Meeting Date	**26 September 2019**	**Agenda Item**	**3.2**
Report Title	Clinical Services Plan and Integrated Medium Term Plan 2020/21-22/23 – Progress Update		
Report Author	Val Whiting, Assistant Director of Finance Kerry Broadhead, Head of Strategy Ffion Ansari, Head of IMTP Development and Implementation		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy Lynne Hamilton, Director of Finance		
Presented by	Siân Harrop-Griffiths, Director of Strategy Lynne Hamilton, Director of Finance		
Freedom of Information	Open		
Purpose of the Report	This paper and accompanying Appendices provide an update of the work undertaken to date in delivering the Clinical Services Plan (CSP) and the aligned process for the development of the Integrated Medium Term Plan (IMTP) 2020/21-22/23.		
Key Issues	The key issues addressed in this paper for the IMTP are: • The development process and timescales for the IMTP • The Whole System Plans • The emerging content and structure of the Plan • Issue, risks and next steps The key issues addressed in this paper for the CSP are: • Pace and scale of progress • Sustaining clinical engagement • Aligning clinical decision making • Understanding the service options and financial implications of these • Aligning CSP, capital and regional CSP plans		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☐	☒
Recommendations	Members are asked to: • **NOTE** the progress in developing the Health Board's Three Year Plan 2020/21-22/23		

	• **APPROVE** the Whole System Plans; • **ENDORSE** the approach to the emerging plan content and structure; • **NOTE** the progress made in delivering the CSP; • **ENDORSE** the arrangements to address the issues in delivering the CSP; and • **CONSIDER** the financial implications identified for delivering the CSP

INTEGRATED MEDIUM TERM PLAN 2020/21-22/23 AND CLINICAL SERVICES PLAN UPDATE

1. INTRODUCTION

This report describes the progress made in delivering our CSP and developing our IMTP. The Health Board has made a commitment to seek to develop an approvable Integrated Medium Term Plan (IMTP) for 2020-23 during 2019. The Executive Board, Senior Leadership Team and Board receive regular updates on progress with its development. Work has been underway to develop the Whole System Plans and detailed Unit Plans. This paper outlines the progress to date and presents the Whole System Plans.

This paper also sets out some of the issues and challenges faced in delivering the CSP, and presents for the Board's endorsement, recent proposals made to key Health Board Forums to address these. The report describes current issues in resourcing CSP delivery and the financial implications of these.

2. BACKGROUND

Integrated Medium Term Plan

2.1 Timeline and Process for Submission of the IMTP

Developing confidence in an approvable IMTP is an enabler to support the organisation out of Targeted Intervention. We are clear however that we are not working solely to develop a plan to meet the national deadline, we also wish to maintain momentum and build on the significant progress that has already been made. We are continuing to engage with Welsh Government in order that our planning and our Plan are developed and submitted through a process which supports our progress. The development of the IMTP has, to date been undertaken on the basis of a national December submission deadline. However, Welsh Government issued a letter on 21st August 2019 (Appendix 1) advising that the deadline for submission was being revised and would now be the 31st January 2020. The rationale for this change is described as a culmination of a number of issues as described below:

'The timing of Brexit and the potential for contingency planning to impact on the production of IMTPs; financial uncertainty associated with Brexit; and the forthcoming introduction of the NHS Executive which will also draw upon planning capacity within Welsh Government. Individually we recognise that these matters could be managed, but together they represent risks that Welsh Government feels can best be mitigated by delaying submission for this year'.

The letter states that the deferment of the submission is intended to '*offer NHS organisations the space to balance and manage the collective issues ahead of submission'.* In response to this letter, the Senior Leadership Team (SLT) on 4th September agreed to continue with the Plan development process as previously set out with the following submission and approval dates:

- 26th September – Board Emerging Plan - Discussion

- 28th November – Board – Draft Plan - Approval
- 30th January – Board – Final Plan - Approval
- 31st January – Welsh Government – Final Plan Submission

The intention is to share our Whole System Plans for the period 2020/21-23 informally with Welsh Government in September following discussion on progress with the Board. This will allow ample time for discussion and engagement with Welsh Government to improve the approvability of the Plan prior to formal submission.

The key steps for plan development are set out in more detail below:

- **By end of April - Setting the Direction** – the Executive Team confirmed the strategic direction for the next 3-5 years using the Enabling Objectives in our Organisational Strategy.
- **By end of June - Defining the Journey –** Development of Whole System Plans for key system areas across the Health Board in alignment with the Clinical Service Plan.
- **By end of August - Planning Delivery** – Delivery Unit and corporate teams to be supported to collaboratively develop operational and performance delivery plans to deliver the Whole System Plans and refine the plans through developing enabling plans for Workforce, Quality, Digital and Finance.
- **By end of November – Review and Refine –** Development of detailed workforce and financial plans and engagement on digital and capital plans. Review of plans and integration of content through engagement across the Health Board and with Welsh Government colleagues in preparation for submission of a final draft to Board in November. Assess whether the Plan is approvable, based on Welsh Government and Performance and Finance Committee advice and submit to Board with recommendations as to the status of the final submission to Welsh Government.
- **By end of January - Finalise the Plan** – Finalise the detailed service, finance and workforce plans to ensure the Plan is integrated and approvable (if a full IMTP is being submitted). We are clear that we are not working solely to develop a plan within a strict deadline, however, we also wish to maintain momentum and build on the significant progress that has already been made. The Executive Board, and Health Board will need to determine at an appropriate point whether an IMTP is being submitted, or whether an Annual Plan will be prepared for 2020/21.

2.2 Whole System and Unit Plan Development

The aim of developing Whole System Plans has been to have clear overarching plans, including the Clinical Services Plan priorities, which set out Health Board-wide aims for the development and improvement of key systems in line with the Health Board's strategic direction. The whole system plans have also been developed to ensure that there is a greater emphasis on improving population health objectives and core immediate prevention objectives have been set for each unit to meet through their unit Plans. The Whole System Plan service areas align with the NHS Wales Planning Framework and form the basis of the IMTP document chapters. This approach is a

decisive move away from the previous Unit-based planning process and enables much wider engagement with clinical teams than in previous years. Whole System Plans were developed for the following areas and are attached for Board approval:

- Unscheduled Care
- Planned Care
- Cancer
- Stroke
- Children and Young People
- Maternity Services
- Mental Health and Learning Disabilities

Other key areas such as primary and community services, partnership working, digital and prevention will be developed into Whole System Plans working from the unit plan contributions due to the cross-cutting nature of these areas.

The Executive Team agreed overarching Whole System Plans on 31st July. The Whole System Plans with accompanying guidance and templates were issued across the organisation for Unit and corporate teams to develop responding plans. The Planning team have been active in supporting Unit and corporate IMTP leads to develop their plans over the summer period. The Unit Plans were presented at the IMTP Workshop on 6th September and drafts were submitted on 10th September and will be followed by Unit Plan meetings which focused on understanding the detailed financial and workforce implications of the plans. Analysis of the interdependencies and risks will be undertaken and proposals for prioritising the plans are being worked up.

The Whole System plans are included as Appendix 2 for Board approval.

2.3 Quality Assurance

Quality assurance formed part of both the IMTP Workshop presentations and the detailed planning meetings. This recognises the vital importance of assuring that the agreed Quality Priorities of the Health Board are being delivered through the plans and the quality impact has been reviewed.

As part of assuring quality, the Whole System Plans will be reviewed by the Quality Forum in a facilitated session led by the Planning team. Detailed Quality Impact Assessments will be undertaken when appropriate as detailed financial savings plans are developed.

2.4 Addressing Organisational Risk

Ensuring plans address the Health Board's and Unit risks is a key part of developing the plans. The Risk Management Group Workshop on 23rd September reviewed the plans through the lens of the Health Board and Unit Risk Registers in order to ensure alignment and identify gaps. This is a significant step forward in strengthening our plans and integrating our planning processes with our Risk Management approach.

2.5 Emerging Three Year Plan Document

The Health Board has received positive feedback from Welsh Government Planning colleagues on its approach to developing the Plan and it is important to continue to meet Welsh Government requirements whilst demonstrating delivery of the Health

Board's Organisational Strategy. The plan outline builds on the plan developed for 2019/20 whilst also strengthening the detailed delivery plans sitting behind the narrative document.

At the time of writing this paper the National IMTP and National Planning Framework have not been issued by Welsh Government, and are expected in week commencing 16th September. These documents will however be closely reviewed in order to ensure that the Health Board's Plan continues to reflect and respond to national guidance and requirements.

Following the Board Development session in May at which the Board considered its approach to the Wellbeing of Future Generation Act, it is imperative that the IMTP also demonstrates the Health Board's commitment to delivering its wellbeing objectives and the National Wellbeing Goals. The proposed outline content of the IMTP for 2020/21-2022/23 will do this and will reflect the Health Board's aim to deliver through implementing the Sustainable Development Principle.

The Plan also includes the following:

1. Setting out the three, five and 10 year outcome statements – these set out how the IMTP delivers the long term strategy of the Health Board.

