Singleton outpatients ETR (Q3)	
						GP Test Requesting (Pathology): Evaluate pilot and commence implementation (Q1), Continue roll out (Q4)	
			STK_3_8	Breakdown silos of care including through collaborative partnership working with Social Services			
			STK_3_9	Agree a minimum service			
			STK_3_10	Explore the potential to pool resources to support stroke pathways	T2	Identify how CNS can input into NPTH Therapy input (Q2)	
					T1_C	MHDU to contribute as appropriate to the regional rehabilitation programme which will include stroke rehabilitation and ESD requirements: Implement and undertake ongoing evaluation of the impact of stroke ESD (Q4)	
		Ensure good hospital care	STK_3_11	Reduce harm from inpatient falls	T2	Nursing and Meds Management interventions Ward reconfiguration AHP involvement. Need to protect rehab space. Older People Pharmacy group leading inpatient pharmacy falls assessment tool (medication review) development and education package: Roll out of training on the new falls policy and new investigation tools (Q1), Draft DU SQuIPs (Q3)	
					T1	Maintain established process for reviewing and learning from cases of harm linked to inpatient falls. Develop and test targeted evidence based improvement actions to deliver harm reducing impact. Improvement actions informed by outcome of regular review of cases. Unit falls dashboard in place to support monitoring of performance: ongoing evaluation and learning (Q1-Q4)	
			STK_3_12	Reduce Pressure Ulcers	T2	Continuation of PUPSG work: Support Dus to assurance rate their QI workstreams (Q1)	
					T1	Undertake a detailed review of moisture lesion cases to provide delivery unit assurance on the improvement position for hospital acquired pressure ulcers. That review will provide and test assurance framework and outcomes will then inform the next steps: ongoing evaluation and learning (Q1-4)	
			STK_3_13	Reduce incidence of HealthCare Acquired Infections	T2	Continue Nursing scrutiny and root cause analysis approach. Consultant antimicrobial pharmacist to review capacity and resources required to meet 25% reduction target for primary care prescribing by 2024 and ongoing 1% reduction target in acute care. Support primary care with roll out of Community Pharmacy enhanced services (relating to infections and antibiotic treatment protocols): Evaluate (Q1-4)	
					T1	Healthcare acquired infection -Maintain robust multi disciplinary scrutiny, review and lessons learnt process to inform improvement actions and change: Evaluate (Q1-4)	
		Ensuring appropriate staff are available an accessible for patients and family members	STK_3_14	Explore stroke consultants available at weekend and holidays	T1	Consider possibility of Dr MEK - on call in SBUHB - ? Impact on SLA with CTM- Whole system pathway not site specific: Commence discussions as part of the CSP (Q1)	
					T1_C	Action will be delivered through the phased implementation plan being developed for HASU: : Develop HASU business case for submission to WG (Q4)	
					T2	Develop agreed pathway for out of hours Thrombectomy for stroke patients: : Develop HASU business case for submission to WG (Q4)	
		Appropriate space available	STK_3_15	Quiet room for end of life conversations/PEG feeding made available within resources	T2	Plan development of Quiet room for end of life conversations/PEG feeding made available within resources (Q1-4)	
			STK_3_16	Ensure stroke ward areas fit for purpose e.g. pre-empts	T1	Ensure Stroke Ward is ring-fenced from pre-emptive transfers to protect patient flow for stroke patients - Linked to all unscheduled care actions: evaluate performance (Q1-4)	

STROKE CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
		Identifying and supporting mental health issues	STK_3_17	Explore options within resources investment in therapies and third sector services	T2	Unit to be participate in the development, implementation and evaluation of an integrated approach to Early supported Discharge across a range of pathways including stroke being progressed through the H2H Programme: implement and evaluate impact (Q2)	
		Access to timely therapies in place	STK_3_18	Ensure a rehab ethos when in hospital co-produced with patients e.g. day room	T2	MHDU to contribute as appropriate to the regional rehabilitation programme which will include stroke rehabilitation and ESD requirements: Implement and undertake ongoing evaluation of the impact of stroke ESD (Q1-Q4)	
			STK_3_19	Explore options within resources for dedicated social workers and therapy teams for stroke across the pathway	T2	MHDU to contribute as appropriate to the regional rehabilitation programme which will include stroke rehabilitation and ESD requirements: Plan (Q1-Q4)	
		Appropriate discharge process with support	STK_3_20	ESD Service in place	T2	Units to be participate in the development, implementation and evaluation of an integrated approach to Early supported Discharge across a range of pathways including stroke being progressed through the H2H Programme: implement and evaluate impact (Q1-Q2)	
			STK_3_21	Understand morbidity and mortality outcomes from stroke to improve stroke outcomes	T1	Performance achievement against SSNAP: Support Morriston Dus - Local processes for the uploading SSNAP data (Q1)	
					T1	Need to have process for collecting stroke outcome information across the pathway - acute phase and post discharge phase. Use this information to inform service development requirements: Link to the esd stroke development (Q1-Q4)	
			STK_3_22	Improve choices and care for patients at end of life	T2	Ensure EOL training for all front line staff. Improve EoL care and pharmacy service to Ty Olwen through investment in MM technician to support pharmacist: Undertake training needs analysis and participate in training (Q1)	
			STK_3_23	Explore options for providing a dedicated person post stroke for information and support	T2	All to engage with option appraisal - Recommend this is the Stroke CNS who can also support and deliver on pathway wide education programme for staff: Plan (Q1-Q4)	
Rehab and Life After Stroke	I want to go home as early as appropriate with th	Co-production approach to recovery planning	STK_4_1	Use of digital technology in home or community settings e.g. virtual visits		Virtual clinics/ telehealth -The provision of virtual clinics and access to key information will provide patients and clinicians with greater opportunity to work together on the management of care pathways. Tools to monitor their condition remotely and provide virtual support as required. Support the changes in clinical pathways need to improve the quality and efficiency of our outpatient services: Business case process started - driven by planning of CSP (Q1), Business case approved (Q4).	NHSDF_21 NHSDF_26 NHSDF_27 NHSDF_28 NHSDF_29 NHSDF_50
						Welsh Community Care Information System (WCCIS) - WCCIS - the implementation of WCCIS will facilitate the knowledge transfer required to improve the flow of patients from secondary to community care. As the Health Board's mobilisation project has proved it will also facilitate the freeing up of capacity in community services: Subject to Business case approval and deployment order sign off and integration - start go live in Swansea community nursing proposal - 1st tranche (Q2), Continue Community Nursing proposal implementation - Health Visitors dependant on data migration (Q4).	
			STK_4_2	MDT in community services			
			STK_4_3	Key worker model			
			STK_4_4	Expert patient programme			
			STK_4_5	Specialist training across			
			STK_4_6	Stroke specific geriatric workers that can work across teams	T2	Pathway remodelling, Across site working, Pathway working - to allow efficient generic working supported by education and competency framework: Plan (Q1-Q4)	
			STK_4_7	Early goal planning			
			STK_4_8	Clear integrated goal planning with individuals and carers with clear clinical pathways		PROMs and PREMs <ul style="list-style-type: none"><li>Improving the effective calculation of treatments that inform service improvement</li><li>Better supporting the fulfilment of ICHOM partnership requirements</li><li>Improving PROMs reporting activity to support the requirements of the Planned Care Board: Implement (Q1-4)</li></ul>	
			STK_4_9	Community stroke services - ease			
			STK_4_10	Access to specialist support			
			STK_4_11	Local areas coordinators /			
			STK_4_12	Ensure access to equipment			
			STK_4_13	Access to care homes			
			STK_4_14	Pooling of existing teams and			
		Access to equitable therapies and community support on Discharge	STK_4_15	Protected therapy space/areas on wards from pre-empts and storage	T2	Understand demand and then capacity remodelling - stroke bed number availability to ensure protected therapy space : Plan (Q1-4)	

STROKE CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
			STK_4_16	Access to psychology support			
			STK_4_17	Self management /peer support groups	T2	CNS and AHPs explore support Stroke Association: Plan (Q4)	
			STK_4_18	Discharged to assess model			
		Ensuring and enabling good end of life services	STK_4_19	Advanced care planning in place	T2	To expand / roll out further via NP team in NPTH : Scope the possibilities to expand the NP team - workforce redesign (Q1)	
			STK_4_20	Training for staff on End of Life	T2	To ensure front line staff have EoL training: Scope training needs analysis and ensure staff attend training (Q1)	
5TIA	I want a diagnosis of a TIA and what it is as early as possible	Access to seven day TIA clinic/services	STK_5_1	Ensure adequate staff with appropriate skills in place	T1_C	Delivery of a 7 day TIA service will be linked to the development of a dedicated out of hours stroke rota - Timeline will be linked to the timeline and plan for the HASU development	NHSDF_21 NHSDF_26 NHSDF_27 NHSDF_28 NHSDF_29 NHSDF_50
			STK_5_2	Ensuring timely referrals from GPs - e-referrals	T2	To develop an electronic e referral system for TIA service. Timeline linked to pilot in Cardiology which will run for 12 month period: Plan introduction of referral system (Q4)	
						WCP - WPRS – Welsh Patient Referral Service - The Welsh Patient Referral Service (WPRS) is a safe and secure method of transmitting patient referral letters and referral information between Primary and Secondary Care Services and between Secondary Care and Tertiary Services: Evaluate Secondary to secondary Cardiology referrals implementation (Q1), Roll out - dependency on NWIS support - awaiting confirmation. (Q4)	
			STK_5_3	Updated primary care pathways enabling fast track to TIA Clinics	T1	Maintain timely access to TIA clinics: Monitor performance(Q1-Q4)	
			STK_5_4	ensure within resources that			
			STK_5_5	Explore within resources wrap around clinics to ensure access to			
			STK_5_6	GP education and Cluster TIA			
			STK_5_7	Undertake capacity and demand			
			STK_5_8	Benchmarking of seven day			
		Access to information and support and services to support health and wellbeing	STK_5_9	Ensure signposting to stroke association	T1	Monitor existing arrangements to ensure current service is maintained and meets service and patient requirements: Monitor performance(Q1-Q4)	
			STK_5_10	Ensure links with pharmacies,			
			STK_5_11	Ensure access to helplines and			
			STK_5_12	Explore within resources developing a one contact point			
6Research	I want the opportunity to take part in stroke research	Opportunities to join research including trials offered	STK_6_1	All patients offered opportunities to participate at appropriate times	T1	Monitor existing arrangements to ensure current service is maintained and meets service and patient requirements: Monitor performance(Q1-Q4)	NHSDF_65 NHSDF_66

PLANNED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
1Helping people choose and live healthily	I don't smokeI'm given every opportunity to eat well	Target Prevention Priorities	PLAN_1_1	Actively promote to all staff and patients at higher risk from influenza	T2	All to promote to colleagues, patients and relatives at every opportunity: Use a team brief session to promote influenza vaccination uptake - annual exercise (Q2)	NHSDF_05 NHSDF_06 NHSDF_07 NHSDF_08 NHSDF_09
					T1	Provision of MECC and measurement of impact on behaviour change: Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required (Q2-Q4)	
					T2	Improve Flu Vaccination uptake rates for children, people with chronic conditions, people over 65 and staff through Flu immunisation campaign and Flu Action Plan through Flu steering group: Evaluation of 19/20 programme and action plan (Q2), Implement flu action plan (Q3-Q4).	
					T1	Implement a range of actions to promote uptake of flu vaccinations with staff and patients: Implement as part of winter plan (Q3-Q4)	
			PLAN_1_2	Adopt a tobacco control approach to smoke free health board premises	T2	Plan to be scoped and developed in conjunction with the Public Health team: Scope plan in conjunction with Public Health (q2)	
			PLAN_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach, Adopting approaches that develop health literacy and Taking action aimed at obesity	T2	Therapies Expanding the MECC to all OP services, including additional staff awareness sessions	
					T1	Provision of MECC and measurement of impact on behaviour change: Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required (Q2-Q4)	
					T2	Development of Podiatry led community vascular diagnostic service in line with Limb at Risk pathway: Implement new model (Q2), Begin evaluation process by analysing data to identify success of model outcomes(Q3)	
					T1	Deliver Sexual Health services within Swansea Bay University Health Board that reflect the five priority areas from Public Health Wales: Review Swansea Bay Health Services against the priority areas and commence plan (Q1), Implement findings from plan(Q2)	
					T1	Roll out of Exercise and Lifestyle programme if pilot results positive: Continue implementation of new programme(Q2), Evaluate success of rolled-out model by data analysis (Q4)	
					T2	MH DU Scoping group to be established with support from Public Health team to identify a list of priority pathways to tackle unhealthy behaviours and promote prevention messages. Set up task and finish implementation groups aligned to agreed prioritised pathways programme. Focus on one cancer related pathway. As part of the implementation plan develop evaluation metrics for each pathway: Identify 5 priority areas and develop approach for reviewing secondary care pathways and developing improvement/ implementation plans (Q1)	
		Develop Community resilience	PLAN_1_6	Implement the Neighbourhood Model	T1	Governance arrangements agreed (Q2)	
			PLAN_1_7	Establish Wellness Centres			
• Tier 1 Choice – Priority action	I know where to go to discuss my conditionI am able to discuss my condition	Up to date, accessible and easy to use	PLAN_2_1	Implement solutions including digital based on pathways of care which provides:- <ul style="list-style-type: none"><li>•information on services available</li><li>•ability to book appointments</li><li>•information on my position on the pathway (tracking)</li><li>•who to contact for advice</li><li>•who is currently responsible for my care</li><li>•information on my condition and how to maintain wellbeing</li><li>•information on triggers for seeking additional care or treatment</li></ul>	T1	Merger of NPT and Swansea Acute Clinical Teams in order to form one service across Swansea Bay University Health Board: Scope both services in order to align and provide consistency across the Health Board footprint. (Q1), Start the process of OCP (Q3), Begin the implementation process of alignment (Q4)	NHSDF_18 NHSDF_52
					T2	Develop sustainable response to Gender Identity reform and statutory obligation for patients with identified needs to have timely and equitable access to SLT services: Scope out number of referrals following the Welsh Gender Identity	
					T2	Roll out of PKB in Urology across other pathways: implement and evaluate impact (Q1-Q4)	
					T1	Hearing loss Pathway has been implemented in Sept 2018. Expected to reduce ENT demand by 1000 cases/year. Additional benefits to ENT should accrue through increased management of complex cases by Audiology: evaluate impact(Q1-Q4)	
					T2	Look at current booking process around Lymphedema linked to DNA and UTA rate.: Map out current process for booking of routine new patients(Q1), Agree revised model for booking (Q3), Recruitment phase (Q4)	
					T2	Information regarding Services for SPC, as per TAITH review to clarify what we do, how we fit into other services: to agree format and content for guide(Q1), Test out with patients draft guide and make any necessary amendments(Q3), Agree communication strategy for circulating(Q4)	