2. Alignment of delivery to Wellbeing Objectives and the National Wellbeing Goals –sets out a proposed approach to illustrating alignment to the National Goals. A highlight summary is included in each section of the IMTP setting out how our Enabling Objectives contribute to the National Wellbeing Goals and our Wellbeing Objectives. The Alignment is set out in Appendix 3.

3. Demonstrating delivery of the Sustainable Development Principle – Each Enabling Objective section of the plan will include a brief description of an example of the way in which the Health Board is delivering the sustainable development principle and the five ways of working.

4. Demonstrating Commitment to a Green Future –This year's plan includes a section specifically detailing the Health Board's environmental and sustainability actions. The Health Board has in recent years delivered and is planning to deliver significant 'green' projects and these should be shared and celebrated through the IMTP to demonstrate our commitment to this issue.

The IMTP 2020/21-22/23 includes focused content that describes the key actions and implications of the Whole System Plans whilst including the Whole System Plans themselves as appendices. The Whole System Plans will provide all the necessary details of the actions, milestones, measures and the associated financial, workforce and digital implications.

The content remains under development and in some instances has not been signed off as Senior Leadership or Executive level. The indicative content has been provided

to Board members via iBabs for information and to demonstrate the development and progress to date. Drafting notes are included to highlight the further work to be undertaken.

2.6 Next Steps

Whole System and Unit Plans

The Whole System and Unit Plans will be developed further with a focus on Quality and alignment to Health Board risk. More detailed work will also be undertaken in terms of financial and workforce implications. These implications will be developed in further detail to inform the Financial Plan and Workforce Plan.

Units will further refine their plans including detailed milestones for delivery. The Whole System Plans will also be refined where appropriate.

Enabling Plans and Partnership Plans

The whole system plans for enabling areas will be further developed:

- The Digital Plans will be reviewed in light of the implications of the Unit Plans and refined. A Digital health and Wellbeing Plan and a Digital Care Plan will be developed as a result setting out the Health Board wide approach to Digital improvements and innovations.
- The Plans for Co-Production and Health Literacy and Partnerships for Health and Wellbeing will be further developed alongside a longer term plan for strengthening our approach to prevention and population health and wellbeing.
- The Health Board is continuing to fulfil its commitments to working with partners across a wide range of statutory partnerships and associated working groups to address key issues. In particular, the Health Board is contributing to each Public Service Board (PSB) and as part of the governance reviews undertaken in 2018 a commitment has been made by Swansea Council, Neath Port Talbot CBC and the Health Board to revise arrangements and streamline the Regional Partnership Board and Public Services Boards structures going forward. There are a number of workstreams which run across the area under the auspices of the individual PSBs, for example Early Years and it has been agreed that where possible single planning and delivery arrangements will be established. This work will be incorporated into and aligned with our Plan for Partnerships for Health and Wellbeing.
- The Regional Clinical Service Plan will form the basis for a significant part of the Partnerships for Care Plan.
- Work will be undertaken to develop the Research, Innovation, Education and Learning Plan.

Cluster IMTPs

Primary Care Clusters have this year, for the first time been required by Welsh Government to develop Cluster IMTPs. Welsh Government have made clear that the alignment of Cluster IMTP and Health Board plans are integral to future planning. As stated by Andrew Goodall:

"*A Healthier Wales set out the need to accelerate the implementation of the Primary Care Model for Wales. Clusters are the underpinning delivery model for this and there*

is a need to ensure they are core and central to our system in terms of planning and delivery."

The primary and Community Care Services Team and the Planning Team will continue to work closely to ensure that the development of these plans is fully supported and that they are developed in alignment with the Health Board's IMTP and CSP.

Workforce Plan

Additional technical templates have been developed and will be completed during October working with the Units and corporate teams in order to develop the detailed workforce plan. The broader workforce plan is being developed in alignment with the Health Board's Workforce and OD Framework.

Financial Plan

The financial plan details will be developed during October and November and finalised prior to the January Submission. This work will be undertaken alongside the units and with the external financial support secured by WG.

Performance Trajectories

Updated performance trajectories for 2020/21-2022/23 will be developed during October and November in alignment with the developing financial context and the in-year performance and delivery.

Value Based Healthcare

The Health Board is embedding a Value Based Healthcare (VBHC) approach as an underpinning ethos to deliver the Clinical Services Plan and IMTP, with specific schemes also aligned to CSP priority areas. The VBHC team are also engaged in priority areas highlighted in the national Efficiency Framework (and CSP efficiency assumptions), particularly around reducing variation. Work will be undertaken in early October to ensure that the Value Based Healthcare Programme is incorporated into and visible within the Health Board's Whole System and Unit Plans.

Three Year Plan Document

The narrative content will be further developed, reviewed and signed off by Executive Leads prior to submission to the Board in November. Summary descriptions of the Plans and implications will be included in addition to the content demonstrating the delivery of the Sustainable Development Principle and additional content where appropriate on patient and staff experience.

Welsh Government Engagement

Engagement with Welsh Government colleagues will continue in order to ensure continued confidence in our processes and progress in developing an approvable IMTP. Direct engagement with Policy leads will be established alongside planning, finance and workforce engagement.

The Clinical Services Plan

2.7 Pace of progress to deliver our CSP

Significant progress has been made in securing clinical leadership and available corporate support for the majority of the CSP year one projects and with putting in place processes and ways of working to manage CSP planning and delivery.

The Strategy Directorate has re-aligned planning capacity to CSP priorities, however some significant priority areas including planning and project management for the Acute Care Model development remain a gap. Additionally gaps exist in;

- Equality Impact Assessment and Quality Impact Assessment
  - *to impact assess our delivery plans*
- Programme and Project Management
  - *to develop delivery plans to create the CSP critical path*
- Financial and Data Analysis
  - *to enable benefit assessment and CSP programme business case development*

In June 2019 Transformation Board members considered a Transformation Portfolio Resource Assessment describing capability and capacity gaps to deliver transformation, including the CSP. A decision regarding how to proceed in securing this additional resource is awaited.

2.8 Sustaining Clinical Engagement

One of the key lessons learned from 'Changing for the Better' was the importance of having a clinical led CSP with highly engaged clinicians driving and informing delivery.

The Health Board supported two CSP Clinical Leadership Events, held in June 2019 with the Advisory Board Group (ABG). The two events were well attended and the clinical community highly engaged. The clinicians identified the need to continue this Swansea Bay approach (CSP MDT) to bringing together clinicians from across professional groups and Delivery Units to share exemplars, new pathways, models of care or ways of working and to drive clinical delivery of the CSP.

Ideas from the two June events have been taken forward by clinicians including successfully securing Welsh Government funding (£108k) to deliver a clinically led ADOPT (Action to Deliver OutPatient Transformation) project.

A number of clinicians have nominated themselves to be part of a small group to look at a future Acute Care Model and also, as suggested by the ABG, visit the Royal Stoke Hospital to learn about their acute care transformation.

To make the CSP MDT successful it is imperative that all sectors of our clinical community are involved, including primary care colleagues. Additionally the ability to resource clinical presentations from other health boards and visits to exemplar sites, also needs to form part of the CSP MDT approach.

2.9 Clinical Service Decisions

There are a number of established routes, for example, Investment and Benefits Group, Service Improvement Boards or individual unit accountabilities, for service change or investment decisions. The need for a focus on transformational change and delivering the clinical services plan suggests a need to further consider how these existing routes align decision making with the broader strategic direction.

The organisation is also in the process of transitioning towards new arrangements including;

- New programme and project arrangements to deliver the CSP
- A refresh of our Improvement Boards
- A review of decision making to provide greater clarity and transparency around the governance framework
- Development of a SBUHB Target Operating Model

The delivery mechanisms for the CSP have been strengthened since its agreement by the Board in January 2019. Some existing groups have been repurposed e.g. the respiratory health improvement group is now the Respiratory CSP Clinical Redesign Group, and overarching structures established e.g. CSP Programme Board to drive delivery of the CSP. These groups will have a role in clinical service change decisions. Over time, it is likely that the Clinical Leads for the CSP will also expect to have a voice in how funding decisions are made in line with the strategic plans, including the submission of bids against external funding sources.

A set of interim service change principles have been approved by the CSP Programme and Transformation Boards. These will improve transparency and strategic alignment of service change decisions whilst new Health Board mechanisms are developed for approval.

2.10 CSP Strategic Programme Business Case

Since approving the CSP the year one 'critical path' has been developed and work initiated to deliver the associated programme and project plans for this. The focus has been primarily on year one work packages aimed at either delivering previously agreed models of care e.g. COPD community services or scoping future options for new models of care e.g. surgical and acute care.

It will be necessary for the Health Board in due course to make decisions regarding these future models of care. To ensure such decisions support a sustainable future healthcare system it will be essential to ensure that the benefits, risks and interdependencies of each option are considered.

Welsh Government and H M Treasury recommend development of a Strategic Programme Business Case (PBC) to support reaching robust business decisions. Therefore work to develop the full five year 'critical path' will be linked to the development of the CSP Strategic Programme Business Case.

The CSP Programme Board considered an outline approach to developing a CSP Programme Business Case in September 2019. The approach will require external

support to be secured at varying stages of the process to bring in specific Strategic Programme Business Case expertise and enhance existing Health Board skills. An initial timeframe for the approach was outlined as;

- Agree development of a CSP PBC and approach : ***September 2019***
- Agree management and governance PBC arrangements: ***September 2019***
- Secure external facilitator for Strategic Case Workshop: ***End September 2019***
- Scope workshop outline with external facilitator, agree audience, prepare key information re PBC scope, objectives, benefits, risks, constraints and dependencies using principle of 'best available'***: End of October 2019***
- Host Strategic Case Workshop: ***November 2019***
- Confirm/approve the core projects and activities, for the 'critical path' to form the five year programme plan and commence option development for the initial priorities: ***End November 2019***

2.11 Aligning CSP, capital and regional CSP plans

Swansea Bay and Hywel Dda University Health Boards have jointly developed a Regional Clinical Services Plan (RCSP), which was approved in draft by the Joint Regional Planning and Development Committee on 21st August and will be sent for approval through both Board's as part of the IMTP process. The RSCP describes our shared intentions for collaborative working to deliver our respective Clinical Services Plan and Strategy.

One of the key enablers to delivering the CSP and future development of services on the Morriston site is submission of a full planning application for a new road infrastructure at junction 46 of the M4 into the Morriston hospital site. This is due to be submitted August 2020. The current outline programme to develop route options and undertake detailed design is as follows:

- Savills initial recommendations regarding land – mid July 2019
- Appoint team for next stage of work by end July 2019.
- Complete design, surveys and preparation of planning application by end April 2020
- PAC running through May, June and July 2020
- Planning submission August 2020 with decision by March 2021
- Land acquired by July 2021
- Procurement of contractor/detailed design and pricing letting contract between Sept 2020 to May 2021
- Construction (of road) June 2021 to November 2022.

The development of a SBUHB Estates Plan will need to be aligned to the Morriston Road plans as well as delivery of the CSP and RCSP ambitions.

The Transformation Board approved a proposal to establish a new CSP Infrastructure Implementation Group as part of the Transformation Portfolio enabling programme. The group will oversee the work required to progress and align the Morriston road and

master plan for the whole Morriston Health Campus and the SBUHB Estates Plan with RCSP and CSP.

2 GOVERNANCE AND RISK ISSUES

- **An Approved Annual Plan 2019/20** - It is important that the Health Board develops a credible Annual Plan 2019/20, which can be endorsed by the Board and Welsh Government in order to ensure a solid foundation from which to build. Welsh Government has indicated that key concerns remain around unscheduled care and financial performance. *Mitigation: The conclusions of the Bridgend arbitration process have been received and the Annual Plan has been updated accordingly. The Annual Plan 2019/20 will be submitted to Board for approval in September and consequently submitted to Welsh Government.*
- **Delivery in 2019/20 –** Future plans are reliant on delivery in 2019/20 in particular in relation to performance and quality targets and financial savings. *Mitigation: The performance management arrangements for delivery of the Annual Plan in 2019/20, have been strengthened into a fortnightly "battle rhythm" and with enhanced reporting to Performance & Finance Committee. Additional mitigations include the development of an internal multi-disciplinary Delivery Team, which is being progressed as a priority to drive improvement. It also includes the external financial support as referenced above.*
- **Timetable –** Developing an approvable IMTP will require significant work within a limited timescale. *Mitigation: A detailed project plan has been developed to deliver the IMTP. Every effort is being made to align processes across the Health Board, however if required specific mechanisms and activities will be arranged to ensure planning activities are undertaken in line with the approval timescale. The Welsh Government have extended the formal submission deadline to January 2020, however the SLT have agreed to proceed with developing a draft for the Board in November.*
- **Refining the Financial Framework –** The Health Board developed a clear methodology to support the 19-20 Draft Plan, building on recommendations from the Financial Governance Review and WAO Structured Assessments. However, this needs further refinement, particularly on our approach to savings identification and delivery and on a financial appraisal of the Clinical Services Plan. *Mitigation: The new Value & Efficiency Group is taking a longer term and more structured approach to identifying benchmarking and efficiency opportunities, and the emerging work programme is intended to inform the development of the IMTP financial plan. As mentioned above, the external financial support being commissioned by Welsh Government will provide targeted resources to consider a pipeline of future opportunities. The forward financial model is being developed to move beyond the traditional focus on core income and operating expenditure. This will include a more targeted approach to generating allocative value and the shifting of resources, with an initial focus on the ensuring the sustainability of proposals funded via the Transformation Fund. It will also include, a more comprehensive assessment of opportunities for income generation, as well as the affordability (and required investment) of key projects within the Clinical Services Plan.*

- **Planning Capacity –** Support will be required for planning (workforce, finance and service) at each stage aligned to the Whole System Plans and Transformation Portfolio Programme Boards and to support Delivery Unit planning in order to ensure plans are integrated, aligned and of appropriate quality. *Mitigation: The potential structures to enable service planning support to units and across Whole System Plans have been considered and support for specific areas has been agreed within the Strategy department structure. However there remain gaps in key areas, including service, workforce and financial planning, programme management Equality Impact Assessment and the resources for Acute Care Model Programme Management.*

- **Resource Gap -** Pace of CSP critical path development is dependent on detailed project level plans. Project planning and delivery is currently impeded due to capacity constraints and gaps in some key roles; e.g. acute care planning, equality impact assessment. Transformation resource assessment does not now fully describe cost of *CSP clinical engagement. Securing additional resource and recruiting to post will take time, impeding progress. *Mitigation: agree approach to reaching a decision on transformation resource assessment. Consider recruiting at risk to some posts. Full risk assessment of impact of no additional funding*

- **Clinical Engagement -** The CSP is premised on clinical leadership and engagement as key to successful delivery. The CSP clinical leadership events have been highly engaged and generated good ideas. Funding is required to sustain the events, GP engagement and clinical confidence in our commitment to their engagement. *Mitigation**:** minimise associated costs with as much in-house resource as possible. Identify annual cost of CSP clinical engagement for inclusion in transformation resource assessment*

- **Clinical** Engagement - Clinicians are stepping into the Acute Care Model development space. Securing planning and project capacity is crucial to maintaining and developing this engagement. *Mitigation: recruit at risk to key posts, agree approach to securing transformation portfolio resource.*

- **CSP Programme Business Case -** Will require significant planning and finance management time. Development of the critical path is directly linked to the PBC. Benefit evaluation will be required this is currently unfunded and included in the Transformation Resource Assessment. External expertise will be required *Mitigation: recruit at risk to key posts, agree approach to securing transformation portfolio resource, and incorporate PBC external resource into transformation portfolio resource assessment.*

3 FINANCIAL IMPLICATIONS

The core financial objective is to develop an IMTP that delivers a sustainable breakeven position. While the UK Government has now provided confirmation of the overall funding increase to the Welsh Government budget for next year, we are still awaiting confirmation of the timing and process for the Welsh Government 2020/21 Draft and Final Budgets and the release of any financial planning assumptions to support the development of IMTPs. The Health Board's initial assumptions to guide the development of the Whole System and Unit Plans have included the rolling forward of budgets and the intention that savings not yet met

recurrently will be recovered and delivered recurrently from next year. Units are working towards a notional 2% CIP. Current high level assumptions also include that any reshaping of the workforce, to staff numbers and skill mix, must be carried out via existing resources and that funding to support developments must be from confirmed sources. These assumptions will be further matured over the coming weeks to support more detailed planning work, and will reflect any national guidance.

The Transformation Portfolio Resource Assessment is being undertaken to address a range of resource gaps, some of which contribute to the development of CSP plans and processes which will need to be represented in the IMTP. The risk assessment outlines these urgent gaps.

4 RECOMMENDATIONS

Members are asked to:

- **NOTE** the progress in developing the Health Board's Three Year Plan 2020/21-22/23
- **APPROVE** the Whole System Plans;
- **ENDORSE** the approach to the emerging plan content and structure;
- **NOTE** the progress made in delivering the CSP;
- **ENDORSE** the arrangements to address the issues in delivering the CSP; and
- **CONSIDER** the financial implications identified for delivering the CSP

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

A Quality Impact Assessment and Equality impact Assessment process will be part of the broader planning arrangements in 2019/20 to ensure that the IMTP is Quality and Equality impact assessed.

Financial Implications

Financial Planning will be fully integrated into the planning process for 2019, and aligned to key developments and enabling plans. The intention is to move into recurrent financial balance from the start of the IMTP, with a financially sustainable operating model.

Legal Implications (including equality and diversity assessment)

A Quality Impact Assessment and Equality impact Assessment process will be part of the broader planning arrangements in 2019 to ensure that the IMTP is Quality and Equality impact assessed. An approved medium term three year plan is a statutory duty for the Health Board.

Staffing Implications

The planning process for 2019 will include strengthened workforce planning including the involvement of the newly established Workforce and OD Forum.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The Clinical Services Plan and IMTP deliver our Strategic Objectives which were aligned to our Wellbeing Objectives through the development of the Organisational Strategy.