PLANNED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21 Citizen held portal via PKB- Offer all patients a platform which they can receive their laboratory results, appointments, documents and letters directly from the national architecture and the ability to communicate and share their information with their clinical teams and carers accordingly, empowering them to manage their health and well-being in a more effective way: Business Case completed and approved(Q2), Procured solution(Q3), Roll out to other specialties aligned to CSP (Q4)	
						PROMs and PREMs • Improving the effective calculation of treatments that inform service improvement • Better supporting the fulfilment of ICHOM partnership requirements • Improving PROMs reporting activity to support the requirements of the Planned Care Board: Implement (Q1-Q4)	
						Patient Appointment Reminders	
						Hybrid mail We will look to improve the way in which we communicate with our patients through the introduction of Hybrid mail. This will improve the efficiency and effectiveness of our processes and facilitate the potential to communicate with our patients electronically.: Solution to be procured(Q2), Implement solution for WPAS(Q4),	
		Ensuring that local primary care provision is accessible and provides a wide range of clinical expertise to make an initial assessment of the patient's condition and provides diagnosis and treatment where appropriate	PLAN_2_2	Implement Multi Disciplinary Cluster triage model			
			PLAN_2_3	Use of Health Maps on Value and Efficiency Framework to work with Clusters to reduce unnecessary referrals			
			PLAN_2_4	Ensure all clusters are operating a multi disciplinary team model			
			PLAN_2_5	Ensure that clusters meet the national standards for opening times			
			PLAN_2_6	Ensure that good quality robust information is available to understand how demand is being distributed across the planned care system	T1	HB undertaking a demand and capacity plan for elective and emergency surgical pathways to inform theatre efficiency and surgical redesign work programme (CSP): Implement (Q1-Q4_	
					T1	Work with GP Clusters to agree referral pathways and address demand through developing alternative models of care: Implement (Q1-Q4)	
						Implement a suite of digital solutions including: -Server - QlikSense -SQL Server Software Assurance -Business Intelligence Plan - Safety Huddle - Phase 2: Implement requirements(Q4) -New to new Server Migration (SQL 2012 to SQL2017): Complete migration(Q1) -Patient Knows Best - extracting data and reporting from the SBPP: Assessment of requirements(Q1) -LIMS Data Acquisition: Complete acquisition(Q1), Develop suite of reports and launch(Q2) - Upskill staff within Swansea Bay to ensure the adoption and usage of data and tools available -Develop and launch mobile BI application solutions for Swansea Bay -Ensure links with Swansea University and Hywel Dda (through ARCH) continue to provide collaborative approach to data solutions: Agree work plan and governance structure(Q2) -Realign BI strategy in line with National Data Resource (NDR) capabilities to establish its functionality -Utilise SNOWMED CT capability with Swansea Bay for analytical purposes -Ensure data warehouse and data lake is fit for purpose -Re-evaluation of BI platforms (currently Qlik) to ascertain strategic direction: Evaluation complete(Q1)	
			PLAN_2_7	Ensure that clinicians are provided with the time to deliver the right balance of face to face and non face to face communication of outcome and that job plans and inter HB contract are amended accordingly	T2	UMD to ensure robust and effective job planning is undertaken - medical colleagues: Annual job planning reviews - adjusting plans to meet the needs within whole system plan(Q1)	
					T1	Ensure that clinicians are provided with the time to deliver the right balance of face to face and non face to face communication of outcome and that job plans and inter HB contract are amended accordingly - link to PLAN_4_23 and PLAN_3_1	
					T2	To work jointly with primary, community and pharmacy colleagues to complete business case for On the Ground Educator based on the All Wales Business Case: Need to understand more clearly the HB boundaries now that POW is no longer in Swansea Bay(Q1), Engage with our community and primary care teams about how we deliver (Q3)	
					T2	Clarifying the evaluation on our project B to enable roll out/continued progress with project within Lymphedema. Funding stream to be agreed (Q1)	



## PLANNED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
3Timely access to modern diagnostics	I am informed as to why a diagnostic test is being requested	Timely access to diagnostics maximising use of direct access from primary care	PLAN_3_1	Explore within resources the potential for clinical interface using digital solutions and access to timely specialist advice (telephone, telemed, email advice)	T1	Roll out of Skype/Facetime digital consultations in Care Homes through the Acute Clinical Team: Review and analyse advantages and impact that initial device has had on ACT service (Q1), Depending on the outcome of analysis, extend roll-out(Q4)	NHSDF_34 NHSDF_33 NHSDF_35 NHSDF_53
						WCP - Welsh information system for diabetes management: Implement (Q1-Q4)	
						Virtual clinics/ telehealth The provision of virtual clinics and access to key information will provide patients and clinicians with greater opportunity to work together on the management of care pathways. Tools to monitor their condition remotely and provide virtual support as required. Support the changes in clinical pathways need to improve the quality and efficiency of our outpatient services: Business case process started - driven by planning of CSP (Q1-Q3), Business case approved(Q4)	
			PLAN_3_2	Explore within resources increased direct access to diagnostics	T1	Scope programme of high priority/impact pathways which would benefit from direct access to diagnostics. e.g. Straight to test for colorectal pathways : Plan (Q1-Q4)	
						WRRS – Welsh Results Reports Service The Welsh Results Reports Service provides users of the Welsh Clinical Portal with the ability to view diagnostic reports and test requests for their patients regardless of where in Wales they were produced: Go live of additional diagnostic information in WCP(Q1-Q4)	
						WCP - Electronic Test Requesting and Phlebotomy Module The implementation of ETR means that clinicians are able to request and review progress of test electronically. This is more efficient and also reduces the number of duplicate test requests being made: Morriston inpatients go live with Phlebotomy module(Q1), Singleton inpatients phlebotomy module implementation(Q2), Radiology test requesting - commence roll out 1st site(Q4)	
						GP Test Requesting (Pathology): Evaluate pilot and commence implementation(Q1), Continue roll out(Q2-Q4)	
			PLAN_3_3	Undertake demand and capacity modelling of diagnostic services across clinical pathways to ensure services are sustainably "right-sized"	T1	Undertake demand and capacity modelling of diagnostic services across clinical pathways to ensure services are sustainably "right-sized" - Roll out approach adopted in cancer across a range of other clinical/patient pathways: Plan (Q1-Q4)	
					T1	Undertake demand and capacity modelling of diagnostic services across clinical pathways to ensure services are sustainably "right-sized" - Demand and capacity plan being developed for Cardiac Echocardiography service to inform service sustainability and workforce requirements: Plan (Q1-Q4)	
					T2	Undertake demand and capacity modelling of diagnostic services across clinical pathways to ensure services are sustainably "right-sized" - Service sustainability plan being developed for cardiac CT and MR (ARCH Regional Cardiology): Implement (Q1-Q4)	
T2	Undertake capacity and demand analysis for hysteroscopy. Agree with Cwm Taf Morgannwg HB whether our services need to meet demand based on CURRENT flows or changes needed. Increase capacity within outpatient hysteroscopy services to meet the demand in line with national guidelines for the management of common gynaecological conditions. Once above complete, scope plans for ambulatory gynaecology unit at Singleton to co-locate EPU/EGU, general gynaecology outpatients, minor ops and commence outpatient hysteroscopy: Agree flows/ LTA with CTM. Undertake GAP analysis for cancer and routine hyst. Identify location for co-located services at Singleton(Q1), Develop and present BC for Ambulatory Gynae at Singleton(Q2), Begin Implementation and ensure outcome measures agreed and baseline established(Q4)						
	Up to date, accessible and understandable information on clinical care pathways available	PLAN_3_4	Implement a digital solution based on pathways of care which provides:- •information on services available •ability to book appointments •information on my position on the pathway (tracking) •who to contact for advice •who is currently responsible for my care		See Action Plan_2_1		
4Timely access to sustainable treatment	I receive my treatment in a timely manner without delay	Timely and efficient referrals to treatment	PLAN_4_1	E-referral route to all healthcare practitioners in a fully integrated way	T2	Service Managers to ensure ongoing compliance : Monthly evaluation of correct referral route(Q1)	NHSDF_36 NHSDF_37 NHSDF_38 NHSDF_39 NHSDF_48 NHSDF_51 NHSDF_53
					T2	Scope a list of priority areas which would benefit from introduction of e referral - Neurology service looking to develop a electronic referral arrangement for the region: Plan (Q1-Q4)	
					T2	Scope a list of priority areas which would benefit from introduction of e referral: Plan (Q1-Q4)	
					T2	Work with Welsh Community Care Information System to ensure e-referrals for all Health Care Professionals is possible into Lymphedema Services in Swansea Bay: this project is linked to NLW project and roll out of WICCS (Q1)	

PLANNED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
						WCP - WPRS – Welsh Patient Referral Service The Welsh Patient Referral Service (WPRS) is a safe and secure method of transmitting patient referral letters and referral information between Primary and Secondary Care Services and between Secondary Care and Tertiary Services.: Evaluate Secondary to secondary Cardiology referrals implementation (Q1), Agree roll out plan for secondary to secondary referrals in other specialties - dependency on NWIS support - awaiting confirmation.(Q2), Roll out - dependency on NWIS support - awaiting confirmation.(Q4)	
						Dental referrals The improvements required in processes for referrals and managing patient pathways will be facilitated by the implementation of new system for Dental: Implement (Q1-Q4)	
		Efficient pre-treatment processes in place alongside prehab schemes to ensure patient preparedness for treatment and improve outcomes	PLAN_4_2	Explore and develop within resources a range of pre-admission services to assist with optimisation of the treatment	T2	MHDU to explore options for ensuring that all current preadmission activities provide maximum value by targeting patients who benefit from the process: Plan (Q1-Q4)	
			PLAN_4_3	Explore digital solution for optimising booking of patient into available capacity	T2	Explore digital solution for optimising booking of patient into available capacity: explore digital solutions for optimising booking of patients(Q3-Q4)	
		Ensure good and timely hospital care and treatment	PLAN_4_4	Improve surgical outcomes	T2	Specialist pharmacist to provide expert advice and prescribing to support medical workforce and technical support for critical care services (1wte 7, 1 wte 5). Development of BC for pharmacist, dietitian and nutrition nurse to provide specialist support to nutrition team after evaluation of current (unfunded) pilot (0.5wte 8a).	
					T2	Utilise national registry/benchmark information to inform clinical improvement priorities. #NOF/NELA/MINAP/ACS treatment standard - various funding issues. Implement and evaluate impact: Implement (Q1-Q4)	
					T2	Utilise national registry/benchmark information to inform clinical improvement priorities. Emergency Laparotomy pathway improvement: Implement improvement plan and monitor progress(Q1-Q4)	
					T2	Utilise national registry/benchmark information to inform clinical improvement priorities. ACS pathway in Cardiology: ongoing evaluation and corrective action as required QQ1-Q4)	
					T1_C	implementation of #NOF service investment and improvements following KPMG, Mortality review and Gold Command steering group”: finalise business case(Q1), phased implementation of case(Q2-Q4)	
					T1	Develop and implement a range of RTT sustainability plans for Urology/Plastic surgery hand service: implement and evaluate impact(Q1-Q4)	
					T2	Continue to focus on the internal process improvements along the vascular pathway. Evaluate impact through a regular dashboard: evaluate performance (Q1-Q4)	
					T2	Continue to monitor progress and impact of the Cardiology ACS pathway: ongoing evaluation of transfer times (Q1-Q4)	
					T1	Develop and implement a backlog reduction plan for long waiting cleft patients waiting for secondary surgery: deliver backlog reduction plan (Q1-Q4)	
					T1	Explore with Primary Care the option of relocating paediatric dentistry from Parkway to Morriston Hospital: Develop implementation plan (Q1-Q2), Implement plan(Q3-Q4)	
					T1	Develop and implement improvement action plan for vascular access peer review process - include addressing the backlog vascular access waiting list: regularly assess impact of increased theatre capacity on backlog position (Q1-Q4)	
					T1	Develop and implement an improvement action plan for the rrails (rapid response to acute illness) peer review report - some of the recommendations are linked to the acute deterioration service actions in the IMTP: Implement agreed improvement actions (Q1-Q2), evaluate improvement actions (Q3-Q4)	
					T1	develop and implement an improvement action in response to the peer review into critical care: Implement agreed improvement actions(Q1-Q2), evaluate improvement actions (Q3-Q4)	
					T1	establishment of 2 all day theatres to support delivery of treatment for long waiting general surgery cases: ongoing evaluation of impact(Q1-Q4)	
					T1	develop a sustainable plan for cleft service: Plan (Q1-Q4)	