- **Long Term** – The proposed approach to the IMTP ensures alignment with the long term vision of the Health Board as set out in the Organizational Strategy.
- **Prevention** – The development of the IMTP and the Planning Framework ensure risks and challenges and health needs (current and future) are considered enabling actions and plans to be preventative wherever possible.

○ **Integration** – Key to integrated planning is the link and alignment of actions across wellbeing objectives. ○ **Collaboration –** Central to the approach to developing an IMTP is the integrated approach across services, units and partner organizations. ○ **Involvement –** The IMTP development approach includes active involvement of partners.	
Report History	The report has previously been discussed by SLT on 4th September
Appendices	Appendix 1: WG Letter regarding Submission Deadline of IMTPs Appendix 2a, 2b, 2c, 2d, 2e, 2f: Whole System Plans Appendix 3: FGA Alignment

Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

NHS Directors of Planning

Our Ref: SSE/Eng 2

21 August 2019

Dear Colleagues

Submission of IMTPs and Annual Plans

I wanted to write to you at the earliest opportunity following the NHS Wales Executive Board meeting yesterday where Chief Executives were notified that the submission date for the 2020-23 IMTPs will be deferred until January 31st 2020.

This decision has not been taken lightly and has been based on a number of issues that cumulatively have the potential to impact on the integrated planning system both in the NHS and in Welsh Government. These issues are various and include: The timing of Brexit and the potential for contingency planning to impact on the production of IMTPs; financial uncertainty associated with Brexit; and the forthcoming introduction of the NHS Executive which will also draw upon planning capacity within Welsh Government. Individually we recognise that these matters could be managed, but together they represent risks that Welsh Government feels can best be mitigated by delaying submission for this year. The submission date will revert to December 2020 for the 2021-24 planning round.

I recognise the commitment that has been demonstrated in your organisations to develop plans for December deadline and your support for the engagement arrangements. This has been a considerable effort and I would like to thank you and your teams for embracing the requirement for earlier submission. The deferment of the submission is intended to offer NHS organisations the space to balance and manage the collective issues ahead of submission. I know a great deal of work has already been done and hopefully this stands all organisations in good stead for a January 2020 submission.

On this basis, I have also taken the decision to convert the meetings scheduled for September to informal engagement meetings rather than the formal planning meetings with Simon Dean. This will provide an opportunity for us to discuss any risks or issues and to answer any questions in relation to this decision.

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In the meantime, we maintain our commitment to issuing the NHS Planning Framework earlier than in previous years, which will also be accompanied by the National IMTP, to assist in providing clarity on context, direction and priorities. We also remain open to receiving plans earlier if they are ready and have been approved through your Board processes.

Thank you for your ongoing support and please do not hesitate to contact the planning team or myself if you wish to discuss this matter.

Yours sincerely

Samia Saeed-Edmonds
Planning Programme Director

cc: Assistant Directors of Planning
Simon Dean, Deputy Chief Executive, NHS Wales
Patricia Harper, Head of NHS Strategic and Operational Planning, Health & Social Services Group

SYSTEM	PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION
	1 Preventing Cancer	**I don't smoke** **I understand so I make good decisions (Support me - digital)** **I'm given every opportunity to eat well** **I'm given every opportunity to exercise regularly** **I have access to support and advice and information** **I consume alcohol responsibly**	Smoking Cessation Services and advice, information are easily accessible	CAN_1_1	Help me quit campaign
				CAN_1_2	Smoking cessation services widely available
				CAN_1_3	No smoking culture on sites
			Every contact with the health service is an opportunity to reinforce healthy lifestyle behaviours	CAN_1_4	MECC is embedded across all tumour sites
				CAN_1_5	Brief intervention embedded across all tumour sites
			Vaccinations	CAN_1_6	Vaccination programme for HPV
			Information and advice made available digitally	CAN_1_7	PKB - Directed information and support
			Self care - medicines management	CAN_1_8	Digital Forums /groups/support/coaching
			Target health inequalities	CAN_1_9	Needs assessments and targeted intervention
				CAN_1_10	Focus on early years healthy behaviours
	2 Detecting Cancer Early	**I know what to look for and self check** **I have access to screening and attend my screening appointments** **I present early to health services as soon as I have concerns** **I want my health care provider to respond quickly and refer me appropriately** **I know what to expect and feel supported** **I am tested quickly when appropriate** **I was diagnosed early**	Access to Information on how/why to check	CAN_2_1	Awareness Campaigns - National
			Promote and target screening	CAN_2_2	Understand screening processes/management
				CAN_2_3	Consider role within MECC
			GP /Optician access	CAN_2_4	Gap training
				CAN_2_5	Implement Primary Care Quality toolkit
			Virtual presentation?	CAN_2_6	Explore opportunities for Virtual self presentation
			Information and support available	CAN_2_7	Primary Care Key Worker to be available within resources
				CAN_2_8	Information and expectation of pathway
			Rapid Diagnosis Centre	CAN_2_9	Expansion of RDC service where possible within resources
			Straight to test	CAN_2_10	One stop shop diagnosis processes for all tumour sites - prioritise lung and breast cancer pathways
				CAN_2_11	Demand and capacity modelling
				CAN_2_12	Improved communication between Primary & Secondary Care
			FIT Testing	CAN_2_13	Implement FIT Testing
			MDT & Outpatient Appointments	CAN_2_14	Implement optimal pathways
				CAN_2_15	Undertake annual assessments of MDT functionality and support and challenge MDT Leads
				CAN_2_16	Developing & implement consistent and efficient HB protocols
			Precision medicine and modern technology	CAN_3_1	NICE guidelines
				CAN_3_2	Access to Clinical trials
				CAN_3_3	Cancer centre - up to date equipment
			Surgical model	CAN_3_4	Demand and Capacity modelling for treatment
				CAN_3_5	Ensure Gynae oncology model is fit for purpose post-Bridgend transfer
				CAN_3_6	Maximise regional opportunities
				CAN_3_7	Improve service resilience (workforce)
			Prehabilitation	CAN_3_8	Develop and implement model for prehabilitation
			Peer review	CAN_3_9	Ensure JACIE accreditation is maintained for BMT
				CAN_3_10	Participate in Peer Reviews
				CAN_3_11	Implement action plans

CANCER SERVICES	3 Delivering Fast Effective Treatment and Care	**I get the treatment and care which are best for my cancer, and my life (most effective treatment)** **I received treatment quickly and safely** **I receive treatment in the most appropriate setting, close to home as clinically safe and appropriate** **I am supported and have the information I need and I am aware of and am doing the things I need to do to support myself through treatment** **I am treated with dignity and respect** **I know what I can do to help myself and who else can help me**	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
			Implement the Non Surgical Cancer Centre Strategy	CAN_3_13 – Develop and improve the infrastructure of the SWW Cancer Centre CAN_3_14 – Ensure demand/capacity is in balance for chemotherapy and radiotherapy CAN_3_15 – Implement a mobile PET-CT scanner CAN_3_16 – Develop a business case for WHSSC for a fixed PET-CT service for the SWW region CAN_3_17 – Continue replacement of LINACS CAN_3_18 – Plan to move to Morriston in line with the CSP CAN_3_19 – Maximise capacity for ambulatory chemo CAN_3_20 – Maximise benefits of surgical re-design CAN_3_21 – Acute oncology services - MSCC pathway CAN_3_22 – Demand and Capacity modelling for treatment CAN_3_23 – Prepare a business case for WHSSC to consider for Unit expansion
			Provide chemo /haematology at home/outreach/alternative settings in line with the Strategy and the CSP (My Home First)	CAN_3_24 – Improve nutritional screening within MDTs and earlier in the pathway within resources CAN_3_25 – Pump primed posts for H & N services where funding available.
			Bone marrow transplant	CAN_3_26 – Improve access to video-fluoroscopy
			Nutrition	CAN_3_27 – Improve rehabilitation within resources CAN_3_28 – Provide Macmillan cancer service and support service pods CAN_3_29 – Improve access to services e.g. dieticians where possible within resources
			Access to information, support and advice	CAN_3_30 – Provide remote monitoring/PKB CAN_3_31 – Expansion of key worker model to multi-disciplinary teams CAN_3_32 – Improve access to Clinical Nurse Specialist within resources
	4 Meeting People's Needs	**My concerns are identified and addressed** **Those around me are well supported** **I can enjoy life** **I feel part of a community and I'm inspired to give something back** **I'm treated as an individual**	Access to information and support	CAN_4_1 – Cancer Alliance (Third Sector) CAN_4_2 – Key worker CAN_4_3 – Offer of HNA
			Mental health and wellbeing	CAN_4_4 – Education patient programme Cymru CAN_4_5 – Hope CAN_4_6 – CISS CAN_4_7 – Maggie's CAN_4_8 – Tenovus CAN_4_9 – Complimentary therapies CAN_4_10 – TYA (teenager and young g adults with cancer)
			Concerns and Complaints	CAN_4_11 – Improve process for addressing concerns and implementing actions

				PROMs / PREMS		CAN_4_12	Implement PROMS & PREMS on a rolling programme
				Treatment Summaries		CAN_4_13	GP Cancer Care review
						CAN_4_14	Interface and communication between secondary and primary care

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Unscheduled Care	1 Helping people choose and live well	**I don't smoke** **I'm given every opportunity to eat well** **I'm given every opportunity to exercise regularly** **I am protected against flu** **I consume alcohol responsibly** **I understand so I make good decisions** **I have access to support and advice and information**	Target Prevention Priorities	USC_1_1	Actively promote to all staff and patients at higher risk from influenza
				USC_1_2	Adopt a tobacco control approach to smokefree health board premises
				USC_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
				USC_1_4	Adopting approaches that develop health literacy
				USC_1_5	Taking action aimed at obesity
			Develop Community resilience and Wellbeing	USC_1_6	Implement the Neighbourhood Model
				USC_1_7	Establish Wellness Centres
	2 Helping people with vulnerabilities, learning disabilities or stable long term conditions to support themselves and 3. Supporting people to remain as independent and well as possible when they have more complex needs	**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_2_1	Implement risk stratification approaches to cohorts of vulnerable people to remain at home with the appropriate levels of care and support, implemented through the Cluster Transformation Model
				USC_2_2	Implement new pathways for Respiratory Health through the New Cluster Model
				USC_2_3	Implement new pathways for Heart Failure through the New Cluster Model
				USC_2_4	Implement new pathways for Diabetes through the New Cluster Model
				USC_2_5	Evaluate and agree recommendations regarding Care and Repair Scheme
				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.
				USC_2_7	Work closely with WAST to ensure appropriate triage preventing hospital admission
				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
				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
			Reducing Unnecessary hospital attendance	USC_2_10	Evaluate and agree recommendations regarding Care and Repair Schemes
				USC_2_11	Develop a Single Point of Access for urgent care needs
				USC_2_12	Improve diagnostic access within the community to prevent admission within existing resources
				USC_2_13	Implement fall response vehicle with WAST (funded through EASC A Healthier Wales monies)
				USC_2_14	Continue multi-agency approach to manage frequent attenders
	3 Providing the right type of rapid response, care	**I can get an urgent GP appointment when needed** **I am provided with care and treatment as close to home as possible** **I am communicated with effectively with regards out of hours visits, ambulance response and treatments** **I am treated and discharged quickly and efficiently when appropriate**	Strengthen urgent care in the community	USC_3_1	Continue remodelling of multi disciplinary primary care out of hour services
				USC_3_2	Implement Acute GP unit triaging from live ambulance stack (if funded)
				USC_3_3	Continue to maximise use of 111
			Improving ambulance handovers at hospital front door	USC_3_4	Test feasibility of decontamination unit holding to release ambulance subject to agreement on protocols
				USC_3_5	Implement the Ambulance Liaison role if funded
				USC_3_6	Implement recommendations of the process mapping ambulance handover exercise
			Improving patient care and managing demand at the hospital front door	USC_3_7	New pathways from Emergency Department to be explored for a Mental Health Distress Sanctuary
				USC_3_8	Improve rapid access to assessment for CAMHs patient through commissioning approaches
				USC_3_9	In line with the CSP, standardise the front door Frailty Model, standards of care and ways of working on all sites
				USC_3_10	Comprehensive Geriatric Assessment embedded across hospital pathways

3	support at times of crisis	**I am treated and discharged quickly and efficiently when appropriate** **I have easy access to advice and support for my mental illness or emotional distress** **I am seen by and treated by the right professionals quickly in relation to my mental health needs**				USC_3_11	Respond as appropriate to the NCCU ED Quality and Delivery Framework
						USC_3_12	Progress Kendal Bluck work on ED rotas
				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%
						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
						USC_3_15	Continue to develop Hot clinics at both admitting sites including AMAU, Vascular & #NOF Pathways
						USC_3_16	Improve choice for patient and care at end of life at front door
						USC_3_17	Improve Psychiatric Liaison Service to meet national standards
	4 Providing the best bed based care when needed, but only for as long as it is of benefit	**I am treated holitically with an understanding of my complex /multiple chronic conditions** **I am treated and cared for by one team not multiple services** **I am transferred to a bed in a reasonable time following admittance** **I am treated with dignity and respect** **I am treated in a safe and clean environment** **I am dishcarged wth the appropriate services in place so that I can live at home supported and safe** **I am discharged home or to my place of care as soon as I am medially fit** **I receive the medicines and treatement I need for on going treatment on discharge**		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
						USC_4_3	Reduce LoS with sustainable improvement over the period of the IMTP in line with the CSP Scenario C efficiency assumptions
						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
						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
						USC_4_6	Explore digital mobilisation in hospitals to develop documentation that is transferable across all parts of the patient pathway
						USC_4_7	Implement actions to delivery CSP scenario C Length of Stay efficiencies
						USC_4_8	Reduce harm from inpatient falls
						USC_4_9	Reduce Pressure Ulcers
						USC_4_10	Reduce incidence of HealthCare Acquired Infections
						USC_4_11	Improve choice for patient and care at end of life
				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
				Improving timeliness of discharge		USC_4_13	Implement the Trusted Assessor model across Swansea Bay
						USC_4_14	Implement the John Bolton Hospital 2 Home Model including a reablement recovery service
						USC_4_15	Explore opportunities for implementing Early supported discharge for specific conditions where opportunities from economies of scale exist
						USC_4_16	Standardising data capture on ready for home patients through roll out of the Singleton live system
	5 Helping people to recover and rehabilitate when leaving hospital after a serious illness or injury	**I am supported to get out and about and feel part of society and valued once I've recovered** **I am given and have access to the information I need on what support is available to me if changes become permanent** **I have access to the information, advice and support I need as a carer when they are discharged**		Ensuring ongoing care and support following discharge from hospital		USC_5_1	Ensure Hospital to Home reablement and recovery service is right sized
						USC_5_2	Ensure use of reablement in residential step down beds is maximised
						USC_5_3	Continue to work through partnership arrangements to rightsize capacity for domiciliary care and longer term residential care
				Develop Community resilience and Wellbeing		USC_5_4	Implement the Neighbourhood approach
						USC_5_5	Establish Wellness Centres

SYSTEM	PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION
	1 Preventing Stroke	**I don't smoke** **I'm given every opportunity to eat well** **I'm given every opportunity to exercise regularly** **I am protected against flu** **I consume alcohol responsibly** **I understand so I make good decisions** **I have access to support and advice and information**	Target Prevention Priorities	STK_1_1	Actively promote to all staff and patients at higher risk from influenza
				STK_1_2	Adopt a tobacco control approach to smokefree health board premises
				STK_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
				STK_1_4	Adopting approaches that develop health literacy
				STK_1_5	Taking action aimed at obesity
			Develop Community resilience and Wellbeing	STK_1_6	Implement the Neighbourhood Model
				STK_1_7	Establish Wellness Centres
	2 **Pre Hospital**	**I recognise the symptoms of stroke and I know where to go and what to do** **I'm given the right support, and am kept informed about what's going to happen and how long it is going to take** **I have a plan in place and the support I need for my dependents** **I'm seen quickly by people with the right skills and receive the earliest possible treatment and care** **I'm taken to the right place as quickly as possible** **My destination has the right information** **My family are supported on arrival.**	Proactive and accessible information and education available and promoted	STK_2_1	Delivery of MECC in particular to those at risk of a stroke
				STK_2_2	Promotional campaigns such as FAST and targeted social media campaigns
				STK_2_3	Education in schools including first aid
				STK_2_4	Local promotion e.g. through involvement of stroke prevention society
			Call handlers and responders give correct and consistent information when possible	STK_2_5	Defined, clear and up to date pathways are in place
				STK_2_6	Shared education and training on stroke pathways for Paramedics, hospital staff, GPs and call handlers so tht taff (call handlers/GP receptionists etc.) are fully trained at recognising the symptoms of a stroke
			At risk and vulnerable people have Urgent Community Support Plans in place	STK_2_7	Work with Community Organisations to explore a model of Urgent Community Support Plans collaboratively developed with partner organisations i.e. advance planning
			Paramedics/HCP provide the right treatment and care	STK_2_8	Dispatched staff trained and skilled in dealing with strokes
				STK_2_9	Effective triage protocols and training in place
			Ambulance Capacity available to respond	STK_2_10	Explore implementation of TWIST scheme - wake up strokes
				STK_2_11	See USC Plan
			HASU model in place in SBUHB in line with the Clinical Services Plan	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
			Effective communication and transfer of information in place between WAST and ED for effective handovers	STK_2_13	Consistent and streamlined systems and processes in place in place
				STK_2_14	Pre alert system from WAST/GP in place
				STK_2_15	Explore implement live transfer of information from ambulance to HASU/ED including patient data
			Information and support is consistently made available to family/carers on arrival	STK_2_16	Explore introducing Stroke passport
				STK_2_17	Explore PALS team utilised to proved information and support
				STK_2_18	Within Resources explore potential for Stroke coordinators CNS in place with communication role at front door
	3 **First 72 Hours**	**I want to be kept informed and for my family /carers to receive the relevant information and be involved in any decisions** **I want any investigations I need completed within 72hours and if not someone will explain why.** **I want a confirmed diagnosis and prognosis and action plan** **I want access to the specialists I need** **I want my (and my family's) emotional needs taken**	Provide information and support to individual and family throughout pathway	STK_3_1	Ensure Visual map of pathways available
				STK_3_2	Implement proactive planning for discharge and transfer
				STK_3_3	Ensure Co-production conversations taking place e.g. ACP/DNACPR
				STK_3_4	Within resources explore the facilitation of nutrition and hydration (swallow test) in ED
			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
			Skilled decision makers immediately available with capacity to deliver care and treatment	STK_3_6	Develop HASU Business Case including workforce requirements
				STK_3_7	Ensure early access to diagnostics
			Seamless care pathways and services	STK_3_8	Breakdown silos of care including through collaborative partnership working with Social Services
				STK_3_9	Agree a minimum service specification
				STK_3_10	Explore the potential to pool resources to support stroke pathways
			Ensure good hospital care	STK_3_11	Reduce harm from inpatient falls
				STK_3_12	Reduce Pressure Ulcers
				STK_3_13	Reduce incidence of HealthCare Aquired Infections