**PLANNED CARE WHOLE SYSTEM PLAN**

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
			PLAN_4_5	Reduce harm from inpatient falls	T2	Nursing and Meds Management interventions Ward reconfiguration AHP involvement. Need to protect rehab space. Older People Pharmacy group leading inpatient pharmacy falls assessment tool (medication review) development and education package: Roll out of training on the new falls policy and new investigation tools (Q1), Draft DU SQuIPs (Q3)	
					T1	Maintain established process for reviewing and learning from cases of harm linked to inpatient falls. Develop and test targeted evidence based improvement actions to deliver harm reducing impact. Improvement actions informed by outcome of regular review of cases. Unit falls dashboard in place to support monitoring of performance: ongoing evaluation and learning (Q1-Q4)	
			PLAN_4_6	Reduce Pressure Ulcers	T2	Continuation of PUPSG work: Support Dus to assurance rate their QI workstreams (Q1)	
					T1	Undertake a detailed review of moisture lesion cases to provide delivery unit assurance on the improvement position for hospital acquired pressure ulcers. That review will provide and test assurance framework and outcomes will then inform the next steps: ongoing evaluation and learning (Q1-4)	
			PLAN_4_7	Reduce incidence of HealthCare Acquired Infections	T2	Continue Nursing scrutiny and root cause analysis approach. Consultant antimicrobial pharmacist to review capacity and resources required to meet 25% reduction target for primary care prescribing by 2024 and ongoing 1% reduction target in acute care. Support primary care with roll out of Community Pharmacy enhanced services (relating to infections and antibiotic treatment protocols): Evaluate (Q1-4)	
					T1	Healthcare acquired infection -Maintain robust multi disciplinary scrutiny, review and lessons learnt process to inform improvement actions and change: Evaluate (Q1-4)	
			PLAN_4_8	Undertake demand and capacity modelling across clinical pathways to include bed modelling, workforce, theatre efficiency to ensure services are sustainably "right-sized", Implementing BADS 50 and improve day case rates to achieve Clinical Services Plan Scenario C efficiency (95th percentile performance)	T1	Continue work on modelling theatre capacity to support surgical speciality demand profiling with suitable acuity patients for NPTH site. Continue to work with CTM/SBHB anaesthetics to agree plan for releasing SLA over next 2 - 3years: Complete modelling(Q1)	
					T1	Undertake demand and capacity modelling across WFI clinical pathways to include outpatient, diagnostic and theatre modelling, workforce, to ensure services are sustainably "right-sized". Quantify the capacity and demand gap and develop sustainable plan: Plan (Q1-Q4)	
					T2	Create a comprehensive plan for a sustainable service model for emergency and elective orthopaedic services in SBUHB including exploring the relocation of elective operating from Morriston Hospital to NPT or creation of a vanguard unit in Morriston Hospital: Plan (Q1-Q4)	
					T1	Evaluate the impact of the introduction of a referral triage for oral medicine patients to manage patients in primary care: evaluate impact of revised pathway (Q1-Q4)	
					T1	Undertake a comprehensive capacity and demand plan for elective and emergency surgery to underpin the overall surgical redesign plan: : Plan (Q1-Q4)	
					T1	Increase in dual site operating for Urology and move the service to a position of sustainability: Finalise plan(Q1), Implement plan(Q2)	
					T2	Increase local consultant MS capacity in SBUHB to ensure a timely response to new NICE treatments for MS due to be approved during the three year lifetime of this IMTP: develop case for new consultant(Q1), submit care for new consultant (Q2)	
					T2	Undertake demand and capacity modelling across clinical pathways to include bed modelling, workforce, theatre efficiency to ensure services are sustainably "right-sized "Plan to improve cardiac CT and MR diagnostic waiting times. Quantify the capacity and demand gap and develop sustainable plan: Implement (Q1-Q4)	
					T1	Evaluate the impact of the establishment of the plastic surgery treatment unit: ongoing evaluation of performance(Q1-Q4)	
					T1	Continue to explore options for the relocation of TAU from vanguard: Implement (Q1-Q4)	
					T1	Ensure theatre staffing skill mix and numbers are appropriate to support the delivery of existing theatre schedules and any proposed changes arising from the CSP and specialty RTT plans: Agree funding required to sustain current sessions due to shortfall within existing establishment(Q1), Implement additional lists and monitor impact (Q3)	
					T1	Continue the implementation of the additional day surgery trolleys/chairs adjacent to Ward 2 Surgical ward and ensure that the surgical footprint has the right mix of beds & trolleys to deliver the activity required under the CSP and specialty RTT plans. Ensure appropriate skill mix in place to deliver changes to elective case mix.: Agree plan for changes to existing sessions AND use of current 'fallow' sessions with Morriston colleagues and Execs.: Monitor KPIs; bed cancellations, theatre efficiency, RTT impact (Q1)	
						TOMs The further development of the Theatre management system will help facilitate the improved utilisation of our theatres, increasing capacity and flow through our planned care pathways: Plan (Q1-Q4)	

PLANNED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
						Fully utilise the capabilities of advanced statistical modelling toolkit such as “R” and Python - provide the organisation with the ability to assess the impact of changes in inputs and outputs on service delivery. Predictive analytics: Training of Information staff(Q2), Gather requirements for a pilot service(Q3)	
						Embed modelling capabilities within Swansea Bay based on exemplar evidence based models from other NHS organisations and private industry: Implement (Q1-Q4)	
			PLAN_4_10	Ensure compliance with INNU policy	T1	Deliver process for reviewing INNU areas and monitor delivery: ongoing monitoring of INNU performance(Q1-Q4)	
			PLAN_4_11	Revisit principles of ERAS	T1	Review ERAS principles across all high impact clinical pathways and develop Unit based improvement plan: develop ERAS improvement plan to link to prehabilitation(Q1-Q2)	
			PLAN_4_12	Implement actions to delivery CSP scenario C theatre efficiencies - aiming for 90% theatre efficiency on all sites , LoS for surgical specialties and admission on day of surgery for 95% of cases and Maximise the efficiency of surgical services and improve patient experience by implementing a new sustainable surgical model in line with the Clinical Services Plan	T1	Theatre Service Group Manager and USD to contribute to the theatre efficiency plan: Further increase support to Urology services(Q1), Support all delivery unit requirements to increase to 90% (Q2)	
					T2	Multi Disciplinary Team to contribute to the HB LoS reduction within surgical specialties: Further increase support to Urology services(Q1) Support all delivery unit requirements to increase to 90% (Q2)	
			Deliver NHS Wales Delivery Measures	Deliver the NHS Wales Delivery Measures for Planned Care including 36-week waits for all specialties by end March 2021	T1	Create a comprehensive plan for a sustainable service model for emergency and elective orthopaedic services in SBUHB including exploring the relocation of elective operating from Morriston Hospital to NPT or creation of a vanguard unit in Morriston Hospital: Plan (Q1-Q4)	
					T2	Develop and implement a range of RTT sustainability plans for Urology/Plastic surgery hand service: monitor impact(Q1-Q4)	
					T1	Increase in dual site operating for Urology and move the service to a position of sustainability: Finalise plan(Q1), Implement plan(Q2)	
					T1	establishment of 2 all day theatres to support delivery of treatment for long waiting general surgery cases: ongoing evaluation of impact(Q1-Q4)	
					T1	Develop and implement a backlog reduction plan for long waiting cleft patients waiting for secondary surgery: deliver backlog reduction plan(Q1-Q4)	
					T2	Appoint Endometriosis Nurse Practitioner to improve communication with patients, ensure compliance with NICE guidelines and act as Surgical Assistant to specialist gynaecologists, by minimising risk of cancellations due to poor theatre utilisation: Develop case and define impact. Review potential for internal funding.(Q1),Identify source of funding and recruit(Q2), Appoint and implement(Q3)	
		Deliver the National Planned Care Programme Priorities	PLAN_4_17	Implement actions to deliver the national planned care programme for Ophthalmology	T2	Introduce Paediatric Ophthalmology Telemedicine service for the ROP Screening of babies: Develop case and define impact. Review potential for internal funding.(Q1), Secure agreement and funding required(Q2), Implement service on regional basis(Q3)	
					T1	Secure recurring funding for the currently WAG funded AMD Community Referral Refinement Centre: Evaluate impact of current service and develop case for recurrent funding(Q1), Implement agreed case(Q2)	
					T1	Deliver sustainable regional paediatric ophthalmology services in collaboration with Hywel Dda: Implement agreed model(Q1), begin continuous evaluation(Q2)	
					T1	Develop sustainable cataract services through; use of Friday pm session, additional theatre sessions vacated by plastics, backfill of sessions by middle grades, increased one-stop 1st OPD/ Pre-assessment clinics. Recruit additional theatre staff, secure funding for job-planned anaesthetic cover, and secure recurrent funding for HCSW for PAC clinics: Implement sustainable sessions as described(Q1), Continue implementation and ongoing evaluation (Q2)	
					T1	Secure recurrent funding to maintain the virtual diabetic retinopathy clinics in order to deliver a sustainable service: Assess impact of 2019/20 developments and future C&D requirements(Q1), Secure funding and recruit additional staff(Q3)	
					T1	Develop sustainable glaucoma services through the continuation of the recruitment of non-medical practitioners and the community ODTC at Strawberry place. Evaluate the outcomes of these developments and where appropriate plan rollout to other areas: Develop and present BC for further capacity, both hospital and community based(Q2)	

PLANNED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
5. Timely access support to manage my condition	I am given the information I need to manage my condition				T1	Eye Care EPR and referrals The improvements required in processes for referrals and managing patient pathways will be facilitated by the implementation of new systems for Eye Care: Implement Referrals(Q2), Test EPR(Q4)	
			PLAN_4_18	Implement actions to deliver the national planned care programme for Orthopaedics	T2	Contribute to planned care programme for Orthopaedics. Review current Pharmacist input into orthopaedics (writing drug charts and other pre-surgical activity) to support medical workforce and ensure BC covers pharmacy services for increased activity. NMP (0.5 8a). Review current Therapies(including Nutrition and Dietetics) capacity within Orthopaedics, to include regional network plans: Plan (Q1-Q4)	
					T2	Focus on PROMS and virtual follow up pathways for Trauma and Orthopaedics : implement and evaluate impact(Q1-Q4)	
			PLAN_4_19	Implement actions to deliver the national planned care programme for ENT	T1	ENT - Priority focus on delivering of service sustainability and addressing capacity gap in follow up care: Implement (Q1-Q4)	
			PLAN_4_20	Implement actions to deliver the national planned care programme for Urology	T2	Contribute to planned care programme for Urology. Review current Pharmacist input into urology (writing drug charts and other pre-surgical activity) to support medical workforce and develop BC for substantive role if activity increases. NMP 8a (0.5). Support demand for further capacity at NPTH re ward, diagnostic and theatre: Plan (Q1-Q4)	
					T1	Urology - Priority focus on delivering service sustainability and introduction of PROMS: Implement (Q1-Q4)	
			PLAN_4_21	Implement actions to deliver the national planned care programme for Dermatology			
		Change the outpatient model of care	PLAN_4_22	Implement digital technology, telemed, telephone and self care approaches.	T2	Link to PLAN _4_23 and PLAN _3_1 Explore within resources the potential for clinical interface using digital solutions and access to timely specialist advice (telephone, telemed, email advice):. Implement (Q1-Q4)	
					T2	Review ability to support and expand our current Haematology "community team". To support reviewing the FUNB list and review patients from agreed patient groups egg. MGUS and overall workforce plan in Haematology: agree funding stream to recruit to workforce model(Q1), implement new model(Q3)	
					T2	Explore opportunities to implement digital solutions for suitable patient groups: Undertake assessment of services to identify potential alternatives to face to face appointments (Q1), Secure funding and develop implementation plan (Q3)	
			PLAN_4_23	Remove follow up appointments as a default	T1	Develop plan for reduction of DNA, New to follow up ratios. Roll out Podiatry SOS (PIFU - Patient Initiated Follow Up) model: Having implemented during 2019/20, being process of evaluation to identify any further improvements required (Q1-Q3), Implement any necessary changes(Q4)	
					T1	• Initiate the ADOPT (Action to Deliver Outpatient Transformation) approach to outpatient transformation which will enable: o Support delivery of SBUHB CSP ambition to transform outpatients and improve quality of patient care and safety o Health Board wide adoption of a clear set of principles for transforming outpatients o To provide appropriate clinical, quality improvement, technical and project management to clinical teams to facilitate change at pace o To embed adoption through evidence, peer support and shared learning: implement adopt actions(Q1-Q4)	
			PLAN_4_24	Implement patient generated recall arrangements	T2	Develop a prioritised programme for the roll out of SOS appointment model to appropriate specialties and pathways: Implement (Q1-Q4)	
			PLAN_4_26	Continue outpatient list validation	T2	Maintain outpatient validation arrangements to ensure accurate and up to date information to support high quality booking processes: Implement (Q1-Q4)	
					T1	Continue outpatient list validation. Explore opportunities for clinical validation sessions once clerical validation is complete.: Assess impact of 2019/20 developments and develop case for continuation(Q1), Secure funding and recruit additional staff(Q2)Implement(Q3)	
			PLAN_4_27	Roll out PROMS to priority specialities	T2	Priority focus through the national panned care programmes in ENT/Urology and Orthopaedics on introduction of PROMS: implement introduction of PROMS(Q1-Q4)	
		Service shifts away from traditional	PLAN_5_1	Examples could include •telemed •SOS	T1	Develop plan to reduce FUNB for Persistent Pain: Identify capacity and demand and potential for re-design of follow-up service(Q1-Q2), Plan in place to meet demand (Q3), Begin implementation of new follow-up service model(Q4)	

PLANNED CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
				•email and phone advice •rapid access clinics		2020/21	
					T2	Neurology ARCH action  Identify specific conditions for support through Primary Care Leads • Identify appropriate staff to support approach • Review job descriptions to facilitate allowing time in job plans to support the staffing of email/telephone helpline • Create telephone/email contact • Promote approach through Primary Care • Launch Identify appropriate staff to support approach and review job descriptions to facilitate allowing time in job plans to support email/telephone helpline(Q1), Create telephone/email contact, promote approach through primary care(Q2), launch and evaluate(Q3-Q4)	
					T1	Assist CKD - a programme where every blood test is checked for developing kidney failure and GPs are notified of the potential risk so that they can refer/address with patients as necessary.: evaluate impact(Q1-Q4)	
					T1	Diabetes: 1. GP will tell patient to ring DSN based on a recent blood test they may have organised. 2. GP will ring DSN directly to discuss a new treatment plan/ refer a new patient directly to prevent an admission/ request earlier review of an existing Secondary care patient with DSN if patient not in clinic for some months 3. District nurses frequently ring for advice re insulin treatment changes. In these instances DSN issue telephone advice and also email the instructions so the GP will then update the patients insulin prescription 4. Also frequently get contacted for general advice from nursing homes : evaluate new arrangements(Q1-Q4)	



CANCER CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES			
						2020/21				
1. Preventing Cancer	I don't smoke I understand so I make good decisions	Smoking Cessation Services are available	CAN_1_1	Help me quit campaign, Smoking cessation services widely available and No smoking culture on sites	T1	Alignment of the Help Me Quit hospital team with the Help Me Quit community team in order to streamline the Smoking cessation service: Following OCP, scope potential premises to co-locate staff (Q1), Roll-out of fully integrated working with both teams working under a single brand (Q4).	NHSDF_05 NHSDF_06 NHSDF_07 NHSDF_08			
					T1	Promote Help Me Quit Services and smoking cessation guidance to the wider NHS, schools, employers and groups with high smoking prevalence: Mapping exercise of existing clinics and services offered (Q1), Re-align resources based on results on the evaluation of the mapping exercise (Q4).				
					T2	MHDU Scoping group to be established with support from Public Health team to identify a list of priority pathways to tackle unhealthy behaviours and promote prevention messages. Set up task and finish implementation groups aligned to agreed prioritised pathways programme. Focus on one cancer related pathway. As part of the implementation plan develop evaluation metrics for each pathway: Identify 5 priority areas and develop approach for reviewing secondary care pathways and developing improvement/ implementation plans (Q1)				
			Every contact with the health system	CAN_1_4	MECC is embedded across all tumour sites and Brief intervention embedded across all tumour sites	T2		Organise workshop to promote MECC approach across staff groups: Plan workshop and approach (Q2), implement (Q4).		
						T1		Provision of MECC and measurement of impact on behaviour change: Measuring impact of MECC intervention on actual behaviour change by reviewing metrics (Q1)		
			Vaccinations	CAN_1_6	Vaccination programme for HPV	T2		Meds management to ensure adequate supplies of vaccines and appropriate storage and transport arrangements and ensure full delivery of programme (Q1-Q4)		
			Information and advice made available	CAN_1_7	PKB - Directed information and support and Digital Forums /groups/support/coaching	T2		Roll out of PKB in Urology across other pathways: implement and monitor impact of PKB roll out (Q1)		
		Target health inequalities	CAN_1_9	Needs assessments and targeted intervention	T2	Evaluate & expand Medicines management work in VTE clinics.				
			CAN_1_10	Focus on early years healthy						
		• The Cancer Centre	I know what to look for and self check I have access	Promote and target screening	CAN_2_1	Awareness Campaigns - National and ensure consistent Understand of screening processes/management		T1	Ensure Unit level clinical teams are engaged and playing a part in National awareness Campaigns and ensure they communicate these to patients as part of MECC: Agree MECC roll out programme(Q2), Implement MECC roll out programme (Q4).	NHSDF_30 NHSDF_31 NHSDF_32 NHSDF_10
GP /Optician access	CAN_2_4						Ensure GP training and Implement Primary Care Quality toolkit	T2	Continue supporting GP education within the RDC	
Virtual presentation?	CAN_2_6						Explore opportunities for Virtual self presentation		We will deliver an electronic continuation sheet, linking it to the clinic outcome form, support electronic internal referrals, MDT's will be documented electronically and will be accessible to all clinicians involved in the patients' care regardless of where they are based: Establish road map and resources to deliver paper light outpatient clinics (Q1), Complete roll out electronic continuation sheet in 1st specialty (Q4).	
					Document management system (DMS) is a key platform for creating and storage of clinic letters and notes for ABM. This system provides essential information for clinicians in patient care. The searchable documents are accessible in the ABM Clinical Portal and feed the All Wales Welsh Clinical Care Record Service (WCCRS) for viewing in other settings, e.g. Health Boards and GPs via Welsh Clinical Portal (WCP). The DMS is developed in ABMU and is regularly updated for functionality. The increased importance of DMS in completing the digital patient record and the potential implications of Office 365 mean that a planned review and potential redevelopment of DMS will be undertaken through the course of this IMTP: Business case process started - driven by planning of CSP (Q1), Business case approved (Q4)					
					Virtual clinics/ telehealth - The provision of virtual clinics and access to key information will provide patients and clinicians with greater opportunity to work together on the management of care pathways.Tools to monitor their condition remotely and provide virtual support as required. Support the changes in clinical pathways need to improve the quality and efficiency of our outpatient services: Business case process started - driven by planning of CSP (Q1), Business case approved (Q4)					
Information and support available	CAN_2_7			Primary Care Key Worker to be available within resources						
	CAN_2_8			Information and expectation of						
Rapid Diagnosis Centre	CAN_2_9			Expansion of RDC service where possible within resources	T2	Scope the resources required for the expansion of the RDC: Describe opportunities to utilise RDC to support additional cancer pathways (Q1)				

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
					T2	Work with RDC team to look at opportunities to implement a MUO pathway that aligns with our RDC model: Scope out current pathway for RDC and AOS/MUO MDT, identifying any opportunities to streamline and join the pathway so there is one point of access for MUO (Q1), Complete action plan for the revised model (Q2), implement new model (Q3)	
		Straight to test and FIT testing	CAN_2_10	One stop shop diagnosis processes for all tumour sites - prioritise lung and breast cancer pathways	T2	One stop shop diagnosis processes for all tumour sites - prioritise lung and breast cancer pathways : plan one stop shop diagnosis processes (Q1)	
					T2	Ensure compliance with optimum pathway for breast cancer: Evaluate current performance against the new pathway and undertake GAP analysis (Q1), secure funding and implement (Q3).	
			CAN_2_11	Undertake Demand and capacity modelling and implement improved communication between Primary & Secondary Care and Implement FIT Testing	T2	Evaluate current communication methods and consider improvements - share learning	
					T1	Focus on introduction of straight to test and FIT/Raman for lower GI USC demand management: implement and evaluate straight to test (Q1-Q4)	
					T1	Implement single cancer pathway funded scheme for straight to test for colorectal pathway: implement and evaluate straight to test (Q1-Q4)	
					T2	Targeted improvement plan to ensure clinical services have consistent and high quality electronic communication arrangements between secondary and primary care along all clinical pathways including cancer: implement targetted improvement plan (Q1-Q4)	
					T2	Look at options available to demand manage Haematology referrals in line with the expansion of the community team and education needed with primary care. Haematology Service to link with Primary Care to educate on appropriate referrals in to service. MDT approach to ensure referral to appropriate service: Review of current practice by lead nurse and community team (Q1), Action plan for communication and education with GPs (Q3)	
						GP Test Requesting (Pathology): Evaluate pilot and commence implementation (Q1), Continue roll out (Q2-Q4).	
			CAN_2_14	Implement optimal pathways	T2	Participate in the implementation of the optimal models pathways Implement prehabilitation across all pathways and tumour sites: Plan (Q4)	
					T1	Work with the Macmillan Quality Improvement Manager and the Cancer Information Manager on undertaking systematic review of the priorities optimal pathways against current service delivery. Identify gaps and develop and implement improvement action: undertake systematic review of the priorities optimal pathways against current service delivery. Identify gaps and develop and implement improvement action (Q1-Q4)	
					T2	Ensure PMB service has sufficient capacity to meet the demand within required timescales - link with Radiology to secure additional ultrasound capacity, assess impact on routine hysteroscopy, appoint second nurse hysteroscopist: Assess impact of 2019/20 developments and future C&D requirements. Develop revised model and associated business case (Q1), Secure funding and recruit additional staff (Q2), implement (Q3)	
			CAN_2_15	Undertake annual assessments of MDT functionality and support and challenge MDT Leads, developing & implement consistent and efficient HB protocols	T1	MDT leads and relevant service managers to participate fully in the MDT support and challenge process: implement any specific improvement actions (Q1-Q4)	
Delivering Fast Effective Treatment	I get the treatment and care which are best for me	Precision medicine and modern technology	CAN_3_1	NICE guidelines	T2	Meds Management require additional resources to ensure NICE technology appraisals, AWMSG decisions and NTF are implemented through the development of implementation plans, patient access to advanced therapy medicinal products & technologies and further horizon scanning work. Additional funding required by Singleton Pharmacy Technical Services to increase capacity to clinically validate prescriptions and manufacture IV preparations (2 wte band 3, 8a ). Ensure therapies are resourced as per NICE guidelines: Plan and Implement (Q1-4)	NHSDf_30 NHSDf_31 NHSDf_32
					T1	HB to develop horizon scanning approach to ensure that NICE guideline development areas are proactively built into HB IMTP . MHDU to progress Unit specific areas in line with HB plan: develop horixon scanning approach (Q2)	
					T1_C	Implement new drugs treatments identified by the pharmacy Dept following horizon scanning of NICE recommendations: Ensure full engagement and clear processes between Service and medicines management - around how we clarify any infrastructure requirements to implement new drugs and how this can respond quickly (Q1)	
			CAN_3_2	Access to Clinical trials	T2	Medicines Management to be fully resourced to ensure adequate clinical trials supply .clinical pharmacist support to increasing numbers/ complexity of trials (8a & 5). Plan and develop BC (Q3)	
			CAN_3_3	Cancer centre - up to date equipment	T1_C	Agree process for implementing Transformational Programme Business Case for SWWCC to including supporting delivery of optimal cancer pathway agreed Nationally: complete the individual BC programmes in line with the Programme Business Case and engage Hywel Dda and others when completing the BC (Q2)	

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
		Surgical model	CAN_3_4	Demand and Capacity modelling for treatment and maximise benefits of surgical redesign	T1	Focus on introduction of straight to test and FIT/Raman for lower GI USC demand management.: implement and evaluate straight to test (Q1-Q4)	
					T1	Implement sustainability plan for Pancreatic surgery	
					T2	Develop a plan for the creation of a sustainable service for sentinel Node Biopsy for Malignant Melanoma: implement service sustainability plan (Q1-2)	
					T2	Implement sustainability plan for Pancreatic surgery - Explore option of developing a EUS service to support pancreatic surgery pathway based in Morriston Hosptial in response to service sustainability issues in Singleton Hospital: Explore option of developing EUS service (Q1-Q2)	
					T1	Implement sustainability plan for Sarcoma surgery : Implement (Q1-Q4)	
					T2	Create dedicated theatre capacity for pelvic oncology cancer pathway: Plan (Q1-Q4)	
					T2	Develop a business case to create a second EBUS list: Develop plan (Q1), Implement plan (Q2)	
					T1	Evaluate the impact of the establishment of mpMRI capacity for prostate cancer pathway: evaluate the impact of mp MRI capacity (Q1-Q4)	
					T2	Create increased theatre capacity in Cardiff and vale health board for robotic surgery for urology: explore option of increasing access to robotic surgery in cardiff (Q1-Q2)	
		CAN_3_5		Ensure Gynae oncology model is fit for purpose post-Bridgend transfer	T2	Physio providing input into Gynae oncology model. Pharmacist currently provides one Gynae oncology clinic session/week. Further funding needs to be identified to backfill Pharmacist to support additional pharmacist clinic requested. Consultant pharmacist post to lead team & develop further BC to assist medical workforce:: Develop BC (Q4)	
					T2	Scope opportunity to develop robotic surgery in SBUHB: scoping exercise with mulit surgical specialties (Q1-Q2)	
					T2	In conjunction with Hywel Dda, agree model for regional gynae-oncology services, to include additional Consultant, additional theatre capacity (with associated on costs; anaesthetic cover, theatre staff etc.): Agree model with clinical and managerial teams of both Health Boards (Q1): Develop Business case and present (Q2)	
					T2	Develop nurse and AHP led follow up clinic patients for gynaecology patients: Plan (Q1-4)	
		CAN_3_6		Maximise regional opportunities	T1	Scope the opportunity to create a south west wales regional thyroid surgical service: plan regional service sustainability plan (Q2)	
					T1_C	Work with Hywel Dda colleagues to support implementation of the business cases/projects as part of the Transformation PBC for SWWCC: : complete the individual BC programmes in line with the Programme Business Case and engage Hywel Dda and others when completing the BC (Q2)	
		CAN_3_7		Improve service resilience (workforce)	T1	Implement sustainability plan for Sarcoma including appointment of consultant/CNS post. (Funded via WHSSC income): Implement service sustainability plan for sarcoma (Q1-Q4)	
					T1	Plan proposal for the development of a SWW Thyroid surgery service including the appointment of a consultant. Exploring the option of pump priming a Thyroid surgery CNS post from Macmillan: plan regional service sustainability plan (Q2)	
					T2	Plan and implement a sustainable South Wales OG Cancer service (including supporting workforce plan): plan and implement service sustainability plan for OG cancer (Q1-Q4)	
					T1	implement sustainable pancreatic surgery service including appointment of consultant surgeon, CNS and Anaesthetic consultant resource. In addition pilot nutrition MDT to provide review of TPN. (Funded via income): Implement service sustainability plan for pancreatic surgery (Q4)	
					T1	Appointment of CNS for pelvic oncology (Macmillan funding): evaluate impact (Q4)	
					T1	Appointment of CNS post to support straight to test pathway (SCP funding): evaluate impact (Q4)	
					T1_C	As part of the PBC case a separate/linked piece of work needs to be undertake around workforce review - skill mixing etc.: Agree how the workforce element of the programmes BC will be progressed and clarified via each BC ensuring synergy between the staffing resources required to support and deliver the changes (Q1), Once process agreed ensure multidisciplinary and skill mix approach is taken with the BC for each programme (Q2).	
					T2	Skill mixing in Med Physics team, to allow practitioners to undertake delegated plan approval to support radiotherapy pathway: find funding stream (Q1)	
					T2	Radiotherapy Staff modernisation, role redesign to move work traditionally undertaken by Clinical Oncologists to Radiotherapy Physics: Recruitment (Q1), Go Live (Q2)	
	Prehabilitation	CAN_3_8		Develop and implement model for prehabilitation	T2	Develop and implement prehabilitation model inclusive of all tumour sites - link to SDDU plan: Plan (Q1-Q4)	
					T2	Develop and implement prehabilitation model inclusive of all tumour sites: Agree way forward with regards to prehabilitation for HB (Q4)	