		I want my (and my family's) emotional needs taken care of **I want to know what's available to me if I am well enough to go home and receive the appropriate treatment and support**		Ensuring appropriate staff are available an accessible for patients and family members		STK_3_14	Explore stroke consultants available at weekend and holidays
				Appropriate space available		STK_3_15	Quiet room for end of life conversations/PEG feeding made available within resources
						STK_3_16	Ensure stroke ward areas fit for purpose e.g. pre-empts
				Identifying and supporting mental health issues		STK_3_17	Explore options within resources investment in therapies and third sector services
				Access to timely therapies in place		STK_3_18	Ensure a rehab ethos when in hospital co-produced with patients e.g. day room
						STK_3_19	Explore options within resources for dedicated social workers and therapy teams for stroke across the pathway
				Appropriate discharge process with support		STK_3_20	ESD Service in place
						STK_3_21	Understand morbidity and mortality outcomes from troke to improve stroke outcomes
						STK_3_22	Improve choices and care for patients at end of life
						STK_3_23	Explore options for providing a dedicated person post stroke for information and support
4 **Rehab and Life After Stroke**		**I want to go home as early as appropriate with the right support and information for both me and my family** **I want effective therapy and support to help me to achieve my agreed outcomes as close to home as possible** **I know what I can do to stop this happening again** **I want a dignified End of Life**		Co-production approach to recovery planning		STK_4_1	Use of digital technology in home or community settings e.g. virtual visits
						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 pathways and into social care
						STK_4_6	Stroke specific geriatric workers that can work across teams
						STK_4_7	Early goal planning
						STK_4_8	Clear integrated goal planning with individuals and carers with clear clinical pathways
				Access to equitable therapies and community support on Discharge		STK_4_9	Community stroke services - ease of access
						STK_4_10	Access to specialist support
						STK_4_11	Local areas coordinators / services
						STK_4_12	Ensure access to equipment
						STK_4_13	Access to care homes
						STK_4_14	Pooling of existing teams and resources
						STK_4_15	Protected therapy space/areas on wards from pre-empts and storage
						STK_4_16	Access to psychology support
						STK_4_17	Self management /peer support groups
						STK_4_18	Discharged to assess model
				Ensuring and enabling good end of life services		STK_4_19	Advanced care planning in place
						STK_4_20	Training for staff on End of Life
5 **TIA**		**I want a diagnosis of a TIA and what it is as early as possible** **I want to be kept informed and be given the appropriate information on what happens next.** **I want to get the best treatment, support and advice on how to reduce my risks of this happening again**		Access to seven day TIA clinic/services		STK_5_1	Ensure adequate staff with appropriate skills in place
						STK_5_2	Ensuring timely referrals from GPs - e-referrals
						STK_5_3	Updated primary care pathways enabling fast track to TIA Clinics
						STK_5_4	ensure withing resources that there are adequate clinics/location for services
						STK_5_5	Explore witin resources wrap around clinics to ensure access to radiology clinics and access to pharmacy
						STK_5_6	GP education and Cluster TIA champions, Primary Care lead
						STK_5_7	Undertake capacity and demand modelling
						STK_5_8	Benchmarking of seven day working service, acute stroke rota, nurse prescribers/consultant led TIA clinics
				Access to information and support and services to support health and wellbeing		STK_5_9	Ensure signposting to stroke association
						STK_5_10	Ensure links with pharmacies, ACT, GPS
						STK_5_11	Ensure access to helplines and third sector
						STK_5_12	Explore within resources developing a one contact point for TIA
6 **Research**		**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

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Planned Care System	1 Helping people choose and live well	**I don't smoke** **I'm given every opportunity to eat well** **I'm given every opportunity to exercise regularly** **I am protected against flu** **I consume alcohol responsibly** **I understand so I make good decisions** **I have access to support and advice and information**	Target Prevention Priorities	PLAN_1_1	Actively promote to all staff and patients at higher risk from influenza
				PLAN_1_2	Adopt a tobacco control approach to smokefree health board premises
				PLAN_1_3	Training staff to deliver very brief interventions to begin to tackle unhealthy behaviours – expanding the MECC approach
				PLAN_1_4	Adopting approaches that develop health literacy
				PLAN_1_5	Taking action aimed at obesity
			Develop Community resilience and Wellbeing	PLAN_1_6	Implement the Neighbourhood Model
				PLAN_1_7	Establish Wellness Centres
	2 Timely access to the most appproriate clinical practitioner to manage the presenting condition	**I know where to go to discuss my condition** **I am able to see the right person quickly at a time and place that's convenient to me** **I am given the information I need to make a personal decision about my care and intentded outcome** **I am quickly referred to the most appropriate healthcare professional to address my condition** **I am kept informed about my progress on my clinical pathway** **I will be discharged in a timely manner with a clear understanding of the ongoing support and treatment in place**	Up to date, accessible and easily understandable signposting and patient's health and care information is available to enable people to stay well at home	PLAN_2_1	Implement solutions inlcuding digital 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 •information on my condition and how to maintain wellbeing •information on triggers for seeking additional care or treatment
			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 proivdes 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
				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
				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 amneded accordingly
	3 Timely access to modern diagnostic services	**I am informed as to why a diagnostic test is being undertaken** **I receive the diagnostic test in the most appropriate timescale for my condition** **I receive only the test required to provide my diagnosis** **I am informed quickly about the outcome of diagnostic test in a compassionate way by the right person** **I have the next stage of the pathway explained to me and I am progressed on to that next stage quickly**	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)
				PLAN_3_2	Explore within resources increased direct access to diagnostics
				PLAN_3_3	Undertake demand and capacity modelling of idagnostic services aross clinical pathways to ensure services are sustainably "right-sized"
			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
			Timely and efficient referrals to treatment	PLAN_4_1	E-referral route to all healthcare practitioners in a fully integrated way
			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
				PLAN_4_3	Explore digital solution for optimising booking of patient into available capacity
				PLAN_4_4	Improve surgical outcomes
				PLAN_4_5	Reduce harm from inpatient falls
				PLAN_4_6	Reduce Pressure Ulcers

4 Timely access to sustainable treatment appropriate to the presenting condition and the most appropriate clinical practitioner to manage ongoing requirements		**I receive my treatment in a timely manner without cancellation or rescheduling** **I understand and I am supported to prepare myself for my treatment to optimise the outcome and my recovery** **I receive my treatment in a facility appropriate to its clinical requirements** **I receive my treatment from the most appropriate healthcare professional** **My treatment will be evidence based, will reflect my personal choice (where possible) and will facilitate the quickest possible recovery time** **My ongoing treatment and support is delivered by the right person quickly at a time and place (where clinically appropriate) that's convenient to me**		Ensure good and timely hospital care and treatment		PLAN_4_7	Reduce incidence of HealthCare Aquired Infections
						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"
						PLAN_4_9	Implement BADS 50 and improve day case rates to achieve Clinical Servces Plan Scenario C efficiency (95th percentile performance)
						PLAN_4_10	Ensure compliance with INNU policy
						PLAN_4_11	Revisit principles of ERAS
						PLAN_4_12	Implement actions to delivery CSP scenario C theatre efficiencies - aiming for 90% theatre efficiency on all sites
						PLAN_4_13	Implement actions to deliver CSP scenario C LoS for surgical specialties
						PLAN_4_14	Implement actions to deliver CSP scenario C efficiencies - admission on day of surgery for 95% of cases
						PLAN_4_15	Maximise the efficiency of surgical services and improve patient experience by implementing a new sustainable surgical model in line with the Clinical Services Plan
				Deliver NHS Wales Delivery Measures		PLAN_4_16	Deliver the NHS Wales Delivery Measures for Planned Care including 36-week waits for all specialties by end March 2021
				Deliver the National Planned Care Programme Priorities		PLAN_4_17	Implement actions to deliver the national planned care programme for Opthalmology
						PLAN_4_18	Implement actions to deliver the national planned care programme for Orthopaedics
						PLAN_4_19	Implement actions to deliver the national planned care programme for ENT
						PLAN_4_20	Implement actions to deliver the national planned care programme for Urology
						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.
						PLAN_4_23	Remove follow up appointments as a default
						PLAN_4_24	Implement patient generated recall arrangements
						PLAN_4_25	
						PLAN_4_26	Continue outpatient list validation
						PLAN_4_27	Roll out PROMS to prioritiy specialities
5 Timely access support to manage the ongoing requirements of the presenting condition		**I am given the information I need to mange my ongoing health and wellbeing needs to maximise the clinical outcome I have previously agreed** **I have flexible access to advice when I need it in a range of outputs**		Service shifts away from traditional follow up care into other settings and via other means		PLAN_5_1	Examples could include •telemed •SOS •email and phone advice •rapid access clinics