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
		Peer review	CAN_3_9	Ensure JACIE accreditation is maintained for BMT	T1_C	Implement JACIE recommendations for delivery of BMT service. MRI for some BMT patients is now standard of care for patients who require further BMT but this is unfunded in the Radiology service:L identify number of patients receiving CT as part of treatment/assessment processes (Q1), If funding available transfer to radiology budget (Q3), assess the impact and service change (Q4)	
			CAN_3_10	Participate in Peer Reviews and Implement action plans	T1	Units participates fully in development and delivery of cancer peer review action plans for the annual programme of cancer peer reviews. Implement and evaluate (Q1-Q4)	
		Optimal pathways (Single Cancer Pathway)	CAN_3_12	Implement optimal pathways through QI approaches for all tumour sites in line with the National programme: - Lung - Breast - Gastroenterology - Head and Neck	T1	Work with the Macmillan Quality Improvement Manager and the Cancer Information Manager on undertaking systematic review of the priorities optimal pathways against current service delivery. Identify gaps and develop and implement improvement action: undertake systematic review of the priorities optimal pathways against current service delivery. Identify gaps and develop and implement improvement action (Q1-Q4)	
		Implement the Non Surgical Cancer Centre Strategy	CAN_3_13	Develop and improve the infrastructure of the SWW Cancer Centre	T1_C	Agree process for implementing Transformational Programme Business Case for SWWCC to including supporting delivery of optimal cancer pathway agreed Nationally: complete the individual BC programmes in line with the Programme Business Case and engage Hywel Dda and others when completing the BC (Q2)	
			CAN_3_14	Ensure demand/capacity is in balance for chemotherapy and radiotherapy	T1_C	As part of the Transformational PBC - implement the plan to improve capacity within Radiotherapy to provide extended day working: Re-review the current business case for extended day working and look at phasing options (Q1), Complete revised BC and SSDU (Q2)	
					T1_C	As part of the Transformational PBC - implement the plan to improve capacity within CDU by increasing SACT chair capacity within current CDU foot print: Take forward the BC for increasing Chair capacity linked to the PBC (Q1), Agree funding stream for the additional capacity (Q2)	
					T2	Work with Service Improvement Lead (CJ) to ensure the processes in place in the HDU deliver maximum benefit to service delivery needs: Agree and support CJ in undertaking a baseline assessment in HDU (Q1), Agree change in model/process and date of change (Q4)	
						Deliver digital support projects for cancer services including: Server - QlikSense: Implement (Q1) SQL Server Software Assurance Business Intelligence Plan New to new Server Migration (SQL 2012 to SQL2017): Complete migration (Q1) Patient Knows Best - extracting data and reporting from the SBPP: Assessment of requirements (Q1) LIMS Data Acquisition: Complete acquisition (Q1) Upskill staff within Swansea Bay to ensure the adoption and usage of data and tools available: Define requirements and training/communication plan (Q3) Develop and launch mobile BI application solutions for Swansea Bay: Acquire access to BI application from NWIS (Q1) Ensure links with Swansea University and Hywel Dda (through ARCH) continue to provide collaborative approach to data solutions Realign BI strategy in line with National Data Resource (NDR) capabilities to establish its functionality: National solution phase 1 available (Q3) Utilise SNOWMED CT capability with Swansea Bay for analytical purposes Ensure data warehouse and data lake is fit for purpose: Leveraging NOSQL and other non-traditional data storage and acquisition methods to create a data lake for big data analytics (Q2) Re-evaluation of BI platforms (currently Qlik) to ascertain strategic direction: Evaluation complete (Q1)	
			CAN_3_15	Implement a mobile PET-CT scanner and Develop a business case for WHSSC for a fixed PET-CT service for the SWW region		PET facility in order to provide clinical PET-CT imaging at the Singleton Hospital site for oncology patients requiring diagnosis, staging and treatment response. A fixed site facility is required and a mobile scanner to be supplied as an interim solution Access to PET scans will result in patients previously inaccurately staged having two main impacts:- • Improved diagnosis will result in some patients who are presently assigned a low stage being moved to a higher stage • In cancers where PET-CT is available, fewer patients will undergo inappropriate surgery which will decrease surgery costs to the Welsh NHS: Mobile scanner operational at Singleton Hospital site as an interim solution (Q1-Q4) Business case development for fixed site (Q1), Obtain approval from WG for fixed site (Q3), Initial planning and design for fixed site (Q4)	

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
			CAN_3_17	Continue replacement of LINACS	T1_C	Continue to plan and implement the LINAC replacement programmes and plan for further bunker and operational LINAC as linked to Transformational PBC: Ensure full engagement and focus on LINAC Replacement programme working alongside planning and CSS colleagues (Q1), Complete BC for new operational bunker as part of SWWCC Transformational PBC (Q2)	
					T1_C	Replacement of aging Radiotherapy Equipment (LinB, LinC, LinD and CT), possibly expand to a 5 linac cancer centre in Singleton, Radiotherapy Physics Staff modernisation to maintain legal compliance, ensure quality and safety, and improve cancer wait times:Install Replacement CT (Q1), Install Lin C Replacement (Q2), CT Go Live (Q3), CT Go Live (Q4)	
			CAN_3_18	Plan to move to Morriston in line with the CSP	T1	Start to scope out the long term requirements and timelines via the CPS programme.	
		Provide chemo /haematology at home/outreach/alternative settings in line with the Strategy and the CSP (My Home First)	CAN_3_19	Maximise capacity for ambulatory chemo	T2	Work is on-going to maximise patients receiving Chemo at home and also SACT. This service is already used:Continue to work closely with PTS, Pharmacy team in Oncology and Haematology with ChemoCare Team and HomeCare team to optimise safe opportunities to deliver SACT treatments as closer to home as possible(Q1)	
			CAN_3_20	Maximise benefits of surgical re-			
			CAN_3_21	Acute oncology services - MSCC pathway	T1	Plan being finalised for the expansion of the SWW Spinal Surgery Service in Morriston Hospital to deliver emergency and unscheduled service, to include MSCC pathway:Complete implementation and evaluate impact of spinal surgery service expansion plan (Q1-Q4)	
		Bone marrow transplant	CAN_3_23	Prepare a business case for WHSSC to consider for Unit expansion	T2	N+D and Meds Management to input into the business case planning for the expansion of the bone marrow transplant unit: Prepare business case (Q1)	
		Nutrition	CAN_3_24	Improve nutritional screening within MDTs and earlier in the pathway within resources	T2	N+D to work with Corporate Nursing and support units HB wide: Nutrition Screening tools to be launched and implemented (Q1)	
					T1	Implement plan to include CNS role in H&N for Oncology patients: Complete BC for H&N CNS (Q1), agree funding stream (Q3)	
					T2	Improve access to dietetics through appropriate early and ongoing screening, plus appropriate referral at all points of the pathway: Plan a screening approached to piloted with MDTs (Q1), evaluate the pilot (Q3), Roll out to other MDTs (Q4).	
			CAN_3_25	Pump primed posts for H & N services where funding available.	T2	Funding to be Identified to support Nutrition +Dietetics H+N Macmillan Posts (end 2020): Identify funding sources Evaluate the service outcomes (Q1)	
					T2	Head and neck dietitian and nutrition nurse are temporary Macmillan funded post that need recurring funding to be found: evaluate impact of service (Q1), Case of need to present to cancer improvement board (Q2)	
			CAN_3_26	Improve access to video-fluoroscopy	T2	Increase provision and access to VF, for head and neck cancer patients: Complete Business Case: funding required to staff additional clinics required to meet NICE guidelines (Q2), If funding is sourced and allocated following completion of business case to increase video fluoroscopy clinic capacity - recruitment to additional clinic sessions (Q3) , Ensure all staff are inducted and embedded into radiography and Speech and Language Therapy Teams to allow additional clinic set up/flow (Q4)	
		Access to information, support and advice	CAN_3_27	Improve rehabilitation within resources	T2	Redesign cancer specialist rehabilitation services, in addition to upskilling and engaging non-cancer specialist rehabilitation providers, to best meet the needs of the population within a sustainable model: N+D, Physio and OT to scope the resources and produce a gap analysis required to improve rehabilitation (Q1-4), pilot the model and agree evaluation criteria (Q2), Evaluate pilot outcome with agreed criteria (Q3).	
			CAN_3_28	Provide Macmillan cancer service and support service pods	T2	Support the Macmillan staff who service the POD on site and evaluate the Macmillan cancer service and support pod established in Morriston Hospital during 19/20: ongoing evaluation (Q1-Q4)	
			CAN_3_29	Improve access to services e.g. dieticians where possible within resources	T2	N+D to scope the resources required and gap analysis to improve access to N+D services: Scope gap analysis (Q1)	
					T1	Scope requirements for a Nutrition MDT to support TPN for pancreatic surgery pathway: scope requirements for a nutrition mdt (Q1-Q2), implement requirements for a nutrition team mdt (Q3), evaluate impact (Q4)	
			CAN_3_30	Provide remote monitoring/PKB	T2	Work is in progress to commence implantation of PKB targeting a specific co-hort of patients initially. This is being led by the "Haematology community team" and Matt Arnold IT: cohort of patients assigned to PKB (Q1-Q2), increase PKB to other cohort of patients (Q3)	
			CAN_3_31	Expansion of key worker model to multi-disciplinary teams	T1	Expansion of CNS posts via a range of externally funded opportunities. Macmillan posts for Pelvic Oncology and Thyroid. Income - Sarcoma and Pancreatic. WG Single Cancer Pathway - CNS to support Straight to test pathway for lower GI	



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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
					T1	The Cancer Clinical Nurse Specialist review is in the process of analysing the job planning data, and the demographic survey. The proces will identify if there are gaps in key worker/CNS provision across the health board and make reccomendations to service/clinical managers. A process for recording 'key worker' on CANISC is being developed to provide a consistent approach to recording and reporting. Secure recurrent funding for the Macmillan Person Centred Care Manager, and the Macmillan Strategic Lead Cancer Nurse in order to continue with Person Centred Care	
					T1	Secure recurrent funding for the MacMillan Physiotherapist for gynaecological cancer patients: Evaluate(Q1), Develop business case (Q2), Present BC and secure funding for 2021/22 (Q3), implement (Q4).	
			CAN_3_32	Improve access to Clinical Nurse Specialist within resources	T2	Band 4 support worker role been established to support improving access to current CNS Workforce- Macmillan funded for 3yrs commenced 2019: Agree what outcomes and benefits we going to measure as baseline (Q1), Evaluate the role and how this benchmarks against the agreed outcomes and measures (Q3).	
					T1	Macmillan have supported pump priming CNS' in Haematology. The exit strategy has been funded through MMG by drug savings. This is a model the service would like to explore further to increase disease specific CNS'. Myeloid CNS specifically: Determine number of patients in Myeloid service and assess the need for CNS (Q1), Business Case for funding to identify potential drug savings (Q2), recruitment process once funding agreed (Q4).	
4Meeting People's Needs	My concerns are identified and addressedThose a	Access to information and support	CAN_4_1	Cancer Alliance (Third Sector), Key worker and Offer of HNA	T1	Secure recurrent funding for the HCSW in gynae-oncology to release the CNS to deliver increased FU outpatient activity.: Evaluate (Q1), Business as usual (Q2)	
		Mental health and wellbeing	CAN_4_4	Work with partners to support people's mental health and wellbeing including:Education patient programme Cymru, Hope, CISS, Maggie's, Tenovus, Complimentary therapies and TYA (teenager and young g adults with cancer)		The health and well-being project group have developed a model of care for delivering education and suport for people affected by cancer. All newly diagnosed cancer patients can be invited to attend a Health and Well-being clinic within 6 weeks of diagnosis. The appointment will be 'workshop' style, providing general information about cancer, cancer treatment, diet, exercise, psychological support, benefits advice and sign posting to other third sector services and EPP. The pilot is planned for April 2020. the pilot will be delivered initially by the Strategic Lead Cancer Nurse and the PCC project manager, however, a resources from within the current workforce will need to be found for long term deliver.	
		Concerns and Complaints	CAN_4_11	Improve process for addressing concerns and implementing actions	T1	Maintain high quality concerns process, which monitors concerns themes and uses information to develop service improvement actions: ongoing monitoring and learning (Q1-Q4)	
		PROMs / PREMS	CAN_4_12	Implement PROMS & PREMS on a rolling programme	T2	PROMS and PREMS being implemented for urology and ENT patient pathways through the National Planned Care Programme: Implement (Q1-4) Electronic Holistic Needs Assessment is being rolled out across the Health Board, the gynae oncology CNS team are piloting the Macmillan eHNA system and the Standard Operating Procedure to evaluate the process. The strategic outputs for eHNA will mean that the system will report on the most common concerns identified by patients which will help direct the provision and design of future services.	
		Treatment Summaries	CAN_4_14	Interface and communication between secondary and primary care	T2	Targeted improvement plan to ensure clinical services have consistent and high quality electronic communication arrangements between secondary and primary care along all clinical pathways including cancer	
					T2	Medicines Management to ensure Mted, Etoc and HEPMA provide sufficient, releavnt and correct information to GPs on discharge. Clinicial Pharmacy workstream leading: Implement (Q1-4)	
5Caring at the End of Life	I want to be supported to die well in the place of	End of Life Care and DNA CPR	CAN_5_1	Plan secure and deliver well-coordinated palliative and end of life care on a 24/7 basis in line with published standards and guidance and Ensure DNA CPR decisions are discussed with patients and families and are recorded and Support all providers who care for dying patients to participate in the All-Wales Audit of the care decisions documentation	T2	Ensure training in EoL care for all front line staff. Medicines Management to review and promote Just in Case box scheme and use in paed.	
					T2	Scope options with relevant stakeholders to develop improved pathways for patients at end of life presenting at front door. Establish local working group which has links to the EOL steering group to provide a MHDU focus on EOL across all aspects of hospital care: plan EOL improvement plan (Q4)	
					T2	Continue robust DNA CPR discussions with patients and families: Audit in patient areas re level of patient and family conversations (Q1)	
		Palliative Care			T2	Ensure EoL documentation is in use: Audit ward areas to undersatnd compliance (Q1)	



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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
		Information and Decision-making	CAN_5_5	Support patient and carer self-management programmes	T2	Input into self management programmes. Develop prehabilitation and CBT approaches	
					T2	MHDU Scoping group to be established with support from Public Health team to identify a list of priority pathways to tackle unhealthy behaviours and promote prevention messages. Set up task and finish implementation groups aligned to agreed prioritised pathways programme. Focus on one cancer related pathway. As part of the implementation plan develop evaluation metrics for each pathway: Identify 5 priority areas and develop approach for reviewing secondary care pathways and developing improvement/ implementation plans (Q1)	
					T1	The person centred care steering group (PCCSG) has been established to support patients and carer self-management .The PCCSG is shaping the delivery of the partnership between Macmillan Cancer Support and the Health Board to deliver the key interventions of the Macmillan Recovery Package and meeting the needs of people affected by cancer. The core aim of the steering group is to ensure that the holistic needs of people affected by cancer are met and patients are empowered to self manage their care where appropriate. The Person Centred Care Steering group provides a steer and direction for the four service improvement project project groups; <ul style="list-style-type: none"><li>• Electronic Holistic Needs Assessment</li><li>• Health and Well-being workshops</li><li>• Cancer Information and support services</li><li>• Treatment Summaries and Cancer care review</li></ul> The Macmillan Lead Cancer Nurse provides strategic leadership for the delivery of Person Centred Care and project management is provided by the Macmillan Person Centred Care Manager. Funding will need to be secured for the continuation of the Person Centred care post from Sept 2020 and for the Lead Cancer Nurse post from Sept 2021.	
					T2	All to have honest conversations with patients and families:Nursing leaders to ensure that conversations are taking place within the inpatient areas (Q1-Q2)	
Improving Information	My care is supported by good information	Improve information systems to support the implementation of the Single Cancer Pathway	CAN_6_1	Move as soon as possible to national platforms, including WCP, and the national picture archiving and communications system PACS		WCP and PACS implemented in Swansea Bay UHB	NHSDF_30 NHSDF_31 NHSDF_32
			CAN_6_2	Adopt SNOMED clinical terms to improve consistency of clinical coding		Utilise SNOWMED CT capability with Swansea Bay for analytical purposes	
			CAN_6_3	Adopt, where feasible, Tracker 7 to monitor component waits and support pathway improvement initiatives		SBU HB were the 2nd HB in Wales to adopt Tracker 7 in 2011.	
			CAN_6_4	Support the replacement of CaNISC and the development of the interim solution through NWIS, to participate in clinical audit and record staging information		Cancer Information Team to continue engagement with NWIS and WCN on the development of a new CanISC system.	