SYSTEM	PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	REF	ACTION
Mentla Health and LD System	1 Mental Wellbeing	**I feel connected to my community and am not isolated.** **I recognise and understand how to maintain my mental wellbeing** **I know how and can easily access information, support and advice in relation to my and my families' mental wellbeing**	My Neighbourhood approach	MHLD_1_1	Implement actions for delivery of Nieghbourhood approach as per the Neighbourhood approach implementation plan
				MHLD_1_2	Support the Cluster transofrmation actions around social prescribing as per the CSP
	2 Learning Disabilities	**I can easily find and understand information about the support and help that is on offer.** **I am able to stay healthy and to feel good.** **I receive the support I need to do the things that are important to me and to have the chance to work or volunteer.** **I get the support I need to help me build safe and healthy relationships in my community.** **When things are not so good I get increased support quickly until I am able to cope once again.** **I get help so I can live in my own home and to be as independent as possible.** **I receive support to make sure I am listened to and with my family**	Addressing health inequalities	MHLD_2_1	Joint approach across Cardiff and Vale, Cwm Taf Morgannwg & Swansea Bay Health Baords for delivering acute hospital liaison services
				MHLD_2_2	Consolidation of specialist pathways including Dementia, epilepsy & autism
			Modernising specialist learning disability services	MHLD_2_3	Redesign of Integrated Community Learning Disability Teams
				MHLD_2_4	Development of 7 day Learning Disability Intensive Support teams across all 3 Health Board areas
				MHLD_2_5	Development of multiagency tertiary support for childrens services using PBS to support transition (Facing the Challenge)
				MHLD_2_6	Redesign of specialist inpatient services
				MHLD_2_7	Commissioning Framework for 3 health boards as per the CSP
	3 Community Mental Health	**I am supported and directed to the services and care I need if I'm concerned about my or my fmailies mental health and wellbeing** **I receive the assessment and care I need in a timely and accessible way** **I reveive appropriate ongoing care for the duration needed that supports me to be as independent as possible (including after an urgent or acute episode)** **If my condition worsens I am able to access the care and support I need in a timely way** **I only have to tell my story once**	Development of Community Mental Health Team services	MHLD_3_1	Review of Community Mental Health Team role and function
				MHLD_3_2	Further development of EIP services for young people
				MHLD_3_3	Development of cluster based Primary Mental Health care
			Improving access quality and range of psychological therapies	MHLD_3_4	Redesign of stepped model of care
				MHLD_3_5	Monitoring of 26 week access target for high intensity psychological therapies
			Addressing health inequalities	MHLD_3_6	Development of physical health monitoring strategy for serious mental illness
			Developing OPMH community facilities as per the CSP	MHLD_3_7	Consolidation of community teams and day hospital service in Swansea
	4 Urgent Response and Acute Care	**I receive the timely and appropriate assessment and care I need for my circumstances** **I only have to tell my story once** **I, my family and carers are kept safe and I am treated with dignity and respect** **I receive care in the most appropriate setting only for the time necessary** **Me and the people who are important to me are kept informed, are supported and are involved in decisions about my care and support**	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
			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
			Delivery of alternatives to hospital admission	MHLD_4_3	Commisisoning of Mental Health Sanctuary service as per the CSP
				MHLD_4_4	Expansion of Acute hospital acute liaison service
				MHLD_4_5	Review of operation of Care Home minreach servcies for Older people
	5 Specialist Rehabilition	**I receive the ongoing support and care I need in a way that enables me to be as independent as possible** **I receive support that is least restrictive to maintain my and other people's safety.** **Me and the people who are important to me are kept informed, are supported and are involved in decisions about my care and support** **I am treated with diginity and respect**	Effective management of Continuing Health care	MHLD_5_1	Expansion of CHC commissioning team as per the CSP
			Development of Gender sensitive services	MHLD_5_2	Scoping of demand and introduction of women's low secure service
				MHLD_5_3	Development of women's pathway for recovery

	6 Dementia		**I am aware of the symptons of dementia** **I receive a timely assessment and diagnosis** **I only have to tell my story once** **I receive the care and support I need to minimise the imapct of my conditions** **If my condition worsens I am able to access the care and support I need in a timely way** **If I need ongoing intensive care I receive this in a timely way, and I have suitable living accommodation tht suits my needs** **Me and the people who are important to me are kept informed. are supported and are involved in decisions about my care and support** **I am treated with diginity and respect**		Remodelling Older People's Mental Health inpatient services		MHLD_6_1	Removal of spare capacity within a remodelled community service.
					Integrated OPMH pathway and implementation of the Dementia Framework as per the CSP		MHLD_6_2	Integrated pathway including memory assessment pathway across priomary and secondary care.
	7 Perinatal Mental Health		**I and my family know how to recognise the issues related to perniatal mental health** **I know how and can easily access information, support and advice in relation to my and my families' mental wellbeing** **I am supported and direceted to the services and care I need** **I only have to tell my story once** **I receive the assessment and care I need in a timely and accessible way** **I am provided care and support that keeps my family together** **I and my family reveive appropriate ongoing care for the duration needed**		Delivery of mental health mother and baby unit		MHLD_7_1	Completion of business cases for capital development
							MHLD_7_2	Development of Perinatal Mental health Network

SYSTEM	PATHWAY COMPONENT	PATIENT EXPERIENCE	SCHEME	Ref
Children's System	**1. Early Years**	**My parents are healthy and make positive healthy behavioural choices** **My mother makes healthy choices during pregnancy** **My family is supported and given the right information after birth to make good choices for my health**		CHI_1_1
			Encouraging/ empowering families to be more aware of Public Health issues : Reduce low weight birth through inclu and reduce complications within pregnancy and ante/postnatal for the mother due to health promotion messages in relation to cessation of smoking, not drinking alcohol, keeping to a healthy weight and having the recommended vaccinations.	CHI_1_3
				CHI_1_4
				CHI_1_5
				CHI_1_6
				CHI_1_7
				CHI_1_8
			Babies are born healthy and childbirth is a safe and positive experience for women in the SBUHB	CHI_1_9
			Increased uptake in the percentage of babies' breastfed at birth and six weeks and 6 months	CHI_1_10
				CHI_1_11
	2. Early Intervention and Prevention	**My mother and I receive fast, effective and safe neonatal care if need** **My family get the information and support they need to provide me with a healthy and happy start to life** **I have opportunities to reach my full potential** **My family and I have access to support and opportunities for fun , play and development** **I have a start to life free of adverse childhood experiences**	Implementing the Neonatal Transitional Care Unit	CHI_2_1
			Ensuring appropriate capacity of critical care across the region	CHI_2_2
			Ensuring appropriate skilled workforce requirements to deliver critical care	CHI_2_3
			Centralise high risk obstetric and neonatal care co-located with appropriate support services.	CHI_2_4
				CHI_2_5
			Empowering parents/carers to maximize their skills as we aim to give their children the best start. This will include working in partnership with local authority to support families with employment and housing issues.	CHI_2_6
				CHI_2_7
				CHI_2_8
			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_9
				CHI_2_10
				CHI_2_11
			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
				CHI_2_13
				CHI_2_14
				CHI_2_15
				CHI_2_16
				CHI_2_17
	3. Safety, Wellbeing and the Health of school aged children and Young People		To work in partnership with the LEA and schools to support learners with additional learning needs from 0-25 years	CHI_3_1
			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
				CHI_3_3
				CHI_3_4
				CHI_3_5
			Support healthy behaviours and choices.	CHI_3_6
				CHI_3_7
	4. Keeping Children and Young People Safe	**I have the right to be kept safe from abuse, neglect and other forms of harm** **If I ever need, I know where to go to get help if I am exposed to any form of abuse or harm** **I'm made safe and taken to a place of safety if required.**	We will work in partnership with other agencies to safeguard children and young people	CHI_4_1
				CHI_4_2
			Ensuring safe and competent workforce to regsonise and deal with children exposed to any form of abuse	CHI_4_3
			Support and implement the SARC regional Plan	CHI_4_4
				CHI_4_5
				CHI_4_6
			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_7
			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
				CHI_4_9
	5. Children and Young People with Complex Conditions	**Early identification and assessment** **Receive the right, timely care in the most appropriate setting** **Effective and safe transition of care to adult services** **Appropriate end of life care as appropriate** **My family is supported and given the information and opportunities for respite they need.**	MDT approach in place to identify complex needs	CHI_5_1
			Ensure safe timely and effective care is in place	CHI_5_2
				CHI_5_3
				CHI_5_4
				CHI_5_5
				CHI_5_6
				CHI_5_7
	6. Emotional Health and Wellbeing	**I will have access to appropriate skilled professional to support my health and wellbeing**	Ensure effective local service for children and young people with Neurodevelopmental conditions	CHI_6_1
				CHI_6_2
				CHI_6_3
			Ensure effective local primary CAMHS services in place	CHI_6_4
				CHI_6_5
				CHI_6_6
	7. Timely care and treatment for children and young people who are acutely unwell	**My family/carer has the information and advice necessary to care or me when I'm ill and if necessary am taken to the right place in a timely manner** **I'm seen by the right person on arrival** **If necessary I'm admitted to the right inpatient facility where I receive safe and effective care** **My family is supported throughout my admission and able to stay with me where appropriate** **I'm discharged with the right support and advice to the right place in a timely manner**	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
				CHI_7_2
				CHI_7_3
			WAST service trained and skilled to manage paediatric emergencies	CHI_7_4
			Development and implementation of the Single Point of Access for Paeds	CHI_7_5
				CHI_7_6
				CHI_7_7
				CHI_7_8

ACTION	Delivery Unit/Dept Lead	
Public Health campaigns	Primary Care Health Visiting	Paula Davies
MECC - Midwives and health visitors	SDU Maternity & PCC Health Visiting	Paula Davies/Sue Jose
Alcohol substance misuse services	Primary Care/Mental Health	Comm Drug & Alcohol Team?
Smoking cessation services - Help me Quit Programme	Primary Care	
Healthy eating/Physical activity (NERS)	Primary Care	
Vaccination programme	Public Health (SIG & CHIG)	
Robust Sexual Health services	Primary Care	Karen Gronert
Robust Maternity Services	SDU Midwifery	Susan Jose
Breastfeeding Coordinators delivering direct support -Infant Feeding Coordinators supporting Baby Friendly standards. Monitor compliance with All Wales Breastfeeding Strategy - 5 year Action plan	SDU Maternity & Neonates	Susan Jose/Sam Williams
Midwives delivering training and support through antenatal classes	SDU Maternity	Susan Jose
Complete build	SDU Neonates	Sam Williams
Implement recommendations of SW Plan - Insert Cot capacity here 8 IC, 9 HD, 13 SC	SDU Neonates	Sam Williams
Staffing to meet BAPM Standards	SDU Neonates	Sam Williams
Develop the 10 year plan for centralisation of services in Morriston	SDU Neonates and Surgery	Sam Williams/Jo Williams/ARCH
Reduce the percentage of young people who smoke and drink alcohol by participating in the HBSC survey.	Public health?	
Implement Family integrated care increasing breast feeding rates for babies discharged from neonatal unit	SDU Neonates	Sam Williams
Identifying and addressing needs at an early stage can help to prevent the difficulties that they can experience from arising.	Primary Care & Public Health/PSB's	School Nursing & Health visiting
Promotion of healthy eating and increasing physical activity for children and young people to encourage a healthy weight and reduce obesity.	Primary Care & Public Health/PSB's	School Nursing & Health visiting
Early identification of speech, language & communication development and any other developmental delays	Therapies/ALN Act	Alison Clarke
Access to services at a universal and targeted level	Health Visiting	Paula Davies
Family Resilience Assessment Instrument Tool	Health Visiting	Paula davies
Perinatal Mental Health Services	SDU Maternity & PCC Health Visiting & Mental Health	Susan Jose/Paula Davies/Janet Williams
Domestic Abuse identification and support	Safeguarding Team	Nicola Edwards
Monitoring of child's growth and development - Childhood Measurement Programme	PCC School nursing	Susan Jones
Development of Wellness Centres	All	
Implement recommendations of School Nursing Framework	Childrens Service Group	HON
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).	SDU/Childrens Services	Head of Nursing
Establish the role of Designated Educational Clinical Lead Officer (DECLO) as required by the ALN Act	ALN Steering Group	Alison Clarke
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.	PSC School Nursing	Susan Jones
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.	PSC School Nursing	Susan Jones
Implement the Healthy Child Wales programme inc Phase 2 when required	PSC School Nursing	Susan Jones
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.	WG RPB	Joanne Abbott Davies
Behaviour training on a multi professional basis. This would include agencies such as police and youth offending teams	WG RPB	Joanne Abbott Davies
Engagement with the Prevent programme to raise awareness of the risk of radicalisation	WG RPB	Joanne Abbott Davies
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	Safeguarding Team	Nicola Edwards
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 substance misuse.	Safeguarding Team	Nicola Edwards
Ensure advocacy service available and actively offered for children	Strategy	Joanne Abbott Davies
Implement sustainable community paediatric workforce including filling consultant vacancies and review of nursing roles	SDU/Childrens	Sam Williams
Implement national revised SARC model	SDU/Childrens	Sam Williams
Identify and develop appropriate site for SARC service	SDU/Childrens	Sam Williams
Need an action	Safeguarding Team	Nicola Edwards
We will ensure that arrangements are in place to meet the statutory requirements for Looked After Children (LAC).	PSC School Nursing	Susan Jones
Ensure Implement risk assessments for young people admitted to adult services	SDU Childrens	HON
Joint working with LA to review arrangements for children and young people with complex conditions	SDU/Childrens Services	HON/Joanne Abbott Davies?
Review of specialist nursing and therapy posts	SDU/Childrens Services	HON
Advance care planning to ensure that families receive the support and care they need in a timely manner. This will include fast track continuing care packages.	SDU/Childrens Services	HON
Psychological and counselling support for both the child and the family.	SDU/Childrens Services	HON
Develop jointly funded posts with partner agencies and ensure appropriate evaluation.	SDU/Childrens Services	HON
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.	SDU/Childrens Services	HON
Bereavement support for the family during and following the child's death.	SDU/Childrens Services	HON
Appropriately resource the Neurodevelopmental Service	SDU/Childrens	Sam Williams
Implement the all wales referral pathway and support the all Wales ND Steering Group	SDU/Childrens	Sam Williams
Identify funding streams to increase post diagnostic support for families	SDU/Childrens	Sam Williams
Develop Paediatric Pyschology Service	SDU/Childrens	Sam Williams
Improve accessibility to CAMHS and specialist advice and support	Corporate Strategy	
Developing sustainable and accessible universal services to support children and young people with emotional health and wellbeing	Corporate Strategy	
Review opportunities with 111 to support emergency pathway for CYP	SDU/Childrens	Sam Williams
Develop email advice line to support GP's and primary care	SDU/Childrens	Sam Williams
Implement single point of acess for CYP seeking emergency care at Morriston (inc work with WAST/Primary Care/workforce review and design)	SDU/Childrens	Sam Williams
Improve ED environment and ward in the medium term	SDU/Childrens	Sam Williams
Workforce plan to ensure sustainability of acute paediatric on call rotas at Morriston	SDU/Childrens	Sam Williams
Develop specialist nurse input/workforce to improve support to families and CYP	SDU/Childrens	Sam Williams
Ensure sustainability of Paediatric Radiology	Morriston DU	
Ensure sustainability of ROP Screening	SDU/Surgery	Adel Davies

National Wellbeing Goals

Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7
A Prosperous Wales	A Resilient Wales	A Healthier Wales	A More Equal Wales	A Wales of Cohesive Communities	A Wales of Vibrant Culture and Thriving Welsh Language	A Globally Responsive Wales

☐ Primary Contribution ● Opportunities between the objective and the goal

			Local Wellbeing Objectives			National Wellbeing Goals						
			1	2	3	1	2	3	4	5	6	7
Aim 1: **Support better health and well-being by actively promoting and empowering people to live well in resilient communities**	1	Partnerships for improving Health and Wellbeing	☐	☐	☐	●	☐	☐	☐	☐	☐	☐
	2	Co-production and Health Literacy	☐	☐	☐	●	☐	☐	☐	☐	●	●
	3	Digitally Enabled Health and Wellbeing	☐	☐	☐	☐	☐	☐	☐	●	●	☐
Aim 2: **Deliver better care through health and care services achieving outcomes that matter most to people**	4	Best Value Outcomes from High Quality Care	☐	☐	☐	●	●	☐	☐	●	●	●
	5	Partnerships fro Care	☐	☐	☐	●	☐	☐	☐	●	●	☐
	6	Excellent Staff	☐	☐	☐	☐	☐	☐	●	●	☐	●
	7	Digitally Enabled Care	☐	☐	☐	☐	☐	☐	☐	●	●	●
	8	Outstanding Research, Innovation, Education and Learning	☐	☐	☐	☐	☐	☐	☐	●	☐	☐

Local Wellbeing Objectives

Wellbeing Objective 1	Wellbeing Objective 2	Wellbeing Objective 3
Giving every child the best start in life	Connecting communities with services and facilities	Maintaining health, independence and resilience of individuals, communities and families