CANCER CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
7Targeting Research	I have the opportunity to participate in clinical tri	Increase research and development within Wales	CAN_7_1	Increase the number of commercial and on-commercial cancer research studies undertaken in the Health Board	T2	Input into any cancer research studies being undertaken within the HB. Therapies and Medicines Management to be fully resourced to ensure adequate clinical trials supply. Therapy researcher and clinical pharmacist support to increasing numbers/ complexity of research studies.	NHSDF_65 NHSDF_66
	I am able to access blood and marrow where nee	Wales Cancer Bank	CAN_7_6	Encourage the targeted consenting patient donations to that Wales Cancer Bank	T2	N+D and Meds Management to input into the business case planning for the expansion of the bone marrow transplant unit: Prepare business case (Q1)	

MENTAL HEALTH & LEARNING DISABILITY WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES			
						2020/21				
1Mental Wellbeing	I feel connected to my community and am not iso	My Neighbourhood Approach	MHLD_1_1	Implement actions for delivery of Neighbourhood approach as per the Neighbourhood approach implementation plan	T1	Governance arrangements agreed (Q2)	NHSDF_08			
			MHLD_1_2	Support the Cluster transformation actions around social prescribing as per the CSP	T1	Review lessons learnt from safeguarding concerns, developing actions around domestic abuse; peri-natal mental health and maternal suicide: Ensuring Ask and Act training compliance with workforce together with completion of FRAIT tool. Plus the completion of the routine enquiry form (Q1)				
					T1	Finalise model for delivery of social prescribing for each primary care cluster (Q1)				
2Learning Disabilities	I can easily find and understand information about	Addressing health inequalities	MHLD_2_1	Joint approach across Cardiff and Vale, Cwm Taf Morgannwg & Swansea Bay Health Boards for delivering acute hospital liaison services	T1	Develop consistent model for delivery of LD liaison in acute hospitals in all 3 Health Boards: Recruitment into new Liaison posts (Q1), End of year report on performance and impact (Q4)	NHSDF_15			
			MHLD_2_2	Consolidation of specialist pathways including Dementia, epilepsy & autism	T1	Review of clinical pathways for Dementia Epilepsy and Autism making connections with primary and secondary care as necessary: develop suite of clinical pathways including- behaviours that challenge services,epilepsy,mental health, autism, complex physical health and forensic (Q2). Monitor against pathways(Q4)				
					T2	Consolidation of specialist pathways including Dementia, epilepsy & autism - Work collaboratively with MHLD Delivery Unit to support planning, implementation and evaluation of agreed action plan (Q1-Q4)				
		Modernising specialist learnin	MHLD_2_3	Redesign of Integrated Community Learning Disability Teams	T1	Development of project structure for review and changed role and function of community learning disability teams: agreement of revised CLDT service specification (Q1), Implementation of resource shift where agreed. Business case for additionally considered by IBG (Q4)				
			MHLD_2_4	Development of 7 day Learning Disability Intensive Support teams across all 3 Health Board areas	T2	Development of business case for delivery of 7 day intensive support service across 3 Health Board areas: Agreement of service specification for 7 day service (Q2), Business case linked to business case for CLDT (Q4)				
			MHLD_2_5	Development of multiagency tertiary support for children's services using PBS to support transition (Facing the Challenge)	T2	Engagement with regional partnership boards in C&V and CTM areas for development of business case for multiagency specialist service for children with LD: Demand mapping and option appraisal (Q1), Discussion of options with Health Boards and LAs (Q3)				
			MHLD_2_6	Redesign of specialist inpatient services	T2	Development of business case for changed use of LD acute assessment unit (reduction in acute capacity): Revised service model for LD (Q1)				
					T2	Development of business cases for changed operational model for LD Specialist residential services to provide clarity of function and best value. (Review proposals for SRS in light of changes to acute (Q2)				
			MHLD_2_7	Commissioning Framework for 3 health boards as per the CSP	T2	Development of overall service model for NHS LD services across 3 commissioning Health Boards within whole system of care and support (Health and Social Care). Agreement of service model by H&SC partners and transformation proposal. (Q1), Implementation plan fro service model change (Q3)				
			• Tier 1 –Priority scheme with	I am supported and directed to the services and c	Development of Community M	MHLD_3_1		Review of Community Mental Health Team role and function	T2	Review of Community Mental Health Team role and function within whole system of MH care and support and implementation of revised operational model: Follow up audit to Joint CIW/HIW CMHT review detailing progress and to report findings / areas for improvement (Q2), Implement changes agreed by partners in response to identified areas for improvement (Q4).
		MHLD_3_2				Further development of EIP services for young people		T2	Development of business case for expansion of bespoke Early intervention in psychosis team for NPT & Swansea: Development of service improvement plan following EIP Network assessment (Q1), Business case presented to MHLD Board (Q4).	
		MHLD_3_3				Development of cluster based Primary Mental Health care		T2	Business case development for ongoing provision of pilot Primary Mental Health care liaison roles as part of cluster transformation programme: Final roll out Primary MH Practitioner pilots to last 4 clusters (Q1). Development of business	
		Improving access quality and	MHLD_3_4	Redesign of stepped model of care	T2	Remodel Primary Care services in HMP Swansea creating a salaried GP model: Developing MDT structure aligning role descriptors to service delivery needs (Q1), Review of MDT structure to further develop on-going workforce model (Q4).				
					T1	Implementation of the Primary Care Mental Health Service within HMP Swansea: Undertake recruitment and training with new staff which will include Mental Health Practitioners, Psychology Therapists and HCSWs. Also need to develop practice and supervision framework (Q1), Review service model and develop plans for further training and up-skilling as appropriate. Strengthen interface between Primary Care and Mental Health (Q4).				
					T1	Implementation of revised stepped model of care for the delivery of high intensity and low intensity psychological therapies: Development plan agreed at board and PTMC (Q2), Begin implementation of Traumatic Stress Initiative (pending WG guidance) (Q4).				

MENTAL HEALTH & LEARNING DISABILITY WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
			MHLD_3_5	Monitoring of 26 week access target for high intensity psychological therapies	T2	Review governance for performance management of high intensity psychological therapy 26 week access target (Q1)	NHSDF_11 NHSDF_12 NHSDF_46 NHSDF_59
		Addressing health inequalities	MHLD_3_6	Development of physical health monitoring strategy for serious mental illness	T1	Development of physical health monitoring strategy and business case for implementation: Identify required appropriate staffing resource, profession and grade required to implement the plan (Q2), Recruit to identified posts and agree timetable for re-audit using NCAP audit criteria and locally developed audit tools for monitoring high dose prescribing, polypharmacy and use of mood stabilisers (Q4).	
		Developing OPMH community facilities as per the CSP	MHLD_3_7	Consolidation of community teams and day hospital service in Swansea	T1	Development of Specialist mental health pharmacy service for community settings: Recruitment of staff completed (Q1), Pharmacists will develop links with GP clusters to address prescribing related issues e.g. antipsychotics, ADHD medication (Q4).	
					T2	Development of business justification case for combining community Older people's MH services for Swansea central on single site.(Q1)	
40Urgent Response and Acute	I receive the timely and appropriate assessment	Development of new Adult Acute assessment service for Swansea Bay	MHLD_4_1	Completion of 5 stage business case for reprovision of adult acute assessment facilities as per the CSP	T1	Service available for dementia population in assessment, inpatient and community environments for communication, swallowing and family support: Appoint to new service (Q1), Scope out and commence data collection (Q4).	
					T2	Development of SOC and subsequent business cases for the reprovision of adult acute assessment facilities for Swansea and NPT: SOC submitted to Welsh Government & approved (Q1), OBC completed / internally Approved by Execs (Q4).	
		Simplified referral routes for mental health services	MHLD_4_2	Delivery of Single point of access for primary and secondary mental health services as per the CSP	T1	Development of service model and implementation of single point of access for primary and secondary mental health services: Recruitment to single point of Access completed (Q1), Service operational (Q3).	
					T2	Delivery of Single point of access for primary and secondary mental health services as per the CSP - Work collaboratively with MHLD Delivery Unit to support planning, implementation and evaluation of agreed action plan: Develop Plan (Q1-4)	
		Delivery of alternatives to hospital admission	MHLD_4_3	Commissioning of Mental Health Sanctuary service as per the CSP	T1	Development and implementation of a Mental Health Sanctuary service across Swansea and NPT for people in mental distress: Commencement of sanctuary service. Contract for evaluation awarded (Q1), 6 month multiagency steering group review (Q3).	
			MHLD_4_4	Expansion of Acute hospital acute liaison service	T2	Development of business case for the expansion of acute hospital psychiatric liaison service to 24 hour provision in ED: Collation of service delivery data and research of 24 hour services already operating. (Q2)	
					T2	Work collaboratively with MHLD Delivery Unit to support planning, implementation and evaluation of agreed action plan: Plan (Q1-4).	
			MHLD_4_5	Review of operation of Care Home minreach services for Older people	T1	Service available for dementia population in assessment, inpatient and community environments for communication, swallowing and family support: Appoint to new service (Q1), Scope out and commence data collection (Q4).	
					T2	Review of operation and impact of Care Home in reach services for older people: Data collection and audit (Q1), Action Plan including recommendations for operational policy across HB (Q4).	
55Specialist Rehabilitation	I receive the ongoing support and care I need in a	Effective management of Continuing Health care	MHLD_5_1	Expansion of CHC commissioning team as per the CSP	T2	Expansion of commissioning team to effect improved governance and control on CHC demand: Recruitment to expanded CHC team completed (Q1), Ongoing collection of data regarding right sizing and cost avoidance (Q4)	NHSDF_11
		Development of Gender sensitive services	MHLD_5_2	Scoping of demand and introduction of women's low secure service	T2	Scoping and development of business case for development of Women's low secure service as part of gender sensitive service model: Demand mapping of low secure placements across SBUHB & CTMUHB (Q2), Agreement of future need and negotiation with CTM regarding capital for changes to existing estate (Q4).	
			MHLD_5_3	Development of women's pathway for recovery	T2	Scope overall service model for Women's rehabilitation and recovery: Plan (Q1-4)	
60Dementia	I am aware of the symptoms of dementiaI receive	Remodelling Older People's Mental Health inpatient services	MHLD_6_1	Removal of spare capacity within a remodelled community service.	T1	Remodelling of inpatient and community services for older people with MH problems including business case for reduction of inpatient capacity: Permanent closure of inpatient beds subject to positive evaluation (Q1), Business case submitted to WG (Q3),	NHSDF_12 NHSDF_59
		Integrated OPMH pathway and implementation of the Dementia Framework as per the CSP	MHLD_6_2	Integrated pathway including memory assessment pathway across primary and secondary care.	T2	Development and implementation of pathway for specialist OPMH service and primary mental health: Revised pathway consulted upon (Q1), Operational procedures revised (Q2).	
					T2	Implementation programme for Dementia Strategy Action plan: Develop plan (Q1-4)	

MENTAL HEALTH & LEARNING DISABILITY WHOLE SYSTEM PLAN							NHS MEASURES
PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	
						2020/21	
					T2	Integrated pathway including memory assessment pathway across primary and secondary care. - Work collaboratively with MHL D Delivery Unit to support planning, implementation and evaluation of agreed action plan: Plan 9Q1-4)	
70Perinatal Mental Health	I and my family know how to recognise the issues	Delivery of mental health mother and baby unit	MHLD_7_1	Completion of business cases for capital development	T1	Completion of business case for delivery of mental health mother and baby unit: Plan pending following site visit by WG 9/10/19 9Q1)	
			MHLD_7_2	Development of Perinatal Mental health Network	T1	Expansion of community perinatal services for SBUHB: Recruitment to perinatal roles for meeting WG standards completed (Q1), Scope expansion of specialist midwife role across the HB and costs (Q3).	

MATERNITY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
Gynaecology	I am treated with dignity and respect	clinks available / one stop clinics		Telephone triage for cold gynae refs			
		Prevention of admissions		Virtual clinic -- cons/specialist nurse			
		Triage		Stop all W/L			
Antenatal	I know how to access maternity care, I understand	The Antenatal Care pathway is	Mat_AN1	Develop various mediums including internet site and potential apps in order to set out the pathway of care and what women can expect from their service	T2	Develop and utilise technology including internet site and apps in order to describe the pathway of care and what women can expect from their service: Agree priorities and platforms (Q2)Develop the apps/ sites(Q3)	NHSDF_01 NHSDF_05 NHSDF_06 NHSDF_09
				Review and develop clear and consistent pathways for all care in the Antenatal period Initial assessment of care needs is undertaken at initial booking visit and the pathway set out and shared with women Needs are assessed at each antenatal visit and the antenatal pathway is adjusted accordingly.	T1	Rollout community midwives mobilisation project: Identify suitable devices and develop business case if required. Develop implementation plan(Q1),Implement with first team (Q2),Develop rollout plan depending on evaluation(Q4)	
		Ensuring continuing professional development of all maternity staff	Mat_AN2	Ensure Statutory and Mandatory training and PADRs are undertaken and up to date across Maternity Services	T1	Midwives and obstetricians are supported to complete all statutory and mandatory training and professional updates	
					T1	Midwives and obstetricians have value based PADRs/Appraisals which will identify service and professional development needs	
		Providing continuity of the carer and services throughout antenatal care	Mat_AN3	Organise services and the workforce to ensure compliance with Birth Rate Plus and RCOG Standards so that women are able to be provided with a named midwife and 'buddy' midwife and/or consultant who will provide continuity of care and service throughout the antenatal period.	T2	Organise services and the workforce to ensure compliance with Birth Rate Plus and RCOG standards. Ensure that women are able to be provided with a named midwife and 'buddy' midwife who will provide continuity of care. The woman will see no more than 2 midwives through pregnancy and the postnatal period. Ensure that there are sufficient staff to allow delivery in place of choice: Continue to assess staffing levels against birth rate plus standards. Secure funding for any shortfall identified(Q1), Implement - Recruit staff through streamlining process(Q2)	
					T1	Implement action that ensures the appropriate named professionals are identified on the All Wales Maternity Record (Q1-Q4)	



PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	

				T1	Implement action that ensures midwives clearly and concisely identify and explain why a referral for additional care has been made (Q1-Q4)
				T1	Services and the workforce are organised so that wherever possible women see their named Obstetrician at their first antenatal clinic appointment (Q1-Q4)
	High quality current evidence based information, support and services are easily available, and proactively provided	Mat_AN4	Information is given and discussions take place at appropriate times to support women's choices on birth.	T1	Antenatal screening information and choices are provided at the booking appointment in line with Antenatal Screening Wales standards(Q1-Q4)
				T1	Birth choices leaflet provided to all women at the booking appointment(Q1-Q4)
				T1	Women will have a discussion about their chosen place of birth at 36 weeks which will include information about postnatal care and length of potential hospital stays(Q1-Q4)
				T1	Bump, Baby and Beyond (or equivalent) book is provided to all women at the first hospital appointment(Q1-Q4)
				T1	When a woman's choice is outside of evidence based clinical guidance an individualised care plan will be co-produced and communicated to the MDT professional team(Q1-Q4)
		Mat_AN5	Health and wellbeing support is provided	T1	In line with Public Health Wales recommendations and the All Wales First 1000 Days, provide services and work in conjunction with external agencies to reduce smoking in pregnancy, maternal obesity and improving perinatal health and wellbeing including Mental Health(Q1-Q4)
		Mat_AN6	Information and treatment is provided on the risks for developing Thrombembolic Disease	T1	Risk scores for the risks for developing Thrombembolic Disease are communicated to patients and appropriate treatments commenced(Q1-Q4)
		Mat_AN7	High quality antenatal classes are available and accessible to all parents to support health in pregnancy and birth preparation.	T1	Review current provision and content of antenatal classes; their accessibility and efficacy(Q1-Q4)
				T1	Develop a directory of suitable antenatal services external to the Health Board for sign-posting(Q1-Q4)
		Mat_AN8	High quality information of the health gains associated with breastfeeding is provided and support is provided to all mothers irrespective of their feeding choice.	T1	Develop and implement an Infant Feeding Plan to fully adopt the All Wales Breastfeeding Five Year Action Plan (Actions related to non breastfeeding choices?)

MATERNITY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
						2020/21	
			Mat_AN9	Additional and/or specific needs are proactively identified with robust referral to specialist services in place where appropriate	T1	Implement action that ensures all maternity staff clearly and concisely identify and explain why a referral for additional care has been made(Q1-Q4)	
					T2	Develop plans to fully implement the perinatal institute GAP/GROW programme for foetal growth surveillance as required by Welsh Government towards reduce the stillbirth rate across Wales: Undertake GAP analysis and develop business case for additionally(Q1)	
					T1	Review and establish effective communication pathways across specialities and Health Board boundaries to ensure seamless care(Q1-Q4)	
Intrapartum	I know where I am going to give birth and I have re	The Antenatal Care pathway is consistent, efficient and well communicated to families	MAT_IP1	Information is provided at the appropriate times to support women's decisions	T1	Provide appropriate information including the Birth Place Decision Booklet at the booking appointment, and ensure regular discussions are had throughout the antenatal period to enable women to make an informed choice on their place of birth (Q1-Q4), Secure funding and develop implementation plan(Q2)	NHSDF_51 NHSDF_53
					T2	Develop the maternity Internet site to set out the pathway of care and what women can expect from their service and to aid in the birth place decision (Q4)	
					T1	Families are provided with up to date and accurate information on transfer times from free standing midwife led birth centres(Q1-Q4)	
					T1	When a woman's choice is outside of clinical guidance, she will be supported by her named Obstetrician and or consultant midwife to co-produce and individualised care plan which will be communicated to the MDT professional team(Q1-Q4)	
		Women give birth in their chosen environment wherever possible	MAT_IP2	A home birth service is maintained at all times	T1	Organise services and the workforce to ensure compliance with Birth Rate Plus to maintain the home birth service (Q1-Q4)	
			MAT_IP3	Services are maintained appropriately at the alongside midwife unit at all times.	T1	Organise services and the workforce to ensure compliance with Birth Rate Plus and to maintain adequate staffing for the alongside midwife unit (The Bay) at all times (Q1-Q4)	
					T1	When the service is experiencing high acuity that has the potential to impact on the safety of women and their babies, women contacting the service must be appropriately communicated with and options for care discussed(Q1-Q4)	
		Women are supported and given the right information about recognising the early stages of labour and know what to do	MAT_IP4	Availability and provision of antenatal information is adequately in place	T2	Review current provision and content of antenatal classes; their accessibility and efficacy to ensure women feel confident about knowing when to call their midwife (Q4)	
					T1	Implement action that ensures the named midwife and contact details are provided in the All Wales Maternity Record (Q1-Q4)	
					T1	Home assessment in early labour will be offered to all women where clinically appropriate (Q1-Q4)	
		The MDT communicates effectively with women to ensure changes to birth plan are fullv understood and	MAT_IP5	Co-production is embedded as a core principle for communication and care planning throughout labour	T1	Health professionals providing care are aware of and have a full understanding of a women's birth plan (Q1-Q4)	

MATERNITY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
Postnatal		Women are supported to fully understand the process for elective C-sections and if required the services are in place to ensure the procedure happens when planned			T1	Women who decline induction of labour when clinically indicated have an agreed individualised plan of care and are informed of the risks and benefits of their decision(Q1-Q4)	
			MAT_IP6	Implement central monitoring to safely monitor the babies wellbeing in labour and identify any need for clinical changes which necessitate a change in birth plan	T2	Procure and implement central monitoring to safely monitor the babies wellbeing in labour and identify any need for clinical changes which necessitate a change in birth plan: Assuming capital funding secured by this point, develop implementation plan(Q1), Begin implementation(Q2)	
					T1	introduce a foetal surveillance midwife role to ensure high quality training and development of all maternity staff in foetal well-being and be able to offer 1:1 support staff who are involved in an incidents where foetal surveillance is identified as sub-optimal : Develop training plan and process for review of incidents. Agree evaluation measures(Q1),Implement the training plan and begin evaluation. Link to implementation of central monitoring (SING_145)(Q2)	
		The process for booking a planned induction is clear with robust criteria for women based on clinical need	MAT_IP7	Ensuring women are booked for induction at the appropriate time based on clinical need	T1	Review the criteria and booking process for induction of labour (Q1-Q4)	
	I want to be supported by maternity staff who are	Postnatal services are appropriately resourced with the correct skill-mix with the correct staff who have the appropriate knowledge and skills	MAT_AP17	Review and develop robust information on elective C-sections that is evidenced based and provided to women when C-section first discussed and Organise services and workforce to ensure an elective can be covered and maintained	T2	Planned elective C-sections have a dedicated elective list to reduce cancellations, increase efficiency and improve patient experience: Recruit additional theatre staff. (Q1),Begin lists and evaluate on ongoing basis(Q2), Develop case for increased number of sessions per week(Q4)	NHSDF_51 NHSDF_53
			MAT_PN1	Effective recruitment strategy is in place to ensure the service compliance with Birth Rate + and RCOG Standards		Review , develop and implement effective recruitment strategy (Q1-Q4)	
			MAT_PN2	Ensure Statutory and Mandatory training and PADRs are undertaken and up to date across Maternity Services	T1	Midwives and obstetricians are supported to complete all statutory and mandatory training and professional updates	
					T1	Midwives and obstetricians have value based PADRs/Appraisals which will identify service and professional development needs	

MATERNITY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
		The appropriate postnatal information and support is available	MAT_PN3	Women are provided with all appropriate information post birth and supported with Skin to Skin contact and Breastfeeding.	T1	Information that has been made available in the antenatal period that prepares women and families for parenthood will be reinforced including safe sleeping, second hand smoking risks (Q1-Q4)	
					T1	All women are offered skin to skin at birth(Q1-Q4)	
					T1	All women are provided with information on the benefits of breastfeeding and offered support with their feeding choices (Q1-Q4)	
			MAT_PN4	Appropriate Analgesia is available	T1	Self administration of analgesia is available to women if appropriate(Q1-Q4)	
					T1	Analgesia is prescribed and administered as required and appropriate(Q1-Q4)	
			MAT_PN5	Contraceptive information and advice is provided	T1	All appropriate Midwives and Obstetricians are trained to provide information and administration of contraception(Q1-Q4)	
		Timely and effective neonatal care pathways are in place	MAT_PN6	Staff and environment for neonatal care are effective, appropriate and high quality	T2	Transitional care unit is completed(Q4)	
					T1	Staff providing care in the post natal period have all the relevant skills and training (Q1-Q4)	
					T1	MDT (Obstetricians, Neonatal, Midwives) ensure that policies and procedures are developed, implemented and adhered to for the provision of evidenced based care (Q4)	
			MAT_PN7	All women are given the opportunity for discussions about their labour and birth	T1	Midwives and obstetricians are competent to undertake debrief discussions including advice regarding future pregnancies (Q1-Q4)	
					T1	Debrief clinics appointments are available as appropriate (Q1-Q4)	
					T1	Signposting and referral is available to other appropriate services for debriefing or trauma work (Q1-Q4)	
				Information and treatment is provided	T1	Risk scores are communicated to patients and appropriate treatments commenced (Q1-Q4)	
		Discharge processes are thorough and streamlined	MAT_PN8	Postnatal support is available and timely	T1	Newborn examinations are available 24/7(Q1-Q4)	
					T1	All relevant discharge documentation is complete and prepared for a timely discharge(Q1-Q4)	
					T1	Information on wound care is provided. The community midwife is the first point of contact where concerns exist (Q1-Q4)	
					T1	Discharge medication is available in a timely way(Q1-Q4)	

MATERNITY CARE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
					T1	Review and streamline the Postnatal Documentation (Q1-Q4)	
			MAT_PN9	Explore opportunities for the development of a discharge lounge which will be supported by maternity care assistants	T2	Explore opportunities for the development of a discharge lounge which will be supported by maternity care assistants: Identify model and location - develop case and secure funding(Q1), Undertake estates/ capital. Recruit MCAs(Q2)	
			MAT_PN10	Additional and/or specific needs are proactively identified with robust referral to specialist services in place where appropriate	T1	Safeguarding issues identified and managed appropriately(Q1-Q4)	
					T1	Staff are aware of pre-existing Perinatal mental health issues and are able to identify and escalate newly arising perinatal mental health issues(Q1-Q4)	
			MAT_PN11	Community midwife services are appropriately resourced and organised	T1	Services and workforce is organised to protect and prioritise the first day community midwife call(Q1-Q4)	
			MAT_PN12	Information and support is provided and sign posted	T1	Community midwife contact number and an emergency contact number is clearly communicated and documented (Q1-Q4)	
					T1	All support groups' information is available (digitally where possible) (Q1-Q4)	
					T1	Infant Feeding Coordinator is available for women with complex feeding problems(Q1-Q4)	
			MAT_PN12	Handover of care from midwife to Health Visitor if Robust	T1	Information sharing between midwife and Health Visitor is high quality, clear and concise(Q1-Q4)	

CHILDREN AND YOUNG PEOPLE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
1.Early Years	My parents are healthy and make positive healthy choices for their children	Encouraging/ empowering families to make healthy choices for their children	CHI_1_1	Support and deliver Public Health campaigns including Smoking cessation services - Help me Quit Programme, Healthy eating/Physical activity (NERS),Vaccination programmes and delivery of MECC - Midwives and health visitors	T1	Foster partnership working across communities and clusters to successfully deliver against the Healthy Child Wales programme in line with the Parliamentary Review of Health and Social Care in Wales and ensure Health Visiting practice utilises the FRAIT tool in assessing the resilience and needs of the family: Review programme and ensure that standards are maintained in line with Welsh Government standards around the delivery of the Healthy Child Wales programme (Q1-4)	NHSDF_01 NHSDF_02 NHSDF_03 NHSDF_19
					T1	SLT will continue to work with local education authority partners and maintained nurseries to deliver WellComm a programme at a universal and targeted level to support early speech and language development, enabling children to have the best start in life: Evaluate impact and feedback QI measures to SBUHB and Local Authority partners (Q1-4).	
					T1	Develop sustainable response to ALN reform and statutory obligation for children and young people age 0-25 with identified needs to have timely and equitable access to SLT services: Work with DECLO and ALN transformational lead to establish full effect of ALNET act (Q1-4)	
					T1	Alignment of the Help Me Quit hospital team with the Help Me Quit community team in order to streamline the Smoking cessation service: Following OCP, scope potential premises to co-locate staff (Q1), Roll-out of fully integrated working with both teams working under a single brand (Q4).	
					T1	Promote Help Me Quit Services and smoking cessation guidance to the wider NHS, schools, employers and groups with high smoking prevalence: Mapping exercise of existing clinics and services offered (Q1), Re-align resources based on results on the evaluation of the mapping exercise (Q4).	
					T1	Provision of MECC and measurement of impact on behaviour change: Continuation of measuring impact of MECC intervention on actual behaviour change by reviewing metrics and making continual improvements as required (Q4).	
					T1	Foster partnership working across communities and clusters to successfully deliver against the Healthy Child Wales programme in line with the Parliamentary Review of Health and Social Care in Wales and ensure Health Visiting practice utilises the FRAIT tool in assessing the resilience and needs of the family: Review programme and ensure that standards are maintained in line with Welsh Government standards around the delivery of the Healthy Child Wales programme (q4).	
					T2	Improve uptake of childhood immunisations, particularly for those in areas of high deprivation through the Childhood Immunisation Group (Q1-4)	
					T1	Improve the oral health of vulnerable groups specifically children, the elderly and housebound: Implement new model for dental domiciliary and other groups (Q1-2).	
					T1	Complete transformation of re-modelled 'Design to Smile' programme focussing on younger children; inclusive of 'Lift the Lip' campaign Health Board wide: Evaluate (Q1-4)	
• Tier 1 –Priority scheme with a focus on supporting families to make healthy choices for their children	My mother and I receive fast, effective and safe neonatal care	Increased uptake in the percentage of babies who are breastfed	CHI_1_10	Breastfeeding Coordinators delivering direct support -Infant Feeding Coordinators supporting Baby Friendly standards. Monitor compliance with All Wales Breastfeeding Strategy - 5 year Action plan	T2	In line with the Baby Friendly Initiative, improve and increase breast feeding rates: Substantive full time Infant Feeding Co-Ordinator should be in post to fully roll-out programme across Swansea Bay (Q1), Establish links and grow role throughout the Health Board (Q3).	NHSDF_01
			CHI_1_11	Midwives delivering training and support through antenatal classes	T2	Paediatric Occupational therapy supporting antenatal classes to discuss attachment and bonding, early positioning and interaction, importance of tummy time and sensory experiences to support development. No budget for this presently . There is a requirement for Physiotherapy support to antenatal services, around health of the pregnant woman. Early physiotherapy intervention and prevention of gross motor delay; no budget for this to develop. additional resources required for N&D to support the training of midwives: Plan (Q1-4)	
			CHI_2_1	Complete Neonatal Transitional Care Unit build	T1	Implement TCU for Neonates: Implement (Q1-4)	
• Tier 2 –Priority scheme with a focus on supporting families to make healthy choices for their children	My mother and I receive fast, effective and safe neonatal care	Ensuring appropriate capacity for neonatal care	CHI_2_2	Implement recommendations of SW Plan - Insert Cot capacity 8 IC, 9 HD, 13 SC	T2	Review regional cot capacity with WHSCC (Q1), Present case to IBG - Linked to BAPM requirements (Q2), Review implementation plan (Q3), Recruitment phase (Q4).	NHSDF_01



## CHILDREN AND YOUNG PEOPLE WHOLE SYSTEM PLAN

PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
		Ensuring appropriate skilled workforce requirements to deliver critical care	CHI_2_3	Staffing to meet BAPM Standards	T2	Ensure staffing includes therapies- Physio/ OT/ SLT/ dietetic and Psychology. :Business case submitted requires additional resources (Q2)	
					T2	Review outcome of Peer Review (Q1), Present case to IBG (Q2), Review implementation plan (Q3), Recruitment phase (Q4).	
			CHI_2_6	Implement Family integrated care increasing breast feeding rates for babies discharged from neonatal unit	T2	Implement Family Integrated Care and improve breast feeding rates: Implementation (Q1-Q4)	
					T2	OT Support for FIC needs ongoing support and increased investment if beds are increased with new unit. Business case submitted for therapies (Q2).	
			CHI_2_7	Identifying and addressing needs at an early stage can help to prevent the difficulties that they can experience from arising.	T2	Designated SLT in neonatal services, NICE standard and develop SLT workforce for neonatal and children's services: Identify funding for additional workforce to achieve targets (Q3).	
		In collaboration with partners in the Local Authority working to support the achievement of improved readiness for school, increased educational attainment reducing inequalities and improved employment opportunities	CHI_2_8	Promotion of healthy eating and increasing physical activity for children and young people to encourage a healthy weight and reduce obesity.	T2	N+D to work with Public Health on the Obesity Strategy-local pathway in development additional funding required. Prevention and early intervention from Physiotherapy to promote activity levels to counteract obesity and complications of sedentary lifestyles. This could be delivered in the development of wellness centres: Support PCC DU developing Wellness Centres (Q1).	
			CHI_2_9	Early identification of speech, language & communication development and any other developmental delays	T2	All therapies - ALN Act requires resourcing as per Business case Early physiotherapy intervention and prevention of gross motor delay Early promotion of physical literacy via universal family focused groups based in accessible community settings i.e. wellness centres: Plan approach (Q1-2)	
					T1	SLT will continue to work with local education authority partners and maintained nurseries to deliver WellComm a programme at a universal and targeted level to support early speech and language development, enabling children to have the best start in life: Evaluate impact and feedback QI measures to SBUHB and Local Authority partners (Q1-4).	
		Every child (0-7 years) and family within SBUHB will receive the Healthy Child Wales Programme, along with a range of assessments	CHI_2_12	Perinatal Mental Health Services	T2	Explore OT support if resources identified- OT unique in being dually trained in both Mental health and physical and experience of working with adults and children. Explore Physio resources into ante natal ward based services. Service requires specialist mental health pharmacist/ prescribers to provide expert advice and prescribing support. Funding to be identified.(Q1-4)	
					T1	Expansion of community perinatal services for SBUHB: Recruitment to perinatal roles for meeting WG standards completed (Q1), Scope expansion of specialist midwife role across the HB and costs (Q3).	
			CHI_2_15	Development of Wellness Centres	T1	Support the development of the Swansea Wellness Centre and decant Child Health Dept Central Clinic to Singleton Site (Q1-4)	
			CHI_2_16	Early identification of children where there are safeguarding concerns and referrals to appropriate services to work collaboratively with services to ensure that their wellbeing needs are holistically met (Social Services Wellbeing Act 2016).	T2	Implement recommendations of Special School Nursing Framework (Q1-4)	
3.Safety, Wellbeing and the H		To work in partnership with the LEA and schools to support learners with additional learning needs from 0-25 years	CHI_3_1	Establish the role of Designated Educational Clinical Lead Officer (DECLO) as required by the ALN Act	T2	Business case developed for therapy input. Also work with education to insure effective implementation of ALN, develop IT infrastructures to collect , report and share data, develop processes and staff to support early dispute resolution (Q1)	NHSDf_04
					T1	Develop sustainable response to ALN reform and statutory obligation for children and young people age 0-25 with identified needs to have timely and equitable access to SLT services: Work with DECLO and ALN transformational lead to establish full effect of ALNET act (Q1-4).	
					T1	Support ALN recommendations through Steering Group (Q1-4).	

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2020/21							
		Offer opportunities for engagement and support recognize the needs of the individual and support them to achieve and Ensuring the framework for School Nursing and the Healthy Child Wales Programme is equitable	CHI_3_2	Facilitate School Health Nursing Service staff to work in partnership with multi-disciplinary and multi-agency colleagues to ensure the best possible outcomes for children and young people in whatever setting they receive their education including EOTAS pupils and pupils who are electively home educated.	T1	SLT will continue to work with local education authority partners and maintained nurseries to deliver WellComm a programme at a universal and targeted level to support early speech and language development, enabling children to have the best start in life: Evaluate impact and feedback QI measures to SBUHB and Local Authority partners (Q1-4).	
			CHI_3_3	Act as advocates in line with the NMC Code, the School Health Nursing Service will support the lobby to make registration of all electively home educated children and young people compulsory and inspection of the education content provided.			
			CHI_3_4	Implement the Healthy Child Wales programme inc Phase 2 when required	T1	Development and implementation of the All Wales acuity tool for Health Visiting across SBUHB to accurately deliver the Healthy Child Wales programme: Continuation of workshops in readiness for the implementation of the acuity tool (Q1-4).	
			CHI_3_5	Work with Western Bay Youth Offending Services to develop access for children and young people to assessment and intervention from speech and language therapy services as appropriate.	T1	In collaboration with Western Bay, continue to develop access to SLT assessment and intervention for Children and Young people in the Youth Justice system: Following successful appointment of new SLTs for Youth Offending service, implement new model (Q1), Evaluate success of the new investment into Youth Offending model (Q4).	
		Support healthy behaviours and choices.	CHI_3_6	Behaviour training on a multi professional basis. This would include agencies such as police and youth offending teams			
			CHI_3_7	Engagement with the Prevent programme to raise awareness of the risk of radicalisation			
		4.Keeping Children and Young	I have the right to be kept safe from abuse, neglect	We will work in partnership with other agencies to safeguard children and young people and ensure a safe and competent workforce to recognise and deal with children exposed to any form of abuse	CHI_4_1	We will ensure that arrangements are in place to consider the impact on children and young people living in an environment where they are exposed to mental illness and substance misuse.	
Support and implement the SARC regional Plan	CHI_4_4			Implement sustainable community paediatric workforce	T1	Implement sustainable community paediatric workforce including filling consultant vacancies and review of nursing roles. Development of Plan (Q1-4)	

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PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION	PRIORITY	MILESTONES	NHS MEASURES
2020/21							
			CHI_4_5	Implement national revised SARC model and Identify and develop appropriate site for SARC service	T1	Develop national revised SARC model: Procurement phase and workforce model for SW Wales hub (Q1-4)	
		We will ensure that arrangements are in place for the prevention, protection and support of children and families experiencing any form of gender based violence, domestic abuse and sexual violence. This will include Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), Honour Based Violence (HBV), Human Trafficking and Female Genital Mutilation (FGM).	CHI_4_6	Ensure that arrangements are in place for the prevention, protection and support of children and families experiencing any form of gender based violence, domestic abuse and sexual violence.			
		We will provide a safe environment for children and young people and consider the Rights of the Child in line with the UNCRC in the provision of all our services.	CHI_4_8	We will ensure that arrangements are in place to meet the statutory requirements for Looked After Children (LAC).			
5. Children and Young People	Early identification and assessment	Receive the right MDT approach in place to identify complex needs	CHI_5_1	Joint working with LA to review arrangements for children and young people with complex conditions	T1	Support review of Children with Complex Needs (review potential for pooled budget) (Q1).	
					T1	Flying Start programme to be reviewed in line with new Local Authority Funding Stream from 2020: Review funding and provide details of programme delivery (Q1), Depending on outcome of funding, implementation of agreed programme (Q2), Further implementation across the Health Board (Q4).	
			CHI_5_2	Review of specialist nursing and therapy posts	T2	Therapists to be part of review , with therapy heads of service identified as responsible person (Q1	
			CHI_5_6	End of life care including provisions for the child to die in their own home, if this is their choice access to support from Ty Hafan and ensure bereavement support for the family during and following the child's death.	T2	Therapy palliative care service to support respiratory needs and allow patient to remain at home and avoid admission at end of life, additional resource required (Q2)	
					T2	Ensure effective End of Life care and bereavement support: Assess requirements (Q1).	
6. Emotional Health and Wellbeing	I will have access to appropriate skilled professional	Ensure effective local service for children and young people with Neurodevelopmental conditions	CHI_6_1	Appropriately resource the Neurodevelopmental Service, implement the all wales referral pathway and support the all Wales ND Steering Group and Identify funding streams to increase post diagnostic support for families	T2	Therapies to be involved and resource required. Paediatric assessment Unit: Funding for Pharmacist to undertake prescribing on admission and clinical medication review; and provide specialist advice on clinical issues and cost monitoring (no service is currently provided). (Q1-4)	NHSDF_40 NHSDF_41 NHSDF_42 NHSDF_43
					T1	SLT role in Neurodevelopmental Disorders pathway for assessment and diagnosis of ASD and/or ADHD in accordance with NICE guideline : Evaluate impact and feedback QI measures to SBUH (Q1-4)	
					T1	Develop and agree plan to resource the Neurodevelopmental Service (Q4)	
		Ensure effective local primary CAMHS services in place	CHI_6_4	Develop Paediatric Psychology Service	T1	Develop plan for Paediatric Psychology Service (Q1-4)	

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						2020/21	
			CHI_6_5	Improve accessibility to CAMHS and specialist advice and support and Developing sustainable and accessible universal services to support children and young people with emotional health and wellbeing		CAMHS - Integration of Primary & Secondary CAMHS including a single point of access. Implementation of an Emotional Health & Wellbeing Service hosted by CAMHS, along with a website for CYP and professionals.	
7.Timely care and treatment for	My family/carer has the information and advice n	Work with primary and community health services partners to promote care at home, with adequate support and advice, for common less serious childhood illnesses and injuries.	CHI_7_1	Review opportunities with 111 to support emergency pathway for CYP	T2	Meet with 111 team in early to review opportunities to support the paediatric ED pathway (Q1)	NHSDf_20
					T1	Review opportunities with 111 to support emergency pathway for CYP: Explore opportunities and benefits (Q1).	
			CHI_7_2	Develop email advice line to support GP's and primary care	T1	Virtual clinics/ telehealth- Support the changes in clinical pathways need to improve the quality and efficiency of our outpatient services: Business case process started - driven by planning of CSP (Q1), Business case approved (Q4).	
			CHI_7_3	Implement single point of access for CYP seeking emergency care at Morriston (inc work with WAST/Primary Care/workforce review and design)	T2	Scope how Therapy acute outreach service to prevent acute admissions and facilitate early discharges (Q1-2).	
					T1-C	To improve the care for children and young people attending acute and emergency paediatric services by integrating paediatric emergency medicine with the paediatric assessment unit, (PAU) to provide a single point of access for paediatrics: Finalise clinical model (Q1), Finalise implementation plan for 2021/22 (Q4).	
		WAST service trained and skilled to manage paediatric emergencies	CHI_7_4	Improve ED environment in the medium term	T2	Implement recommendations from Youth Board 15 steps” across ED environment: Plan implementation (Q1-4)	
		Development and implementation of the Single Point of Access for Paeds	CHI_7_5	Workforce plan to ensure sustainability of acute paediatric on call rotas at Morriston	T2	Develop workforce plan to ensure sustainability of acute paediatric on call rotas at Morriston: Finalise sustainable clinical model (Q1), Finalise implementation plan for 2021/22 (Q4).	
					T1	Develop service sustainability plan for paediatric radiology (Q1-4).	
					T2	To develop a sustainable service plan for paediatric echocardiography - including a robust succession plan (Q1-4).	
					T2	Ensure sustainability of ROC screening: Review options (Q1).	
			CHI_7_6	Develop specialist nurse input/workforce to improve support to families and CYP	T2	Develop plan for specialist nurse input/workforce to improve support to families and CYP (Q4).	